University of Prince Edward Island
School of Nursing

Guide to PRECEPTORSHIP

UNIVERSITY of Prince Edward ISLAND

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This document has been adapted with permission from the University of Alberta, Faculty of Nursing.

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INTRODUCTION

Preceptorship is an exciting, innovative strategy for teaching undergraduate and graduate nursing students the complexities of professional nursing practice in the clinical setting. According to the Canadian Nurses Association (CNA) (1995, p. 13), preceptorship is described as "a formal, one-on-one relationship of pre-determined length, between an experienced nurse (preceptor) and a novice (student) designed to assist the novice to successfully adjust to and perform a new role" Preceptorship typically is comprised of three participants: the student, the preceptor, and the faculty member. The relationship among all three is critical to the teaching and learning process and must be a strong one if this experience is to engender the best possible outcome for all involved *(Myrick & Yonge, 2005)*. There are many different types of preceptorship arrangements with varying lengths of time and differing objectives. For example, there are arrangements in which the student may be preceptored by a team and not just by one particular preceptor.

Upon completion of a preceptorship rotation, the student and preceptor may evolve into a mentorship relationship. The word "mentor" implies wise guide or protector. In this case the student continues to seek out the preceptor as needed and both mutually agree to continue the relationship.

The term preceptorship originates from the Latin precept a derivative of the Latin word praeceptum which means maxim, rule, or order and from the Latin *praecipere* which similarly means to give rules to, to order, or to advise *(Harper, 2010)*.

THE PRECEPTORSHIP TRIAD: ROLES AND RESPONSIBILITIES

Preceptorship consists of a triad, the preceptor, the student and the faculty advisor, all of whom play integral roles in the success of the preceptorship experience. Following is a summary of the various roles and responsibilities intrinsic to each of the members of this triad.

THE PRECEPTOR

The preceptor is responsible for socializing the student to the values of the nursing profession through teaching, supporting, role modeling, facilitating, guiding, evaluating and by being authentic *(Myrick & Yonge, 2005)*.

ROLE MODEL

As a role model, the preceptor:

a) provides patient care in accordance with established, evidence-based nursing practice standards;
b) fulfills nursing responsibilities according to the standards and ethics of nursing practice while adhering to the clinical site's policies and procedures;
c) maintains professional working relationships with other health care team members; and d) uses resources safely, effectively and appropriately.

TEACHER

As a teacher, the preceptor:

a) identifies learning needs;
b) sets goals in congruence with curricular expectations and in collaboration with the faculty member;
c) provides feedback; and
d) plans the learning experiences to assist the student in meeting weekly professional and clinical learning goals.

FACILITATOR

As facilitator, the preceptor works with the student to develop meaningful learning experiences by:

a) helping the student connect with others in the institution and in the health care system who have different expertise;
b) encouraging the student to check and assess their own nursing care so that they develop an awareness of their progress, rather than relying solely on the opinion of others;
c) socializing the student into the unit culture by making them feel welcomed by peers and coworkers; and
d) assisting the student in establishing relationships and becoming familiar with the written and unwritten norms of the clinical site.

GUIDE

As guide, the preceptor fosters the student's critical thinking ability in their approach to nursing care. The preceptor guides the student by:

a) showing them the way to provide safe, competent and optimal care;
b) tailoring experiences so that the learning objectives can be achieved; and
c) optimizing all learning opportunities in the clinical practice setting *(Myrick & Yonge, 2005)*.

EVALUATOR

As evaluator, the preceptor provides ongoing feedback to assist students integrate work and educational values to improve their psychomotor skills. Evaluation involves a process of observing the attitudes, professional values, and competence that are to be developed; giving feedback in a constructive manner, for example; and at all costs avoiding any embarrassment of the student in front of patients, other students, staff, or health professionals; and by being objective and fair at all times.

SAFETY NET

The preceptor also serves as a safety net as the student adapts to professional practice. Continuous and consistent support is a key responsibility. Similar responsibilities are perceived in the role of teacher and facilitator.

BEING AUTHENTIC

You truly teach who you are *(Brookfield, 2006)*. Each preceptor has a personal style. They inspire trust and encourage students to express their ideas, opinions and feelings openly in a safe learning environment. By being authentically and genuinely who they are, they will connect with the student and create a positive influence on both their learning and strengthen the preceptorship experience.

THE STUDENT

The role of the student is one of an active learner who contributes directly to the success of the preceptorship experience. The student is required to behave in a manner that is professional, reliable, accountable, and self-evaluative *(Myrick & Yonge, 2005)*.

PROFESSIONAL

Appropriate in one's communication with all members of the preceptorship triad, as well as with patients.

RELIABLE

Assumes responsibility for one's own learning.

ACCOUNTABLE

Assumes responsibility for her/his own professional actions. They will provide feedback to the preceptor as to their objectives, interests and progress.

SELF-EVALUATOR

Self- reflective about performance in a professional capacity.

The student will advance in their nursing knowledge and competencies. They will experience a change of behavior in themselves.

THE STUDENT AS ADULT LEARNER

When the preceptor meets with a nursing student, it is important to remember that they are meeting with an adult learner. Thus, when working with the student throughout the preceptorship experience, as follows in Table One, there are four basic principles of adult learning that need to be kept in mind.

TABLE ONE: BASIC PRINCIPLES OF ADULT LEARNING

Adults prefer to be in control of what is being learned	Previous experience is a rich resource	Learning that is most effective is relevant, useful, and perceived as significant	Learning is enhanced in a climate that is supportive, open to inquiry, and free from threat
invite the full participation of the learner	assess those previous experiences—e.g. personal or family history of asthma/allergy history can influence their sensitivity to patients experiencing similar symptoms	help learners develop and grow in problem-solving and decision-making skills within the framework of the immediate clinical site	demonstrate acceptance of the learner as a less experienced colleague
encourage an attitude of "ownership" of their learning experience	consider cultural values and life views when planning learning experiences	provide opportunities for the student to apply the information as soon as appropriate	be genuine, consistent, and approachable
expect students to show initiative and to be proactive in any learning experience			encourage questioning

Adapted from *Ready? Set! Precept!* A resource guide for the staff nurse precepting senior baccalaureate nursing students by W. Kabatoff, 2006.

THE STUDENT OF TODAY: A GENERATIONAL VIEW

The nursing student of today is not the traditional student of the past. While some students continue to enter university nursing programs directly out of high school, some enter only after a hiatus from studying. A larger number of students are older, while others may possess degrees outside of nursing. More international students, students from disadvantaged groups, and students with disabilities are entering the profession of nursing. There is also an increase in the number of men entering the profession. As well, it is not unusual for some students to occupy multiple roles, such as a spouse, a parent, and/or an employee *(Scanlan, Care, & Gessler, 2001)*. Moreover, the student of today is more diverse, complex and multifaceted.

As also alluded to, the nursing student may be described as an adult learner. "Learners are defined by their life experiences, and beliefs and values shape how and what one learns" *(Billings & Kowalski, 2004, p. 104)*. Not only are the demographics of students changing, but the generations are also changing. Although descriptions of generational characteristics are available in the literature, it is important to remember that while students may fit a particular generational profile, they are still individuals possessing their own uniqueness and life context. In other words, students may possess some, all, or none of these descriptors. Following is a summary of the characteristics observed in four generations that may be present in today's clinical setting. There is also an emerging generational group referred to as Generation Z. This group includes anyone born between 2000-2020.

