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A Productive Paradox

*A mixed methods study examining the Clinical
Academic model within the University of Waikato
nursing programmes*

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Abstract

Background: The nursing workforce, both globally and nationally, faces significant challenges that impact nursing education and professional development, highlighting the need for innovative approaches to support workforce development. The Clinical Academic role is one such response, a position in which nurses engage concurrently across both clinical and academic settings to integrate research and evidence into clinical practice. In 2020, the University of Waikato nursing programme adopted a Clinical Academic model, utilising advanced-level registered nurses to bridge education and practice and to strengthen partnerships with clinical partners. This study explores Clinical Academics' experiences, the roles impact on student learning and how the model has met its intended outcomes.

Methods: A mixed methods convergent parallel design with a qualitative dominant focus was used. Semi-structured interviews with eight Clinical Academic staff were analysed thematically, and an online survey of pre-registration nursing students provided descriptive quantitative data on perceptions of Clinical Academics during clinical placements. Findings were integrated to provide a comprehensive understanding of the role.

Results: Eight Clinical Academics (Designated Senior Nurse, n=6; Registered Nurse, n=2) participated in interviews, and 48 surveys were returned by students across the Bachelor of Nursing (n=33) and Master of Nursing Practice (n=15) programmes (19.7% response rate). Qualitative data revealed four themes: clarity and complexity, enhancing learning and practice, collaboration and connection and systemic pressures. Quantitative survey data showed no statistically significant associations.

Conclusion: The Clinical Academic role is highly valued, with collaboration and connection strongly represented across academic and clinical contexts. Challenges related to role ambiguity, structural tensions and sustainability were evident. While joint appointments offer substantial benefits, their effectiveness depends on clear role definition, supportive structures, resource allocation and alignment between academic and clinical expectations.

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Contribution

I, the researcher undertook all aspects of this study under the direct guidance of my supervisors. This entailed selecting the appropriate research design, the data collection and analysis, and the publishing of the findings in this thesis.

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Chapter I: Introduction

The important thing is not to stop questioning. Curiosity has its own reason for existing.

Albert Einstein

Clinical Academic roles within nursing play a pivotal part in bridging the gap between theory and practice by integrating clinical expertise, research and education to enhance patient care and professional development (Henshall et al., 2020). In the context of education, joint appointments that bridge academic and clinical environments allow nurses to support students to apply theoretical knowledge in real-world practice and to engage with evidence-based practice through teaching and supervision (Fowler et al., 2008). In 2020, the University of Waikato adopted a Clinical Academic model to support the development and delivery of a newly established nursing programme. This model was introduced to embed expert clinical knowledge, support student learning, and build a collaborative partnership between the clinical and academic domains that benefits the wider health system (University of Waikato & Waikato District Health Board, n.d.).

As a newly established programme, the early experiences of Clinical Academics provide an important opportunity to explore how the role is enacted in practice, the challenges encountered, and the factors that shape its implementation into nursing education. Understanding these experiences is particularly relevant given the evolving demands placed on nursing education within the current health context.

While the value of Clinical Academics is recognised internationally, existing literature highlights that the role is often complex, variably defined and may be associated with role ambiguity and competing demands across dual organisations (Pfister et al., 2021). These tensions may affect role clarity, sustainability and professional identity. Despite this recognition, there remains limited empirical insight into how Clinical Academic roles are experienced, particularly in relation to education.

To address this gap, this study employed a mixed method design to examine the Clinical Academic model within the University of Waikato's nursing programme. The

research combined interviews with Clinical Academics, with surveys of students enrolled in two pre-registration programmes, the Bachelor of Nursing or the Master of Nursing Practice. By integrating these perspectives, the study explored how the role is experienced in practice and how Clinical Academics navigate a dual presence in academic and clinical environments. The principal finding, that the Clinical Academic model represents a paradox of collaboration and connection, provides an evidence-based foundation to support ongoing programme development, enhance student learning experiences and strengthen partnerships between clinical and academic organisations to enhance patient care.

This chapter provides a contextual foundation for understanding the current nursing landscape and the factors that have influenced the development of Clinical Academic roles within nursing, and in particular, nursing education.

1.2 Background

Internationally, nursing practice is shaped by workload pressures, increasing population health needs, and the need for evidence-informed care, prompting the development of innovative models that better integrate clinical practice, education, and research.

In New Zealand, these global challenges are experienced alongside additional local contexts, such as culturally safe care that is responsive to Te Tiriti o Waitangi and geographical limitations. These have guided the development of new approaches to education, such as the University of Waikato nursing programme. In line with these factors, this chapter explores the role of the Clinical Academic within the nursing context, providing a foundation for understanding its relevance to nursing education.

1.2.1 Global Nursing Pressures

The international nursing workforce is facing increasing pressure as health systems experience workforce shortages, higher patient acuity, and complex care demands (World Health Organisation, 2025). While the overall number of nurses has increased, significant inequities exist regarding the availability and distribution of the workforce.

Low and middle-income countries continue to struggle with training, employing and retaining nurses, while high-income countries face an ageing workforce and a growing reliance on internationally recruited nurses to fill gaps (World Health Organisation, 2025). These disparities create significant challenges in achieving an equitable and sustainable nursing workforce.

The International Council of Nurses' (ICN) document *Our Nurses, Our Future 2025* survey highlights that many nurses are at breaking point, reporting increasing physical, mental, and emotional pressures exacerbated by poor working conditions, exposure to workplace violence, and inadequate organisational support (ICN, 2025). In many countries, nurses also experience insufficient pay recognition and challenges in career progression, which contribute to difficulties retaining staff and providing a high-quality, sustainable workforce (ICN, 2025). The World Health Organisation (2025) highlights that organisational responses to these pressures are limited, with only 42% of countries providing structured mental health and wellbeing support for nurses.

At the same time, changes in population demographics and health needs are compounding these pressures. Populations are ageing, and the prevalence of chronic disease and multimorbidity is rising, increasing the complexity of patient care. OECD Patient-Reported Indicator Survey data indicate that 82% of primary care users aged 45 years and over report at least one chronic condition and 52% report two or more (OECD, 2025). These population trends require higher-level clinical reasoning, advanced evidence-based practice, and time-intensive care, all of which are difficult to provide when staffing and resources are limited (WHO, 2025). While many countries are investing in advanced nursing practice roles and leadership development to meet these needs, inequitable access to education and professional development continues to create barriers (WHO, 2025).

Many of these systemic pressures extend into nursing education and the development of the future nursing workforce. Clinical environments are increasingly limited in their capacity to support clinical placements, as staffing shortages and increased clinical demands reduce time available for supervision and teaching. Understaffing in clinical learning environments has been shown to reduce the quality of supervision and mentoring available to nursing students, often leaving them feeling vulnerable (Oshodi

& Sookhoo, 2025). Similarly, studies in resource-limited clinical settings highlight that limited staff and other resources are associated with fragmented integration of theory and practice, with students often being used to cover workforce shortages rather than supported in learning (Mafumo & Maputle, 2025). Student nurses have been shown to experience high levels of stress and psychological burnout (Solomon et al., 2025), contributing to rising attrition from nursing programmes, with rates ranging from 10% to 30% across countries and programmes (Sheikoleslami et al., 2025).

These pressures also extend to nursing faculty, with many countries struggling to recruit and retain educators with both academic qualifications and adequate clinical experience (WHO, 2025). Other aspects of education are also noted to create barriers to ensuring a sustainable pipeline of future nurses, with limited clinical training sites, infrastructure constraints and insufficient investment in education, all of which restrict the ability of education providers to expand enrolments and prepare graduates for increasingly complex practice environments (WHO, 2025).

Taken together, these pressures indicate that the current global nursing context has significant implications for both the current and future nursing workforce. Addressing these challenges requires intentional investment in workforce wellbeing, education capacity, and supportive practice environments to ensure the sustainability and resilience of the global nursing workforce.

1.2.2 The New Zealand Context

The nursing workforce in New Zealand reflects many of the same challenges observed globally, including sustained workforce shortages, as well as distinctive demographic, geographic, and equity-related factors. These challenges have implications not just for health service delivery and the workforce, but also for nursing education and the development of a fit-for-purpose nursing pipeline (Nursing Council of New Zealand, 2025; Te Whatu Ora – Health New Zealand, 2023).

Nursing shortages in New Zealand remain a concern, with an estimated shortfall of approximately 6.8% of the workforce required to meet population needs (New Zealand Nurses Organisation, 2025). In response, the New Zealand health system has

become increasingly reliant on internationally qualified nurses (IQNs). This reliance has increased significantly over recent years, from 29% of nursing registrations in 2019 to 46.6% in 2025 (Nursing Council of New Zealand, 2025). While IQN's are an essential part of the workforce, reliance on this group presents significant challenges in both responding to population need and creating a sustainable workforce, with reports indicating that approximately 71% of IQNs remain in New Zealand for fewer than three years (Health New Zealand Te Whatu Ora, 2025).

This reliance on IQNs also exacerbates persistent inequities in Māori and Pacific representation within the nursing workforce. Māori and Pacific nurses remain underrepresented, making up approximately 7% and 4% of the workforce, respectively (Nursing Council of New Zealand, 2024). This underrepresentation has significant implications for culturally safe practice, workforce equity and the health system's ability to meet its obligations to Māori under Te Tiriti o Waitangi, as well as to address inequities in health outcomes experienced by Māori and Pacific communities.

Rural workforce shortages further compound these challenges. While between 13.3% and 19% of New Zealanders live in rural areas, only approximately 4% of nurses report working in rural settings (Hendry, 2024). This imbalance reduces access to healthcare services for the rural population and increases pressure on already-constrained rural health services.

Workforce pressures have also increased in recent years as clinical services face growing demand and operational strain. Data from the New Zealand Nurses Organisation (NZNO) indicate that public hospitals were short hundreds of nurses per shift over the 2022-2024 period, highlighting persistent gaps between staffing levels and patient demand (NZNO, 2024). These gaps have been linked to increasing workloads and professional attrition, including burnout and nurse emigration, adding further pressure on those remaining in practice (Nursing Council of New Zealand, 2025; Toma et al., 2025). These conditions have contributed to sustained industrial action and ongoing debate about working conditions and workforce capacity (Inside Government NZ, 2025), providing important context for understanding the pressures experienced in clinical environments and their potential impact.

The impact of these pressures is particularly evident within clinical education settings. Nursing students are frequently placed in environments characterised by staffing shortages, high patient acuity and competing clinical priorities. As a result, preceptors and senior nurses often have limited capacity to provide supervision and support. These conditions can significantly affect learning experiences, professional socialisation, and students' preparedness for transition to practice (New Zealand Nurses Organisation, 2023).

These challenges occur alongside persistently high rates of nursing student attrition. Nationally, approximately 30% of nursing students do not complete their programmes, with attrition rates disproportionately higher among Māori and Pacific students (Health New Zealand Te Whatu Ora, 2025). Despite this, government policy continues to prioritise expanding nursing student clinical placement capacity to address workforce shortages (Verrall, 2023). While well-intended, this approach does not address the challenges in the clinical context and places additional pressure on clinical placements and supervision within an already constrained system, raising concerns about the quality of nursing education.

Together, these factors highlight the complex and interrelated challenges facing nursing in New Zealand. Workforce pressures converge with the clinical learning environment, shaping the experiences of nursing students and newly qualified nurses. Understanding how students navigate and are supported within this context is therefore essential to strengthening both nursing education and workforce sustainability.

1.2.3 Te Whare Wananga o Waikato – The University of Waikato Nursing Programme

In response to these national and regional challenges, the University of Waikato established a new School of Nursing in 2020, aiming to develop a fit-for-purpose nursing programme designed to prepare a clinically capable and culturally responsive workforce for both New Zealand and the Midland region (University of Waikato, 2022). From its inception, the programme placed a strong emphasis on equity for

Māori and Pacific health, alongside an intentional focus on mental health and rural and community health contexts (University of Waikato, n.d.).

Since its establishment, the programme has experienced significant and sustained growth in student enrolments, from an initial cohort in 2021 of 50 Bachelor of Nursing students to 200 new first-year enrolments in 2026 across the Bachelor of Nursing and Master of Nursing Practice programmes (J. Barlow-Armstrong, personal communication, February 9, 2026). The programme's growth is presented in Table 1.

Table 1: *Nursing Programme Year 1 Enrolment Figures*

	Bachelor of Nursing Year 1	Masters of Nursing Practice Year 1	Total No.
2021	50	0	50
2022	80	25	105
2023	140	75	215
2024	131	67	198
2025	128	51	179
2026	150	50	200

The programmes were developed in close collaboration with regional clinical partners, reflecting a commitment to meeting the needs of both the workforce and population. Distinct from more traditional models of nursing education, the programme adopts an integrated approach to learning and assessment that promotes coherence between theory and practice. Mental health and well-being are embedded across the programme rather than siloed, reinforcing their centrality to nursing practice in Aotearoa (Cameron et al., 2023).

Bicultural values, underpinned by Te Tiriti o Waitangi, are foundational to the programme. These principles inform curriculum design, teaching approaches, and student support to ensure culturally responsive education (University of Waikato, n.d.).

Central to this is whakawhanaungatanga¹, which emphasises the development of meaningful relationships, trust and connection among students, educators, clinical partners and communities. This relational focus not only supports students to engage authentically with diverse communities but also places student hauora² at the centre of learning, supporting well-being, resilience, and the development of both cultural and professional identity. These values are operationalised through the Integrated Assessment Framework, which draws on the meihana model and hui process to support holistic, culturally responsive nursing practice grounded in trust, partnership, and relational engagement (Cameron et al., 2023).

Clinical learning is a core feature of the programme and occurs across a range of health care settings within the Midland region, including rural, primary and community contexts. Experiential learning is emphasised as central to nursing education, supporting students in integrating theory with practice and developing an understanding of current and emerging health issues in New Zealand, including inequities in health outcomes.

To strengthen academic-clinical integration, the University of Waikato implemented a Clinical Academic joint appointment model (University of Waikato & Waikato District Health Board, n.d.). This model utilises clinically active, advanced-level registered nurses to educate, mentor, and support students across academic and clinical environments, whilst maintaining their own clinical practice and development. The model seeks to ensure positive clinical learning experiences for students, promote engagement and mutual respect between organisations, and support Clinical Academics in furthering their own professional development while maintaining high levels of role satisfaction (University of Waikato & Waikato District Health Board,

¹ Whakawhanaungatanga – process of establishing relationships, relating well to others (Te Aka Maori Dictionary, n.d.)

² Hauora – Defined by Te Aka Maori Dictionary (n.d.) as health, vigour. However within this thesis hauora encompasses a wider understanding of health incorporating physical, social, mental and spiritual wellbeing.

n.d.). The model aimed to achieve several key outcomes listed below, however this research will look at outcomes 3, 5 and 7.

1. Clinical Academics will be recruited across acute and primary care within each of the seven localities (Diversity and Equity)
2. The ethnicity of Clinical Academics reflects population health needs of Waikato
3. Clinical Academics will enable undergraduate and postgraduate University of Waikato nursing students to have a positive clinical experience (Integration of Theory and Practice)
4. Clinical Academics to facilitate a positive and productive learning experience within their own locality (Future Orientated)
5. Clinical Academics to report high satisfaction in the role and express a desire to continue in the partnership (Partnership)
6. Organisations responsible for the Clinical Academic feel engaged, respected and supported in the partnership (Mutual Respect)
7. Clinical Academics are able to utilise the partnership to further their own clinical practice and improve the health of those clients /tangata whaiora under their care (Our People)

1.3 Definition of Terms

It is important to define the key terms used throughout the study. The term ‘Clinical Academic’ refers to a dedicated role in which a health professional combines clinical practice with academic responsibilities, such as research, teaching and the development of evidence-based practice (Newington et al., 2022). While the role is increasingly recognised, its definition remains ambiguous, with variation in how it is interpreted and implemented across different settings (Carrick-Sen et al., 2019). This ambiguity will be explored further in the literature review. ‘Joint appointment’ (Fowler et al., 2008) describes a collaborative arrangement in which an employment is negotiated between two or more organisations, with the purpose of sharing expertise, time and

resources. In this study, these terms are closely linked, as joint appointments are a primary mechanism for operationalising Clinical Academic roles, and the literature includes many studies examining the wider joint appointment model. As such, the term 'Joint appointment' may be used as an umbrella term encompassing Clinical Academic roles and other internationally used titles within nursing education that, while not consistently or formally recognised, share the defining characteristics of dual employment across academic and clinical practice settings. By clarifying these terms, this thesis establishes a foundation for understanding the roles, structures and challenges discussed in the literature review and subsequent analysis.

1.4 Clinical Academics in Nursing

Clinical Academic roles in nursing play a critical part in connecting academic knowledge with the clinical environment, supporting the integration of research into practice, and enhancing professional development in clinical settings (Paterson & Strickland, 2023). By bridging academic and clinical domains, these roles ensure that nursing practice is responsive to up-to-date research and evolving patient needs. Although often discussed in the literature, there remains no consistently applied definition, and interpretations of the role vary across contexts (Newington et al., 2022).

The concept of the Clinical Academic is not new in nursing practice. Early literature describes roles combining clinical practice and academic responsibilities as a response to tensions arising from the separation of nursing education from clinical settings and the resulting theory–practice gap (Tamlyn & Myrick, 1995). Since its introduction, the literature has continued to explore Clinical Academic roles across a range of nursing contexts, examining how organisations, leadership and structured career pathways enable nurses to combine academic and clinical environments (Aspinall et al., 2024).

Although Clinical Academic pathways have been long established in medicine and dentistry, nursing has historically lagged in developing formalised joint Clinical Academic roles (Paterson & Strickland, 2023). Reasons for this slower uptake are multifaceted but may include workforce pressures, limited protected research time, and the absence of clearly defined career pathways (Carrick-Sen et al., 2019). Historic context also may contribute to this, as nursing education traditionally offered limited

research training and did not routinely expose students to research processes, reducing interest in research related careers (Brady, 2017).

Internationally, Clinical Academic positions are often structured as joint appointments across academic and clinical organisations. These roles typically involve split responsibilities across research, teaching, and clinical practice, and incorporate multiple reporting lines and organisational priorities. The complexity of managing dual roles is central to the hybrid nature of the role and highlights the need for strong leadership, organisational support and clearly defined role expectations.

1.5 Organisation of the thesis

This chapter has provided an overview of the context and rationale for this study, outlining the challenges facing the nursing workforce and the impact these have on education and the development of the University of Waikato nursing programmes. It has also introduced the concept of the Clinical Academic within a nursing context as an innovative response, highlighting its intended benefit of bridging the gap between theory and practice and enhancing evidence-based practice within the clinical space. Building on this foundation, Chapter II presents a detailed review of the literature on both the Clinical Academic and the broader joint appointment, exploring the understanding, implementation, and complexities of the role. Chapters III and IV then outline the research design and methodology employed in this study. Subsequent chapters present the study findings, followed by discussion and conclusions.

Chapter II: Literature review

Research is formalised curiosity. It is poking and prying with a purpose.

Zora Neale Hurston, 1903 – 1996

2.1 Introduction

This chapter provides a narrative literature review examining the roles of the Clinical Academic and the joint appointment within nursing practice, providing a foundation for understanding how these roles have been conceptualised, implemented, and experienced across different contexts. It details the review's design and process and synthesises key findings, themes, and patterns from the literature, highlighting gaps in current knowledge to inform the rationale and design of the present study.

2.2 Rationale

The use of a narrative literature review provided a broad overview of studies that explore both quantitative and qualitative data, as well as theoretical and experiential literature, to develop a comprehensive understanding of the topic (Ferrari, 2015). The ability to review a diverse range of studies enables a deeper understanding of the subject's multifaceted nature, incorporating various perspectives and methodologies. Narrative reviews enable researchers to both describe what is known and explore and critique the literature, including future developments and theories, and their application to practice (Sukhera, 2022). This is deemed particularly useful when the research topic is complex, emerging or inconsistently defined. Narrative reviews are not limited to summarising existing research; they also offer the opportunity to further explain theories, review evidence, analyse patterns and trends, and identify gaps in the current body of knowledge (Sukhera, 2022).

The broad and varied nature of this topic meant that a broader overview of the existing literature was ideally suited, rather than excluding research that did not follow a particular methodology, as seen in more restrictive approaches such as meta-analysis or systematic reviews (Grant & Booth, 2009). Consequently, this review did not

exclude other literature reviews or scoping reviews that contributed meaningfully to understanding the topic area.

While a narrative review offers an opportunity for an expansive exploration of the literature, it remains important to identify clear boundaries and inclusion and exclusion criteria to maintain a clear focus. It is also worth noting that narrative reviews often involve a reflexive and evolving engagement with the literature, enabling researchers to adapt their scope and interpretive focus as their understanding of the topic develops (Sukhera, 2022).

2.3 Study Identification and Selection

2.3.1 Search Methodology

A comprehensive database search was conducted across CINHAL, PubMed, Scopus, and Google Scholar. These databases were selected for their broad coverage of both nursing and health care-related literature, ensuring a diverse range of sources for the review. No date parameters were applied to capture the full evolution of literature on the Clinical Academic role and to avoid unintentionally excluding relevant foundational studies.

Developing an effective search strategy required careful consideration of terminology. It became evident early in the process that the term Clinical Academic is used inconsistently and is often associated with broader discussions of nursing research. Most commonly, it was understood to be an individual holding a joint appointment across clinical and academic settings to conduct and implement research in practice. This understanding, however, did not address the University of Waikato nursing programme's Clinical Academic model, encompassing teaching, mentoring, and supporting students across the clinical and academic spaces, while also presenting opportunities to engage in research development. Consequently, narrowing the search to Clinical Academic roles specifically related to research activity yielded very few results and excluded literature relevant to the current research.

The final search employed phrase searching using the terms ‘clinical academic’ and ‘joint appointment’, combined with the truncated term nurs* to capture nursing-specific literature. This approach enabled the identification of studies describing dual clinical and academic roles while remaining aligned with the focus of this research. The process also highlighted the importance of defining appropriate exclusion criteria and incorporating additional literature identified through citation tracking and reference checking, including peer-reviewed articles not retrieved in the initial database searches (Stillwell et al., 2010). Relevant grey literature, including organisational reports and policy documents, was also included to ensure coverage of evidence not available within databases (Paez, 2017). Additional seminal documents relating to the establishment of the University of Waikato's nursing programme were also reviewed to provide further contextual evidence.

The initial database searches produced 1439 records. Following the removal of duplicate records and an initial screening of titles and abstracts, 152 articles were retained for further assessment.

2.3.2 Eligible Studies

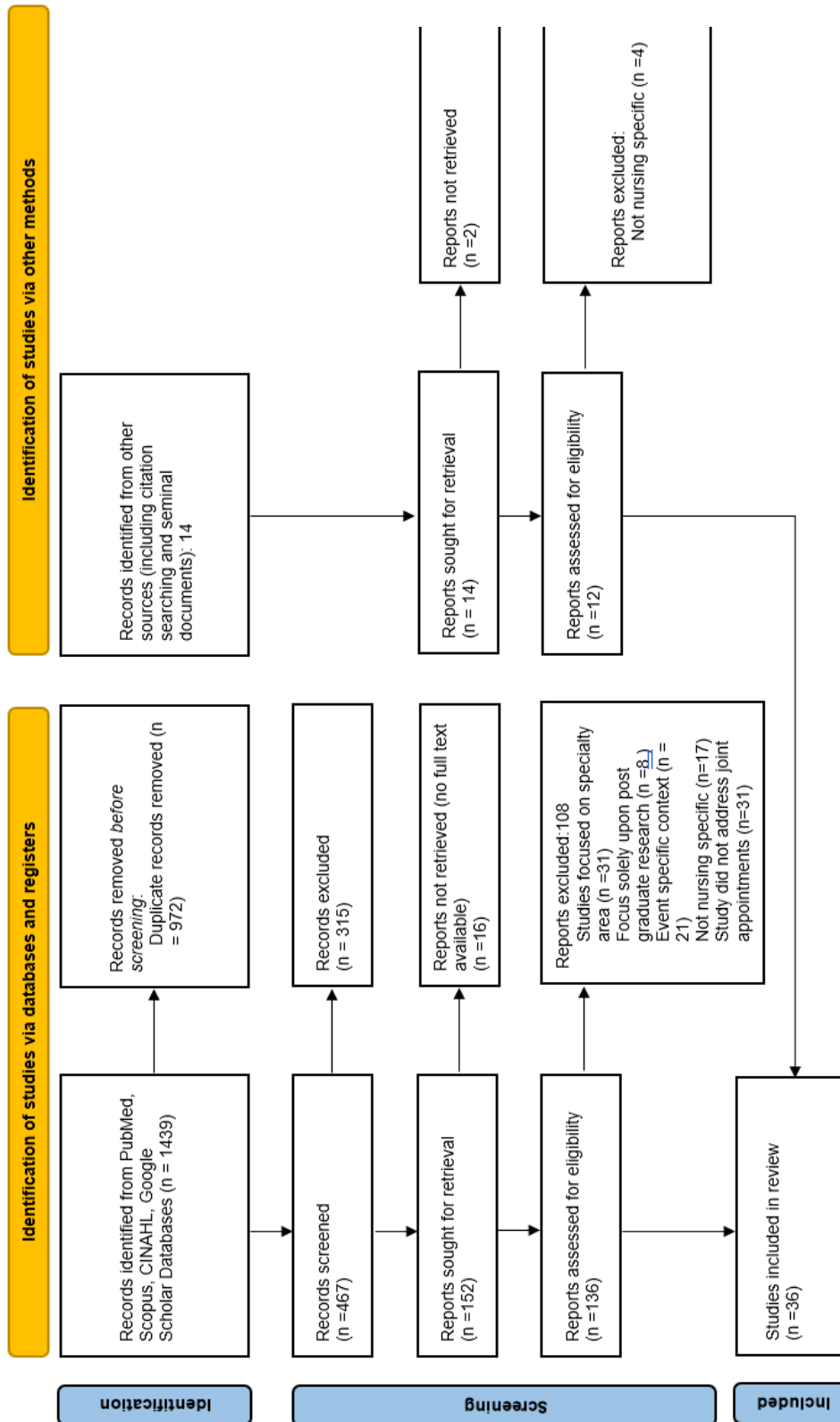
To meet the aims of the review, studies were required to meet at least one of the inclusion criteria outlined in Table 2. Articles that met one or more of the exclusion criteria were removed. The use of clearly defined inclusion and exclusion criteria is essential in a narrative literature review to refine large search results and ensure only relevant studies are included (Jesson et al., 2011).

Table 2: *Inclusion and Exclusion Criteria*

Inclusions	Exclusions
Articles that explore nursing joint appointments between clinical practice and academic settings, such as a university.	Not published in English
Research that explores role enactment, experiences, challenges or professional development of Clinical Academics.	Literature focusing on Clinical Academic roles within medicine or other related professions
Studies examining integration of clinical and academic responsibilities, including teaching supervision, research and clinical practice.	Focus on a pre-determined population, i.e., mental health, aged care
	Directly related and responsive to a particular event ie COVID

The study selection process is illustrated in a PRISMA flow diagram (Figure 1). While narrative reviews do not require PRISMA reporting as systematic reviews do, their use in this study enhances transparency and credibility (Ferrari, 2015). This review does not aim to provide an exhaustive account of all Clinical Academic literature; rather, it offers a comprehensive, contextualised overview of the existing literature relevant to nursing joint appointments between clinical and academic settings, highlighting key themes, challenges, and areas requiring further research. Following full-text review, 35 articles met the inclusion criteria and were retained for analysis.

Figure 1: PRISMA Flow Diagram



2.4 Analysis

Following study selection, the 35 articles were read and analysed in detail. Initial review of the articles found considerable variation in study design, focus and depth of evaluation. Of the included studies, fifteen presented empirical research, comprising six mixed methods studies (Bowles et al., 2021; Gustafsson et al., 2015; Luckenbach et al., 2021; Luckenbach & L'Ecuyer, 2023; Moss et al. 2023; Trusson et al., 2019) , seven qualitative studies (Dirik et al., 2025; Fowler et al., 2008; Hoffman, 2019; Mathisen et al., 2023; Newington et al., 2021; Sharabani & Cojocaru, 2018; van Oostveen et al., 2017) and two cross sectional surveys (Avery et al., 2020; Yi et al., 2020). Eight empirical studies focused on joint appointments within undergraduate nursing programmes. Of these, only three explored the experience of the joint appointment model from the perspective of the appointee (Fowler et al., 2008; Luckenbach et al., 2021; Mathisen et al., 2023). Five of these studies included the perspective of nursing students (Dirik et al., 2025; Gustafsson et al., 2015; Luckenbach et al., 2021; Sharabani & Cojocaru, 2018; Yi et al., 2020).

