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# Approachability of the Nursing Clinical Instructor: Psychometric Assessment of a Scale Development

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## Introduction

Approachability has been identified as an important characteristic of an effective instructor (Ernstzen, 2013; Ingrassia, 2011; Lempp & Seale, 2004, Perrine, 1998; Pierson, 2003; Viverais-Dresler & Kutscher, 2001; and Weick, 2003). Effective education in any discipline is crucial to the preparing the future workforce. Millennials currently comprise 82% of nursing students (National League for Nursing, 2014) and will comprise the majority of the nursing workforce within the next two decades as both the need for nurses and the number of retiring registered nurses (RN) continue to rise.

For millennial students, the relationship between the teacher and student is a critical component to learning (Shelton, 2003). Clinical instructors should strive to create a constructive learning environment even in an unpredictable clinical setting. In order to accomplish this feat, the instructor must ascertain many characteristics, however approachability has been identified as a distinguishing factor between an effective and an ineffective clinical instructor (Collier, 2019). Although the importance of approachability of the instructor is established, measuring approachability has been impossible because no measure has been available. The purpose of this study was to examine the validity and reliability of the newly developed Approachability of Nursing Clinical Instructor (ANCI) scale.

## Statement of Problem

A call for reform in clinical education in nursing by the National League for Nurses in 2003 spotlights the need for nursing academia to further investigate the characteristics of an effective clinical instructor from the student perspective. The majority of new nursing students in the coming years will consist of the millennial population born between 1980-2000 (LaCore, 2015). Millennial students prefer learning from a professor they view as caring (Dunneback & Therrell, 2015) and value relationships with professors who relate to them on a personal level (Bart, 2011). Considering the influx of millennial students in nursing programs, there should be a focus on meeting the needs of this generation, specifically the desire to establish an interpersonal relationship with their instructors.

According to millennial students, the key component of an effective nursing clinical instructor is approachability thus creating a vital need to understand and measure the components of approachability. The term clinical instructor and clinical teacher are used interchangeably in the literature. In this study, the clinical instructor is defined as a registered nurse employed by the nursing school that has oversight of the students in direct patient care settings. For the purposes of this study preceptors were excluded because most preceptors are nurses that are employed by the hospital not the nursing school. During a concept analysis (Collier, 2014), a definition of approachability within the context of clinical nursing education was developed. This definition included active and subtle behaviors. Some of the active behaviors included encouraging questions, answering questions without belittling the students, and showing an interest in students. The subtle behaviors involve being aware of non-verbal communication and being available. The Approachability of the Nursing Clinical Instructor (ANCI) scale operationalizes and measures this important concept.

## Significance of Study

The National League for Nurses (NLN) (2003) developed a position statement regarding nursing education calling for nursing education programs to re-think clinical education in order to meet students' needs. Many current nursing educators were taught during an era when nursing education was rigid and non-personal but the NLN statement suggests current educators cannot teach current students in the same way in which they were taught. This shift in nursing education highlights the imperative to amplify the needs of the millennial students as this generation will be the future nursing workforce, replacing the current retiring nurses. Nursing education reform requires a partnership between students and teachers in which the students view their nursing clinical instructors as approachable. Historically, the concept of approachability within the context of clinical nursing education has been immature and obscure. The ANCI scale operationalizes and measures the concept of approachability allowing for the assessment of approachability in clinical nursing educators.

## Theoretical Framework

Knowledge is the process of building on past experiences and interpretation of new experiences. According to Piaget, this process requires a cognitive process of assimilation and accommodation (Wood & Bennett, 1998). According to the Social Constructivist Theory, knowledge is obtained through past experiences and advanced through sharing various experiences (Sincero, 2011). Within this theory, motivation for learning is both intrinsic and extrinsic. Students develop their own learning intrinsic goals and receive extrinsic rewards from their peers. Instruction in this model is usually group based and the teacher acts as a facilitator and guide to the group (Sincero, 2011).

Concepts**.** Within the Social Constructivist theory, there are three concepts: Zone of Proximal Development (ZPD), Role of Social Interaction in Cognitive Development and the More Knowledgeable Other (MKO) (Sincero, 2011). The ZPD is the progression of actual development levels to higher levels. The actual level of development is the knowledge the learner has already achieved. The higher potential development is the level the student is actually capable of reaching. The higher level of development is achieved with guidance of instructors and collaboration with peers. The potential development zone is where learning occurs. Learning occurs by social negotiation and joint knowledge construction.