TABLE TWO: CHARACTERISTICS OF THE GENERATIONS

	SILENT 1920-1940	BOOMER 1940-1960	GEN X 1960-1980	MILLENNIAL 1980 AND ONWARD
CHARACTERISTICS	Current age range: 76-96 Value loyalty to the workplace Team oriented and disciplined Expect & appreciate reward for hard work Make decisions from a militaristic authority position Respect authority and hierarchy Diversity in the workplace was not common, thus conformity, consistency, and uniformity were valued	Current age range: 56-76 Have the buy now, pay later mentality Rebellious and questioned the status quo Moved away from extended families Identify with their jobs Equate work with self-worth—driven and dedicated Believe they can change the world Believe they do not have to grow old and sedentary	Current age range: 36-56 Ironic, cynical, adept, clever, & resourceful Define themselves in opposition to parents Do not belong to any group Know how to win Manage on their own and participate in discussions Comfortable with technology Balance job and leisure time Adapt well to change Anxious when faced with decisions of adulthood Try to attain several goals at once	Current age range: 36 and younger Optimistic, assertive, positive, & friendly Accept authority – rule followers Accustomed to structure Cooperative team players Most racially and ethnically diverse group Think of themselves as global Prefer to multitask Difficulty honing skills of critical analysis due to volume of info available
OUTLOOK	Practical	Optimistic	Skeptical	Hopeful
WORK ETHIC	Dedicated	Driven	Balanced	Ambitious
VIEW OF AUTHORITY	Respectful	Love/hate	Unimpressed	Relaxed and polite
LEADERSHIP	Hierarchy	Consensus	Competence	Achievers
RELATIONSHIPS	Personal sacrifice	Personal gratification	Reluctant to commit	Loyal
PERSPECTIVE	Civic	Team	Self	Civic

	SILENT 1920-1940	BOOMER 1940-1960	GEN X 1960-1980	MILLENNIAL 1980 AND ONWARD
LEARNING STYLES	Prefer to learn in a stress-free environment and at a pace that is not rushed Most not really comfortable with the current array of information technology in educational settings Like to be actively involved in learning Motivated and disciplined group—want expectations to be explicit	Appreciate contact with faculty and prefer caring environment Prefer lecture format and are accustomed to being dependent on educator Learn best when they can relate personal experiences to the subject matter Enjoy positive reinforcement for their efforts and want to do well Connect learning to mission of agency—want to be connected	Self-directed learners; learn quickly & efficiently Want clear information with practical value—need to know vs nice to know Do better when they learn on their terms Enjoy flexibility in learning times Can manage delayed gratification	Have always experienced digital media and internet—use technology whenever available Use mobile devices to access/process information Prefer to work in teams and groups "Always on" connectivity blurs work and social time Active learners—seek innovation Zero tolerance for delays Learn immediately from mistakes (e.g. Nintendo)

Adapted from *Preceptorship and the Intergenerational Workplace Environment*, by V. Earle and F. Myrick, 2008; *Connecting generations: The sourcebook for a new workplace* by C. Raines, 2002, Copyright by Crisp Publications, Menlo Park, CA.; *Coaching generations in the workplace* by M. Weston, 2001; *Nursing Administration Quarterly*, 25(2), p. 11-21

THE FACULTY ADVISOR

In preceptorship, the faculty advisor role is different from that of the preceptor role. The faculty advisor (assigned faculty member) is a resource, a custodian of the teaching and learning process and evaluator of the overall experience. The role of the faculty advisor, therefore, should not be peripheral as their teaching expertise is invaluable *(Myrick, 2002)*.

RESOURCE

As resource, the faculty advisor:

a) ensures appropriate preparation for the preceptor and student roles;
b) provides critical support about the teaching and learning process;
c) is responsible for providing adequate student orientation to preceptorship and to the assigned practice setting;
d) assesses the student's readiness for the practicum *(Scanlan, Care, & Gessler, 2001; Yonge et al., 1997b; Yonge, Myrick, & Haase, 2002)*;
e) is also there as a support to the preceptor in their role as clinical teacher. "Clinical teaching and supervision is a skill, and it cannot be assumed that, by virtue of their knowledge and expertise, practitioners can automatically function as preceptors" *(Kaviani & Stillwell, 2000, p. 221)*;

f) can ease the transition for the preceptor by providing ongoing feedback and sharing teaching strategies *(Byrd et al., 1997)*; and
g) is a constant source of knowledge for both preceptor and student. In this capacity the faculty advisor must be readily available to meet with the preceptor and/or student, visit the clinical site routinely if geographically possible *(Myrick & Yonge, 2005)*.

The faculty advisor must remain connected, and be easily accessible to both the preceptor and to the student either by phone, pager, via the internet and/or email *(Myrick & Yonge, 2005; Yonge et al., 2002b)*. The faculty advisor's first priority is student learning, for which constant support is provided which in turn contributes to the student's level of competence and confidence.

CUSTODIAN

Although the faculty advisor is not the primary teacher in the preceptorship experience, they must nevertheless assume responsibility for the overall teaching/learning process *(Yonge et al., 2003)*, as the preceptorship experience is a requirement of the academic institution's nursing program. As the custodian of the teaching/learning process, the faculty advisor is responsible for ensuring "that the preceptorship experience meets the goals and objectives of the academic program and that the preceptor's expectations align with the overall learning objectives" *(Myrick & Yonge, 2005, p. 51)*. The faculty advisor clarifies the educational perspective *(Myrick & Yonge, 2005)*. In consultation with the preceptor and the student, the faculty advisor also provides regular feedback about the student's progress while ensuring that the learning experience is congruent with both the program and student's learning objectives *(Myrick & Yonge, 2005)*.

If required, the faculty advisor can provide:

a) guidance or input on student learning opportunities;
b) discuss potential teaching strategies;
c) clarify learning expectations; and
d) advise the preceptor about setting realistic goals for student independence *(Ferguson, 1996; Myrick & Yonge, 2001, 2005)*.

It is important to maintain open lines of communication between the academic institution and the clinical environment. In this regard, the faculty advisor acts as a liaison.

EVALUATOR

For success to occur, the faculty advisor acts as advisor about the evaluation process *(Myrick & Yonge, 2005)*. Research has shown that preceptors do not often feel sufficiently prepared to evaluate the student *(Coates & Gormley, 1997)*. Clinical evaluation is a key determinant of the student's future competence as a professional hence preceptors need ongoing support in assessing student performance and completing student evaluations. The faculty advisor can also advise the student as to how they can reach their goals and be successful *(Myrick & Yonge, 2005)*. If either the preceptor or student raises concerns about performance, the faculty advisor acknowledges these concerns and takes action immediately. The faculty advisor investigates the feedback and responds accordingly in an effort to ensure a successful outcome at the completion of the preceptorship experience. Part of the faculty advisor's role is to ensure the student's knowledge application *(Yonge et. al. 2003)*. Legally and ethically, the faculty advisor is responsible for the academic evaluation of the student's competency. Working with the preceptor, therefore, throughout the evaluation process is important to the faculty advisor in receiving ongoing feedback on the student's progress. Interestingly, Ferguson and Calder (1993) found educators and preceptors to be more similar, than different, in the valuing of clinical performance criteria. If a student's performance is evaluated as having an unacceptable level of practice by a preceptor, it is likely that the educator will arrive at the same conclusion.

The faculty advisor can also provide the preceptor with feedback on their performance as preceptor *(Myrick & Yonge, 2005)*. In fact, it is important for the faculty advisor to provide ongoing constructive feedback and support to the preceptor with regard to their performance as a clinical teacher *(Myrick & Yonge, 2005)*. This kind of support can serve to acknowledge that which the preceptor is doing well and provide the support they require to continue to provide a positive learning experience for the student, or it can be an opportunity to provide suggestions to integrate new teaching strategies to improve student learning.

