Scenario one:
You are assessing your preceptee (graduate nurse) to complete the medication administration practical. Your preceptee does not meet the required standard.

- She is not able to describe indications of use and expected drug action
- You need to remind her to wash her hands
- She does not give the patient any education
- She administers the drug too fast

1. Discuss the scenario within your group
2. Role play the feedback to be given to preceptee
3. After the role play – each person to talk about how the role play went
4. Using the displayed overhead write down what your feedback would be and if further follow up needed – this is for discussion with the larger group

Scenario Two:
You are preceptoring a second year nursing student and you notice that the student appears to have a lack of knowledge re disease processes and appears disinterested in being on the ward/unit. He does not actively participate in ward/unit activities, does not ask questions and often is late to work or retuning from meal breaks.

1. Discuss the scenario within your group
2. Role play the feedback to be given to preceptee
3. After the role play – each person to talk about how the role play went
4. Using the displayed overhead write down what your feedback would be and if further follow up needed – this is for discussion with the larger group

Scenario Three:
You are preceptoring a proficient level nurse who has transferred from another area. You come across this nurse on the phone discussing a patient loudly at the nurse's station in front of visitors. You note that this is not the first time this has occurred.

1. Discuss the scenario within your group
2. Role play the feedback to be given to preceptee
3. After the role play – each person to talk about how the role play went
4. Using the displayed overhead write down what your feedback would be for discussion with the larger group

Scenario 4:
Your preceptee makes you feel uncomfortable when you ask her questions about the patient care she has planned for patients. Answering with…..
"I'm too busy right now", "I'm fine", "No I don't need help". She does not share information and you are finding it difficult to assess her.

1. Discuss the scenario within your group
2. Role play the feedback to be given to preceptee
3. After the role play – each person to talk about how the role play went
4. Using the displayed overhead write down what your feedback would be for discussion with the larger group

Scenario 5:
You observe your preceptee talking to an elderly patient who has rung the bell and asked for assistance in the shower. The nurse says, with a hint of attitude "I am too busy love, you are not my only patient you know."

1. Discuss the scenario within your group
2. Role play the feedback to be given to preceptee
3. After the role play – each person to talk about how the role play went
4. Using the displayed overhead write down what your feedback would be for discussion with the larger group

Scenario 6:
You have noticed that your preceptee regularly does not introduce himself to the patient or their family. On this day you are with you preceptee to check the PCA pump. He does not introduce himself, does not explain what we are going to do or how long it will take.

1. Discuss the scenario within your group
2. Role play the feedback to be given to preceptee
3. After the role play – each person to talk about how the role play went
4. Using the displayed overhead write down what your feedback would be for discussion with the larger group

EDUCATION

Becoming a super preceptor: A practical guide to preceptorship in today's clinical climate

Elizabeth R. Barker, PhD, FNP, BC, FAANP, FACHE (Associate Professor, Clinical) **& Oralea Pittman,** MS, FNP, BC, FAANP (Clinical Instructor)

College of Nursing, The Ohio State University, Columbus, Ohio

Keywords
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Correspondence
Elizabeth R. Barker, PhD, FNP, BC, FAANP, FACHE, College of Nursing, The Ohio State University, 1585 Neil Avenue, Columbus, OH 43210.
Tel: 614-292-5684;
Fax: 614-292-7976;
E-mail: barker.203@osu.edu

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Abstract

Purpose: To provide both potential and active preceptors with practical information that will help with the decision to become a preceptor, and to develop the preceptor partnership among the preceptor, the faculty, the student, and the patient. The article suggests ways to apply realistic techniques to assure that the preceptorship is successful in today's fast-paced practice climate. The article also presents successful evaluation strategies for the experience.

Data sources: Evidence-based reports, anecdotal experiences, personal conversations, and reports of proven preceptorship techniques.

Conclusions: Through a review of available literature and the authors' experience as preceptors and faculty, it is clear that it is possible to implement a mutually beneficial preceptor experience even in today's productivity-based practice models. Preplanning and use of suggested strategies can make precepting an enjoyable and rewarding experience.

Implications for practice: The education of tomorrow's practitioners is a mutual professional partnership among the stakeholders in the educational process. Application of practical strategies for enhancing this partnership will make the experience realistic and rewarding.

The need for excellence in the preceptor role has been well documented in the literature over the past two decades. However, there is little that is current and few contributions that present practical tips on being a preceptor in today's ''productivity'' environment. Furthermore, there is little in the current literature that prepares the newer preceptor to ask the right questions and plan the appropriate experiences for students. This article is designed to help the faculty and the preceptor build a professional partnership that will result in a positive learning experience for today's nurse practitioner (NP) student.

The preparation of nursing students for successful transition to real world role implementation has always been a challenge in nursing education. The use of preceptors as role models and teachers in the clinical setting has been employed for many years. Indeed, with the expansion of programs in advanced practice to encompass distance learning, and the need to place students in clinical experiences where it is not possible for the academic faculty to observe the students on a first hand basis during the clinical portion of the courses, the role of the preceptor has become essential in the educational process (Burns, Beauchesne, Ryan-Krause, & Swain, 2006). A preceptorship is usually a time-defined relationship with externally defined objectives, and has as its goal the instruction of a neophyte in the proficiencies of a new role (Barker, 2006). Within this relationship, the preceptor models the realities of practice for the student and helps guide the student to organize behaviors and strategies for effective and efficient patient care. In addition, a preceptorship provides the student with the opportunity to experience the pressures of day-to-day relationships with patients, other professionals, the referral system, local, state, and federal rules and regulations, and the realities of productivity-based

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practice. Preceptors are the vital link between the concepts and evidence-based approaches to care and the realities of actual practice.

Being a preceptor is a valued professional activity and is rewarded by the certification authorities by giving credit for recertification in advanced practice by the American Nurses Credentialing Center (ANCC, 2008). The impact of the preceptor on the student's formation has been cited repeatedly in the literature (Lyon, 2001; Hayes, 1994, 1998; Yonge, 2005). Each of these authors describes ways in which the preceptor's unique position influences the way in which the student forms a basic framework for practice. As important as the preceptor's experience is on the formation of the student's professional development, the relationship is forged in the crucible of a clinical environment that is not designed to allow for the time it takes to implement the teaching process.

Preceptorships are frequently short term and dependent on the length of the student's course. The time that students spend with the preceptor is determined by overall clinical hour requirements rather than the student's individualized learning needs. The availability of the preceptor and the student for mutually convenient hours and the structure of the clinic's patient care hours are also essential ingredients in the equation. This reality demands that the preceptor quickly identify the student's learning needs and select patient encounters to meet those needs and then fit them into the available time constraints. This is a difficult and often frustrating activity.

Students often present themselves to the preceptor with few, if any, formal objectives for the experience aside from the requirements of the course. Most often, the preceptor is still expected to maintain the level of productivity that existed before the preceptorship and assure that all regulations and policies are followed. This presents an environment that is not conducive to the development of self-efficacy in the student (Hayes, 1998) or enthusiasm on the part of the preceptor. In a recent meeting at a large advanced practice symposium in 2008, many preceptors reported that a lack of communication between the professors and the preceptor, a lack of relationship building efforts on the part of the faculty, and a general sense that the professors are not clinically current were identified in group discussion as barriers to the faculty–preceptor relationship.

In spite of all the pitfalls in the preceptorship experience, it is possible to construct a rewarding experience for all participants: the student, the clinical preceptor, the patient, the practice, and the faculty. This article will describe practical and effective tips for enhancing the outcomes of the precepted experience and forging mutually beneficial relationships among the people engaged in the process.

Becoming a preceptor

Making the decision to become a preceptor is not an easy one. Trying to squeeze extra time out of an already packed schedule often seems to be an impossible task. Remuneration for the time and energy expended is usually low or not offered. What then, would motivate one to become a preceptor? Research has supported the notion that that for NPs a powerful influence on the decision is personal satisfaction and a desire to ''give back'' to the students to repay those who invested in their education. Another factor is the perception of the quality of the communication between the faculty and the preceptor. Open dialogue between the preceptor and the faculty not only enhances the preceptee's experience but also provides the preceptor with much needed peer support and a narrowing of the theory–practice gap (Kaviani & Stillwell, 2000; Lyon & Peach, 2001; Hayes, 1994, 1998). Students and recent graduates have also indicated that the decision to be a preceptor in their careers is also based on the experience that they had while being precepted (E. Koenig, personal communication, January 5, 2008). Some recent graduates have considered the preceptor role because they ''remember how it feels to be a student'' and how helpful a great preceptor had been in their formation.

Negative experiences as a preceptor can also influence decision making. Being ''responsible'' for the success or failure of a student is a heavy burden. Many potential preceptors are reluctant to undertake the role because of a perceived lack of skill in techniques to manage conflictual situations with a student who is not performing well. A past history of unsuccessful preceptorships is also a powerful influence on the decision. Situations in which the preceptor's input was either not solicited or not used to make progression decisions have a negative impact on the decision to repeat the experience. The authors have had the experience of being exhausted at the end of a preceptorship because the student could not be trusted to see a patient safely, discussions with the student were not fruitful, and repeated attempts to contact the instructor were unacknowledged. When the student passed the course in spite of documented lack of achievement, discouragement and anger were powerful ''demotivators.'' In the stressful world of primary care, one less stressor is a welcome respite. How, then, does one become a successful preceptor? What does it take to have interactions with students that bring a sense of achievement to both parties?

Precursors of successful preceptorships

First, it is essential that before a clinician agrees to be a preceptor, he or she should have some indication of the expectations of the program for the precepted experience. These expectations should include the level of practice expertise the student has achieved (Are they beginners or on their last rotation? Are they experienced nurses or new to the profession?). The clinician should ask for the objectives for the course, the course syllabus, and the number of hours over a specific time frame the student is expected to spend with the preceptor. This will provide the focus of the course and help the preceptor plan the time the student spends in the practice more effectively. It is quite appropriate for the preceptor to expect that the student display professional behaviors, be mentally and physically prepared for the experience, and be willing to supplement the time in clinic with specific readings to improve his or her ability to manage the patient's conditions.

Second, the preceptor should have some sort of communication, either face to face, telephonically, or electronically, with the student before the onset of the preceptorship. Some areas of discussion might include mutual expectations for the conduct of the preceptorship including dress code, charting parameters, and urgent contact information in case either party cannot be available for an agreed-upon meeting. Additionally, a brief description of the practice routines and a general sense of the patient population will give the student a better sense of how to prepare for the experience. If the preceptor is specific about these basics, it can eliminate poor first impressions and save instructional time in the long run.

Third, it is helpful if the preceptor has some understanding of generational differences in learning patterns. Research indicates that the length of experience as a nurse is not correlated with level of competency in NP students (Rich, 2005). The combination of a younger student with limited or no experience in nursing with an experienced NP who is a new preceptor can often lead to frustration on the part of both parties. This frustration can be diminished by open communication of expectations, mutual willingness to offer constructive feedback, and the formation of a good partnership with the faculty member. It is suggested that the faculty member make at least one visit per precepting period, either in person (the best strategy) or via telephone. This improves the sense of a teaching partnership and allows for a more satisfying experience.

Table 1 Barriers to precepting success

Detrimental effect on productivity
Practice not designed to include students
Patients' expectations for care provider's attention
Discomfort with the teaching role
Short duration of the precepting experience

Barriers to precepting

The most common perceptions of barriers to precepting are listed in Table 1. The literature does not have many current economic analyses of these factors; however, one study indicated that community physicians who were precepting third year medical students actually saw 1.4 fewer patients and spent 51 min longer at work than physicians who did not have students with them (Levy, Gjerde, & Albrecht, 1997). Another study of rural clinics indicated that there was no difference in the billing charges that were generated between sites that had students and those that did not (Amella, 2001). The question of productivity often is largely dependent on the level of the student and the fit between the student and the preceptor. This area needs further research, particularly in today's practice climate.

Another perceived barrier is the requirements that Medicare place on the structure of the visit. The regulations state: ''Any contribution and participation of a billable service must be performed in the physical presence of a teaching (physician or resident) in a service that meets teaching (physician) billing requirements'' (Centers for Medicare and Medicaid Services, 2007). (Note that the guidelines do not discuss NPs, the brackets are the authors' notation.)

The Center for Medicare Services (2007) rules for documentation by students indicate that a student can document only the review of systems, and the past medical, social, and family history. The preceptor must document the history of present illness and the physical examination. Initialling the student's charting is not sufficient to meet the requirements. Following these rules does increase the time and complexity of the visit.

Another barrier is the perception that ''the patients do not want to have a student.'' This is certainly true in some cases, particularly when there is a strong emotional or intimate problem overlay to the visit. Having a student see the patient can often extend the duration of the visit and the patient may have to endure a second history or physical examination session. If the patient refuses to have a student, the patient's wishes must always be respected. This can be an excellent topic for the reflection portion of the student's day. It is an excellent learning experience to assure that students do not take the rejection personally or as a reflection of their expertise.

The authors have often had success in these cases when the patient is told that he or she was specifically chosen as an important example of a skill or condition about which the student needs to learn and that the preceptor will be with the student every step of the way. Another helpful approach is that the student is providing fresh eyes and a possible new tactic for a problem that has been difficult, and that students are excellent sources of the ''latest and greatest.'' Furthermore, the authors have often had the experience of the patient being happy that there is a student because that implies that the preceptor is so well respected that he or she is chosen as a preceptor by the academic community. This often gives enhanced status to the preceptor and to the practice.

Preceptor fatigue is another barrier to effective preceptorships. If a potential preceptor is asked to precept by medical schools, allied health programs, and nursing programs, the amount of personal satisfaction for patient contact and the experience that one is ''always on'' can lead to burnout and frustration (S. Hatem, personal communication, January 15, 2008). It is a reality that advanced practice programs are experiencing increases in enrollment and the number of precepted experiences has increased as well. Individual tracks within a program as well as multiple programs within a University or College or within a geographic area often place the potential preceptor in the middle of a cacophony of requests for the service. This is frustrating and can lead to a desire for ''them all to go away and leave me alone'' (L. Sedlock, personal communication, May 15, 2008).

Practical strategies for successful precepting

It is human nature to often apply the same strategies that were used ''on us,'' even if they were not particularly helpful. It is important to realize that different techniques for different learners should be selected depending on the student's and preceptor's personality and level of experience, as well as the pace of the practice. A constellation of techniques is summarized in Table 2. In order to meet Medicare guidelines, a successful approach is for the student to do the history and physical exam (H&P) while the preceptor sees another patient. When the preceptor returns to the room, the student presents the H&P and the preceptor and student develop the plan together based on findings from the observed examination. Points for improvement can be discussed after the visit, but the preceptor can amend the pattern of the examination as it occurs. This demonstrates a collaborative approach and eliminates the patient having to have the same exam twice.

Another technique is the so-called ''One Minute Preceptor'' model (Neher, Gordon, Meyer, & Stevens, 1992). The authors' experience is that it takes longer than one minute, but it is an effective approach. In this classic model, there are five microskills used.

> *What do you think is going on?* (get a commitment)
> *What led you to that conclusion?* (probe for supporting evidence)
> *Many times when . . . . .* (teach general rules)
> *You did an excellent job of . . . . .* (reinforce what was right)
> *Next time this happens, try . . . . .* (correct mistakes) (p. 419)

The advantages of this model are that it allows the preceptor to undertand student's critical thinking pattern, it communicates general rules of encounter with patients and it provides for immediate feedback about what was good and what needed improvement in the encounter.

There still remains the problem of productivity and how to get through a busy schedule with a student and not be at the clinic until midnight. Table 3 summarizes some suggestions that have worked for the authors. One approach is a focused half day. The preceptor can see the projected schedule and select one or two patients on whom the student can concentrate. The focus can be related to age, condition, assessment skills, or aligned with the objectives for the course the student is taking. In this strategy, students will have time to review necessary information from the chart and/or from the evidence base so that they will be prepared to ask the patient appropriate questions and perform a focused examination. While the student is preparing or while the student is in the initial encounter, the preceptor can be seeing other patients and keeping the schedule on track. Although this only provides for the student to see one or two patients, it gives the student the opportunity to have an in-depth experience and learn approaches that can be used in subsequent encounters (Taylor, 1998). This technique can

Table 2 Techniques for precepting students

Case discussions
Matching patients and the student for a specific learning experience
Direct questioning
Think aloud sessions
Assignment of directed readings
Coaching and cheerleading
Direct observation

Table 3 Scheduling strategies for precepting

Focused half days
Focused observation
Wave-scheduling
Appointment modification

increase confidence in the student, is less overwhelming to the neophyte, and keeps the preceptor on course for the day's schedule.

In the initial part of the precepting experience, the focused observation is often helpful. During this time, the student adopts a ''fly on the wall'' approach with the patient encounters. This gives the student the opportunity to observe you as a role model for specific aspects of the patient visit and provides material for a period of reflection at the end of the day in which the student may understand how the preceptor introduces variations depending on the patient's needs, and identify what the preceptor believes is important in every encounter. This technique is excellent for the beginning student or it can be useful on a day when there is not a lot of time for teaching because of a heavy schedule. This technique is not appropriate for a student's entire rotation. A third useful technique is ''wave-scheduling.'' In this pattern, two or three patients are scheduled at the same time and then that time slot is followed by a 10 or 15 min break. The student can see one patient while the preceptor sees the others. There is time for the preceptor to see the student's patient and not fall behind. This allows for the full complement of patients to be seen during the day, and it eliminates the back-up that occurs with the more usual 15 min/patient pattern.

Another variation on the above technique is to remove one appointment from the morning session and one or two from the afternoon session so that the preceptor and the student have ''catch up'' time. This pattern can potentially decrease the productivity of the day's schedule and so the preceptor needs to have support from the practice management to allow for this kind of flexibility. In some practices where the authors have worked, there is constructive ''preceptor'' time that is built into the productivity analysis that allows for the clinician to precept twice a year for 10–15 weeks. This eliminates the problem with productivity bonuses, as precepting is considered part of the productivity equation.

Student evaluation

This area is often a stressful one for preceptors, particularly when there is a necessity to give negative feedback. Hayes (1994) reported that feedback, no matter how well intentioned, may batter the self-esteem of the student. Responses of the student may range from appreciation and acceptance to tearful anger accompanied by defensiveness or passivity. In spite of these expected responses, honest feedback is essential in the precepting process. A summary of tips for giving feedback is found in Table 4.

Table 4 Evaluation tips

Base on performance not personality
Understand student's response to the feedback
Put the behavior in the context of the patient's outcomes
Assure privacy for evaluations
Be honest and constructive in your intent
Communicate feedback to faculty in a timely manner
Mutually devise a strategy for improvement
Do not generalize to an entire group of students

Evaluation should be specific, timely, include the student's assessment of the problem areas, positive as well as negative and give the student the opportunity to participate in the amelioration of the problem (Benzie, 1998). The focus should be on behavior and not personality. The authors have found that putting the behavior in the context of how it affects the patient's outcomes is often most helpful. Evaluative comments can come at any time in the day's schedule, but should be performed privately, gently, honestly, and in the spirit of producing growth. The authors cannot think of a time when negative evaluation comments are appropriate in front of the patient or practice staff.

Evaluation comments should be communicated to the faculty member in a timely manner. This report should include a description of the problem, the approaches to rectification and the progress that has been achieved. Positive feedback should be communicated in a similar manner. If the preceptor is having difficulty with the student or the experience is not going well, it is essential that the faculty member be apprised of the problem promptly so that a mutually beneficial solution can be designed. In addition, generalizing one student's problems to an entire group of students is neither helpful nor appropriate.

Conclusion

Effective precepting is a partnership of the skilled practitioner, the nurse practitioner faculty, and the focused student. While it takes time, it is a rewarding experience for all parties. Students learn best by being given the opportunity to practice in a supportive and realistic environment. The skills of NP graduates are often directly attributable to the quality of the precepted experiences students had while in their program. It is essential for all of us as skilled professionals to take time to prepare the next generation of NPs. In today's productivity-based practice environment, it is often a challenge to provide an effective learning atmosphere; however, implementation of some of these strategies and a bit of planning can produce amazing results.

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✣ **RESEARCH PAPER** ✣

Professional socialization: The key to survival as a newly qualified nurse

Mary Mooney RGN, RM, RNT, MSc (Nursing), Higher Diploma
Lecturer, Trinity College, Dublin, Ireland

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Mooney M. *International Journal of Nursing Practice* 2007; **13**: 75–80
Professional socialization: The key to survival as a newly qualified nurse

The impact and prevalence of professional socialization in nursing has been written about extensively. Despite the many positive developments that have taken place in nursing within the past decade, the role of professional socialization remains heavily weighted and is of particular significance to those nurses who are newly qualified. The account given by newly registered nurses in this study demonstrates that their ability and willingness to become professionally socialized determines their ease of survival at clinical level. Twelve newly qualified Irish nurses, from two separate cohorts, were interviewed to ascertain their perceptions of becoming newly qualified nurses. A grounded theory approach was used and data were analysed using thematic analysis. A category that emerged was linked very strongly with professional socialization. The respondents did not refer to professional socialization per se, but through the coding process this emerged as the linchpin of the discussion.

Key words: holistic nursing, professional power, qualitative research, socialization, stress.

INTRODUCTION

The professional socialization of nurses has been the subject of discussion for several years. This term refers to the process through which novice practitioners are merged into the profession to become professional practitioners.[1] Within this system newcomers are instructed in the ways and attitudes of the organization and gradually adopt the attitudes, values and unspoken messages within the organization.[2] The newly qualified nurses, who were individually interviewed for this study, provided lively descriptions of ritualistic practices, hierarchical attitudes and strict observance of rules. These accounts were reflective of the six processes associated with the socialization of nurses into nursing identified by Melia.[3] These included learning the rules, getting through the work, learning and working and passing through. The problems associated with the transition of nursing students to professional nursing practice have been acknowledged as being traumatic and stressful.[3–6] The majority of nurses in this study felt frustrated, vulnerable, stressed and disappointed post qualification. Although all 12 respondents supported the taught practice of holistic nursing and evidence-based care, only one nurse actually witnessed it in practice. As newly qualified nurses, the participants felt unable to exert any influence over the ward ethos in their clinical areas. The findings of this research study, together with the literature, suggest that professional socialization in nursing continues to contribute significantly to the enduring problems faced by newly qualified nurses.

ETHICAL APPROVAL

Before commencing the study, ethical approval was granted from the research ethics committee in which

Correspondence: Mary Mooney, School of Nursing and Midwifery, Trinity College, Dublin, 24 D'Olier Street, Dublin 2, Ireland. Email: mooneyma@tcd.ie

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the study took place. The researcher ensured that the correct procedures were undertaken concerning informed consent, autonomy, anonymity and the maintenance of confidentiality.

METHODS

Collection and analysis of data

A grounded theory approach was chosen as a framework for this study. The inductive approach, which is intrinsic to this method, allows the real issues in the study to emerge. This is assisted by the simultaneous collection and analysis of data. Individual in-depth interviews were held with 12 newly registered nurses, from two separate cohorts, who were qualified between 6 and 10 months. Eleven of the 12 nurses agreed to have their interviews recorded and all 12 interviewees consented to note-taking throughout the interviews. The interviews were typed verbatim. The notes from the unrecorded interview were rewritten immediately following the interview so that no valuable information would be lost or forgotten. These notes were also included in the analysis process.

A feature of grounded theory is the simultaneous collection, coding and analysis of data. The only occasion on which data were collected in isolation from the other procedures was during the initial interview. Thereafter, the process of data collection and coding, theoretical sampling and data analysis were concurrent. Theoretical sampling, which was employed in this study, involves sampling on the basis of the emerging concepts that emerge from the preceding interview. This necessitated systematic and detailed record-keeping. It was through the employment of theoretical sampling that the deviant case became so apparent. The sample size is normally determined by data saturation, which refers to informational redundancy. The researcher had considered that data saturation had been achieved after 10 interviews. It is interesting to note, however, that the deviant case emerged at the 11th interview. A limited time frame precluded more than 12 interviews.

Data were analysed throughout the interviews and during transcription. The analysis was assisted by actively listening when interviewing, exploring phenomena to which the participants referred and use of memos taken during the interviews. Data were handled manually using index cards, notes and charts. Line-by-line analysis was used to develop the open codes and subcategories, while main categories were developed through axial coding. This timely and rigorous process yielded exclusive categories which, when closely scrutinized, appeared to fit the yielded data. Data were revisited several times and changes were frequently made. This ensured that all data were included.

RIGOR

As the researcher is the research instrument in qualitative research, it was essential that careful attention was paid to the maintenance of accuracy throughout the study. Sandelowski delineates four aspects of trustworthiness within the naturalistic paradigm.[7] These include credibility, consistency, confirmability and applicability. These issues were addressed in this study. Credibility is enhanced when the readers can identify with the experience. In order to maximize credibility, all interviews except one were recorded. Detailed notes were taken during, and rewritten following, the unrecorded interview. This reduced the chance of losing important information. Data and interpretations were presented to three participants who were asked to verify the appropriateness of the findings. Two meetings took place between the respondents and the researcher. An initial briefing was held before each interview. These meetings were considered essential to overcome any potential barriers or threats that the researcher might pose to the respondent. Each interview lasted at least 45 min. Such prolonged interaction with the respondents provided the researcher with an increased understanding of what was being said.

In terms of consistency, a clear decision trail was provided. One peer assessor was provided with the interview notes and asked to trace the audit trail to ascertain the enquiry process. This cross-checking of data provided new insights and clarifications.

The use of a reflective journal assisted with the establishment of confirmability. A lengthy dialogue took place with the peer assessor who challenged the researcher's assumptions and provided clarity in some aspects of the study.

In an effort to achieve applicability, the researcher aimed to have a representative group involved in the study. It is acknowledged that those people who are less vocal tend to participate less in qualitative studies. To overcome this possibility, a strict inclusion criterion was set out for involvement in the study, clear details about the study were provided in advance and a briefing meeting was arranged before all interviews. This time was used to answer questions and get to know the participant. Data

are presented in this paper in the form in which they were derived, which further enhances the assertion that trustworthiness was preserved.

FINDINGS

All 12 nurses who participated in the study had been in the same research site (hospital) as undergraduate nurses and were employed there afterwards as newly qualified nurses. One nurse, whose stories differed from the rest, described her clinical area as one that fostered change, encouraged questioning and had a patient-centred approach to care. The presence of a deviant case such as this enhanced the trustworthiness of the findings and enriched the study. The remaining 11 participants recounted stories and post qualification experiences all of which were aligned with the presence of professional socialization in nursing. The category which was related to these descriptions was entitled 'Old Habits Die Hard'. This title was chosen as it described the ritualistic and rigid behaviours that dispirited the enthusiasm of the 11 newly qualified nurses in the clinical setting. The category emerged from two subcategories called 'Set in Stone' and 'Without a Voice'.

Set in stone

This subcategory related to the ritualistic clinical practices and routines which the newly qualified nurses found frustrating. The participants found it difficult to reconcile themselves to ward routines in the clinical area. Respondents had considered that they would be able to change these practices when they qualified and were determined to do so initially. Some of the nurses tried to make changes at ward level but got no encouragement from staff or clinical managers.

> *The drugs that are prescribed for 2 pm are given at 12 md, which I thought was ridiculous. I said it one day; why can't we just give them at 2 pm. The response I was given [from the ward manager] was that it has always been done this way. That's the way it's done on this ward.*

The work was portrayed as being ritualistic and non-patient-focused. From the interviews, it was apparent that the newly qualified nurses had difficulties with tasks taking precedence over other aspects of care and they took exception to the way work was organized in the wards. The newly qualified nurses felt less pressurized at work when the manager was not there, as everything was more relaxed in his/her absence. Although routines were still maintained by senior staff, it was to a less extent of rigidity than when the manager was present. One participant told a story about how she and another nurse had been reprimanded by the ward manager because they went ahead and made some beds while they were waiting for the bathrooms to become vacant. The ward rule was, however, that all washes had to be completed before the beds were made.

> *We are supposed to get all the washes done in the morning and all the beds made in the morning and the washes have to be done before the beds. It's such a nightmare trying to get everything done.*

In relation to the difficulties associated with routines, the nurses expressed disappointment and disturbance at the negative attitudes of some staff towards psychological care. Participants felt that talking was seen as not working. They were keen to 'fit in' with the ward routines and not cause trouble for themselves so soon after they qualified.

> *I am forever hearing people say she [the ward manager] won't bother you if you look busy. You have to make sure you run around constantly and you'll know she won't come near you and she won't give out.*

The deviant case nurse did not identify with these findings. Conversely, she felt that the ethos on her ward was one of patient and staff centredness. She felt that she had time to talk to patients and that while the ward was busy, the workload revolved around the patients' needs:

> *Yeah, we are really busy most of the time, but we are always allowed to talk to the patients. The ward sister X [named] talks to them herself. X is not fussed about beds and tidy wards. I am delighted I got back to X ward for staffing.*

Participants described how 'fitting in' meant you would be highly thought of by other members of qualified staff:

> *There could be one person that you don't get on with but they can make life very difficult for you. I think that people expect you to try to fit in.*

Eleven of the 12 participants spoke of a desire to make changes and some tried with little success. All 11 nurses

eventually conceded that the rituals and routines were set in stone and would not change. They expressed that as students they were somewhat unaware of the implications of routines, but as staff nurses, this awareness had a profound effect. Respondents felt frustrated and disillusioned by the ritualistic practices and the reluctance of others to change.

Without a voice

This subcategory referred to the vulnerability and powerlessness experienced by the newly qualified nurses. Although they had transcended a period of insignificance as students, they were now the most junior of those who were significant. They were collectively known as 'the juniors' and accentuated the supremacy of being senior while highlighting the prevalence of hierarchy. Some of the nurses talked about how they resented that only junior nurses were sent to help out on busy wards, if their own ward was not busy.

> *She [the ward manager] says there has to be perks [benefits] for somebody, that's 10 or 20 years qualified.*

Respondents felt they were blamed disproportionately and distrusted when things went wrong. One respondent spoke about four separate occurrences of drug errors on the ward. One error involved a junior nurse while the remainder involved senior nurses. The problem of 'juniors' making drug errors was highlighted at the staff meeting. There was no mention of the errors made by the senior nurses. It was agreed at the meeting that junior nurses should do drug rounds with a senior nurse at all times.

> *I was the only junior on [duty] at the staff meeting and I was made to feel like this tiny speck of dust on the carpet and I just felt so small.*

Eleven of the 12 respondents described how the nurse manager holds the reigns of professional nursing power within clinical areas. One example, which was given repeatedly, was related to the assumption that the newly qualified nurses would cover the night duty rosters over Christmas and New Year. They felt discriminated against, as this was an automatic, autocratic decision. Respondents felt they were not heard when they argued their point and all too often they gave up and conformed:

> *I feel like I can't speak up that much because I am only newly qualified. I don't have the same voice as if I was 10 or 20 years qualified. I don't think they would listen to anything I had to say.*

Participants talked of ward managers who admonish staff in public. This accounted for respondents being stressed and frightened during handover of care. The newly qualified nurses felt that senior staff should speak up for junior staff, but nobody ever did. The importance of learning to survive and making life easier was transparent. The 12th nurse, who presented as the deviant case in this study, reported feelings of security and equality as a junior staff nurse. She discussed how she was assigned to a preceptor when she went to the ward initially and spoke of how effective and reassuring it was to have someone to rely on:

> *I know from hearing the others (newly qualified nurses) that I am lucky to have been placed where I am. It helped a lot that everyone on the ward knew I was the junior who had just qualified. I depended on that for survival. I am really happy and well looked after, but all the staff on x ward seem really happy.*

It is evident from these contrasting descriptions by newly qualified nurses that support and contentment levels are dependant on the ward to which the nurse is allocated.

The category called 'Old Habits Die Hard' represented participants' descriptions of stress, powerlessness and disappointment post qualification. Despite a desire to challenge structures and ward routines, participants identified that as newly qualified nurses they exerted minimal impact at ward level. The junior status of these nurses was reinforced through hierarchical rules and attitudes, with distrust of junior nurses on some wards. Within the first 10 months post qualification, 11 participants in this study admitted that they had conformed to ward rules and routines. The newly qualified nurses valued knowing the 'ward rules', as this information made their lives easier as registered nurses.

DISCUSSION

A study by Philpin described incongruence between the personal values of newly qualified nurses and the values set by clinical areas.[6] Hunt suggests that within clinical areas there are two sets of values. The first and official

set comprises of the explicit statements, such as policies, mission statements and other important documents. The second set of values is unspoken, implicit and virtually silent, yet known to those who are exposed to them.[2] It has been shown that newly qualified nurses have an interest in providing holistic, patient-centred nursing care but quickly become socialized and conform to ward cultures.[8–10] This has been referred to in the literature as learning how to play the game within the organization.[2] Treacy demonstrated that talking did not constitute working and highlighted the importance of appearing to be busy, in an effort to conform to such ward cultures.[11] Participants in the current study acknowledged the prevalence of this ethos but were personally opposed to it. Jackson proposed that newly qualified nurses today might possibly uphold the division of tasks and routines as a means of organizing their own workloads and providing patient-centred care, through care planning, as opposed to simply fulfilling tasks or maintaining rituals.[12] This suggestion was not, however, supported in this study.