The student then reconstructs meaning to existing prior knowledge and experiences. However, this cognitive process can only mature by guidance. Within this theory, the interaction with the instructor can be very influential to the learning process. Social Constructivism implies both a proactive and responsive role of the instructor (Wood & Bennet, 1998). The goal of the instructor is to assist in maneuvering the student from the Zone of Proximal Development to the More Knowledgeable Other. Instructor guidance provides a scaffold in the learning process. Teachers must incorporate appropriate material, tasks, questioning, explanation and feedback during the process (Wood & Bennet, 1998; Wu, 2003). If the student perceives the clinical instructor as approachable, then he or she will be more likely to ask questions, understand expectations and receive feedback during the learning process (Kube, 2010).

The ANCI measures how approachable the student perceives the instructor. The more approachable the instructor is scored by the student, the better the "scaffolding" to assist the transitioning from one level of learning to another. Using this theory, the instructor could assist the student in the transition from the Zone of Proximal Develop to the More Knowledgeable Other.

## Literature Review/Background

Some consider nursing to be the oldest occupation (Cohen, 1984). Historically, nursing occurred in the home where women, often mothers, cared for the children and family, essentially fulfilling the role of nurse. Nursing skills developed from apprenticeships and few women were paid for their provision of care. For many years, the clinical education portion of nursing was in the wards of hospitals under the supervision of a "ward sister," a role which would be considered today's nurse manager (Dunn & Burnett, 1995). Clinical education included rigid task assignments with strict hierarchical demands.

Clinical education has remained a hospital-based apprenticeship but under the supervision of clinical faculty. According to the aforementioned NLN position statement, nurse educators should strive to create a partnership between students and teachers while also conducting research to develop effective and meaningful innovations in nursing education. Benner et al., (2010) further stress that experiential learning is directly dependent on the environment, and more specifically the ability of the clinical faculty to engage the student with feedback, articulation and reflection specific to student performance. Tanner (2006) suggested a new model of clinical nursing education to incorporate interaction between the student and instructor that supports learning such as guiding and questioning. Despite a call for reform for over a decade, clinical nursing education has experienced little change.

Few valid and reliable tools exist to evaluate clinical teaching effectiveness. One of the most notable scales is the Nursing Clinical Teacher Effectiveness Inventory (NCTEI) developed by Knox and Mogan (1985). The NCTEI is a 47-item Likert-type scale with subscales addressing teaching ability, nursing competence, evaluation, interpersonal relations and personality. Within the interpersonal relationship category, one of the questions used to determine the effectiveness of the clinical teacher includes "is approachable." Although approachability is one of the variables within the NCTEI scale to evaluate teaching effectiveness, to date, it has never been the purpose of the scale with defining characteristics to measure this concept.

## Instrument Development

There are five steps to developing a new scale; (1) defining the construct, (2) designing the scale, (3) piloting the scale, (4) administering the scale and conducting item analysis, and (5) validation and norming (DeVellis, 2012).

Defining the Construct. The first step of instrument development is defining the concept. Many disciplines, including nursing, education, medicine, and psychology, discuss the importance of approachability within the context of clinical education. However, few studies have developed a conceptual definition or provide a robust description of approachability (Collier, 2014).

As a result of a concept analysis using Roger's Evolutionary Method, approachability in the nursing clinical setting was defined as a dynamic concept defined theoretically as the process of implementing active and subtle behaviors of approachability. This analysis identified the antecedents, attributes and consequences of approachability for the clinical nursing instructor. The identified antecedent was a student-centered teaching philosophy. The attributes were divided between active and subtle behaviors of approachability. The active behaviors include encouraging questions, answering questions without belittling the students, showing an interest in students and being flexible. The subtle behaviors include an awareness of non-verbal communication and being perceived as 'available' by the students. The consequences of implementing approachable behaviors include building an interpersonal relationship with the students and creating a positive clinical experience (Rodgers & Knafl, 2000).