Of particular significance to the preceptorship relationship is the establishment of professional boundaries. Following is a discussion of the meaning of such boundaries within the context of the preceptorship experience.

THE MEANING OF PROFESSIONAL BOUNDARIES IN THE PRECEPTOR STUDENT RELATIONSHIP

Boundaries are important in establishing and maintaining professional, therapeutic and educational relationships. Within the nursing profession, boundaries are most often viewed as limits that protect the space between the professional's power and the patient's vulnerability. Maintaining appropriate boundaries serves as a control for this power differential and allows for a safe connection between the professional and patient based on the patient's needs. Registered nurses (RN) working with students must also be aware of boundary issues. Preceptors can ensure that professional boundaries are respected by applying professional association guidelines to their nursing practice. Overall, maintaining professional boundaries protects the safe space and enhances the building of the trust which is essential in the preceptorship relationship.

Because the preceptor is required to evaluate the student's performance, it is essential that they refrain from developing a personal relationship with the student during the clinical practicum. It is also important that the preceptor-student relationship be devoid of any real or apparent conflicts of interest. Concerns about conflict of interest can arise if, for example, a student is a relative of the preceptor, or if the agency is actively recruiting the student for employment during the clinical practicum. Conflicts of interest must be identified and acted upon immediately by all parties involved in the conflict to facilitate a change of role assignments. An aspect of this relationship that frequently concerns new preceptors is how friendly the relationship can become. Common sense and personal judgment must be exercised. In making decisions about socializing with the student, preceptors are asked to keep in mind that they cannot be perceived to be giving this student an unfair advantage over past or future students or other students currently being precepted in the agency. Maintaining professional boundaries creates and protects the safe space and enhances the building of the trust, which is essential in the relationship. All nursing competencies, including the establishment of therapeutic boundaries, are achieved by thinking about and reflecting critically on one's actions, asking necessary questions, and putting principles into practice.

It is important to maintain a fine line between a professional and personal relationship with students. The information that preceptors and students share should be related to their work experiences. In the event that students reveal information

about themselves that indicate personal problems, preceptors should be able to refer students to relevant resources. Key to the decisions regarding the appropriateness of shared information is its relationship and impact upon the student's ability to perform in the clinical area.

A boundary violation can occur when the nurse, consciously or unconsciously, uses the preceptor- student relationship to meet personal needs rather than learner needs. Examples of violations include persuading students to purchase a product they are selling or endorsing, unduly influencing students to share transportation to and from work or becoming involved in their financial affairs (lending money). Boundary signs are warning signals that professional boundaries are in question, or have already been crossed. They serve to inform the RN to stop and take another look at a relationship. To circumvent such violations from occurring then, it is prudent to ask ongoing questions and to learn as much as possible about the signs.

Preceptors are encouraged to discuss concerns about performance with the faculty advisor. It is important to recognize that the evaluation of the student lies within the boundaries of this relationship and the relationship with the faculty. Information is shared within the guidance provided by the principle of "need to know", for example, sharing when students need direct supervision for specific procedures to insure safety for all involved. Legal and ethical issues may arise out of issues related to professional boundaries. The next section of the Guide will explore legal and ethical issues.

THE LEGAL AND ETHICAL ISSUES IN PRECEPTORSHIP

Each individual is accountable and responsible for their own actions and only for their own actions. Understanding legal implications for student actions should assist staff to delegate to students with less cause for concern. It is inaccurate to assume that students practice under the preceptor's license or under the faculty member's license. When providing nursing care, students are held to the same standard of care as the RN: that is, what would the reasonable prudent nurse with similar education and experience do? They are not held to a standard of perfection; rather they are held to the standard of their peers.

Students are expected to adhere to professional standards of practice and the code of ethics that have been developed to guide the profession, even though the students' educational experiences are not completed. They are responsible for clear communication of any limitations in ability to provide the assigned care, and for becoming familiar with the policies of the institution and to adhering rigidly to them. If there is no clear policy allowing nursing students to perform a particular nursing action, the student is best advised to not carry out the nursing intervention.

Preceptors are responsible for knowing and understanding the level of preparation of the student and the specific assignments of the student. Each preceptor must be able to use effective communication skills in interactions with students and educators. When an error is made by a nursing student, the context of the situation is taken into account.

Delegation and supervision are important components of the clinical experience. The preceptor is responsible for supervising and delegating appropriately to the nursing student. Preceptors are advised to provide direct supervision until both the student and the preceptor are comfortable with the level of competency demonstrated. In deciding how much responsibility to assign to the student, patient safety is paramount. The level of responsibility varies from student to student, from site to site, and from day to day at a given clinical site. Denying access to clinical learning activities owing to unsafe practice is an appropriate response to protecting the rights of patients to safe, competent and ethical care.

Communication among the student, the preceptor and the faculty member is critical. If a student demonstrates clinical performance that is potentially unsafe, the student and the preceptor who generated the assignment may be liable for any subsequent injury to the patient. Failure of clinical faculty to intervene when an unsafe situation exists with a student's level of performance could conceivably place the faculty member, the clinical agency and the educational institution in a legally liable situation. Understanding learning and personality styles is critical to preceptorship. Following is a discussion of learning and personality styles and their influence on preceptorship.

LEARNING AND PERSONALITY STYLES: IMPLICATIONS FOR PRECEPTORSHIP

An understanding of individual learning and personality styles can: a) contribute considerably to a productive preceptorship experience; and b) ensure a more individualized experience *(Brunt & Kopp, 2007)*. With regard to learning styles, it is important to note that there are neither good nor bad learning styles, they are simply the way individuals "receive, process and integrate new material" *(Brunt & Kopp, p 42)*. The term "learning style" itself has been used to exemplify thinking, perceiving and remembering the scope of acquiring knowledge. Learning styles influence how individuals acquire knowledge but not only in an educational sense. They also influence how people acquire knowledge in the broader aspects of everyday life; for example decision-making and problem-solving, *(Colucciello, 1999)*. Given the diversity of learning styles, it is not surprising then that identical instruction will not be effective for all students *(Myrick & Yonge, 2004; Dunn et al, 2001)*. One way to better understand how students learn is to be familiar with the different learning styles and the subsequent learning style students prefer. Students may be auditory, visual, kinesthetic, or tactile learners or some may be a combination of these. Students may also prefer individual or group learning techniques. Outlined below is Kolb's (1984) learning style model.

TABLE THREE: MODES OF LEARNING

MODES OF LEARNING	CHARACTERISTICS
CONCRETE EXPERIENCE (CE)	» require complete involvement, intuition, and feeling » function well in unstructured situations and are open-minded
REFLECTIVE OBSERVATION (RO)	» desire understanding of the meaning of new phenomena » different perspectives, different points of view and impartiality are valued » what is true or how things happen is important to these learners
ABSTRACT CONCEPTUALIZATION (AC)	» use logic, ideas, and concepts to generalize the meaning of what was observed » thinking in the scientific approach generates new theories » precision, rigor, and quantitative analysis are regarded in detail
ACTIVE EXPERIMENTATION (AE)	» prefer active testing of generalizations » practical application of what works is important » taking risks to accomplish goals are favorable among these learners

Adapted from *Preceptorship: teaching and learning manual resource*, by P. Bienvenu, 2005; *Experiential learning: Experience as the source of learning* by D. A. Kolb, 1984. Copyright by Prentice-Hill, Englewood Cliffs, New Jersey.