The impact of professional socialization in nursing has been addressed in the United States,[5] the United Kingdom[3] and Ireland,[11] and the presence of hierarchical structures in clinical environments has been recognized as an important component of this process.[13,14] It has been advocated that socialization experiences are determined by the scope and ability of the qualified nurse, which impacts directly on the quality of patient care.[12,13] Hierarchical structures are cyclical and tend to be perpetuated through example and role modelling of senior staff within the midwifery profession.[15] It has been suggested that it is primarily the ward manager's preferences that are most frequently met.[3,13] In this study, those newly qualified nurses who initially challenged issues of concern became quickly discouraged when neither defended nor supported by their senior colleagues. The adherence to ward managers' preferences, by the majority of qualified nurses, provided little scope for these newly qualified nurses to introduce change or use initiative. It has been shown that nurses are often subjugated to the values of others in their work environments.[16]

Participants in this study described feelings of powerlessness and vulnerability following registration. Six to 10 months after qualification, many felt that they had not developed sufficient skills of assertion, although most were more assertive than they had been as students. Some nurses described negative sanctions against them, as a result of their junior status, while others reported fears about asking questions. Professional socialization has been linked to the development of self-esteem.[17] Self-esteem tends to be generally low among nurses and midwives.[18] The way in which professional socialization is imposed upon nursing professionals might account for their low levels of self-esteem and their failure to be assertive, questioning and challenging. Valentine found that nurses adopted behaviours such as avoidance to deal with conflict, which is associated with people who have reduced confidence and skills of assertion.[19] This finding is reflected in this research study and in other research studies as well.[6,8,20]

Some studies have shown however, that some newly qualified nurses are forthcoming, assertive and fearless in admitting limitations.[10,21,22] Nurses who display assertiveness skills might originate from clinical areas where questioning is fostered and supported, which was the situation with the one nurse in this study who did not support the above findings. This is an interesting aspect that might be researched in the future but was not addressed in this study. If nurses are subjected to domination and powerlessness, then the cycle of oppression will continue, which has implications not only for newly qualified nurses but for those patients in their care. Professional socialization is an inevitable consequence of entry to any profession and plays an important role in the development of a professional identity. It assists practitioners with the development of decision-making abilities and the promotion of working relationships.[18,23,24] However, its value, meaning and context can all too easily become obscured by professional power, domination and hierarchy.

CONCLUSION AND RECOMMENDATIONS

This study set out to ascertain the perceptions of newly qualified nurses of their transition to becoming registered nurses, using a grounded theory approach. However, the information that unfolded with the simultaneous collection and analysis of data related to issues surrounding the professional socialization of nurses. The descriptions in this study of ward routines, task-focused care and powerlessness were supported in the literature.[8,10] This can result in frustration and resentment towards the hierarchy, whose needs are frequently met.[3,13] Because of countless reasons, many nurses avoid challenging those issues and philosophies with which they disagree and

instead conform to the accepted ward culture through the process of professional socialization. Although nursing as a profession in the 21st century has progressed via the improvements in education and increased opportunities, many newly qualified nurses remain restrained in their daily practices and continue to work within confined limitations. If nurses fail to develop skills of assertion, reflection and critical thinking, then the goals of evidence-based practice and holistic care cannot be fulfilled. The implications of the negative experiences associated with professional socialization include stress in nursing, a reduction in the quality of patient care and dissatisfaction among nurses generally. It would appear therefore that the issues surrounding professional socialization in nursing are multifaceted and have the potential to disenfranchise nurses as autonomous professionals.

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Team Preceptorships

A New Approach for Precepting New Nurses

Pauline Beecroft, PhD, RN, FAAN
Ana McClure Hernandez, MSN, RN, CCRN
Debbie Reid, BSN, RN, CCRN

In acute care facilities, the orientation period for new graduates has been lengthened to ensure that the new nurse can confidently care for patients. The resulting extension of precepted time places preceptors at a high risk for burnout. To address this issue, team preceptorships during a nurse residency program were implemented as an alternative to a single-preceptor approach. The development, implementation, and evaluation of the team preceptorship model are discussed.

In 1998, the Registered Nurse (RN) Residency in Pediatrics was developed to bridge the gap between academic preparation and the clinical demands of acute pediatric nursing care (Beecroft, Kunzman, & Krozek, 2001). As a component of the residency program, team preceptorships were created to address preceptor burnout during the lengthy program and provide the RN resident with the most appropriate bedside support in the clinical setting. The development, implementation, and evaluation of the team preceptorship model are discussed in this article.

IDENTIFYING THE PROBLEM

Three months into the development of the RN residency, a task force was assembled to work out a system for clinical orientation of new nurses. The task force included managers, staff RNs who were recent new graduates, and nursing staff who were current preceptors for new graduates. Initially, the task force surveyed how new graduates were managed currently during their clinical orientation. Task force members were dismayed to find inconsistent and haphazard preceptor assignments. A new graduate was assigned a primary and an alternate preceptor, but when these preceptors were unavailable, the new nurse was placed with any available RN. The result was an inappropriate match on skill level and competencies between the substitute and the new nurse. As a corollary, frustration and discord were evident as the substitute preceptor lacked information about the new graduate's prior performance. Moreover, the 8-hour preceptor preparation class did not address the unique needs of new nurses or the distinctiveness of the RN residency program with its novice-to-expert framework.

Another discovery was that the same individuals were always assigned as primary or alternate preceptors. It was clear that their risk for burnout was high in the lengthy residency program (almost 6 months). Although the preceptor pool was inadequate, nurses who wished to precept believed that the opportunity was not available. On the one hand, competent-newer nurses did not perceive themselves as ready to

Pauline C. Beecroft, PhD, RN, FAAN, is Consultant in Research, Evaluation, and Education, Los Angeles, California.

Ana McClure Hernandez, MSN, RN, CCRN, is Nursing Instructor, San Joaquin Delta College, Stockton, California.

Debbie Reid, BSN, RN, CCRN, is Education Manager, Hematology/Oncology Unit, Childrens Hospital Los Angeles, Los Angeles, California.

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precept; on the other hand, expert-older nurses did not believe that less experienced nurses should precept. As a result, the competent nurses were intimidated by the expert nurses and were fearful that they would be undermined and held responsible if the orientees they precepted were less than successful. Expert nurses perceived that the newer nurses were invading their "turf." Also, the enthusiasm and aspirations of newer nurses to further develop their skills were somewhat intimidating to older staff who appeared content with the status quo.

At the same time, information-gathering interviews were conducted with former new graduate RNs, preceptors, and managers to capture what they considered essential for new graduates. A number of suggestions about preceptorships emerged from the interviews (see Table 1). With this information and other observations, the task force concluded that major modifications in the preceptor program were necessary for success of the residency. As a result, a critical overhaul was undertaken, with specific emphasis on heading off preceptor burnout and a diminishing preceptor pool.

EVOLUTION OF A SOLUTION

Two overall goals were identified for the makeover of the preceptor program. First, the redesign would take into account modification of the preceptor role to accommodate the needs of new graduate nurses on the home unit as well as the vision for the RN residency. Second, a structure for new nurse training that prevented burnout of current preceptors was needed. A preliminary literature review facilitated clarification of the preceptor role and preparation as well as the structure and design of the program.

For almost three decades, preceptorships have been the method of choice for orienting new graduate nurses and nurses entering new specialty areas. The term preceptor was first introduced into the nursing literature in 1975 and was described as a peer nurse accountable for the orientation of a new nurse to a particular unit for a limited period of time (Bellinger & McCloskey, 1992). Preceptorships are shown to be an optimal mode of clinical orientation for new graduate nurses. The literature suggests that novice nurses can provide independent care for less complex assignments in the area of choice after orientation with this kind of system.

TABLE 1 Suggestions About Preceptorships That Emerged From the Group Interviews

Select a preceptor with experiences close to the new nurse.
Match preceptor personality with preceptee.
Provide ongoing communication with daily evaluations.
Offer support and empathy for the new graduate experience.
Maintain consistent and realistic expectations.

In general, successful preceptors are highlighted as integrating several responsibilities, which include socialization, skill-building techniques, critical thinking facilitation, and assignment management. Socialization was noted to be the number one undertaking that preceptors must accomplish (Baltimore, 2004; Bellinger & McCloskey, 1992; Hand, 2002). Although socialization would seem to be the easiest aspect of orientation, requiring that preceptors merely introduce new nurses to healthcare team members, facility, and the unit environment, this does not appear to be the case. Baltimore (2004) claimed that the most common reason why employees leave their jobs within the first year of employment is because they do not believe that they fit into the work area. To understand the reasons for socialization failure of the novice nurse, it is necessary to understand the full scope of the preceptorship and the current environment supporting the preceptorship.

Although preceptors are described as peer nurses, most preceptors are chosen for their clinical experience and seniority. With fewer expert nurses available because of the nursing shortage, the same nurses were required to orient new staff. As a result, preceptors who experience burnout and job dissatisfaction may more readily belittle the idealistic views of novice nurses (Wright, 2002). Using staff who do not want to precept because of burnout or other reasons gives preceptees mixed messages, leading to feelings of inconsistency and frustration (Baltimore, 2004). Further frustration for novice nurses occurs when any staff nurse is assigned as preceptor when the primary or backup preceptor is sick or has a schedule change or when there is insufficient time to make an appropriate match or reschedule the assignment. Preceptees have expressed dissatisfaction when this occurs, stating that they lost ground in their progress and that precepted hours were a waste of time. Preceptor consistency is as indispensable as preceptor performance of necessary responsibilities. Given the dearth of existing preceptors compared to the burgeoning numbers of novice nurses needed to fill open positions, an alternate approach to precepting new graduate nurses was considered essential.

The old method that compressed skill acquisition, competency assessment, and patient care experiences into 4 or 6 weeks was revamped to accommodate the increased time frame now offered and to reflect the novice-to-expert framework. Unit organization, basic nursing skills, and care of uncomplicated patients were

the focus for the first 10 weeks and became the foundation for adding specialty knowledge, advanced nursing skills, and the care of difficult, complex patients later. This framework offered insight into a novel arrangement for precepting that provided training for new nurses as well as guided experiences for new preceptors. It was suggested that two nurses with varying levels of experience be assigned to each orientee—one nurse who has little or no precepting experience and the other who has much experience with many precepting episodes.

Countering this approach, Yong, Krahn, Trojan, Reid, and Haase (2002) stated that placing skill-deficient orientees with preceptors who may be less confident and experienced can be problematic to the professional relationship, which is key to the preceptorship. On the other hand, Modic and Schloesser (2006) suggested that newly competent nurses with at least 1 year of nursing experience and 6 months in the facility can be extremely effective when paired with a more experienced nurse. The newly competent nurse easily remembers what it was like to be new and can sympathize with the stresses and strains of adapting to the work role. As a novice preceptor, the newly competent nurse can socialize new nurses into the work group, teach basic nursing skills regardless of work area, and introduce unit routines on scheduling, payroll, policies, and procedures. Once the new nurse is ready to move on to more complex patients, the experienced preceptor takes over orientation (Modic & Schloesser, 2006).

Thus, the idea of a team approach to precepting the new graduate nurse took shape. An experienced nurse teamed with a novice nurse would not only oversee the orientation of a new nurse but also facilitate the career development of a new preceptor. By teaming a new nurse with a novice preceptor, expert nurses would not have to deal with the frustrations generally experienced because of the gap in skill level between themselves and new nurses. Furthermore, the novice preceptor is more likely to understand the new nurse's perceptions of a clinical situation and facilitate problem solving that is consistent with their current abilities.

TEAM PRECEPTORSHIP MODEL

In a team preceptorship, a novice preceptor teaches basic nursing skills and provides an orientation to the home nursing unit. During the novice preceptor's tenure, the expert preceptor oversees the instruction by literally precepting the preceptor. The expert preceptor takes over the orientation on the novice preceptor's scheduled days off. As the new nurse becomes proficient in basic skills, assessment, and patient care, he or she makes the transition to the expert preceptor.

The time frame for the residency facilitates orientation of new graduate nurses as well as the growth and learning of new preceptors. New preceptors add to the available pool of preceptors and contribute to the relief of expert preceptors. Overall pressure from continuous precepting of new nurses is relieved.

Moreover, the novice preceptor is a nurse whose recent experiences are closer to those of the new nurse. Expert nurses have difficulty relating to new nurses and their needs because their grasp of a situation is very different from that of the new nurse. The work of Benner (1984) has shown that expert nurses demonstrate a direct clinical grasp of the whole situation and attend to context and environment. On the other hand, the novice and the advanced beginner nurses have a very different view, with a focus on learning, concern with technical mastery and organization, and use of formal, rule-based understanding of aspects. Therefore, a key benefit of the team preceptorship is support and empathy for the new graduate from less experienced preceptors because their understanding of a patient care situation is similar to that of the new nurse. They are less likely than the expert nurse to assume that the new graduate already knows or should know how to behave or perform. Another advantage is the increased communication and collaboration among preceptors that assures that team members have sufficient information about the new graduate's performance. Furthermore, the new nurse garners a broader and more diverse pool of resources with exposure to a variety of patient care approaches from different preceptors. Overall, the team approach engenders a more supportive environment that promotes socialization of the new nurse to the unit.

SELECTION OF PRECEPTORS

Selection criteria for preceptors were assessed for alignment with the RN residency. The facility's commitment to a residency was based on providing support for the growth and development of nurses with the aim of advancing the nursing profession and providing a competent workforce to care for acutely ill children. To this purpose, the novice-to-expert framework, which is an application of the Dreyfus Model of Skill Acquisition, was adopted for the residency (Benner, 1984). This framework illustrates that nurses with various skill levels develop along a continuum that is lifelong as they progress in diverse specialties of healthcare. Specifically, the Dreyfus Model emphasizes movement from abstract to concrete, a shift from rule-based analysis to intuition, change in perception from parts to whole, and shift from detachment to engagement. The goal of the residency is to move the new graduate from a novice nurse to an advanced-beginner-level pediatric RN.

TABLE 2 Preceptor Selection Criteria

Minimum Clinical Nurse II with at least 1 year of experience on unit
Knows and uses resources
Role models the values of the facility
Consistently seeks learning opportunities and is forward thinking
Demonstrates effective communication and critical thinking skill
Respected for honesty and trustworthiness
Demonstrates commitment to home unit
Promotes a nurturing and empathetic environment to the new graduate experience
Demonstrates and encourages maturity under highly emotional situations and inspires independence and growth
Demonstrates a family-focused/educational approach to the process of moving the patient and family to recovery
Demonstrates team leadership skills as part of the implementation of the nursing process

Therefore, selection criteria for preceptors were proposed to reflect the vision for nurses who are graduates of the nurse residency. Criteria incorporated professionalism, commitment to facility values, and dedication to the learning experience of the new graduate nurse (see Table 2). Although, initially, preceptors may not meet these criteria fully, the goal was to have them in place for future programs.

When selecting the novice preceptor, some additions to the criteria for the expert preceptor were made. Most importantly, novice preceptors must recognize their limitations and be role models for new nurses by including them in seeking out more experienced nurses to troubleshoot novel situations. Thus, it was crucial that novice preceptors not only recognize their limitations but also accept them as a learning experience rather than as incompetence. Failure to do so may result in the novice preceptor becoming resentful and bitter, which could cause a breech in the preceptor–preceptee relationship. Finally, skills necessary for novice preceptors to succeed in their first orientation experience include (a) being able to confront conflict in a mature manner, (b) giving constructive feedback without judgment, (c) sharing knowledge of self, and (d) participating enthusiastically in the development of the new graduate nurse. The nurse educator or clinical nurse specialist is in a prime position to identify nurses in the work area who meet these criteria and are ready to become novice preceptors.

PRECEPTOR PREPARATION

Because the preceptor is the keystone for any program preparing or orienting nurses to the facility, preparation for this role was critically reviewed. The 8-hour workshop for preceptor orientation was completely revamped to include the novice-to-expert framework as well as other key concepts that reflected expectations for nurses at the facility. Overall workshop goals include building preceptor skills and providing resources and tools to develop into the preceptor role. Workshop topics are listed in Table 3. As a prerequisite, participants watched a video illustrating Benner's levels of competency (Benner, Tanner, & Chesla, 1992) and then their reactions to the vignettes were discussed in class. Emphasis is placed on differentiating the novice level from the more advanced levels and how this information may be applied to working with new graduate nurses or experienced nurses. Other key activities in the workshop allowed participants to determine their learning and conflict resolution styles. Psychometrically established tools are used for these activities. The strengths and appropriate use of participants' natural styles are shared, and tools and techniques to evaluate and solve problems are provided. In addition, a "miniature guide to critical thinking" is given to each new preceptor. Finally, a step-by-step model for providing feedback is presented along with the characteristics of positive feedback.

In addition, the logistics of team preceptorship and operationalization in the clinical setting were presented. A preceptor notebook provided information about the residency program, role of the preceptor and new graduate, and resources related to preceptorships in the residency program.

IMPLEMENTATION OF THE MODEL

Implementing the team preceptorship model presented several obstacles especially when applying the concept to actual clinical practice. Choosing the

TABLE 3 Contents of 8-Hour Preceptor Workshop

Benner's novice-to-expert role identification
Learning styles and principles of adult learning
Critical thinking and problem solving
Conflict resolution
Developing reflective practitioners
Strategies for effective feedback
Tools to enhance performance

TABLE 4 Preceptor Satisfaction During Team Preceptorship Implementation

		December 1999		February 2000	
		n	%	*n*	%
Being a preceptor for a resident	Not satisfied	1	2.6	3	5.6
	Satisfied	37	97.4	51	94.4
	Total	38	100	54	100
Meeting with the resident to discuss progress	Not satisfied	1	2.7	2	3.8
	Satisfied	36	97.3	51	96.2
	Total	37	100	53	100
Staying in touch with the resident through the program	Not satisfied	1	2.8	3	5.8
	Satisfied	35	97.2	49	94.2
	Total	36	100	52	100

appropriate team of expert and novice preceptors proved to be no easy task, even with the preceptor selection criteria. Also, the nurse educators found that they needed the expert preceptors to "buy in" to the idea of precepting two nurses at the same time—the novice preceptor and the new graduate nurse.

At the same time, as the expert preceptors complained about burnout because of the amount of time they spent precepting, they were also vocal about their skepticism and distrust of novice nurses becoming preceptors. Without the support of these valuable resources, the success of the team preceptorship model was in jeopardy. Individual in-service education classes were given to explain in detail how the program was going to work and to allow ventilation of their concerns. During the first year, experience with the new system and availability of more preceptors resulted in the expert preceptors becoming advocates and offering to participate as needed.

In addition to these initial obstacles, several limitations were encountered on the nursing units outside the intensive care units (ICUs). Many units did not have either enough expert preceptors or sufficient nurses who were ready to become preceptors. For example, the hematology/oncology unit was seriously lacking in both expert preceptors and nurses ready to begin precepting. On the other hand, the ICUs had a larger number of staff ranging from new graduates and competent nurses to seasoned nurses with a considerable expertise. As a result, the ICUs managed to implement the model during the first residency, with few deviations from the original depiction of the team preceptorship. Unexpected sick calls, special skill assignments of preceptors, or a mismatch between the two preceptors and the new graduate nurse were infrequent. Ironically, the limitations experienced by the units outside of the ICUs were resolved thanks to the residency program. The large influx of new nurses coupled with their critical thinking skills contributed to a substantial pool of preceptors who were eligible for team preceptorships. As a result, the team preceptorship model was successfully integrated onto the hematology/oncology unit.

PRECEPTOR EVALUATION

Satisfaction with various aspects of the preceptorship was high during the implementation year (1999–2000), with more than 94% of preceptors indicating satisfaction with being a preceptor, meeting with the resident to discuss progress, and staying in touch with the resident throughout the program (see Table 4). Although recent evaluations by preceptors for comparison have low return rates, all respondents (n = 11) in the February 2005 cohort indicated satisfaction with their precepting experience.

A sampling of recent comments by preceptors about their experience are encouraging and suggest successful model implementation:

> The team approach worked well and gave the resident a different perspective.

> We spoke regarding what our [sic] resident still needed to learn so that we could keep our ears open for any new opportunities for her to grow.

> We communicate well together and listen as well as support one another.

> This is a great program. It gave me the foundation I needed to begin my career. It has opened more opportunities for me and has allowed me to grow professionally.

There were 3 preceptors this time. I don't feel that it was beneficial. Two is enough.

From the residents' perspective, they wrote:

Although she was a recent graduate herself, she is very knowledgeable, resourceful, excellent teacher, and a great role model. She has a great personality and pleasant to work with. She is a great team worker. She always established great rapport with patients and families that I want to follow and learn from her. She has been very supportive throughout the residency program. She is a great nurse and a great preceptor.

EB was my first preceptor. She was very nice and awesome at orienting me to the unit and introducing me to the doctors and nurses. We got along great. She taught me the beginning of it all.

A newer nurse so she remembered exactly what it's like and what I'm going through. . .very supportive.

She understood where I was coming from and having graduated from the residency program had better understanding of new grads and my needs. Throughout the program, she has been very supportive and very encouraging. She satisfied my learning needs. She is a great preceptor.

Because she was new, I sort of "outgrew" her and needed someone more knowledgeable and more experienced before my time with her was over.

She was my first one and taught me things from a novice perspective which I needed. She always told me if I did something wrong so that the next time I do it, I could get it right. She didn't treat me as a student but as a colleague.

I liked having two different main preceptors because then what I didn't learn from one, I could learn from the other, which happened toward the end of the program.

RESULTS AND CONCLUSION

With more than 7 years of experience with team preceptorships, the new system is now fully integrated into the residency program. Initial roadblocks were overcome as the benefits of the structure for the preceptors and new nurse became obvious. Recent evaluations suggest success with the team model but also uncover some areas that call for further attention. For example, an exploration of more than two preceptors per resident is needed to make recommendations on the optimal number of preceptors. Also, timing of the transition from novice to expert preceptor may vary for each resident depending on learning pace. Again, another look to determine the "right" time for changing preceptors with further guidelines on when this should occur will be helpful.

It is apparent that after a strong orientation and another 6–12 months of clinical experience, new nurses are ready for the challenge of precepting. The newly competent nurse relieves the expert nurse of the tedium of teaching basic nursing skills and unit routines. Expert nurses now use their expertise to direct development of a novice preceptor and expand upon the basic competencies of the new graduate. This is a win–win situation for everyone.

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ADDRESS FOR CORRESPONDENCE: Pauline Beecroft, 46 Cresta Verde Drive, Rolling Hills Estates, CA 90274 (e-mail: pcbeecroft@verizon.net).

Untitled Story – Task Sheet

As he left for a visit to his outlying districts, the jealous Baron warned his pretty wife:

“Do not leave the castle while I am gone, or I will punish you severely when I return!”

But as the hours passed, the young Baroness grew lonely and despite her husbands warning, decided to visit her friend who lived in the countryside nearby.

The castle was located on an island in a wide, fast flowing river, with a drawbridge linking the island and the land at the narrowest point in the river.

“Surely my husband will not return before dawn”, she thought and ordered her servants to lower the drawbridge and leave it down until she returned.

After spending several pleasant hours with her friend playing music, talking and dancing, the Baroness returned to the drawbridge, only to find it blocked by a madman wildly waving a long and cruel knife.

“Do not attempt to cross this bridge, Baroness or I will kill you”, he raved.

Fearing for her life, the Baroness sought out a boatman on the river, explained her plight to him and asked him to take her across the river on this boat.

“I will do it, but only if you can pay me my fee of five marks,” said the boatman

“But I have no money with me!” the Baroness protested.

“That is too bad. No money, no ride,” the boatman said flatly.

Her fear growing, the baroness ran back crying to the home of her friend and after explaining the situation, begged for enough money to pay the boatman his fee.

“I never loan money to anyone,” he said, not even to my best friends. Besides, if you had not disobeyed your husband, this would not have happened.”

With dawn approaching and her last resource exhausted, the Baroness returned to the drawbridge, attempted in desperation to cross to the castle and was slain by the madman.

Response Sheet:

1. Which one person in your opinion was most responsible for the death of the Baroness?
   Who was the least responsible?
   Check over the list below. Put a 1 by the person you feel is most responsible. Continue 1 through 5 to rate all the characters.

   Friend
   Baron
   Baroness
   Boatman
   Madman

2. Now get an agreement on the order from your group. Be prepared to give reasons for your group's order.

3. Write three possible titles for this story. Choose one title which your group feels is most appropriate. Be prepared to explain why your group thinks this title is best.

VARK. By Neil D. Fleming (Christchurch, NZ) & Charles C. Bonwell (St. Louis, USA) January 1998.

A VISUAL PREFERENCE:

If you have a strong preference for **Visual (V)** learning then you should use some or all of the following:

INTAKE To take in the information	SWOT Study with out tears	OUTPUT To perform well in the examination
Underlining Different colours Symbols Flow charts Charts Graphs Pictures, videos, posters, slides Different spatial arrangements White space Textbooks with diagrams, pictures Lecturers who us gestures and picturesque language	Convert lecture notes into a learnable package by reducing them (3:1) into page pictures Use all techniques above to do this Reconstruct the images in different ways-try different spatial arrangements Redraw your pages form memory Replace words with symbols or initials Look at your pages	Recall the "pictures" made by your pages Draw things-use diagrams Write exam answers Practise turning your visuals back into words
You are holistic rather than reductionist in your approach. You want the whole picture Visual learners do not like handouts, words, lectures, textbooks, or any assessments that relies on word usage, syntax, and grammar. You are probably going to watch TV.		

VARK.

AURAL PREFERENCE:

If you have a strong preference for **Aural (A)** learning then you should use some or all of the following:

INTAKE To take in the information	SWOT Study with out tears	OUTPUT To perform well in the examination
Attend lectures Attend tutorials Discuss topics with other students Discuss topics with your lecturers Explain new ideas to other people Use a tape recorder Remember the interesting examples, stories, jokes.. Describe the overheads, pictures, and other visuals to somebody who was not there Leave spaces in your lecture notes for later recall and "filling'	Convert your lecture notes into learning package by reducing them (3:1) Your lecture notes may be poor because you prefer to listen. You will need to expand your notes by talking with others and collecting notes from the textbook Put your summarised notes onto tapes and listen to them Ask others to "hear" your understanding of a topic Read your summarised notes aloud Explain your notes to another "aural" person	Talk with the examiner Listen to your voices and write them down Spend time in quiet places recalling the ideas Practise writing answers to old exam questions Speak your answers.
You prefer to have this entire page explained to you. The written words are not as valuable as those you hear. You will probably go and tell somebody about this.		

VARK.

A READING AND WRITING PREFERENCE:

If you have a strong preference for **Reading and Writing (R & W)** learning then you should use some or all of the following:

INTAKE To take in the information	SWOT Study with out tears	OUTPUT To perform well in the examination
Lists Headings Dictionaries Glossaries Definitions Handouts Textbooks Readings-library Lecture notes (verbatim) Lecturers who use words well and have lots of information in sentences and notes Essays Manuals (computing & laboratory)	Convert lecture notes into a learnable package by reducing them (3:1) Write out words again and again Read your notes (silently) again and again Rewrite the ideas and principles into other words Organise any diagrams, graphs …into statements eg the trend is.. Turn reactions, actions, diagrams, charts and flows into words Imagine your lists arranged in multichoice questions and distinguish each from each	Write exam answers Practise with multiple choice questions Write paragraphs, beginnings, and endings Write your lists (a,b,c,d & 1,2,3,4) Arrange your words into hierarchies and points
You like this page because the emphasis is on words and lists. You believe the meanings are within the words, so any talk is OK but this handout is better. You are heading for the library.		

VARK.

KINESTHETIC PREFERENCE:

If you have a strong preference for **Kinesthetic (doing) (K)** learning then you should use some or all of the following:

INTAKE To take in the information	SWOT Study with out tears	OUTPUT To perform well in the examination
All your senses-sight, touch, taste, smell, hearing…. Laboratories Field trips Field tours Examples of principles Lecturers who give real-life examples Applications Hands-on approaches (computing) Trial and error Collections of rock types, plants, shells, grasses…. Exhibits, samples, photographs… Recipes-solutions to problems, previous exam papers	Convert your lecture notes into learning package by reducing them (3:1) Your lecture notes may be po0r because the topics were not "concrete" pr " relevant" You will remember the "real " things that happened Put plenty of examples into your summary. Use case studies and applications to help with principles and abstract concepts. Go back to the laboratory or your lab manual. Recall the experiments. Field trips	Write practice answers, paragraphs… Role play the exam situation in your own room
You want to experience the exam so you can understand it. The ideas on this page are only valuable if they are practical, real and relevant to you. You need to do things to understand		

VARK

visual aural read/write kinesthetic

The VARK Questionnnaire (Version 7.0)

How Do I Learn Best?

Choose the answer which best explains your preference and circle the letter(s) next to it.
Please circle more than one if a single answer does not match your perception.
Leave blank any question that does not apply.

1. You are helping someone who wants to go to your airport, town centre or railway station. You would:
    a. go with her.
    b. tell her the directions.
    c. write down the directions.
    d. draw, or give her a map.
2. You are not sure whether a word should be spelled `dependent' or `dependant'. You would:
    a. see the words in your mind and choose by the way they look.
    b. think about how each word sounds and choose one.
    c. find it in a dictionary.
    d. write both words on paper and choose one.
3. You are planning a holiday for a group. You want some feedback from them about the plan. You would:
    a. describe some of the highlights.
    b. use a map or website to show them the places.
    c. give them a copy of the printed itinerary.
    d. phone, text or email them.
4. You are going to cook something as a special treat for your family. You would:
    a. cook something you know without the need for instructions.
    b. ask friends for suggestions.
    c. look through the cookbook for ideas from the pictures.
    d. use a cookbook where you know there is a good recipe.
5. A group of tourists want to learn about the parks or wildlife reserves in your area. You would:
    a. talk about, or arrange a talk for them about parks or wildlife reserves.
    b. show them internet pictures, photographs or picture books.
    c. take them to a park or wildlife reserve and walk with them.
    d. give them a book or pamphlets about the parks or wildlife reserves.
6. You are about to purchase a digital camera or mobile phone. Other than price, what would most influence your decision?
    a. Trying or testing it.
    b. Reading the details about its features.
    c. It is a modern design and looks good.
    d. The salesperson telling me about its features.
7. Remember a time when you learned how to do something new. Try to avoid choosing a physical skill, eg. riding a bike. You learned best by:
    a. watching a demonstration.
    b. listening to somebody explaining it and asking questions.
    c. diagrams and charts - visual clues.
    d. written instructions – e.g. a manual or textbook.

8. You have a problem with your knee. You would prefer that the doctor:
    a. gave you a web address or something to read about it.
    b. used a plastic model of a knee to show what was wrong.
    c. described what was wrong.
    d. showed you a diagram of what was wrong.
9. You want to learn a new program, skill or game on a computer. You would:
    a. read the written instructions that came with the program.
    b. talk with people who know about the program.
    c. use the controls or keyboard.
    d. follow the diagrams in the book that came with it.
10. I like websites that have:
    a. things I can click on, shift or try.
    b. interesting design and visual features.
    c. interesting written descriptions, lists and explanations.
    d. audio channels where I can hear music, radio programs or interviews.
11. Other than price, what would most influence your decision to buy a new non-fiction book?
    a. The way it looks is appealing.
    b. Quickly reading parts of it.
    c. A friend talks about it and recommends it.
    d. It has real-life stories, experiences and examples.
12. You are using a book, CD or website to learn how to take photos with your new digital camera. You would like to have:
    a. a chance to ask questions and talk about the camera and its features.
    b. clear written instructions with lists and bullet points about what to do.
    c. diagrams showing the camera and what each part does.
    d. many examples of good and poor photos and how to improve them.
13. Do you prefer a teacher or a presenter who uses:
    a. demonstrations, models or practical sessions.
    b. question and answer, talk, group discussion, or guest speakers.
    c. handouts, books, or readings.
    d. diagrams, charts or graphs.
14. You have finished a competition or test and would like some feedback. You would like to have feedback:
    a. using examples from what you have done.
    b. using a written description of your results.
    c. from somebody who talks it through with you.
    d. using graphs showing what you had achieved.
15. You are going to choose food at a restaurant or cafe. You would:
    a. choose something that you have had there before.
    b. listen to the waiter or ask friends to recommend choices.
    c. choose from the descriptions in the menu.
    d. look at what others are eating or look at pictures of each dish.
16. You have to make an important speech at a conference or special occasion. You would:
    a. make diagrams or get graphs to help explain things.
    b. write a few key words and practice saying your speech over and over.
    c. write out your speech and learn from reading it over several times.
    d. gather many examples and stories to make the talk real and practical.

VARK
visual aural read/write kinesthetic

The VARK Questionnaire Scoring Chart

Use the following scoring chart to find the VARK category that each of your answers corresponds to. Circle the letters that correspond to your answers

e.g. If you answered b and c for question 3, circle V and R in the question 3 row.

Question	a category	b category	c category	d category
3	K	V	R	A

Scoring Chart

Question	**a** category	**b** category	**c** category	**d** category
1	K	A	R	V
2	V	A	R	K
3	K	V	R	A
4	K	A	V	R
5	A	V	K	R
6	K	R	V	A
7	K	A	V	R
8	R	K	A	V
9	R	A	K	V
10	K	V	R	A
11	V	R	A	K
12	A	R	V	K
13	K	A	R	V
14	K	R	A	V
15	K	A	R	V
16	V	A	R	K

Calculating your scores

Count the number of each of the VARK letters you have circled to get your score for each VARK category.