Designing the Scale. The second step of instrument development is designing the scale. Three semi-structured focus groups were conducted to explore approachability of the nursing clinical instructor. The first focus group included ten senior BSN students who had completed four semesters of clinical instruction in various settings. The second focus group included eleven senior BSN students who had completed three semesters of clinical instruction in various settings. The third focus group included six BSN clinical instructors who were currently teaching clinicals. Five guiding questions were used in all three focus groups.

During the focus groups, the students appeared passionate about the topic of approachability. They were eager to contribute answers and share stories related to the guiding questions. Session transcripts were read by one member of each focus group for a member check. The results were divided into themes, coded, and reviewed by a subject matter expert (BSN student/current clinical instructor) to verify the codes. Six themes emerged from the focus groups including: (1) Accommodating, (2) Verbal Communication, (3) Perception of Helpfulness, (4) Feedback (Evaluation Process), (5)-Body Language, and (6) Creating the Learning Environment.

Piloting the Scale. The third step of instrument development is conducting a pilot study. Based on the themes that emerged from the focus group sessions items were developed for the new Approachability of a Nursing Clinical Instructor (ANCI) scale. The original scale contained 45 items with a five-point Likert-type response scale (1-strongly disagree to 5-strongly agree). These items were reviewed by 29 BSN students for readability and identification of any questions that were confusing or ambiguous. No items were removed as a result of this review and the full 45-item instrument was administered to a sample of 108 BSN students, none of whom participating in the initial item review.

A principal component analysis (PCA) was conducted using the Statistical Package for the Social Sciences (SPSSv24). Visual inspection of the screen plot indicated one overarching factor with six possible components. An exploratory factor analysis (EFA) using Varimax rotation revealed 11 total factors each with an Eigenvalue greater than one which explained 72.95% of the variance. However, upon further review, three of the factors had only one item loading. Additionally, the negatively worded items were loading on one factor even though they were designed to represent different dimensions of approachability. The six negatively worded items were deleted, resulting in 39 items remaining. The EFA was conducted again using the 39-item

reduced scale. The results revealed nine factors with an Eigenvalue greater than one that explained 69.99% of the variance. Two items ('discusses personal experiences' and 'allows to make mistakes') loaded equally on three different factors and were subsequently removed. The EFA was conducted a third time resulting in a six-factor solution. During this analysis, 11 items had equal loadings across multiple factors and it was determined that these items did not properly discriminate between the different facets of the construct resulting in their elimination from the scale. The EFA was conducted a final time on the reduced 26-item scale. One overarching factor was identified explaining 40.94% of the variance, however, six factors had an Eigenvalue greater than one, with three to five items loading, and together explained 67.63% of the variance. The overall Kaiser-Meyer-Olkin (KMO) value was 0.896 and Bartlett's Test of Sphericity was statistically significant ($p = .000$) indicating that the data was likely factoralized. These six factors were consistent with the six themes identified in the previously conducted focus groups. Therefore, the final ANCI scale contains 26 items representative of six domains of approachability (See Appendix A).

## Methods

Five steps are involved in any newly developed scale (Spector, 1992). Those include: 1) Defining the Construct 2) Designing the Scale 3) Piloting the Test 4) Administering the test and conducting an item analysis 5) Validating and Norming the scale. The researcher completed the first four steps involved in instrument development in prior work. The purpose of this study was to complete the fifth step of development which is validation and norms.

## Participants

Undergraduate nursing students from four different nursing schools, two Bachelor of Science in Nursing (BSN) and two Associate degree programs (ADN), participated in the current study. All schools were located in Southeast United States. IRB approval was obtained and permission was granted from the dean or director of each nursing program. The principal investigator forwarded the survey link to the contact faculty at each school and the link was subsequently forwarded via email to all undergraduate nursing students who had completed at least one semester of nursing clinical education. The survey link was open for one week.

Demographic information including year of birth, degree program (BSN or ADN), gender, number of clinical semesters completed in nursing school, and types of clinical experience (i.e. fundamental, critical care, obstetrics, etc.) was collected from each participant.

Inclusion/Exclusion Criteria. Participation was strictly voluntary and included all undergraduate nursing students who had completed at least one nursing clinical rotation. First semester nursing students were excluded from the study because they do not have at least one semester of clinical nursing experience. Despite the potential for past clinical experiences, RN-BSN students were also excluded because the curriculum for RN-BSN degree includes limited clinical experiences.