"For example, one could start with a concrete, immediate, here-and-now experience, reflect on the experience, think about the experience (thus leading to abstract conceptualization), and then end with active experimentation or testing of new ideas" (Myrick & Yonge, 2005, p. 99). Nursing students in the learning environment are frequently found at the concrete experience mode Based on these characteristics and preferences, from this model, Kolb (1984) identified four learning styles. As learners then, nurses tend to be primarily Divergers while Convergers are more likely to enjoy Context Based Learning (CBL) (Myrick & Yonge, 2005).

TABLE FOUR: LEARNING STYLES

LEARNING STYLES	CHARACTERISTICS
DIVERGER	» concentrates on feeling (CE) and watching (RO) » is imaginative » appreciates various perspectives » generates ideas » brainstorms well » is interested in people
ASSIMILATOR	» concentrates on thinking (AC) and watching (RO) » uses logic and inductive reasoning to create theories to understand concepts and observations
CONVERGER	» concentrates on thinking (AC) and doing (AE) » uses deductive reasoning and practical applications of ideas to solve problems » is more interested in things than people
ACCOMMODATOR	» focuses on feeling (CE) and doing (AE) » is an opportunity-seeker and risk-taker » solves problems by the trial-and-error process » adapts by carrying out plans » is comfortable with people and will use them to gather information

Adapted from *Preceptorship: Faculty advisor teaching and learning manual resource*, by P. Bienvenu, 2005; *Experiential learning: Experience as the source of learning* by D. A. Kolb, 1984. Copyright by Prentice-Hill, Englewood Cliffs, New Jersey.

Bloom's Taxonomy, consists of three domains of learning.

TABLE FIVE: DOMAINS OF LEARNING

THREE DOMAINS OF LEARNING	CHARACTERISTICS
COGNITIVE LEARNING	» involves mental skills » is further categorized into six levels: (a) knowledge or memory recall (b) comprehension or understanding (c) application or the use of facts, rules, and principles (d) analysis or separating and distinguishing (e) synthesis or building back up (f) evaluation or making judgments
AFFECTIVE LEARNING	» involves feelings, emotions, and attitudes
PSYCHOMOTOR LEARNING	» involves manual or physical skills

Adapted from *Preceptorship: teaching and learning manual resource*, by P. Bienvenu, 2005.

Knowing how students learn enables the preceptor to confidently create an effective learning environment by incorporating appropriate teaching strategies to facilitate student learning. When adapted to the preceptorship experience "… students are likely to learn more, retain information for greater periods of time, experience less anxiety, enjoy the learning process, and effectively manage unexpected events" *(Myrick & Yonge, 2005, p. 99)*. A mismatch of learning styles may lead to conflict *(Byrd et al., 1997)*. Research, however, is inconclusive on compatibilities.

PERSONALITY STYLES

Personality style relates to how an individual may be described as a person *(Myrick & Yonge, 2005)*. For example, a person may be described as extroverted, introverted, optimistic, pessimistic, etc. These styles need to be considered during preceptorship especially in light of the fact that the preceptor and student will be working together for a concentrated period of time under what may be described as a demanding set of circumstances. In such a close working relationship, inevitably there is the potential for misunderstandings owing to personality styles and the resultant perceptions. Understanding the different personality styles therefore can serve to allow both the preceptor and the student to more readily understand one another's responses to different situations and thus avoid any possible misconceptions of each other.

There are a variety of assessment tools that have been described in the literature for determining personality style. *The Myers-Briggs Type Indicator*, cited by Anderson (1998), identifies four personality styles, which are summarized below.

TABLE SIX: PERSONALITY STYLES

PERSONALITY STYLES	CHARACTERISTICS
EXTRAVERSION AND INTROVERSION	» is related to a person's orientation toward life » extroverts like working in groups, use trial-and-error methods to solve problems, are active, and think on the go » introverts, on the other hand, like working independently and learning the material before experiencing it; they tend to prefer lecture styles, and are inclined to reflect on things
SENSING AND INTUITION	» is concerned with a person's manner of perceptions » sensing people are detail oriented, want facts, and prefer practicality » intuitive people rely on their intuition, enjoy the abstract, and like to discover new possibilities
THINKING AND FEELING	» needed for decision-making » thinking people prefer the logical, the objective, and fairness » feeling people thrive on personal relationships, being respectful of human values and beliefs
JUDGING AND PERCEIVING	» involves dealing with the outside world » judging people are focused on completing a task, decisive, and organized » these people prefer structure » perceptive people are curious, adaptable and spontaneous, and flexible

Adapted from *Preceptorship: Faculty advisor teaching and learning manual resource*, by P. Bienvenu, 2005; *Preceptorship: Preceptee manual*, by P. Gittins, P, 2007; *Ready? Set! Precept! A resource guide for the staff nurse precepting senior baccalaureate nursing students* by W. Kabotoff, 2006; *Orientation with style: Matching teaching/learning style* by J. K. Anderson, 1998, *Journal for Nurses in Staff Development* 14(4), 192-197.

People do not fit neatly into these categories, however. In fact, each person may possess characteristics from a combination of these styles. Ideally, preceptorship would be most successful if personality styles could be matched, but practically, this is not often feasible. The greatest compatibility issue appears to arise between the introvert and extrovert personalities. Matches in this area reveal greater satisfaction, but does not detail how effective the teaching was. Research is lacking in this area. A mismatch between these two personality styles could be challenging, but may encourage personal growth. Of utmost importance is the awareness of preferences. Styles can then be modified to support learning *(Anderson, 1998)*.

SUGGESTED APPROACHES TO PROMOTE CRITICAL THINKING

A major focus in baccalaureate nursing education is the promotion of critical thinking. It is important that critical thinking be fostered, facilitated and supported throughout preceptorship.

What is critical thinking?

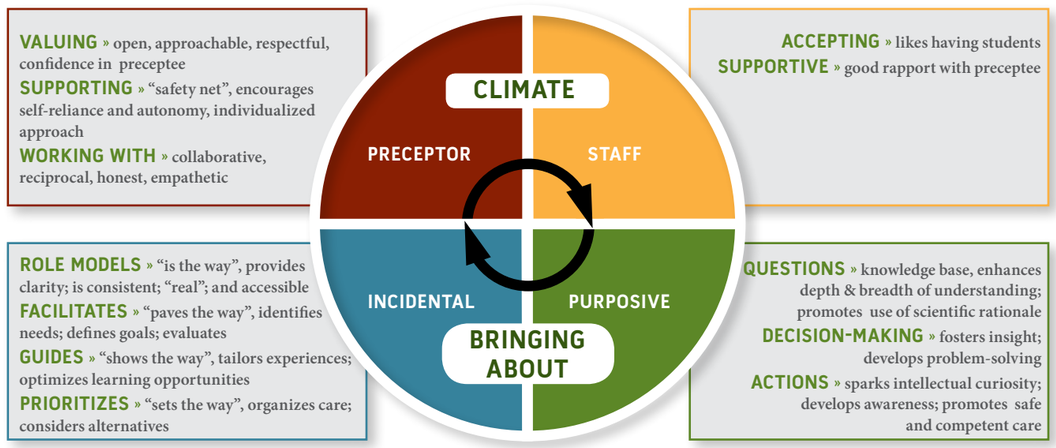
The term critical thinking is often described in a variety of ways. According to Brookfield (1987) and Paul (1993), critical thinking refers to:

» Purposeful, informed, results-oriented thinking requiring careful identification of problems, issues, and involved risks.
» The use of both logic and intuition, based on knowledge, skills, and experience and is supported by professional standards and ethics.
» The constant re-evaluation, self-correction, and striving to improve.
» Imagining and exploring alternatives.
» Reflective skepticism.
» Thinking outside the box, challenging the status quo and putting it all together all at the same time!
» The questioning of your own assumptions or how and why you respond to situations the way you do.