Case studies and program evaluations were notable within the articles, with nine studies exploring the implementation of joint appointment initiatives (Buron et al., 2024; Cole, 2024; Cooper et al., 2019; Granger et al., 2012; Ogilvie et al., 2004; Paton et al., 2022; Pattison et al., 2022; Peterson et al., 2019; Pfister et al., 2021). Of these, six originated in the United States and three in the United Kingdom.

Overall, the literature in this review was predominantly centred in the United States (n=15) and the United Kingdom (n=10), with limited representation from Australia (n=2) and New Zealand (n=1). Publication trends indicate growing interest in joint appointment roles over time. Three studies were published between 2000 and 2010, 12 between 2010 and 2019, and 21 between 2020 and 2021, reflecting expanding attention to academic-practice partnerships, workforce development, and the integration of academic and clinical practice within nursing (See Appendix I for a full literature summary).

Participants in the included studies included individuals with joint appointments, tertiary nursing faculty, Registered Nurses, nursing students, and managers involved in joint appointments.

2.5 Findings

Literature examining Clinical Academic roles specifically within nursing education remains limited. As a result, this review examines both literature exploring the Clinical Academic role across diverse clinical and academic contexts and literature on the broader joint appointment employment model used to bridge these settings.

An ongoing challenge within this body of literature is the inconsistent use of terminology, with roles integrating clinical and academic work variously described and operationalised. In this review, the term Clinical Academic is used when referring to research that explicitly examines a defined and formalised Clinical Academic role, while the term joint appointment is used when exploring positions or role characteristics applicable to roles combining both clinical and academic responsibilities, irrespective of whether these are formally designated as Clinical Academic roles.

The literature examined highlights the potential of Clinical Academic and joint appointment positions to enhance evidence-based practice, professional development, research capacity and service improvement across a range of clinical and academic settings (Kaunda et al., 2025; Ogilvie et al., 2004). In the context of ongoing challenges in nursing practice and education, including workforce pressures, the increasing complexity of care, and rising expectations for evidence-informed practice, Clinical Academic roles are positioned as an innovative approach to strengthening the integration of research, education, and clinical practice.

Despite this growing interest, the literature shows notable discrepancies in the understanding and use of terminology, role expectations, and implementation models. Variability in how these roles are defined and implemented has continued to create ambiguity about their purpose, scope, and value within nursing practice and education.

The literature is reviewed and presented across five key areas. These areas are used to examine the experiences associated with Clinical Academic and joint appointment roles and to inform exploration of the Clinical Academic model within an undergraduate nursing context.

2.5.1 Ambiguity

Much of the current literature agrees that while the role of Clinical Academic is becoming increasingly promoted as a means of strengthening the relationship between practice, research and education, it remains poorly understood with significant ambiguity surrounding its purpose, scope and expected contribution (Carrick-Sen et al., 2019; Henshall et al., 2020; Newington et al., 2022). Despite growing interest in Clinical Academic models within nursing, there is a persistent lack of clarity surrounding the definition, resulting in considerable variation in how the role is conceptualised, implemented, and experienced across settings (Aspinall et al., 2024; Newington et al., 2022; Paterson & Strickland, 2023)

Across the literature, definitions vary, with most describing the role as a shared or joint appointment between clinical and academic organisations. Carrick-Sen et al. (2019) describe the role as that of a health care professional who works concurrently in clinical and academic environments, with activities that span research and/or education. The Council of Deans of Health (2018) offers a similar description; however, it places the individual within a higher education institution that provides clinical expertise for health and clinical care.

Many of the existing definitions place a strong emphasis on research, positioning the Clinical Academic primarily as a research-focused professional, and often do not explicitly address or incorporate the ability of the role to be embedded within education (Aspinall et al., 2024; National Institute for Health Research, 2016; Pattison et al., 2022). Aspinall et al., (2024) use the term Clinical Academic interchangeably with nurse scientist, a role deemed to be clinically active, research active and doctorally prepared, and identify the adoption of the term Clinical Academic by some institutions, such as the University of Waikato, as misunderstood. However, other literature clearly identifies education and teaching as key components of the role (Kaunda et al., 2025;

Newington et al., 2022). Further complicating the clarity of the role, many joint appointment positions that meet broad criteria of a Clinical Academic and work within a similar remit while not formally defined as such, are evident across the literature. The terminology used to describe these roles varies, with both similar variations of the term and completely unrelated terminology, including joint appointment, affiliate faculty, clinical faculty, academic practice partnership, practitioner-teacher, and lecturer-practitioner, applied to describe these positions (Cole, 2023; Kleinpell et al., 2015; Luckenbach et al., 2021; Mathisen et al., 2023). This variation in terminology and emphasis further reflects the lack of consensus regarding the scope, purpose and contribution of Clinical Academics in nursing, even when the underlying principles are maintained.

As a result, multiple interpretations exist, and the role's operation varies widely across individual appointments. Regardless of definition, Beitz et al. (2000) note that the role's contribution is often determined by organisational priorities within each partnership rather than by a predetermined set of responsibilities. Newington et al. (2022) illustrate this variation through a qualitative study of eight health care managers and 12 research active clinicians, reporting that some participants perceived their role as heavily research-oriented, others emphasised leadership or education, and several did not identify as Clinical Academics at all, despite holding posts that met the criteria associated with the title. This evidence illustrates the extent to which the role's meaning remains unclear, even among those occupying it.

Ambiguity persists when looking internationally at how the Clinical Academic is formalised. Carrick Sen et al. (2019) highlight that availability and knowledge of Clinical Academic roles is often limited, with formal positions more commonly available at senior levels in countries such as Australia, the USA and Canada. Although the literature consistently reports strong interest and motivation among nurses to pursue Clinical Academic careers, the absence of clearly defined pathways and transparent role structure is perceived as a significant barrier to engagement and retention (Avery et al., 2020).

The implications of this ambiguity are evident across both Clinical Academic and broader joint appointment models. Individuals are required to navigate dual

organisational structures, competing priorities and differing expectations across academic and clinical settings. Studies describe the challenges of managing dual reporting lines, balancing academic and clinical workloads and negotiating professional identity across two different organisational cultures (Avery et al., 2020; Beitz & Heinzer, 2000; Trusson et al., 2019; van Oostveen et al., 2017). Beitz and Heinzer (2000) argue that for joint appointments to function effectively, responsibilities must be mutually established across both organisations, with shared accountability and compatible expectations, ultimately treating the position as one appointment. However, in practice, competing demands for time and difficulties in prioritisation are commonly reported, particularly where the role is treated as two separate positions rather than a genuinely integrated or blended role.

Evidence within the New Zealand context remains particularly limited, further constraining understanding of how Clinical Academic roles are conceptualised, accessed and enacted locally. Aspinall et al. (2024) was the only New Zealand-based study identified in this review; however, although authored in New Zealand, the integrative review examined international literature and did not provide further insight into Clinical Academics in a New Zealand context. In a related initiative, a Health Research Council-funded project led by Slark et al. (2023) explored barriers and facilitators to developing Clinical Academic roles across New Zealand. While this initiative highlights growing national attention to these roles, no published empirical findings have been identified on how they are implemented in practice. This gap highlights the need for research focused on local contexts that explores how Clinical Academic roles are experienced and enacted.

The literature clearly articulates that ambiguity exists at both the conceptual and operational levels. Variation in how the role is understood, defined and implemented creates uncertainty for individuals and organisations attempting to adopt this clinical model. Importantly, the persisting lack of role clarity has been associated with poor understanding of Clinical Academic roles among colleagues and stakeholders, contributing to challenges in recognition and role legitimacy (Paterson & Strickland, 2023). Until greater consensus is achieved on scope, identity, and role definition, these discrepancies are likely to persist, affecting how the role is perceived and implemented. Based on the literature identified in this review, much of the existing work on Clinical

Academic roles is conceptual or descriptive, with relatively few empirical studies. Most sources consist of discussion papers, opinion pieces, or case studies, resulting in extensive debate and theoretical discussion but relatively little robust evidence on how the role functions in practice or its impact on outcomes.

2.5.2 Benefits of the Joint Appointment

Throughout this thesis, ‘joint appointment’ is used as a broad term for nursing roles that span both academic and clinical contexts, including but not limited to Clinical Academic positions. While these roles are described using a range of titles and lack consistent formalisation, they are unified by dual engagement across academic and clinical practice settings. Despite this variability, the literature consistently identifies joint appointments as mutually beneficial, benefiting individual appointees, health organisations, health consumers, higher education providers, students, and the nursing profession. Notably, these benefits are repeatedly observed across the literature and have remained largely stable over time, including within more recent publications (Kaunda et al., 2025; Ogilvie et al., 2004; Trusson et al., 2019).

A key benefit of joint appointments is their ability to bridge the theory-practice gap (Luckenbach et al., 2021; Mathisen et al., 2023). By connecting the academic and clinical environments, joint appointments strengthen links between settings, improving communication, collaboration, and the integration of clinical expertise into education (Ogilvie et al., 2004; Pfister et al., 2021; Luckenbach et al., 2021). Students can access experienced clinical nurses who demonstrate up-to-date practice, support skill development and provide real-world contexts for academic work (Luckenbach et al., 2021; Mathisen et al., 2023; Phillips et al., 2019).

A further benefit is that the role promotes evidence-based practice (EBP) in the clinical setting. Joint appointments guide the application of research into clinical policies, guidelines and improvement initiatives, resulting in improved patient outcomes and generating a culture of inquiry among clinical staff (Bowles et al., 2020; Cooper et al., 2019; Granger et al., 2012; Phillips et al., 2019; van Oostveen et al., 2017). For example, Phillips et al. (2019) describe a project in which students developed evidence-based proposals based on real-life practice issues identified by clinical staff. The initiative

engaged students in EBP, motivated nurses to participate in evidence-based projects, and enhanced broader research interest among the clinical team.

Individuals working within these roles report multiple professional and personal benefits. Evidence suggests these roles enhance professional development, career motivation, skill acquisition and job satisfaction (Fowler et al., 2008; Paton et al., 2022; Sharabani & Cojocaru, 2018; Trusson et al., 2019; van Oostveen et al., 2017). In a scoping review of Clinical Academic joint appointments, Kaunda et al. (2022) note that individuals report being highly motivated and more satisfied with the ability to meet the challenges inherent in these positions. Fowler (2008) highlighted the flexibility of joint appointments, enabling nurses to trial new roles without jeopardising employment contracts or being forced to make permanent career decisions. This allows individuals to pursue educational and research opportunities while maintaining clinical responsibilities, thereby supporting both professional growth and career satisfaction. Collectively, these findings suggest that joint appointments help individuals develop confidence, specialised skills, and a stronger professional identity, while also motivating continued engagement in research and evidence-based practice.

At an organisational level, these roles strengthen partnerships between academic and clinical institutions, improving communication, collaboration and integration of practice and research (Bowles et al., 2020; Fowler et al., 2008; Granger et al., 2012). They support workforce sustainability by addressing staff shortages, improving recruitment and retention, and facilitating the development of a future nursing workforce (Baptiste et al., 2021; Buron et al., 2024; Luckenbach et al., 2021; Sadeghnezhad et al., 2018). Their presence in clinical areas enhances patient safety, ensures application of current policies and procedures, and enables translation of research into improved care (Kaunda et al., 2025; Luckenbach et al., 2021; van Oostveen et al., 2024).

While the literature reports individual and professional benefits of these positions, these outcomes are highly context dependent. Across numerous studies, the effectiveness of these roles is consistently reliant on institutional support, clarity of role expectations and the availability of resources such as office space, technology access and structured and thorough orientation programmes (Buron et al., 2024; Fowler et

al., 2008; Hoffman, 2019; Luckenbach & L'Ecuyer, 2023; Mathisen et al., 2023). Orientation and mentorship are particularly important in establishing these roles. Hoffman (2019) highlights that a transition from clinical practice to an academic environment, particularly in teaching, requires structured support and time for role socialisation. When applied to joint appointments, this highlights the importance of providing adequate resources and time to establish the role, particularly given competing priorities within each organisation. Even with clear orientation and awareness of organisational processes, significant variability in the role can occur, such as differences in how the individual evaluates students or implements educational requirements.

A recurring barrier identified in the literature is the complexity of navigating dual responsibilities across academic and clinical settings (Fowler et al., 2008; Hackett et al., 2016; Mathisen et al., 2023; Paterson & Strickland, 2023; van Oostveen et al., 2016). Joint appointments frequently involve competing priorities and multiple organisational expectations, requiring individuals to adapt and negotiate across settings (Beitz et al., 2000; Fowler et al., 2008). This is further compounded by cultural differences between academic and clinical environments, where differing values can create tension and undermine the role. Several studies report a lack of understanding of these roles, leading individuals to repeatedly justify their contributions and positions (Fowler, 2008; Mathisen et al., 2023).

Operational challenges also feature significantly. Practical constraints, including inconsistent access to physical workspaces, institutional systems and flexible scheduling, are shown to negatively affect job satisfaction and role effectiveness (Buron et al., 2024; Fowler et al., 2008; Luckenbach et al., 2021). These challenges highlight that successful implementation depends not solely on individual motivation or resilience, but on organisational readiness and resourcing. In the absence of adequate institutional support, joint appointments may struggle to achieve intended outcomes such as conducting research, delivering education, and embedding evidence-based practice into clinical settings, leading to role conflict and dissatisfaction within the position (Buron et al., 2024; Fowler et al., 2008; Luckenbach & L'Ecuyer, 2023).

2.5.3 A Focus on Education

Although much of the literature on Clinical Academics focuses on research pathways and the development of academic careers, there is growing recognition of their potential contribution to education, particularly regarding pre-registration nursing students and the associated clinical training requirements.

Over recent decades, nursing education has shifted from vocational, hospital based training to formalised academic programmes offered by higher education providers. While this has strengthened the status of the profession, it has also been linked to a disconnect between theory and clinical practice and raised concerns regarding student preparedness (Hickerson, Taylor & Terhaar, 2016; Purssell & McCrae, 2021). In response, joint appointment roles have developed to bridge this theory-practice gap, using clinically active staff to connect classroom teaching with real-world practice (Ogilvie et al., 2004; Pfister et al., 2021). In a mixed methods survey of 75 students and 25 affiliate faculty, Luckenbach et al. (2021) reported that both students and faculty showed increased perceived safety and greater ability to apply knowledge in practice through the implementation of joint appointment models. This study highlighted that key practice knowledge held by joint appointments, such as current policies and procedures, and knowledge of the health system, enabled safe patient care and an improved learning environment. Faculty also provided relatable, relevant education through clinical examples. While Luckenbach's results were based on a good sample size, the quantitative results did not provide in depth exploration. By contrast, Mathisen et al. (2023) conducted qualitative interviews with 12 faculty. Mathisen et al. found that joint appointments involving both academia and clinical care helped align theory and practice, enabling facilitation of a common understanding between the two settings and identifying significant discrepancies in taught content and practical application. Mathisen's study was able to explore meanings within the qualitative data but lacked the statistical power for generalisation.

The integration of evidence-based practice into the nursing curriculum further underscores the value of joint appointments in the education space. Bowles et al. (2020) note that nurses are required to keep pace with an ever-changing health care system, which requires effective evidence-based practice. A strong theoretical

foundation of evidence-based practice within the curriculum is most effectively maintained through partnerships with clinically active nurses, who can provide both current knowledge and practical application.

The concept of clinical currency was also explored throughout the literature, with multiple studies emphasising the importance of those providing nursing education maintaining up-to-date clinical knowledge and real-world practice insights (Gustafsson et al., 2015; Sharabani & Cojocaru, 2018). In a Swedish mixed methods study, Gustafsson et al. (2015) surveyed 114 nursing students and further interviewed eight, to compare educators working solely in academic roles with those holding dual clinical appointments and found that, from students' perspectives, ongoing clinical engagement supported the maintenance of practical competence. However, it is important to note that the findings also indicated that clinical currency is not solely dependent on active clinical practice and can be sustained through engagement in clinical partnerships, exposure to research, and collaboration with practising clinicians. Students further indicated that they also found benefit in those without joint appointments, as they were able to provide a neutral perspective, allowing them to debrief in a space free from clinical challenges. Sharabani & Cojocaru (2018) present similar findings in a qualitative study of 20 students and 13 faculty, incorporating the perspective of those working in both sole academic teaching roles and joint appointments. Findings support the idea that educators working concurrently in active practice reported that their dual roles enabled them to maintain current knowledge of research and evidence, provide clinically based rationales in teaching, and maintain a sense of pride in bridging theory and practice. Similarly, those holding solely academic positions noted that they maintained this clinical currency through research engagement and periodic clinical contact. Of note, many who had experience working across dual contexts reported challenges in finding an adequate balance and meeting requirements in both settings.

While the use of joint appointments in nursing education is seen to contribute significant value, the literature also highlights challenges relating to teaching competence and academic processes. Hoffman (2019) noted in a qualitative study of 15 nurses' experience of transitioning to nurse faculty roles, that clinical nurses often

require additional support to understand educational theory and curriculum requirements. This is supported by a discussion paper by Buron et al. (2024), who, in reporting on the implementation of a clinical academic partnership model, reported significant variation in student assessment practice among joint appointments, with some being overly critical and others hesitant to fail students. Luckenbach & L'Ecuyer (2023) highlight the positive impact of formalised training programmes in supporting this transition as demonstrated through their quantitative survey of 26 joint appointments, noting improvements in confidence, competence, and consistency in academic roles, however, note that this did require an ongoing commitment and increased resource.

Despite the acknowledged value of the joint appointment in relation to nursing education, student perspectives remain underexplored. Only a few studies have directly investigated how students experience joint appointments (Buron et al., 2024; Dirik et al., 2024; Luckenbach et al., 2021; Sharabani & Cojocaru, 2018; Yi et al., 2020). Most research has explored the organisation's or staff's perspective, leaving questions about how students perceive, engage with, or benefit from joint appointments. Case studies exploring the experiences of joint appointees further illustrate the complexities of balancing dual responsibilities and highlight the role's benefits and challenges. These findings indicate that, while the educational contributions of joint appointments are increasingly recognised, more research is needed to fully understand student experiences and optimise joint appointment models to support both organisational objectives and student learning outcomes.

2.5.4 Collaboration and Leadership

Effective collaboration and partnership between academic institutions and clinical organisations is consistently identified as a central underpinning of successful joint appointment models (Aspinall et al., 2024; Beitz & Heinzer, 2000; Henshall et al., 2020; Ogilvie et al., 2004; Pfister et al., 2021). Ogilvie et al. (2004, p.111) note that joint appointment roles are 'inherently collaborative', requiring coordinated engagement between organisations to integrate research, education and practice. Trust, shared goals and mutual understanding are emphasised throughout the literature as essential for sustaining joint appointments, with both academic and clinical partners needing to

recognise the value of the role and its contribution to organisational objectives (Pfister et al., 2021).

Leadership is closely intertwined with collaboration and is frequently identified as a key enabler of successful Clinical Academic pathways, supporting the integration of research, education, and clinical practice. Studies exploring joint appointments across clinical and academic settings, often with an education focus, consistently highlight the importance of leaders who actively promote partnerships across organisational boundaries. Baptiste et al. (2022), in a discursive review, suggest that leaders who engage in collaborative partnerships establish a presence in each other's worlds, demonstrating shared commitment to faculty, staff, and students. This perspective is supported with evidence from Mathisen et al. (2023), whose qualitative study of 12 practice education facilitators found that managers were critical in the facilitation of these roles, demonstrating flexibility and support for integrating educational and clinical responsibilities. Similarly, Dirik et al., (2021), in a qualitative study of 36 interviews, emphasises that leaders' willingness to partner and plan for organisational barriers is central to successful role enactment. Together, these studies highlight that partnership, flexibility, and the presence of managers are key enablers of joint appointments.

In contrast, leadership challenges are more pronounced when examining studies relating to defined Clinical Academic positions. Aspinall et al. (2024), in an integrative review synthesising multiple international studies, highlight that managers may fail to recognise the value of academic practice within clinical settings, a finding echoed in systematic review evidence from Henshall et al. (2021), which emphasises the critical role of executive-level leadership in establishing pathways. Qualitative studies support these findings. Newington et al. (2022) in 20 interviews with healthcare managers and research active clinicians, found that non-facilitating managers acted as barriers, often perceiving Clinical Academics as needing to be more visible to establish credibility, while van Oostveen et al. (2017) in 24 interviews and two focus groups with participants who held interest in Clinical Academic pathways, report that leadership is frequently absent at all organisational levels, and managers may critique academics for invisibility in practice. These studies all demonstrate that insufficient engagement from leadership is a key barrier to both establishing and gaining recognition, career

progression and institutional support for Clinical Academic roles, with systematic and integrative reviews providing the wider evidence across contexts and qualitative studies providing specific ways in which leadership affects the Clinical Academic role.

Despite collaboration being central to these roles, it is frequently challenged by differences in organisational culture, priorities and professional expectations (Granger et al., 2012; Ogilvie et al., 2004; van Oostveen et al., 2017). Joint appointments are required to navigate both distinct cultural differences between academic and clinical settings as well as cultural division within internal organisations, reflecting differing expectations of research, education and clinical service delivery (Fowler et al, 2008; Paterson & Strickland, 2023; Thamm et al., 2025). Qualitative studies exploring the experiences of joint appointee's report that this division is clear both when clinical staff enter academic environments for the first time (Fowler et al., 2008) and within health care organisations themselves, where research and education are often seen as less of a priority to direct patient care (van Oostveen et al., 2017). Unlike medicine, where research is often embedded within practice roles, nursing academics have historically been isolated from clinical settings, limiting opportunities for integration and reinforcing perceptions that research and education are secondary to the delivery of patient care (Paterson & Strickland, 2023).

Even with recognised benefits, Clinical Academic roles are vulnerable when collaboration and leadership are lacking, leaving them exposed to competing priorities and unclear expectations. Multiple studies emphasise that, regardless of positive outcomes, holding a shared accountability across different organisations can put the joint appointment role between competing agendas, making them at risk of deprioritisation if collaboration is not actively maintained (Aspinall et al., 2024; Ogilvie et al., 2004; van Oostveen et al., 2017). For example, Ogilvie et al. (2004) highlighted the disestablishment of an otherwise successful joint appointment programme, noting that limited understanding of the role's value, a focus on service delivery, and inconsistent leadership within one organisation were detrimental to the programme's sustainability.

Collectively, the literature highlights that the sustainability and effectiveness of Clinical Academic roles, regardless of their focus, depend on intentional efforts to build ongoing collaboration and align priorities. Effective partnerships, with active engagement on both sides, shared vision and mutual understanding of role value are consistently reported as key enablers of successful joint appointment pathways (Baptiste et al., 2022; Pfister et al., 2021; Aspinall et al., 2024). Conversely, when collaboration is neglected, Clinical Academics face workload pressures, reduced job satisfaction, and difficulty meeting organisational expectations (Fowler et al., 2008; Paterson & Strickland, 2023; Thamm et al., 2025).

2.6.5 The Right Fit

The literature review shows that both Clinical Academic roles and the wider joint appointment are complex, requiring nurses to manage the dual demands of academic and clinical environments (Beitz et al., 2000; Thamm et al., 2025; van Oostveen et al., 2017). Success in these roles relies not only on high levels of motivation and resilience but also on the ability to manage competing priorities, negotiate organisational challenges, and maintain professional credibility across both clinical and academic settings (Beitz et al., 2000; Paterson & Strickland, 2023). Many of these traits are observed at different stages of nurses' careers, and as a result, significant divergence is evident in the literature regarding the level of experience a nurse should have before engaging in a Clinical Academic or joint appointment position.

Several studies emphasise that experienced, senior nurses are more suited to manage the complex organisational, cultural and relational dynamics required for a joint appointment role, having established clinical expertise and leadership skills (Fowler et al., 2008; Trusson et al., 2019). Fowler et al. (2008) argue that effective joint appointments require substantial clinical expertise alongside the ability to navigate competing expectations from academic and clinical settings. Langner & Wolf (1996) describe the characteristics of an individual working across clinical and academic domains as “an individual who is able to move between academic and clinical worlds, someone who is tenacious, perseveres in rapidly changing organisational climates, is able to say ‘no’ and who remains convinced of the value and synchrony of research

and practice” (p. 49). These studies consistently note that resilience, credibility and leadership skills are essential for sustaining effectiveness in joint roles.

In contrast, multiple studies emphasise that Clinical Academic pathways should be made accessible to nurses early in their careers to enable the promotion and integration of research activity (Avery et al., 2020; Cooper et al, 2019; Henshall et al., 2020; Trusson et al., 2019). Early exposure is argued to support the development of research skills, foster engagement in evidence-based practice, and cultivate a research-active nursing workforce. Trusson et al. (2019) report that early-career exposure can enhance research capability; however, the wider literature suggests that nurses at this stage may lack the leadership, clinical judgment, and organisational awareness required to balance dual expectations effectively.

Analysis of the literature highlights that this division largely reflects the underlying focus of joint appointment roles. Research-oriented pathways emphasise skill development, academic engagement, and early exposure, aligning with the strengths of early-career nurses; however, it is important to note that targeting these aspects of the role does not negate the complexities that are highlighted as inherent to all joint appointment models. Conversely, roles with a strong education or clinical leadership component require the credibility, resilience, and organisational insight typically associated with more experienced nurses. This distinction suggests that the “right fit” for a Clinical Academic role is determined not solely by career stage but by the role's foundational focus. Across both contexts, successful joint appointments are characterised by substantial clinical expertise, effective communication, leadership ability, and resilience, highlighting the importance of clearly defining role scope, expectations, and objectives to support effective implementation and sustainability.

2.7 Research underpinning the study

This study draws on a growing body of nursing literature examining both Clinical Academic roles and the wider joint appointment. Much of the published research remains descriptive, conceptual, or focused on case examples, providing insights into role development, integration of clinical and academic environments and potential

benefits for workforce development (Aspinall et al., 2024; Baptiste et al., 2022; Cole et al., 2024; Henshall et al., 2020; Kaunda, 2024). A meta-aggregation review of Clinical Academic nurses further found that few empirical studies have examined role experiences or outcomes, highlighting a gap in evidence on the practical implementation and impact of these roles (Paterson & Strickland, 2023). Scoping and integrative reviews further indicate that Clinical Academic roles are inconsistently defined across countries and professional contexts, reflecting a lack of clarity around terminology and scope (Newington, 2022; Paterson, 2023).

While international literature provides valuable insights into role development and academic-clinical integration, its applicability to the New Zealand context is limited due to differences in nursing education pathways, clinical placement models and health system organisation. Consequently, there is limited understanding of how Clinical Academic or joint appointment models are experienced locally. This highlights the need for studies that explore these roles within the specific educational, clinical, and cultural context of New Zealand, providing evidence to inform workforce development, strengthen the integration of education and practice, and the design of Clinical Academic roles that are responsive to workforce needs.

2.7.1 Identified Gaps in the Literature

Despite the growing interest in Clinical Academic roles, several gaps remain in the existing literature. No studies were found that present a comparable example of a fully defined Clinical Academic role incorporating research, teaching, student support, and clinical practice. This absence of evidence highlights the uniqueness of the University of Waikato context.

Methodologically, most studies have focused on the perspectives of Clinical Academics and healthcare leaders, primarily through qualitative interviews (Fowler et al., 2008; Newington et al., 2022; van Oostveen et al., 2017). Mixed method studies are comparatively rare, particularly those examining specifically defined Clinical Academic roles (Trusson et al., 2019). While a few studies provide student perspectives, these are all in the context of broader joint appointment models rather than explicitly defined Clinical Academics (Bowles et al., 2022; Dirik et al., 2025; Gustafsson et al., 2015;

Luckenbach et al., 2021; Moss et al., 2023; Yi et al., 2020). Consequently, the predominance of descriptive and single-perspective research limits understanding of how Clinical Academic roles influence undergraduate learning and the student experience in clinical placements.

These gaps informed the design of the present study. A mixed-methods approach was adopted to capture the lived experience of Clinical Academics, while incorporating qualitative student data to provide complementary insight. By situating the study within the University of Waikato nursing programmes, it provides locally grounded evidence to a field dominated by international research and research-career-focused studies. In doing so, it contributes context specific empirical knowledge relevant to New Zealand, strengthens the research underpinning Clinical Academic roles and joint appointments in nursing education and supports evidence informed development of these roles in local clinical and academic settings.