Total number of **V**s circled =	
Total number of **A**s circled =	
Total number of **R**s circled =	
Total number of **K**s circled =	

Calculating your preferences

Use the VARK spreadsheet (which can be purchased from the www.vark-learn.com web site) to work out your VARK learning preferences.

Workbook: CMDHB Nursing Orientation

Learning for Life
Matauranga mo te Oranga

Workbook Number:		**Version:**	1.0
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Counties Manukau District Health Board			

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CMDHB Nursing Orientation

Acknowledgements and thanks to:
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Senior Nurses at Starship Children's Emergency Department
Senior Nurses Kidz First and Women's Health

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1.0 INTRODUCTION

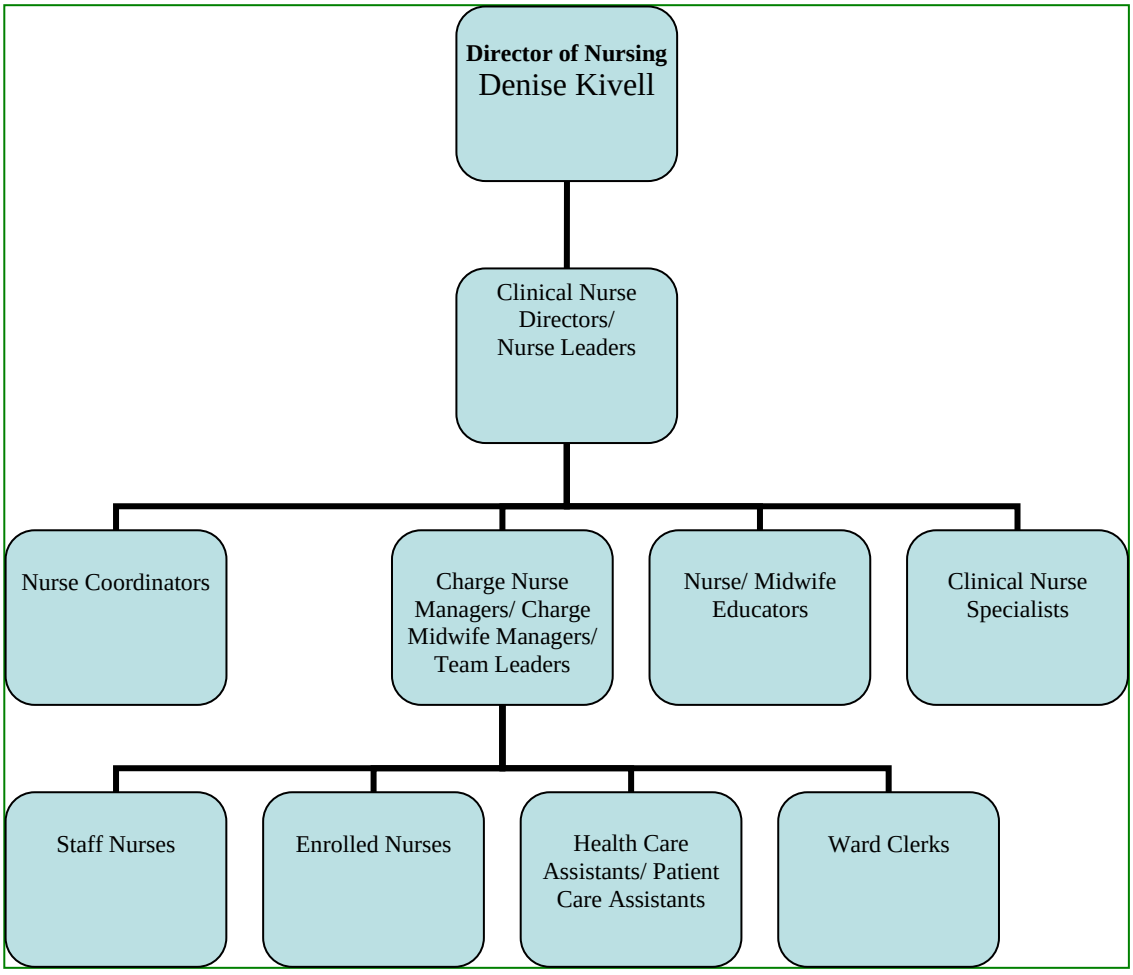
Welcome to Counties Manukau Health Nursing team. We hope you enjoy your time at Counties Manukau Health.

Counties Manukau Health Nursing Generic Orientation programme has been developed to provide you guidance to support you to obtain the necessary knowledge and skills required to work here.

Counties Manukau Health Nursing orientation programme has three steps:

1. Organisational specific
2. Service specific
3. Specialty specific

1.1 **Counties Manukau Health** Nursing Structure



COUNTIES MANUKAU HEALTH STANDARDS OF NURSING PRACTICE

It is the expectation of Counties Manukau Health that all nurses will, at all times, adhere to the

- New Zealand Nursing Council's (NCNZ) Nurse Practitioner/Registered Nurse/Enrolled Nurse Competencies (http://www.nursingcouncil.org.nz/index.cfm/1,22,0,0,html/Scopes-of-Practice),
- NZNC's Code of Conduct (2012) (http://www.nursingcouncil.org.nz/index.cfm/1,255,0,0,html/Code-of-Conduct-and-Guidelines)
- NCNZ's Guidelines: Professional Boundaries (2012) http://www.nursingcouncil.org.nz/index.cfm/1,255,0,0,html/Code-of-Conduct-and-Guidelines)
- The Health and Disability Commission's Code of Health & Disability Services Consumers Rights (http://www.hdc.org.nz)
- New Zealand Nurses Organisation (NZNO)Code of Ethic (2010) (http://www.nzno.org.nz/LinkClick.aspx?fileticket=t6vd5nIYak4%3d)
- NZNO Social Media and the nursing profession: a guide to online professionalism for nurses and nursing students (2012)
- Counties Manukau Health Vision and Values (http://www.cmdhb.org.nz/About_CMDHB/Overview/shared-vision-values.htm)
- Counties Manukau Health Tikanga Best Practice Policy (2010)
- Counties Manukau Health Ti Kanga Responsiveness Guidelines (2011)

Please ensure that you are very familiar with these documents as they are the basic documents that formulate New Zealand's and Counties Manukau Health's nursing standards. This document will assist nurses by giving some practical examples of how to apply these to your every day nursing practice and will help you to meet the above standards.

Standard	Examples
• **Nursing Council of New Zealand RN/EN Competencies** Domain One: Professional Responsibility • **NCNZ Code of Conduct** Principles 1, 2, 3, 5,6, 8	• Introduce self and your role to patient/family/health professionals at each interaction utilising AI²DET • Ensure patient safety at all times • Acknowledge patient/ family and visitors promptly and politely • Be punctual at beginning of shift, meal times and handovers • Do not contact patients outside the work environment unless directly related to work, e.g. do not text patients unless directly related to work or do not 'friend' patients or their relatives on any social media sites

• **NZNC Professional Boundaries (page 7,9,10,13, 14)** • **NZNO Code of Ethics** • **HDC Code of Patient Rights:** Rights 1, 2, 3, & 4 • **Counties Manukau Health Values**: Professionalism & Responsibility • **Ti Kanga Best Practice Policy & Ti Kanga Responsiveness guidelines**	• Do not discuss colleagues, employer or patients in public places including social media sites e.g. emails, Facebook, blogs, networking sites. • Be careful about the information you put onto social media sites- these sites can be viewed by employers and others • Question doctors and other colleagues if unsure • Be a role model for other staff members • Adhere to Counties Manukau Health dress/uniform and conduct codes, policies, procedures and guidelines • No conversing re own or other staff members personal details when in vicinity of patients/families • Complete documentation as per Counties Manukau Health policy, procedures and guidelines • Be accountable for own practice at all times • Apply New Zealand Nursing Council's direction and delegation principles as and when appropriate • Ensure annual practising certification is current • Ensure PDRP portfolio is current • Commit to on-going learning to ensure own patient care is evidence based and best practice • Do not talk about the patients you are caring for outside the work environment • Do not access any family members' or friends clinical notes unless you are looking after them • Do not access own clinical notes/results unless undertaken Counties Manukau Health procedure to do so • Respect patient's culture which includes: age or generation, gender, sexual orientation, occupation, socio-economic status, ethnic origin or migrant experience, religious or spiritual beliefs and disability. • Remember you are a nurse 24 hours/ 7 days per week. Maintain a high standard of professional and personal behaviour- do not compromise your practice by the use of alcohol or drugs.
• **Nursing Council of New Zealand RN/EN Competencies** Domain Two: Management of Nursing Care • **NCNZ Code of Conduct** Principle 1,2, 3 & 4 • **NZNC Professional Boundaries (pages 15-23)**	• Check patient's understanding of any information given by using open ended questions • Refer to and engage interpreting services to ensure clarity and comprehension of health information provided to patient and whanau. Maintaining informed consent. • Respond promptly to patient needs e.g. answering patients'/clients' bells promptly • Informing patients/clients of timeframes for providing care (e.g. When leaving and returning from breaks) • Provide informed consent/ education to patients/clients about their condition, any procedures, and treatments given in a timely fashion e.g. medication education

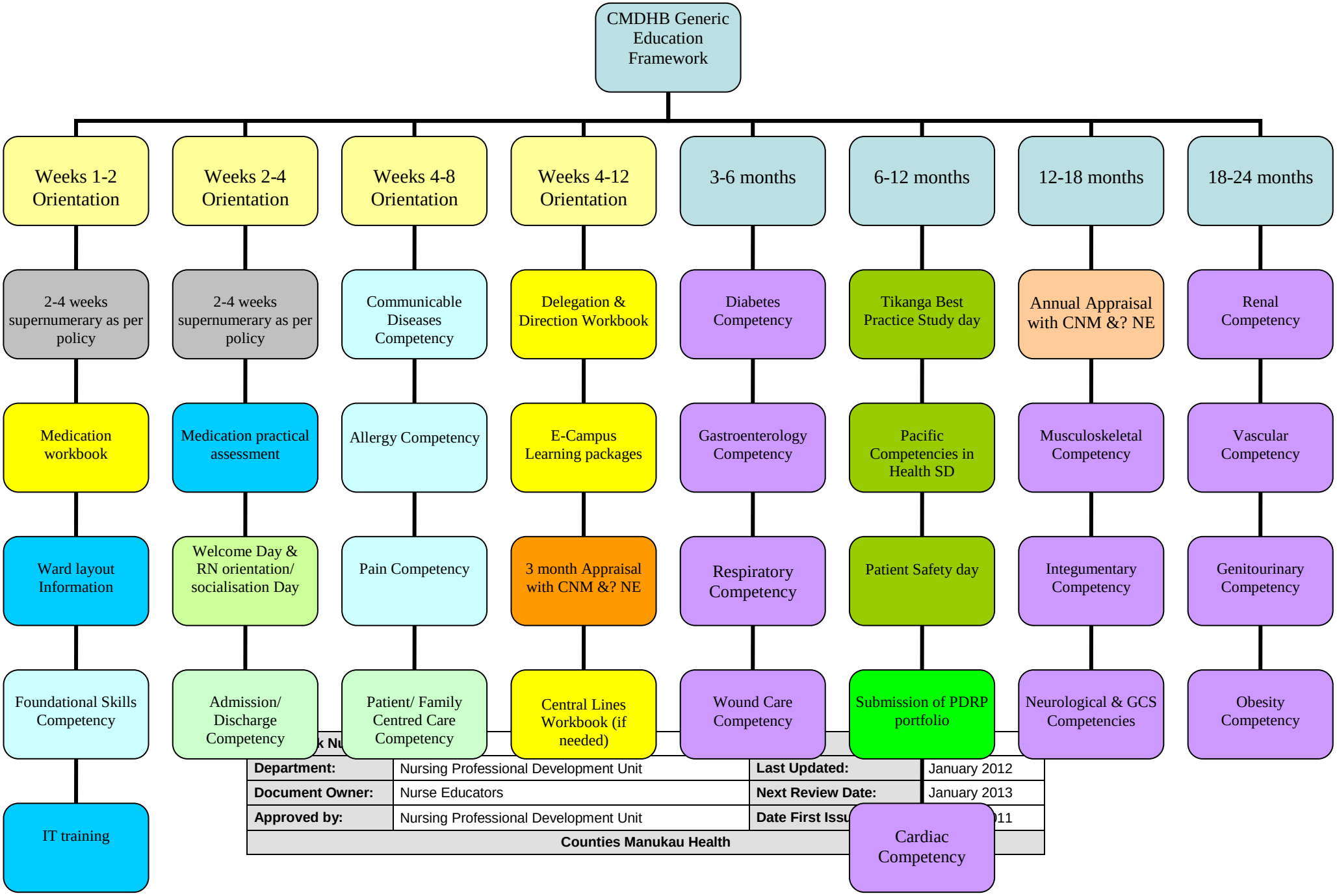
• **NZNO Code of Ethics** • **HDC Code of Patient rights:** Rights 4, 5, 6, 7 & 8 • **Counties Manukau Health Values:** Care & Respect & Partnership • **Ti Kanga Best Practice Policy & Ti Kanga Responsiveness guidelines**	• Administer medication as prescribed and as per Counties Manukau Health polices, procedures and guidelines • Actively participate in ward rounds (as appropriate to work area practices) to provide support and advocacy for the patient • Undertake nursing assessments including pain, falls and pressure injury risk assessments and implement management strategies including administering medication as prescribed • Undertake patients' hygiene requirements e.g. mouth cares, washing of patient, shave patients, undertake pressure area prevention, meeting toileting nutrition and hygiene requirements. • Document all cares given or not given including rationales • Challenge unsafe practices e.g. not following Counties Manukau Health policies, procedures or guidelines • Being responsive/flexible to the patient/family's needs
• **Nursing Council of New Zealand RN/EN Competencies** Domain Three: Interpersonal Relationships • **NCNZ Code of Conduct** 2,3,6, & 7 • **NZNC Professional Boundaries (page 15-23)** • **NZNO Code of Ethics** • **HDC Code of Patient rights: Rights** 1, 2, 3 & 8 • **Counties Manukau Health Values:** Teamwork, Professionalism, Care & Respect • **Ti Kanga Best Practice Policy & Ti Kanga Responsiveness guidelines**	• Demonstrate polite and respectful manner consistently towards patients/clients/ families and staff • Speak English in clinical areas unless clinically indicated by patient's/client's situation (e.g. speak non-English to patient/client to help facilitate patient's education and treatment) • Utilise Whaanau support workers / Pacific Support personnel to provide culturally appropriate advice that is responsive from the patients perspective • be friendly, positive, empathetic and caring at all times • Set patient/family/ whanau/fono centred goals/cares with the patient/family/whanau/fono • Maintain professional boundaries between yourself and patients/family/whaanau or fono.

• **Nursing Council of New Zealand RN/EN Competencies** Domain Four: Interprofessional Health Care and Quality Improvement • **NCNZ Code of Conduct** Principle 2, 5, 6,7 & 8 • **HDC Code of Patient Rights:** Rights 4, 9 & 10 • **NZNC Professional Boundaries** • **NZNO Code of Ethics** • **Counties Manukau Health Values**: Innovation. Teamwork & Partnership • **Ti Kanga Best Practice Policy & Ti Kanga Responsiveness guidelines**	• Support and nurture each other especially junior/new staff and students • Proactively assist colleagues as required with nursing cares • Participate in all quality initiatives- consistent with the Organisational Quality Strategy and patient safety initiatives • Focus on working across divisions and DHB external partners e.g. Primary Healthcare Organisations (PHOs), Aged Related Residential Care (ARRC) Facilities and Non-Government Organisations (NGOs) • Work with the multi-disciplinary team for the best outcome of the patients • Work with community base agencies to enhance patient/client care by sharing accurate and up to date information through effective handover practices utilising Counties Manukau Health framework e.g. SBAR • Work in collaboration with services that are culturally appropriate and responsive to meet patient/whanau needs from their perspective and upholds informed choice .e.g.: Hau Ora team, Pacific Unit • Articulates the relationship between Mana Whenua and the DHB. This relationship is a Tiriti of Waitangi relationship and utilises the principles of partnership, protection and participation framework. • Implements the 8 core values of Tikanga (Te Ao Maaori) into all DHB processes and work practices of nursing staff. They are: Kaitiakitanga (Guardianship) Mana Whenua (Local people) Mana Tupuna/Whakapapa (ancestoral, Geneology), Te Reo Maaori (Maaori language) Manaakitanga (Caring, nurturing) Whanaungatanga (making connections) Wairuatanga (spiritual Aspect), Rangatiratanga (Leadership)

Discussion with Charge Nurse Manager/Charge Midwife Manager/Team Leader:
Comments:

CNM/CMM/TL Sign: Date:

Staff Member sign: Date:



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Counties Manukau Health			

RECOGNTION OF PRIOR LEARNING

Here at Counties Manukau Health we are keen to build on your existing skills and knowledge. Please discuss with your Preceptor/ Charge Nurse Manager or Nurse Educator where you have worked before and what you have had to do e.g. skills learnt, areas worked, patient load. Think about what you did well in your last role. Also discuss what you would like to/need to develop while you are working here at Counties Manukau Health.

LEARNING CONTRACT

All new staff members are required to enter into a Learning Contract. The purpose of a Learning Contract is to ensure the Preceptor and Preceptee are aware of the responsibilities and commitment (both personal and professional) associated with their relationship and that this relationship is recognised. It is suggested that two copies are made and that both are signed. The preceptor and the preceptee then both have a copy. It is your joint responsibility to sign the Learning Contract.

Learning Contract between New Staff member and Preceptor

I, _____ (Preceptor) agree to provide preceptorship to

_____ (New Staff Member) in Ward ____ commencing on _____

and finishing on _____.

As a Preceptor I will provide the following

- Sharing and role modelling of my clinical expertise and skills
- An understanding of the requirements of the programme
- Facilitation of learning experiences for the new staff member
- Opportunities for self directed learning for the new staff member
- Encouragement and support for the new staff member to identify their own learning needs and the resources available
- A colleague to provide support if I an unavailable
- Regular feedback to progress in meeting competencies
- Assessment of clinical competencies

I will be involved in the following activates to support my role as a Preceptor:

- Participation in training workshops
- Taking responsibility to seek assistance when encountering problems/ conflicts
- Keeping the clinical area informed in relation to the programme.

Signature: _____ Date: _____

I, _____ (New Staff member) agree to participate in the preceptorship provided by _____ (Preceptor) commencing on

_____ and finishing on _____.

I agree to take responsibility for the following:

- Negotiate learning contract and time frames with preceptor
- Participate in clinical teaching experiences provided
- Develop a plan to meet the requirements provided
- Develop a plan to meet the requirements of the clinical competencies
- Acknowledgement of own skills and knowledge level
- Seeking out support and information required
- Negotiate constructive feedback provide by preceptor
- Increasing responsibility in the role of a Registered Nurse
- Taking the opportunity provided to develop my nursing skills
- Participating in team meetings
- Seeking and discussing feedback from peers
- Reflecting on my clinical practice and demonstrating self-awareness.

Signature: _____ Date_____

Other identified and agreed upon responsibilities:

Initials Preceptor _____ Initials Preceptee _____

FIRST DAY CHECKLIST

ITEM	Shown, discussion, comments	Signed
Tour of work area Timing of breaks- where to get food Standards of dress or uniform ID badge Parking for staff and patients Time sheets/ payslips Area Rostering requirements How to book annual leave Welcome days booked or completed Basic Life Support training booked or completed Pyxis Training (as required) Other:		

The Team

Team Member	Met or knows how to locate, comments	Signed
Charge Nurse Manager/Charge Midwife Manager/Team Leader Nurse Educator Clinical Nurse Director Service Manager Consultants Medical teams Clinical Nurse Specialists Resource Nurses Social Worker		

Physiotherapist Occupational Therapist Speech Language Therapist Dieticians Pharmacists Cultural Support Team Ward Clerks Cleaners Orderlies Interpreting Service X-Ray Laboratory Blood Bank District Nurses Psych Liaison Team NZNO/PSA union delegate Others:		

Familiarisation

Things you will need to know how to locate or undertake:

The nurse will know how to locate and utilise the following:

Item	Located , discussion of main points	signed
Disaster Box and Flip chart Emergency Response procedures Cascade list Fire Exits and extinguishers and procedure to undertake if fire occurs. Communication Book Southnet Polices including: 1. Nursing Policies 2. Nursing Procedures 3. PDRP 4. Area Specific procedures & policies 5. Medication management policies, procedures and guidelines Other:		

Equipment you will need to be able to locate and use:

The nurse must be able to state their responsibility associated with checking equipment, understand its function and the actions required for missing or poorly functioning equipment.

Equipment	Location and Use, Comments	Signed
Wall Oxygen and suction Portable Oxygen and suction Resuscitation trolley Defibrillator Emergency Drugs Controlled Drugs checking policy Emergency Numbers 888 & 777 Nurse Call system Lamson Tube Computer Systems • Concerto • Wims • Outlook –email • Sluice Room Store rooms Location of Patient Information (Patient Charts Cupboards) Stationery stores Equipment • Cleaning • Warrant of Fitness • Fault Card Other:		

Workbooks or E-Learning required to be completed:

Discuss time frames with your Nurse Educator

Workbook or E- Learning	Dates to be completed:	Signed
1. Fire e-learning package 2. Consent e-learning package 3. Emergency Response e-learning package 4. Health Information & privacy e-learning package 5. Infection Control e-learning package 6. Occupational Health & safety e-learning package 7. PUP (Physiological unstable patient) e-learning package 8. Risk Management e-learning package 9. An Introduction to Restraint Minimisation e-learning package. 10. Effective Communication & De-Escalation e-learning package. 11. Liten up training 12. Patient Safety Training e-Learning package. 13. Smokefree policy and undertake smoking cessation/ quit card training 14. Complaints, incidents & risk management and check that Riskpro training booked 15. Medication workbook 16. Delegation and Direction workbook 17. CALD- Culturally and		

Linguistically Diverse Programme: 18. Other		

Competencies to be completed:

Competencies	Dates to be completed:	Signed
Core: 1. Foundational skills 2. Admission/Discharge 3. Patient and Family Centred Care 4. Allergy 5. Communicable Diseases 6. Pain **Others:** 7. Wound 8. Vascular 9. Renal 10. Integumentary 11. Respiratory 12. Cardiac 13. Diabetes 14. Gastro-Intestinal 15. Neurological • Glasgow coma scale 16. Musclo-Skeletal		

Foundational Skills

Learning Objective

On completion of this competency the nurse will be confident in utilising foundational skills that are part of a comprehensive adult assessment as per Counties Manukau Health policies, procedures and guidelines.

Pre Requisite

Orientation to the equipment utilised when measuring vital signs and weight within area of practice.

Learning Parameters and Audit

On completion of this competency the nurse will:	Initial	Comments to support competency
1. State Counties Manukau Health policy on hand hygiene and demonstrate the application of same • before • after 2. The nurse will state the components of the initial assessment (primary survey) of an adult and articulate how to assess each component • Airway • Breathing • Circulation • Disability • Exposure 3. State the normal range of vital signs (including blood glucose) for adults and older adults 4. Discuss and state rationale for the frequency of measuring vital signs in relation to • Patients' presenting condition and ongoing monitoring requirements. • In relation to the Physiological Unstable Patient (PUP) and the requirements associated with the early warning system (as appropriate to your area) 5. Respiratory rate • Observe shape, size and symmetry of the thoracic cavity and note type, quality, depth, rate and regularity of respirations • Note respiratory effort and appearance of retractions, nasal flaring and use of accessory muscles • Identify audible breath sounds including wheeze, stridor and grunting • Discuss respiratory rate in relation to PUP (as appropriate to your area) 6. Heart rate, pulse volume, and capillary refill • Identify central and peripheral sites for checking heart rate on an adult. • Discuss the different terms for describing pulse volume.		

- Demonstrate measuring peripheral capillary refill.
- Discuss heart rate and rhythm in relation to PUP (as appropriate to your area)

7. SaO2 Monitoring
   - Identify which patient conditions require SaO2 assessment.
   - Demonstrate correct placement of the oximetry probe.
   - Discuss infection control requirements of the oximetry probe.
   - Discuss O2 saturations in relation to PUP (as appropriate to your area)

8. Blood pressure
   - Identify those patients that require blood pressure measurement.
   - Demonstrate placement of the appropriate size cuff.
   - Discuss Blood pressure measurement in relation to PUP (as appropriate to your area)
   - Discuss infection control requirements of the sphygmomanometer

9. Temperature
   - Identify when an adult requires an oral, auxilla and tympanic temperature.
   - Demonstrate correct use of the tympanic thermometer.
   - Identify when subnormal thermometers are required
   - Demonstrate correct method for temperature measurement.
   - Discuss temperature in relation to PUP (as appropriate to your area)

10. Blood Glucose
    - Demonstrate the correct use of blood glucose test
    - Describe the signs and symptoms of hypoglycaemia and hyperglycaemia
    - Describe immediate assessments and actions for a patient with a blood glucose level of
      - Severe/Life threatening hypoglycaemia in adult patients who are unconscious, very aggressive or unable to swallow
      - Hypoglycaemia in a conscious, cooperative adult patient who is able to swallow

11. Weight
    - Identify those patients who require a weigh.
    - State the rationales and importance of when weights are required.
    - Discuss normal ranges of weight parameters.

12. Fluid Balance:
    - State the rationale and importance of fluid balance monitoring
    - Articulate what interventions are recommended and when to implement.

13. Level of consciousness

- Mini Mental Status (MMS)
- AVPU (Alert, Voice, Pain, Unconscious)
- Discuss level of consciousness in relation to PUP (as appropriate to your area)

14. Glascow Coma Scoring
    - Demonstrate use of Glascow Coma Scoring (GCS) for adults with rationale for undertaking GCS
        - Eye Opening
        - Motor Response
        - Verbal Response
        - Pupils
        - Limbs
        - Vital signs

15. Pain
    - Perform a systematic pain assessment of a person inclusive of the following:
        - Appropriate pain scale used
        - **O**nset of pain
        - **L**ocation of pain
        - **D**uration of pain
        - **C**haracteristics of pain
        - **A**ccompanying symptoms'
        - **R**adiating anywhere else
        - **T**reatment already given
        - Non verbal pain behaviours
        - Intervention/ medications that relieves the pain

16. Pressure Injury

State the rationale for undertaking a Pressure Risk assessment including:

- Demonstrate pressure area assessment / scoring and articulate what interventions are recommended
- Articulate the different bundles of care related to pressure injury prevention and when you would implement this care.
- Demonstrate an understanding of the requirements for re-assessment and any interventions implemented

17. Morse Risk Falls

State the rationale for undertaking a Morse Risk Falls assessment including: admission & reassessment

- Demonstrate Morse Risk Falls assessment/scoring and articulate interventions are recommended
- Articulate the different bundles of care related to falls risk prevention and when you would implement this care.
- Demonstrate an understanding of the requirements for re-assessment and any interventions implemented

18. Demonstrate the documentation requirements for all risk assessments of all above as appropriate for your area.

19. State the components of the SBAR (Situation, Background, Assessment and Recommendation) communication tool and demonstrate correct use of this

tool in your clinical setting, this may include: • Handover to nursing/midwifery colleagues- within Counties Manukau Health and outside Counties Manukau Health • Requesting medical review • Briefing the multidisciplinary team • Clinical notes 20. State the rationale for the implementation of systematic smokefree interventions including: • The impact on vulnerable and disadvantaged groups • Strength based approaches • The ABC's of smoking cessation intervention • The role of Nicotine Replacement Therapy. 21. Articulate the importance of patient and family/whaanau centred care and discuss how you would address patient and family/whaanau anxiety • Discuss the Patient code of rights 22. Discuss Tikanga Best Practice and the principles of Te Ao Maaori and how you might apply them when caring for a person/ whaanau • Kaitiakitanga (Guardianship) • Mana Whenua (Local People) • Mana Tupuna/Whakapapa (Ancestral/ Genealogy) • Te Reo Maaori (Maaori Language) • Manaakitanga (caring, nurturing) • Whanaungatanga (making connections) • Wairuatanga (Spiritual Aspect) • Rangatiratanga (Leadership) 23. Discuss planning for discharge including: • Education • Action plan • Primary Health Care and Community Links		

Completed on: _____

Audited by: _____

Signature: _____

Designation: _____

References

Bickley, L.S. (2009) Bates' guide to physical examination and history taking (3rd Ed.) Wolters Kluwer, Lippincott. Williams & Wilkins. Philadelphia.

Weber, J. & Kelley, J. (2003). Health assessment in nursing (2nd Ed.). Lippincott. Williams & Wilkins. Philadelphia.

Leonard, M., Graham, S. & Bonacum, D. (2004). The human factor: the critical importance of effective teamwork and communication in providing safe care. *Quality and Safety in Health Care, 13,* 185-190.

Pope, B., Rodzen, L., & Spross, G. (2008). Raising the SBAR; how better communication improves patient outcomes. *Nursing2009, 38(3),*41–43.

Polices, Procedures & Guidelines

Procedure: Formal Patient Identification
http://cmdhbdocuments/docsdir/opendocument.aspx?id=A30712

Policy: Nursing Handover (Exp Dec 12)
http://cmdhbdocuments/docsdir/opendocument.aspx?id=A13412

Procedure: Nursing Handover http://cmdhbdocuments/docsdir/opendocument.aspx?id=A13413

Policy: Adult Physiologically Unstable Patient (PUP) Early Warning
http://cmdhbdocuments/docsdir/opendocument.aspx?id=A5562

Guideline: Communication pathway – PAR Team
http://cmdhbdocuments/docsdir/opendocument.aspx?id=A17449

Procedure: Watches – Responsibilities and Processes
http://cmdhbdocuments/docsdir/opendocument.aspx?id=A3338

Guideline: Patient Falls – The Immediate Management
http://cmdhbdocuments/docsdir/opendocument.aspx?id=A3338

Guideline: Waterlow risk assessment utilisation to monitor and prevent CMDHB acquired Pressure Injuries (Adults)
http://cmdhbdocuments/docsdir/opendocument.aspx?id=A36465

Guideline: Assessing Level of Consciousness – Glascow Coma Scale
http://cmdhbdocuments/docsdir/opendocument.aspx?id=A2599

Wong Baker foundation http://www.wongbakerfaces.org/

Policy: Smokefree
http://cmdhbdocuments/docsdir/opendocument.aspx?id=A5746

Smokefree Best Practice : Education for Health Professionals
http://cmdhbdocuments/docsdir/opendocument.aspx?id=A11533

Tikanga Best Practice
http://cmdhbdocuments/docsdir/opendocument.aspx?id=A5535

Tikanga Responsiveness Program
http://southnet/MaaoriHealth/Training/Default.htm

Professional Development Hours allocated on completion and audit of this competency: **4 hours.**

Third Month Review:

Your 3 month review is due 12 weeks after you start at Counties Manukau Health. As you prepare for this think about what you have achieved over the last 3 months. Think about the good things as well as the things that have not gone so well. It is a time to start to think of what you would like to achieve in the next 12 months. Please consider completing a preceptor evaluation form and giving it to your CNM/CMM/TL or NE.

▪

PRECEPTOR EVALUATION FORM

Preceptor _____ Date _____

Please use this form to provide specific and constructive feedback to your Preceptor on their contribution to your orientation time. Please give the completed form to your Charge Nurse Manager and/ or Nurse Educator.

How did your Preceptor:

1. Make you feel welcome, e.g.:

- socialisation
- feel part of the team
- ensure you knew what was expected of you

2. Provide effective teaching and learning opportunities, e.g.:

- independent decision making
- recognition of prior learning
- clear explanations
- accessing resources

. Act as a supportive role model, e.g.:

- constructive feedback
- emphatic

- willingness to share
- knowledge
- relationship with other staff
- advocacy on your behalf

Any further comments you wish to add:

Preceptee Date:

Preceptor Date:

Person in Charge Date:

Nurse Educator Date:

For the Office-based Teacher of Family Medicine

William Huang, MD
Feature Editor

Editor's Note: The "One-minute Preceptor" is a widely accepted teaching model that summarizes important tasks or "microskills." In this month's column, Jon Neher, MD, and Nancy Stevens, MD, MPH, explain the five microskills in the model and give specific suggestions on how office-based teachers can use them in their interactions with learners.

I welcome your comments about this feature, which is also published on the STFM Web site at www.stfm.org. I also encourage all predoctoral directors to make copies of this feature and distribute it to their preceptors (with the appropriate *Family Medicine* citation). Send your submissions to williamh@bcm.tmc.edu. William Huang, MD, Baylor College of Medicine, Department of Family and Community Medicine, 5510 Greenbriar, Houston, TX 77005-2638. 713-798-6271. Fax: 713-798-8472. Submissions should be no longer than 3–4 double-spaced pages. References can be used but are not required. Count each table or figure as one page of text.