All cognitively intact people are capable of critical thinking, however, they have to want to use that ability and need to be encouraged to do so.

The Preceptorship Critical Thinking Model (PCTM) is a research-generated model that visually represents the multifaceted process that occurs in the preceptorship experience to enable students and preceptors to develop and promote their ability to think critically. This model emanates from a research study involving both preceptors and students *(Myrick, 2002)*. Three key concepts emerged in this model: the importance of the learning climate and the indirect and direct behaviors that preceptors use to "bring about" critical thinking.

FOSTERING CRITICAL THINKING IN PRECEPTORSHIP



Adapted from Preceptorship and critical thinking in nursing education by F. Myrick, 2002, *Journal of Nursing Education* 41(4), p. 154-164

The Climate found to be most effective in fostering learning is one that provides support, is devoid of threats, and promotes openness, inquiry and trust *(Myrick, 2002; Myrick & Yonge, 2005)*. If students are in constant fear and experiencing a high level of anxiety, they are unable to think critically or unable to think at all. The preceptor needs to be able to support, work with, value and respect the student. The safety to err, an atmosphere of inquiry as opposed to inquisition, and openness to new ideas are essential for effective learning to take place. Working collaboratively, the preceptor gains the student's trust. In turn, such trust allows students to discover and seek out new experiences, to become responsible and accountable for their own decisions and to think critically about those decisions and their ability to reach the decision autonomously. While other staff members may not be directly responsible for the student's learning, they do contribute significantly to the creation of a positive learning environment. Staff attitudes including receptivity and rapport, facilitating access to learning experiences and the willingness to engage in a teaching relationship contribute to a positive learning environment.

INCIDENTAL BEHAVIORS

Within this supportive climate, preceptors are able to bring about critical thinking indirectly through their role modeling, facilitating, prioritizing and guiding behaviors *(Myrick, 2002; Myrick & Yonge, 2005)*.

ROLE MODELS: Students can learn as much from their preceptor's behaviors as they do from their verbal communications. Usually, only the outcomes of critical thinking are observable. The preceptor, however, can make critical thinking processes "visible" by pointing out what they observed to trigger the process, what additional information they needed to act, how they interpreted that information, how they chose the particular action, how they evaluated and will continue to evaluate the efficacy of the chosen action. Thinking aloud permits the preceptor to more effectively model the skills and thought processes involved in prioritizing, managing time, and delegating. Critical thinking can also be promoted when the preceptor asks the student to think aloud. The preceptor can thus clearly identify gaps in understanding and offer corrective feedback. Externalization of the thinking process is what is meant by modeling critical thinking.

FACILITATES: By drawing on their own expertise and experience, a preceptor can pave the way for students to discover what they require to achieve their individual learning goals. *(Myrick, 2002; Myrick & Yonge, 2005)*. Effective facilitation requires collaboration, open communication, as well as expertise/resources in the clinical practice setting. Collaborating with students in the selection of appropriate experiences accommodates individual styles of preferences, interests, and learning. The preceptor can facilitate students' learning by exposing them to the many resources that already exist in the clinical practice setting by arranging for students to attend rounds, case conferences, or meetings that relate to their learning objectives, and arranging for access to technology, audio-visual aids and learning centers.

GUIDES: The preceptor guides students' practice by validating psychomotor competencies, foster- ing clinical judgment, and giving immediate performance feedback as necessary *(Myrick, 2002; Myrick & Yonge, 2005)*. The preceptor supports the student in acquiring the knowledge and skills that they require for the provision of safe and competent patient care, and for assuming the role and responsibilities of the nurse in the clinical setting. The preceptor also assists the student in formulating and revising their learning objectives and goals.

PRIORITIZES: One of the areas in which preceptors consistently find that nursing students need the most assistance is in priority setting and time management *(Myrick, 2002; Myrick, 2005)*. By assuming a helping rather than a corrective manner, preceptors can encourage students to examine the thinking underlying their prioritization. Sharing the clinical site's preferred method of organizing staff nurse responsibilities, as well as offering a variety of approaches, can equip the student with some basic tools to use in organizing patient care.

Inherent to preceptorship is providing feedback to novice nurses. The next section will explore strategies for effective feedback.

EFFECTIVE FEEDBACK STRATEGIES

Feedback is literally feeding back what the preceptor sees and hears. It is a snapshot of behavior. Students, especially those of Generation X and Y, crave feedback on their performance. Feedback, positive or negative, serves six major functions for both the student and the preceptor:

- offers on-going information about student progress
- forms the basis of the preceptor's final evaluation
- reinforces appropriate behavior
- assists in professional development
- assists students in reaching their goals (Kabatoff, 2006)

GUIDELINES FOR FOCUSED FEEDBACK:

1. BE SURE YOU UNDERSTAND THE PURPOSE OF THE FEEDBACK.
What do you want to achieve by providing the feedback?

2. CONSIDER THE TIME AND PLACE.
Select a time when the student is calm and not feeling vulnerable and a place that is private. If others are present, feedback about a situation that did not go well can be both humiliating and distracting for the student.

3. DESCRIBE THE SPECIFIC BEHAVIORS THAT YOU HAVE OBSERVED.

a) Avoid opinions, rumors, gossip or second-hand information. Focus on the facts of the situation.
b) Be specific when describing the behavior indicating when and where it occurred, who was involved and what the results were.

4. DESCRIBE YOUR REACTION TO WHAT YOU OBSERVED BY SHARING WITH THE STUDENT HOW THE BEHAVIOR MADE YOU FEEL BY:

a) Using "I" statements to lessen defensiveness and resistance to what you say. For example: "I am concerned about the safety of the patient when the call bell is not within reach" instead of "How could you be so forgetful to leave the patient without his/her call bell." "I was disappointed when you did not call to inform me/us that you would not be here yesterday" instead of "You were irresponsible and thoughtless. You know it is important to inform me/us."
b) Using an even, calm tone of voice.
c) Being positive, ensuring that negative phrases are distinct from positive ones. For example, omit words such as "but" "however" "having said that" after saying something positive. Such words serve to increase anxiety by "setting" the student up for the words that follow them which inevitably feel more like criticism rather than feedback that is corrective and constructive.
d) Addressing behavior that can change, not characteristics that cannot be changed.

5. FOCUS ON TIMELINESS.
Feedback is generally meaningful if given as soon as appropriate following the observation, otherwise inaccurate recall can occur. Defer feedback if it means a delay in patient care, or embarrassment to the student.

6. FOCUS ON THE VALUE OF THE FEEDBACK FOR THE STUDENT.
The feedback should serve the learning needs of the student rather than provide release for the preceptor.

7. FOCUS ON THE AMOUNT OF FEEDBACK THAT THE STUDENT CAN USE; DO NOT FOCUS ON HOW MUCH YOU MIGHT LIKE TO GIVE.
Overloading the student with feedback reduces the possibility that the feedback will be used. Avoid, "and here's something else to think about".

8. **CHECK THE STUDENT'S UNDERSTANDING, ASKING HER/HIM TO EXPLAIN WHAT WAS HEARD FROM YOU.**
   Pay close attention in the event that clarification is required.

9. **EXPLORE WITH THE STUDENT HOW HIS/HER BEHAVIOR CAN TO BE CHANGED TO RESOLVE THE ISSUE.**

10. **BE SUPPORTIVE.**
    Let the student know you believe in her/his capability of following through with the plan for improvement. This technique can be fast, efficient and well suited to the time constraints of nursing practice.