2.8 Limitations

Whilst the literature highlights key themes and acknowledgement of the perceived benefits of Clinical Academic joint appointment roles, several limitations are evident. Many studies remain largely descriptive, discussing programmes and frameworks without formal empirical evaluation and there appear to be no long term follow up studies. A significant proportion of the literature consists of discussion papers, commentaries or descriptive reports, rather than peer-reviewed methodologically robust studies. Despite these methodological limitations, the findings of discussion-based papers often align with empirical studies, supporting recurrent themes such as collaboration, leadership and integration of research and practice.

Another notable gap is the lack of direct evidence from students. While the impact of joint appointment roles on student learning and outcomes is frequently discussed, only a limited number of studies actively engaged nursing students or provided direct evidence of outcomes. This limits understanding of how joint appointments influence students' experiences, preparedness, practice, and the integration of academic learning into clinical placements.

Terminology and role ambiguity further limit the literature. Inconsistency in language and definitions introduces uncertainty and may mean that relevant programmes or studies using alternative terminology, yet exploring the same concepts, were not captured. This inconsistency also reflects broader uncertainty around the purpose, scope and expectations of Clinical Academic roles.

2.8 Summary

Several key areas were identified in the literature regarding both the Clinical Academic role and the wider joint appointment model. The literature highlights a range of benefits associated with these roles, alongside significant challenges related to role ambiguity, organisational support and sustainability. These informed the foundation of this research and guided the exploration of factors that enable or constrain the effectiveness of the Clinical Academic role.

Overall, this literature review provided the foundation for the development of the research design, including interview and survey questions and informed the broader discussion of the experience of Clinical Academics within the University of Waikato nursing programmes. It identified notable gaps in the literature, particularly regarding the Clinical Academic role within a New Zealand context and its specific application to nursing education. Given the limited evidence in these areas, further research is required to better understand how Clinical Academic roles are supported and experienced, and how they may contribute to strengthening nursing education and workforce in New Zealand

Chapter III: Methodology

Research is to see what everybody else has seen, and to think what nobody else has thought

Albert Szent-Györgyi

3.1 Introduction

Methodology relates to the philosophical assumptions that guide a researcher in designing a research approach to collect, analyse and interpret data (Creswell & Creswell, 2018). This chapter outlines the research design and methodology used to explore the study's research question. It will highlight the theoretical underpinnings of the research methods described in Chapter IV by first discussing the philosophical foundations that guide the research approach, including the paradigmatic stance taken, and then exploring the rationale for using a mixed methods design in relation to this study.

3.2 Research Aims

1. Explore the experiences of Clinical Academics working within the University of Waikato Nursing programmes
2. Evaluate the impact of Clinical Academics on student learning during clinical placements
3. Assess how well the Clinical Academic model supports the following outcomes
 - a. Integration of theory and practice
 - b. Clinical Academic job satisfaction in the role
 - c. Professional development of the individual Clinical Academic

3.3 Research Question

‘How is the Clinical Academic model at the University of Waikato Nursing School experienced by Clinical Academics and pre-registration nursing students, and to what extent does it support the achievement of identified outcomes within the pre-registration nursing programmes in the current health context?’

3.4 Ontology and epistemology

This section explores the ontological and epistemological foundations that support the design of this study. These concepts are essential for developing appropriate and relevant research methodologies that align with the research aim.

Ontology concerns the nature of reality, recognising that it is a construct that varies across contexts (Pretorius, 2024). Bryman (2016) explains that ontological views are expressed along a continuum, from objectivity, in which social phenomena exist independently of human involvement, through to constructivism, which focuses upon human processes and interactions. In this study, I adopted a pluralistic ontological stance, accepting that both objective views of reality and subjective experience are valid philosophical stances regarding knowledge of reality (Creswell & Plano Clark, 2017). This view of the nature of reality is particularly significant in health care and nursing, as health care professionals often experience distinct yet valid realities and utilise either subjectivist or objectivist perspectives in different situations. When considering the role of the Clinical Academic, it is essential to acknowledge the contrasting realities of the clinical and academic fields. On the one hand, the Clinical Academic role can be defined objectively, outlining the key functions and structure required to achieve the desired outcome. This realist approach to ontology, however, does not consider the subjective experience of the Clinical Academic, which is an essential component of the role; accordingly, it is necessary to employ a constructivist approach, which understands reality through individual experience and perception (Bryman, 2016).

Epistemology focuses on the nature of understanding and on how knowledge is acquired and validated (Pretorius, 2024). A pragmatic epistemology reflects the constantly changing nature of health care and the realities that health care practitioners

face. Pragmatic epistemology enables methodology to be guided by what works and what is required in the context, rather than dictated by research methods alone. This flexibility allows the researcher to explore both subjective experience and objective data to answer the research questions effectively (Feilzer, 2010).

With these underlying principles in mind, this research adopted a pragmatic design that integrated quantitative and qualitative data. Using a mixed methods approach, the study aims to comprehensively explore the research questions, addressing both objective findings from student feedback and subjective experiences of Clinical Academics in their roles (Pretorius, 2024). Consideration was given to a purely constructivist approach commonly used in healthcare; however, this was felt to overlook important contextual factors by focusing solely on individual experiences. It is vital to acknowledge the multiple realities to fully understand the research topic.

Overall, this mixed methods design aligns with the pragmatic paradigm, allowing for a more integrated perspective than either quantitative or qualitative methods alone could achieve. This approach positions the research to effectively capture the diverse experiences and dynamic realities of Clinical Academics as they manage the complexities of the role.

3.5 Mixed Methods Research

This section will explore the use of mixed methods design, emphasising the importance of integrating quantitative and qualitative approaches to address complex research questions. By utilising the strengths of both methods, this approach draws on multiple data sources from individuals actively involved within the context.

Creswell & Plano-Clark (2017) define mixed methods design as a methodology for collecting, analysing, and integrating quantitative and qualitative data within a single study. Traditionally, there has been a strong argument for viewing quantitative and qualitative research as distinct and incompatible; however, mixed methods design offers a framework that unifies these two approaches, utilising their individual strengths to create a comprehensive overview of the research problem (Johnson & Onwuegbuzie, 2004).

Given the aim of this research to both quantify the effectiveness of the Clinical Academic through student feedback and concurrently explore the lived experience of those working in the role, a mixed methods approach was appropriate. Andrew and Halcomb (2009) highlight the effectiveness of mixed methods for exploring complex, multifaceted research, particularly within the health care setting. Health care is particularly complex, and the added complexities of joint appointments, as seen within the Clinical Academic model, including conflicting values and contrasting expectations, mean that the research needs to capture these dynamics. A mixed methods research design allows for a more in-depth understanding of the role by supporting multiple perspectives and data sources, enabling a broader understanding of the research question.

A further key rationale for adopting a mixed methods design is the intentional integration of datasets to gain a rich, in-depth understanding of the research questions. Data integration refers to the deliberate combination and connection of quantitative and qualitative data during collection, analysis, or interpretation (Creswell & Plano Clark, 2017). This dramatically improves the value of the research by making the datasets interdependent through comparison, relating, or merging data (Bazeley, 2024). This integration can serve multiple purposes, including complementarity, in which one

dataset may further expand on the findings of another, and triangulation, in which the rigour and validity of the research are improved through the convergence of findings (Johnson & Onwuegbuzie, 2004). Alternatively, findings may contradict or diverge, prompting more in-depth exploration of the research question (Fetters et al., 2013). The specific processes for data merging are further explored in the research design below.

3.6 Research Design

Mixed methods research offers several design options, including sequential designs, where one data strand informs the other over time, and convergent designs, in which qualitative and quantitative data are collected and analysed independently but concurrently, with integration occurring at a later stage (Morse & Niehaus, 2009). The choice of design depends on the purpose of the study, the priority of each data strand, and how the data is intended to be integrated.

This study adopts a convergent parallel design with a qualitative-dominant approach (QUAL + quant), in which quantitative and qualitative data were collected and analysed independently but concurrently, with integration occurring during the discussion phase (Morse & Niehaus, 2009). Convergent parallel design benefits from multiple independent data sets, allowing direct comparisons that triangulate and complement findings, thereby enhancing the validity of the results (Morgan, 2014). In adopting a qualitative dominant approach, the study prioritises in-depth exploration of Clinical Academics across the wider University of Waikato nursing programmes. The quantitative survey data provides a complementary perspective, capturing pre-registration nursing students' perception of working with Clinical Academics in clinical practice. This dual approach allows the study to contextualise and corroborate the qualitative findings, identifying areas of convergence and divergence. Together, the two strands provide a more nuanced understanding of the Clinical Academic role, offering both rich insight and measurable evidence to answer the research questions.

Within this design, the quantitative strand used a descriptive quantitative approach, exploring trends, patterns, and frequencies to understand why the phenomenon occurs (Ghanad, 2023). Unlike experimental designs, the quantitative descriptive design of

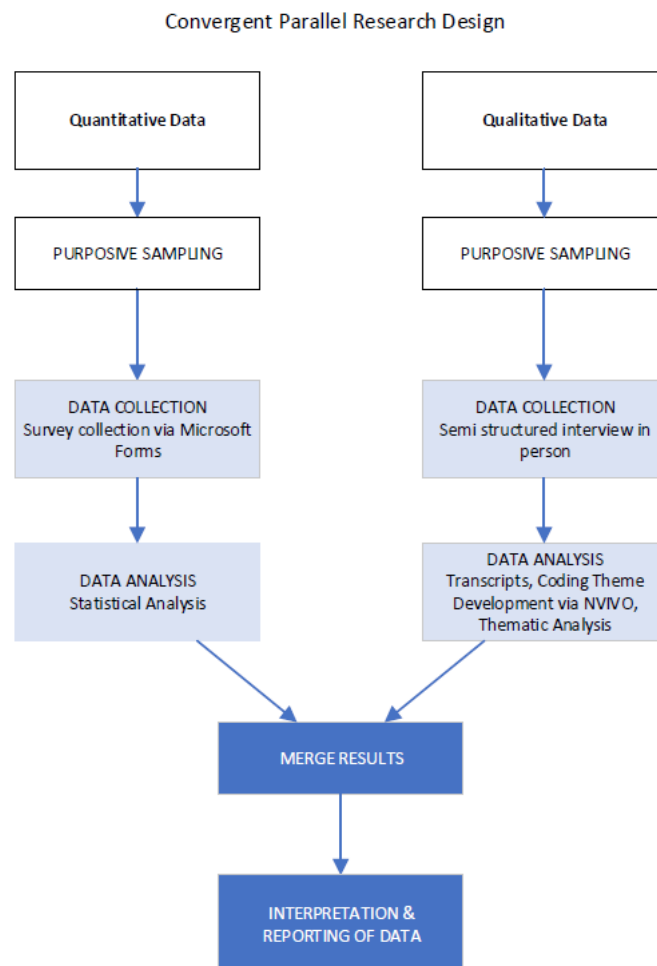
this study does not manipulate variables through the researcher's intervention; instead, the data were generated by seeking participants' quantitative responses related to their experiences. This approach was chosen to complement and support the qualitative data, using a cross-sectional survey to provide a different perspective on the topic at hand from nursing students within the programme. Using a cross-sectional survey enabled data collection from a larger number of students and the assessment of numerous variables to explore potential patterns or trends (Bryman, 2016).

In turn, the qualitative strand adopted a qualitative descriptive approach, chosen for its suitability in providing a low-inference, factual, and pragmatic account of the Clinical Academic's experience (Doyle et al., 2019). Qualitative description presents a foundational approach to research, seeking a clear and accurate account of findings that is easily accessible (Sandelowski, 2000). The use of a qualitative descriptive approach enables rich, detailed accounts that authentically reflect the Clinical Academic's experience, avoiding strongly theoretical interpretation and instead applying pragmatic insights that can inform future practice and research within nursing education.

3.6.1 Integration of Qualitative and Quantitative Components

Integration within mixed methods research serves the purpose of linking quantitative and qualitative findings to develop a more in-depth understanding (Creswell & Plano-Clarke, 2017). Fetters et al., (2013) demonstrate three levels of integration within key stages of mixed methods research: design, methods and interpretation and reporting. Consideration of integration at all levels of the research process enhances the validity of the research output.

Integration through Design - A convergent parallel research design was utilised to collect quantitative data via an online survey and qualitative data via semi-structured interviews. Figure 2 illustrates the planned integration in this study. Both quantitative and qualitative data were collected in parallel before the intentional merging of data post-analysis.

Figure 2: *Mixed Methods Research Plan*

Integration through Methods - Quantitative and qualitative data were collected concurrently, and integration was achieved by merging the datasets. Unlike alternative approaches, merging allows the datasets to remain independent of one another until they are brought together for comparison post-analysis (Fetters et al., 2013). Whilst the datasets did not inform or guide one another, the development of both the survey and semi-structured interview was planned to be conducive to the merging of data at a later stage of the research. This intentional consideration of the relationship between quantitative and qualitative components in the study enabled their natural merging.

Integration through Interpretation and Reporting - Following the data merge, more extensive integration and interpretation were required. This was achieved through the integration of narrative within the discussion chapter, allowing qualitative and quantitative findings to be examined together. The integration was guided by thematic analysis, which facilitated identification of key patterns across datasets, consistent with approaches to mixed methods integration described by Fetters et al. (2013)

Chapter IV: Methods

Not everything that counts can be counted, and not everything that can be counted counts.

William Bruce Cameron

4.1 Introduction

This chapter describes the methods, that is, the systematic procedures and techniques used to collect and analyse data in order to answer the research question (Creswell & Plano-Clark, 2017). Given the complexity and scope of the research question and the need to capture both measurable outcomes and lived experiences, a mixed methods approach with a convergent parallel design was used. This enabled the study to utilise the strengths of both quantitative and qualitative methods, providing a comprehensive exploration of experience and outcomes (Creswell & Plano-Clark, 2017). The chapter systematically outlines the research methods used in this design, including detailed descriptions of data collection and analysis, followed by techniques employed to ensure validity and reliability.

4.2 Qualitative Methods

4.2.1 Participants and Sampling

The qualitative component of this study sought to explore the experiences of individuals who held Clinical Academic joint appointments at the University of Waikato School of Health. Purposive sampling was employed to recruit individuals likely to provide high-quality data relevant to the phenomenon of interest (Patton, 2015). This approach was preferred to exclude individuals who did not meet the study's specific inclusion criteria, thereby ensuring the sample consisted solely of participants capable of making rich and insightful contributions.

Sample size was established in accordance with recognised methodological standards and the small cohort of eligible individuals. In qualitative research, the focus on sample size often shifts from the actual number of participants to the depth and quality of the information obtained (Holloway & Galvin, 2017). Creswell and Plano Clark (2017) note that qualitative components of mixed method research seek complementarity and an explanatory understanding of the phenomena in question, rather than statistical generalisation, which requires much smaller samples. During the research design process, it was clear that, given the programme's relatively recent establishment, the pool of relevant individuals to meet the research needs was limited. Between the programme's conception in 2020 and data collection, 38 individuals were appointed to Clinical Academic roles at the University of Waikato, of whom 26 were joint appointments. After discussion with my supervisors, the desired sample size was set at eight to ten participants, at which point data saturation, the point at which no new codes, categories, or insights emerge from the data, would be assessed (Hennink & Kaiser, 2022).

Inclusion criteria for interviews were that individuals were to currently and/or had previously worked as a Clinical Academic for the University of Waikato nursing programmes in a joint appointment capacity (defined as also having concurrent employment in a nursing position external to the University of Waikato). Clinical Academics employed solely by the University of Waikato, with no concurrent clinical employment, were excluded, as this employment model did not align with the research questions. The inclusion criteria also required that participants had been involved in supporting students during clinical placement as part of their role.

Recruitment of interview participants was via an Expression of Interest sent to the Clinical Academic team via their direct line manager. This was further supplemented with a participant information sheet (Appendix II). This Expression of Interest was also promoted during a Clinical Academic professional development day, with the opportunity for interested individuals to ask any further questions. Clinical Academic staff who wished to participate were asked to contact me, the researcher, directly via email.

Nine expressions of interest were received for the semi-structured interviews. As this was within the desired number and all individuals met the inclusion criteria, no selection process was required, and all applications were accepted for interview. It was made clear that participants could withdraw at any point before or during the interview, and up until data analysis had commenced. During this process, one participant resigned from their Clinical Academic position and withdrew from the research.

4.2.2 Data Collection

Semi-structured interviews were used to explore the experience of Clinical Academics working within a joint appointment. I chose this method to allow flexibility in questioning while still maintaining consistency in key questions and a framework to follow. Semi-structured interviews enable the researcher to explore responses in depth, identifying areas that may provide further relevant context while still gathering the required data to address the research question (Jordan et al., 2021).

Interview questions were developed around the study's aim and included questions about participants' experiences and knowledge, as well as a limited exploration of their backgrounds. In developing these questions, I reflected on my worldview and was mindful that my experience did not translate into them, maintaining an objective, neutral stance. Questions were submitted to my research supervisors for review before the initial interview to enhance validity. An initial pilot interview was conducted to assess the flow and make any necessary adjustments to wording. During this, I felt the flow of questions was somewhat disjointed, and at times I found myself wanting to jump ahead to future questions in light of the answers provided. Following this pilot interview, I adjusted the question order and added one additional question after an answer prompted an area that had not been addressed. The interview template is provided in Appendix III.

Interviews took place between December 2024 and June 2025 and involved eight participants. Length ranged from 19 to 51 minutes. All interviews were conducted face-to-face in private locations, guided by participants' preferences, at a time convenient for them. All interviews were recorded via Microsoft Teams for transcription, which was completed verbatim by myself as the researcher.

Participants were welcomed at the start of the interview, and every effort was made to ensure they felt comfortable. In line with best evidence, the environment was quiet and free of distractions, and the participant was clear about what to expect from the process (Jordan et al., 2021). The opportunity to ask any questions was provided before the interview began, along with a reminder that they may withdraw at any stage or decline to answer any questions. At this stage, consent was obtained (See appendix IV). Participants were reminded that the information obtained during the interview would be anonymised and no identifying features would be used in reporting the data.

To maximise participants' responses, active listening techniques were demonstrated. I engaged with participants throughout, making an intentional effort not to guide their answers, while acknowledging their responses through eye contact and nods. When necessary, I guided the participant to explore something in more detail using follow up questions. Throughout the interview, I took brief notes to guide follow-up questions while remaining mindful that my focus remained on the participant. At the end of the interview, I used open-ended questions to give the participant the opportunity to share any further thoughts. Participants were then thanked verbally for their time and contribution and asked whether they wished to receive the resulting report.

After eight interviews reflection indicated that saturation was reached for several core themes, while others remained less developed. This reflected the diversity in participants' experiences and the independent variability inherent within the role. As a result, analysis focused on areas that were significantly developed while still acknowledging areas where further data collection could extend understanding.

4.2.3 Data Analysis

The qualitative data were analysed using Braun and Clarke's (2006) six-phase model of thematic analysis. This model enables meaning to be derived from interview data through six defined stages: familiarisation, coding, generating themes, reviewing themes, defining and naming themes, and producing a report (Braun & Clarke, 2006). This straightforward and flexible approach ensures transparency and rigour, systematically working through each stage while allowing the researcher to interpret

patterns and themes that emerge from interview data. Braun & Clarke (2006) approach thematic analysis with the understanding that researchers are not neutral parties but actively construct meaning from data through an individual lens guided by their own experiences and frameworks.

The first stage of analysis involved familiarising myself with the data. While the interviews provided an initial awareness of this, becoming fully immersed and familiar required a more comprehensive exploration. Consistent with recommendations in the literature (Finlay, 2002), I maintained awareness of my own biases during this process, thereby remaining open to any themes or directions the data may take. Following each interview, I completed an initial read of the transcript provided via Microsoft Teams to understand the content and ensure it was verbatim and accurate to the original intent. To validate the transcripts, I cross-referenced them with audio recordings and manually corrected and clarified any transcription errors. This process was arduous, and at times it was tempting to skip over content or assume intent; however, approaching this in such detail enabled initial thoughts to be guided by the content rather than preconceived notions. I immersed myself in both reading the transcripts and re-listening to the interviews, taking note of particularly strong or key phrases and writing down thoughts, using a notebook to keep track of ideas and statements. Final transcripts were then submitted to my supervisors for feedback and discussion to maintain rigour. The transcription of the first interview was critically reviewed with my study supervisors, which guided subsequent data coding. This collaborative review process was consistently employed for the remaining seven interviews.

After thoroughly familiarising myself with the data and gathering initial impressions, I progressed to generating codes. Codes were developed through an inductive process utilising open coding methods. Inductive analysis plays a crucial role in qualitative research, enabling the identification and exploration of codes, categories, and themes as they emerge directly from the data rather than relying on predetermined frameworks (Bingham, 2023). This approach ensured that the analysis accurately reflected participants' experiences while minimising my influence as a researcher.

To start the open coding process, I examined the data line by line, identifying segments that held significant meaning. This technique helped me see insights that might have been easily overlooked. NVivo software was used to aid the organisation and analysis of data, allowing for a more systematic approach to coding. Where interview data were particularly rich, I applied in vivo coding, using participants' own words as codes, preserving their original language and maintaining authenticity and intent (Saldaña,2021). The code-generation process was iterative; as more interviews were conducted, new patterns and ideas emerged. I made it a priority to revisit earlier interviews, taking into account these emerging concepts, which sometimes led me to reword or refine initial codes to better reflect my understanding of the content. To enhance the validity of the analysis, the codes and themes were discussed during supervision meetings, and alternative interpretations were considered.

After the initial development of codes, I organised them into categories based on shared concepts and patterns. This helped to clarify relationships in the data and highlighted potential areas for thematic grouping. Some codes, however, did not clearly fit into any category and were temporarily set aside. As I reviewed these categories and compared them with the original data, themes began to emerge that captured broader patterns across participants' experiences. A visual diagram illustrating the relationships among codes, categories, and resulting themes is presented in Appendix V.

Throughout this process, I continuously reflected on whether the themes accurately represented the data and discussed my thoughts with my supervisors to consider alternative perspectives. Through this iterative and reflective process, themes were refined, clarified, and named, resulting in a final set that balanced rigour with accuracy to participants' accounts and captured the depth and variation of their experiences.

4.3 Quantitative Methods

4.3.1 Participants and Sampling

The quantitative component of this research aimed to explore nursing students' experiences and perceptions of Clinical Academic support during clinical placement. As explored in the qualitative component, the quantitative strand also used purposive

sampling to select participants. After thorough consultation with my study supervisors, the survey was distributed to 244 students, with a target sample size of 50.

Recruitment of survey participants was limited to individuals enrolled in a pre-registration University of Waikato nursing programme. This was completed via QR codes linked directly to a Microsoft Forms survey. These QR codes were provided to programme year leads and displayed on respective Moodle platforms for voluntary anonymous participation, with the survey link remaining active for four weeks. Information sheets were provided alongside the survey (Appendix VI). To support engagement with the survey, I attended lecture sessions to explain the research purpose and to provide opportunities for questions or clarification, noting that evidence supports the view that face-to-face recruitment is most effective in health care research (Bruneau et al., 2021).

Inclusion criteria required students to be studying at the University of Waikato and enrolled in a Bachelor of Nursing or Master of Nursing Practice qualification between 2021 and 2024. Students enrolled in their first year of either programme in 2024 were excluded, as at the time of data collection they had not yet completed a clinical placement and, as such, had not worked in the required capacity alongside a Clinical Academic. No other exclusions applied to survey participation.

A total of 48 students participated in the survey. They were diverse in terms of programme level, culture, and age (Table 3). This represented a response rate of 19.7%. While lower than that of traditional paper-based surveys, this rate is understandable given the voluntary nature of participation and the use of electronic survey collection (L'Ecuyer et al., 2023).

Table 3: Survey Participant Demographics

Programme Year		Ethnicity		Age Range	
Bachelor of Nursing	22	NZ	13	18-24	19
Year 2		European			
Bachelor of Nursing	11	Maori	9	25-34	17
Year 3					
Masters of Nursing	15	Pacific	2	35-44	10
Practice Year 2					
		Asian	17	45-54	2
		Other	7	55+	0

4.3.2 Data Collection

Cross-sectional surveys were used to explore the impact that Clinical Academic staff had on nursing students completing clinical placements. A survey was selected as the quantitative data collection method because it enables the collection of multiple variables efficiently and in a replicable manner, whilst remaining generalisable, that is, maintaining an objective and systematic approach to data collection regardless of context or process (Morgan, 2014). This is well aligned with a descriptive approach, enabling the quantification of perceptions and experiences in a way that supports generalisation to a broader population (Polit & Beck, 2021). The use of a survey was considered an effective complement to the qualitative strand of the mixed-methods design, providing an objective perspective to integrate with thematic findings (Creswell & Plano Clark, 2017).

Within the survey, I included a range of closed-ended questions, Likert scales, and open-ended responses to understand the frequency and nature of meetings with Clinical Academics, the perceived benefits of their involvement, and overall satisfaction (See appendix VII). Questions were developed based on existing literature and consultation with supervisors. In addition, demographic data was collected to contextualise the responses.

Data collection was conducted over four weeks in June and July 2024. The survey was available via Microsoft Forms and made available to 244 students via programme year leads. Informed consent was implied by voluntary participation in the survey, and no identifying information was collected. As this survey utilised a self-report format, response bias was a consideration, particularly acquiescence bias. Acquiescence bias is a tendency for participants to agree with statements regardless of their genuine feelings. This can be seen in self-reporting surveys, particularly when wording is phrased positively, which can distort findings by increasing agreement (Bogner & Landrock, 2016). To reduce this, steps were taken, such as clearly stating that all responses were anonymous, providing neutral answers, and balancing both positive and negative worded statements. Completed responses were stored on the University of Waikato's designated computer storage, accessible only to me as the researcher. In recognition of Māori data sovereignty, data storage and management were aligned with the principles of Te Tiriti o Waitangi and best practice for Māori data governance.

4.3.3 Data Analysis

Quantitative data were collated and analysed using Microsoft Excel descriptive statistics and IBM SPSS Statistics version 30.0.0.0. Before analysis, the data were screened to ensure they were usable and complete. There was no missing data in the responses. Some free-text responses did not relate to the questions or provide relevant information, and these answers were disregarded.

Descriptive statistics, including frequencies, percentages, and ranges, were used to summarise participant demographics and key characteristics relevant to the study. Chi-square tests, were conducted to examine associations between categorical variables relevant to the research questions. Assumptions for Chi-square tests, such as minimum expected cell counts, were assessed to ensure test validity (Agresti, 2018). To prepare the data for analysis, categorical responses were assigned numerical values and variables were appropriately coded.

Consideration was also given to open ended questions in which valuable commentary was provided. While qualitative in nature, these statements were used to support the interpretation of the quantitative findings (Creswell & Plano-Clark, 2017). Responses

to open-ended questions were collated and thematically analysed, a process fully described in the previous qualitative stage of the study.

4.4 Trustworthiness, Validity and Reliability

The concept of validity is essential to research, exploring the accuracy of the findings in relation to the phenomenon being studied (Creswell & Creswell, 2018). Within a mixed methods design, achieving this is particularly challenging due to the distinct requirements of different research paradigms (Giddings & Grant, 2009). To achieve validation, processes must adapt and be responsive to the dominant research paradigm, with no single way or set of standards that can be applied; instead, addressing both quantitative and qualitative strands (Creswell & Plano Clark, 2017). While quantitative research emphasises validity and reliability, qualitative research emphasises trustworthiness achieved through credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). These concepts are discussed in greater detail below.

4.4.1 Validity and Reliability

The quantitative component of this study aimed to measure students' experience alongside Clinical Academics using a structured cross-sectional survey. To establish the rigour of the quantitative data and support the validity of inferences drawn from the findings, multiple forms of validity and reliability were considered (Giddings & Grant, 2009).

Construct validity refers to the extent to which an instrument accurately measures the concept it is intended to assess (DeVellis. 2017). The survey was developed after a review of the literature around the Clinical Academic model and student learning experiences. This ensured that survey items were theoretically grounded and aligned with the concepts that underlie the research, thereby supporting the instrument's construct validity.