## Procedure

Participants accessed the survey using an electronic link distributed via email. They were instructed to think of their most approachable instructor and respond to each item with that instructor in mind. Upon completion of the 26-item ANCI, participants were logged out of the survey software and the data was aggregated and subsequently downloaded into SPSS v25 for analysis.

## Results

There were 755 students from the four nursing schools who qualified for participation in the survey. A total of 221 students responded to the survey for a return rate of 29%. Nine surveys were incomplete and were eliminated from the analysis for a final sample size of 212 completed surveys.

## Demographic Data

The 212 respondents represented four different nursing schools in the Southeastern United States. Age ranged from 19-51 with a mean age of 24.39 (SD = 5.39) (See Figure 1) with 50% of the sample born after 1993 (</= 24 years). When comparing this finding to generational dates, 95% of the respondents were born between 1980 and 2000 placing them in the millennial generation.

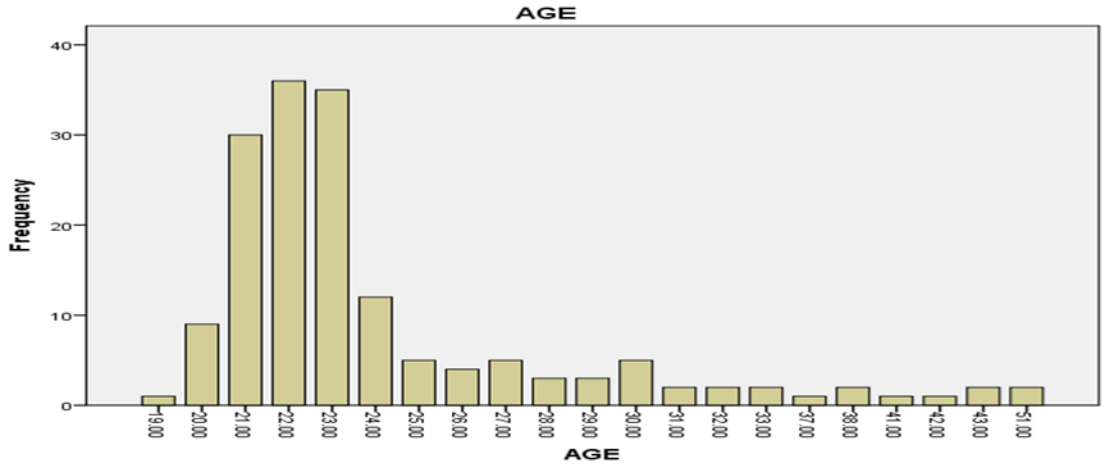


*Figure 1:* Age of Participants

Females represented 82.1% (n=174) of the sample while male representation in the sample exceeded the 15% national average at 17.9% (n=38) (NLN, 2014) (See Figure 2).

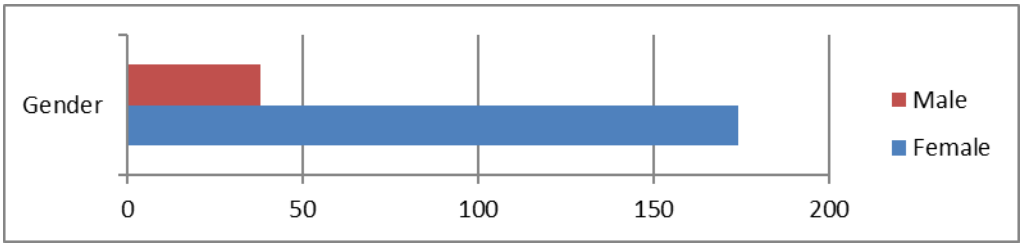


*Figure 2*: Gender of Participants

A majority of the respondents (75.47%, n=160) were from the two BSN programs while the remaining 24.53% (n=52) were from the two ADN programs (See Figure 3). Approximately a quarter of respondents (25.94%, n=38) reported previous, non-nursing-related clinical education experiences.