THE FEEDBACK SANDWICH: THE BASIC RECIPE

This exchange focuses on the student's patient-communication skills.

PRAISE "You did a good job reflecting the patient's emotion. I observed tears in her eyes when you said, 'This diagnosis must feel devastating to you.'"

CRITIQUE "When you moved on to the exam, she was still crying. I suggest waiting 30 seconds more in silence. It is healing to have someone give you room to feel."

PRAISE "The patient shared her feelings with you, because you appeared supportive, professional, relaxed and comfortable with her emotions." *(Dohrenwend, 2002)*

EXAMPLES OF FEEDBACK

BLAMING OR CRITICAL	"I" STATEMENTS
You really need to work on your charting.	When I reviewed your charting, I noticed that the morning charting did not include any reference to morning care.
You have a bad attitude!	I have heard a number of concerns and I am wondering if you could tell me about your perspective on this situation.
Your documentation was a real mess last week!	At the end of the week, I reviewed the documentation and noted that specific information was missing; additionally, some patient information was misfiled.
Why did you talk to the patient that way this morning?	I am wondering if you could tell me about your interaction with the patient this morning.
You're so disorganized.	I have noticed that patient tasks are not completed prior to the completion of the shift. Could you please tell me exactly how you organize patient tasks?
That was a truly insensitive thing to say. Why do you always interrupt? And by the way, you were late again this morning!	Reflecting on your conversation with the patient, what did you notice went well and what did not go well? It is important to consider the feelings of others when talking and it is critical to listen carefully before responding. (Preceptor could also initiate a role play to re-do the conversation.) Additionally, I have noticed that you are often not on time; are there specific challenges to your arriving promptly?
You might have done that dressing well enough but it took forever. Did you notice that the patient was in a lot of pain?	The dressing was completed correctly (i.e., list the specific components observed). Let's discuss two areas to consider when performing a dressing change: pain levels and timeframes.

WAYS TO FACILITATE THE EVALUATION PROCESS

There are three major reasons for evaluation:

1. It is a basic expectation of any learning experience.
2. It promotes modeling as to how to assess current strengths and areas for improvement for the purpose of fostering professional growth and development.
3. It enhances the quality of the learning experience. *(Kabatoff, 2006)*

The preceptorship experience—from setting expectations in the first week to ongoing observations and behavior-specific feedback is based on evaluation. An awareness of the evaluation process should be maintained throughout the experience. It is not just the scheduled formal session at the completion of the placement. Feedback plays a critical role in evaluation. The ongoing evaluation that occurs is often referred to as formative evaluation, a process in which the student is assessed by the preceptor "for" their learning. In other words, it is carried out to determine where the student is in their learning and what exactly does the student require to facilitate their learning. Students need an opportunity to internalize the knowledge that they acquire in the clinical setting before any appreciable change can occur in their performance. That is why it is so important to ascertain exactly what each individual student requires before beginning the process of evaluation. When summarized over a period of time and analyzed in terms of improvements made, your feed- back is the basis of your final or summative evaluation. Writing the final evaluation (referred to as summative) can be carried out much more smoothly if evaluation methods/tools have been used throughout the experience.

Evaluation tools include direct observation, anecdotal records, daily or weekly journals, learning plans, student led seminars, scholarly papers or projects.

1. Observation of students' care of clients and decisions made about that care. Personal observations are the primary source, however observations from the nursing and other staff and patients also need to be considered. At times, these individuals will approach the preceptor who then needs to document or record the specifics of their observations of the student or what they heard the student do or say.

2. Records of these observations are referred to as anecdotal notes. These records should include notes of the student's daily and weekly assignments and must be factual and nonjudgmental, identifying both strengths and areas that require improvement. Such notes provide documentation that the student has been provided with adequate opportunity to meet the clinical learning objectives and has been afforded due process or the ability to be able to improve their performance in a reasonable amount of time.

REMEMBER TO: PRAISE IN PUBLIC, CRITIQUE IN PRIVATE

3. Student self-assessment/evaluation is a powerful method of evaluation and can initiate performance evaluation in a nonthreatening manner. Even if students do not fully achieve what they had hoped to achieve, it is important that they leave the experience feeling that they have gained something positive from the experience, discovered more about themselves, and identified new learning needs previously unknown to them. Information from the student's evaluation tool should be compared with information from the preceptor's tool.

4. Critical incidents should be documented immediately. The "Reflecting on Your Practice" form provided by CARNA to its members is an easy format with which to initiate the process. When a preceptor has concerns about the student's performance they should first and foremost contact the faculty advisor. With the faculty advisor's assistance, the preceptor will be able to identify the actions taken and the other individuals with whom the behaviors have been discussed and collaboratively outline the plan for follow-up.

5. Faculty involvement—Addressing a situation about which the student has been unable to meet the performance expectations is always stressful. While these situations are the exception and not the rule, when they do occur, preceptors need the support of the faculty advisor when they occur. Failure to address the situation, on the other hand, can have personal, professional and legal repercussions.

Remember: There should be no surprises in the final evaluation meeting if communication has been open and consistent for all participants. As previously alluded to, this process is referred to as "due process;" a process to which every student is entitled. In other words, every student deserves the right to have the opportunity to improve upon their performance prior to any final evaluation.

Sometimes, there is a need for more intensive feedback or intervention when patient safety is an issue. Following is a discussion on addressing unsafe practice.

GUIDELINES FOR ADDRESSING UNSAFE PRACTICE

THE UNSAFE STUDENT: WHAT TO DO

Paramount to nursing practice is patient safety. There are times, however, when a student may demonstrate insufficient knowledge, skills and/or attitudes. In such circumstances preceptors must attend first to patient safety and second to the student. The question thus becomes how best to address unsafe student practice. The most recent literature on precepting the unsafe student details strategies for supervising and teaching students as well as definitions for providing understanding and context.

Beginning with definitions, Scanlan et al. (2001) explain unsafe practice as "an occurrence or a pattern of behaviour involving unacceptable risk" (p. 25). Throughout the literature (Hrobsky & Kersbergen, 2002; Scanlan et al., 2001; Yonge et al., 2002), "the term unsafe student is used to refer to students whose level of clinical practice is questionable in the areas of safety or to students with marked deficits in knowledge and psychomotor skills, motivation, or interpersonal skills" *(Luhanga, Yonge, & Myrick, 2008, p. 214)*. Most notable is the focus on safety and risk; preceptors are ultimately responsible for patient safety and thus must be aware of student behaviours that may result in patient risk or harm. Of equal importance yet different is the need for preceptors to be aware of a student's interpersonal skills and personal motivation. Harm may be visited upon a patient in which the unsafe student does not possess the motivation to respond appropriately to a patient's language, symptoms or signs of distress, or when the student struggles to engage in interpersonal relationships.

There are a number of strategies for precepting the unsafe student in the research literature *(Kleffner, 2002; Langlois & Thack 2000; Shapiro, Ogletree, & Brotherton 2002; Teeter, 2005; Vaughn, Baker, & DeWitt, 1998)*. The most recent research reveals that strategies engaged in by preceptors can be organized into three headings that reveal the progression of activities which preceptors must undertake: "(1) strategies for the prevention of unsafe practice; (2) early identification of unsafe practices; and (3) dealing with unsafe practice" *(Luhanga, Yonge, & Myrick, 2008, p. 216)*.

1. STRATEGIES FOR AVERTING UNSAFE PRACTICE

The idiom, an ounce of prevention is worth a pound of cure, is important to keep in mind at all times. To that end, the preceptor needs to:

» Be familiar with the program and course expectations.
» Understand what the student is required to learn and know.
» Communicate expectations to the student in a clear and thoughtful way.
» Set the standard for behaviour, professionalism and clinical competence.