Face and content validity, referring to the extent to which an instrument appears to measure the intended concept and represents all relevant aspects of that concept (Polit

& Beck, 2021), were supported by expert review from study supervisors, who assessed relevance, clarity, and the representation of the study's aim. Validity was further assessed using pilot testing with a small group of students (n=4). Participants were asked to confirm that items were clear and accurately captured their experiences. Feedback indicated that the questions were generally understandable and accurate, prompting minor adjustments to wording where necessary.

The survey's reliability was assessed to ensure consistent measurement. Internal consistency of the Likert-scale items was evaluated using Cronbach's alpha, a widely accepted measure of scale reliability (Cronbach, 1951; Tavakol & Dennick, 2011). The survey demonstrated excellent internal consistency, with a Cronbach's alpha of 0.933, indicating that the items consistently measured the intended construct.

Together, these strategies support the methodological rigour of the quantitative component of this mixed methods study and enhance confidence in the reliability and validity of the findings.

4.4.2 Trustworthiness

While processes of validation and reliability remain relevant in the quantitative field, the change to a less systematic and transparent process for qualitative data and thematic analysis requires the researcher to demonstrate trustworthiness. Trustworthiness involves adopting processes that ensure the researchers interpretation and conclusions are credible and coherent (Korstjens & Moser, 2018). Unlike quantitative data collection, which is concise, qualitative research cannot be fully replicated; that is, replicating the process will not yield the same narrative from each individual participant (Holloway & Gavin, 2017). Thus, trustworthiness is essential for describing and maintaining sound methodological processes.

To ensure trustworthiness within the qualitative component of this study, the key criteria established by Lincoln & Guba (1985) were followed. These include credibility, transferability, dependability and confirmability, each relating to conventional quantitative measures but grounded in qualitative epistemology. Ahmed (2024) describes how researchers can build credibility by gaining confidence in findings

through strategies such as prolonged engagement, persistent observation, member checking, and triangulation. At the same time, transferability is demonstrated through rich, descriptive detail that enables others to judge whether the results can be applied to another context. Dependability is achieved through consistent and transparent explanation of the research process, and conformability ensures that conclusions are grounded in the data, rather than influenced by researcher bias, achieved through reflexivity (Korstjens & Moser, 2018).

In order to achieve this, I engaged in genuine connection with the participants, providing adequate time for in-depth discussion and building rapport. Participants were encouraged to support their statements with examples, and appropriate follow-up questions were asked. Persistent observation was demonstrated through ongoing reflection and repeated engagement with the data, allowing me to continually refine themes and meaning. The research process was clearly defined, with thick descriptions providing context for the study, the methods and participant demographics, thereby supporting transferability. My research gained dependability through regular supervision throughout the coding process and by applying systematic and transparent processes, including the use of NVivo software to support data management and analysis.

However, these measures alone do not fully account for the researcher's influence on data collection, interpretation, and analysis. Reflexivity addresses this by requiring researchers to critically reflect on their own perspectives, assumptions, and biases throughout the research process (Berger, 2015). The following section discusses reflexivity in this study.

4.5 Researcher Positionality and Reflexivity

A key aspect of research is reflexivity, which involves critically examining the researcher's role and the potential impact they may have on the research process. Reflexivity involves awareness of how the researcher's background, assumptions and interactions with participants or research materials may influence the collection, interpretation and integration of data (Ascroft, 2025). Although more often associated

with qualitative research, it was important to consider this factor within this mixed-methods design to ensure the qualitative findings were interpreted transparently.

Berger (2015) highlights that a researcher may influence the research process in three major ways: access to participants, shaping the nature of the relationship and the worldview and background the researcher holds. Each interviewee brings their own perceptions of me as the researcher, complicating the notion of complete neutrality. In this study, participants were both fellow nurses and fellow Clinical Academics, making full neutrality particularly difficult. This awareness highlighted the need for transparency and openness throughout the research process. Berger (2015) further notes that participants' willingness to share insights may be influenced by their perception of the researcher, either facilitating nuanced discussions or prompting caution in what is shared.

This reflexivity statement aims to highlight my conscious engagement with my positionality, with a deliberate effort to be aware of the impact it may have on data collection and analysis, ultimately enhancing the credibility and quality of the research findings

Within the context of this research, I was very aware of how integrated my role was in this space and how this could impact, particularly in the collection of data from individuals working in close proximity. When I commenced this research, I was only recently employed within the University of Waikato School of Health. I came with the perspective of an outsider, having witnessed the programme's establishment without internal visibility into its processes and rationale. My nursing experience was primarily rooted in acute care within a relatively large city, my exposure to Te Ao Māori, rural contexts and mental health and addictions was limited and my understanding of pre-registration students was from the lens of the clinical setting. In the early stages of the programme, my involvement was somewhat reactive, addressing issues only when they arose or outcomes were not being met. I found myself working with the University of Waikato team to identify solutions that would help students succeed in clinical placements, providing solutions without fully understanding the underlying processes. Previous senior nursing positions in leadership, coordination, education and change

management had oriented me towards problem solving and being systems driven, also shaping my lens as a researcher.

As I moved into direct employment within the Clinical Academic team, my perspective shifted from observer to active participant. This transition provided a deeper understanding and appreciation of the work being done, positioning me as an insider. While this came with advantages, it also introduced challenges, including awareness of power dynamics and potential biases. Throughout the research, my role evolved further as I assumed a team lead position, providing both insight and also requiring careful attention to the influence this might have on participants and the interpretation of data.

I was acutely aware of these dynamics within my research design. In recruiting interview and survey participants, I ensured that participation was voluntary and that all data were anonymised. At the commencement of each interview, I reiterated the voluntary nature of participation and confidentiality measures. My background and position contributed to my understanding of the topic and facilitated rapport during interviews, but I remained mindful to avoid projecting my perspectives onto participants' accounts.

To support reflexivity, I maintained a reflective journal throughout data collection and analysis, noting down any assumptions I made, reactions to findings and thought processes. I engaged in regular discussions with peers and study supervisors to critically examine my interpretations and ensure that findings were reflective of participants' experiences rather than my own preconceived ideas. I also utilised triangulation through multiple data sources, as highlighted earlier within trustworthiness, to further support credibility and minimise personal bias.

Through these strategies, I aimed to ensure that my positionality enhanced the research process, contributing to the credibility, dependability and overall trustworthiness of the study.

4.6 Ethical Statement

This study was conducted by a researcher from the University of Waikato and data was collected from staff and students within the University of Waikato nursing programmes. Prior to the commencement of this research, ethics approval was obtained through the University of Waikato Human Research Ethics Committee on 21st May 2024 (Approval code HREC (Health)2023#64; See appendix VIII). No additional ethical approval was required. All participants received detailed information about the study through information sheets (Appendix II and V) and provided written consent prior to participation. Consent forms were signed by interview participants and retained by the researcher. All participants were informed of their right to confidentiality, and interview participants were informed of their right to withdraw from the study at any time.

4.7 Summary

A descriptive mixed methods design was selected to answer the research questions. This follows a convergent parallel design, concurrently collating both quantitative and qualitative data before intentional integration during the discussion. The quantitative strand presents a cross-sectional survey of nursing students, measuring the perceived experience and impact of working alongside those in Clinical Academic appointments. Descriptive analysis is used to present patterns and trends. Concurrently, the qualitative strand explores the experience of those working in Clinical Academic roles, utilising semi-structured interviews. Thematic analysis is used to explore and present the data. All processes and methods are fully presented to maintain rigour and validity. Findings are presented in the following chapter, with integration of both strands following within the discussion.

Chapter V: Findings

The world cannot be understood without numbers. But the world cannot be understood with numbers alone.

Hans Rosling, 1948 – 2017

5.1 Introduction

This chapter presents the study's findings in relation to the research question. Findings from the qualitative stage, based on semi-structured interviews, are presented first, reflecting the qualitative dominant research design. This is followed by the presentation of quantitative survey results from nursing students within the programme, which provide additional contextual information and a broader perspective on the issue. Integration and interpretation of findings will occur later in the Discussion chapter.

A general inductive approach was used to analyse the qualitative data. Four key themes emerged from the qualitative analysis and are outlined in this chapter. Quantitative data were analysed using descriptive statistics, including means, standard deviations and chi-square tests to examine statistically significant differences.

Part 1: Qualitative findings

This section presents the qualitative findings from semi-structured interviews conducted with Clinical Academic staff. These interviews explored the experiences, perceptions and challenges of working within a Clinical Academic joint appointment within the University of Waikato nursing programmes. All participants interviewed worked as Clinical Academics alongside at least one other nursing role, with some holding three or more positions. Full-time equivalent (FTE) within the Clinical Academic position ranged from 0.1 FTE to 0.5 FTE. Of the eight participants, two worked clinically as Registered Nurses providing direct patient care. The remaining six held Designated Senior Nurse positions in which they did not have direct patient responsibility; however, were clinically relevant due to their active engagement in education and leadership. Pseudonyms were applied to ensure participants' anonymity and confidentiality, as per Table 4.

Table 4: *Participant pseudonyms and associated roles*

n1	Nurse Co-ordinator
n2	Nurse Co-ordinator
n3	Nurse Educator
n4	Registered Nurse
n5	Nurse Educator
n6	Nursing Team Lead
n7	Registered Nurse Prescriber
n8	Nurse Educator

Thematic analysis was used to identify key insights and themes. Four key themes are discussed in detail below with supporting findings.

5.2.1 Role Complexity and Clarity

The theme of role complexity and clarity underpinned much of the interview for all participants. This encompassed a wide range of aspects of the role, from the definition

and expectations to operational challenges and the navigation of providing individualised, holistic support for students. Much of this stemmed from balancing dual roles, with participants noting difficulties with time management, blurred lines between roles, and ethical conflicts arising from joint appointments.

In exploring the understanding of the Clinical Academic appointment, all participants highlighted that the primary focus of the role was to provide clinically relevant support to students to meet the objectives of their clinical placement.

So a real clinical focus, a real clinical space in terms of working alongside students, an awareness of what the competencies or the objectives were, working with them to get those formalised and to structure a plan on how they were going to obtain those objectives over the period of their placement (n3)

Participant n1 further supported this.

It was about kind of being a link for the students and the clinical environment and the tertiary provider for supporting that student, integrating the theory into practice and supporting them with understanding the practical application of our competencies and what they need to be doing to develop the practice to meet these.

Many participants saw the Clinical Academic role as a mentor and guide for students, supporting the transition from task-based care to the holistic model adopted by the University of Waikato nursing programme.

...help them think and see what being a nurse is as opposed to completing a task and that's what I try to get my students to understand is that you know nursing is different than the work we do, which is part of it, but nursing is the caring, the talking, the seeing, the understanding (n8)

In seeking further clarification of the role, it was noted that participants held significantly different views on how they pursued this objective. Participants reflected that the role lacked a clear definition and structure, and there was notable uncertainty around the correct approach. One participant reflected that the role was open to

individual direction and that they personally found benefit in establishing group meetings to nurture whakawhanaungatanga and relationships.

We had our job descriptions which were quite generalised. Every one of us probably did things a lot different... But I didn't see that as a negative. The good thing about the way in which you are working is it's up to you how you manage your time and what you consider is beneficial and what you consider is a nice to have. For me our lunchtime group meetings were beneficial because we built whakawhanaungatanga so well, and whakaruruhau, the real safe space (n5)

However, for others, this lack of direction conflicted with their expectations for the role, leading to frustration and dissatisfaction. Participant n1 stated.

It was really different in practice is what I found the reality of the role to what I thought the role was going to be. I imagined there'd be a lot of vision and I guess conciseness to the role and the parameters of the role, but there really wasn't.

Examples of how participants used their available time reflected these variations in the approach of individual Clinical Academics, as demonstrated by participant n5.

So we meet at lunchtime and I'd book out a room and we'd all bring a shared kai and we'd sit there and we'd talk about things that were going well, things that weren't going well. And I do kind of an impromptu facilitation of what I knew they were struggling with in classes

Participant n8, conversely, provided an example of prioritising the development of the clinical skills needed for practice.

...we go and we have a catch up and we talk about what their week looks like, the types of patients they've looked after, what they've learned... I like to find out their thinking and how they think through situations...I'm actually going to do more clinical skills with my group that's just started. And we're going to do some vital signs, we're going to do, practical hands on things. I want to know that what they're doing in practise is the right thing. And I know that the realities on the floor, sometimes the nurses aren't showing them best

practise and sometimes the nurses are hesitant to let the students do things...I want to make sure they know how to do it properly.

Regardless of these variances in practice, the need for the Clinical Academic to provide a safe and supportive environment for students featured strongly, at times as much as the need to be clinically relevant.

Whakawhanaungatanga was really important in that first connection to find out what was going on for them as a person and what would we need to consider in this kind of journey together...But definitely my focus is always you as a person first and then you as a student second and then obviously the placement wrapping around as well (n6)

A specific illustration of the benefit of this support is provided by participant n1.

One of the students in particular was really not progressing and wasn't completing the competencies. I was having constant conversations with her and a lot of it came down to eventually, at the end of the placement, we got to the fact that the area that she was in had patients with an oncology diagnosis and her mother had been going through that same battle. And so it had been influencing that she didn't want to come to placement because it was bringing up all those emotions. And so it was a lot of pastoral support to help her try and access supports. You know what's available at the uni. A lot of extra visits to go into her and to support her to help her actually progress, to be able to complete the placement and pass.

Following an exploration of the role itself, participants reflected on the complexities of its actual application. As defined by the role, participants held dual, and at times triple, employment between the University and clinical partners. All participants noted that the demands of the Clinical Academic role were unique and that balancing these presented significant challenges, with clinical placement hours, fixed teaching, and primary role requirements competing for priority. Clinical placement requirements were inconsistent, not only across the academic year but also within the week itself, with variable and unpredictable student rostering, which directly correlated with challenges in time management—for one participant, managing these complexities significantly affected their job satisfaction.

It was horrific. I'll put that out there right now (n5)

Participant n1 supported this, noting that, despite their enjoyment of the job and satisfaction in supporting students, these challenges were significant enough to prompt their resignation.

Spending time with those students and seeing them developing as future nurses was also a real cup filling moment for me and actually was a huge highlight and just a privilege to be part of that and I think that maybe if circumstances around the role were different, I may have continued on because that was a real privilege to be part of.

Participants who held Designated Senior Nurse positions indicated that they balanced their roles through the flexibility of their primary positions. One participant described feeling that working as a Clinical Academic would not be possible without this autonomy.

Working clinically on the floor there was no way you could intermingle the two roles. Whereas as a nurse educator or then the job I'm currently in, they're a lot more autonomous. So you could meet with your students first thing in the morning, do a couple of hours of your primary role and then go back and see a student (n2)

Participant n1 agreed, however, reflected that this too had an impact.

I could flex my hours in that role to suit what was needed in the Clinical Academic role. But the downside of that was the CA role became more encompassing and entered into my primary role. I got really emotionally burned out because I felt having to invest so much of myself to support their students in a small FTE and that's a huge reason why I didn't continue in the role.

The same sentiment was supported in discussions among participants holding Registered Nurse positions; however, without the autonomy of their own schedule,

the impact was seen differently, with the Clinical Academic role impeding on participants' personal time. Participant n4 noted.

I was probably still doing the same amount of my paid hours but distributed across a week in a way that meant I wasn't really getting a nice chunk of time off. So yes, in terms of well-being and work life balance, yeah, it was challenging.

All participants, however, were clear that effectively managing multiple roles depended on their ability to differentiate between them and to allocate time for the mental transition required to focus on both clinical and academic responsibilities. Participant n7 provided the following example.

I had dedicated days that I was able to go out and support students and I think that that was that worked well for me. I don't believe it would have been manageable if I had have been working increased FTE in the clinical space and then try to see students on top of that. And I felt like having that dedicated time allowed for my head to switch out of a clinical practice and to supporting students you have that clear differentiation between the two.

Participant n5 agreed, suggesting that navigating the role within a small full time equivalent was challenging.

And then on your days off, you decompress in that time. And when you have a 0.1 FTE or even a 0.2 FTE one day a week. But one day a week it takes you kind of half a day of decompression before you can actually get back into it. So the disjointedness of that, I know that some academics really struggled with theirs.

These time management complexities were often exacerbated by other unpredictable elements of the Clinical Academic role, including the individual and unpredictable nature of clinical placements. Multiple participants spoke of the need for a response to crises and of their physical presence in the clinical setting, even while working in their primary role, leading them to act as emergency responders at the request of the off-site academic team.

I did tend to get a few phone calls as an emergency CA, but because I was just on site available and generally able to reshuffle my workload at relative short notice, I would go and attend to students' needs at very short notice, sometimes with them depending on the crisis within half an hour or so (n2)

While some spoke to this as a challenge, it was not seen as solely negative. Participant n8, conversely, said of the benefits of this physical presence, indicating that it provided an added support structure for students.

Because I'm always there, they don't ever feel alone

Having highlighted the challenge of physical presence, some participants then reflected on more nuanced complexities arising from the clear division of roles. For those participants holding Designated Senior Nurse roles, the advantages of autonomy and flexibility also came with added responsibility within the organisation. At times, this meant access to information that was not readily available or openly shared. It was noted that the participants who held these roles all spoke of navigating 'blurred boundaries' and challenges in distinguishing a clear division between the roles. Participant n3 spoke of navigating this.

...that was really tricky, like the ethical, the moral dilemma as well knowing things as a CA that I am partial to then the next day as an Educator or a Charge Nurse Manager, but not being able to contribute then to that conversation because actually there were real boundaries around privacy ... Every day and every conversation that I had I had to actively put myself into a CA role as opposed to an Educator role or a CNM role, and so that means because there was two ways, maybe three ways, that you would answer a conversation depending on what hat you would wear

This was supported by participant n8, who discussed the difficulty of leaving her primary role behind when working as a Clinical Academic.

I say if you're a nurse, you're always a nurse. I don't think you're ever not a nurse, and it's the same thing when I'm an educator, I'm always an educator.

The student's perspective was also addressed in this context. Participants who reflected on their own challenges in distinguishing boundaries considered how students could manage this, particularly when working with an individual holding multiple leadership roles that influence their practice. Participant n3 commented on this.

The challenge for the student who once again was seeing one face and getting you as the Clinical Academic say one thing, then you as a Nurse Educator say another...how do they negotiate that?

5.2.2 Enhancing Practice & Learning

A clear positive theme that emerged was that the Clinical Academic role supported increased learning and improved practice in both academic and clinical settings. This was demonstrated through examples of both student and staff practice, as well as through further development and learning for the participants themselves.

All participants shared the view that the Clinical Academic role addressed the theory-practice gap between classroom teaching and clinical practice. Participant n5 summarised what this looked like for them.

The point of the role was to enable nurses who worked on the floor, so who had a clinical background to be able to take what was happening in theory at the University and be able to replicate or dovetail that into practise. So, our job was to support the students in recognising what they were learning in theory in the real world, because prior to this particular programme, there was quite a disconnect. You did your theory, you did your assignments, and then you went out into practical. I remember back when I was studying to be a nurse, I couldn't see that correlation. I knew the theory of it, but I couldn't understand why we were learning all the theorists because you actually didn't see that much in practice. But when you reflect on it, it's there, you just don't realise.

Participants reflected on their own clinical practice to determine how they could achieve this objective. Some participants noted that being clinically relevant in their

dual role heavily influenced their ability to support students during clinical placement. They said this enhanced the learning they could provide, as they held relevant, in-depth knowledge of current policies and practices. Participant n7 commented on how the ever-changing nature of health care required this up-to-date knowledge.

You are up to date and current in your practise. I feel like there's a real need for that because things are shifting so quickly. Updates and best practise are evolving and if we are not up to date with it ourselves, how can we support the students in that space?

For some participants, there was a strong correlation between their experience as students and what they felt was needed in this role. There was a sense that an individual who understood and had lived experience of the current health context would provide a much more relevant and relatable learning experience than one long removed from clinical practice. Participant n4 commented.

Anecdotally, I remember feeling that some of my tutors were dinosaurs, you know, and nurses reflect on their own experience of their tutor turning up to placement and just being like, you're all good...and having no understanding of what the current clinical environment is actually like. So in the context of a healthcare system under a lot of pressure, I think having a CA that has a joint appointment is a really nice touch point to be able to bring in the kind of high standards and ideal we teach academically and help them to reconcile that with what we are seeing on the floor. Rather than just being a tutor that maybe hasn't worked on the floor for 10 years saying, this is how we did it in my day, I can say, yeah, I had a similar situation. This was my reflection on it. And then you can have kind of quite an encouraging moment together.

Participant n7 further agreed, recalling the disconnect they felt in practice.

Thinking back to when I was a student, I had clinical preceptors that like had been out of practice forever and ever and they had no idea and that as a student I remember thinking that doesn't make sense.

While the need to provide clinically relevant support was clear, participants' perceptions of how best to achieve it varied, with many reflecting on different

approaches to engaging students in clinical practice. For some participants, there was a clear expectation that the Clinical Academic should directly assess and guide the student in the clinical setting. Those who worked in this way were clear that being in practice alongside students gave a unique opportunity to gain insight. Participant n7 noted

You're almost like that fly on the wall observing them because you kind of trust that what they're telling you is happening in placement is happening. It's that high trust model right? And particularly for the RN preceptors what they're observing and then feeding back to you versus the reality, again it's high trust that you're hoping that what they're telling you is actually true and correct.

Participant n5 reflected on their own learning style, indicating that some students require this practical approach to succeed.

Because I wasn't an academic person myself, so I knew I didn't shine on the academic side, but I shone in the doing of the doing side and I wanted a very holistic view of each student and in order for me to get there, it was to see them in practice....I thought from a student's perspective, what would I want as a student and it was like I actually want someone to see me interacting with real people.

Conversely, some participants felt it was neither appropriate nor possible to work alongside the student in a clinical capacity or within the clinical space. Several participants noted resource and practical constraints that limited their ability to work in this capacity; as a result, they rarely utilised this method of supporting students, even though their dual employment allowed it. Acceptance from both the patient and the clinical staff was also considered a factor. Participant n4 commented.

I can't be in theatre with them. It's not really appropriate. And then even on the ward, I think because it's not something that happens very often, it doesn't really feel like there is a space for me to be like, oh, can I just come with you and watch you do this for a patient? And I don't know how comfortable the wards would feel with that either, or the patients. You're kind of a random person even though you're in uniform, which makes a big

difference in terms of identifying yourself. But I don't know that to me, it doesn't really feel like there's a space for me to jump into, to be like, let's go do a set of vitals.

However, in practice, despite clinical support, most participants believed that even if they were not working directly with the student in a clinical capacity, their current knowledge of the health care system and up-to-date practice provided a better learning experience for the student.

Another aspect was the area in which Clinical Academics were allocated, which was also a point of contention, with some participants clearly in favour of working in their own speciality. For some participants, working as a Clinical Academic in their area of expertise enabled them to further demonstrate enhanced learning and knowledge, supporting a greater ability to understand the dynamics of the clinical area and relay this to students' learning. Participant n1 explained.

It definitely enhanced having familiarity I think with the clinical services because I went back there as a CA in areas where I had worked so I knew the people, I knew the philosophy of the wards, I understood the clinical processes that were happening which actually meant I could help push their thinking a bit more past the service level because I knew the processes that were happening or why we'd be doing things. I knew the clinical process for a patient. For example, the disease process, what they would look like in this area. So it actually meant that I feel I was able to do the role better with that knowledge.

In contrast, others highlighted the need to separate from their primary employment and felt it was necessary to be placed elsewhere to create clear boundaries, as earlier noted.

The University initially really pushed for the CAs to be working in the areas where they have their own portfolios because they came with that clinical depth and that clinical knowledge. And I really advocated and pushed for people to move out of those spaces because it just become too complicated (n3)

For some, the clinical area itself was deemed to be irrelevant, and participants felt that the Clinical Academic should hold the skills necessary to apply learning to any clinical placement. Participant n5 gave an example, highlighting that strong relationships support application within any context.

In theory, every ward is set out the same. If we're talking about the hospital, every ward is set out the same. So you knew where the sluice was, you knew where the medicines were. You know, it was nothing to have a conversation with the charge nurse and just talk about how they ran the ward. I'd always make sure I touch base with the educator of that area to make sure that it wasn't stepping on toes. So that relationship building was huge.

While many participants emphasised the importance of strong clinical knowledge, viewing it as essential for credibility and effective teaching, others took a different view. Some participants noted that they did not necessarily feel that providing clinical support enhanced their ability to support students' learning during clinical placement; instead, they indicated that the Clinical Academic role benefited students through pastoral and person-centred care. Participant n2 spoke to the ability to serve as a neutral party.

...but even the clinical hands on knowledge, I wasn't really able to support them with that, but I was able to sort of support them with conversations about how they could have conversations with preceptors or what sort of questions and ways of thinking would be beneficial to them in their placement. But then also being an external person where you can just let them debrief and be like this happened.

This was supported by another participant, who highlighted that the foundational concept of whakawhanaungatanga significantly benefited student outcomes. Participant n5 reflected that while they have the clinical knowledge, their connection and understanding of the student was paramount.

Where I can draw on my knowledge of clinical, I will, but it's more around what can I bring from my experience of nursing to the table. That whakawhanaungatanga was really important in that first connection to find out what was going on for them as a person and what would we need to consider in this kind of journey together.

While much of the discussion centred on how the Clinical Academic role enhanced student learning, participants also reflected on the enhanced practice that stemmed from involvement in the academic space. The need to be up to date with evidence-based practice and able to address student questions was seen as a driver for some participants in refreshing their knowledge.

So teaching students how to do a respiratory assessment that highlighted lots of my own knowledge or something that I maybe had learnt you know 10 years ago. Yeah. And have just not really thought about since. And that's also made me reflect more on like evidence based practise. But when you're teaching a student, you really have to have an evidence base. And that's what we should be doing clinically as a nurse on the floor too. So I think it has totally improved my clinical professional development and my on the floor nursing (n4)

Participant n7 agreed, noting that the role prompted a lot more self reflection.

What worked really well was the fact that you were you were as up to date as you could be with your own practise. What it did is it made you reflect on your own practise a lot more so when a student came to you and asked you a question, you couldn't just say it's just because we do it like that. You actually had to take time and go what do we do? Oh, that's right. So actually I loved it because it kept me fresh. It kept me up to date and these guys were learning the most up to date

However, this did also highlight the need for Clinical Academics to engage in learning about aspects of the programme unfamiliar to them.

I felt I need to look this up myself and actually do some of my own professional development...the integration of the HUI process in particular because I wasn't taught that when I studied and it definitely wasn't a space that we were very good at at the practise that I was working in. And so that became quite apparent quite quickly. I was like, oh, this is new. I need to actually take the time to ensure that I am up to date with what they have been taught there.

In addition to the need to update clinical practice, the Clinical Academic role also required participants to engage in marking and assessment, areas they had not previously encountered in traditional nursing practice. While some participants brought experience in education from the clinical setting, nearly all noted knowledge deficits in aspects of academia they had not previously encountered. Participant n1 commented

And then the next one you think I marked that a bit softer, mark the next one harder, but we didn't get a lot of support in that respect and that was a bit frustrating because we'd mark things, and I don't know about you, but I overthink stuff and you know the first one I mark, I mark it relatively soft and the next one I can't go. Oh God, that was better than that one. But that one I gave an A and this one how am I gonna mark this one now? 'cause. It was better than that one. So you start second guessing.

Participant n5 agreed, reflecting on the division seen between clinical and academic worlds.

And when you see from a clinical mind, not an academic mind the marking can be a little different and the rubrics can be a little murky

One participant spoke of the same challenge, however further highlighted that this was compounded when also faced with insufficient knowledge of the programme and content.

...trying to figure out if you were being a fair marker or too harsh compared to what other people were marking and not knowing enough about the program, content and expectations of students learning at different levels. It did make it challenging to know whether you're making accurately (n1)

For some, the Clinical Academic role also enabled formal learning opportunities in the form of postgraduate research. Two participants reflected on their own postgraduate research, completed within their roles, demonstrating mutually beneficial outcomes for both the University and the clinical setting. One of these participants further indicated that her involvement has made her somewhat of a 'representative', noting that

colleagues know she works for the University and seek her guidance in their own development, an outcome that benefits the clinical department by promoting further research and learning.

And it's not that I'm giving them academic advice, but I can just be like, oh, so maybe have you thought about this or this could be a pro and con of this decision and this could be a pro and con of this decision (n5)

5.2.3 Collaboration and Connection

A further theme to emerge from the data highlighted the importance of collaboration and connection in shaping the experiences and outcomes of the Clinical Academic model. Participants consistently emphasised the value of strong relationships, including connections with academic teaching staff, students, and the clinical setting. This collaborative dynamic supported the application of the holistic model that underpins the programme and was explored through both positive and negative examples.