The One-minute Preceptor: Shaping the Teaching Conversation

Jon O. Neher, MD; Nancy G. Stevens, MD, MPH

In 1992, the five-step "microskills" model of clinical teaching—commonly known as the One-minute Preceptor—first appeared in the family medicine literature.[1] The method is used in medical training settings where a learner initially assesses a patient and then seeks help from a preceptor. The One-minute Preceptor is a framework around which teacher-student conversations can be built and is particularly helpful for newer teaching clinicians. It is quite brief, easy to learn, and has been shown to improve key teaching behaviors.[2,3] In the decade since it was first described, it has been widely adopted in fellowship and teaching programs. This article reviews the method and includes some tips on its application.

(Fam Med 2003;35(6):391-3.)

From the Valley Medical Center Family Practice Residency, Renton, Wash (Dr Neher); and the Department of Family Medicine, University of Washington (Dr Stevens).

The One-minute Preceptor consists of five tasks or microskills that you try to accomplish when discussing a clinical case that a learner has just presented. The microskills are (1) Get a commitment, (2) Probe for supporting evidence, (3) Teach general rules, (4) Reinforce what was done right, and (5) Correct mistakes.

This sequence fosters learner ownership of the clinical problem and allows you to both identify gaps in the learner's knowledge base and focus teaching appropriately to learner needs. Once familiar with the steps, you may want to modify the order, or use only selected microskills as they fit the situation. In learning the skills, it helps to focus on one skill at a time in a given clinical teaching session. Taking a few minutes at the end of the teaching day to reflect on your microskill use hastens acquisition of the skills and comfort with the method.

Get a Commitment

The first microskill is used immediately after the learner has presented a patient to you and asks a specific question or remains silent—asking, in effect, "What do I do now?" To get a commitment, you simply ask in a nonthreatening way,

"What do you think is going on?" or "What do you want to do?" Your objective is to get the learner to process the information he or she has just collected concerning the patient.

Occasionally, you will need to ask one or two clarifying questions about the presentation before you ask for a commitment. Questions such as "Does the child have a fever?" are reasonable, but avoid the temptation to ask so many questions that you take over the case.

Often, you can teach learners to begin with a commitment. This saves time in precepting, helps learners identify their own areas of weakness, and allows you to attend to key clinical details during the case presentation.

Making a commitment can be difficult for some learners because of the risk of being wrong and concerns about being evaluated. The question, "What if I weren't available, what would you do for this patient?" will often get around this impasse. A general statement to the learner before you start—"I am particularly interested in what you are thinking because it helps me be a better teacher"—may encourage them to share their thinking more openly.

For more-advanced learners, remember that commitments may focus on any aspect of clinical care, including diagnosis, diagnostic trees, treatment plans, follow-up, etc. Learners should be constantly challenged to make intellectual commitments just beyond their level of comfort. In very complex cases, commitment requests may take the form of "How do you plan to find the diagnosis?" or "What do you plan to write for admission orders?" or "How are you going to chip away at this situation?"

Probe for Supporting Evidence

Next, you ask the learner what underlies his/her commitment. This has been described as exploring the learner's "mind map," pieces of information (basic science or clinical) that may be loosely connected to each other.[4] To explore the learner's fund of knowledge and ability to connect different pieces of information on his or her mind map, you can ask questions such as, "What factors did you consider in making that decision?" or "Were there other options you considered and discarded?" Listening carefully allows you to understand the learner's clinical reasoning and to find deficits in his or her knowledge base. For a reluctant or resistant learner, you may find further elaborations helpful.[5] Questions like, "If this patient was pregnant, would it alter your management?" or "What are your thoughts on the risks and benefits of empirical treatment as opposed to obtaining a definitive diagnosis first?" can bring out the learner's thinking and knowledge.

Teach General Rules

Every case has teaching value, and your goal is to target your teaching appropriately. Once you understand what the learner knows, you are in a position to teach one or more general rules, which are targeted to the current case but also generalize to other, similar cases. For example, "It is well established that ACE inhibitors reduce morbidity and prolong life in patients with dilated cardiomyopathy" is more appropriate than "This patient needs captopril." Your general rules might summarize anything from the key features of a particular diagnosis, the management of a demanding patient, or effective use of phone consultation.

A common problem for new teachers is trying to teach everything on one case. Learners cannot integrate more than a few general rules per case, so focus on the important areas for them and the patient. Avoid the temptation to focus primarily on what you know best. Also, learners with little knowledge in an important clinical area, where their commitment is a blind guess and they offer no supporting evidence, may need more than a quick "sound bite." If time allows, a mini-lecture may be useful, or you may need to assign reading or plan a review session with the learner in the future. In a busy clinic, the most helpful general rules may be just how to get through the day.

Reinforce What Was Done Right/Correct Mistakes

The final two steps of the teaching conversation are verbally reinforcing those behaviors that were highly effective and suggesting new behaviors that may be helpful in the future. As with all feedback, it should be well timed, expected, case specific, and behavior focused and utilize descriptive rather than evaluative language.[6]

Since we all learn most from the mistakes we identify ourselves, one strategy is to ask the learners to identify what they did right and what they would like to do better. Another is to ask learners in advance how they like to get feedback. This lets them know they will be getting feedback and invites their participation in the process.

Another variation is to give some positive feedback early in the teaching conversation, before probing for supporting evidence, to reduce learner performance anxiety. If you find you are never getting to the feedback steps as you work together, try setting aside a specific time for feedback (for example, after all observed encounters or observed procedures), allowing teacher and learner to sit down and discuss "how it went in there."

In summary, the One-minute Preceptor model continues to provide a reliable framework on which good teaching conversations can be built. The model is most helpful when it is not viewed as static and rigid but as a pliable set of guidelines that can

be shuffled and altered as the ever-changing teaching situation warrants. You can acquire these microskills yourself with practice and reflection on your own teaching encounters.

Corresponding Author: Address correspondence to Dr Neher, Valley Medical Center Family Practice Residency, 3915 Talbot Road South, Suite #401, Renton, WA 98055. 425-656-4287. Fax: 425-656-5395. jneher@vmc.fammed.washington.edu.

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3. Salerno SM, O'Malley PG, Pangaro LN, Wheeler GA, Moores LK, Jackson JL. Faculty development seminars based on the One-minute Preceptor improve feedback in the ambulatory setting. J Gen Intern Med 2002;17:779-87.
4. Neighbor WE Jr, Dobie SA. Microskills model of clinical teaching. J Am Board Fam Pract 1993;6:86-7.
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6. Ende J. Feedback in clinical medical education. JAMA 1983;250:777-81.

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Results of a mail survey of 295 preceptors indicated preceptoring nursing students can be a stressful experience, with overwork identified as the main source of stress. Overwork resulted from unsuitability of students for the clinical area, lack of time, and insufficient feedback and guidance. The findings suggest that both students and preceptors require proper readiness assessment and preceptorship preparation. Preceptorship stress needs to be acknowledged; it can be addressed through workload adjustments and by providing feedback and support from nurse educators, peers, and managers.

KEY WORDS
PRECEPTORSHIP
NURSING EDUCATION
STRESS

BEING A PRECEPTOR IS STRESSFUL!

Olive Yonge, PhD, RN, CPsych, Harvey Krahn, PhD, Lorraine Trojan, RN, MN, MBA(c), Doreen Reid, MEd, RN, and Mary Haase, RN, PhD(c)

Preceptors are essential to provision of nursing education by providing nursing students with reality-based and skills-oriented experience. As experienced nurses, preceptors play a key role in student development, and can influence students' long-term role satisfaction and performance. Although the nurturing of students by expert clinicians is a much-needed service, it requires additional time, energy, and patience in an increasingly busy and complex work environment. Therefore, in order to fill this role effectively, preceptors require proper support. This research-based article seeks to highlight, from the preceptor's perspective, the nature of stress in the preceptor role and to identify the kind of support that is needed to make the preceptorship experience valuable.

Review of the Literature

Preceptoring is a demanding and often stressful role, which offers many reported rewards, but still can be perceived by preceptors as a burden (Atkins & Williams, 1995;

Olive Yonge, PhD, RN, CPsych, is Professor, Faculty of Nursing, University of Alberta, Edmonton, Alberta, Canada.
Harvey Krahn, PhD, is Professor and Associate Dean, Faculty of Arts, University of Alberta, Edmonton, Alberta, Canada.
Lorraine Trojan, RN, MN, MBA(c), is Community Health Nurse, Medical Services Branch, Government of Canada, Edmonton, Alberta, Canada.
Doreen Reid, MEd, RN, is Director of Health Disciplines, Department of Health and Wellness, Government of Alberta, Edmonton, Alberta, Canada.
Mary Haase, RN, PhD(c), is a doctoral student, Faculty of Nursing, University of Alberta, Edmonton, Alberta, Canada.

Grealish & Carroll, 1998). Many of the senior clinical practicums that use preceptorship rely on assigning students to the same proven, experienced full-time nurses. However, there is a cost. Nurses who are repeatedly asked to act as preceptors may experience stress and burnout (Letizia & Jennrich, 1998), particularly with continuous reoccurrence of short preceptorship experiences and if multiple nursing programs share clinical facilities concurrently. Preceptor stress is not limited to repeated preceptorships. Students view the preceptorship relationship as an opportunity to tie together the loose ends of their education (Lunday, Winer, & Batchelor, 1999); however, preceptors may find precepting a student detracts from their satisfaction of providing total patient care (Grealish & Carroll, 1998). Robinson, McInerney, and Sherring (1999) found preceptors may experience difficulty balancing close supervision of a student while simultaneously allowing clinical independence. Nurses in the current study commented on how they had "to be on their toes" because they constantly felt "responsible for the student's learning experience." While many preceptored students are near completion of their programs and should have advanced skills, their levels of expertise can vary greatly. Because preceptors are ultimately responsible for patient care (Robinson et al.), and although students can assume several physical duties, marginal students require greater supervision if a high standard of care is to be maintained.

Heavy workloads have been, and remain, a standard feature of clinical nursing. Multiple responsibilities as clinicians, teachers, mentors, and friends mean preceptors' energy must be divided between patient care responsibilities and their students' needs for direction (Coates & Gormley, 1997; Hallett, 1997; LeGris & Cote, 1997; Stevenson, Doorley, Moddeman, & Benson-Landau, 1995). When these responsibilities conflict, priority must be given to patient care, which, as preceptors acknowledge, can lead to a sense of pressure and a sense of guilt for being unable to fully meet students' needs. Alspach (1989) reported that preceptors found lack of relief from normal workloads to be the most stressful aspect of their role. Precepting has resulted in some preceptors being assigned more or sicker patients because of increased staff-to-patient ratios, instead of having their patient assignments reduced to allow time for their students. Preceptors described the resulting experience as exhausting, and the stress and responsibility at times overwhelming.

> ...preceptors found lack of relief from normal workloads to be the most stressful aspect of their role.

The complexity of preceptor/student relationships can be a stressor also (Robinson et al., 1999). While the value of relationships between learners and preceptors is evident, preceptors have gained in their preceptees constant "shadows" needing support and guidance. Students may ask endless questions, often focusing on small details that preceptors would otherwise disregard. Continuous contact between learners and preceptors allows little relief from the bombardment of questions and continuous observation. As Hayes (1994) stated, preceptors must be on "good behaviour" at all times. Several preceptors in the current study feared their knowledge base was not large enough to meet the needs of the student, and they had a fear of failing to do a good job. Yet, termination of a preceptoring experience, allowing for return to a "normal day," ironically brings the stress of losing a close friend.

Evaluating students is another source of stress. Staff nurses who are comfortable assessing the outcomes of their own care often are uncomfortable in formally evaluating care given by others, particularly when negative feedback is required (Hayes, 1994). Negative evaluations also prompted several responses in preceptors including a sense of guilt over having not spent sufficient time with students, flashbacks to their own student days, and sensitivity to memories of negative feelings (Lewis, 1990; Rittman & Osburn, 1995).

This review of the literature establishes stress as a key issue in the preceptorship experience. However, it leaves unanswered several important questions. Among the most pressing are "How extensive and severe is stress among nursing preceptors?" and "What are its primary sources?"

Research Method

A descriptive, exploratory survey research design was used in this study. A questionnaire was drafted, examined by a panel of experts (preceptors, nurse educators, and managers), and then pilot tested with 25 preceptors prior to dissemination. The sample consisted of the total population of nursing preceptors in Alberta who taught basic clinical nursing skills to students in RN or BScN programs. The sampling frame was obtained through Directors\Deans of Nursing of all nursing programs in Alberta, who provided the names of 500 preceptors.

A total of 295 (59%) preceptors responded; 281 of whom were staff nurses and 14 of whom were managers. Most had 16 years or less nursing experience and 88% had diplomas in nursing as their highest educational preparation. Nearly all respondents (96%) were female. Respondents ranged in age as follows: 20 to 30 yrs, 38%; 31 to 40 yrs, 33%; 41 to 50 yrs, 23%; 51 to 61 yrs, 6%. Surgery was the most commonly reported clinical area, followed by medicine, while the least common was psychiatry.

Findings

Four tables were developed from the results of the mail survey. The survey included the question, "How stressful do you find preceptorship?" Respondents were asked to rate the stress of their preceptorship experiences on a scale of 1 (nonstressful) to 5 (extremely stressful). Respondents who found preceptoring mildly, moderately, or very stressful were asked to explain in more detail. Their narrative comments were coded and used to create the four tables. As Table 1 shows, 24% found preceptorship nonstressful and 75% reported some degree of stress; none found it extremely stressful.

As shown in Tables 2, 3, and 4, the most common sources of stress reported were preceptors' sense of having added responsibilities and the extra time required when units were busy. Respondents felt responsible for students' work habits, nursing care, and mistakes. Additionally, they felt greatly stressed by students who were not suited for certain clinical areas or whose expectations were unrealistic, coupled with busy work environments. Respondents reporting moderate or more stress noted having to spend time with students, particularly those lacking skills or confidence, contributed to their own stress level.

To reduce the stress of overwork, preceptors need to have their normal workloads adjusted while they supervise students.

Discussion

The reasons for preceptorship stress most frequently cited in this study were that preceptorship, in the respondents' own words "adds to preceptors' responsibility," is time consuming, and increases "workload." This finding echoes and validates the work of Alspach, 1989; Coates and Gormley, 1997; Hallett, 1997; LeGris and Cote, 1997; and Stevenson et al., 1995.

It is evident that the data relate to overwork, a complication of preceptorship of which nurse educators must be aware in arranging placements. Preceptors who feel they have been overworked in the past may be less eager to accept students again, assume nurse educators are simply "dumping" students on them, or resent their peers who do not have preceptorship responsibilities. Overwork can be inadvertently fostered by managers who are unaware of preceptors' hidden work and assign preceptors additional patients or duties in the belief that students provide extra help. Students can, of course, be of some use, but only after having spent enough time in the work area to gain both competencies and the preceptor's trust.

The various types of deficits among students is another common source of preceptor stress. Seventeen preceptors reported negative reactions to students' characteristics or performance, citing laziness, illness, poor English, lack of confidence, or poor attitude. Such deficits are likely to stress even the most experienced nurse educators who are equipped with the skills and resources to modify them. However, placing skill-deficient students with preceptors who may be less confident and experienced with students can be problematic and potentially damaging to the professional relationship on which preceptorship arrangements depend. Most preceptors are colleagues who volunteer to assist in the education and socialization of students out of commitment to the profession of nursing. Evaluation of skill-deficient students may be a difficult and negative experience, as found by Grealish and Carroll (1998) and Yonge, Krahn, Trojan, and Reid (1997).

The compatibility of particular students and preceptors needs to

TABLE 1
Preceptors' Evaluation of Levels of Stress

Category	Total No.	%
1. Nonstressful	72	24.2
2. Mildly stressful	156	52.5
3. Moderately stressful	57	19.2
4. Very stressful	8	2.7
5. Extremely stressful	0	0.0
No Response	4	1.4

TABLE 2
Preceptors' Reasons Why the Experience Was Mildly Stressful

Category	Total No.	%	Description
1. Preceptorship is time consuming	24	15.4	• preceptorship takes time • stress increases when the clinical area is busy
2. Preceptorship adds to preceptors' responsibility	37	23.7	• responsibility for student increases stress • nurse feels responsible for student's work, work habits, and learning
3. Preceptorship adds to workload	13	8.3	• preceptorship increases workload on the preceptor
4. Insufficient guidance provided to preceptor	8	5.1	• no orientation • coworkers believe student is doing work of preceptor • unrealistic expectations of preceptor and the student
5. Preceptorship ties down nurse	4	2.6	• "shadow" • constant presence • 1:1 is tiring
6. Individual characteristics/traits of the nurse may affect stress	11	7.1	• stress • incompatible personality • poor skills of student • lethargic student • poor English skills
7. Preceptor feels inadequate or insecure for position	6	3.9	• Preceptor fears knowledge base is not large enough to meet student's needs • fear of failing to do a good job
8. The duty to patient and student result in moral and ethical dilemmas	9	5.8	• preceptor fears the student may not provide safe care; however, the student must be provided with opportunity to learn
9. Student evaluation	2	1.3	• this category deals with extreme circumstances (e.g., failing a student)

be considered when placements are being arranged. Certainly, students need to learn; it is the reason why such work experience placements are part of their training. Consequently, preceptors cannot expect students to arrive fully skilled. Nonetheless, preceptors cannot be responsible for all of a student's deficits. Preceptors are entitled to expect a certain level of student skill to be present at the start of the preceptorship experience, depending on the area to which the student is assigned. It is largely the responsibility of the nurse educators, negotiating such relationships, to ensure compatibility of this kind. There is also a role for onsite coordinators or agency personnel to support students and preceptorships (McGregor, 1999). Their role may vary from being available, to orienting students and preceptors, to mediating conflicts.

It is critical to the success of preceptorship relationships that nursing instructors are aware in advance of the impact they can and do have on the preceptorship experience and on reducing preceptors' stress. They need to identify and employ strategies aimed at minimizing preceptorship stress, regardless of the obstacles that may stand in their way, such as distant placements preventing personal visits or personal or preexisting professional relationships with preceptors that might otherwise inhibit follow-up contact. Nursing managers also have a role to play in decreasing the stress of preceptors, as do preceptors' peers. They can, as needed, arrange "breaks" from teaching responsibilities, adjust patient assignments, and provide opportunities for talking about the experience.

Recommendations

1. To reduce the stress of overwork, preceptors need to have their normal workloads adjusted while they supervise students. Initially, they require lighter patient assignments to allow more time for

TABLE 3
Preceptors' Reasons Why the Experience Was Moderately Stressful

Category	Total No.	%	Description
Preceptorship is time consuming	10	17.5	• preceptor feels pressured to spend time with student • time spent interferes with workload in the clinical area
Preceptorship adds to workload	11	19.3	• preceptorship is work • adds to workload
Preceptorship is added responsibility	13	22.8	• feeling responsible for student's learning • feeling responsible for student's mistakes and nursing care
Preceptorship requires learning new skills and work patterns	9	15.8	• new experience • preceptor must learn to describe actions and rationale for these actions • not a familiar role
Students not suitable for clinical work	2	3.5	• poor attitude of student • ill prepared

orientation. However, as students gain experience, they require less supervision and contribute more to the clinical setting, at which point preceptors can assume more work responsibilities.

2. Students need to be carefully screened before placement in preceptorship programs. Those with marked deficits in knowledge, motivation, or language should not be placed until those deficits have been corrected. It should not be assumed that all students are ready for a preceptorship experience in the final year of their programs.

3. The fact that preceptors will have stress and will require support, and may experience burn-out if stress is too prolonged, needs to be recognized and anticipated by nurse educators, peers, onsite coordinators of preceptorship programs, and nurse managers. A consequence of this should be that preceptors, just like students, be assessed for readiness for the preceptorship experience. Onsite coordinators can also be pivotal in anticipating potential problematic situations and in supporting preceptors and students through early consultation.

Summary

Research on preceptor stress has found that preceptorship can be stressful to a significant percentage of preceptors because of increased workloads relating to unsuitable students, lack of time, and insufficient support and guidance. Such results have clear implications for the roles of nurse educators in preparing students and arranging and following up on placements, nurse managers in planning workload assignments, and colleagues in offering support. Above all, pre-

TABLE 4
Preceptors' Reasons Why the Experience Was Very Stressful

Category	Total No.	%	Description
Student not suited for clinical area	4	50.0	• illness of student • student has no experience • lazy student • lack of confidence in student
Unrealistic expectations of student	1	12.5	• preceptor expects students to work at a certain level of competence
Responsibility too great	1	12.5	• responsibility for student more than preceptor can realistically handle in light of the busy clinical area
Dislike of preceptorship	1	12.5	• preceptor dislikes the responsibility
Lack of preparation for preceptorship	1	12.5	

ceptors need to be treated as co-educators and with respect. To the nursing profession as a whole, they are a valuable, but not an infinite, resource.

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Address for reprints: Olive Yonge, PhD, RN, CPsych, Professor, Faculty of Nursing, 3rd Floor, Clinical Sciences Building, University of Alberta, Edmonton, Alberta, Canada T6G 2G3; e-mail: olive.yonge@ualberta.ca.

Characteristics of the Adult Learner

1. Adult learners are anxious because they lack confidence in their learning ability-fear of losing face in comparison with others.

2. Adults bring to learning a great deal of knowledge and experience which the tutor can draw on.

3. If new learning can be linked to what they already know, material is meaningful and adults can learn quickly and effectively.

4. Adults need to feel autonomous in a learning situation as in any other area of life.

5. Adults are used to setting their own goals.

6. Adults like to see the value of any piece of learning to their goals.

7. Because of a gradual decline in the part of the memory that sorts out incoming information, adults need to deal with one thing at a time and make sure of it before going on to the next step.

8. Adults learn at varying rates and do best when this is allowed for and they are not in a strongly competitive situation.

9. Adults learn best when they are physically and mentally comfortable-when they know and feel at ease with their teachers and fellow students.

10. Once an adult makes a mistake and persists in it a while without being corrected, it is very difficult to unlearn it.

11. Adults need to experience success in their learning as quickly and often as possible to maintain and increase their motivation.

12. Adults need plenty of varied practice in using new skills and ideas.

Question:
Which of the above FOUR characteristics would you consider MOST important?

Foreign-educated nurses
Strangers in a strange land?

To successfully assimilate foreign-educated nurses into your hospital system, target competency, communication, culture, and compassion.

José Ortega

By **Terry V. Bola**, RN, BSN, **Karen Driggers**, RN, BSN, **Chris Dunlap**, RN, BSN, and **Markita Ebersole**, RN, BSN

Abstract: Review a model for seemlessly integrating foreign-educated nurses into your unit. [Nurs Manage 2003:34(7):39-42]

Imagine that you're an immigrant nurse from Russia. You've heard that the United States is experiencing a nursing shortage and jobs are plentiful. You land a position with ease, but your troubles begin almost immediately. Documentation, measurements, names of medications, even your approach to interacting with patients—it's all different. Welcome to the challenge of bringing foreign-educated nurses into the American health care system.

Organizations are scrambling to recruit staff in the wake of today's well-documented nursing shortage. The current registered nurse workforce is getting older and the present shortage of employable registered nurses is expected to worsen.[1] Nursing schools continue to experience decreasing enrollment; many don't anticipate a turnaround for at least 2 to 5 years.[2] In response, a growing number of employers and recruiters are turning to foreign-educated nurses to fill vacancies.

This staffing approach isn't new. Foreign nurses have filled nursing positions in the U.S. since World War II.[3] And although recruiting foreign nurses may reduce short-term staffing woes, it demands a solid commitment: Somebody has to manage the foreign nurses' assimilation into their new organizations.

What do they already know?

Organizations begin the assimilation process by assessing the nurse's competency and technical skills. The Commission on Graduates of Foreign Nursing Schools (CGFNS) helps ensure safe patient care for the American public and prevent the

exploitation of graduates of foreign nursing schools who come to the U.S. to practice nursing.[4]

Through its certification program, the CGFNS:
1. reviews an applicant's credentials
2. tests his or her nursing knowledge through the CGFNS qualifying exam, which was developed through a contract with the NLN (the organization who designed the NCLEX-RN)
3. examines his or her English language proficiency.

Since its inception in 1977, the CGFNS has boosted the licensure rate from a range of 15% to 20% to 85% to 90%.[5] In addition to a satisfactory score on the CGFNS qualifying exam, the applicant needs to show proof of graduation from an educational program comparable to a U.S. state-approved nursing program. He or she must also provide a current, unrestricted license from another country or state. Finally, the CGFNS has to validate the applicant's proficiency in written English.[6]

The CGFNS certification process addresses basic competency issues. But it's only an assessment tool; it doesn't measure every aspect of a nurse's ability. Let's explore the additional issues an organization may encounter that aren't fully addressed by the CGFNS certification process.

Lost in translation

Lack of communication skills hinders foreign nurses from assuming professional nurses' roles and responsibilities. Communication barriers lead to frustration for the nurse, other staff members, and patients. The differences in medical terminology, abbreviations, jargon, medication names, suffixes, and prefixes—even the names of common items—can pose a significant limitation for these nurses.

The inability to properly communicate a change in a patient's condition could delay care or cause injury. In addition, improperly written communication is a liability for the nurse and organization. Lastly, nonverbal communication that differs from the established norm may be interpreted as inattentive, subservient, or disrespectful.

Enunciation and pronunciation are difficult to master when learning English as a second language (ESL). One nurse's lack of understanding led to multiple misinterpretations. "Atrial fibrillation" was incorrectly called "arterial fibrillation." "SVR" was improperly interpreted as "SBR." Although the nurse may be extremely knowledgeable, the language barrier is often a source of anxiety. In emergency situations, additional time for mental translation may not be available.[7]

Unsuitable written-word selection is also a source of documentation errors. A nurse may mistakenly refer to a male

A model for culturally competent leadership

Leininger's Sunrise Theoretical/Conceptual Model of Cultural Care Diversity and Universality allows you to develop an orientation plan for foreign-educated nurses.[1] The model offers seven cultural and social structure dimensions, each one focusing on factors that influence the nurse's well being.

1. *Technical factors:* Explain standard topics such as OSHA and JCAHO requirements, employee benefits, standards of care, monitoring equipment, and computer use. Specialized orientation includes: an individual assessment of needs; cross-cultural learning classes; occupational ESL training; refresher instruction in basic nursing skills such as assessment, data collection, documentation, evaluation, monitoring devices, medication, American weights and measures, and pharmacology; assertiveness training; psychosocial aspects of care; discharge planning; ethical/legal issues; and a clinical preceptor training assignment.[2]

The manager and preceptor develop specific measurement criteria to assess the new nurse's technical competence level. They also provide critical feedback to keep the new nurse on track.

2. *Religious and philosophical factors:* Enlist the assistance of resource managers, social workers, and chaplains to explain your facility's mission, values, and customer service goals. Consider providing an introduction to your community's demographics, cultures, and religious norms.

3. *Kinship and social factors:* While these elements generally aren't covered in orientation, they may prove essential to successfully transitioning foreign employees into a new cultural environment.[3] Consider asking existing employees to serve as a resource for this task.

4. *Cultural values and lifeways:* Consider the impact of very apparent *and* less obvious personal aspects of diversity. Strive to foster not only diversity awareness and appreciation, but also specific diversity management skills. Advocate willingness to communicate, relationship development, self-monitoring, and self-evaluation.[4]

The initial interactive diversity training session can consist of a general discussion of the differences between the cultures, focusing on positive points from each culture. A second session could take place after the new nurse has had 1 or 2 weeks of exposure to the workplace. This session should examine the differences between foreign- and U.S.-provided health care.[5] As a result, the employees learn to communicate effectively, even when they have differences. They also learn to accurately evaluate how their behavior impacts group interaction and how to react to differences in a realistic, less judgmental manner.[6]

5. *Political, legal, and economic factors:* These elements include ethics, patient rights, verbal order usage, patient education, informed consent, discharge planning, and advanced directives. Emphasize the legalities of documentation, because studies identify this as a problem for many foreign-educated nurses.[7]

6. *Educational factors:* When assessing educational factors, you may also encounter two situations: The foreign-educated nurse requires additional education outside your organization's orientation program, or the foreign-educated nurse may meet and exceed educational requirements for general practice and may be prepared for advanced practice. Given this scenario, some organizations have established a fast-track orientation program that recognizes advanced training and places foreign-educated nurses in advanced practice roles.[8]

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patient as "she." Or the nurse may document a medication by using the native country's trademarked name rather than the name of the ordered drug. In these examples, the nurse has unwittingly committed documentation errors, which may result in patient care errors and diminished credibility in the eyes of physicians and coworkers.[8,9] Improper documentation may even result in litigation.

Culture shock

Each culture maintains different expectations regarding nonverbal communication. Patients or staff with limited cultural competence may interpret nonverbal communication, such as eye contact or smiling, as disrespectful, inattentive, or subservient. This difference in cultural norms could further hinder the nurse's assimilation.

Cultures are either *high-context*—meaning people depend on a greater degree of nonverbal codes—or *low-context*—meaning communication relies on the spoken words. The U.S. is a low-context culture, while many Asian countries are high-context. An example: Smiling or making eye contact with others while talking is rarely done in Korea. Smiles are usually considered untrustworthy; making eye contact is considered impolite and arrogant.[10] Conversely, these communication behaviors are common and expected in American culture.

Whether verbal, written, or nonverbal, foreign nurses must be able to offer and receive communication in a manner that leaves no room for misinterpretation.

A new, confusing place

Foreign-educated nurses leave familiar settings and move into a system with which they're not accustomed. For example, in San Francisco, Calif., where a large Russian immigrant population resides, several problems were identified when Russian-educated nurses entered the U.S. health care workforce: Nurses didn't understand documentation, medication dosages, operation of medical equipment, or pharmaceutical/medical abbreviations.

From the employee perspective, these difficulties weren't necessarily the result of inability. Instead, Russian-educated nurses explained that differences in nursing practice and training between the two countries contributed to the confusion. Specifically, Russian nurses have limited or no training in the death and dying process, patient education, psychosocial support of patients, patient advocacy, critical thinking, or decision-making. In addition, universal precautions aren't widely practiced in Russia, due to shortages

of personal protective equipment.[11,12]

Health problems vary from country to country. Foreign-educated nurses are often trained in dealing with communicable diseases and acute illness, not chronic health problems. Health problems in the U.S. are both acute and chronic. In addition, technology varies from country to country. Most education for foreign nurses focuses on the technology available in their native country, which may differ greatly from U.S. technology.[13]

By accepting positions in the U.S., foreign-educated nurses agree to enter a different culture and environment. Without a support system, these nurses may doubt their ability to solve problems and function successfully, and values and behaviors that were helpful in problem-solving in their home country may not be helpful here. These factors contribute to culture shock, depression, and homesickness, all of which adversely affect job function.[14]

At the same time, existing staff members are expected to accept coworkers from a different culture and background. Given the potential difficulties mentioned earlier, this acceptance may not be easy. Successful assimilation plans examine ways to integrate new nurses into the existing culture and educate existing employees on the benefits of cultural diversity.[15]

Through effective diversity leadership you can transcend cultural identity, appreciate different perspectives, serve as a unifying force for the team, and strengthen the positive aspects of work group diversity.[16] (See "A model for culturally competent leadership.")

Unlimited perspective

Given current health care recruitment and retention initiatives, chances are you'll face, at some point, the task of integrating foreign-educated staff into your organization. While this presents numerous challenges, it also gives you and staff the opportunity to expand your perspectives. A foreign-educated nurse certainly requires a specialized orientation process, but he or she brings unique personal and professional talents to your facility's environment. NM

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About the authors

Terry V. Bola, Karen Driggers, Chris Dunlap, and **Markita Ebersole** are masters

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Hallmarks of Unsafe Practice

What Preceptors Know

Florence Luhanga, PhD, RN
Olive Yonge, PhD, RN
Florence Myrick, PhD, RN

During a preceptorship experience, certain students do not progress in their learning at the same rate as others and may engage in unsafe practice. Twenty-two preceptors working with fourth year baccalaureate nursing students for 340 hours in a final practicum were interviewed. This study reaffirmed that early identification and intervention of unsafe practice are critical and consist of red flags regarding knowledge, attitudes, skills, and professionalism.

Preceptorship programs are widely used in undergraduate and postgraduate nursing programs in North America and the United Kingdom as an available, alternative teaching–learning method to the traditional approach to clinical teaching (Ellerton, 2003; Hardyman & Hickey, 2001; Myrick & Yonge, 2001). The purpose of most senior nursing students' practicum experience is to facilitate smooth transition from student to graduate role (Hardyman & Hickey, 2001; Rush, Peel, & McCracken, 2004).

Although preceptored students are near completion of their program and are expected to have advanced knowledge and skills, their level of expertise can vary greatly. Some students require closer supervision than others if high standards of patient care are to be maintained (Yonge, Krahn, Trojan, Reid, & Haase, 2002a). When a student barely passes a clinical assignment and may be unsafe, precepting becomes a tedious and challenging process of remedial skill development rather than the provision of exciting learning opportunities (Rittman & Osburn, 1995). Preceptors recognize the competing demands of encouraging student independence and the professional obligation to ensure safe and competent practice. This leads to the dilemma of facilitating the entry of an unsafe student into the profession upon graduation (Duffy, 2004; Hrobsky & Kersbergen, 2002; Rittman & Osburn, 1995). To identify unsafe practice, it is important that preceptors recognize the "red flags" or hallmarks of unsafe clinical performance.