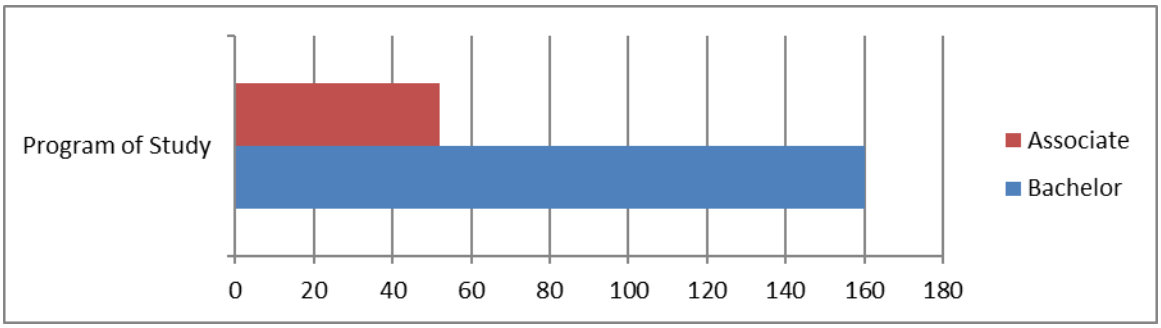


*Figure 3*: Program of Study

The number of nursing school semester completed was somewhat evenly distributed ranging from 13% (1 semester) to 27% (4 semesters) indicating a sample representing various levels of nursing exposure and experience (See Figure 4).

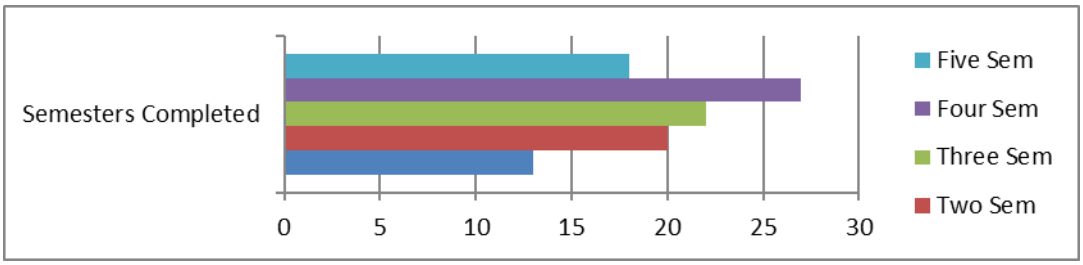


*Figure 4*: Number of Semesters Completed by the Participants

The majority of respondents (67%) had three or more semesters of contact with faculty providing clinical instruction with a wide range of nursing school clinical experiences (See Figure 5).

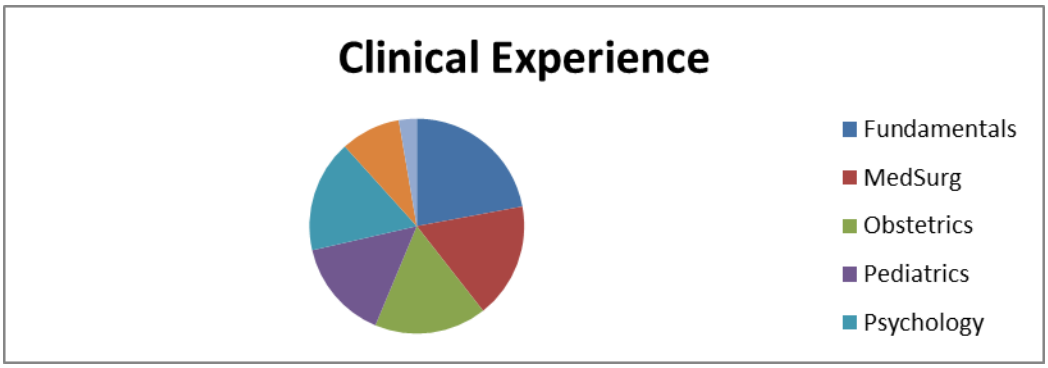


*Figure 5*: Clinical Experiences of the Participants

**Scale Descriptive**

The ANCI is a 26-item scale with response options ranging from 1 (Strongly Disagree) to 5 (Strongly Agree), resulting in a potential total score range of 26-130. The minimum total ANCI score for this study was 46 and the maximum total ANCI score was 130 with a mean of 112.73 (SD=16.31), median of 115.5 and a mode of 130. The ANCI scale was negatively skewed (-1.376) leptokurtic (2.247) (See Figure 6).