Seen clearly in participant responses, the connection between the Clinical Academic team and the teaching team was identified as pivotal to the practical application of the Clinical Academic model. Participant n6 reflected on these strong connections as a point of difference in the programme, noting the wrap-around support students received.

It is kind of pioneering, but really student centered and not system driven. So the relationship between clinical academic and student was quite strong, but also Clinical Academic with the teaching team was quite weaved in. So we were really interconnected.

Participant n5 further supported this, noting ongoing points of connection in highlighting students needing additional support.

At the beginning, we'd meet once a fortnight when we first started, and then it went to monthly, and we'd meet with the academics, as well as us as the CAs, as well as the

faculty. And in those meetings we would talk about who was struggling... It recognised that some people needed additional support and that was what the programme was meant to be designed for.

Participant n2 commented on the positive impact of this connection on the Clinical Academic themselves, reflecting that this created an environment that provided guidance and support.

As a Clinical Academic having a foot in the academic and clinical world epitomises the vision of the Waikato programme to provide holistic wrap around care. It gave me as a Clinical Academic a bit more awareness of how to support the students in that transition, especially the challenges of being comfortable in the current clinical space and then where you could I guess direct them in terms of support.

This connection between the teaching and Clinical Academic teams extended beyond clinical placement. While this enhanced the Clinical Academic experience in supporting processes, many participants spoke of their involvement in teaching, marking, and guiding clinical skill development as both key to gaining an understanding of the programme and integral to embedding themselves within the team.

I think being so connected to the team here has made it much easier for me to look after the students on placement because I know so many of the other Clinical Academics, I've been involved with teaching some of the curriculum development stuff, you know, even just the competency workshops over summer. Even if I haven't been directly involved with them, knowing what's going on is helpful whereas I think if I didn't spend any time here at the University, you could become very isolated and could be just doing your own thing. Maybe very well-intentioned, but without that strong connection to the core team here. So I think I've been able to really keep my foot in both camps and that's just given me a lot more confidence to be like, no, this is the standard we expect (n4)

Participant n2 supported this, noting how this dynamic enhanced the ability to provide a cohesive flow of support from teaching to practice.

We supported the lecturers by taking the tutorials in the paper and as part of that also assisted with marking of student assignments, and it really opened the door to have a full awareness of actually, what does the university teach? How are they teaching? What are we wanting to then see taken from the lectures and how are they applying that in clinical in real life, with all the challenges that come from working in a compartmentalised, rigid healthcare system?

This notion was strongly represented, with other participants also reflecting this in their experiences. Multiple participants spoke of how the role is embedded throughout the programme, from teaching clinical skills to supporting clinical placements and completing formal assessments alongside the teaching team. Participant n3 commented on this, noting also the reciprocal benefit for the clinical setting.

So we did have the portfolios of running the workshops. For example like hand hygiene, the clinical skills group and stuff like that. And definitely the best part was that we knew exactly what the expectations were at Waikato Hospital and what needed to be said, and the level that we wanted them to be working at so we could work to our policies and guidance and our standards because we had that insight.

Participant n2 provided an additional perspective, proposing that any Clinical Academic not working in this capacity would encounter challenges understanding the programme's foundations, potentially limiting their capacity to meet the demands of the role effectively.

For new Clinical Academics that came on board who weren't able to have that foot in the academic space and the foot in the clinical space they may have struggled, particularly if they had come on and hadn't had the opportunity to attend any of the professional development days with the emphasis on holistic care. There were several Clinical Academics that I really had to support regarding that because they just didn't quite understand

While connection and collaboration amongst the team were largely positive, some participants expressed feelings of isolation and disconnect in their roles, highlighting that experiences were not universally positive. When discussing the management of

student issues in practice, some participants voiced feelings of isolation and uncertainty. While they indicated they received verbal support and guidance, the actual act of navigating confronting conversations was challenging. Participant n1 provided this example.

Having to have conversations with students around their behaviours, the attitudes, the way that they're conversing with patients and what our professional responsibilities are. And telling them that they're not meeting their competencies and they're not going to pass the paper, and having multiple conversations continually about this. It's quite isolating because I could ring the module lead and be like, hey, this is what I've done and they're like, yep, you've done the exact right things, just keep me in the loop. But you felt really isolated at the time when you were having these meetings with them and you are trying to judge how hard do I be? How soft do I be? How supportive do I be? Because there was no training or process or learning on how to manage those situations.

Participant n2 supported this, noting a disconnect between their expectations of support and what was provided.

There was very much a 'we'll support you', but there wasn't any tangible support...The rapport with the academic colleagues needed to be fostered in order to engage in a meaningful way to be effective for students

Beyond the relationships between Clinical Academic and the teaching team, participants also highlighted the importance of connection with the student. The holistic nature of the programme centres the student as the focal point, with all aspects of teaching, support, and development structured around them, as reflected in the discussion. Participant n5 noted this point of difference: the flexibility to address students' needs rather than focusing solely on academic achievement.

You could flex in and respond as a full team, both academic and clinical academic to what either the student group needed or what individual students needed, so I feel like that's probably quite different to a tutor student relationship, where it's probably traditionally more focused on the students academic journey only and not them as a person.

This sentiment was common among participants, with many highlighting how they integrated connection with the student into their regular touchpoints. At times, this was noted as the central focus of their meeting, acknowledging that the Clinical Academic's role did not solely relate to the guidance of clinical practice or the completion of assessment components. Participant n2 reflected this in their discussion.

I'll try to really make sure if there's a bit of a well-being check in moment there right at the start. And for some students, there's a lot they need to break down there and then that may end up being a huge amount of what we talk about.

Additionally, participants reflected on the experiences of Māori and Pacific students, noting that the strong connection with the student was integral to providing culturally safe care that aligned with the bicultural lens of the nursing programme. Participant n6 provided an example of how this connection and flexibility were integral to the student's success.

Because she was a Māori student, that different way of relating and supporting her and understanding some of the things that were going on from a te ao Māori point of view kind of helped her journey and she, I mean, she honestly would say the same thing. So I think sometimes having that ability to move Clinical Academics to focus that way rather than saying you're acute, you're only doing acute. You're primary you'll only do primary. For the 80% of the students, they're going to be fine for the 20 you might need to think about different ways. And then within that 20, there might be a real core who actually we notice when they were with this person, things seem to be better in their life because things were getting sorted out and their learning was able to be applied so let's think about how we can connect and keep that whanaungatanga going into this placement.

The final point of connection explored in this space was the collaboration that existed within the clinical setting, with participants frequently emphasising its importance. Collaborative engagement with clinical teams was seen as essential for students to succeed during clinical placement, regardless of the Clinical Academic's clinical

presence in the space. Participants unfamiliar with a clinical area all noted the importance of establishing and maintaining solid relationships with the clinical setting.

I worked quite hard to build strong relationships. I thought that was pretty cool to actually connect with people within different community settings as well and just have really clear communication...What I did find is that they received me each week more warmly, because obviously I'm a stranger to them in those first weeks, but going back, and you're that constant clinical academic, you could say that they started to trust me. I became more of a familiar face to them as well. And in that, dialogue actually happened more naturally as opposed to sitting down and be like, right, let's talk about XYZ (n7)

Participants who held existing relationships with clinical areas also reiterated the importance of ongoing points of connection, however they did note that these existing relationships aided in establishing a strong Clinical Academic presence.

...in some placement areas, it's really easy. I always send the e-mail to the nurse educator and the charge nurse, just to even reintroduce myself. I'm still going to be your Clinical Academic, I'm still the person to talk to. When I'm visiting the students on the ward, if I see the leadership team around, I'll always make a point to just check in and say hi and remind them to talk to me if they have any problems and they always do. (n8)

Finally, the reciprocal nature of this connection and collaboration was also explored by some participants, who noted that, at times, the University programme had unrealistic expectations that did not align with the realities of the health care system. Participants spoke about how their joint appointment gave them both clinical insight and awareness of academic endeavours, enabling them to advocate for effective, practical processes.

the reality actually that was huge for me because sometimes the university would say things or have expectations and you know, not having that clinical insight or coming from the hospital, you know, you could speak to actually, this is what the reality of you know, if you're saying that you want to do that, this is actually what will happen or this is what we'll see. Well, this is what we need to do to ensure that that is brought into place as well. So yeah, probably those insights were really, really beneficial (n3)

5.2.4 Systemic Pressures

The final theme that emerged from the data concerns systemic pressures that impact the Clinical Academic role. Participants identified a wide range of barriers that influenced their ability to navigate the role effectively.

For some participants, practical limitations were significant, with one participant noting that the workspace was inadequate and that, at times, this would dictate the nature of the student encounter.

There is really limited physical space to meet in the hospital, especially in theatre. There's no offices. We would have to leave their placement to find somewhere we could talk that was private (n4)

Challenges also related to staffing and the clinical setting. Participant n1 highlighted challenges regarding the support provided to students.

So every time I saw the student, I would ask the preceptor for some feedback...more often than not, the preceptor would be a different one every single day

Challenges were not just operational but also highlighted issues with the employment model. Some participants referred to the challenges faced in clinical practice, noting that the practice setting is 'chaotic' and under pressure, having a direct impact on joint appointments. Participant n8 reflected on how times of uncertainty within their primary role directly impacted the support and allowance they were given to complete their Clinical Academic responsibilities.

It's heavily reliant on their engagement and their willingness to come to the party. I feel like there's an uneven power balance and I feel like that the power does sit a lot more with the primary employer than it does with the University. I understand why they did it, but I didn't like bringing me back because it just left everyone in limbo (n8)

Participant n5 supported this giving an example of clinical demand creating challenging dynamics.

And if they went back to the wards that they were on, which quite often they did, if you were a surgical nurse and you got the surgical students, you were pulled into stuff on the floor, if there was a need, if they were short staffed, if you know there was no coordinator and they knew you were a coordinator, then it just got a little bit messy.

This also resulted in difficulties with planning, as it was hard to anticipate whether staff from particularly busy or pressured wards would be released to meet their Clinical Academic requirements.

Those that were being bought back from things like medical wards, surgical wards, their release was a lot harder than what mine was, so the buyback was I'd say very fragile semester to semester (n5)

For some individuals, the uncertainty and demands in the clinical environment had a significant impact on their ability to remain positive and support students' integration into a pressured healthcare system.

It's all chaotic and we have no staff and those are just the realities of the healthcare system at the at the moment. So sometimes having to kind of still give students that hope and teach them that like best practise and what we're aim for can just stay a little bit challenging because, you know in yourself that that's not what they're going to face when they are a fully fledged new graduate. (n4)

Conversely, one participant felt the Clinical Academic played an essential role in bridging this divide between the reality of the health service and the values promoted within the nursing programme. Participant n2 saw the Clinical Academic role as key to integrating necessary change within the health context.

I think what the University is trying to do with the ethos and the vision is what our health care needs, what our health care service needs as a whole. I do acknowledge it will put our new grads in an awkward position when they graduate which is where I think the Clinical

Academic role is a vital role to be able to plug that gap of this is what the uni is teaching us this is the clinical space that we'll be working in. How are you going to navigate that? Because that is a huge challenge (n2)

The division between the nursing programme and the realities of practice was also explored in the context of organisational values. Multiple participants reflected on the differences in the ethos of the University programme, compared with the more traditional expectations and processes seen within the clinical setting.

One thought I have is that, because of the holisticness of the vision of the university, we need to work around what's best for both the patient and the health care provider. Which sometimes came into friction with clinical areas when they had very clear rules about what they expected... We obviously had the overarching vision of ensuring that our new graduates, when they were registered and qualified, would be able to be a voice, a really holistic compassionate voice for patients. And really drive a cultural shift because historically we tend to compartmentalise and as soon as you get into clinical you start working by that by default, because that's what the environment dictates

Systemic challenges were also highlighted as significant in the programme's development. While the processes around establishing the programme were not a primary focus of this research, this was strongly represented in the voice of the participants, and in hearing these perspectives, it did highlight the challenge of how the Clinical Academic model aligns with the need to support much larger student numbers than at the point of programme commencement.

Five participants made a clear reference to the programme's rapid growth and the increased number of students, presenting a significant challenge to the Clinical Academic model as initially intended. Some participants reflected on the programme's initial phase and how this morphed, with many stating that they were 'flying the plane as they were building it'. Participant n2 commented.

So in terms of expectation, you knew what the long term goal was. It was a rocky road trying to figure out how to how to get there, especially since you know most of us hadn't

necessarily started a nursing programme before. So we're all learning together and changing things.

Participant n5 raised concerns that the programme shifted from its core values, and the ethos was threatened as systemic challenges became the greater priority.

...we're going to employ you on whatever hours you can and you can go and see these students. It wasn't to me a clear selling of the kaupapa of the programme and a clear plan of employing people for how they see the programme and how they can add value, and I think we lost our way.

For multiple participants, the inability to provide the level of support that they felt the role required greatly impacted job satisfaction. Participant n3 commented.

And there's just no way that you can do that justice. And you know that's a disservice to the students. It's a disservice to their service who's providing a placement for their students in terms of, like, the necessary support they need. And also, it's a slap in the face to the CA as well in terms of, you want me to do my job well, I need that at the very least, the time to be able to support these students.

As student numbers increased dramatically, it became challenging to maintain the same level of holistic care, and key functions of the role became unfeasible. Participants reflected on reducing time spent directly with students and no longer attending meetings.

When we first started, we had weekly meetings, fortnightly meetings. And again, we had the ability, the flexibility because of the work load. As we progressively got more students, the ability to attend those meetings got removed because you just couldn't feasibly attend and see your students (n2)

This was supported by Participant n5, reflecting a need to adapt to meet practical limitations.

If I had the capacity for it, I would actually, I'd go and work with students like work alongside them on the wards and in practise but as the programme developed, that got less and less, you know, just like I say in terms of like the numbers of students that were coming through. There just wasn't the capacity.

Part 2: Quantitative findings

The quantitative survey collected data on students' experiences and perceptions of their engagement with Clinical Academic staff during clinical placement. Descriptive statistics were used to summarise the findings, followed by further exploration of statistical significance and insights gained from responses to open-ended questions.

5.3.1 Response Rate and Participant Demographics

Of the 244 students invited to participate, 48 (19.7%) completed the survey. Table 5 displays the demographics of the participants.

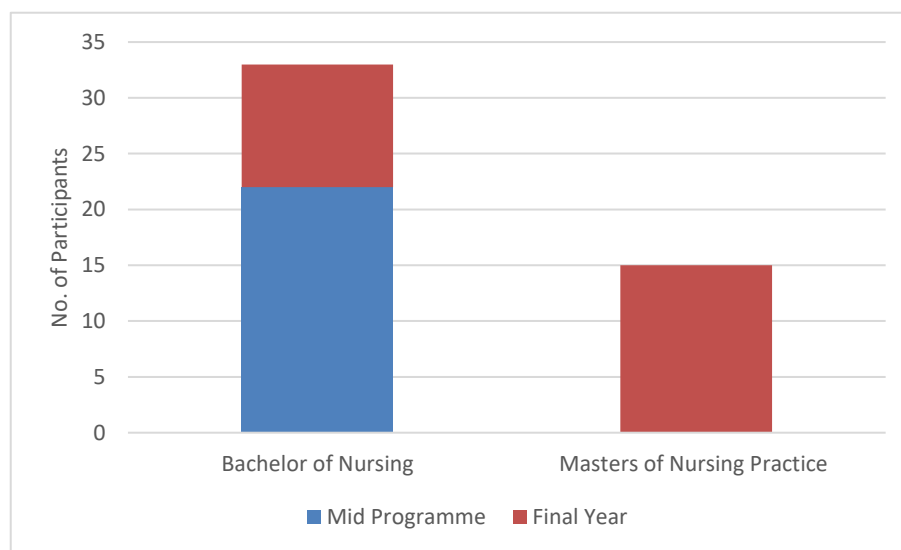
Table 5: *Survey participant demographics*

Variable	Category	n	%
Age Group	18-24	19	39.6
	25-34	17	35.4
	35-44	10	20.8
	45+	2	4.2
Ethnicity	NZ European	16	33.3
	NZ Māori	9	18.8
	Pacific	2	4.2
	Asian	18	37.5
	Other	8	16.7
Programme	Bachelor of Nursing	33	68.7
	Masters of Nursing Practice	15	31.3
Year Level	BN2	22	45.7
	BN3	11	23
	MNP2	15	31.3

The age distribution of participants demonstrated that most were in the younger age categories. Specifically, 39.6% (n=19) were aged between 18 and 24 years, 35.4% (n=17) were between 25 and 34 years and 20.8% (n=10) were between 35 and 44 years. Only 2 participants (4.2%) were aged 45 years and above. Ethnicity was self-identified,

and participants were able to select more than one ethnicity; therefore, some identified with multiple ethnic groups. Those who self-identified as Asian represented the largest cohort, accounting for 37.5% of the sample (n=18), followed by those who identified as New Zealand European (33.3%,n=16). New Zealand Māori accounted for 9 participants (18.8%), Pacific, 2 participants (4.2%) and 8 participants selected 'Other' (16.7%). 'Other' was not further defined. Compared with the New Zealand nursing workforce, where 49% identify as New Zealand European, 7% as Māori, and 4% as Pacific, New Zealand European participants were under-represented, while Māori and Asian participants were over-represented (Nursing Council of New Zealand, 2024). Figure 3 shows the distribution of programme type and year level in which participants were enrolled at the time of the survey.

Figure 3: *Programme type and year of study*



The majority of participants (68.7%, n=33) were enrolled in the Bachelor of Nursing programme, while 31.3% (n=15) were enrolled in the direct entry Masters of Nursing Practice programme. Of these participants, 45.7% (n=22) were mid way through their nursing programme of study, while 54.2% were in their final year of their respective programmes (n=26).

5.3.2 Nature of Clinical Academic Meetings

Participants were asked to explore the nature of their meetings with their Clinical Academics. Table 6 demonstrates the frequency and duration of meetings students received from Clinical Academics during clinical placement.

Table 6: *Clinical Academic Meeting Frequency and Duration*

Meeting	n	%
Frequency of Visit		
Once a week	42	87.5%
More than once a week	3	6.2%
Fortnightly	1	2.1%
Other	2	4.2%
Length of Visit		
Less than 30 min	16	33.3%
30-60 min	24	50%
1-2 hours	8	16.7%

The vast majority of participants indicated that they saw their Clinical Academic once a week during clinical placement (87.5%, n=42). 3 participants (6.2%) indicated that this was more than once a week, and 1 participant (2.1%) noted that they only saw their Clinical Academic once a fortnight. 4.2% of participants (n=2) answered 'Other'. Open text provided further clarification of this and it was noted that these students did not see a Clinical Academic at all during at least one of their clinical placements.

Figure 4 illustrates the distribution of meeting duration reported by participants. Meeting durations were divided into three categories. Most meetings fell into the 30-60 minute category (50%, n=24), followed by meetings less than 30 minutes (33.3%, n=16). Longer meetings between 1-2 hours accounted for 16.7% of all findings (n=8).

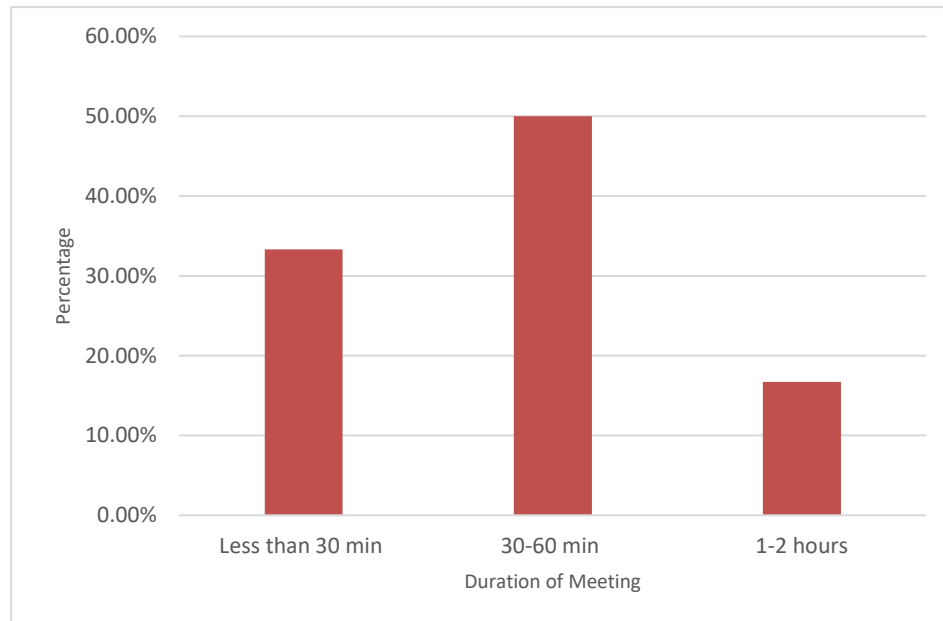
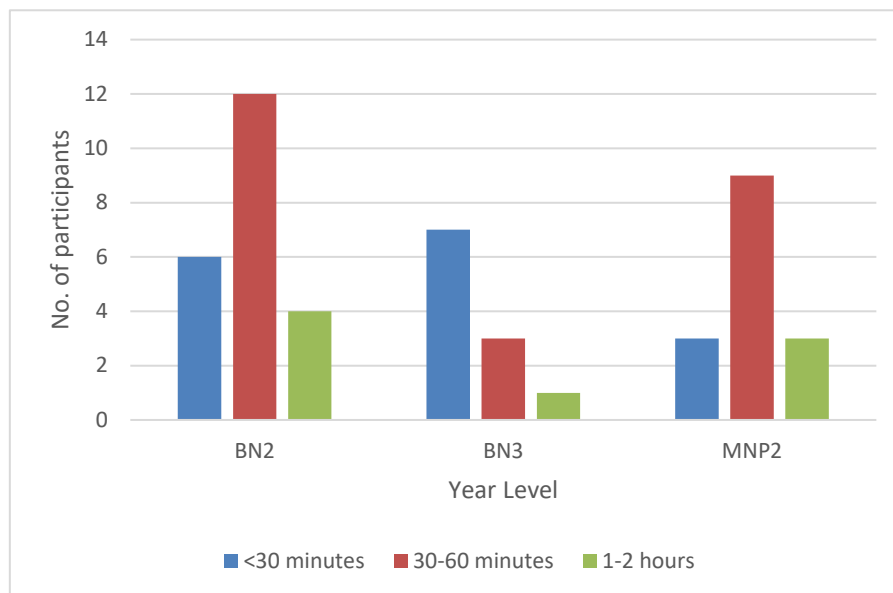
Figure 4: *Duration of Clinical Academic Meetings*

Figure 5 explores the duration of Clinical Academic meetings specifically by year level. BN2 participants most frequently reported meetings lasting 30–60 minutes (54.5%, $n=12$), followed by those lasting less than 30 minutes (27.3%, $n=6$), with fewer lasting 1–2 hours (18.2%, $n=4$). BN3 participants most commonly reported meetings of less than 30 minutes (63.6%, $n=7$), with fewer meetings in the 30–60 minute category (27.3%, $n=7$) and only 1 reporting they spent between 1 and 2 hours (9.1%). In contrast, MNP2 participants predominantly reported meetings lasting 30–60 minutes (60%, $n=9$), with smaller numbers reporting meetings of less than 30 minutes (20%, $n=3$) or 1–2 hours (20%, $n=3$).

Figure 5: *Duration of Clinical Academic Meetings per Year Level*

Participants were asked to indicate what format their meetings with Clinical Academics took, as shown in Table 7. It is noted that participants were able to select more than one option, and as a result, the percentages exceed 100%.

Table 7: *Format of Meetings with Clinical Academic*

Format of Meeting	n	%
In person 1:1	45	93.80%
Phone	5	10.40%
Email	11	22.90%
Group Sessions	25	52.10%

Note: Percentages exceed 100% as participants were able to choose multiple options.

Figure 6 clearly demonstrates that the vast majority of meetings were conducted in person in a 1:1 format (93.8%, n=45). 52.1% (n=25) of participants also indicated that they partook in group sessions at times during their clinical placement. Some

participants noted that meetings at times were conducted via phone (10.4%, n=5) and others via email (10.4%, n=5).

Figure 6: *Format of Meetings with Clinical Academics*

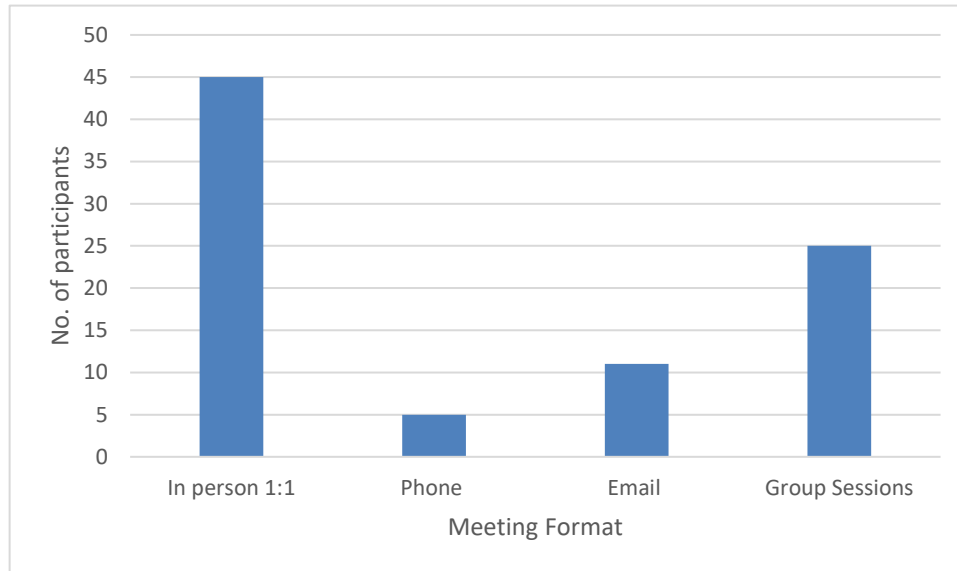
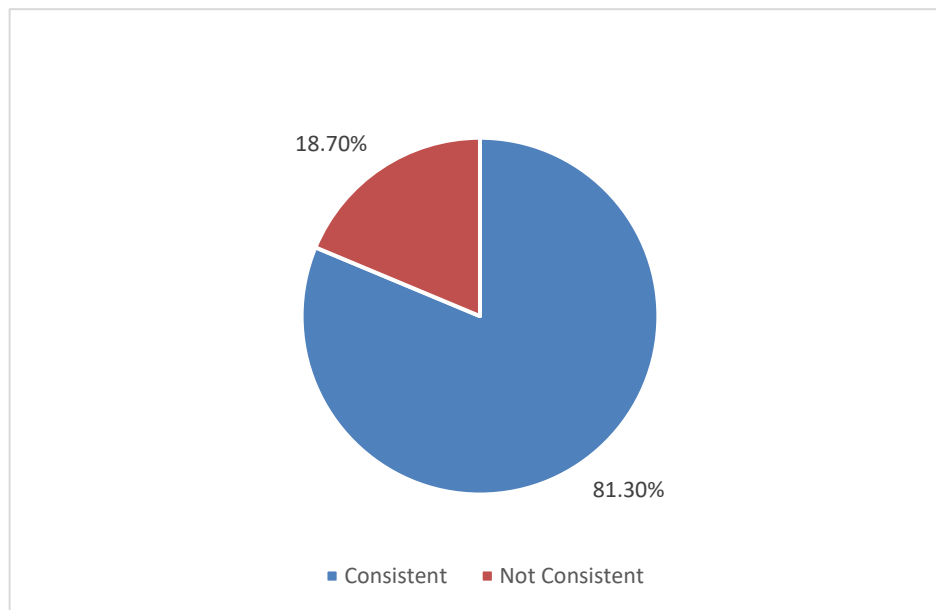


Figure 7 illustrates the consistency of Clinical Academic presence during clinical placement. 81.3% of participants (n=39) indicated that their Clinical Academic was consistent throughout their placement, with 18.7% (n=9) noting that they had an inconsistent Clinical Academic.

Figure 7: *Consistency of Clinical Academic during placement*

5.5.3 Content of Meeting

Participants were asked to rank the primary focus of their meeting with their Clinical Academic, exploring the priority of competencies, debriefing, assessments and education and teaching during their time spent together (1 = highest priority, 4=lowest priority).