Most literature on preceptorship confirms the rewarding experience of precepting students because of an experienced increase in personal and professional growth (Glass & Walter, 2000), enhanced self-esteem and confidence (Green & Puetzer, 2002), and career advancement (Allen, 2002). However, the conflict between fostering learner independence and commitment to the profession, the extra time required for teaching and the greater-than-average workload associated with student evaluations because of the necessary documentation, and the need for confrontation can create a great deal of preceptor stress. Some excellent preceptors have "burned out" and refused to precept after a difficult encounter with a student (Langlois & Thach, 2000a; Yonge et al., 2002a).

In the nursing and other health professional education literature, the term "unsafe student" is used to describe students whose level of clinical practice is questionable with regard to competence, whose knowledge and psychomotor skills are lacking, or whose motivation or interpersonal skills are less than adequate (Hrobsky & Kersbergen, 2002; Rittman & Osburn, 1995; Scanlan,

Florence Luhanga, PhD, RN, is Assistant Professor, School of Nursing, Laurentian University, Ontario, Canada.

Olive Yonge, PhD, RN, is Professor and Vice-Provost Academics, University of Alberta, Edmonton, Alberta, Canada.

Florence Myrick, PhD, RN, is Associate Professor, University of Alberta, Edmonton, Alberta, Canada.

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Care, & Gessler, 2001; Yonge et al., 2002a; Yonge, Krahn, Trojan, Reid, & Haase, 2002b). Hendricson and Kleffner (2002, p. 44) defined the "challenging student" as one with one or more of the following characteristics: has difficulty learning or performing up to expectations; is easily distracted and does not devote full attention to academic responsibilities; is difficult, frustrating, and unpleasant to work with; has an attitude problem or is defensive; and does not appear to be motivated to learn. Unsafe practice in a clinical setting may be defined as any act by the student that is harmful or potentially detrimental to the client, self, or other health personnel.

The research has suggested that some of these challenges, particularly in the domain of attitudinal problems, are a result of intergenerational conflict within the nursing profession (Oblinger, 2003; Skiba, 2003; Wieck & Landrum, 2006). Generation "Y" (born between 1980 and 2000) comprises most current nursing students. They are characterized as self-reliant, questioning, technologically advanced, capable as multitaskers, optimistic about the future, with high self-expectations, and often focused on achieving high grades. They tend to have shorter attention spans and a low threshold for boredom and require structure and clear guidelines in a new situation and yet do not hesitate to challenge authority (Oblinger, 2003; Skiba, 2003). The "boomer" generation comprises most preceptors. They are characterized by dedication, sacrifice, hard work, conformity, respect for authority, duty before pleasure, and adherence to rules (Hart, 2006). Because of a difference in values, ideas, ethics, and culture between these two generations, there is the potential for conflict, the perception of students as "difficult," and disrespect for the "culture" of nursing relating to attitudes toward work, work ethics, and the concept of professionalism.

Rittman and Osburn (1995) used a case study method to analyze the process of precepting a nursing student with unsafe practices. "Assessing dangerousness" was seen as a critical skill in precepting students. The following were cited as hallmarks of unsafe practice: students who (a) do not recognize gaps in the patient's care, (b) have difficulty in prioritizing or organizing basic patient care activities, (c) do not report important observations or occurrences to the preceptor, and (d) fail to critically question their practice and show an alertness to the possibility of making an error (Rittman & Osburn, 1995).

Hrobsky and Kersbergn (2002) conducted a qualitative study to investigate preceptor perceptions of an unsatisfactory clinical performance and to evaluate how the liaison faculty could improve the process of supporting preceptors when a student's clinical performance was unsatisfactory. Data analysis revealed three primary themes: (1) hallmarks of poor clinical performance (i.e., red flags), (2) preceptors' feelings, and (3) the liaison faculty's role. Red flags tended to occur early in the experience and reflected behavior and attitudes signaling potential for unsatisfactory performance.

The assumption that all students in their final semester just prior to graduation are ready for a preceptorship experience may not be valid. Many cases of reluctance to award a failing grade and of "giving the benefit of the doubt" to marginal students are well documented in nursing literature (Boley & Whitney, 2003; Duffy, 2004; Scanlan et al., 2001). The reasons cited for the reluctance to fail students when their performance was not up to the standard include (a) lack of experience and confidence (Duffy, 2004; Scanlan et al., 2001); (b) inability to identify or deal with the students' problems early enough during the clinical placement; (c) the threat of appeals (Duffy, 2004; Dudek, Marks, & Regehr, 2005); (d) reluctance to fail students early in the program with a hope that students would pick up the necessary skills in future placements (Duffy, 2004; Scanlan et al., 2001); (e) reluctance to jeopardize the students' future just prior to graduation (Duffy, 2004; Hawe, 2003); and (f) personal consequences such as anxiety, guilt, fear, or a feeling of personal failure (Duffy, 2004; Hawe, 2003). Such a decision has serious implications for the entry of unsafe students into practice upon their graduation.

There is inadequate literature to guide preceptors in difficult situation when students are failing or displaying unsafe practice (Hrobsky & Kresbergen, 2002; Scanlan et al., 2001). To identify unsafe practice, it is important that preceptors recognize red flags or hallmarks of unsafe practice.

THE STUDY

Design/Methodology

Grounded theory was used to explore how nursing preceptors manage or deal with students whose level of performance is borderline or unsafe (Glaser & Strauss, 1967; Strauss & Corbin, 1998). The aim of the grounded theory approach is to develop substantive theory about common social patterns.

The foundations of grounded theory emanate from symbolic interactionism in which the processes of interaction between people's social roles and behaviors are explored (McCann & Clark, 2003). Meanings are created by experience, and although these experiences are unique to each individual, it is acknowledged that individuals sharing common circumstances, such as preceptors, experience common perceptions and thoughts and display common behaviors—the essence of grounded theory (McCann & Clark, 2003).

Sample/Participants

Twenty-two nurse preceptors associated with a final-year clinical practicum provided the sample for the study. Most participants were women and two were men. The participants' age ranged from 26.5 to 62 years.

although three quarters of the preceptors ranged between the ages 40 and 60 years. Almost two thirds of the preceptors who participated in this study had a diploma level of preparation, and slightly more than one third was prepared at the baccalaureate level. About half of the preceptors in this study worked on surgery units, less than one third on psychiatric and medical units, and one on a burn unit. The main criteria for inclusion were previous knowledge and experiences in dealing with students engaging in unsafe practices.

As the data emerged, however, a select number of preceptors with no direct experience of such students were also asked to participate. This process enabled the researcher to search for "negative cases." Theoretical sampling continued until theoretical saturation was achieved. Saturation in grounded theory occurs "when no new data emerges relevant to particular categories and subcategories, categories have conceptual density, and all variations in categories can be explained" (McCann & Clark, 2003, p. 11).

Data Collection

Data were collected mainly through one-to-one semi-structured interviews with individual preceptors that lasted between 20 and 50 minutes. The study was conducted in selected acute care practice settings. Interviews with participants, initially accessed through the respective hospitals, were conducted at a mutually agreed upon place and time. A review of official documents such as guidelines for preceptorship was also conducted to supplement data whenever necessary. It was assumed that the mixed approach to data collection would provide richer data than a single approach would. The interviews evolved, in content, based on responses from participants. The questions in the interview guide were obtained and compiled from the literature.

Validity and Reliability

The researcher had the participants validate the findings of the study through member checks and member validation as proposed by Sandelowski (1986) to ensure credibility. Credibility was achieved by the researcher engaging with participants over time and by developing rapport, establishing trust, and working collaboratively with them. Fittingness was enhanced by collection of data from different acute care settings. The researcher ensured that there was a comprehensive audit trail for future use by others to ensure confirmability.

Ethical Considerations

A letter of permission and ethical approval from the ethics review committee were obtained. To ensure confidentiality, names of the participants were not used on the audiotape recordings, written transcripts, or field notes.

Data Analysis

Data were analyzed by the researcher using constant comparative analysis as described by Glaser (1978). The main goal of data analysis in a grounded theory approach is to discover a core variable that illuminates and explicates the main theme of the preceptor's experience (Glaser, 1978; Streubert & Carpenter, 1999). Data analysis began simultaneously with data collection and was achieved through the process of coding. Coding occurred at three levels: open coding, theoretical coding, and selective coding. Open coding is the process of "fracturing" or breaking down the data into discrete parts to identify and name relevant categories (McCann & Clark, 2003). Theoretical coding is a process in which the ordering of the data and the interrelation of the substantive categories occur. During selective coding, the researcher moved from data analysis to concept and theory development. This was accomplished through the process of data reduction, by filtering information relevant to the topic, discarding extraneous information, and applying selective sampling. During this stage, the core category that ties together all other categories in the theory was identified and related to other categories (Glaser, 1978). The data analysis revealed a multifaceted process, which was labeled "promoting student learning and preserving patient safety" as the core variable or main process involved in precepting a student with unsafe practice. Five major categories were revealed: (1) hallmarks of unsafe practices, (2) factors contributing to unsafe practice, (3) preceptors' perceptions and feelings, (4) grading issues, and (5) strategies for managing unsafe practice. This article will focus on the category "hallmarks of unsafe practice."

FINDINGS

The preceptors described several behaviors that prompted them to consider the possibility of unsafe practice. These were categorized into four subcategories: (1) inability to demonstrate knowledge and skills, (2) attitude problems, (3) unprofessional behavior, and (4) poor communication skills. Although signs of unsafe practice could occur at any stage in the preceptorship experience, most preceptors in this study indicated that these occurred early in the preceptorship experience. Once they identified unsafe practices, some preceptors indicated that they gave students usually a week or two to become familiar and comfortable with the routines on the units before addressing the problem or asking for external assistance.

Inability to Demonstrate Basic Knowledge and Skills

The most common behavior prompting preceptors to intervene in this subcategory related mainly to the students' lack of knowledge and poor skill performance. Other common behaviors were sloppiness or lack of organizational skills; students' inability to ask questions; ineptness to follow instruction, resulting in frequent repetitive mistakes; and lastly, failure to practice basic safety measures (such as aseptic technique).

Inadequate knowledge and inability to perform skills

While in the preceptorship experience, students are expected to practice with increasing independence under the supervision of the preceptors. The main concern among preceptors was that students were ill prepared for the preceptorship experience as many still lacked basic clinical skills. Preceptors felt frustrated when some students exhibited minimal clinical skills, leaving the preceptor to spend time teaching the basic skills instead of providing the "finishing touches" prior to graduation. As this preceptor commented:

> when we get a student that's [sic] not up to par because by the time they [sic] are ready to graduate, there shouldn't be a lot of stuff that I have...to teach them [sic]. I should serve as just kind of smooth the edges, so to speak...

Other preceptors believed that students were unsafe because they lacked the knowledge base to carry out the required skills. One of the most striking findings was the prevalence of medication errors among students. Three quarters of the preceptors who were interviewed reported this occurrence. One of the critical skills for nursing students is the ability to calculate drug doses accurately. Most preceptors in this study, however, indicated that some students were deficient in this skill. As one preceptor explained:

> There was a medication incident, specifically I believe it was Zofran and I think the order was 4 mg...It comes in a 4 mg dose and she was going to give 2 [tablets] so the patient would have had 8 [mgs]...there were other cases where she didn't compute properly...but quite often she got things wrong.

In addition, preceptors indicated that they became concerned if a student did not seem alert to the possibility of making mistakes.

Sloppiness or lack of organizational skills

Many students were unable to organize basic patient care activities or also demonstrated careless behavior. Although preceptors expect students in their final practicum to be well organized, with strong time management skills, this was not always the case. One preceptor described a student who was displaying careless behavior on the unit:

> There was...an incident where one of my students accidentally knocked over some pills. The patient brought them in...She would leave stuff lying around, leaving the med room open...not signing up for medications. I had to constantly be on her back all the time.

Not asking questions

Preceptors also indicated that they preferred students who asked questions to those who did not and then made mistakes. Preceptors also indicated that they tended to trust students who asked questions because they could then ascertain their level of competence and assist them accordingly.

Inability to follow instructions and safety measures

Other behavior of great concern and frustration for preceptors was related to the students' inability to follow instructions. One preceptor expressed her frustration:

> You tell her to go into a patient's room to discontinue this IV, then they [sic] always go to the wrong patient... every time you give them [sic] instruction it seems like they [sic] will do it wrong. Those I think were the hardest.

Although preceptors acknowledged that "we all make mistakes," they still believed that, when students do not follow instructions and make repetitive errors, they are unsafe and should not be trusted with patient safety. A final subcategory of behavior identified by a few preceptors was related to students who did not practice basic safety measures or principles of surgical asepsis.

Attitude Problems

Most of the preceptors who were interviewed indicated that students with attitude problems were the most difficult to work with. Under this subcategory, the common behaviors alerting preceptors to unsafe practice related to overconfidence or a "know-it-all" attitude, defensiveness or an unreceptive attitude to feedback, and an indifferent, "I don't care" kind of attitude.

Overconfidence

Three quarters of the preceptors indicated that most of the fourth year students tended to be overconfident or "cocky." Preceptors believe that overconfidence can be unsafe because, in most cases, students think they know what they are doing when, actually, they do not. These overconfident students often interpret supervision

as a lack of trust on the preceptor's part, which can be frustrating for both parties.

Unmotivated to learn or work

Nearly half of the preceptors acknowledged that it was difficult and frustrating to work with students who did not seem to be interested in learning, were not interested in nursing, or were lazy. One preceptor confirmed:

> She would do as little as she could because as a preceptor I would still be there to help her out with certain things. . .I still found she preferred to do the minimum but I still had to really push her.

Preceptors expressed concern about students who tended to dismiss certain learning opportunities once they had accomplished a task by saying "done that before" or "I don't want to repeat it." Other preceptors made reference to the fact that the present generation did not work as hard as they did as students:

> I think some of the students are so relaxed; you know, they don't work as hard as when we were students.

Defensiveness or unreceptive attitude toward feedback

Preceptors believed that students who were unreceptive toward feedback were the most difficult to teach and manage. Not only was it difficult to trust such students, but also, preceptors were especially concerned if a student did not seem alert to the possibility of making mistakes.

Unprofessional Behavior

Preceptors also described a number of behaviors and actions that were identified as unprofessional. These behaviors and actions were related primarily to a poor work ethic, dishonesty, lack of confidence or extreme nervousness, and intentional unsafe behavior.

Poor work ethic

More than half of the preceptors identified behaviors related to a poor work ethic, most of which reflected behavior that demonstrated an inability to meet the demands and expectations of a work environment, such as negligence, laziness, gossiping, crying, eating, or using cell phones while on duty. Another preceptor described a student whom she believed was lazy and disrespectful to the staff on the unit. She explained:

> She spent a lot of time visiting and laughing, and just having a good time. . .She comes in to the report, puts her feet on the table, and she eats her breakfast in the report. She didn't seem to have respect. . .or if it's just the generation thing, where people are more relaxed and think that's okay.

Lack of confidence

About half of the preceptors identified extreme nervousness as a warning sign of poor performance or unsafe practice. As expressed by one preceptor:

> She was extremely nervous, even the patient commented that she was nervous.

Other preceptors also commented that when a student was hesitant and unsure, it was difficult for them to trust such a student with patient safety.

Dishonesty

One third of the preceptors identified behavior related to dishonesty as unprofessional. These included lying, hiding errors, and not admitting one's own mistakes.

Intentional unsafe practice

Other behavior that would alert a preceptor to unsafe practice involved verbal or physical abuse of patients and acts of embellishment. There was, however, no direct evidence of a student who either verbally or physically abused a client. One preceptor described a student who used to embellish stories, which led the preceptor to mistrust the student.

Poor Communication Skills

Behavior related to poor communication or to interpersonal skills involved inappropriate interaction with the preceptor or instructor (being too argumentative and disrespectful); inappropriate interaction with patients; and inappropriate nonverbal communication such as eye rolling, sighing in front of patients, chewing gum, or yawning.

Inappropriate interaction with preceptors or instructors

This included personal behavior that interfered with the students' ability to self-evaluate and perform their work responsibilities. For example, one preceptor recalled an incident where a student had an intense argument with the instructor, to the point where the preceptor believed that the student was being disrespectful. Another preceptor described an encounter she had with a student after giving the student final evaluation:

> She cried and cried. . .basically told me it was my fault that she was going to fail. It wasn't her fault, it was my fault

because I was a poor preceptor and she had said that previously all of her other preceptorships and in all the other courses she was an honors student.

Inappropriate interaction with patients

Inappropriate interactions with patients included boundary crossings such as self-disclosure, which was indicated by one quarter of the preceptors, most of whom were working in psychiatric settings. For instance, one preceptor recalled an incident which she described as unprofessional and "kind of weird," in which she observed a student on her knees beside the bed talking to a patient. Other preceptors gave examples whereby students would share personal information that had nothing to do with the patient's therapy.

Inappropriate nonverbal interaction with preceptors

Another behavior identified by preceptors as unprofessional related to inappropriate nonverbal interaction with preceptors, such as eye rolling, yawning, or sighing in front of patients. As one of the preceptors commented:

> I will be in the room and trying to teach her to do a dressing and she will be rolling her eyes and sighing in front of the patient, which I thought is unprofessional...

DISCUSSION

The results of this study indicate that the first process in managing a student with unsafe practice is the actual identification of unsafe practices. To identify unsafe practice, the preceptors noted that they initially had to recognize the red flags or hallmarks of unsafe clinical performance which generally occurred early on in the preceptorship (Duffy, 2004; Hrobsky & Kersbergen, 2002). Behavior or attitudes that alerted preceptors to be more vigilant or watchful over the student were related to inability to demonstrate knowledge and skills, attitude problems, unprofessional behavior, and poor communication skills (Hendricson & Kleffner, 2002; Hrobsky & Kersbergen, 2002; Wolff-Burke, 2005).

While in a final practicum, students are expected to perform all role functions and to assume an increasingly larger patient assignment in a more proficient, organized, skillful, and independent manner (Hill, Wolf, Bossetti, & Saddam, 1999). As some students were still lacking in these skills, there exists the possibility, therefore, of some students becoming registered nurses without mastering some basic skills. In fact, this observation was affirmed by one preceptor who gave an example of a bachelor of science in nursing graduate who did not know how to give an injection. This concurred with findings in a study where students were concerned that they had not gained sufficient experience in a number of basic skills such as taking blood pressure or giving injections (Dolan, 2003).

Preceptors in this study believed that students were unsafe because they lacked the knowledge base to carry out required skills. Preceptors, however, need to be realistic about their expectations of students in relation to both clinical knowledge and practical skills. Students enter the preceptorship experience with varying levels of knowledge and skills and different types of clinical experiences (Langlois & Thach, 2000a, 2000b; Myrick & Yonge, 2005; Oermann & Garvin, 2002). Rather than viewing the student as incompetent, therefore, preceptors must instead plan patient assignments and learning activities that will enable students to develop the competencies that they are lacking (Bick, 2000; Oermann & Garvin, 2002). One preceptor in this study emphasized the need for faculty members to ensure that the clinical setting to which they assign students offers the experiences that will provide the learning opportunities necessary for students to meet their objectives.

One of the most striking findings in this study was the medication errors discovered to be common among students. One preceptor attributed this lack of knowledge and skill to the fact that nursing students are not taught basic courses such as pharmacology, which she believed were fundamental in drug administration and nursing (Bullock & Manias, 2002; King, 2004).

Organizational ability and priority setting are essential to professional practice (Myrick & Yonge, 2005). Preceptors expected students in the final practicum to be organized and have time management skills, but this was not always the case. However, these are skills that are difficult to teach in university but are better learned through experience in the clinical setting (Bick, 2000).

The kind of questions that students asked helped the preceptor to determine their level of competence, plan appropriate learning experiences, judge when and how to provide backup to safeguard patients' well-being, and build a trusting relationship. It is important for preceptors, however, to realize that a student with a weak knowledge base may not feel comfortable asking or answering questions for fear of not knowing the correct answers.

Attitudinal problems that were particularly frustrating and challenging and that alerted preceptors to possibilities of unsafe practice included acute defensiveness, unenthusiastic attitude toward learning or work, and the cocky, know-it-all attitude (Duffy, 2004; Hendricson & Kleffner, 2002; Hrobsky & Kersbergen,

2002; Wollf-Burke, 2005). Preceptors in this study described students who were unreceptive to feedback as the most difficult to teach and manage. Some students may undermine the preceptor or project their failure onto the preceptor. It is important, therefore, that feedback be given cautiously and in an advisory rather than accusatory manner; otherwise, the student may become dissatisfied with the evaluation process and then lose trust in the value of self-assessment.

Preceptors expressed concerns about students who did not seem to be interested in learning (Hill et al., 1999). Students, however, must be assisted to practice what they are learning and be made aware that performing a task once is not enough to become proficient. Preceptors need to be aware that, sometimes, acute defensiveness, lack of motivation, and a know-it-all attitude may be behavioral manifestations of underlying learning deficiencies or medical problems (Hendricson & Kleffner, 2002).

Older nurses expect the younger nurses to be committed to work (Wieck & Landrum, 2006). They often complain that younger nurses are disloyal and spoiled and are more interested in technology and money instead of nurturing. Younger nurses, on the other hand, see their older colleagues as out of touch and stuck in a work model that disappeared years ago (Domrose, 2001). Preceptors in this study believed that students did not work as hard as previous generations of students. These sentiments by preceptors may be a reflection of the differences in the values and work ethics between the multiple generations currently in nursing practice settings. Potential misunderstanding regarding generational values and work ethics can contribute to stress and conflict during the preceptorship experience. An awareness of the different needs of each learner will help create learning strategies and an environment suitable for varied generational needs to maximize the learning experience (Oblinger, 2003; Wieck & Landrum, 2006).

A student who lacks confidence in performing a skill will normally demonstrate extreme nervousness. Extreme nervousness or high levels of anxiety, however, can impair concentration and the ability to receive and process information; thus, it impedes a student's clinical performance (Langlois & Thach, 2000b).

Preceptors described various behaviors that were identified as unprofessional. Dishonest behavior such as lying violates both legal and ethical standards of nursing practice (Canadian Nurses Association, 2002). Gaberson and Oermann (1999) further suggested that clinical dishonesty among students is usually a result of one or more of the following factors: competition for good grades in clinical courses, educational emphasis on perfection, poor role modeling, and impaired moral development. Because of its potentially devastating impact, prevention of clinical cheating or lying should be a priority for preceptors and nursing faculty. It is also suggested that nursing curricula must reflect the values of the profession and be structured to nurture the moral development of students (Gaberson & Oermann, 1999).

CONCLUSIONS

This study revealed that early identification and intervention of the student with unsafe practices are crucial when working with such students in the clinical setting. The study findings suggest that there is the perception that students may not always be receiving adequate practical skills or basic knowledge from the university program, such as drug administration. Nursing faculty must ensure that students possess the required knowledge, skills, and competencies to participate in the preceptorship program. This finding implies that students need to be adequately prepared and assessed for their readiness for the preceptorship experience. Selecting suitable students for preceptorship is important for client safety, student achievement of course objectives, and minimization of the level of burden on the preceptor.

It is recommended that unsafe students be identified early so they can be given the opportunity to improve. Descriptions of unsafe and unprofessional behaviors identified in this study could be used by preceptors to identify early warning signs of poor performance or unsafe practices. Ongoing support and workshops geared toward staff development in the area of preceptorship also need to be in place to improve preceptor confidence in identifying and assisting students with unsafe practice. Preceptors are responsible for identifying and fostering behavior that is consistent with professional expectations and for modeling that behavior themselves.

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ADDRESS FOR CORRESPONDENCE: Olive Yonge, PhD, RN, University of Alberta, 3rd Floor Clinical Science Building, Edmonton, Alberta Canada T6G 2G3 (e-mail: olive.yonge@ualberta.ca).

Policy: Nursing Orientation

Purpose

The purpose of this policy is to ensure all new, returning or transferring nurses and health care assistants are provided with a structured, competency based orientation programme to ensure a safe introduction to their new work environment.

Note: **This policy must be read in conjunction with** the Nursing/ Midwifery Preceptorship Policy and The Nurse Entry to Practice programme handbooks.

Scope

This policy is applicable to all nursing staff including health care assistants and their line managers.

Note: **Nurses are responsible and accountable for their practice at all times.**

Policy

All new, returning or transferring nursing staff including health care assistants are to have a defined orientation programme on commencement of work at CMDHB.

Each area/service must have a defined orientation programme.

All nursing staff undergoing orientation are to be allocated a preceptor and be rostered together as per the nursing/midwifery preceptorship policy.

All new, returning or transferring nursing staff are to have an assessment of their individual orientation requirements undertaken by their Clinical Nurse/Midwife Manger or Team Leader and Nurse Educator. The area orientation plan will then be adapt to meet the individual learning needs to the staff member.

All newly qualified (less than post one year registration) registered nurses must participate in CMDHB's formal Nurse Entry to Practice Programme.

All staff must attend the mandatory training as per the Organisational Learning & Development policy.

A performance review will be undertaken by the Charge Nurse/Midwife Manger or Team Leader at the end of three (3) months. This will

comprise of a review of progress in the completion of the orientation book as well as the identification of ongoing professional development needs. Where a new employee requires more that the recommended supernumerary period, the Charge Nurse/Midwife Manager or Team Leader will develop a performance plan with the new employee, preceptor and Nurse Educator. If a graduate nurse, the Nurse Educator (NETP) must be informed.

Requirements	**Graduate Registered Nurse (NETP Programme)**	**Registered/ Enrolled Nurse new to Organisation**	**Registered /Enrolled Nurse Internal transfer (same service specialty)**	**Registered/ Enrolled Nurse Internal Transfer (general to specialist area)**
Supernumerary	If undertaking 2 rotations- 4weeks shared load first rotation, 2 weeks second rotation. If undertaking 1 placement- 6 weeks shared load	10 clinical days Specialised areas may require longer	By mutual agreement with nurse, preceptor, educator and manager	As per specialist areas guidelines
Preceptorship	12 months. Full caseload graduated by mutual agreement with nurse, preceptor, educator and manager	12 weeks. Full caseload graduate by mutual agreement with nurse, preceptor, educator and manager	12 weeks. Full caseload graduate by mutual agreement with nurse, preceptor, educator and manager	12 weeks. Full caseload graduate by mutual agreement with nurse, preceptor, educator and manager
Orientation	Complete generic orientation manual within first 3 months. Complete service orientation within agreed timeframes	Complete generic orientation manual within first 3 months. Complete service orientation within agreed timeframes	Complete service orientation within agreed timeframes	Complete service orientation within agreed timeframes
Skills/ competencies	Complete mandatory requirements as per the Organisational Learning & development policy Complete area specific skills/competencies within agreed timeframes	Complete mandatory requirements as per the Organisational Learning & development policy Complete area specific skills/competencies within agreed timeframes	Complete mandatory requirements as per the Organisational Learning & development policy Complete area specific skills/competencies within agreed timeframes	Complete mandatory requirements as per the Organisational Learning & development policy Complete area specific skills/competencies within agreed timeframes
Orientation Assessment/ Performance review	3 month performance review with preceptor, educator (as appropriate) and manager	3 & 12 month performance review with preceptor, educator (as appropriate) and manager	3 & 12 month performance review with preceptor, educator (as appropriate) and manager	3 & 12 month performance review with preceptor, educator (as appropriate) and manager

Nursing Orientation

Requirements	Bureau	Nursing Bureau Resource team	Health Care Assistants
Supernumerary	As discussed between nurse, and bureau manager	As discussed between nurse, and bureau manager	5 clinical days Specialised areas may require longer
Preceptorship	As discussed between nurse, and bureau manager	As discussed between nurse, and bureau manager	During orientation, work with HCA under delegation & direction of RN
Orientation	Complete generic orientation manual within first 3 months	Complete generic orientation manual within first 3 months	Complete HCA generic orientation manual within first 3 months
Skills/ competencies	Complete mandatory requirements as per the Organisational Learning & development policy	Complete mandatory requirements as per the Organisational Learning & development policy	Complete mandatory requirements as per the Organisational Learning & development policy
Orientation Assessment/ Performance review	3 & 12 month performance review with preceptor, educator (as appropriate) and manager	3 & 12 month performance review with preceptor, educator (as appropriate) and manager	3 & 12 month performance review with preceptor, educator (as appropriate) and manager

Associated Documents

Other documents relevant to this policy are listed below:

NZ Legislation	Nursing Council of New Zealand Standards for Nursing Entry to Practice Programmes (2005) HPCA Act (2003)
CMDHB Clinical Board Policies	Organisational Learning and Development Policy (2008) Recruitment Policy Framework for Education Development Policy (2008) Good Employer Policy
NZ Standards	Nursing Council of New Zealand Competencies for Registered Nurses (2010) Nursing Council of New Zealand Competencies for Enrolled Nurses (2010)
Organisational Procedures	Professional Development and Recognition Programme (nursing & Midwifery) 2010

Other related documents	Nurse Entry to Practice (NETP) Specifications and Learning Framework (2010) Preceptoring for Excellence National Framework for Nursing Preceptorship Programmes (2010) CMDHB Preceptor handbook (2006)

References (Evidence Based Practice)

Auckland District Health Board (2009): Clinical workload sharing & Orientation for Nurses & Midwives.

Capital & Coast District Health Board (2009) Nursing and Midwifery Orientation Policy.

Definitions

Terms and abbreviations used in this document are described below:

Term/Abbreviation	Description
CMDHB	Counties Manukau District Health Board

Policy: Nursing/Midwifery Preceptorship

Purpose

The purpose of this policy is to provide all new/new-to-area nurses/midwives/students at CMDHB with a structured teaching and learning relationship and environment providing them with:

- access to an experienced and competent role model
- a supportive teaching and learning relationship for a negotiated period of time
- a smooth transition to practice in a specific clinical setting
- an opportunity for new nurses/midwives to familiarise themselves with the work area and unique practice requirements
- opportunity to link theory to practice
- assist with the socialisation to the work area
- opportunity to reflect on practice
- meaningful and purposeful feedback
- opportunity to set learning goals

Note: This policy must be read in conjunction with the CMDHB Preceptor Handbook.

Scope

This policy is applicable to all nurses/midwives employed at CMDHB and nursing/midwifery students gaining clinical experience within CMDHB.

Note: Nurses/ Midwives are responsible and accountable for their practice.

Policy

Principles

- Preceptorship is essential in facilitating the safe and effective integration of new staff and students to a clinical area.
- Effective preceptorship leads to improved recruitment and retention of nursing/midwifery staff, which in turn leads to improved patient outcomes.
- Orientation and preceptoring are not the sole responsibility of the preceptor, Person in Charge or Nurse/Midwife Educator. Every team member in the clinical area has a responsibility to ensure the successful

orientation and retention of new staff. PRECEPTORSHIP IS A TEAM EFFORT.

- Roles and responsibilities of all the Preceptoring team members are outlined in the CMDHB Preceptor Handbook and must be adhered to.

- Each area/service must have a defined orientation programme that encompasses the generic orientation.

- Each preceptor must complete a Preceptorship Training Programme and attend a 2 yearly update.

- Liaison between the line manager, nurse/midwifery educator, graduate nurse coordinator (as required) and the preceptors should be undertaken to ensure a new staff member is with an appropriate preceptor. In the case of students liaison with the appropriate lecturer would be required.

- Competency of the preceptor will be evaluated in the annual performance process

- The preceptee can formally feedback to the preceptor using the Preceptor Evaluation Form. I

- The preceptee/ student shares a clinical workload with a preceptor for a negotiated period relative to their experience and identified learning needs. The shared clinical workload is defined as two nurses/midwives working together (normally within a preceptorship model), who share and are responsible for the care of a clinical client group.

- The preceptee mirrors the preceptor's shifts, following the supernumerary period, where possible, for a further negotiated period, allowing for on-going mentoring and feedback. Students will work rostered shifts which may differ from their allocated preceptor apart from their Transition placement when students will work the same shifts as their preceptor.

- The following six weeks involve a formal supportive educational partnership with regular feedback between the Preceptor and the Preceptee. Ongoing support and coaching is negotiated between the two individuals.

- Orientation to night shift (if appropriate) should occur with their preceptor or experienced night staff.

- Workload allocation should be fair and consistent reflecting the additional responsibilities of the preceptor and the learning needs of the preceptee/ student. Effective preceptoring involves some degree of clinical slowdown in the area and this needs to be acknowledged by other staff members.

- Time must be allocated for one-to-one preceptor/preceptee objective setting, planning, feedback and discussion.

- The line manager and nurse/miwive educator schedule regular meetings to review progress with the preceptor and preceptee. For students, the lecturer will be involved in these regular meetings.

Note: For graduate nurses involved in a NETP programme adherence to the preceptor specification outlined in the NETP framework must occur.

For Graduate Nurses:

- Total 6 weeks supernumerary
- Preceptorship is for total of 12 months
- NETP specifications allow the preceptors and graduates to be released together from clinical practice for an equivalent of two 'development days' (16 hours) over the 12 month period of the programme.

Associated Documents

Other documents relevant to this policy are listed below:

NZ Legislation	New Zealand Nursing Council Standards for Nursing Entry to Practice Programmes (2010). HPCA Act (2003)
CMDHB Clinical Board Policies	Organisational Learning & Development Policy (2010) Performance Development Policy (2010) Recruitment policy (2010). Framework for Educational Development policy (2011). Professional Development and Recognition Programme Policy (2012)
NZ Standards	Nursing Council of New Zealand competencies for registered nurses.(2010) Nursing Council of New Zealand competencies for enrolled nurses.(2010) Midwifery Council of New Zealand. (2010)
Organisational Procedures	Preceptor Handbook (2006).