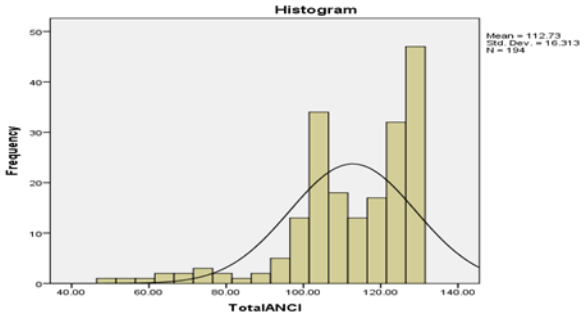


*Figure 6*: Scale Distribution

Validity. Four types of validity were explored including face validity, content validity, construct validity and criterion-related validity.

Face Validity. As previously mentioned, face validity was established during a prior pilot study (n=29) undergraduate nursing students. Via Qualtrics survey, students were asked to assess question readability and offer suggestions for rewording. Changes were made and three senior nursing students, considered subject matter experts (SMEs), reviewed the edited survey. The SMEs agreed that all items appropriately measured approachability of the clinical instructor and the scale readable and understandable.

Content Validity. Due to the novel nature of the approachability construct, senior nursing students and experienced clinical faculty were considered subject matter experts for the scale for the purpose of establishing content validity. Six senior nursing students and four faculty members, each with at least five years of clinical nursing experience, served as SMEs. Each SME reviewed the scale individually, made written comments, and were given the opportunity to

discuss the scale with the principal investigator. Independently, all student and faculty SMEs agreed the scale contains all characteristics of an approachable clinical instructor.

Construct Validity. A Principal Components Analysis (PCA) was conducted using Statistical Package for the Social Sciences (SPSS v24). Visual inspection of the Scree plot indicated one overarching factor with three possible underlying factors (See Figure 7). A confirmatory varimax rotated factor analysis was also conducted. The results revealed that three factors had an Eigenvalue greater than one. However, upon further analysis, these items were not designed to load together. For example, items addressing non-verbal communication were in the same category as office hours. This confirmatory analysis indicated a one-factor scale with 56.1% of the variance explained. To further confirm the findings, the overarching one-factor scale was revealed in both of the Scree plots of the exploratory and confirmatory analysis. The overall Kaiser-Meyer-Olkin (KMO) measure was 0.955. Bartlett's Test of Sphericity was statistically significant (.000) indicating that the data was likely factoralized.

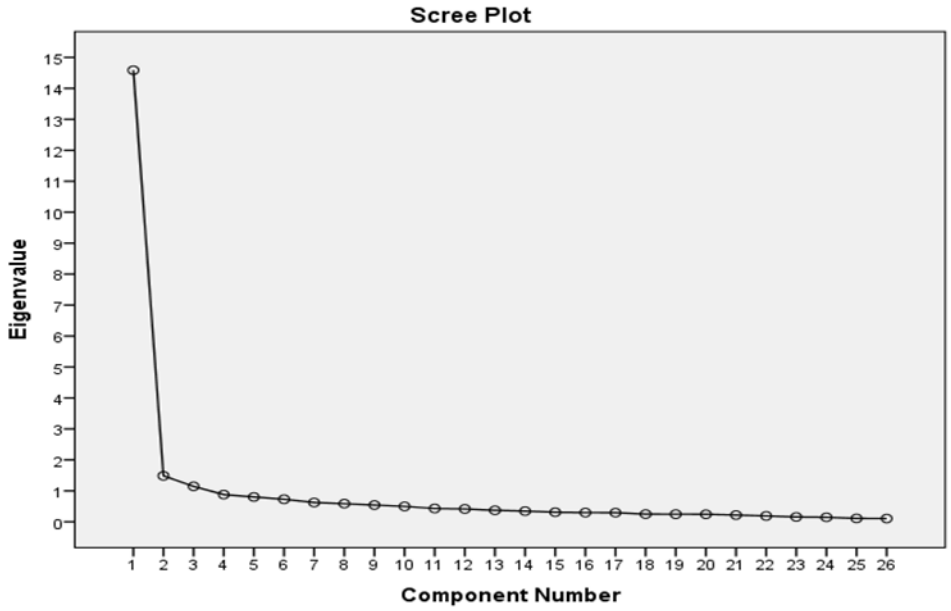


*Figure 7*: Scree Plot of Confirmatory Analysis

AMOS (v24) was used to further evaluate the goodness of fit for both the six factor and single factor models. The first analysis included the six factors revealed in the pilot study. Of the 15 possible relationships, 13 resulted in values of 0.90 or above indicating strong intercorrelations. These results suggested the six factors were too highly inter-correlated to be identified as separate and distinct factors. The goodness-of-fit resulted in a Chi-square value of 790.937 which was significant, CFI=0.880. CFI values of 0.9 or higher indicate adequate fit of the model.