The results in Table 7 show apparent differences in the prioritisation of discussion topics during meetings between students and Clinical Academics. *Competencies* obtained the lowest mean rank ($M=1.77$), indicating participants highlighted this as the primary focus. This was followed closely by *debriefing* ($M=1.96$), suggesting that participants also found reflective discussion central to meetings with Clinical Academics. In contrast, *assessments* ($M=2.88$) and *education/teaching* ($M=3.4$) were both ranked lower, with education/teaching clearly reflected by participants as the lowest priority during their meetings with Clinical Academics. Overall, these rankings suggest that, from the students' perspective, meetings with Clinical Academics emphasise competency development and structured debriefing over clinical skill teaching and support.

Table 8: *Ranking of Primary Focus of Clinical Academic Meeting*

Content	Mean Rank	Interpretation
Competencies	1.77	Highest Priority
Debriefing	1.96	Second Highest Priority
Assessments	2.88	Second Lowest Priority
Education /Teaching	3.4	Lowest Priority

5.3.4 Perceptions of Clinical Academic Impact in Practice (Likert-scale Items)

Participants were asked to indicate, on a Likert scale, the impact that the Clinical Academic had on their clinical placement, exploring a range of seven aspects, including overall improvement, the application of theory to practice, and the facilitation of a positive experience. Participants rated each statement using a 5-point Likert scale ranging from 1 (strongly agree) to 5 (strongly disagree). To ensure the reliability of the survey items, internal consistency was assessed using Cronbach's alpha. The scale demonstrated excellent reliability, with $\alpha=0.933$, indicating that the items consistently measured the intended construct (DeVellis, 2017). The measure of each item is demonstrated below in Table 9.

Table 9: *Variances and Internal Consistency Reliability (Cronbach's Alpha)*

Item	Variance (VAR.S)
Q1	1.188
Q2	1.188
Q3	0.903
Q4	1.232
Q5	1.300
Q6	1.323
Q7	1.000
Sum of item variances	8.342
Total score variance	41.68015
Cronbach's alpha (α)	≈ 0.933

Table 10 demonstrates the findings from the Likert scale rankings. The mean scores ranged from 3.67 to 4.15, indicating generally positive perceptions across all areas. The lowest mean score, though still favourable, was in relation to collaboration between the Clinical Academic and clinical placement (mean=3.67, SD=1.09) suggesting more variability in the experience of students around this. The highest mean related to the Clinical Academic’s capability in supporting knowledge within the clinical specialty (mean=4.15, SD=1) indicating strong confidence in the expertise of the Clinical Academic. Other highly rated items included “The Clinical Academic helped apply theoretical learning into practice” (mean=4.08, SD=0.95) and “I received consistent feedback from preceptor and Clinical Academic” (mean =4.08, SD=1.15). Median scores were consistent at 4 across most items, reinforcing the consistency of favourable responses among participants. Standard deviations ranged from 0.95 to 1.15, indicating moderate variability in responses across the items. Overall the results demonstrate a strong perceived contribution of the Clinical Academic to enhancing the clinical experience, supporting learning and bridging the gap from theory to practice.

Table 10: *Descriptive Statistics for Perceptions of the Clinical Academic Role*

Statement	Mean	Median	SD
The Clinical Academic improved the clinical experience	3.83	4	1.09
Clinical Academic and Clinical Placement worked collaboratively	3.67	4	1.09
The Clinical Academic helped apply theoretical learning into practice	4.08	4	0.95
Knowledge of key theories and models	3.98	4	1.11
Facilitated positive and productive learning experience	3.94	4	1.14
Consistent feedback from preceptor and Clinical Academic	4.08	4.5	1.15
Capable of supporting knowledge in the clinical specialty that you were placed	4.15	4	1

5.3.5 Consistency of Information and Expectations

Participants were asked if they received consistent information and expectations from their Clinical Academics during clinical placement. Most students (72.9%, n=35) indicated that information was very consistent or noted only minor inconsistencies. A similar response was observed regarding the consistency of expectations, with 79.1% (n=28). Very few students noted significant discrepancies in the information (4.2%, n=2) and expectations (4.2%, n=2) they received.

Table 11: *Student Perception of Consistency of Information and Expectations*

Response Category	Consistency of Information <i>n</i>(%)	Consistency of Expectations <i>n</i>(%)
Very Consistent	30(62.5%)	29(60.4%)
Minor Inconsistencies	5(10.4%)	9(18.7%)
Some Inconsistencies	11(22.9%)	8(16.7%)
Significantly Inconsistent	2(4.2%)	2(4.2%)

5.3.6 Exploratory Investigations

Following the descriptive analysis, further exploratory investigations were conducted to examine potential relationships and patterns within the data. This analysis is not intended to test formal hypotheses but rather to provide additional insight into associations between variables.

Chi-squared tests of independence were performed to explore associations between key study variables. The results of these analyses are presented below in Table 12.

Table 12: *Chi-Squared Analysis of Variables*

Variable 1	Variable 2	X ²	df	P	N
Programme	Overall Impact	.213	1	.644	48
Year Level	Overall Impact	.494	1	.482	48
Meeting Duration	Overall Impact	1.745	2	.418	48

Nb: For chi-square analysis, some categories were collapsed to meet statistical assumptions regarding expected cell counts.

The chi-squared analysis indicated no statistically significant associations between explored variables and the impact of the Clinical Academic on clinical placements (all $p > .05$). Specifically, the programme of study that participants were enrolled in, was not significantly related to the perceived overall impact ($p=0.644$), nor was year level ($p=0.482$), or meeting duration (0.418). These results suggest that perceptions of the impact of the Clinical Academic on clinical placement was consistent across year levels, programme type and meeting duration, indicating a similarly positive experience among participants regardless of characteristics.

5.3.7 Narrative Insights from Quantitative Open Text

The survey included two optional open-ended questions: one inviting any additional comments and one asking respondents to highlight their expectations of Clinical Academics. These responses provided brief contextual information to support the interpretation of the quantitative results. Responses to both questions were analysed together using a descriptive qualitative approach because substantial overlap was evident. This approach enabled a concise summary of recurring ideas while avoiding duplication. While these comments offer additional insight into student perspectives, they do not constitute in-depth qualitative data, which were generated through interviews with Clinical Academics and are reported separately

The findings from the open-ended responses are presented below, organised into broad descriptive categories that reflect recurring aspects of students' experiences and expectations of Clinical Academics.

Accessibility, availability and visibility

Students frequently emphasised the importance of Clinical Academics being accessible and visible during clinical placement. Knowing when Clinical Academics would be present, being able to confirm meeting times, and having flexible availability to meet were viewed as central to being supported during clinical placements. Limited availability and scheduling uncertainty were described as barriers to effective engagement, particularly when Clinical Academics worked limited days or visiting schedules were not communicated ahead of time. One student commented, *"It can be really hard to get hold of the Clinical Academic when you need them."* Another noted, *"We understand they may have second Amabi, but it is good to know in advance when and where they will be able to meet."* A third student highlighted scheduling uncertainty, noting, *"A lot of the time you didn't know when they were coming until that day and it was hard to have everything ready all of the time."*

Debriefing and Support

Many students described Clinical Academics as a key source of emotional support during placement. Opportunities to debrief, discuss challenging situations, and feel heard were considered particularly valuable for managing the stress of clinical learning environments. As one student explained, *"Clinical debriefing and being a listening ear as placement can be quite full on and stressful."* Another noted, *"I think support is the main thing that improves a placement for me. Being able to debrief with a CA allows me to understand clinical situations better and also allows my CA to give me feedback which I think improves my practice."*

Students also highlighted the importance of having a safe and private space to debrief, noting that limitations in available spaces sometimes restricted their ability to fully engage: *"I did find it hard to find places to spend time with my CA, and sometimes it wasn't private so felt like I couldn't fully debrief."*

Communication and Consistency

Clear communication and alignment between the University and placement expectations were recurring concerns. Students valued proactive communication about expectations, visit timing, and preferred contact methods, as well as consistency between academic and clinical requirements. A student commented, *“A lot of the time they were confused or had differing opinions on things we were to complete in placement from what we were told in class.”*

Connection

Students reported that continuity between classroom teaching and clinical support enhanced their learning. Having Clinical Academics who both taught practical skills and supported students during placement allowed them to apply theoretical knowledge in practice and receive immediate guidance: *“It is great having CAs teaching us in class and doing practical skills with us and then supporting us during clinical placement. We can talk about what we learnt from them in a more practical way because we have applied it to actual patients. We spend a lot of time debriefing which is good because my placement is quite stressful and my CA is able to support me to manage that.”*

Variation in experiences

While many students reported positive experiences with Clinical Academics, a small number described less supportive interactions or inconsistencies between different Clinical Academics. As one student noted, *“It can sometimes be hard doing one thing for one CA and another thing for another CA.”* Another noted, *“I have felt more supported with some Clinical Academics than others.”*

Despite this variation, most comments expressed appreciation for the role of clinical academics and their contributions to student learning and wellbeing during placement: *“They are amazing — please keep them.”* Another student shared, *“The Clinical Academics’ have played a huge role in my learning and nursing practice. Having begun my studies at a different institution, I think the clinical academics at the university are well advanced in supporting students and making their clinical placement experience better.”*

Chapter VI: Discussion

*He aba te mea nui o te ao
What is the most important thing in the world?
He tangata, he tangata, he tangata
It is the people, it is the people, it is the people.*

6.1 Introduction

This study is the first in New Zealand to examine the Clinical Academic model within nursing education as an innovative response to the dynamic and evolving needs of the current health care context. Conducted within the University of Waikato nursing programme, where Clinical Academics are embedded across both academic and clinical settings, the study provides insights into how these roles support students, align curriculum with placement expectations, and strengthen the connection between theory and practice across contexts. Using a mixed methods design combining interview and survey data, the study captured complementary perspectives on how Clinical Academics integrate academic and clinical responsibilities and contribute to professional development, guided by a pluralist ontological stance that acknowledges the influence of context, culture and organisational factors on individual experience.

The findings highlight that connection and collaborative partnerships are critical enablers of successful Clinical Academic pathways, while navigating dual responsibilities across clinical and academic settings presents ongoing challenges. Participants emphasised the value of these roles in facilitating the integration of theory and practice and aligning curriculum goals with student learning. Results illustrate the potential of established Clinical Academics to assist students in bridging the theory-practice gap, something long considered to be a critical issue in nursing education (McCaugherty, 1991). Importantly, the study provides a new perspective on the New Zealand context, highlighting the centrality of connection and collaboration when exploring Clinical Academic roles from an education focused perspective, which has not been extensively addressed in prior literature. The purpose of this discussion

chapter is to interpret these findings in relation to the research questions and situate them within the existing literature, exploring their implications for practice, theory and future research. In accordance with the study's mixed methods design, this discussion integrates findings from the qualitative and quantitative components.

6.2 Addressing the Research Question: Experiences and Outcomes

This discussion first examines participants' experiences of the Clinical Academic role and how these experiences relate to the achievement of programme outcomes. The discussion addresses the research question below;

‘How is the Clinical Academic model at the University of Waikato Nursing School experienced by Clinical Academics and pre-registration nursing students, and to what extent does it support the achievement of identified outcomes within the nursing programme in the current health context?’

The question has two closely connected components. The first addresses the experiences of both Clinical Academics and students within the programme. The second examines the extent to which the Clinical Academic model supports achievement of the outcomes identified at the outset of the study.

To explore both questions, the discussion is centred around four themes identified through qualitative thematic analysis: Clarity and Complexity, Enhancing Learning and Practice, Connection and Collaboration and Systemic Pressures. Within each theme, qualitative findings from Clinical Academics are integrated alongside quantitative data from student surveys and interpreted in relation to relevant literature. Each theme is considered in relation to both aspects of the research question, demonstrating how participants' experiences influence the ability to achieve programme outcomes and, conversely, how outcomes may shape experience. This is then followed by a discussion on understanding the broader implications for practice, programme development and the Clinical Academic model within nursing education in New Zealand.

6.2.1 Clarity and Complexity

This theme addresses the first component of the research question by exploring how Clinical Academics experience role clarity, ambiguity, and role complexity, and the second by examining how these dynamics impact the ability of the role to support student learning and programme delivery. In doing so, it highlights how clarity and complexity within the role shape students' clinical learning experiences and the programme's ability to achieve outcomes related to positive placement experiences and partnership.

To understand the Clinical Academic experience, it was necessary to explore both participants' understanding of the role and their perception of how it functions in practice. The themes of clarity and complexity were strongly featured throughout qualitative data, alongside insights from the quantitative strand. This aligns with international literature indicating that these traits are inherent to both Clinical Academic roles and the wider joint appointment position, in which ambiguity in definition and expectation, competing priorities, and cultural divisions create a multifaceted and dynamic environment (Fowler et al., 2008; Pfister et al., 2021).

Findings from qualitative interviews indicated that while participants clearly understood that a key purpose of the role was to bridge the theory-practice gap, there was notable uncertainty about the role's expectations and structure, with no formalised role definition or guidance. While the intention was clear, no participants clearly defined themselves as Clinical Academics or demonstrated a strong understanding of the defining features of a Clinical Academic role; rather, they described varying objectives as central to the role, including differing emphases on education, clinical development, and pastoral care. This variation reflects the findings of Newington et al. (2020), which explored the concept of a Clinical Academic from the perspectives of managers and research-active clinicians, with participants demonstrating diverse understandings of the role. This alignment with the present study reinforces the ongoing ambiguity surrounding Clinical Academic roles across different contexts.

Interestingly, qualitative findings indicated little emphasis on research as a defining feature of the Clinical Academic role. While a few participants touched upon

involvement in research activities through their engagement with the University, this was a secondary consideration rather than their primary objective. This contrasts with much of the literature, which often identifies research productivity as a key characteristic of Clinical Academic positions (Aspinall et al., 2024; Pattison et al., 2022). The absence of this within these findings may reflect the practice-focused orientation of the University of Waikato model and highlights how Clinical Academic roles can be shaped by local context and priority.

This ambiguity surrounding both the role definition and application influenced how the role was enacted, with individuals shaping their own practice and identifying that it was up to each individual to determine what they considered beneficial in their role. For some participants, the absence of clear expectations and role ambiguity contributed to dissatisfaction and role strain, which in turn influenced individuals' decisions to leave the role. Others thrived under the autonomy of a role that was responsive and adaptable to both student need and provided an opportunity for individualised career growth. In this way, the Clinical Academic position enabled participants to explore academic and educational aspects of practice without relinquishing their clinical positions, a feature that has been associated with increased professional satisfaction and retention within joint appointment roles (Kaunda et al., 2025; Paterson & Strickland, 2023).

These findings indicate that the achievement of programme outcomes is closely linked to how effectively individual Clinical Academics navigated role ambiguity. Where autonomy was experienced as enabling, Clinical Academics were able to respond flexibly to student needs, supporting positive clinical experiences and continuity of learning. Conversely, where ambiguity contributed to dissatisfaction, students experienced inconsistent clinical support, constraining the model's capacity to reliably deliver intended outcomes.

In further exploring participants' perceptions of the role, many of the complexities identified in the literature were also evident in qualitative narratives and students' insights. There is strong evidence in the literature that joint appointments are inherently complex, presenting competing organisational demands and conflicting

expectations (Beitz & Heinzer, 2000; Fowler et al., 2008; Pfister et al., 2021). This was reflected in qualitative accounts, in which participants highlighted the challenge of balancing dual academic and clinical responsibilities. Clinical Academics described ongoing challenges in managing time, prioritising competing demands, and responding to expectations across two distinct professional environments, experiences that at times elicited strong responses, with one Clinical Academic describing the management of this as 'horrific'. The requirement to be simultaneously available to students, responsive to clinical settings and engaged in academic functions created tensions that were difficult to resolve. These complexities appeared to limit the role's adaptability and responsiveness, with participants noting that, to support students, they often sacrificed meeting attendance or engagement with academic or organisational responsibilities.

Although students demonstrated limited insight into the complexities of the Clinical Academic role, the quantitative data reflected practical consequences of these challenges. Student responses highlighted challenges in accessing Clinical Academics, noting issues with availability, communication, and inconsistent or occasionally inaccurate information. Some students reported uncertainty about expectations during clinical placement, reflecting the variability in support and guidance they received. Further insight was gained through open-ended responses, in which students highlighted accessibility as a barrier to engagement with the Clinical Academic. These findings align with the qualitative data, suggesting that while students may not be fully aware of the organisational complexities underpinning the role, the effects are evident in the support they received during clinical placement. This convergence supports the interpretation that challenges in managing joint appointments are not solely individual concerns but have direct implications for the role's effectiveness. Quantitative findings, however, did demonstrate some divergence from this, with overall satisfaction ratings indicating that, despite these challenges, students generally perceived the Clinical Academic as having a positive impact on their clinical placement experience.

The capacity to manage the complexities of the Clinical Academic role is further explored by considering the level of experience required before commencing the role. Multiple studies highlight that senior nurses, with greater clinical expertise,

professional credibility, and leadership capabilities, are better positioned to manage the competing demands inherent in joint appointments, bringing resilience, adaptability, and advanced decision-making skills to the role (Fowler et al., 2008; Trusson et al., 2019). This need for seniority and a high level of clinical expertise was evident in the qualitative findings, as comments reflected Clinical Academics' ability to navigate the demands of both organisations. While the University of Waikato clearly intended to recruit Registered Nurses working at an advanced level in clinical practice (University of Waikato, n.d.), it was not only the level of clinical expertise that enabled effective management of the role, but also the autonomy associated with designated senior nursing positions. Participants in these roles noted that they were able to be more responsive and adaptable, changing schedules in response to student and placement needs and providing an 'emergency response' to unexpected situations in clinical placement when required. These participants expressed that they could not comprehend how this level of responsiveness may work for nurses in positions with fixed shift requirements and limited flexibility. In contrast, participants in Registered Nurse positions in which shift requirements did not allow the same level of autonomy reported that they were mostly able to meet the requirements of their Clinical Academic position; however, this often came at the cost of personal time. These accounts raised concerns regarding the sustainability of the role and aligned with existing literature describing the mental and emotional drain associated with joint Clinical Academic appointments (Beitz & Heinzer, 2000).

However, while designated senior nurses showed high levels of responsiveness and flexibility, the findings also highlighted that boundaries were at times challenged. Clinical Academics described difficulty defining boundaries between their academic position and senior clinical identity, often being drawn into leadership and operational responsibilities beyond their academic remit and struggling to separate these roles. Participants also expressed concerns about the potential impact on students. In particular, they noted the risk that students might receive conflicting guidance from a Clinical Academic who simultaneously held a clinical leadership role such as Nurse Educator or Charge Nurse Manager. Participants further highlighted the challenges such dual roles may pose for acting as a neutral advocate for students, highlighting potential issues around power dynamics within the clinical environment. While previous research has largely explored boundary tensions between research and clinical

duties (Paterson & Strickland, 2023), the current study shows additional, distinct boundary complexities within the Clinical Academic role. A notable dichotomy emerged between the benefit of autonomy associated with senior positions and the inherent involvement in clinical leadership, which may compromise the ability to engage from a neutral or solely academic perspective and could affect students' perceptions of the Clinical Academic as a safe and impartial source of support. Notably, the quantitative findings did not reflect this dichotomy, with no indication in the narrative feedback that students noticed any difference in Clinical Academics holding designated senior positions or otherwise.

From a programme outcome perspective, these tensions have implications for the sustainability of Clinical Academic partnerships. While individual Clinical Academics often mitigated these challenges through personal effort, reliance on goodwill rather than structural clarity risks undermining both Clinical Academic satisfaction and the longer-term viability of the partnership model.

6.2.2 Enhancing Learning and Practice

This theme directly addressed both components of the research question by examining how Clinical Academics experience their role in supporting learning and practice and how this support shapes students' clinical experiences. The theme further demonstrates how the role contributes to key programme outcomes, particularly students' ability to integrate theory and practice, experience clinical placement positively, and develop capabilities that support safe, effective nursing care and improved patient outcomes.

While complexity is inherent in the joint appointment model, the benefits of these roles are well documented. Joint appointment positions provide opportunities for professional development, enhance the use of evidence based practice, strengthen connections between clinical and academic settings and support the integration of theory into practice (Kaunda et al.,2025; Luckenbach et al., 2021; Ogilvie et al, 2004) In this study, the findings demonstrate that the Clinical Academic plays a significant role in enhancing learning and practice for both students and Clinical Academics. Across both qualitative and quantitative data, the role was consistently described as

central to supporting student learning, particularly through bridging theoretical knowledge with clinical practice. Clinical Academics described taking what was taught in the classroom and replicating that into a practical application within the clinical setting. This resulted in supporting critical thinking and building confidence in students' practice, reflecting international findings in which joint appointments support theory-practice integration and enhance experiential learning (Luckenbach et al., 2021). Quantitative survey data reinforced these findings, showing that students perceived Clinical Academics' involvement in both classroom and clinical settings as highly effective in helping them apply theoretical knowledge to real patient care.

While there was consensus on the value of the role, Clinical Academic participants showed significant variation in how they achieved it. This was particularly notable in their perceptions around clinical engagement. Some participants highlighted that being clinically present in the setting with students enabled firsthand accounts of their practice, immediate responses to educational opportunities, and the ability to gain genuine engagement with students who may thrive in direct patient-contact environments. Others felt uncomfortable in this space, noting they did not belong, but recognised the benefit of supporting students through reflective discussion, debriefing and pastoral care. Several Clinical Academics described pastoral support as the primary mechanism by which learning was enhanced, regardless of direct clinical involvement or knowledge of the clinical area. They emphasised that, due to the demanding nature of the clinical setting, students require opportunities to debrief, reflect, and work through challenges to engage fully with learning. This level of variation of response may reflect the contextual and individual factors that shape student needs; it is not a case of either or, but that the balance between pastoral support and clinical guidance is contingent on factors such as student experience, clinical complexity and human factors influencing engagement with learning. Consequently, to obtain optimal learning, a flexible and responsive approach is needed in which different supports are provided as needs change, recognising that students' capacity to learn in practice is shaped not just by clinical activity but also by the structure, quality and adaptability of supervision and the learning environment (Cant et al., 2021).

Evidence from the literature supports these observations. Lesa et al. (2022) highlight that different learning environments and approaches provide distinct yet complementary learning opportunities, suggesting that variation in support aligns with students' different needs and learning preferences. Consequently, the effectiveness of the Clinical Academic depends not just on what is taught, but also how it is provided, requiring flexibility to meet both changing demands of the clinical settings and the individual needs of the student.

Quantitative findings demonstrated the same variation, with open text responses highlighting differing priorities. Some students wanted more hands-on engagement, indicating that working alongside Clinical Academics in practice would both support Registered Nurse preceptors but also enable the Clinical Academic to gain a first-hand understanding of the students' competence. Others emphasise the value of pastoral support and reflective discussion, indicating this is the primary requirement for them to manage clinical placements. This variation may also reflect the diversity of student learning needs and the different needs encountered by students throughout clinical placement. Students may value different forms of support, with some preferring hands-on engagement and others benefiting from more reflective discussion and pastoral support. This highlights the importance of supervision that is responsive and adaptable to individual learning preferences and contextual demands in order to optimise learning within practice. However, regardless of these differences, students rated the impact of the Clinical Academic positively across all indicators related to clinical placement, learning support, application of theory to practice and overall placement quality. These ratings were consistent across the cohort and did not appear to be contingent on a Clinical Academic working within a speciality area, suggesting that the learning received was not directly dependent on specific clinical knowledge. Results further highlighted that, when asked about meeting priorities with Clinical Academics, students ranked Competencies and Debriefing highest, with education and teaching receiving the lowest ranking, reinforcing the importance of reflection and relational engagement.

These findings suggest that theory-practice integration was achieved not solely through clinical instruction, but through reflective discussions and relational engagement. The

Clinical Academics' ability to facilitate learning therefore extends beyond the content delivered, encompassing their presence, mentorship and engagement with students. Reflective practice has been found to significantly enhance nursing students' learning during clinical placement, building clinical reasoning skills, emotional resilience, and improving confidence (Bowers et al., 2025). By fostering these skills and supporting students to integrate academic knowledge with clinical experience through guided reflection and mentorship, Clinical Academics contribute to students' development of professional competence and confidence, supporting progression and achievement of programme outcomes. Variations in how participants enacted the role suggest that the impact of learning depends not only on the tasks undertaken but also on the quality of their relational and reflective engagement with students. By supporting students to integrate academic knowledge with clinical experience through mentorship and guided reflection, Clinical Academics enhance professional competence and confidence, reflecting evidence that trusting, communicative faculty–student relationships strengthen clinical reasoning, resilience, and the application of theory to practice (Opoku-Danso et al., 2025).

In exploring the role of the Clinical Academic in clinical practice, Clinical Academics also reflected on their knowledge and presence in the current clinical context and the impact this has on their role. Hackett et al. (2016) discuss these concepts as credibility, currency and competence, noting that while they are often used interchangeably, a clearer definition is required. While clinical currency refers to up-to-date knowledge of practice, credibility relates to how that knowledge is perceived by students and colleagues, and competence is the ability to perform clinically. The findings of this study reflect this conceptual ambiguity, with participants expressing varied views on how Clinical Academics' clinical skills were maintained. Some participants strongly associated credibility with active clinical practice, noting ongoing clinical involvement as essential to maintaining relevance with both staff and students. Others demonstrated this through professional experience, noting that while they may not currently be clinically active, they could still support students in navigating clinical placements.

While terminology may have varied, there was a strong consensus that maintaining an up-to-date understanding of the contemporary health care environment was essential to the role. Participants emphasised the importance of awareness of organisational pressures, workforce challenges, and the realities of nursing practice to genuinely engage with and support students. Several Clinical Academics reflected on experiences during their own nursing education, in which their tutors were unable to relate to students and were perceived as ‘dinosaurs’, not fully aware of current clinical practice needs. For Clinical Academic participants in the current study, this recollection of personal experience reinforced the need to stay clinically current to ensure that students received relevant guidance. This understanding of the clinical setting enabled Clinical Academics to validate students' experiences, debrief on practice challenges, and connect with them.

The benefits of enhanced learning were not limited to students in this study; Clinical Academics also reported their own professional development. Participants reported that they actively updated clinical knowledge and policies to ensure teaching across both the academic and clinical settings remained evidence-based and up to date. Participants viewed this as essential to maintaining confidence in their teaching and effectiveness in the role, consistent with literature indicating that the role of Clinical Academic supports engagement with evidence-based practice (Kaunda et al., 2025). However, participants often noted that this further professional development was undertaken during personal time and out of their own motivation to ensure what they were saying was accurate. This reliance on the use of personal time to maintain professional currency raises further questions about role satisfaction and sustainability, which are central to maintaining partnership outcomes over time.

Clinical Academics also explored their own development through engagement with new academic skills, particularly in assessment and marking. While these skills were beneficial for professional development, participants described challenges in obtaining guidance and understanding requirements. One participant noted that a ‘clinical mindset’ did not always align with academic frameworks and required adjustment, while others highlighted the need for sufficient time to become familiar with course content, learning outcomes, and assessment criteria. These challenges are consistent

with literature exploring the transition from clinical to academic roles, which emphasise that nurses often feel well prepared clinically but underprepared for academic responsibility such as teaching, assessment and evaluation (Hoffman, 2019). In the context of a joint appointment, this represents a further consideration, highlighting the need for structured support when exploring how roles are enacted.

6.2.3 Collaboration and Connection

This theme explores how collaboration and connection shape the lived experience of the Clinical Academic role and of students' clinical placements. It directly addresses programme outcomes related to positive clinical learning experiences, student satisfaction, and an effective academic-clinical partnership, highlighting connection as a key mechanism for achieving these outcomes.

Connection and collaboration are fundamental to the Clinical Academic role, shaping both how students and those within the role experience learning, support and professional development across academic and clinical contexts. These themes are strongly woven throughout qualitative and quantitative findings, demonstrating that connection is not only beneficial but a critical mechanism through which Clinical Academics support student learning. Participants described the importance of being strongly embedded in both academic and clinical settings, noting that this dual presence allowed them to integrate curricular knowledge, clinical insight, and best practices while providing a strong and consistent presence for students. Narrative insights from students reinforced this relational focus, highlighting that support and debriefing were critical to their learning and well-being.