Other related documents	Preceptoring for Excellence National Framework for Nursing Preceptorship Programmes (2010). Nurse Entry to Practice (NETP) Learning Framework (2006) CMDHB Adult Services Generic education Orientation and Framework (2012)

References (Evidence Based Practice)

Counties Manukau District Health Board. (2010). Nursing Preceptor Handbook.

New Zealand Nurse Educators (2010) *Preceptoring for Excellence National Framework for Nursing Preceptorship Programmes.* Report to the Nurse Executives of New Zealand from the New Zealand Nurse Educators Preceptorship Subgroup.
http://www.dhbnz.org.nz/Site/Future_Workforce/NETP/Default.aspx

New Zealand Nursing Council (2010). *Standards for Nursing Entry to Practice Programmes.*
http://www.dhbnz.org.nz/Site/Future_Workforce/NETP/Default.aspx

NETP Programme Steering Group (2006). *Nurse Entry to Practice (NETP) Learning Framework.*
http://www.dhbnz.org.nz/Site/Future_Workforce/NETP/Default.aspx

Bay of Plenty District Health Board. (2006). Preceptorship Policy.

Definitions

Terms and abbreviations used in this document are described below:

Term/Abbreviation	Description
NETP	Nurse Entry to Practice- a programme aimed at providing recently graduated New Zealand trained nurses with a safe and well supported environment enabling them to develop skills to become confident in their practice.
PDRP	Professional Development and Recognition Programme.
Preceptorship.	A period of practical experience and training for a student, or new staff member, especially of medicine or nursing, which is supervised by an expert or specialist in a particular field.
Preceptor:	An experienced nurse/midwife with excellent clinical skills (for their level) and has the ability to facilitate learning and build confidence in the learner. They should have completed an identified preceptor course.
Preceptee:	Nurse/midwife who requires precepting to an area and is usually a novice practitioner to that area. A novice practitioner can be a student nurse, a new graduate nurse, or an experienced nurse/midwife who is new to the particular area.

Preceptorship and Critical Thinking in Nursing Education

Florence Myrick, PhD, RN

ABSTRACT

Although preceptorship is being used increasingly by nursing faculty in the practice setting, little is known about how preceptors teach and even less is known about how critical thinking is being fostered in that relationship. The purpose of this study was to examine the process used in preceptorship to develop and promote the critical thinking ability of baccalaureate nursing students. Using the grounded theory method, this study was conducted in a large tertiary care hospital. Participants included fourth-year baccalaureate nursing students (preceptees) and their staff nurse preceptors. Data collection was composed of semistructured interviews and observations of the preceptors and preceptees as they worked together in the practice setting. Secondary data sources included documents considered appropriate to the study (e.g., nurse notes, student journals). By constant comparative analysis of the data, the findings of this study revealed a process that reflects the enabling of students by preceptors to develop and promote their critical thinking ability in the practice setting.

A major goal of baccalaureate nursing education is the development and promotion of critical thinking in students. Nurse educators are faced daily with the challenge of preparing graduates who must be adept at coping with the growing body of nursing knowledge, the rapid advances in science and technology, and the economic constraints that continue to result from massive health care changes (Jacobs, Ott, Sullivan, Ulrich, & Short, 1997; Laschinger & MacMaster, 1992). In a practice profession such as nursing, acquisition of knowledge is demonstrated by its application in the practice setting. However, this application is not an instinctive outcome of classroom instruction. On the contrary, "it must be nurtured, organized, and carefully sequenced...classroom and clinical learning must reinforce each other" (Malek, 1986, p. 20). Therefore, the obligation is on nurse educators to explore teaching approaches that promote effective clinical teaching and learning and foster critical thinking. Although preceptorship is one approach being endorsed and used increasingly by nursing faculty throughout Canada, the United States, and Great Britain (Bowles, 1995; Marchette, 1985; Myrick & Barrett, 1992), little is known about how preceptors teach and even less is known about the process of thinking that occurs in that relationship.

SIGNIFICANCE OF THE STUDY

The notion that critical thinking must be fostered for all learners is evident. The more pressing issue is whether such thinking is being fostered in the preceptorship experience. Can nurse educators say with certainty that preceptorship fosters critical thinking, or is it a modern-day version of the apprenticeship model, "which achieved bureaucratic loyalty at the expense of professional role enactment" (Andersen, 1991, p. 17)? Although it has become the teaching approach of choice in the practice setting (Bowles, 1995; Marchette, 1985; Myrick & Barrett, 1992), there is no evidence to support the idea that preceptorship provides students with the opportunity to develop their critical thinking ability. Even more

Dr. Myrick is Associate Dean, Graduate Programs, Faculty of Nursing, University of Calgary, Calgary, Alberta, Canada.

Address correspondence to Florence Myrick, PhD, RN, Associate Dean, Graduate Programs, Faculty of Nursing, University of Calgary, 2500 University Drive NW, Calgary, Alberta, Canada T2N 1N4.

striking is the lack of research regarding the role of preceptorship in promoting critical thinking. To date, no studies have been conducted to examine the process used in preceptorship to develop and promote the critical thinking ability of baccalaureate students. Such research could:

- Influence future preceptorship programs.
- Provide innovative strategies for fostering critical thinking in the preceptorship experience.
- Contribute to the enhancement of the preceptor-student (preceptee) relationship.
- Affect the relationship between nursing education and practice.

PURPOSE OF THE STUDY

The purpose of this study was to generate data that would lead to discovery of the process used in the preceptorship experience to develop and promote the critical thinking ability of baccalaureate nursing students.

LITERATURE REVIEW

Preceptorship

In the past 2 decades, much research has been conducted examining the preceptorship relationship from many perspectives. A major theme throughout the research literature has been the effect of preceptorship on the socialization and role transition of nursing students and neophyte graduate nurses (Clayton, Broome, & Ellis, 1989; Dobbs, 1988; Estey & Ferguson, 1985; Goldenberg & Iwasiw, 1993; Spears, 1986). The influence of preceptorship on nursing performance has been the focus of several studies that also have yielded diverse conclusions (Brasler, 1993; Huber, 1981; Jairath, Costello, Wallace, & Ruby, 1991; Marchette, 1985). Findings range from preceptorship resulting in no change in graduate nurse performance to significant improvement in diploma-prepared nursing student performance, while having no apparent effect on the performance of baccalaureate nursing students.

The focus of more current studies indicates that issues that are key features in a successful preceptorship experience include preceptor role modeling, one-to-one supervision, knowledge of the preceptoring process, and preceptor/preceptee compatibility (Byrd, Hood, & Youtsey, 1997; Coates & Gormley, 1997). The influence of preceptorship on the clinical competence of nursing students also has generated considerable interest, but no consensus has been reached. Some findings reveal no difference in the competence of preceptored students (Myrick, 1986; Olson, Gresley, & Heater, 1984), while others suggest the contrary (Laschinger & MacMaster, 1992; Ridley, Laschinger, & Goldenberg, 1995; Scheetz, 1989). Inconclusive evidence remains to support the idea that preceptorship does enhance, or make any difference in, the performance or clinical competence of nursing students or newly graduated nurses (Yonge, Krahn, Trojan, & Reid, 1997).

A variety of qualitative studies also have been conducted that examined areas such as:

- Preceptorship program evaluation (Allanach & Jennings, 1990; Hsieh & Knowles, 1990).
- Instructor facilitation of the preceptorship relationship (Hsieh & Knowles, 1990).
- Student preceptors' views of the experience (Peirce, 1991).
- The effect of preceptorship on moral reasoning (Andersen, 1991).
- The role of the preceptor in changing long-term psychiatric-mental health care (Armitage, Champney-Smith, & Andrews, 1991).
- Perceptions of nurse preceptors regarding the preceptor role (Stevenson, Doorley, Moddeman, & Benson-Landau, 1995; Yonge et al., 1997).
- Precepting an unsafe student (Rittman & Osburn, 1995).
- Analysis of common meanings and relational themes in the preceptorship experience (Nehls, Rather, & Guyette, 1997).
- The development of a framework designed to discuss expectations among preceptors, nursing unit managers, orientees, and clinical nurse educators (Balcain, Lendrum, Bowler, Doucette, & Maskell, 1997).

These qualitative studies provide further insights into preceptorship. The pursuit of such knowledge is significant for the nursing profession as a whole. Because of the pivotal role of preceptorship in clinical teaching, it is important that nurse researchers continue to be diligent in their scrutiny of preceptorship to determine whether, in fact, it is achieving what it is purported to achieve, which is the provision of safe, competent clinical practitioners who can think critically and, thus, use their judgment effectively in clinical decision making. This determination can be made primarily through the ongoing research that can serve to corroborate or refute the various findings. As a result of such a process, preceptorship will be theoretically strengthened and validated.

Critical Thinking

Currently, there is no clear consensus in the literature regarding the definition of critical thinking. In fact, the definitions of critical thinking are as diverse as the experts who define it. However, despite this lack of unanimity, educators regard critical thinking as an important educational requisite (Bandman & Bandman, 1995; Brookfield, 1987; Glen, 1995; Meyers, 1986; Paul, 1993). "Critical thinking as an educational ideal is based on the philosophy that critical thinking is essential to true autonomy in our complex society" (Jones & Brown, 1991, p. 529). Students must be taught how to think, not merely what to think. For the purpose of this study, the definition used was, "Critical thinking is a nonlinear, recursive process in which a person forms a judgment about what to believe or what to do in a given context" (Facione & Facione, 1996, p. 131).

Of the studies conducted on critical thinking in nursing, most have been quantitative. While various researchers have examined the effects of nursing education on students' ability to think critically (Brooks & Shepherd, 1992; Gross, Takazawa, & Rose, 1987; McCarthy, Schuster, Zehr, & McDougal, 1999; Pepa, Brown, & Alverson, 1997; Vaughan-Wrobel, O'Sullivan, & Smith, 1997; Wilson, 1996), studies also have been conducted to explore the relationship between critical thinking and the various measures of success in nursing education (Bauwens & Gerhard, 1987; Behrens, 1996; May, Edell, Butell, Doughty, & Langford, 1999; Sullivan, 1987; Tiessen, 1987).

Others have investigated the relationship between critical thinking and variables such as clinical decision making (Brooks & Shepherd, 1990; Shin, 1998), clinical competence (May et al., 1999), and moral reasoning and clinical or diagnostic reasoning (Ketefian, 1981; O'Neill, 1999; O'Neill & Dluhy, 1997). Researchers also have examined the critical thinking ability of nursing faculty (Hartley & Aukamp, 1994; Saarmann, Freitas, Rapps, & Riegel, 1992), while others have compared the critical thinking of novice and graduating nursing students (McCarthy et al., 1999). Recently, a study examined the dispositional differences among several university majors and across gender (Walsh & Hardy, 1999). As with the research into preceptorship, no real patterns can be gleaned from the studies conducted.

Qualitative research on critical thinking in nursing has addressed various questions salient to nursing, including:

- The role of critical thinking in the care of AIDS patients (Lewis & Eakes, 1992).
- Evaluation of a model designed to teach critical thinking skills (Callahan, 1992).
- Critical thinking of novice baccalaureate nursing students during the first clinical course (Sedlak, 1997).
- The prevailing practice of critical thinking in baccalaureate schools of nursing (Videbeck, 1997).
- The experiences of novice baccalaureate nursing students developing clinical reasoning and critical thinking (Haffer & Raingruber, 1998).

The responsibility of nurse educators is to ensure that nursing students develop the necessary critical thinking skills to cope with the accelerated changes occurring in the health care system. Research on the way nurses process information will provide a body of knowledge specific to the nursing profession and should focus on ensuring that nurses not only know what to think, but more important, know how to think (Allen, 1992).

In reviewing the current state of knowledge regarding preceptorship and critical thinking, it is evident that no research has been conducted to ascertain any link between these two variables. Because of its widespread use as an approach to clinical teaching in the practice setting and the fact that baccalaureate prepared nursing students are expected to be prepared as critical thinkers, preceptorship must be examined to determine if, in fact, it is fostering critical thinking and is not "a modern version of apprenticeship" (Andersen, 1991, p. 17).

ASSUMPTIONS UNDERLYING THIS STUDY

Because a primary goal of university education is the development and promotion of critical thinking, it naturally follows that the approaches used to teach within that educational system are designed to foster critical thinking. Because preceptorship is a primary teaching method in the practice setting in baccalaureate nursing education, it must be assumed that it plays a major role not only in fostering clinical competence but in developing and promoting critical thinking.

RESEARCH QUESTIONS

- In preceptorship, what is the process used to develop and promote the critical thinking ability of baccalaureate nursing students?
- How do preceptors perceive critical thinking and the process it entails?
- How do preceptees perceive critical thinking and the process it entails?

RESEARCH DESIGN

Given the lack of research in the area of preceptorship and critical thinking, a grounded theory approach was considered to be the most appropriate method for this study. This method is especially useful for acquiring a new perspective in a familiar situation or, as in this study, for identifying, describing, and illustrating relationships among previously unexplored variables (Stern, 1980; Wuest & Stern, 1990). This method was considered the most suitable because it allowed the researcher to explore the process used in the preceptorship experience to develop and promote critical thinking and to directly address what is happening in that process, rather than what should be happening.

Participants who were completing an elective course and the final clinical practicum of their program were recruited from the fourth year of a baccalaureate nursing program in a large university. The courses the students were taking were offered consecutively during a 14-week period, during which time students were assigned to preceptors in the practice setting. A total of six preceptors and six preceptees participated in the study. The preceptees were women who ranged in age from 24 to 29. Two preceptees previously had completed 2 years of university education in the faculty of science, while one previously had completed 1 year in that same faculty. The three remaining preceptees, who had each completed 1 year of university education, did not specify in which discipline. The preceptors were women who ranged in age from 29 to 54. All were diploma prepared. Two had completed a post-RN baccalaureate degree in nursing. Experience as a preceptor ranged from 1 to 10 years. The nursing experience

of the preceptors ranged from 7 to 30 years. Participants were required to meet three criteria:

- Speak and understand English.
- Either be or have been involved in a structured clinical preceptorship.
- Sign a consent form agreeing to participate in the study.

The study was conducted in a large tertiary care setting/teaching hospital composed of the units to which the students were designated for the duration of the preceptorship experience. In accordance with their individual clinical preference, students were assigned to a preceptor in the following areas:

- Emergency.
- Child health center.
- Neurosurgery.
- Cardiothoracic surgery.
- General surgery and liver transplant unit.

PROCEDURES AND DATA COLLECTION

The researcher collected data during audiotape recorded interviews with the participants, which subsequently were transcribed by the researcher. Demographic data were obtained from all participants prior to these interviews. A total of 12 participants were interviewed, six preceptors and six preceptees. Six preceptees and three preceptors were interviewed three times each, two preceptors were interviewed two times each, and one preceptor was interviewed one time. Overall, 32 interviews were completed. During the interactions, an interview guide was used and contained open-ended questions, which included:

- "Tell me about your role as preceptor/preceptee."
- "How would you [preceptor] describe the process that you go through when guiding the preceptee to think about their patient assignments?"
- "How would you [preceptee] describe the process that your preceptor goes through when guiding you to think about your patient assignments?"
- "What do you [preceptor/preceptee] think is meant by the term critical thinking?"

These questions were a beginning guide only and were revised as data emerged. Interviews, each lasting 15 to 90 minutes, were conducted with the participants at a time and place convenient for them. Verification of information was obtained during these times. Secondary data sources included direct observations in the practice setting, together with access to daily journals chronicled by individual preceptees. Nurses' notes recorded by the preceptees also were read.

At a mutually convenient time, the researcher visited the practice setting to observe both the preceptor and the preceptee interact, while they planned and implemented their nursing care. The researcher adopted the role of participant-observer by being present in the practice setting but not participating or interacting with other people to any great extent (Spradley, 1979).

As with the interview, an observation guide was used that served to permit the researcher to clarify information. Sample questions included:

- "How do the preceptor and preceptee interact as they plan, implement, and evaluate care?"
- "What kind of discussion is occurring (i.e., analysis, synthesis)?"
- "How is the preceptee being challenged in his or her thinking?"

This guide was a beginning point only and, like the interview guide, was revised as data emerged.

Observations were conducted until sufficient data were processed, which, in conjunction with the interviews, ensured saturation of the data. On average, the observations lasted approximately 4 hours. Data collection also was augmented by the recording of field notes. In addition, a journal reflecting the personal component of the field work was chronicled by the researcher. For the sake of accuracy, data were confirmed by participants to determine whether the researcher's findings adequately reflected their perspectives.

DATA ANALYSIS

After the data were collected, analysis began almost immediately. The first level of analysis, referred to as open coding, was begun. Each piece of the data or phrase was scrutinized carefully and compared with other data. According to Glaser (1978), this immediate analysis is crucial because it helps the researcher take the study in the direction prescribed by the data. This process of open coding resulted in the generation of approximately 80 substantive codes or categories and their characteristics from indicators such as actual events, definitions, and meanings derived directly from the research data (Mullen, 1975). Because these indicators were multidimensional, each was coded into as many categories as possible. Substantive codes or categories are classified in two ways:

- Those derived directly from the participants' own words or language, referred to as in vivo words. Examples in this study were "approachable," "independent," and "know how."
- Those implied codes created by the researcher, such as "learning" or "expertise," or codes derived directly from the data (e.g., "facilitate," "role model," "prioritize").

The second level of analysis involved theoretical coding, a process in which ordering data and the interface among substantive codes occurred. It was through this phase of analysis that the dimensions of the categories were established. Examples of theoretical codes include causes, context, conditions, contingencies, consequences, and covariances (Glaser, 1978). It was at this stage that the emergent codes were found to be properties, dimensions, conditions, and contexts of a few higher level concepts, such as "purposive" and "incidental," and not discrete codes as originally thought. The theory was beginning to take form.

The next level of analysis, referred to as selective coding, was an integral part of the discovery process because it was this phase that generated the core variable. Coding then was restricted to only those categories directly related to the core variable, which in turn became the guide for further collection and theoretical sampling. Thus, the research became guided by the core variable (Glaser, 1978). Memos became more focused, while at the same time reflected gaps for theoretical sampling. A sample memo would involve the researcher questioning the relationship of one code or category with another or whether one code or category was a property of another. As a result of this process, the categories of "role models," "facilitates," and "prioritizes," which at first were considered separately, were found to be subcategories or properties of the higher-order category of "incidental."

It was through this process of reduction and comparison that the core variable "enabling" emerged. It became clear that "enabling" accounted for the process used to develop and promote the critical thinking ability of baccalaureate nursing students in this preceptorship experience. Writing memos also served to develop the properties of each of the categories and subsequently defined them operationally. Questions about relationships among the categories, their properties, or both were delineated and then were integrated with clusters of other categories, which in turn, helped generate the theory (Glaser, 1978; Glaser & Strauss, 1985). Some of the questions derived in this regard included:

- "What overriding issues exist in the preceptorship experience that conspire to develop and promote the critical thinking ability of preceptees in the practice setting?"
- "Are there specific preceptor attributes that affect the development and promotion of the preceptees' ability to think critically?"
- "Are there any issues extraneous to preceptorship in the practice setting that affect the development and promotion of critical thinking?"

Thus, the theory of enabling in the preceptorship experience emerged.

MECHANISMS TO ENSURE FOR RIGOR

There are four criteria against which rigor in qualitative research is measured (Guba & Lincoln, 1989), including:

- Credibility.
- Fittingness.
- Auditability.
- Confirmability.

Throughout this study, specific mechanisms were instituted to ensure that these criteria were achieved, thus enhancing the rigor of this investigation.

ETHICAL CONSIDERATIONS

Prior to undertaking this study, permission was obtained from the dean of the Faculty of Nursing and ethical approval was acquired from the appropriate Ethics Review Committees. Each participant was provided with a verbal explanation of the interview process and the purpose of the study. Participants were requested to sign a written consent form before being interviewed and audiotaped, apprised of their right to refuse to answer any questions without fear of reprisal, and advised that they were free to withdraw from the study at any time. To ensure confidentiality, the names of the participants were removed from the audiotape recordings and transcriptions, and notes were retained in a locked cabinet. Following completion of the study, the code sheet containing participants' demographic information was destroyed. The audiotape recordings were retained for later use, subject to appropriate ethical review. Specific references to or descriptions of participants were excluded from the final report of the study and accordingly will be excluded from any subsequent publications or presentations.

FINDINGS AND DISCUSSION: THE ENABLING PROCESS

The researcher was motivated to conduct this study by a twofold concern:

- Because preceptorship may be limited to promoting the socialization of nursing students to the idiosyncrasies of their assigned units and staff, it may not be providing an appropriate forum for the development and promotion of critical thinking.
- Preceptorship may be a current version of apprenticeship, the modus operandi of which is the development and promotion of psychomotor skills frequently to the exclusion of critical thinking.

In this study, it was discovered that a multifaceted process occurred in preceptorship to develop and promote critical thinking. The researcher labeled that process "enabling," a conceptual depiction of which is reflected in Figure 1.

The enabling process was found to be an interpersonal or interactive dynamic in which preceptees are directly or indirectly afforded opportunities to develop their ability to think critically. This dynamic may be fraught with many complexities, not the least of which is the fact that preceptorship often occurs between two complete strangers. As one preceptee stated at the beginning of her preceptorship experience:

> You don't know what's expected of you really. You have no clue what's going on. You're blind, and it's a stressful experience and to not know the person is stressful...I didn't know her, and she didn't know how to take me, and you spend so much time walking around on eggshells.

The preceptor's perspective was equally insightful:

> I wasn't sure what the student could and could not do.... It takes a couple of weeks to assess the student individually, where they're at, their skill level, their knowledge level, their strengths, and where they need improvement.

Two key variables emerged as integral to the enabling process, including:

- The climate.
- Bringing about.

The Climate

The climate reflected the context or the environment in which the preceptorship experience occurred. Many issues affected this climate, but two variables, the preceptor and the staff, emerged as having a major influence. The preceptors played a pivotal role in influencing the nature of the practice setting and the degree to which the preceptees were supported in their learning experience and, thus, were enabled to think critically. As one preceptee reflected, "I think it makes it even easier 'cause [*sic*] all the staff like her [preceptor], so I mean they like her and I'm kind of an extension of her."

Much has been documented regarding the importance of the environment or climate as it affects learners (Brookfield, 1986, 1987; Flynn, 1997; Friere, 1997; Knowles, 1988; Mesirow, 1990). Most experts would concur that the climate most effective in enhancing learning or critical thinking is one that reflects support; is devoid of threat; fosters openness, inquiry, and trust; and avoids competitive performance judgments (Manley, 1997).

In this study, the preceptors were instrumental in setting the tone for the learning climate through their supportive attitudes, their valuing of the preceptees, and their ability to work with them, as opposed to directing them, throughout the experience. In the words of a preceptee, "we sit together and we talk about who I am going to nurse and who she's going to nurse and we go through what needs to be done." One preceptor related, "we have found often on night shifts it's a good time to sit down and look at her [preceptee] objectives and what she is accomplishing and what she still hopes to accomplish." Another preceptor provided the following insight:

> I think they [preceptees] do worse if they feel intimidated and they're not allowed to make mistakes. If they're really uptight with you...they're not going to learn. All they're worried about is making mistakes and they're just going to learn how to survive.

Preceptors who were effective in encouraging their students to think critically were those who were open and approachable, and who responded to the preceptees. One preceptor stated, "my approach the first day is to make them [preceptees] feel comfortable so that they are not afraid, that I will accept them and they won't be afraid to ask me questions." A preceptee indicated, "I've never felt I've had a stupid question with her [preceptor]."

"There is an uneasy tightrope to be walked in developing critical thinking in others" (Brookfield, 1987, p. 73). For the preceptors in this study, it was a balancing act among fostering an egalitarian approach, valuing preceptees as individuals, and providing a safe and supportive environment in which they were sufficiently challenged.

Whether the staff in the practice setting accept preceptees as part of the team was found to be of major significance to the climate of the preceptees' experience and ultimately to their ability to think critically. Although the preceptor was the primary influence, others in the setting also were found to affect the learning climate. One factor

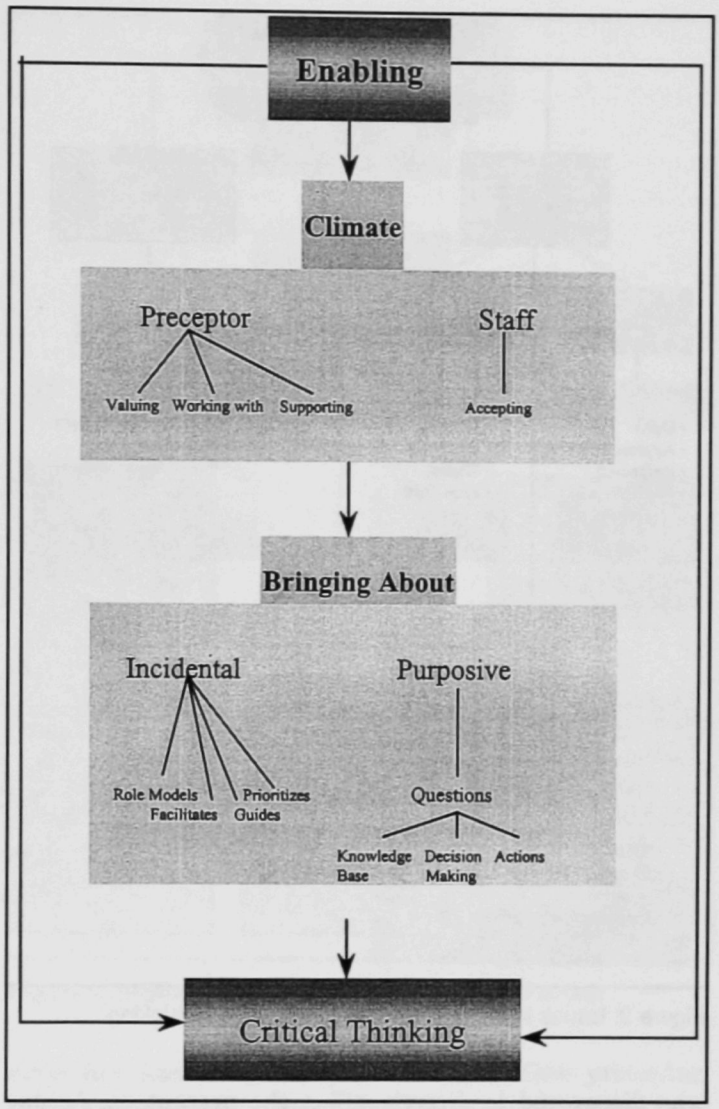

Figure 1. Preceptorship and critical thinking: The enabling process.

deemed essential for the ultimate success of students in meeting their learning goals and objectives in the practice setting was staff attitude. One preceptee recounted:

> It's so different from past clinical experiences. I feel more like staff than a student coming on, and I don't feel like a burden...it's like the way everyone approaches me.... They treat me as an equal.

Another preceptee stated:

> In the past I've had one nurse one day and another nurse another day, and a lot of them weren't interested. They didn't teach me anything. They liked the fact that I helped them make beds or I helped them to do this, but they weren't interested in me.... I was basically on my own.

A climate that is most effective in enhancing learning is one with available learning resources (Manley, 1997). A large proportion of those resources include the staff with whom the preceptees must work, staff who also possess expertise that may contribute to the preceptorship experience. A major influence in that experience is how the staff and the preceptor interact with one another. In this study, the preceptors' relationship with their colleagues

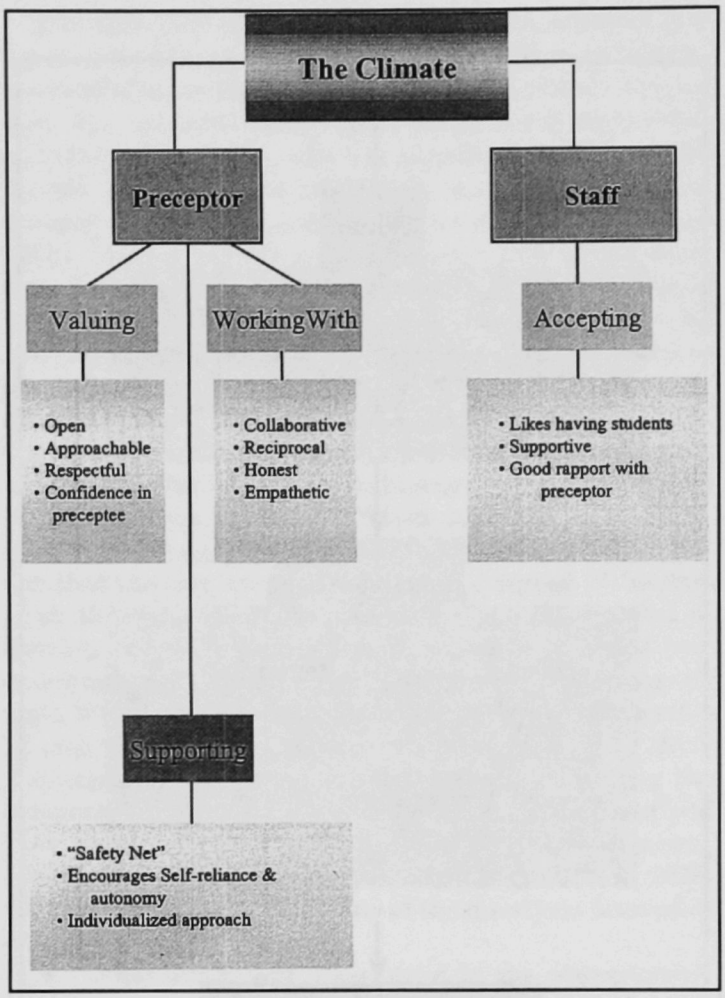

Figure 2. Issues in the climate that enable critical thinking.

was discovered to directly affect the preceptees. As one preceptee recalled, "she's [preceptor] liked by the staff, and they know she's competent...I guess 'cause [*sic*] the staff respect her it actually amazingly rubs off on me," or as another stated, "because she's [preceptor] treated me like a colleague, it seems like the people she's friends with treat me like a colleague too." The effect of the climate, with its components of preceptor and staff, on the ability of preceptees to think critically in the practice setting was fundamental to the enabling process. In the words of one of the preceptees, "without it the rest doesn't happen." Figure 2 depicts the climate and its properties.

Bringing About

The second major variable that emerged as part of the enabling process was labeled bringing about. This component reflected the facet of the process in which preceptors encouraged their preceptees to pose questions, examine problems, and consider alternate ways of thinking about patient situations. This process was found to occur incidentally, purposively, or both.

Incidental describes the indirect enabling of critical thinking. For example, it was through the preceptor's behaviors of role modeling, facilitating, guiding, and prioritizing that the preceptees were stimulated to think critically, although the preceptors may not have intentionally set out to do so. In other words, the preceptees were indirectly stimulated to think critically. As articulated by one preceptee, "when I do get a chance to watch her I pick up on things, my thinking would be triggered." Another preceptee stated, "I think I've got some knowledge myself just from watching what she does." By modeling critical thinking, preceptors "can do much to encourage this frame of mind in their students" (Meyers, 1986, p. 47). The preceptors who also facilitated preceptees' learning ultimately enabled them to think critically when confronted with different clinical situations. Ostensibly, the preceptorship experience placed preceptees in a very vulnerable position. Their "learning occurs as a public event, in front of others" (Reilly & Oermann, 1992, p. 148). It is within this context that preceptors facilitated the preceptees to discover what they needed to know and achieve in their practice. One preceptee recounted, "she [preceptor] cues me on things that I don't know or she'll give me little points, and if I can't answer, she'll wait for me to put it together." Another stated, "she [preceptor] just really lets me go at my own pace, and that's really helped my critical thinking." One preceptee described it this way, "sometimes my methods are a little bit different than hers, and she never says you shouldn't do that 'cause [*sic*] my way is better. Like we talk about different ways of doing things." One preceptor said, "they've [preceptees] a ton of information that comes in, and it's like teaching them to put it in a funnel and let the stuff come through a little bit at a time so they can deal with it. I try to diffuse situations so that they're not totally overwhelmed."

A major strength in the preceptorship experience is the individual guidance preceptees receive in formulating and revising their learning objectives and goals (O'Mara, 1997). In this study, this one-to-one relationship was discovered to contribute to not only the development of the preceptees' self-confidence and competence in performing clinical skills but also the promotion of their ability to think critically. One preceptee summarized the relationship as follows, "I guess you'd call her [preceptor] a safety net almost because if you need help or you need a question answered you have someone right there." As one preceptor stated, "they [preceptees] do grow and they do need that resource [preceptors]. They just couldn't survive."