Invite the student to share his/her expectations in an effort to understand their perspective, and ensure congruency with course objectives

2. EARLY IDENTIFICATION OF UNSAFE PRACTICES

Preceptors need to be aware of a student's performance from the very beginning. Awareness and knowledge of a student's performance is based on:

a) observing the student directly;
b) listening to feedback from colleagues and patients;
c) receiving information from faculty advisors; and
d) being vigilant in monitoring the student's activities.

It may be necessary to solicit additional feedback from colleagues or faculty advisors to confirm the student's competency level and to ascertain whether what is being observed is an ongoing behaviour or a lone incident. Of key importance is to "maintain an ongoing record." Observations should always be documented in an objective format so that there is a detailed record of circumstances to which to refer.

3. ADDRESSING UNSAFE PRACTICE IMMEDIATELY

It is generally agreed, notwithstanding which strategy is employed to mitigate the consequences of unsafe practice, that the situation be addressed immediately and with a focus on patient safety. This process will most often mean that the preceptor must complete the delivery of clinical services. Following the incident, follow-up is required. Luhanga, Yonge, & Myrick (2008) found that preceptors employed the following strategies for addressing unsafe practice:

» Convey the problem to the learner in a private setting, as soon after the incident as is possible and determine if the student is aware of the problem prior to addressing the concern.
» Develop a plan of action for further knowledge and skill development to which preceptor and student agree and which is documented.
» Communicate the incident to the faculty advisor. Do not wait for a second occurrence.
» Interrupt and explain the correct approach in the event of a major mistake. In this way, the preceptor models the correct approach. Potentially, the student will have another opportunity at another time to return demonstrate.
» Provide consistent support and constant observation to determine if and when the student has integrated the correct knowledge, skills and/or attitude necessary to engage in safe practice.
» Encourage practice as a way to achieve proficiency in skills.
» Question and give reading assignments to assist students to grasp the necessary knowledge for practice.
» Create an environment conducive to learning. Students must feel safe in a relationship. When preceptors have a positive attitude, students feel safe to ask questions and to 'not know".
» Insure privacy when giving timely, specific, honest, ongoing and constructive feedback. Learning ceases when specific, honest, constructive feedback is not given either in a timely manner or in an appropriate and respectful setting.
» Engage in self-evaluation for own personal growth and confidence.
» Maintain a high standard of practice. Such practice demonstrates professionalism and integrity.
» Do not be reluctant to seek assistance from others, either the faculty advisor or colleagues, especially early in the process of identifying unsafe practice.

» Should all of the above fail, "change of environment or preceptor, reduction of the student's patient load, review of areas of practice with instructor, additional/repeat practicum, and counseling of the student to discontinue the program" may be required. ***Patient safety is always paramount.***

Part of safe practice includes awareness of and attention to diversity. The next section of this Guide will highlight cultural competence and safety.

THE RELEVANCE OF CULTURAL COMPETENCE AND SAFETY TO PRECEPTORSHIP

Facilitating the learning of nursing students in preceptorship can be, on the one hand, exciting and, on the other, quite challenging. With the escalating numbers of international students in nursing programs for whom English may not be their first language, it is increasingly incumbent upon preceptors and faculty advisors to provide a safe and supportive learning environment *(Seccombe & Roeters, 2010)*. "Recognising cultural perspectives is an essential component of respect for the person" *(De & Richardson, 2008, p. 39)*.

In order to provide a culturally safe and effective teaching and learning environment, it is critical to recognize that people vis à vis students are diverse and do not necessarily think the same way as the preceptor or faculty advisor *(Seccombe & Roeters, 2010)*. Being culturally safe requires that preceptors and faculty advisors be aware of diversity and take the time to examine their own beliefs, values and assumptions that they make about such diversity. The term safety is prominent in the nursing profession and has usually been interpreted to imply that the individual nurse is competent and fit to practice. Traditionally, preceptors have been taught to treat all patients equally, however, currently it is recognized that difference should be celebrated and not dismissed or indeed repressed. Preceptors and faculty advisors who make unsubstantiated assumptions or who have stereotypical attitudes about students can seriously impair the teaching and learning experience and for that very reason cultural safety is a must *(De & Richardson, 2008; Papps & Ramsden, 1996)*.

The term cultural safety is a relatively new concept within the nursing literature, a complex one that identifies the need for nurses, and all professionals, to be critically aware of the dominant influences that predispose their individual attitudes and knowledge to a specific way of viewing and categorizing each person based on his/her appearance and/or identification with a particular group within society. The primary objective for raising cultural safety to our professional and personal awareness is to contribute to a sense of increased equity: "…a focus on power imbalances and inequitable social relationships in health care" *(Browne,Vacoe, Smy, Reimer-Kirkham, Lynam, & Wong, 2009, p. 168)*. It is also a

call to action; a robust reminder that all people are deserving of the highest caliber of health care available regardless of their history or present circumstances and likewise all students are deserving of the highest caliber of teaching or precepting. Seccombe and Roeters (2010) report that nursing students were able to articulate that, "… on the most basic level, understanding that people are different to you and don't think the same way is crucial in providing culturally safe and effective nursing practice." (p. 22).

In order to demonstrate competence in a culturally sensitive approach to care, research is revealing that self-awareness is a critical component. Similarly, such awareness is also integral to a successful preceptorship experience with regard to the context of student learning. Jirwe, Gerrish, Keeney and Emami (2009) completed a study in which they discovered that self-awareness is essential to the ability of the nurse to provide culturally competent care to patients. "In this regard, nurses need to develop an understanding of their own cultural identity, stereotypical assumptions and potential ethnocentrism to adopt a nonjudgmental approach in their interactions with people from a different culture to their own." (p. 2630). Their study also revealed the following important components of cultural competency: respect, compassion, openness and tolerance as well as flexibility, empathy, understanding and awareness of the breadth of difference in the world. These concepts are all key to a successful preceptorship so that preceptors, students and faculty advisors alike recognize their own stereotypical assumptions and take steps to insure that they extend to one another the best possible preceptorship experience.

SUMMARY

Preceptorship can be described as a major milestone in every nursing student's undergraduate program. Preceptorship is "a model or approach to teaching-learning in the practice or field setting that pairs students or novice nurses with experienced practitioners" *(Myrick, & Yonge, 2005, p. 3)*. Such pairing is designed to foster professional socialization, promote critical thinking, enhance learning, and facilitate competence. Preceptorship requires a successful relationship among the triad (preceptor, student, faculty advisor) in particular between the student and the preceptor. Without that connection, the experience can prove to be an unsuccessful one.

This Guide to Preceptorship is designed to provide the preceptor, the student and the faculty advisor with the knowledge to inform their approach to the preceptorship experience. It provides insights into specific considerations that contribute to the context of preceptorship and elucidates research evidence that is available to support ways to best support the teaching learning experience in the clinical practice setting.

FAQS—QUESTIONS PRECEPTORS FREQUENTLY ASK

1. I don't feel prepared to be a preceptor. Where can I go for help?
   The primary faculty contact for preceptors is the individual faculty advisor assigned to the student. Preceptors are, however, also welcome to contact the course coordinator about any preceptorship concerns that need to be addressed.

2. How do I contact the faculty advisor?
   The faculty advisor's contact information will be given to you via letter and personal contact (e.g., visit email or telephone call).

3. What are the advantages of my being a preceptor?
   Because of your experience as a clinician you will have the opportunity to share your knowledge and skills, the satisfaction of witnessing the student develop into a more confident, self-directed, and integrated part of the nursing team and the opportunity to learn up-to-date nursing information from your student.