The existing literature recognises connection as a central aspect of joint appointment roles. Ogilvie et al. (2008) describe joint appointments as “inherently collaborative”, with trust and shared values widely acknowledged as underpinning their effectiveness and sustainability. Many studies, however, discuss collaboration primarily from a strategic or operational lens, focusing on establishing relationships to support organisational implementation (Aspinall et al., 2024; Baptiste et al., 2022). In contrast, this study highlights that when applied to an educational context, connection is not only important across academic and clinical domains, but also in the relationship

between the Clinical Academic and student. This aspect of connection underpins much of the role's effectiveness and is central to its ability to support students in navigating the complexities of clinical learning, particularly in clinical environments characterised by workforce shortages, nurse burnout and high patient acuity.

Operationally, qualitative findings highlight the importance of Clinical Academics establishing and maintaining strong connections with both academic and clinical settings. Clinical Academics described the importance of establishing and sustaining strong working relationships as essential for integrating students into placement environments and highlighting challenges in practice at an early stage. At the same time, they emphasised the need to be well embedded in the academic environment to understand curriculum requirements and translate them into practice effectively. When these connections were limited or absent, participants reported feelings of isolation and being overwhelmed, struggling to navigate complex student dynamics, academic processes and placement requirements. Quantitative findings support this, with students at times reporting inconsistent information and expectations as highlighted earlier in the discussion. Students also noted variation between Clinical Academics, describing challenges when different academics required different approaches, reflecting the operational impact of ineffective integration and connection between both settings.

The study also emphasised the strong collaboration that places students at the centre of learning, with the Clinical Academic playing a central role in bridging this connection. Both Clinical Academics and students consistently described connection and mentorship as a primary foundation underpinning the role's impact, at times more than the specific content or expertise the individual provided. The strong presence of this theme within the research may reflect the University of Waikato's student-centred approach and bicultural underpinnings, particularly the integration of Te Ao Māori worldviews and relational pedagogy into clinical education. This represents a clear extension of existing literature, suggesting that pedagogy grounded in relationships and pastoral care may play a more significant role in Clinical Academic support than previously highlighted.

An example identified in this study was the role of Clinical Academics in guiding students in managing professional boundaries and developing resilience, particularly when emotional challenges arose during clinical placement. Participants reflected on key values of the programme, citing *whakawhanaungatanga* as foundational to establishing trust and understanding students as people first, before addressing academic or placement requirements. This relational approach enabled Clinical Academics to identify personal factors influencing student engagement and learning and to respond in a supportive rather than punitive way. The emphasis on *whakawhanaungatanga* positioned relationship-building as foundational to learning rather than supplementary, supporting students belonging and confidence during clinical placement and contributing to high levels of reported satisfaction and positive engagement with learning. This approach aligns with literature on pastoral models of clinical teaching, which emphasise that supporting well-being and resilience is critical to professional development and learning (Levett-Jones & Lathlean, 2008; Price, 2019). Research indicates that when educators prioritise pastoral care, characterised by trust, presence and responsiveness, students are more capable of navigating challenges encountered in clinical environments (Levett-Jones & Lathlean, 2008).

Clinical Academics described how students often encountered emotionally challenging situations, such as caring for patients whose experiences mirrored their own. In these moments, students struggled to manage their responses while maintaining placement requirements, highlighting the need for timely support. As illustrated in the qualitative findings, Clinical Academics demonstrated sustained engagement with students experiencing such challenges, identifying underlying emotional factors affecting their engagement rather than interpreting difficulty in meeting competency through a performance lens. The responses involved sustained pastoral care, access to University support services and increased presence within the clinical setting, highlighting that connection and collaboration were central to successful progression throughout the clinical placement.

This study's findings of high levels of emotional demands align with the existing literature, which indicates that nursing students are frequently unprepared for the emotional demands of clinical placement. McCloughen et al. (2020) report that while students are expected to regulate emotions in clinical environments and have a clear

understanding of the need to maintain a professional demeanour, socialisation is often focused on technical competence and being accepted into the team dynamic, with limited emphasis on managing emotional challenges or developing strategies to process difficult clinical experiences. Similarly, Weurlander et al. (2018) found that students struggled to maintain professional boundaries when they related strongly to patients on a personal level, often relying on emotional distancing or peer support in the absence of timely supervisory debriefing. The present study extends this literature by demonstrating how a sustained connection with a Clinical Academic provides a trusted space for students to process emotionally challenging experiences, develop professional boundaries, and build resilience through guided reflection.

Quantitative findings further support the importance of this connection, indicating that students earlier in their programme spent more time with Clinical Academics during clinical placement than those with more experience and time in the clinical setting. While students further along in the programme may be more focused on advanced clinical skills and clinical reasoning, this increased engagement among students earlier in the programme suggests a greater need for relational, emotional and pastoral support as students transition into clinical environments. When considered alongside the qualitative findings, this convergence indicates that the Clinical Academic role is particularly influential during early professional socialisation, where connection functions as a key mechanism for supporting students' emotional adjustment, development of professional identity, and ability to engage confidently in clinical practice.

Beyond student outcomes, participants reflected on the personal and professional significance of these connections. Spending time with students, supporting their learning, and witnessing their growth as future nurses was described as a privilege and deeply rewarding, reinforcing the meaningfulness of the Clinical Academic role. Connection was experienced as a genuine relational practice that profoundly impacted both students and Clinical Academics. For students, it provided a trusted space to navigate emotional challenges and build professional identity. For Clinical Academics, it offered fulfilment and insight into the real-world impact of their role, highlighting connection and collaboration as central to supporting learning and sustaining the role's significance.

6.2.4 Systemic Pressures

This theme examines how systemic pressures shape the experience of the Clinical Academic role and influence the extent to which programme outcomes can be consistently achieved. It highlights how organisational constraints affect both Clinical Academics capacity to enact the role and students experience of support during clinical placement.

The study showed that systemic pressures significantly impact the Clinical Academic's experience, evident in both academic and clinical domains. Qualitative and quantitative data highlighted that both operational constraints, organisational values, and workplace culture shaped how Clinical Academics supported students' learning and engaged with the broader academic and clinical environment.

Practical and operational constraints were frequently identified. Participants described limited access to office space, computers, and private areas for meeting with students, which often made it difficult to facilitate confidential debriefing or reflective discussion within the available time. These practical limitations were echoed in students' open-text responses, which reported a lack of privacy and the absence of suitable spaces to meet with their Clinical Academic, hindering meaningful, open engagement and effective debriefing. This aligns with the literature, which notes technology and resourcing as barriers to effective integration of clinical and academic responsibilities (Fowler et al., 2008). Quantitative survey data also indicated variability in engagement, with some students reporting brief periods of contact with Clinical Academics and communication via email or telephone rather than face to face. While the survey did not directly capture the reasons for these variations, these patterns may suggest that the practical pressures described by Clinical Academics translate into reduced time or alternative means of engagement. Despite these constraints, students continued to report positive benefits from Clinical Academic support. This suggests that the relational and pastoral dimension of the role functioned as protective factors, buffering the impact of systemic constraints on clinical learning experiences.

Challenges of a more complex nature were also highlighted, with qualitative findings providing insight into the impact of workplace culture and the conflicting nature of clinical and academic domains. Joint appointments face unique challenges in balancing distinct responsibilities with patient facing care often taking precedence (Avery et al., 2020; van Oostveen et al., 2017). Participants reflected this tension in their discussion, noting difficulties with planning, availability, and completing academic activities because clinical demand or staffing requirements took precedence over academic responsibilities. These patterns may reflect broader organisational expectations rather than isolated incidents, representing an ingrained cultural norm in which patient facing duties are consistently prioritised. This was further highlighted at a larger scale, with one participant reflecting that, due to operational demands, she was withdrawn from her joint appointment with little notice, leaving her Clinical Academic duties unfulfilled and students on clinical placement without immediate support. Such experiences highlight how systemic pressures and competing priorities can shape role enactment, aligning with Ogilvie et al.'s (2004) observations that joint appointments are operationally vulnerable, with the sustainability of these roles dependent on full engagement from all parties involved in supporting both the clinical and academic components

Cultural differences did not just feature in relation to clinical priorities. Participants' accounts reflected differences in values and expectations between organisations, which often took an emotional toll. The clinical environment was described by some participants as 'chaotic', reflecting the high acuity, fast-paced nature of patient care and the competing demands on staff. Participants described the challenge in maintaining optimism and providing students with the vision of best practice, even when the realities of the health care system were difficult and unpredictable. They described the emotional labour involved in sustaining students' hope and engagement, despite their own frustrations, and reflected on the divisions between organisational constraints and the ideals of best practice.

Clinical Academics also reflected on the friction between the University's holistic vision and the norms of clinical practice, with the overarching goal of producing graduates equipped for culturally safe and responsive care, sometimes conflicting with

rigid expectations of clinical areas. Several participants emphasised their role in driving a cultural shift, working to maintain holistic, patient-centred approaches in challenging environments. These experiences illustrate the complex interplay among clinical culture, organisational expectations and educational goals. Clinical Academics must navigate a demanding environment, which requires substantial emotional effort to balance competing priorities.

Student responses to open text questions further converged with qualitative accounts in highlighting the emotional intensity of clinical placements. Students described placements as ‘full on and stressful’ and noted the value of Clinical Academic support in helping them manage stress, maintain motivation and remain engaged when clinical staff did not have the capacity to support them.

Programme growth and a newly developed programme further shaped the experience of the Clinical Academic. While not directly addressed in interviews, a significant number of participants emphasised these factors in shaping their experience of the Clinical Academic role. While growth reflects achievement, the combination of increasing student numbers and evolving programme structures challenged the operational delivery of the programme and its sustainability, as Clinical Academics at times struggled to provide the level of support they desired. Some participants felt they were doing an injustice to students, and others highlighted that they adapted the way they worked based on their professional values or original role intentions to manage an unexpected increase in workload. Participants further described how growth exacerbated existing organisational strain, requiring them to decide which aspects of the role to prioritise. Most often, direct student support was prioritised over attendance at meetings or engagement with broader organisational responsibilities, which at times limited access to information required to perform their role effectively. This dynamic suggests that programme growth or increasing operational pressures may shift practices towards reactive approaches, focused on immediate student needs at the expense of wider organisational engagement, thereby reinforcing systemic vulnerability. The quantitative findings also suggest that this increase in student numbers and pressure on the system may partially account for shortened interactions

and modified ways of engagement, although survey data alone cannot establish a direct causal link.

Despite these systemic pressures, students consistently reported positive benefits of the Clinical Academic role, particularly in emotional support, stress management, and maintaining a positive learning experience in challenging clinical environments. This divergence reflects patterns identified in the joint appointment literature, where organisational vulnerability and inconsistent engagement place pressure on individuals to sustain the role across competing contexts (Ogilvie et al., 2004). This highlights that while systemic challenges shape how the role is operationalised, the pastoral care and connection demonstrated through the role remain visible and valued by students. In this way, Clinical Academics appear to buffer the impact of organisational constraints, preserving the quality of student experience despite structural limitations. However, the divergence between students' positive experiences and Clinical Academic reported strain raises further concern about sustainability. While the model currently enables positive clinical experiences and learning outcomes, continued reliance on individual resilience risks undermining Clinical Academic satisfaction and the long-term strength of the programme.

6.3 The Clinical Academic as Relational Practice

Nursing, as a discipline, has always been grounded in care, connection, and attentiveness. This was exemplified by Florence Nightingale, who viewed nursing not as a set of tasks but as the care of the person as a whole, encompassing physical, social, emotional, and environmental dimensions (Riegel et al., 2021). This responsiveness to context and approach to the whole person reinforces that nursing practice has long been informed by holistic principles rather than technical skill alone. While originally applied to patient care, these principles are highly relevant in nursing education. Developing competent, reflective and holistic nurses requires educators to attend to not just teaching skills and procedures, but to address the emotional, professional and contextual aspects of care if we wish to build a workforce responsive to the complexities of current nursing practice and population need.

Within the University of Waikato nursing programme, these principles are foundational to both the curriculum and the lived values of the programme. Hauora and wellbeing are prioritised, and whakawhanaungatanga underpins the student experience. These principles guide the enactment of the Clinical Academic role, influencing how participants engage with students, clinical teams and academic colleagues. In effect, the role functions less as a formal position and more as a lived, relational practice in which responsiveness to student needs, presence across academic and clinical settings, and clinical credibility are inseparable. These principles are embedded not only through teaching and mentorship but also in everyday interactions and collaborative practice, fostering authentic engagement and a sense of belonging. At its core, the role is relational, responsive and holistic, guided by principles that prioritise connection, collaboration and meaningful engagement.

However, while connection underpins the effectiveness of the Clinical Academic role, it in no way negates the importance of clinical currency, credibility and competence. Increasing patient acuity and multimorbidity require nurses to maintain up-to-date, evidence-based practice and respond effectively to clinical realities. As students progress through the programme, the level of clinical complexity they are expected to manage increases, reaching its peak during the final transition placement, where students are required to demonstrate clinical competence and preparedness for practice. Education and mentorship must therefore be informed by clinical insight if students are to be adequately prepared for authentic practice experiences, which will support the development of clinical competence. Clinical knowledge also reinforces relational connection; engagement informed by lived experience strengthens the capacity to support student learning. Students are more likely to engage meaningfully with someone they perceive as clinically competent, demonstrating that the relational presence and clinical credibility are mutually reinforcing. Notably, many of the Clinical Academics within this study held positions somewhat removed from clinical practice, instead occupying roles as leaders, educators, facilitators and coordinators. This raises important questions about what constitutes clinical credibility within the Clinical Academic role and whether hands on practice is essential, or whether maintaining contemporary clinical knowledge and contextual understanding is sufficient to support effective student learning.

Navigating this dual expectation positions the Clinical Academic in a paradoxical middle ground: being responsive, adaptable, and student-centred while simultaneously operating within process-driven, structured, and clinical systems. This tension highlights the hybrid nature of the role, requiring fluid movement between relational, educational and clinical responsibilities. Balancing these domains requires constant negotiation and adaptation, particularly as student needs, programme demands and clinical environments evolve over time. Understanding how this operates in practice is critical, particularly given the complexities of concurrent academic and clinical responsibilities.

6.4 Operationalising the Paradox: Trust, Shared Priority and Structural Vulnerability

The findings of this study highlight the delicate balance required to navigate the multifaceted demands of Clinical Academic joint appointments. When either the academic or clinical component of the role is challenged, the model's integrity is compromised. Ultimately, it does not matter how strong either the clinical or academic domain might be in isolation; without strong collaboration that integrates them into a cohesive role, there is an inherent risk of role fragmentation. Conversely, when engagement is supported across both contexts, the role is more likely to achieve its intended outcomes. Students are more likely to receive consistent, authentic support, while Clinical Academics experience professional satisfaction and an integrated identity across both academic and clinical practice.

Clinical Academics described managing the balance between academic and clinical domains through flexibility and personal commitment, noting working beyond contracted hours, disregarding days off, and upskilling during personal time. While the literature frequently highlights motivation and commitment as characteristics of the Clinical Academic role (Kaunda et al., 2025; Trusson et al., 2019), these findings reveal a key vulnerability: the adaptive and relational practice that underpins the role's effectiveness relies heavily on individual capacity and goodwill. This dependence raises

concerns about sustainability, particularly as programme growth and operational pressures increase workload demands.

The relational, adaptive nature of the role can sit in tension with the operational demands of joint appointments and the more defined and procedural realities within the clinical setting. This can be seen in both how Clinical Academics manage their own clinical workload and how they respond to clinical placement demands. Maintaining this dual focus is challenging, requiring ongoing responsiveness and flexibility while managing conflicting demands. Despite these challenges, what was consistently valued by students and participants alike was connection and collaboration: the ability to engage genuinely with students, respond to their needs, and contribute to the development of a capable and confident future nursing workforce. Participants described a sense of professional fulfilment in being part of change and in supporting student growth, rather than simply adhering to prescribed processes or narrowly defined role boundaries.

The University of Waikato outline a key principle of the Clinical Academic partnership to be that education and health outcomes are to take shared priority (University of Waikato & Waikato District Health Board, n.d.), however this cannot simply be assumed from policy but must be actively enacted. To support the model's sustainability, shared priority must be accompanied by adequate resources. This includes protected time for delivery of the education role and for professional development, clarity of expectations, and agreed processes for responding when one domain experiences increased demand. Without adequate support, reduced presence in either academic or clinical settings limits the role's capacity to function effectively.

In order for the Clinical Academic model to be sustainable, collaboration is essential at all levels. While participants within this study highlight collaboration in the daily enactment of the role, much of the wider literature approaches collaboration from a strategic or organisational perspective. What can be inferred from this is that both are important. Organisational collaboration provides the structural and governance foundations required to legitimise and protect the role, while relational collaboration

shapes the lived experience of Clinical Academics, influencing how effectively the role supports student learning and clinical integration.

The vulnerability associated with the Clinical Academic role is therefore significant. As highlighted by Ogilvie et al. (2004) and reinforced within this study, the role relies heavily on trust from both those within the role and the organisations that support it. From an operational perspective, this trust often manifests as autonomy and flexibility. However, without clear structures, adequate support, and agreed processes, it can expose Clinical Academics to role overload, professional strain, and challenges in maintaining effective engagement across both clinical and academic domains.

6.5 Clinical Academic Roles in the International Literature

Having described how participants in this study experience the Clinical Academic role, it is useful to consider how the University of Waikato model is situated alongside Clinical Academic roles internationally. As noted within the literature review (Chapter 2), international literature commonly emphasises research as a foundational component of Clinical Academic positions; however, some authors have highlighted that due to diversity in understanding and enactment, multiple terms may be required to capture the complexity of these roles (Newington et al., 2022).

While the Waikato model meets the core criteria of a Clinical Academic, in working concurrently across clinical and academic settings whilst providing clinical care, education and research, student engagement distinguishes it from many roles described elsewhere. Notably, the level of collaboration and connection observed in this study appears higher than that reported in Clinical Academic appointments described in international literature, potentially reflecting the added dimension of student engagement and the person-centred values underpinning the programme. Despite this, many operational challenges remain consistent, including navigating dual responsibilities, balancing priorities and relying on effective organisational partnerships.

Acknowledging both the unique position of the Waikato model, and its commonalities with other Clinical Academic roles provides a nuanced perspective for role definition,

sustainability and the development of Clinical Academic pathways in nursing education. This highlights the importance of considering context when interpreting the literature.

6.6 Limitations

Acknowledging limitations in research is essential to address potential weaknesses that may influence the interpretation of findings and conclusions, including practical and ethical considerations (Ross & Bibler Zaidi, 2019). Mixed methods research aims to address design weaknesses by utilising the strengths of different research methods; however, no research design is without limitations, and these should be considered when interpreting the findings of this study (Creswell & Plano-Clark, 2017).

This study used a concurrent mixed methods design. While this allowed the qualitative and quantitative components to be conducted simultaneously, the quantitative survey was developed prior to the completion of qualitative thematic analysis, and as a result, themes that emerged inductively through interviews could not be incorporated into the survey. As Mason (2006) argues, inductive qualitative analysis is iterative and evolving and often produces insights that cannot be fully anticipated during the design stage, especially in qualitative-dominant mixed methods designs. This limited the extent to which qualitative findings could directly inform the quantitative measures and may have constrained the survey's ability to capture the full extent of participants' experiences.

The qualitative component, while providing rich and nuanced insights into the experiences of Clinical Academics, is also shaped by the limitations of participant focused methodologies. These approaches prioritise in-depth understanding of context and meaning over statistical generalisability. As Polit and Beck (2021) note, qualitative findings are best considered in terms of transferability to similar contexts and cannot be applied broadly to all settings. It is important to note that the researcher's role in collecting this data through interviews introduces a risk of bias or subjectivity, which, while helpful for gaining rich, insightful data, further limits the generalisability of the results. To address this, every effort was made to ensure data collection was undertaken consistently. The same set of questions was used for each

interview, and all interviews were conducted and transcribed by the lead researcher. Discussion of emerging themes with research supervisors was aimed at minimising interpretive bias.

Limitations also arose from the quantitative component of the study, which used online surveys to collect data from nursing students in the programme. The use of surveys, while efficient and able to reach a wide range of participants, is associated with several methodological challenges. Limitations include poor response rates, response bias, misinterpretation of questions, incomplete responses and superficial data (Bryman, 2016). Attempts were made to address these limitations during the research process, including piloting the survey to test face and content validity, the use of additional open text questions, in-person clarification where possible and assurances of anonymity. The use of Likert scales also aimed to reduce bias and improve consistency where possible, ensuring that all participants responses could be compared across items while still capturing a range of perspectives.

While all attempts were made to reduce limitations, several considerations need to be given to the research study. Sample size was one such limitation. While the interview sample was relatively representative of the available Clinical Academics, the number of participants was constrained by the programme's short duration at the time of recruitment. Conducting interviews over a longer period might have allowed a larger participant pool as new employees joined the programme. Similarly, the survey was limited by the modest number of participants (n=48) and the non-validated nature of the survey instrument. These limitations place constraints on the generalisability. The survey primarily focused on student engagement with Clinical Academics during clinical placement, rather than capturing their broader engagement across the wider programme.

The scope of the study was also limited. While bicultural, rural and mental health are integral to the design of the University of Waikato nursing programme, this study was only able to explore these aspects to a limited extent. At the stage examined, relatively few Clinical Academics worked exclusively within rural contexts. These factors constrained the ability to fully examine how the Clinical Academic models function in

rural environments or support student learning within these contexts. Exploring the role from a bicultural perspective also required a larger, more focused investigation and was beyond the scope of this study.

Finally, as often found within Masters-level research (Theofanidis & Fountouki, 2019), there was limited capacity to fully explore the complexity of the Clinical Academic model. While this study provides important insights into the relational, educational and practice components, fully capturing its impact, including bicultural, rural, mental health and workforce implications, would require more extensive research across wider cohorts and settings. These limitations nonetheless highlight valuable opportunities for future research to build on the findings presented here and to further strengthen understanding of Clinical Academic roles within nursing education.

6.7 Implications for Practice

The findings of this study have several important implications for nursing education and the operation of the Clinical Academic within the University of Waikato nursing programme.

Firstly, if joint appointments are to be maintained, careful consideration is required regarding how these roles are structured and resourced. The findings suggest that the Clinical Academic in this context may be more sustainably aligned with existing roles in the clinical setting aligned with education, such as educator or clinical coach positions, which already incorporate flexibility, practice engagement, and student-facing responsibilities. Aligning Clinical Academics with these roles may reduce competing demands and role ambiguity by embedding clinical engagement within established educational frameworks. Clear role definition, explicit expectations, protected time, and organisational support are essential to enable Clinical Academics to manage dual obligations effectively and to ensure consistent student support, staff wellbeing, and programme continuity, particularly amid ongoing nursing workforce pressures.

Second, the findings challenge the assumption that ongoing dual clinical employment is the primary or only means by which Clinical Academics can maintain clinical

credibility and competence. While maintaining clinical credibility and professional engagement is critical, participants indicated that continuous employment in a clinical setting is not always sustainable or necessary. As identified by Gustafsson et al. (2016), credibility may also be supported through alternative approaches, such as structured partnerships with clinical services, planned opportunities for clinical immersion, and ongoing professional development. These approaches may help Clinical Academics remain current in practice while preserving sufficient focus on education, student support, and research, and may also reduce the operational risk inherent in joint appointments. These approaches reduce the pressure from competing demands while maintaining strong professional connections with clinical environments.

Lastly, consideration should be given to alternative approaches to clinical placement experiences. Exploring opportunities that address workforce challenges while enabling Clinical Academics to engage directly in practice and supervise students is important. Student-led clinics, which are gaining increasing attention, provide immersive, practice-based experiences where clinical academics can be hands-on, model authentic clinical practice, and guide students, while simultaneously meeting community health needs and supporting collaborative learning, potentially reducing structural vulnerabilities associated with joint appointment models (Tokolahi et al., 2021). Such models can strengthen integration between education and practice, support student learning outcomes, reinforce clinical credibility, and may reduce some of the structural vulnerabilities associated with traditional joint appointment models by embedding clinical engagement within a curriculum-aligned, practice-based setting.

6.8 Future Research

This study highlights several areas for future research, particularly outcomes of the Clinical Academic model that were not addressed within this study. These include the role of the Clinical Academic, specifically in rural and primary health settings; the representation of the Clinical Academic workforce reflecting population diversity; and the experiences of key stakeholders engaged in Clinical Academic partnerships. Additionally, longitudinal research following nursing students through the duration of their programme, rather than focusing primarily on their clinical placement experience, would provide valuable insight into how the Clinical Academic model influences

learning outcomes, student development and engagement across the broader nursing programme.

6.9 Reflection of Mixed Methods Research

As outlined in Chapter III, a mixed methods design was used because of its ability to unify the strengths of both qualitative and quantitative data to provide a comprehensive overview of the problem (Johnson & Onwuegbuzie, 2004). This strengthened the study by enabling both breadth and depth of understanding of the Clinical Academic role within the University of Waikato nursing programme, capturing both the lived experience of the Clinical Academic and the impact on students during clinical placement.

Qualitative interviews provided an in-depth exploration of the complexities the Clinical Academic faces in managing dual clinical and academic responsibilities. This highlighted the relational, operational, and organisational demands inherent in joint appointments, providing insight into how the role functions in practice. In contrast, quantitative surveys provided complementary insight into the impact on students during clinical placement, highlighting the perceived value of the role for learning and support.

Taken in isolation, each dataset would have presented a different and potentially incomplete picture, with qualitative data focusing upon role complexities and quantitative data emphasising the value of the role. The decision to use mixed methods proved justified in the way the survey results were able to provide a counterpoint to the narratives, highlighting points of convergence and divergence where students' value of the role differed from the lived experience of Clinical Academics, illustrating how integration of datasets can uncover multiple perspectives that would not be inferred from either dataset alone (Fetters et al., 2013).

Overall, the mixed methods design facilitated a more comprehensive understanding of the Clinical Academic role, demonstrating its suitability for exploring both the measurable impact of the role and the lived experiences of those enacting it

6.10 Conclusion

Joint appointments are complex roles. They are characterised by ambiguity in definitions and tensions between their multiple components. And yet, as this research has shown, joint appointments can provide significant benefits both to students and to Clinical Academics. If the Clinical Academic role is to continue to have a place in pre-registration nursing education, it must be supported by clarity in definition and adequate resources. The Clinical Academic functions best as a structured collaboration that enables both clinical and academic engagement. Ensuring sustainability will require recognising the relational and adaptive nature of the role and implementing strategies to mitigate its associated vulnerabilities, so that Clinical Academics can maintain clinical credibility, provide high-quality mentorship, and contribute meaningfully to education, research, and patient care.

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Appendices

Appendix I: Summary of Literature Reviewed

Author	Year	Title	Aim	Design	Country	Summary
Aspinall et al.	2024	The role of healthcare leaders in implementing equitable clinical academic pathways for nurses: An integrative review.	To summarise evidence on the role of healthcare leaders in developing clinical academic pathways.	Integrative Review	NZ	Transformational leaders are required to ensure the success of CA pathways and overcome long ingrained challenges. Collaboration is important – but from the lens of developing relationships re funding and support. Operational pressures difficult to release staff. Leaders may have competence anxiety – lack of understanding
Avery et al.	2020	Enablers and barriers to progressing a clinical academic career in nursing, midwifery and allied health professions: A cross-sectional survey	To understand the route by which nurses, midwives and allied health professionals pursue a research career	Cross-sectional survey	UK	Whilst support is being implemented to encourage clinical academic careers, the lack of certainty and role definition creates a barrier which is further enhanced with clinical practice taking over priority of academic work. Needs to be established earlier in careers
Beitz & Heinzer	2000	Faculty practice in joint appointments: Implications for nursing staff development	To explore the types of faculty practice models and discuss the benefits and challenges of joint appointments.	Review article	USA	Proven benefits to joint appointment models are clear for both the individual and organisation; however, the role is demanding, and within a resource-limited service, true collaboration is required for this to succeed. No clear definition – parameters defined by the organisation. Several models were explored, including a joint appointment. To succeed, there needs to be mutual accountability. An individual needs to be transformative and adaptable. Challenging role. Role is usually senior nurse.
Baptiste et al.	2022	Approaches for establishing and sustaining clinical academic partnerships: A discursive review	To highlight the need for a formal, structured process that bridges academic and clinical needs.	Discursive paper	USA	Partnerships can be used to achieve a lot of benefits but needs commitment. Collaboration between leaders and stakeholders. Formalised frameworks are required and establishment of definitive roles.
Bowles et al.	2021	Academic-clinical nursing partnerships use an evidence-based practice model	To compare the experience of a new clinical model with traditional clinical teaching	Mixed-method design	USA	Strong clinical and academic partnerships are essential for effective undergraduate teaching and this needs to incorporate current practice environments. This model proved successful; however, resources and finances would be a significant challenge for a wider implementation.