Interestingly, one of the most common concerns initially confronted by the preceptors in this study was their preceptees' inability to organize and complete their work in a timely manner. As one preceptor commented, "it's not with the skills that she [preceptee] needs help. It's more with the organizing of everything so that she gets things done on time and doesn't forget the medications or the charting." In particular, at the beginning of their experience, preceptees must learn to decide which activities require action and which do not. One preceptee explained, "my preceptor helps me prioritize things. She says you have to think about what you're doing first," or as a preceptor stated, "I try to give a good example to get her to think about things that have to be done first and things

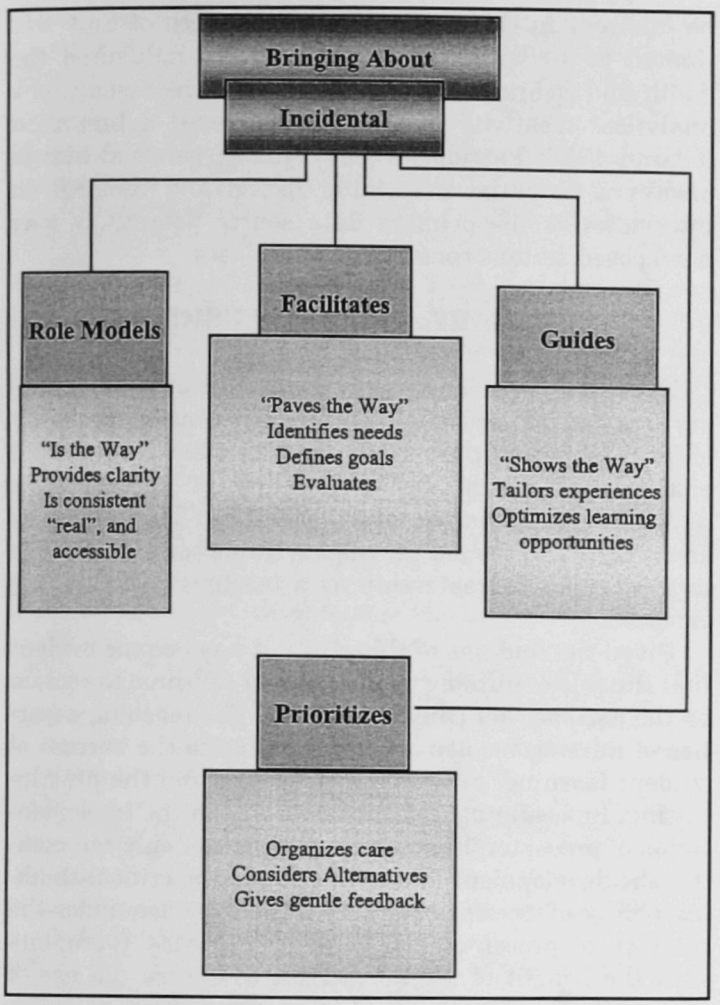

Figure 3. Incidental preceptor enabling of critical thinking.

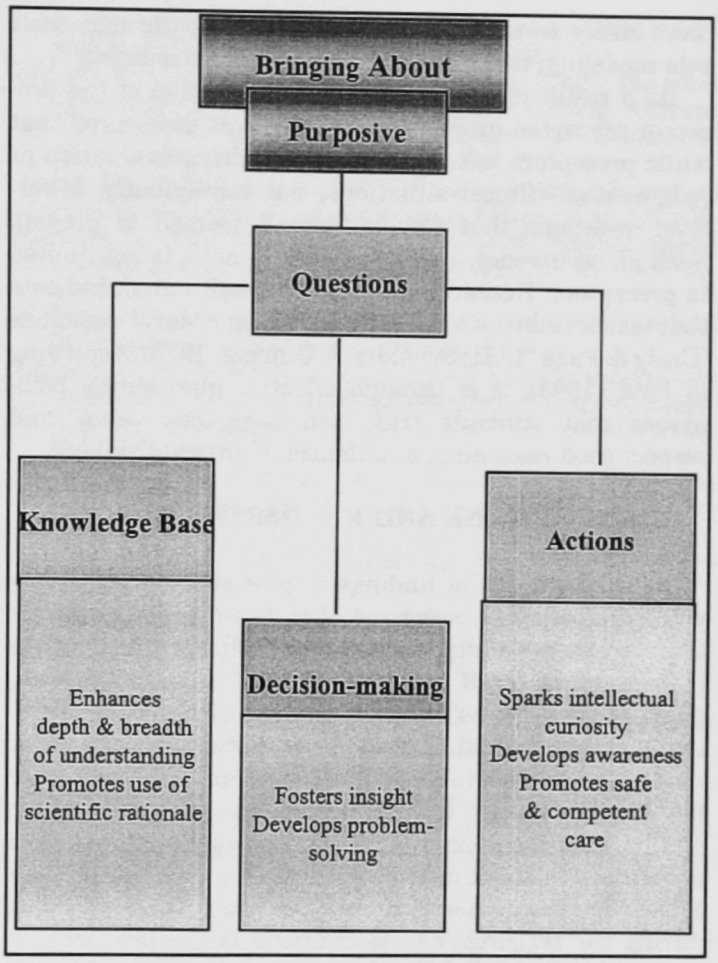

Figure 4. Purposive preceptor enabling of critical thinking.

that can wait." See Figure 3 for a conceptual illustration of incidental bringing about.

Unlike incidental bringing about, the second component, labeled purposive, was discovered to be a deliberate or intentional process in which the preceptors encouraged preceptees to think critically through the direct questioning of the preceptees' knowledge base, decision making, and actions. The preceptors used questions to direct, stimulate, and challenge the preceptees' thinking process; provoke their interest; set the tone for learning; promote discussion; and evaluate their learning (House, Chassie, & Spohn, 1990). One preceptor described how she questioned her preceptee regarding a particular patient situation:

> If we have a cardiac patient, okay, what are the three main arteries, what is the problem, what can you anticipate? I want you to come back and tell me what medications will work for this or not. If we have a trauma, okay, what are your ABCs? Tell me about the airway, the lungs, what do you see? So she tells me, and I see how far her knowledge has come and then I try and expand on it or we research it together.

Another preceptor reflected, "I go through the Kardex [nursing care plan] with her, and we talk about the diagnosis, and I ask her what that entails and try to determine her knowledge of the situation." One preceptor, referring to a particular patient situation, described how she questioned the preceptee:

> Okay, when is it [patient's condition] acutely urgent? And she [preceptee] stopped and thought. Okay, now you're assuming you see a man arriving with back pain and you see that he's got renal colic. Well, we walked through the process, for example when it's urgent it could be an aneurysm. You can't assume. Stop and think about it. Don't assume that this patient has renal colic. He's grey, he's sweaty, and he's got a low blood pressure. Change your opinion. Now tell me what we could be working with here?

See Figure 4 for a conceptual depiction of purposive bringing about.

An interesting discovery was made in this study. As the process evolved, it was found that incidental bringing about was much more prevalent than purposive bringing about. Preceptors were more likely to enable critical thinking indirectly through their role modeling, facilitating, guiding, and prioritizing than they were to directly enable preceptees' critical thinking through questioning. Observations of preceptor and preceptee interaction in the practice setting corroborated this finding. It became apparent that while preceptors did question the preceptees about their patient situations, they were much

more likely to stimulate critical thinking through their role modeling, facilitating, guiding, and prioritizing.

As a result of the researcher's observation of the preceptor-preceptee interactions, it also was discovered that while preceptors asked questions requiring evaluation or judgment of clinical situations, not infrequently, lower-level questions that required recall seemed to prevail. Such an occurrence, it is important to note, is not limited to preceptors. Research studies, although dated, indicate that teachers do not ask powerful or higher-level questions (Craig & Page, 1981; Scholdra & Quiring, 1973). According to Paul (1993), it is through effective questioning techniques that students truly can recognize, value, and respect good reasoning, a hallmark of critical thinking.

IMPLICATIONS AND RECOMMENDATIONS

As a result of the findings of this study, several key points have been recognized that have implications for the preceptorship experience. First, although extrinsic to preceptorship, staff acceptance was found to directly affect the preceptees' ability to think critically in the practice setting. Second, preceptor behaviors, such as role modeling, facilitating, guiding, and prioritizing, were found to indirectly trigger preceptees' critical thinking ability. To a lesser extent, the preceptors directly sparked preceptees to think critically when they questioned their knowledge base, decision making, and actions. Third, during the researcher's observations in the practice setting, it appeared that the preceptors were inclined to ask lower-level questions. However, this finding may have been caused by the time constraints imposed by the study, and higher-level questioning may have been more prominent during those periods when the researcher was not observing.

Given the discoveries generated by this study, a variety of recommendations are appropriate. First, owing to the effect of staff acceptance on the preceptorship experience and ultimately the enabling of critical thinking, faculty should conduct routine assessments of the individual units to which students are assigned and continuously monitor the experience. This would, in turn, afford faculty a firsthand impression of staff-student interactions. Second, faculty need to actively seek ways to work with individual preceptors to improve questioning techniques for the enhancement of preceptees' critical thinking. Third, faculty should precept the preceptor. Such an endeavor would provide faculty with the opportunity to work directly with the preceptor as a resource concerning the teaching-learning process. Finally, it is recommended that further research be conducted to examine preceptorship not only in baccalaureate nursing education but also within the context of graduate nursing education.

LIMITATIONS

Despite the fact that there were mechanisms in place to ensure the rigor of the study, several limitations may be inherent in this study. First, the length of time was limited to 14 weeks, which could have influenced the depth and richness of the data. Second, the researcher's analytical creativity also may have posed a limitation (Glaser, 1978; Patridge, 1983). Finally, personal bias is always a potential overriding factor, and reliance on interviews as the primary data source potentially may have posed serious constraints and biases.

SUMMARY AND CONCLUSIONS

This study has generated a plausible substantive theory that can be used to understand the contextual reality of the preceptorship experience and how that relationship enables the critical thinking ability of baccalaureate nursing students in the practice setting. The process of enabling that emerged provides a framework with which to strengthen preceptorship as a teaching and learning experience.

Given the findings of this study, it has become evident that the role of nursing faculty cannot continue to remain on the periphery of clinical teaching. The teaching expertise of nursing faculty is indispensable to the success of student learning, in both the classroom and the practice setting. In assuming a more active role in the implementation of preceptorship, nursing faculty not only can monitor the development and promotion of the critical thinking ability of nursing students while they are under the tutelage of preceptors but also can provide preceptors with the benefit of their expertise to ensure the use of strategies that directly enable critical thinking.

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Joyce L. Nelson
Debra K. Apenhorst
Lisa C. Carter
Eunice K. Mahlum
Janel V. Schneider

Coaching for Competence

The preceptors and leadership team on a busy acute care general medical unit collaborated on a temporary plan to provide clinical support for 38 nurses who had been hired during the year. A pilot role was created and designated "unit coach." Each coach questioned and prompted reflective practice in building confidence and critical thinking.

Joyce L. Nelson, MS, APRN, BC, is a Nursing Education Specialist, Mayo Clinic, Rochester, MN.

Debra K. Apenhorst, BSN, RN,C, is a Staff Nurse, Preceptor, and Unit Coach, Mayo Clinic, Rochester, MN.

Lisa C. Carter, MA, BSN, RN, is a Nurse Manager, Mayo Clinic, Rochester, MN.

Eunice K. Mahlum, RN, is a Staff Nurse, Preceptor, and Unit Coach, Mayo Clinic, Rochester, MN.

Janel V. Schneider, BSN, RN, is a Staff Nurse, Preceptor, and Unit Coach, Mayo Clinic, Rochester, MN.

Note: A poster of this project was originally presented at the 10th Annual Academy of Medical-Surgical Nurses Convention, Kansas City, MO.

Nursing is a complex endeavor which manifests itself in acts of utility and comfort. Those acts are based both on science and on art. Practice must occur within a complex health care delivery system with multiple demands and constraints. Best practice interventions must be translated into personalized care for each patient. Nursing academic preparation frames the values, theories, and concepts of the practice. Training by the employer relates these concepts to practice within a health care system. What remains after education and training is *praxis*, the wedding of theory or values with action in practice. According to Lutz, Jones, and Kendall (1997), praxis could be considered "the synchronous joining of thinking and doing"(p. 24).

Praxis is only possible if the practitioner steps outside of personal and professional assumptions and reviews actions in the clinical world for effect and outcome. This is no small challenge for new nurses who are often overwhelmed by multiple demands and conflicting priorities. The fast pace of acute care may not provide opportunity or support for the reflective practice that develops awareness and meaning. Flaherty (1999) asserts that reflective practice with a trusted coach is the only way to change work behavior and to facilitate development of self-directed, self-correcting, and innovative strategies in dealing with challenges. In relating this to nursing, Grealish (2000) advocates cognitive coaching as a deliberate strategy employed by expert nurses to move newer nurses into a "healthy skepticism" (p. 233) toward their own practice.

The Coaching Concept Model Overview

How can the coaching concept be put into action on a nursing unit? A model was developed to select, educate, and empower coaches. The model, developed collaboratively by the nursing leadership (nurse manager, clinical nurse specialist, and nursing education specialist) and unit preceptors in response to preceptor diagnosis and request, envisioned using coaches as supportive colleagues who would have the time and motivation to ask the questions that consistently prompt reflection and thinking in newer staff. Coaches were to be witnesses to actual practice but never were disciplinarians with retributive responses. Coaches were to help newer nurses, who had finished orientation yet remained somewhat tentative in practice, to identify areas for improvement. They would provide the specific feedback to clarify issues, reveal alternatives, weigh options, and evaluate outcomes. The coaches' major responsibility was the affirmation and growth of the new nurses.

Success was the desired outcome. Like the professional sports model, the unit coaches recognized potential and targeted the growth of individuals through careful attention to actual performance. The intent was to prompt reflection upon changes in the nurse's performance that would bring action closer to professional values.

Model Implementation

This coaching model was used to develop the staff on a 37-bed general medical unit that is part of a 2,000-bed hospital system known for its strong

professional department of nursing and supportive environment. The medical specialty leadership team of a nurse manager, clinical nurse specialist, and nursing education specialist met with a group of experienced preceptors. The group's charge was to help the unit orient a number of new nurses hired to provide care for patients of increasing acuity who were being admitted to the unit. Orientees arrived every 2 weeks during the summer, and preceptors were actively involved with new staff during almost every shift. They were handling this challenge with competence and good will, but the volume of new staff necessitated a shortened time for that supportive relationship to continue. The orientation model provided gradual transition into the management of patients by assigning a preceptor and orientee together to first one, then two, then more patients until the orientee could handle a full patient assignment independently. The preceptor was there every shift during the first 6 to 8 weeks, planning learning activities, modeling nursing care, observing technique, explaining concepts, asking questions, and providing feedback. The next 4 weeks involved oversight by what was called a *resource*, a nurse with a full assignment who accepted the charge to be available for advice to the newer nurse. The coaching model was introduced to try to extend this support beyond the first 10 to 12 weeks and thus extend the learning environment. As the orientee's need for support diminished in intensity, the coach could do what a preceptor does for several newer nurses at once, provided that coaching was the assigned role, not patient care. This was supportive, yet efficient and cost effective.

Preparation of Unit Coaches

Unit preceptors were invited to apply to become coaches. These nurses had proven histories of nurturing young staff in the orientation process. They had a firm commitment to finding the special talents of every novice and encouraging the growth of each nurse. As preceptors, they demonstrated sound clinical expertise, but more importantly, they were also trusted advocates of novice development. They knew that all of the essential territory mapped out for orientation had been covered in the 6 weeks of double-assigned support from a preceptor. Central orientation classes and specialty education laid the groundwork upon which the unit preceptors built the core of the program. Every skill had been itemized and each orientee assessed for need for instruction, practice, or demonstrated competency. These experienced preceptors recognized that prioritizing, pacing, and reorganizing the workload were areas for improvement.

The preceptors wanted to build critical thinking skills and judgment in the newer staff to allow them to become confident and competent more quickly, an important goal when a large proportion of the staff were novices. They wanted to apply the skills of questioning, mental rehearsal (Grealish, 2000), feedback, and reflection to promote professional growth. A preceptor council oversaw the medical specialty orientation in the authors' hospital. That group of representative preceptors from 10 nursing units had been developing activities to share in the units to build critical-thinking skills. However, the council wanted a way to encourage newer nurses to employ these skills in the course of actual clinical practice. The coaching model was a way to model and invite critical thinking.

The position of unit coach was advertised and offered to preceptors. A selection was made from those who applied and met the qualifications of sound teaching and clinical skills. The leadership team worked with three selected coaches in a coaching clinic to define the role, focus efforts, and develop necessary parameters. Observations about novice practice were made by the preceptors based on their experiences with newer staff. The preceptors were well acquainted with the challenges of time management, prioritizing, and decision making that sometimes overwhelm the newer nurses. A list of preferred activities for coaches was created (see Table 1).

The coaches proposed the following areas for focused intervention: accurate medication administration, precise and timely documentation, thorough patient assessments, discharge planning coordination, delegation of tasks, redistribution of workload in times of overload, and management of psychosocial needs of patients and families. Defining what a coach should *not* do also helped to redirect staff interpretation of the role. Using these suggested points of intervention, the coaches defined their boundaries. Coaches did not engage in housekeeping tasks, patient transfers, or actual nursing interventions. The coach's role was to prompt thinking and action, not to "do for."

Each coach needed to develop a style built upon a proliferation of questions. Each coach was as good as her questions. Could the coach trigger thoughtful reflection in a newer nurse who was in a hurry to prove efficiency in practice? This deliberate processing and weighing of options were invited and modeled. Coaches generated lists of questions to ask in the "coaching clinic," a 4-hour training session held before initiation of this project. Coaches used questioning instead of telling whenever they could, thus promoting the critical thinking and reflective practice elements (see Table 2).

Launching the Program

The coaches wanted to broadcast the new role in a memorable way. They made posters, advertising the kick-off with a sports theme. They brought hot dogs for a potluck lunch and distributed printed explanations of the role, with a focus on the benefit to the whole team.

A whistle was worn by the coaches, not to be actually blown, but to symbolize the role of on-the-spot provider of assistance and feedback. The first day demanded some effort to divert the coach from hands-on care, but people soon learned to value them in their new role. It was tempting to empty laundry bags, but this was not the most needed investment of time in this practice environment. The goal was to move the staff to thinking of the coaches not as an extra pair of

Table 1.
Activites of the Unit Coach

- ❑ Listen to report (taped or oral).
- ❑ Ask each nurse on the unit to briefly summarize what she/he has before her/him on this day, and to articulate priorities and possible problems.
- ❑ Identify yourself as a coach, a supportive resource.
- ❑ Scan medication Kardexes, paying attention to pain medications, medications used in patients undergoing dialysis, and antibiotics; make notes of good times to be available in the medication room for advice.
- ❑ Enter rooms when a nurse is doing assessments, seeking to validate and discuss relevant data. Don't do this for every patient, but try to *choose one patient per new nurse. Ask the nurse which patient* sounds most complex.
- ❑ If there is something seen less frequently, such as a tracheostomy, parenteral nutrition, patient-controlled analgesia, an insulin drip, or a PEG, ask if there are any procedures about which the nurse feels unsure and offer to work together on a procedure or set-up.
- ❑ Encourage the nurse to be present at physician rounds and assess how much information is given by the nurse to the doctors. Reflect on ways to improve communication.
- ❑ Review charting for assessment of response to pain medication, exercise, and treatments.
- ❑ Check for followup on issues such as hypoglycemia, fever, complaints of pain, and anxiety. Check documented interventions.
- ❑ Listen to exchanges with distressed families and reflect on the outcome of the interaction. Elicit suggestions for improvement.
- ❑ Whenever advice is sought, ask questions first to evaluate the nurse's thought process. Work to get the nurse engaged in an internal dialogue: "I'm doing this because...," or "This is one way to do it, but I could also try...," or "I'm seeing this response which could mean...or it could mean...I'll reassess at frequent intervals."
- ❑ Listen to phone calls to physicians to see if information is complete, respectful, inclusive of nursing interventions, appropriately timed.
- ❑ Look through labs and discuss implications of results.
- ❑ Discuss how co-morbidities are presenting a challenge to care.
- ❑ Assess for followup teaching for patients on warfarin (Coumadin®), insulin, Medic Alert.
- ❑ Discuss how and when to question orders.
- ❑ Evaluate report to charge nurse as authentic reflection of workload.
- ❑ Offer ideas or model behaviors for reducing anxiety, increasing comfort, and increasing confidence in care.
- ❑ Check for expiration of physician orders and plan timing request for renewal.
- ❑ Ask nurses about discharge plans.
- ❑ *If prioritizing, delegating, or organizing is a problem, work with the* nurse before the shift to set goals, check progress at intervals, and discuss ideas that have worked for you. Work on a better informal note system to guide care if this is a problem.
- ❑ Check charts and discuss charting that does not capture the shift's activities.
- ❑ Review the twice-daily patient assessments and see if changes are addressed in the plan of care.
- ❑ Watch how RNs supervise PCAs, LPNs, and students.
- ❑ Be alert to cultural issues and demonstration of respect for diversity.

hands, but as a generator of thinking, a processor of procedure, and a reflection of practice.

Evolution Over Time

The first weeks of the program bore witness to the need for newer nurses to receive point-of-care guidance. They asked questions such as, "Can you tell me...," "Can you show me...," How do you do...," and "Can you watch me?" They also wanted help in prioritizing. The newer staff, while dedicated and *bright, sometimes didn't know* what they didn't know. The coaches helped by asking them to think about principles and predictions. They also had questions about responsibilities in the discharge process. For example, arrangements for home oxygen were completed with coaching support. Issues relating to medications included determining if a drug could be given in a general care area without monitoring. Appropriate patient teaching resources were suggested and selected from the large on-line database. Specific teaching strategies for the patient being discharged with a prescription for low molecular weight heparin were discussed and employed.

After a few days, charge nurses began to ask the coach for advice on prioritizing and using resources. Classifying patients for acuity to determine staffing needs also took place. Workplace competency issues were addressed such as supervising others, delegating to cover crises, and working with students. Nurses also asked about the finer points of documentation and charting. This improved communication resulted in more accurate assessment and more coordinated care planning.

After 3 weeks, the questions became more sophisticated, relating to use of resources and selection of appropriate diagnoses. Questions might include points such as, "Who can I consult to clarify...?" There were considerations about patient management for conscious sedation and IV push medications. Developing finesse for calming anxious patients also came under review. Handling the death of a patient was done with more grace

Table 2.
Questions to Help with Reflective Practice

1. Why are you doing it this way? What is the rationale?
2. What are your main concerns with this situation?
3. How do you know this?
4. How can you test the appropriateness of your interventions?
5. In your opinion, why is the system set up this way?
6. What could go wrong here?
7. What makes you think so?
8. What evidence supports your conclusion?
9. What do you think you should do next?
10. What is confusing to you?
11. How long can you wait to intervene?
12. How will you know when the situation requires additional resources?
13. Are you making any assumptions that could be false?
14. How can I help you make some connections?
15. What will tell you your interventions worked?
16. What task can wait until later?
17. Who can assist you?
18. How can you learn from this experience?
19. What would you like to see happen?
20. How can nursing care make a difference here?

upon the prompting of the experienced coach.

Evaluation

Staff members were positive about the impact of the coaches as reflected in a survey taken after implementation. They felt newer orientees were thinking through practice more carefully and checking their own practice. Newer staff identified that anxiety over new situations was lessened and that they were planning more efficiently. The time spent with the coaches clarified areas of practice that were not clear earlier. Charge nurses were occasionally tempted to use the coaches in a different way when staffing became tight. The coaches resisted for the most part, but they knew when to be flexible. The program was extended due to the staff survey that indicated early approval. When a new clinical nurse specialist (CNS) was hired, the coaches changed to evening shifts as the CNS could largely do the same role during the day. When confidence levels improved and the targeted areas showed improvement, the coaches returned to their regular assignments.

When the summer included the welcoming of 19 new staff, in addition to the 10 added from January to May, the demand, "Bring back the coaches," was heard. It was decided not to employ the coaches because of budget constraints, but to apply the principles of coaching instead. The coaches had established the culture and helped colleagues relate in a new way. The leadership and coaches then began training preceptors to use the coaching techniques every day on the job with all colleagues. Training sessions focused on situational leadership principles, illustrating the need for support and direction in a challenging environment. These ideas were tied to Patricia Benner's levels of skill development and the Seven Domains of Nursing. A preceptor handbook was devised that articulated elements of each domain, explained departmental structural support for ideal nursing practice in that domain, and recorded an exemplar of nursing care that resulted in good patient outcomes (Benner, 1984). All preceptors were encouraged to promote a culture of reflective practice. They examined and practiced a coaching model that would make the application of questioning and reflection easier so nurses could help each other to practice improvement. The ongoing preceptor council, monthly unit meetings, a special 4-hour workshop, and preceptor newsletter served to propagate the elements of the program.

This program may not be appropriate for all times and places. It was invaluable during a time of rapid turnover and acculturation of many new nurses at once. The coaches were able to give novices and advanced beginners encouragement to develop sound thinking skills and to develop a work pace that suited the situation. Giving support lessened anxiety, improved confidence, and minimized errors. Wright (2002) reports that "a positive learning environment can foster an increase in professionalism and collegiality with a resultant decrease in turnover of staff" (p. 40). Unit turnover dropped in this period of time. However, many other retention efforts were underway, including the coaching clinic. It was difficult to attribute cause and effect. Three of the 38 coached nurses left the organization to be near family or friends. Eventually, three others left the unit to work elsewhere in the organization. This rate of retention was higher than in previous years. Preceptors and novice nurses did voice satisfaction with the program. Newer nurses asked for development opportunities during their first year, demonstrating growing confidence in their own abilities. Nurses wanted to be preceptors, a sign that the culture recognized and supported their contributions. More importantly, the self-actualized staff will renew the mission of healing with their daily actions. This is a good return on a small investment. ■

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The Hospital Clinical Preceptor: Essential Preparation for Success

Jane J. Baltimore, RN, MSN, CCRN, CS, CPAN

ABSTRACT

Hospitals have a responsibility to provide preceptors with the knowledge and skills required to provide bedside instruction to and evaluation of orientees. Formal preceptor preparation programs that provide practical information for immediate application are necessary for successful transition of orientees into patient care environments. Essential content includes the importance of socialization, skill building techniques, critical thinking facilitation, and assignment management. Preceptor preparation courses need to be based on adult learning principles and incorporate interactive and creative teaching strategies.

Hospitals across the nation are hiring increasing numbers of nurses with little or no clinical experience who are new graduates from schools of nursing, former employees of less acute care settings such as long-term–care facilities, or nurses who have prior experience but have been out of the workforce for a period of years. Today's workplace challenges the less experienced and newly graduated nurse to perform competently and proficiently in the short period of time provided in orientation. The stresses of these expectations contribute to a high attrition rate for new graduate nurses during the first year of employment. Nursing units are affected financially by staff attrition and staff vacancies negatively affect the morale of senior staff who work longer hours and with less support. Furthermore, staff may be asked repeatedly to orient novice nurses, which can contribute to "burnout" (Greene & Puetzer, 2002).

Preceptors are accountable for providing bedside instruction to and competency evaluation of new nurses on a daily basis. Hospitals have the responsibility to provide preceptors with the knowledge and skills required to meet the orientees' multifaceted needs. Selection, development, and coaching of preceptors are critical (Connelly & Hoffart, 1998). The ideal preceptor preparation program provides aspiring and experienced preceptors with practical information that can be immediately applied to their next precepting experience. Vital components of preceptor preparation include (a) socialization, (b) skill building techniques, (c) critical thinking facilitation, and (d) assignment management. Assignment management encompasses organization, prioritization, delegation, and confidence building. Additionally, preceptors should also receive information on preceptor roles and characteristics, preceptor–orientee matching, and orientation resources. Preceptor education should be interactive and based on adult learning principles. It should employ creative teaching strategies.

Ms. Baltimore is Clinical Educator, Harborview Medical Center, Seattle, Washington.

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Address correspondence to Jane J. Baltimore, RN, MSN, CCRN, CS, CPAN, Clinical Educator, Harborview Medical Center, 325 Ninth Avenue, Clinical Education Box# 359733, Seattle, WA.

PRECEPTOR PREPARATION PROGRAM

A formal preceptor preparation program is essential to any orientation process and is designed to prepare qualified staff nurses as preceptors who will ensure the development of competent and safe practitioners. One of the obstacles to effective preparation is the amount of information preceptors have to digest and assimilate in a relatively short period of time. Educators must evaluate the essential content domains that follow to ensure they are presenting what is needed for a successful orientation process rather than the extraneous material that is "nice to know" (Connelly & Hoffart, 1998). Content must be practical as opposed to theoretical and able to be applied to future orientation opportunities.

The Importance of Socialization

The most common reason for employees to leave jobs within a year is because they do not feel that they

Preceptors' primary roles include role modeling, socializing, and educating.

"fit in." Therefore, the opening session of a preceptor preparation course should focus on the importance of welcoming and socializing new staff into the institution and work area. Preceptors need to be educated about the value of getting to know their orientees before working together in the clinical setting. Getting to know orientees allows them to succeed (Fawcett, 2002). Preceptors and orientees should exchange information about their personal and professional backgrounds, teaching–learning and communication styles, and common reactions to stress. By asking questions, preceptors may learn about particular circumstances that could potentially affect learning, such as the fact that orientees have never worked the night shift or that they are the parents of young triplets. Social invitations from preceptors to orientees are also welcoming gestures.

In the patient care setting, orientees need to be introduced to the unit's staff, culture, norms, physical layout, and daily operations. Preceptors should assume primary responsibility for introducing orientees to all members of the healthcare team and for sharing details about how a unit functions in terms of staffing, scheduling, payroll, dress code, chain of command, and resources such as supplies and support staff. Orientees are then able to progress to the more advanced concepts inherent in direct patient care delivery.

Preceptor Roles. Preceptors' primary roles include role modeling, socializing, and educating. As role models, preceptors lead by example, demonstrating and personifying competent nurses. They also help orientees to integrate clinical and professional practice. Preceptors act as socializers when actively integrating orientees into the social culture of the unit and the facility. Helping orientees to feel welcomed by peers and coworkers, and assisting them in establishing relationships and becoming familiar with the written and unwritten norms of the unit are further examples of socialization. Educator roles require assessing orientation needs, planning learning experiences, and facilitating assignment selection to achieve identified learning needs and goals. Preceptors implement a teaching plan and evaluate and document progress based on mutually agreed upon orientation goals on an ongoing basis.

Preceptor Characteristics. Preceptors are role models whom others strive to emulate. Memorable preceptors have patience, enthusiasm, knowledge, a sense of humor, and the respect of peers. They must be competent and have a willingness to learn and change. They must be advocates, teachers, and confidants. They must be nonthreatening, nonjudgmental, and cognizant of personal weaknesses (Fawcett, 2002). Preceptors who posses these qualities foster healthy learning environments.

Before placing staff members into preceptor roles, consider their emotional intelligence. Emotional intelligence, a popular concept in corporate America, is based on a long history of research and theory in personality, social, and industrial and organizational psychology (Cherniss, 2000). Current research shows that an employee's emotional intelligence is twice as important to professional success as technical skills and cognitive abilities (Hand, 2002). Candidates with positive emotional intelligence possess five key personality characteristics:

1. Self-awareness or the ability to recognize and understand their own moods, emotions, and drives, as well as their impact on others.
2. Self-regulation or the ability to control or redirect disruptive impulses and moods.
3. Motivation or a passion to work for reasons that go beyond money or status and a propensity to pursue goals with energy and persistence.
4. Empathy or the ability to understand the emotional makeup of other people and the skill to treat people according to their emotional reactions.
5. Social skills or proficiency in managing relationships and building networks and the ability to find common ground and build rapport (Hand, 2002).

Preceptor–Orientee Pairing. Pairing orientees with preceptors is often a random choice based on who happens to be working and their willingness and ability to serve as preceptor. This type of system often results in multiple preceptors for one orientee and a general lack of continuity. Furthermore, assigning staff who do not want to precept leaves orientees with mixed messages and feelings of inconsistency and frustration (Anderson, 1998). Unwillingly, preceptors perceive the added responsibility as work overload, which translates to decreased job satisfaction and retention, which in turn results in a suboptimal learning environment for orientees.

Matching on the basis of learning style and personality characteristics can enhance satisfaction and productivity of the preceptor–orientee relationship

(Anderson, 1998; Carroll, 1992; Hardy & Smith, 2001). When styles are mismatched, learning time increases and retention decreases. Matching preceptors and orientees based on learning styles allows learners to progress at a comfortable pace and preceptors to teach in a comfortable method. Examples of tools to assess learning style are the Multi-modal Paired Associates Learning Test, the Perceptual Modality Preference Survey, the Edmonds Learning Style Identification Exercise, the Gregorc Style Delineator, and the Visual-Aural Digit Span Test.

In addition to learning styles, personality styles also can influence the learning environment created by preceptor–orientee dyads. Understanding the personality types of others and ourselves helps to gain insight into how and why people think the way they do and determines what information is noticed and recalled, the way decisions are made, and how much structure and control is preferred. Examples of tools to assess personality style are the Myers-Briggs Type Indicator, the Hartman Personality Profile, and the DiSC Personal Profile System®. Preceptor preparation programs should include learning style and personality style assessment. Preceptors who are aware of their styles are better able to be matched with orientees with similar characteristics.

Orientation Resources. Preceptors need to be educated about resources available to assist them with the process of orienting new staff. Common orientation resources include nurse managers and their assistants, nurse educators, clinical nurse specialists, and charge nurses. Because each of these has a responsibility to track the progress of orientees, regular communication among all relevant parties is essential. Nurse managers and their assistants are helpful when performance issues arise and when clarification of job roles and responsibilities is necessary. They can also coach preceptors on delivering appropriate feedback.