The second analysis included a single factor solution. Of the 26 items, all but one had a relationship of .50 or higher, with a range of .58-.94. The Chi-square value was 892.356 and was again significant (p=.000). Because of the large sample size, a significant finding is not

concerning. The RMSEA was .93 and the CFI was .86 indicating a mediocre goodness of fit. The researcher decided one overarching factor of approachability should be used for this scale.

Criterion-related Validity. Both convergent and discriminant types of criterion-related validity were examined during this study. The Interpersonal subscale of the Nursing Clinical Teacher Effectiveness Inventory (NCETI) was used to establish convergent validity. The resulting strong, positive correlation between the NCETI and the ANCI was statistically significant ($r = .895$, $p = .000$). A modified portion of the Observations of Nursing Teachers in Clinical Setting (ONTICS) was used to establish discriminant validity. These questions were chosen because they are negatively worded. The resulting strong, negative correlation between the ONTICS and the ANCI was statistically significant ($r = -.738$, $p = .000$). These results support the conclusion is the ANCI scale has convergent and discriminant validity when compared to previously established scales.

Reliability. Internal consistency reliability was examined for the scale as a whole using SPSS v24. The resulting Cronbach's alpha (□=.967), which is greater than the prescribed value of .80 (Polit, 2010), a result greater than .80 is desirable. Due to IRB constraints, test-retest reliability was not an option because there was no way to match students for multiple iterations of test administration.

**Discussion**

According to Spector (1992), the development of a scale consists of five steps: (1) Defining the Construct; (2) Designing the Scale; (3) Piloting the Test; (4) Administration and Conducting Item Analysis; (5) Validation and Norming. Defining the construct began with a concept analysis of approachability related to nursing clinical instructors that resulted in the realization that no measure of approachability existed. The definition of the construct was further informed by the specific needs of the millennial nursing student that currently fills most of the seats in any nursing program. A literature review and subsequent focus groups confirmed the preference for an approachable clinical instructor (Viveralis-Dresler & Kutschke, 2001; Wieck, 2003) and directed the development of survey questions. The resulting pilot survey was administered to 108 senior undergraduate nursing students and refined based on the results of the item analysis.

The final step, and focus of the current study, was the validation of the ANCI. Results confirm the newly developed ANCI meets all four aspects of validity and reliability is established. Face validity was confirmed during the pilot study. Content validity was confirmed by 10 subject matter experts who unanimously agreed the items in the scale adequately measured approachability of a nursing clinical instructor. Construct validity identified a one factor scale identified by the researcher as approachability. Criterion-related validity for the ANCI was also confirmed. Convergent validity was demonstrated by a high positive correlation with the Nursing Clinical Teacher Effectiveness Inventory (NCETI). Discriminant validity was demonstrated by a negative correlation with a modified portion of the Observations of Nursing Teachers in Clinical Setting (ONTICS). Reliability of the scale was analyzed using Cronbach's Alpha which revealed high reliability. Each of these pieces of validity and reliability evidence support the conclusion that the Approachability of the Nursing Clinical Instructor (ANCI) scale is both a valid and reliable tool for assessing approachability in nursing clinical instructors.

## Limitations

A primary limitation in this study is the use of a convenience sample from four nursing schools in the Southeastern United States. The results may not be generalizable to the nursing student population across the country or internationally. Another limitation is the lack of an analyzable test-retest administration of the ANCI. Due to the restricted IRB approval, the students could not be identified, and test-retest reliability could not be analyzed.

Subsequent administrations of the ANCI within different nursing student samples are needed to ensure the consistency of the approachability construct across geographic and cultural regions. Future exploration of the psychometric properties of the ANCI should include a test-retest reliability analysis.