Author	Year	Title	Aim	Design	Country	Summary
Buron et al.	2024	Reimagining the future of clinical nursing education: a cohort partnership model	Discussion of a proposed Clinical Cohort model aligned with an academic/clinical partnership to address nursing faculty shortages.	Descriptive Article	USA	This model was successfully implemented, providing financial, staffing, recruitment, and employment advantages to the school of nursing, students, and the health care provider. Challenges were noted around lack of consistency in staff assessment and lack of understanding of academic processes however enhanced communication and orientation addressed this.
Carrick-Sen et al.	2019	International perspectives of nurses, midwives and allied health professionals' clinical academic roles: Are we at a tipping point?	To explore and discuss the experiences and challenges faced by clinical academics in an international context.	Review article	UK	There are noted to be significant discrepancies internationally around the development and definition of the clinical academic role. This, along with poor resourcing and limiting pathways restrict the development of this role. Barriers still include middle management, competence anxiety and misunderstanding. High-level management recognises it. Needs role clarity to make progress. Needs an international agreement on a clinical academic definition.
Cole	2024	Leased clinical faculty model: Bridging gaps in nursing education	Outline of an initiative within a US hospital to lease clinically based nurses to address the shortage of clinical faculty.	Descriptive Article	USA	This collaboration ensures clear orientation and onboarding of staff and initial feedback highlights positive outcomes for staff and students. This could be a viable strategy to combat faculty shortages and meet healthcare demands. Generally successful- improved bridging gap. 4-hour orientation for staff to teach assignments and learning objectives. Clinical rotations are managed around faculty availability. Only 100 students. Attend meetings and feel engaged. Outcomes are student engagement is up. Results indicate joint appointments are prepared in policies. However, continued reliance on untrained agency nurses. Ongoing will address challenges with staff shortages, financial barriers..
Cooper et al.	2019	Developing the role of the clinical academic nurse, midwife and allied health professional in health care organisations	To explore the development of clinical academic roles across a number of settings and provide recommendations of how to support these roles.	Descriptive article	UK	Research proven to improve patient outcomes. Foundational structures needed to be embedded to promote research and EBP. Drive to engage individuals into CA careers. Found to be leaders, trail blazing
Dirik et al.	2025	Academic-clinical collaborative partnerships: a qualitative exploration of facilitators and barriers from the perspective of nurse	To identify barriers and facilitators of academic and clinical collaboration.	Qualitative Study	Turkey	Themes found within this study generally align with previous research in that clinical academic partnerships foster improved practice, staff shortages and poor communication and planning created barriers to the collaboration.

Author	Year	Title	Aim	Design	Country	Summary
		academics, clinicians and students				
Fowler et al.	2008	Joint appointees' experience within a school of nursing and midwifery	Evaluation of experiences of joint appointees	Qualitative Study	UK	Joint appointee roles, whilst mutually beneficial to both organisations, require experienced individuals who are clinically skilled, whilst also being able to manage conflicting cultures.
Granger et al.	2012	An academic-health service partnership in nursing: Lessons from the field	Description of the development of a academic practice partnership in order to increase evidence use in practice.	Descriptive case study	USA	Research-focused. Difficult to cultivate and sustain. Collaborative. Evn with aligned values, challenges such as time, scheduling and role expectations differ
Gustafsson et al.	2015	Nurse teacher models in clinical education from the perspective of student nurses – A mixed-method study	Description and comparison of clinical teachers' roles in clinical placement from the perspective of nursing students	Mixed methods	Sweden	University nurse teacher (UNT) vs clinical nurse teacher (CNT). The study suggests that clinical credibility does not imply participation in clinical work. Both UNT and CNT could integrate theory and practice; however, CNT does so to a slightly greater extent. Strong connection feature of CNT role; however, UNT had advantages in providing advocacy, managing conflict and challenging critical thinking. CNTs at times did not understand learning outcomes but did reduce feelings of isolation. Both models have risk of imbalance and deficiencies.
Henshall et al.	2021	Interventions and strategies aimed at clinical academic pathway development for nurses in the United Kingdom: A systematised review of the literature	To review interventions and strategies designed to progress UK clinical academic career pathways in nursing	Systematised review	UK	A number of initiatives and processes have been established to support clinical academic pathways in the UK, cohesion is lacking. Focus on research. Highlighting that 10 studies reported on pathway development. Imperative to have commitment from both partners and effective leadership. Research not a priority in the workforce. Lack of mentors.
Hoffman	2019	Transitional experiences: From clinical nurse to nurse faculty	To explore the lived experiences of clinical nurses as they transition to nurse faculty positions	Qualitative Study	USA	Participants reported a challenge in returning to a beginner-practitioner level of knowledge of an academic system, having come from advanced practice. The need for clear orientation and familiarisation with academic process was evident.
Kaunda	2024	Do jointly appointed nursing and midwifery clinical academics provide benefit to patients, individual joint	To assess the evidence of benefit to joint appointees and the value to their contribution to key stakeholders.	Literature review	UK	The number of clinical academics in nursing and midwifery in the UK accounts for less than 0.1% of the workforce. This review found benefits to the individual CA, healthcare organisations, and academic institutes, including evidence-based practice, reduced mortality and individual career development. This aligned with previous research.

Author	Year	Title	Aim	Design	Country	Summary
Luckenbach et al.	2021	Appointees, academic institutions and health and social care organisations? A scoping literature review Affiliate faculty in nursing clinical education.	An exploration of the efficacy of an affiliate faculty model from the perspective of nursing students and faculty.	Mixed methods design	USA	The use of the affiliate faculty model was seen from nursing students to bridge the theory practice gap and increase readiness for practice. This is mutually beneficial for both the academic provider and the clinical setting. Sustainable. Students unable to tell the difference. Scheduling and balancing challenge.
Luckenbach & L'Ecuyer	2023	The clinical academic partnership for excellence: Lessons learned from a clinical faculty onboarding program.	A study to explore the competency of clinical faculty in teaching and explore the benefits of an onboarding program named CAPE.	Mixed design method	USA	The CAPE program has proven an effective model in supporting the employment of clinical faculty. This may be a suitable model to guide additional schools. Clinical proficiency does not translate to academic competence* Found the programme promoted mentorship and debriefing of staff – not just teaching skills and curriculum. Taught how to give feedback, encouraged to engage in the curriculum. Found positive outcomes.
Mathisen et al.	2023	Practice education facilitators' perceptions and experiences of their role in the clinical learning environment for nursing students: a qualitative study	Exploration of the use of nurse educators in joint university and clinical roles to enhance the experience of nursing students within clinical placement.	Qualitative study	Norway	Nurse educators working across both sectors can significantly improve students' clinical experience through their knowledge of both settings. These benefits were, however, limited to personal attributes as well as organisational and functional limitations. Very similar to clinical-academic joint appointments. Discussed strong links between areas. But also noted lack of role clarity, feeling overwhelmed and isolated. Noted lack of empirical knowledge on how roles strengthen the environment. Found that they do strengthen but are reliant on time provided, personal attributes and management anchorage. Challenges – time, RNs' competing demands (limited flexibility of seniors), visibility, and accessibility impacted the perception of the role. Bridge theory practice gap.
Moss et al.	2023	Development and Validation of an Operational Model for Nursing Academic-Practice Partnerships	To describe the development and validation of an operational model for nursing academic practice partnerships	Mixed design method	USA	The OMAP was found to be a basic operational model to guide the development of academic practice partnerships within nursing. Benefits to marginal populations – resources of large academic institute. Best practice to service. Student opportunity to be exposed to different types of populations. Joint appointments increased satisfaction. Flexibility – person-centred

Author	Year	Title	Aim	Design	Country	Summary
Newington et al.	2022	What is a clinical academic? Qualitative interviews with healthcare managers, research-active nurses and other research-active healthcare professionals outside medicine	To explore perceptions and understanding of what is a 'clinical academic' is outside the role of medicine	Qualitative study	UK	care, good but difficult to replicate. Found competing priorities. It can be challenging for a less experienced individual. Research-heavy. Clear evidence that the title of Clinical academic incorporates education, research and clinical practice; however, there is a significant lack of clarity around this. Mindset more important than title.
Ogilvie et al.	2004	Value and vulnerability: Reflections of joint appointments.	Exploration of the withdrawal of a joint appointment initiative and the vulnerable position that joint appointments may hold.	Journal Article – program evaluation	UK	Regardless of perceived value, the role of the CA is vulnerable when not fully understood
Paterson & Strickland	2023	The experiences of clinical academic nurses: A meta-aggregation	A synthesis of qualitative evidence to explore the experience of clinical academic nurses	Systematic Review	Australia	Experiences of clinical academics vary internationally, reflecting the variety of pathways and processes that support them. It was noted that there is a wide-ranging discussion around this, but limited empirical evidence to support it.
Paton et al.	2022	Journey to a new era: An innovative academic-practice partnership	To describe a new partnership initiative between advanced practice nurses at a Magnet standing children's hospital and a college of nursing at a local tertiary institute.	Descriptive-reflective Article	USA	Strong collaboration between organisations resulted in a positive transition to faculty roles. The success was deemed to be a result of a shared vision, transparent communication and organisational buy-in. Model hired 'clinical faculty' who worked clinically 95% of the time and taught 5% of the time (with some ability to discuss alternate needs). A lot of benefits to this joint model- students gain access to clinical experts (and teachers). Supports clinical placement obtaining. Individuals obtain further support for research, to access resources, and for professional development. The program is undergoing ongoing change – new needs for individuals are being explored. Noted important to have communication between teaching faculty and clinical faculty
Pattison et al.	2022	Florence Nightingale's legacy for clinical academics: A framework analysis of a clinical professorial network and a model for clinical academia	Case study analysis to inform a new model for Clinical Academic pathways	Discursive paper	UK	Limited in this context

Author	Year	Title	Aim	Design	Country	Summary
Pedregos a et al.	2020	Effective academic-practice partnership models in nursing students' clinical placement: A systematic literature review	Review looking at the effectiveness of partnership models, including clinical faculty in improving students' clinical learning	Systematic Review	Spain	Clear that it reduces theory practice gap.
Peterson & Morris	2019	Creating synergy between academia and practice: the Arizona State University and Mayo Clinic Arizona Model	To describe the development of a partnership model and highlight how the model enables collaboration between clinical practice and academia.	Case study	USA	Similar to findings internationally – barriers to partnership include communication, finance, difference in processes and non aligning systems. Communication and aligned values highlighted as key to overcome this.
Pfister et al.	2021	Living the Manatt report: Advancing the future of nursing through joint academic appointments	To describe the implementation of a joint appointment model in response to recommendations from the Manatt report.	Descriptive Article	USA	Highlights the need for a structured approach to the establishment of joint appointment roles. Collaboration and intentional and deliberate management are required for a joint appointment to succeed with mutually held goals and values. Many opportunities for JA to be beneficial-address theory practice gap, clinical credibility, and able to provide didactic content to students. However, face burnout, a mismatch of expectations, and cultural differences. Time commitment does not match the division of labour. The capacity and skill of educators vary. Vulnerable to leadership changes. Individuals need to be focused and creative
Phillips et al.	2019	Academic-practice partnerships: A win-win	To highlight the mutual benefits of partnerships between academic and clinical organisations.	Commentary	USA	Not employed by same employer so does have some differences. About the challenge in integrating EBP into practice. Hybrid DEU with constant faculty to drive a culture shift to use EBP. Great collaboration and trust, mutual respect, and partnership was emphasised
Sadeghne zhad et al.	2018	Mutual benefits in academic service partnership	Aim to identify benefits in academic clinical partnerships through the literature.	Integrative Review	Iran	Benefits of academic service partnerships. Need mutual benefits. Address HR shortages, better student readiness, bridges theory practice gap
Sharabani & Cojocar	2018	Joint appointments in nursing – A necessity or a hindrance?	To examine the attitudes of nurses around clinical reliability of nursing teachers	Qualitative	Israel	Teachers need to be up to date with clinical knowledge and the political climate. Those with 2 jobs suffer anxiety, pressure and cannot balance the roles. Note that learning how to complete clinical roles does not teach the theory that teachers require to teach. Teachers provide significant connection and support for students regardless. Consensus that direct patient contact is necessary for professional competence; however, students could not distinguish between joint appointments and solely academic teachers, noting that the discrepancy can be bridged through regular contact and updates.

Author	Year	Title	Aim	Design	Country	Summary
Thamm et al.	2025	Why is starting and sustaining a clinical academic role in nursing still so difficult?	Exploration of the challenges in developing clinical academic roles in nursing.	Commentary	Australia	Significant challenges remain in the space of clinical academics. To succeed in sustaining this role, significant change needs to happen in culture and valuing the place of research and innovation. Support that CA roles increase EBP and bridge theory practice gap. Cas contributes by including outcomes at the research, staff, patient and organisational levels. Remains poor understanding of roles. Culture remains an issue. Direct patient care remains a priority. Research not valued. Need for robust nursing research.
Trusson et al.	2019	A mixed-methods study of challenges and benefits of clinical academic careers for nurses, midwives and allied health professionals.	Exploration of the progression and experiences of nurses, midwives and allied health professionals through a clinical academic pathway.	Mixed method design	UK	Participants noted organisational barriers to the progression of clinical academic pathways with the need for clear support and prioritisation of research within roles in order to further grow this. Dual roles need to be definable within a single role. Progression is occurring, but not necessarily through the official pathway. Lack of organisation and managerial support. Culture is not research-friendly. Promote early-career nurses into the CA path – concerns about the ages of those pursuing it. Promote a culture where research is the norm. disconnect between management's priorities and floor-level priorities.
Van Oostveen et al.	2017	Combining clinical practice and academic work in nursing: A qualitative study about perceived importance, facilitators and barriers regarding clinical academic careers for nurses in university hospitals.	To obtain insight into the perceptions of nurse academics and other stakeholders regarding the importance, facilitators and barriers for nurses combining clinical and academic work.	Qualitative Study	Netherlands	Nursing culture and a poor understanding of the clinical-academic role create barriers to role development. Organisational and leadership limitations need to be overcome before this can succeed. Currently, the priority is to be at the bedside; the importance of research is not evident. Leadership is not supportive of the pathway. No infrastructure to support.
Yi et al.	2020	The role of academic-practice partnership from perspectives of nursing students: A cross-sectional study	To gain the perspective of nursing students on academic practice partnerships	Cross-sectional survey	Korea	Big on collaboration. EBP improved. Found that it directly impacted the interaction of students and nurses. Mutually beneficial. Students need to understand the partnership to obtain true learning.

Appendix II: Interview Participant Information Sheet



TE HUATAKI WAIORA
SCHOOL OF HEALTH

Navigating Excellence: A Critical Review of the Clinical Academic Model in Tertiary Nursing Education

Participant Information Sheet – Clinical Academic

Dear participants,

I am Claire Campling, principal researcher for this study into the Clinical Academic Nursing Model. This is being undertaken as part of a Masters degree. I currently work within the Nursing Programme at the University of Waikato and have a background in the management of preregistration clinical placements. Your participation plays a vital role in reviewing and improving the clinical experience for nursing students.

Should you have any questions or concerns, please don't hesitate to contact me at Claire.campling@waikato.ac.nz

Research Aim:

The basis of this research is to review the Clinical Academic Nursing Model utilised by the University of Waikato Nursing Programmes to support students in clinical placement. It aims to explore both the successes of the model and the barriers to meeting key outcomes. From this the study will develop key recommendations to enhance the sustainability and satisfaction of the model.

Your participation:

As a current Clinical Academic you have lived experience in the application of this model to clinical practice. This research requires participation of 10 current Clinical Academic staff to participate in a 20–30-minute semi structured interview. This interview will explore your understanding of the Clinical Academic role, what this looks like in practice and barriers to the model. The findings of the study will be the foundation of key recommendations for future development of the Clinical Academic role.

Confidentiality:

Your involvement in this study is confidential. All identifiable information will be removed during the research process and every effort will be made to ensure confidentiality by the researcher through the following methods;

- Numerical codes will be applied to all individual interviews. Any identifying features / names will be removed, and pseudonyms applied.
- All information collected will be stored securely in a locked cabinet at the University of Waikato for 5 years following completion of the study. Digital information will be stored within a password protected computer.

Voluntary participation:

Participation within this research is voluntary. You have the right to ask any additional questions about the research before, during or after the interview and the right to decline to answer any particular question. Should you change your mind you have the right to withdraw at any point during the interview or up until the data is analysed. No reason needs to be given should you decline to answer a question or withdraw from the interview and you will not be asked to supply one. Please contact Claire Campling should you wish to withdraw.

Research Outputs:

On the completion of this research a written thesis will be published, and the study will be submitted for publication in a peer reviewed journal. A summary of key findings will be presented both in written form and a PowerPoint presentation to key stakeholders and participants.

This study has obtained ethics approval through the University of Waikato Human Research Ethics Committee

Appendix III: Interview Template



Interview Questions - Clinical Academic

1. How long have you worked as a Clinical Academic?
2. Tell me about your role/s (if joint appointment explain briefly both roles held)
3. Can you explain to me your understanding of the Clinical Academic role, expectations and requirements?
4. What do you think works well with the model? What could have gone better? Can you describe an example of this?
5. What do you think is the biggest challenge in working in a Clinical Academic appointment/what has been your biggest challenge? Please describe examples of these challenges in practice.
6. Other than direct work with students in a Clinical Academic capacity, what involvement have you had with the University of Waikato nursing programmes? (e.g. teaching, marking etc)
7. Can you describe for me a typical session with a student? (Where, how long, breakdown of time spent)
8. Tell me about your relationships within the clinical placement?
 - a. Have you / How often do you meet with the leadership team within clinical placements?
 - b. How do you obtain feedback from the clinical placement in regards to student performance?
9. How do you resolve a concern regarding a student in placement?
10. How would you rank your understanding of the assessment criteria for students whilst in clinical placement? (1 – 5 Ranking Scale) Please explain your answer.
11. If needing further information or to discuss a concern/query, how would you manage this?
12. Any other comments?

Appendix IV: Participant Consent Form

UNIVERSITY OF WAIKATO

PARTICIPANT CONSENT FORM

[A completed copy of this form should be retained by both the researcher and the participant]

Name of person interviewed:

I have received a copy of the Information Sheet describing the research project. Any questions that I have, relating to the research, have been answered to my satisfaction. I understand that I can ask further questions about the research at any time during my participation, and that I can withdraw my participation at any time up to four weeks after the interview.

During the interview, I understand that I have the right to decline to answer any particular question. I can stop the interview at any time, and I can ask to have the recording device turned off at any time.

When I sign this consent form, I will retain ownership of my interview, but I give consent for the researcher to use the interview for the purposes of the research outlined in the Information Sheet.

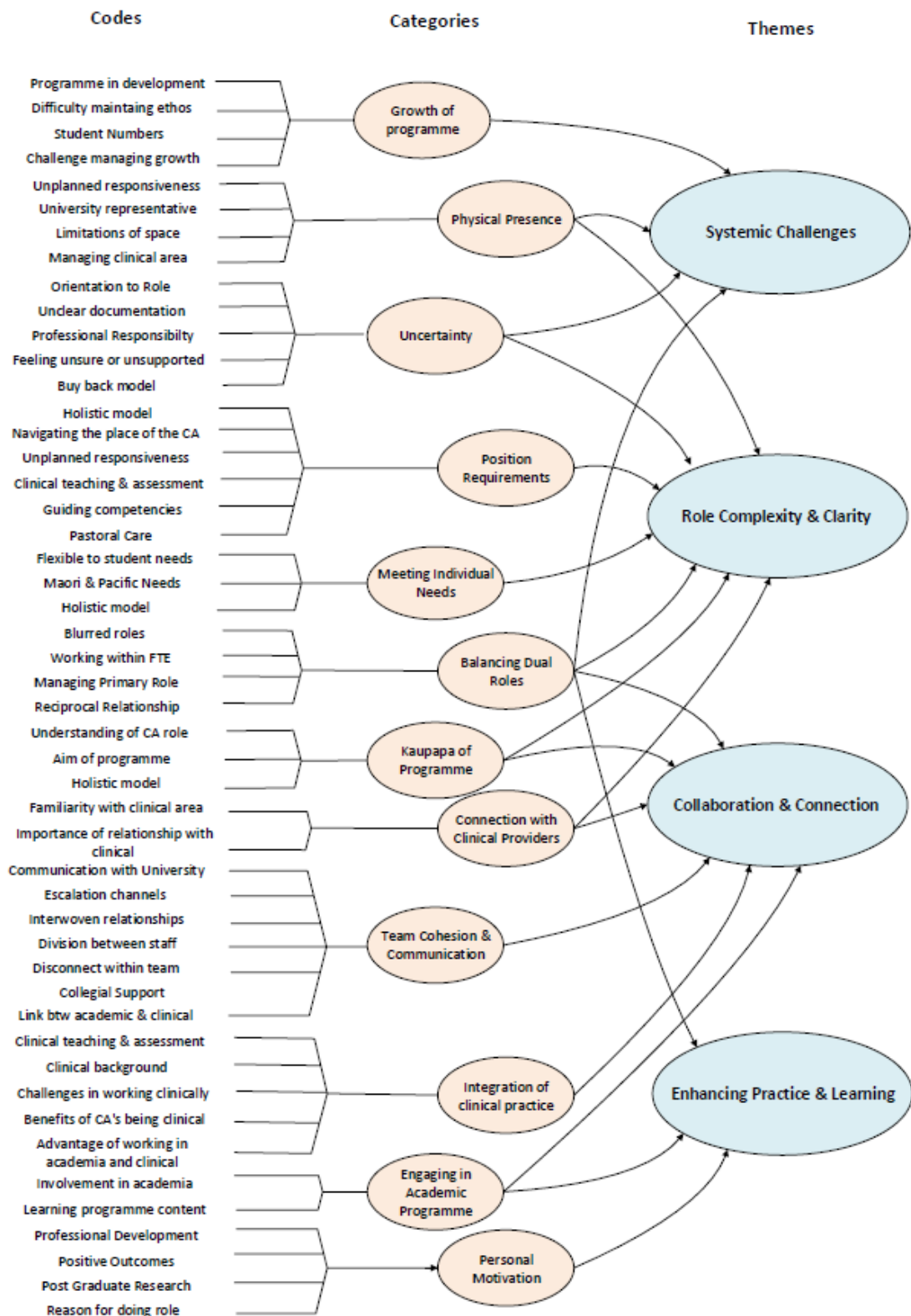
[I understand that my identity will remain confidential in the presentation of the research findings]

Please complete the following checklist. Tick [✓] the appropriate box for each point.	YES	NO
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<i>[I wish to receive a copy of the findings.]</i>		
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Participant :	Researcher :
Signature :	Signature :
Date :	Date :
Contact	Contact
Details :	Details :

Appendix V: Thematic Analysis Coding Diagram



Appendix VI: Survey Participant Information Sheet



Navigating Excellence: A Critical Review of the Clinical Academic Model in Tertiary Nursing Education.

Participant Information Sheet – BN/MNP Student

Dear participants,

I am Claire Campling, principal researcher for this study into the Clinical Academic Nursing Model. This is being undertaken as part of a Masters degree. I currently work within the Nursing Programme at the University of Waikato and have a background in the management of preregistration clinical placements. Your participation plays a vital role in reviewing and improving the clinical experience for nursing students.

Should you have any questions or concerns, please don't hesitate to contact me at Claire.campling@waikato.ac.nz

Research Aim:

The basis of this research is to review the Clinical Academic Nursing Model utilised by the University of Waikato Nursing Programmes to support students in clinical placement. It aims to explore both the successes of the model and the barriers to meeting key outcomes. From this the study will develop key recommendations to enhance the sustainability and satisfaction of the model.

This research aims to address the following research questions;

- a. Does the Clinical Academic model meet the desired outcomes outlined at the commencement of the programme?
- b. How does the Clinical Academic model address the evolving needs and challenges in the current health context?
- c. How can the Clinical Academic model be enhanced to address current challenges, promote sustained effectiveness and optimise the integration between education and clinical practice?
- d. What feedback mechanisms could be implemented within the Clinical Academic model to ensure continuous improvement and responsiveness to student and health care provider needs?

Your Participation:

As a current student within a nursing programme at the University of Waikato you work directly alongside the Clinical Academic team during your clinical placements and are able to provide key information regarding how this role functions. Provided alongside this information sheet is a link to a survey for you to complete. This survey will take 10-15 minutes. The data collected from these responses will help to analyse the successes of the model as well as identify key challenges to be addressed.

Confidentiality:

As this survey is anonymous it will be unknown who the participant is. No identifying information will be collected during this survey.

Voluntary participation:

Participation within this research is voluntary and as such you have the right to decline to answer any particular question or to withdraw at any time during completion of the survey. To withdraw you will either directly close the survey at any stage or fail to click the submission button. You also have the right to ask any further questions regarding the research before, during or after completion of the survey. To do this please email the principal investigator with the contact details listed at the top of this sheet. By choosing to complete and submit this survey you consent to this information being used for the research described.

Research Outputs:

On the completion of this research a written thesis will be published and the study will be submitted for publication in a peer reviewed journal. A summary of key findings will be presented both in written form and a powerpoint presentation to key stakeholders and participants.

This study has been obtained ethics approval through the University of Waikato Human Research Ethics Committee.

Appendix VII: Survey Questions

Survey Questions - Nursing Students

1. What year level are you currently enrolled in?
 - a. BN2
 - b. BN3
 - c. MNP2
2. What is your age group?
 - d. 18-24
 - e. 25-34
 - f. 35-44
 - g. 45-54
 - h. 55+
3. Please identify which ethnic group you identify with?
4. How often on average did you see a Clinical Academic during your clinical placements?
 - i. More than once a week
 - j. Weekly
 - k. Fortnightly
 - l. Other
5. How long on average did you spend with your Clinical Academic during your meeting?
6. Did you have a consistent Clinical Academic throughout the duration of your clinical placement?
 - m. Yes
 - n. No
7. What form did these meetings take? (select all that apply)
 - o. In person 1:1
 - p. Via phone
 - q. Via email
 - r. Group sessions
8. Please outline how your time was spent when meeting with a Clinical Academic (Rank 1-4).
 - s. Debriefing
 - t. Competencies
 - u. Completing Assessments
 - v. Education and Teaching
9. Please answer the following statements (Rank on scale from strongly agree to strongly disagree)
 - w. The Clinical Academic improved your clinical experience
 - x. The Clinical Academic and clinical placement worked collaboratively
 - y. The Clinical Academic demonstrated clear knowledge of key theories and models taught in the programme
 - z. The Clinical Academic facilitated a positive and productive learning experience

- aa. Feedback was consistent between your preceptor and clinical academic
 - bb. The Clinical Academic was capable of supporting your knowledge within the specific clinical specialty
10. Did the Clinical Academic make you aware of any issues or concerns highlighted with your performance in placement?
11. Do you believe you received consistent information / expectations from Clinical Academics that you have been assigned? Please rank below and provide comment.
- cc. Significantly inconsistent information provided / very different expectations
 - dd. Some inconsistencies / difference in expectations
 - ee. Minor inconsistencies
 - ff. Very consistent in what information you received / what was expected from you
12. What do you feel a Clinical Academic would best improve your Clinical Placement?
13. Any other comments?

Appendix VIII: Ethics Approval

The University of Waikato
Private Bag 3105
Gate 1, Knighton Road
Hamilton, New Zealand

Human Research Ethics Committee
Roger Moltzen
Telephone: +640218581119
Email: humanethics@waikato.ac.nz



21 May 2024

Claire Campling
Te Huataki Waiora School of Health
DHECS
By email: claire.campling@waikato.ac.nz

Dear Claire

HREC(Health)2023#64 Navigating Excellence: A Critical Review of the Clinical Academic Model in Tertiary Nursing Education

Thank you for your responses to the Committee feedback.

We are now pleased to provide formal approval for your project.

Please contact the Committee by email (humanethics@waikato.ac.nz) if you wish to make changes to your project as it unfolds, quoting your application number with your future correspondence. Any minor changes or additions to the approved research activities can be handled outside the monthly application cycle.

We wish you all the best with your research.

Regards,



Emeritus Professor Roger Moltzen MNZM
Chairperson
University of Waikato Human Research Ethics Committee