Nurse educators and clinical nurse specialists, who often coordinate area or department orientation programs, can be especially helpful in arranging special learning experiences (e.g., arranging for clinical time in an outpatient surgery unit for the purpose of practicing venipuncture skills). They are excellent resources if questions or issues related to the overall orientation program structure or framework arise. And, they often have the necessary time and educational skills to review or reinforce skills that preceptors with direct care responsibilities may be unable to cover thoroughly. Charge nurses can be helpful in identifying and facilitating learning experiences on a shift-to-shift basis, as well as ensuring preceptor-orientee dyads do not receive an assignment unrealistic to the orientees' current level of performance.

Preceptors should allow for practice, repetition, and self-correction.

Skill Building

Psychomotor skill development is a vital component of orientation. Preceptors need to be introduced to the multiple ways to teach psychomotor skills. They also need to know how to modify their teaching techniques to match orientees' learning styles. Preceptors need to place the primary responsibility for skill development on orientees and expect them to take an active role in identifying areas of competency and inability. Preceptors should allow for practice, repetition, and self-correction. Preceptors should allow orientees to focus on the steps of a skill and not be distracted with other duties during performance.

Adult Learning Principles. Preceptor preparation programs and the instruction provided by preceptors need to be based on adult learning principles:

1. Content should be based on perceived needs of the learner.
2. Content should be repeated and sequenced in a logical fashion.
3. Active learning methods should be used to facilitate retention.
4. Care should be given to provide a safe and supportive learning environment for participants (Clay, Lilley, Borre, & Harris, 1999).

Knowledge and skill retention are optimized when instruction is based on adult learning principles, when expectations are based on experience level, and when consistent competency evaluation and constructive feedback are provided.

Learning for adults is needs based. Adults have little patience with educational materials that they perceive to be theoretical or esoteric. Education that covers content meaningful to the participants is preferred and best retained by adult learners (Clay et al., 1999). Preceptor programs must address the learning needs of the staff. These programs must provide practical information that can be applied immediately to the next precepting experience. Likewise, instruction provided by preceptors should be competency based, with little time and effort spent on skills that have been mastered.

Second, busy adults have little tolerance for disorganization, especially with content presented for them to learn. Adult learners need to become familiar with the overall learning objectives of educational programs, the sequencing of content to be presented, and how content areas interrelate (Cafferella, 1994). Preceptor preparation programs should provide participants with handouts that detail the program's overall goals, specific learning objectives, schedule, and evaluation.

Third, adults must be active learners. Adult learners would rather discuss a topic than hear a lecture. Adults learn best when previous knowledge and experience can be related to the new information. Content that enables the learner to draw on past experiences is easier to remember and use (Clay et al., 1999). Effective preceptor preparation programs and instruction capitalize on the participants' prior experiences and use them as best/worst practice discussion platforms. Learning situations that use past experiences signal respect for the learners and their achievements.

Finally, a supportive and nonthreatening environment maximizes adults' abilities to learn effectively (Clay et al., 1999). An environment conducive to learning is one with sensitivity to physical needs such as frequent breaks, temperature moderation, and room size appropriate to the number of participants. Psychological needs are met in an effective learning environment that creates a community of learners where ground rules and norms forbid embarrassment, intimidation, or promotion of feelings of inadequacy. Class instructors and preceptors should be thought of as facilitators of learning who help participants and orientees assimilate new information into their daily practice rather than simply as presenters of information. Integration of these four adult learning principles into preceptor preparation and orientation programs is essential to their success.

Evaluation. Preceptors are responsible for ongoing evaluation of orientees' progress toward role expectations. Evaluation requires an understanding of the differences between experienced nurses and novices. Patricia Benner (1982) applied the Dreyfus Model of Skill Acquisition to nurses as they passed through the five levels of proficiency: novice, advanced beginner, competent, proficient, and expert. Benner's application of this model offers guidelines for professional, knowledge, and skill development. The levels reflect changes in two general aspects of skilled performance. The first change is the shift from the dependence on abstract principles to the use of past, concrete experiences as paradigms. The second change is in perceptions and understanding of complex situations. Complex situations are seen more as a whole picture rather than a collection of parts. Elements of these situations are analyzed for relevence and not automatically considered as such (Benner, 1982). As orientees progress from one level to the next, preceptors must adjust their focus, emphasis, and expectations. Table 1 provides a description of orientee characteristics and preceptor implications for each level (Benner, 1982).

Competency Validation. Competency validation is an important preceptor responsibility. Skills requiring validation should be performed under preceptor supervision. Preceptors must validate skills only when they are performed safely and effectively. Prior to performing skills, preceptors need to insist orientees review relevant policies and procedures. Experienced orientees should review policies and procedures to identify differences in practice from past experiences.

Providing Feedback. Providing constructive feedback can be challenging for preceptors yet vital to orientees' professional development. Preceptors need to inform orientees that they will receive feedback from preceptors about both strengths and areas for improvement. Feedback should be given in a private place and be objective in nature. Preceptors should use "I" statements (e.g., "I noticed. . .") and avoid judgmental statements (e.g., "You should have known better."). Self-evaluation (e.g., "How do you think you did?") can be a powerful method of evaluation and can initiate performance evaluation in a nonthreatening manner. Likewise, preceptors should welcome ongoing feedback from orientees regarding the orientation process.

Critical Thinking

Nurses are frequently involved in complex situations that demand high level problem solving and decision making. Because optimal patient outcomes depend on clear and focused thinking, nurses must view themselves as thinkers and not simply doers (Alfaro-LeFevre, 1999). "Critical thinking is the key to resolving problems. Nurses who don't think critically become part of the problem" (Alfaro-LeFevre, 1999, p. 4). Stimulating and fostering orientees' critical thinking is an important preceptor responsibility that requires familiarity with the concept of critical thinking, good habits of inquiry, and opportunities for promotion of critical thinking.

Critical thinking entails purposeful, informed, results-oriented thinking that requires careful identifi-

TABLE 1
ORIENTEE CHARACTERISTICS AND PRECEPTOR IMPLICATIONS

Stage	Orientee Characteristics	Preceptor Implications
Novice	• No experience with situations in which they are asked to perform tasks • Inability to use discretionary judgment • Use of context-free rules to guide actions • No rule about which tasks are most relevant in a real-world situation or when an exception to rules is necessary	• Teach rules to guide actions that can be recognized without situational experience • Must be backed up by a competent nurse
Advanced Beginner	• Demonstrates marginally acceptable performance • Is gaining experience with real situations to note meaningful patterns and attributes (or have them pointed out by preceptor) • Can formulate guidelines for actions in terms of patterns and attributes • Difficulty identifying important aspects; treats all attributes as equally important	• Shift from teaching rules to guidelines • Help to recognize patterns and their meanings • Assist in prioritizing • Must be backed up by a competent nurse
Competent	• Begins to see his or her actions in terms of long-term goals or overall plan • Begins to distinguish between relevant and irrelevant attributes • Feels the ability to cope and manage the unforeseen events • Lacks the speed and flexibility of a proficient nurse	• Focus on improving decision-making skills and ways to improve coordination of multiple, complicated care needs of patient assignments • A good preceptor for a novice nurse
Proficient	• Can discern situations as wholes rather than single pieces • Uses past experiences rather than rules to guide practice • Can recognize when the expected normal picture is absent • Considers fewer options and hones in on accurate elements of problems	• Use complex case studies to facilitate learning • A good preceptor for a competent nurse
Expert	• Practices holistic rather than fractionated • Grasps situation intuitively and correctly identifies solutions without wasting time • Extraordinary management of clinical problems • Considered an expert by others	• Often not possible to recapture mental processes • Encourage exemplars and descriptions of excellent practice • A good preceptor for a competent nurse

Data from Benner, P. (1982). From novice to expert. *American Journal of Nursing, 82*, 402-407.

cation of problems, issues, and involved risks. It is based on principles of the nursing process and scientific method and is driven by patient, family, and community needs. Critical thinking uses both logic and intuition; is based on knowledge, skills, and experience; and is supported by professional standards and ethics. Preceptors and orientees think critically when constantly reevaluating, self-correcting, and striving to improve (Alfaro-LeFevre, 1999).

To assist orientees to think critically, preceptors must also possess good habits of inquiry including habits that help search for the truth, such as having an open mind, verifying information, and taking enough time to fully understand a situation. Preceptors must also look for flaws or false assumptions in their own thinking. By asking themselves or their colleagues "What am I missing?" or "How can I make this better?," they can evaluate their own thought processes and make improvements (Alfaro-LeFevre, 1999). In turn, they are better able to assess the thought processes and decision making of orientees.

Preceptors can facilitate critical thinking in many ways, especially by communication. Preceptors should use strategies to gain accurate and comprehensive information from orientees and not make

Preceptors must help orientees accept the fact that they cannot do everything themselves, become comfortable with seeking assistance from other colleagues, and learn when the assistance of other disciplines is necessary.

false assumptions. They can do this by asking open-ended questions using exploratory statements such as "Tell me more about. . ." or "Help me to understand. . . ." They need to avoid leading questions or those that lead others to a desired answer. Body language should be put into words (e.g., "You seemed a little upset. . .") to validate orientees' nonverbal communication (Alfaro-LeFevre, 1999).

Preceptors have many opportunities to stimulate critical thinking. Errors on the part of orientees can be turned into learning opportunities. Preceptors should allow orientees to make mistakes or "near" mistakes as long as they do not put the patient at risk for harm. One tends not to forget lessons learned or knowledge gained from one's own mistakes. Similarly, preceptors can facilitate critical thinking by not answering all questions directly and allowing orientees to problem solve on their own.

Certain types of questions can encourage critical thinking. Preceptors need to ask "What else. . . ?" and "What if. . . ?" questions. Asking what-else questions encourages thoroughness, whereas what-if questions promote creative and proactive thinking. Orientees benefit when they are helped to anticipate what question they may get from others, particularly during shift report or when communicating with physicians (Alfaro-LeFevre, 1999). Shift report can be used as an excellent tool to stimulate critical thinking in that its purpose is to summarize key patient care issues, events, goals, and outcomes in a succinct manner.

Managing the Assignment

Management of the assignment is the final topic addressed in the program and involves some of the final skills mastered by orientees: organization, prioritization, and delegation.

Although orientees become increasingly independent with their cognitive and psychomotor skills, preceptors need to continue to act as advocates and resources for orientees while giving them the freedom to manage an assignment in a way that works for them. Preceptors need to help orientees to expect the unexpected, cope with obstacles and multiple demands, request needed assistance, and build confidence.

Organization. Preceptors play a major role in assisting orientees to develop an organized approach to patient care assignments. Preceptors must insist orientees formulate a daily routine and plan. These dyads must also devise a system for following up on pertinent patient care issues and patient responses to interventions. Orientees should be encouraged to observe other coworkers' methods of organization and then formulate their own. When orientees use different organization methods than preceptors, the key is to determine if it is merely different or if it is ineffective. Solid organizational skills will help orientees cope with the many unexpected occurrences and competing responsibilities inherent in daily clinical practice.

Prioritization. Preceptors need to be taught how to help orientees juggle multiple responsibilities for multiple patients. Without the ability to prioritize, orientees tend to handle whatever issues arise in the order that they arise. This can result in delayed interventions on urgent patient care matters. Preceptors can help orientees to categorize duties based on their urgency, the level of skill required to complete tasks, and the consequences of delay or inaction.

Delegation. Once orientees no longer have preceptors to assist them, they will need to delegate to other staff members to meet the demands of most patient care assignments. Preceptors must help orientees accept the fact that they cannot do everything themselves, become comfortable with seeking assistance from other colleagues, and learn when the assistance of other disciplines is necessary. Just as there are "5 Rights" of medication administration—right medication, patient, route, time, and dose (Karch, 2003)—preceptors should reinforce the "5 Rights" of delegation. These are right task, person, situation, communication, and feedback (M. Cahill, RN, BSN, personal communication, February 13, 2003). Communication and feedback related to delegation should be clear, complete, and courteous (J. Kruitoff, RN, MSN, personal communication, January 28, 2002). Effective delegation will ensure that orientees meet the multiple demands of patient care assignments during orientation and beyond.

Confidence Building. In addition to the ability to think, organize, and delegate, orientees need to develop self-confidence to truly be successful. Preceptors who act as resources and encouragers can help orien-

tees to develop confidence and self-assurance. Confidence is built slowly over time as skills are successfully performed and appropriate decisions are made. It can be easily damaged by unsolicited advice, inappropriately challenging learning experiences, and hypervigilance.

As orientees develop their individual practice habits and manner of organizing and accomplishing their work, guidance and advice can become increasingly unwelcome. Preceptors need to remember that their way is not the only way and to be accepting of other methods as long as they meet safety and practice standards. Preceptors need to acknowledge and appreciate the orientees' needs for independence and skill to function independently. Another pitfall for preceptors is assigning learning experiences that are beyond the skill level of orientees. Orientee assignments should gradually increase in complexity with highly challenging patients reserved until the latter part of orientation.

Finally, preceptors need to refrain from hypervigilance and the tendency to take control of problems and issues as they arise. Except for situations where patients' safety is in jeopardy, preceptors are not helping the orientees by rescuing them from difficult decisions or situations. Rather, preceptors need to coach orientees through the decision-making process by stimulating the orientees' thinking and problem-solving skills. Orientees will not develop independent problem-solving skills if they are continually "saved" by preceptors.

Throughout orientation, preceptors need to monitor orientees' progress and success. Check-point questions, such as "What do you like about what you did today?," "If you could do it over, what would you do differently?," and "What would you like to work on next shift?," facilitate self-evaluation on the part of the orientee. Orientees' self-evaluations can illuminate issues relating to overconfidence or underconfidence, assist in identifying additional learning needs, and help to formulate a plan for future shifts.

Successful orientees can confidently organize, prioritize, and delegate role responsibilities. Preceptors can help or hinder orientees' abilities to develop these skills and confidence in their abilities to perform their role.

TEACHING STRATEGIES

Learning and retention are enhanced when material is presented through a variety of interactive teaching methods (Clay et al., 1999). Interactive teaching methods engage the learner and do not allow learners to be passive. Interactive strategies are based on adult learning principles and encourage participants to take an active role in their learning. A variety of interactive teaching strategies can be employed in preceptor preparation programs, including name tents, voicing and documenting learning needs of participants, video role playing, brain storming, skill instruction exercises, and group discussion and sharing (Table 2).

TABLE 2
TEACHING STRATEGIES FOR PREPARING PRECEPTORS

- Name tents
- Voicing and documenting learning needs of participants
- Video role playing
- Brain storming
- Skill instruction exercises
- Group discussion and sharing

Name tents are an effective way for course participants to share their name and other information with other course participants. A name tent is created by folding card stock paper in half. Name tents can include more than just names. Participants can be asked to draw a picture depicting their motivation for attending the preceptor preparation class. Some participants may draw a dollar sign to indicate their interest in a preceptor pay differential, whereas others may draw an apple or school books to connote their interest in teaching. This exercise helps to illustrate the various motivating factors for wanting to become a preceptor.

A valuable technique to ensure that learning needs of participants are being met is to ask the group to voice any concerns they have related to precepting new staff. Such questions or issues should be documented and posted for the group to see. Throughout the course, all questions and issues should be addressed and checked off the list. This exercise ensures that participants receive practical information they can apply to their next precepting experience.

Another creative teaching strategy is video-taped role playing. Video role playing can be used to illustrate both positive and negative behaviors visually and sometimes add an element of humor. For example, faculty can play the roles of preceptors and orientees and participants can analyze their interaction and identify the positive aspects and what could have been done or said differently.

Role playing can also be an effective strategy for instruction on how to give feedback. Communicating negative feedback to orientees can be challenging and uncomfortable. A role playing exercise can provide a

safe environment in which to practice this skill. Participants can be divided into groups of three where they assume the roles of preceptor, orientee, and observer. Each group is given a scenario involving delivery of feedback and then role play the interaction between the preceptor and orientee as the observer critiques. This activity can also be video-taped to allow participants to observe their verbal and nonverbal communication.

A fourth active teaching method is brain storming. Brain storming is a problem-solving technique that involves the spontaneous contribution of ideas from all members of the group. Brain storming is a useful exercise to engage class participants in describing preceptor or critical-thinking characteristics. The technique requires participants to analyze past experiences as both orientees and preceptors and identify behaviors and characteristics to be emulated and those that should be eliminated or improved.

Psychomotor skills can be taught in a variety of ways. Prior to performing new skills, orientees may be asked to read a policy and procedure, review a nursing text or skill checklist, watch preceptors perform the skill, or be talked through the skill step-by-step. An effective method of illustrating the many ways to teach skills is to do just that—give the group a new skill to learn (e.g., folding a napkin into a swan) and teach them in a variety of ways. For instance, the skill can be taught by participants through written instructions, by watching a demonstration, by being talked through the skill step-by-step, or by a combination of methods. This interactive exercise illustrates the various ways in which a skill can be taught and gives participants valuable insight into their own learning style and teaching preferences.

One of the simplest interactive learning techniques is group discussion and sharing. Although some participants may have little or no preceptoring experience, they will have been orientees at some point and have likely had both positive and negative experiences as such. By sharing experiences with peers, participants take on the role of "instructor" and learn from one another while validating past experiences. Group discussions and sharing of best and worst practices and "war stories" also promote camaraderie and the formation of a supportive network. Group discussion can be stimulated by issues brought forth by participants, by case scenarios, or by past or current real life events.

CONCLUSION

Hospitals have a responsibility to provide preceptors with the knowledge and skills required to provide instruction to and evaluation of orientees. Formal preceptor programs that provide practical information for immediate application are essential for successful transition of orientees into patient care environments. Essential program content includes the importance of socialization, skill building techniques, critical thinking facilitation, and assignment management. Preparation courses need to be based on adult learning principles and incorporate interactive and creative teaching strategies.

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ASSESSING THE ASSESSOR

COMPETENCY AUDIT AND SKILLS ASSESSMENT CERTIFICATION

Course Participant: _____

Area of work: _____

Date of Preceptor Course attended: _____

The Counties Manukau District Health Board Competencies provide a comprehensive framework for developing knowledge and skills. The competencies are designed to support and extend an individuals nursing/midwifery practice and are viewed as the foundational knowledge and skills. In completing the competencies critical thinking is utilised and professional accountability displayed.

The objective of the audit tool is to verify that the nurse/midwife meets the criteria for auditing competencies and has successfully met the following standards that underpin nursing/midwifery councils' competency.

Competence:	The combination of skills, knowledge, attitudes, values and abilities that underpin effective performance as a nurse/midwife.
Competency:	A defined area of skilled performance.

The above definitions of 'competence' and 'competency' are taken from Nursing Council of New Zealand, *Competencies for the registered nurse scope of practice*, 2007.

Professional practice development hours are allocated for each competency contributing to Nursing Council of New Zealand's educational requirements.

Each competency has learning outcomes, suggested readings and is then audited by your allocated preceptor within your nursing/midwifery service.

At the end of each competency there is an audit tool which supports achievement of the learning outcomes. Each competency must have the audit completed to gain professional practice development hours. Timeframe for completion of this workbook is negotiated with your CNM, CMM, Team Leader and Nurse/Midwife Educator.

To support your learning each competency has references and there is recommended texts. You can use any of your own preference or choice.

Acknowledgement:

NPDU Senior Nursing team

Sarah Little (Clinical Nurse Director Kidz First and Womens Health, CMDHB)

Senior Nurses at Starship Childrens Emergency Department

Senior Nurses at Kidz First

ASSESSING THE ASSESSOR

Scale/Performance Criteria: **1=Independent 2=Supervised 3=Assisted, 4=Marginal 5=Dependent, N/O=Not observed**		
Definitions for this assessment: Course participant: The person who has attended the preceptor course and is being assessed completing an assessment Learner: The person who the course participant is assessing Assessor: A suitably qualified assessor who is assessing the course participant complete an assessment for the learner		
	Scale	**Comments**
Course Participant preparation prior to assessment:		
• Displays nursing/midwifery practices that are underpinned by CMDHB best practice policies, procedures and guidelines		
• Learner aware that participant is being assessed.		
• Appropriate time and place organised for assessment		
• Course participant is prepared for assessment of learner (prior reading and knowledge; familiar with assessment tools and relevant policies, procedures and guidelines)		
• Learner has copy of assessment tool prior to assessment		
• Learners needs determined e.g. level of practice established		
• Appropriate equipment and resources organised and available e.g. checklists, assessment tools		
During Assessment:		
Communication: • Introduces self/others. Makes learner comfortable		
• Uses eye contact and speaks directly to learner		
• Uses appropriate language (is not emotional nor uses emotive words/uses descriptive words/non-judgemental)		
Cultural safety: • Adapts session to learner's needs		
• Allows learner time to provide		

COUNTIES MANUKAU HEALTH

ASSESSING THE ASSESSOR

answers/does not interject		
Documentation: • Uses a relevant assessment tool		
• Documents objectively noting specific actions supporting performance scale selected		
Occupational Health & Safety • Patient safety maintained. Practice in accordance with CMDHB policy		
Knowledge/rationale • Is aware of performance management procedure		
Skill/task/procedure • Verbalises the observed values/ attributes/ professional judgement of the learner		
• Provides appropriate cues when/where necessary		
• Allows time for questions from learner		
• Makes review time if necessary		
• Gives feedback to learner appropriately (balanced/timely/to the point/confidential)		
Course participant self assessment/reflection		
• Evaluates own use of resources/ checklist/knowledge		
• Identifies positive actions and reinforces these to themselves for use in future assessments		
• Identifies deficits and reorganises assessment approach if necessary		
• Understands notification process to appropriate responsible group, e.g. NE,CN of assessment difficulties & documents appropriately.		

Additional Comments:

_____

_____

_____

_____

Assessor: _____Signature: _____ Date: _____

Course participant: _____Signature: _____

ASSESSING THE ASSESSOR

Performance Scale/Criteria:

Scale label	Standard	Quality of clinical performance	Assistance
1 Independent	Safe, accurate	Proficient, co-ordinated, confident. Within an expedient time period Accurate knowledge	Without supportive cues
2 Supervised	Safe, accurate	Efficient, co-ordinated, confident. Within reasonable time period. Needs occasional prompting with relevant knowledge	Occasional supportive cues
3 Assisted	Safe, accurate	Skilful in parts of behaviour Inefficiency & unco-ordination. Within a delayed time period. Has some knowledge still requires explanation.	Frequent verbal & occasional physical & directive cues in addition to supportive ones.
4 Marginal	Safe but not alone. Performs at risk.	Unskilled, inefficient. Prolonged time period. Needs continual cues as to relevant knowledge	Continual verbal & frequent physical cues.
5 Dependent	Unsafe. Unable to demonstrate competency.	Unable to demonstrate procedure/behaviour. Lacks confidence, efficiency. Has very limited knowledge related to the competency.	Continuous verbal & physical cues
N/O	Not observed		

Adapted from: Bondy, K.M. (1983). Criterion – referenced definitions for rating scales in clinical evaluation. Journal of Nursing Education. 22: 376-381.
Endorsed by the SAH NEs & the Clinical Educator Women's Health 12.01

ASSESSING THE ASSESSOR

The CMDHB criteria for signing competencies are:

- No nurse/midwife in new graduate year is to sign another RN/RM's competency
- RN/RM has practised for six months in the department or had previous relevant experience and has practised for three months in the department
- Taught by N/ME to audit competency prior to auditing other RNs/RMs
- Must be a RN to assess another RN
- Must be a RM to assess another RM

ASSESSMENT	POSITIVE BEHAVIOURS	NEGATIVE BEHAVIOURS	POSSIBLE COMMENTS
Communication	Introduces self and assessor Gains consent for assessment from patient Outlines what is going to happen at patient level of understanding and relevant to age Positive body language – welcoming and friendly Focus is on task and patient Plans the process with patient Builds a rapport with patient Use of AI^{2}DET	No introductions Performs task without consent No explanations to patient or patient unable to understand properly due to language used Closed body language – no dialogue No patient involvement No rapport and dialogue with patient	Introduced self and assessor to patient. Gained consent adequately Adequately outlined the process to the patient before commencement. Patient understood well. Could possibly improve on dialogue with patient. Could have involved the patient a little more. Did not appear to dialogue with the patient during the procedure.
Cultural Safety	Respect - introductions No assumptions about ethnicity/culture Use of interpreter when required Language usage is appropriate for age and culture Awareness of own beliefs and culture	Disrespectful – no introductions etc Domination of patient Assuming about ethnicity/culture No interpreter when patient does not understand Enforces own cultural beliefs on patient via action/communications etc	Ascertained well the patients' level of understanding. Patient participation was sought Interpretation services utilised. Did not appear to respect the patients dignity Could have utilised interpretation service
Documentation	Legible, accurate, objective Documentation as per CMDHB policy The documentation is appropriate to the skill assessment – meds,	Illegible, inaccurate , not appropriately signed and dated – policy disregarded Appropriate charts not utilised Subjective assessments	The documentation was clear and concise in line with CMDHB policy Would recommend using a format to develop a flow of documentation. Subjective assessments added –

	wound assessment charts Plans are ongoing	documented No ongoing plans	would suggest only objective data is for entry. Does not appear to have adequate planning for future events
Infection Control	Appropriate hand hygiene technique Keeps to CMDHB Infection control policies Aseptic technique Standard precautions Traffic light system utilised (if appropriate) Seeks advice if unsure	No evidence of hand hygiene or poor technique Policies ignored or not familiar Poor aseptic technique Does not employ standard precautions Unaware of traffic light system Does not seek advice if unsure	Hand hygiene technique was appropriate for procedure performed. Carried out procedure with aseptic technique. Needs to maintain asepsis during procedure and understand rationale for same. Did not maintain asepsis to the desired level.
Knowledge/Rationale	Knowledge is appropriate to level being assessed Can articulate the theory related to the practice at level being assessed Utilises research findings to inform practice Assesses patient holistically	Knowledge is not appropriate for skill assessment Is unable to articulate the theory required at the level being assessed Practice is not evidence based Does not assess patient holistically	Assessed patient well and related procedure using assessment and own knowledge. Can provide competent level of patient assessment from a holistic perspective. Has sound basis of knowledge on which to build Unable to articulate knowledge behind procedure. Unable to answer patients' questions. Provided out dated information, not research based
Occ health and Safety	Hand washing etc is good	Poor technique in hand washing etc	Operates in a safe manner

	Uniform policy adhered to Follows policies Ensures safety of self and others	Wearing jewellery, nail varnish and inappropriate uniform Not aware of safety issues	following policies well. Does not follow CMDHB policies. Needs to be further aware of uniform policy and removal of jewellery The safety of self and patient was not secured
Skills	Safety is considered Clinical knowledge and choice of skill for assessment is appropriate to level being assessed Overall performance of task is appropriate to level being assessed Preparation for task was appropriate and organised Confidence in task performance is evident	Safety is not considered Clinical knowledge is lacking Skill to be assessed is inappropriate for level being assessed Overall performance is poor Prompts did not ensure performance was good and at the appropriate level Inadequate preparation /poor organisation Not confident in task performance	Practiced in a safe manner Appropriate skill choice with good knowledge to base performance May need further support for skill performance. Confident and knowledgeable Demonstrates awareness of CMDHB policies Has a sound knowledge base on which to build but will need further assistance to attain…….. level.
Feedback	Ask person how they felt it went When offering feedback allow adequate time to discuss the performance and above issues Provide an overall summary of level of performance Highlight the positives and give appropriate praise Offer suggestions or plan for further development to aid improvement Offer support for further educational requirements in areas that have been highlighted as lacking Provide a time frame for improvement if necessary Remember that the level at which the performance is being assessed shapes the expectations of the assessor and the person being assessed		

Learning Contract	Achieved	Part achieved	Not achieved	Reviewee's reflections (including learning needs identified)	Reviewer's reflections (including learning needs identified)
Objective: What do you want to learn, develop or examine? Consider your current abilities. Set time frame. **Key Steps**: What will you utilise to achieve your learning outcomes? Be specific- consider how you learn best. **Measurement**: How can you show to yourself and others that you have met your learning outcomes? Proof				What have you gained? What went well? What would you do differently? Set next goal…	Frequent, Accurate, Specific, Timely.
Objective: Key Steps: Measurement:					
Objective: Key Steps: Measurement:					

MEDICATION CERTIFICATION PRACTICAL ASSESSMENT FORM

NAME: _____ **WARD/DEPT:** _____

Calculation test completed	_____	Signature : _____
Practical Assessment completed	_____	Signature: _____
Medication Workbook completed	_____	Signature: _____

Guidelines for practical assessment of medication administration:

RN/RM to complete assessment of IV/Oral medication depending upon area of practice
EN/NA to complete assessment of oral medication

- **To successfully complete this assessment the candidate MUST demonstrate independent practice as described in scale 1 below:**

Scale label	Standard	Quality of clinical performance
1 Independent	Safe, accurate	Proficient, co-ordinated, confident. Within an expedient time period Accurate knowledge

COMPETENCIES	Comments	Scale
Cultural safety		
• Demonstrates respect for the individual • Introduces self and assessor		
Communication		
• Explains the procedure to the patient • Ensures patient receives appropriate education regarding medication and any subsequent monitoring required • Communicates therapeutically with patients/clients & or whanau (as appropriate). • Communicates professionally within the multidisciplinary team &/or within professional networks.		
Health & safety		
• Identify patient as per Hospital policy e.g. addresses patient by name & by wristband • Ensure call bell available to patient and explanation of side effects provided		
Documentation		
• Documentation completed as per CMDHB Clinical Board policies & Medication Certification Policy		
Infection control		
• Adheres to universal precautions e.g. hand washing and non touch technique • Disposes of equipment used as per CMDHB infection control policy and procedures •		
Knowledge/Rationale		
• Describes patients diagnoses, indications for use and expected drug action • Describes the usual dose range, frequency of administration, potential side effects and contraindications • State the recommended administration compatibilities and dilution • Demonstrates rationale for drug calculation		
Occupational Health and Safety		
• In accordance with CMDHB policy. • Refer Southnet Occupational Health and Safety Policies		

Skill Task Procedure		
• Medication dispensed correctly All administration routes: • Checks five 'R's- right patient, right drug, right dose, right time, right route • Checks if any known allergies • Ensures medication administered If IV administration, • Checks luer site as per CMDHB policy • Administers medication as per recommended CMDHB guidelines and IV therapy policies, procedures.		
Comments:_____ _____		
	Signature & designation assessor:	Date:
NE/CN Signature: _____	Onestaff updated: Yes\No	Date:

	Assessment scale for clinical assessments		
Scale label	Standard	Quality of Performance	Assistance
1 Independent	Safe, accurate	Proficient, coordinated, confident Within an expedient time period Accurate knowledge	Without supportive cues
2 Supervised	Safe, accurate	Efficient, coordinated, confident Within reasonable time period Needs occasional prompting with relevant knowledge	Occasional supportive cues
3 Supervised	Safe, accurate	Skilful in parts of behaviour Inefficiency and unco-ordination Within a delayed time period Has some knowledge still requires explanation	Frequent verbal & occasional physical & directive cues in addition to supportive ones
4 Marginal	Safe but not alone Performs at risk	Unskilled, inefficient Prolonged time period Needs continual cues as to relevant knowledge	Continual verbal & frequent physical cues
5 Dependent	Unsafe Unable to demonstrate competency	Unable to demonstrate procedure/behaviour Lacks confidence and efficiency Has very limited knowledge related to the competency	Continuous verbal & physical cues
N/O	Not observed		

Adapted from: Bondy, K.M. (1983). Criterion – referenced definitions for rating scales in evaluation. Journal of Nursing Education. 22: 376-381.

When completed return to your NE.

Practice Assessment Form

COUNTIES MANUKAU HEALTH

Name: ..... **Procedure** ..... **Date:** .....

Criteria	Comments	Scale
1 – Independent, 2 – Supervised, 3 – Assisted, 4 – Marginal, 5 – Dependent, N/O = Not observed		
Communication		
• Communicates therapeutically with patients/clients & or whanau (as appropriate). • Communicates professionally within the multidisciplinary team &/or within professional networks.		
Cultural Safety		
• Demonstrates respect for the individual		
Documentation		
• In accordance with CMDHB policy Refer SouthNet Documentation policy.		
Infection Control		
• In accordance with CMDHB policy Refer SouthNet Infection control policies.		
Knowledge/rationale		
• Knowledge/rational provided on: • Patient/client assessment including (as appropriate): physical, emotional, social & spiritual. • Physiological process in the patient/client.		
Occupational health & safety		
• In accordance with CMDHB policy Refer SouthNet Occupational Health & Safety policies.		
Skill/task/procedure		
• Performed as per CMDHB policy • Able to anticipate potential & or real risks & modifies behaviour/plan accordingly • Continuously evaluates care.		

Feedback .....

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Assessor's signature, designation & date: .....

Scale label	Standard	Quality of clinical performance	Assistance
1 Independent	Safe, accurate	Proficient, co-ordinated, confident. Within an expedient time period Accurate knowledge	Without supportive cues
2 Supervised	Safe, accurate	Efficient, co-ordinated, confident. Within reasonable time period. Needs occasional prompting with relevant knowledge	Occasional supportive cues
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