## Future Directions

Further Psychometric Testing. First, to ensure the consistency of the approachability construct across geographic and cultural regions, subsequent administrations of the ANCI should include a more representative sample of nursing students. Next, test-retest reliability should be established to support the use of the ANCI for nursing clinical instructor development. Finally, confirmatory factor analyses could be re-evaluated using a larger, more representative sample.

Potential Theory Testing. The ANCI scale could be used to test the theory that millennial nursing students will achieve greater learning gains when paired with an approachable clinical instructor. Student ratings of clinical instructor approachability could be evaluated as a predictive factor in their pre vs post benchmark test scores in a particular content area.

Education and Screening of New Clinical Instructors. Current nursing faculty need to be aware of millennial students' affinity for approachable clinical instructors. Additionally, clinical instructors need education and mentoring on how to be more approachable in their interactions with students. The ANCI can work as an assessment and coaching tool for new, and seasoned, clinical instructors as well as a measure of growth after specific interventions and/or education has been implemented. The clinical instructor should strive to create an optimal clinical learning environment by attempting to become the "ladder" to a higher level of learning. The ANCI could also be used as a self-evaluation for potential clinical instructors to assess areas of strength and areas of opportunity related to approachability. These self-evaluations could later be compared to their students' evaluations (ANCI) for continued development.

Expanding ANCI Within Nursing. Currently, the ANCI has only been tested in a traditional undergraduate program. This efficacy of the ANCI should also be evaluated using students in RN to BSN and various MSN programs. Students in different types of programs or in different specialty areas of nursing may have differing opinions on the importance of individual components of approachability for clinical instructors.

Expanding ANCI to Other Disciplines. The ANCI, with minor discipline-specific changes, may be appropriate for use in other professional preparation disciplines with a clinical component

such as education, medicine and physical therapy in which students are required to interact with a ‘clinical’ instructor outside of the classroom environment.

## Conclusion

In conclusion, the ANCI is a valid and reliable tool. It has the potential to assist in call by the NLN for clinical nursing education reformation. This tool can also assist with education and screening of potential nursing faculty. The ANCI great potential in nursing education as well as other disciplines with clinical experiences.

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## Appendix A

Approachability of Nursing Clinical Instructors Scale

Think of your clinical experiences and identify the instructor you considered most approachable. Keeping that instructor in mind, answer the following questions:

My instructor is flexible in response to my individual learning needs.
- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

My instructor provides constructive feedback.
- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

I receive one-on-one (personal) instruction in the clinical setting when possible.
- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

I do not feel intimidated by my instructor.
- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

My instructor knows my name.
- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

My instructor gives undivided attention when responding to questions.
- o Never
- o Rarely
- o Sometimes
- o Most of the Time
- o Always

My instructor uses an appropriate tone of voice.
- o Never
- o Rarely
- o Sometimes
- o Most of the Time
- o Always

My instructor has an open body posture during discussions (i.e. not crossing arms, facing me, etc.).

- o Never
- o Rarely
- o Sometimes
- o Most of the Time
- o Always

My instructor gives clear instructions prior to the beginning of the clinical day.
- o Never
- o Rarely
- o Sometimes
- o Most of the Time
- o Always

My instructor is available during office hours if needed.
- o Never
- o Rarely
- o Sometimes
- o Most of the Time
- o Always

I receive positive reinforcement from my instructor.
- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

My instructor answers e-mails in a timely manner.
- o Never
- o Rarely
- o Sometimes
- o Most of the Time
- o Always

My instructor admits when he/she does not know the answer to a question or situation.
- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

My instructor creates a team feeling.
- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

My instructor is willing to demonstrate technical skills.
- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

My instructor is willing to discuss with students without being defensive.

- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

My instructor is willing to explain situations or procedures.
- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

My instructor is willing to listen to students.
- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

I do not feel shamed by my instructor.
- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

My instructor is clinically competent.
- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

My instructor appears to enjoy his/her job.
- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

My instructor has a good reputation with the staff nurses of the unit.
- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

My instructor has a friendly personality.
- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

My instructor smiles.

- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

My instructor has a positive reputation among former students.

- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

My instructor provides encouragement during clinicals.

- o Never
- o Rarely
- o Sometimes
- o Most of the Time
- o Always