4. What teaching skills do I need to be a preceptor?
   This question is a complex one and is dependent on a number of factors. The degree of motivation, confidence, and independence of your student will determine what is expected of you. The following strategies may be useful to you:

   Orientation Plan: Since the student is new to your area they will need an orientation to your agency which might include reviewing the policies and procedures, identifying availability of re- source manuals, locating equipment, and describing the formal and informal communication structures. You may have the student conduct a scavenger hunt or answer direct questions.

   Demonstration of Skills: Frequently you will have to demonstrate how to carry out a nursing intervention. To demonstrate a psychomotor skill, the initial demonstration should be carried out slowly with exaggerated movements, complex aspects of the procedure being repeated. Before or after the demonstration, discuss with the student the principles underlying the intervention so they are able to integrate the theory and practice components.

   Guided Practice Skills: When the student feels they can perform the demonstrated skill, allow them time to explore and work with the equipment as soon as possible after the demonstration. This approach will decrease their anxiety and fears of making an error. While the student is returning the demonstration, give specific feedback on their practice (do so in a private location). You will have to decide if the student is ready to independently perform this skill.

   Role Modeling and Discussion Skills: If you are engaged in health teaching or providing support to a patient, the best practice is to role model what you do. You may have different values than your student. If so, be free to debate them and if resolution is not possible, you may have to agree to disagree. When there is conflict and the usual solutions involving compromise or negotiated outcomes cannot be reached, consult the clinical faculty advisor.

5. Who is legally responsible for the student?
   The student is legally responsible for his/her own actions. If she/he acts under your direction and the action is negligent, then both of you are responsible. The educational institution has malpractice insurance that covers the student when acting in accordance with policy. The best protection for the student is to read the policies of the institution and to adhere rigidly to them. If there is no policy for a particular nursing action, the student should not carry out the nursing intervention.

6. How do I go about helping the student adjust and feel comfortable on my unit?
   There are many ways to do this but many preceptors meet with the student prior to the experience and take them on a tour through the unit and introduce them to the staff. Other preceptors talk with the student on the phone and meet them the first day to show them around the unit. It is also helpful to have your student observe you and the unit for at least one shift to lessen the anxiety (buddy shift).

   It is also recommended that you take your breaks together/at the same time until you both feel comfortable with each other. Aside from orienting the student to the unit, please arrange for the student to have a tour of the health facility.

7. My student worked this summer as an Employed Nursing Student and believes that he/ she is able to carry out procedures because they did so this summer. However, I think that the procedure is outside what they are allowed to do. What do I do?
   This situation is a common challenge owing to the current nursing shortage. The best advice is to practice safely by exploring the changing policies in your agency and possibly those that are unique to your clinical site. The Clinical Nurse Educator for your area is an important information resource for this concern.

8. We are short on the unit today and the manager wants to use my student to fill in for one of the nurses? How do I respond to this request?
   The student is not to be considered staff. He or she should always be assigned with you and under no circumstances is the student to replace a regular staff member.

9. What skills may the student perform?
   The skills students can perform can be different depending on where you work. Your educator and/or manager may have senior student policies that you need to follow. You can also check with the faculty advisor and the student for the University of Prince Edward Island, School of Nursing policies.

10. What happens if the student is ill?
    The student is required to notify the clinical site and the clinical faculty advisor. The student is expected to complete 320 hours of clinical practice in the final preceptorship course. Hours missed due to illness will need to be completed by a course specified date.

11. What happens if the student sustains an injury while on the unit?
    The student must fill out the Workers' Compensation Board (WCB) forms from your (the preceptor's) agency and also the University of Prince Edward Island School of Nursing forms. The preceptor, faculty advisor and course coordinator must be notified immediately.

12. What if I am just too busy to explain what I am doing to the student?
    One idea is to have your student write down his/her questions and plan a five or ten minute question session two or three times during your time together. Any time you carry out a procedure and explain it to the patient, invite your student to listen in.

13. What do I do if there seem to be too many questions?
    Lots of questions can come from enthusiastic and sometimes nervous students and for the most part, questions from nursing students should be welcome. However, if the questions do arise out of nervousness instead of critical thinking, try giving the student a short assignment to complete independently that might be related to the questions being asked. Then, spend an agreed upon time discussing what the student was able to find. If that does not work, call the faculty advisor to help you and student draw up a plan. Using the process of constructive feedback, you can let your student know the effect of excessive questioning and look for alternative solutions.

14 How do I help my student organize for the day?
Share with him/her how you organize for the day. Share tips and organizational strategies that you use. Take five minutes at the beginning of the shift to assist him/her to plan their day.

15. My student is having difficulty with daily documentation in the chart. How can I be of help?
It may be helpful to have the student write out documentation and show it to you before writing it in the chart. You could provide your student with some scenarios and have them do mock documentation for your critique. Many agencies have documentation guidelines that can be shared with the student.

16. My student is very quiet. I am having a difficult time engaging him/her to participate in nursing conferences. How can I encourage him/her to be more active in this role?
Quiet students may present a challenge, as it is difficult to know what they are thinking or what they know. Through a constructive feedback process, speak privately with the student and work out an alternative solution. While it is not a matter of asking for a change in personality, the ability to make verbal contributions in the health care setting is a skill that needs to be practiced. With your direction and support the student will become more confident to speak up. This is a time when you might want to contact the faculty advisor for working through a plan with the student.

17. My student has reported to me that another health care provider has acted in an unethical/unsafe manner. What do I do now?
The first priority must be to ensure patient safety. Document, document, document (facts and behaviours). Report to charge nurse and faculty advisor. The incident may need to be reported to the professional conduct committee of CARNA. Support your student. This can be a very stressful time.

18. What are the main reasons for which I should contact the faculty advisor?
Contact the faculty advisor when you need to discuss the progress your student is making. While this often relates to areas of concern, it should also include sharing what your student is doing well. Your observations and experiences with the student are important to the faculty advisor.

19. How do I go about evaluating the student?
Please discuss this with the faculty advisor. Refer to the section in the guide on evaluation.

20. At what level should the student be working at the midterm? At the end of the rotation?
Each student is different but usually, at midterm, the student should be comfortably assuming at least half of a patient assignment to that of a graduate nurse and managing with minimal assistance. There is no expectation that a student should assume a full patient assignment by midterm. At the end of the rotation, the student should be working with a full patient assignment for a graduate nurse with minimal assistance. The complexity of the clients will differ depending on the site. Please consult with the faculty advisor to discuss these expectations.

21. Any suggestion on when I can let the student "fly" on their own? How will I know they are ready?
You are the clinical expert here. How are they managing with return demonstrations of procedures? Are they practicing safely? Will they ask for help if needed? Stand back and observe from a distance.

22. My student does not have the basic skills necessary to provide safe patient care. How do I acquire extra help for him/her?
Inform the faculty advisor of your concern. Together work out a daily and/or weekly plan of action incorporating the student's goals. Allow for extra "shadowing" time and provide more demonstrations of procedures.

23. What if I think things are not going well and I am not sure if I should say anything?
Always talk about your concerns with your student as soon as possible. If you would like some assistance in how to approach the subject with your student, contact your faculty advisor – she/he will have strategies for this type of situation. Early intervention is always the best plan rather than waiting until midterm or final evaluation. The safety of the patient is paramount.

24. Will I have input into my student's final grade?
You will complete mid-term and final preceptor evaluation forms for the student. Your evaluative comments are very important for the faculty advisor when the final grade is determined. You can refer to the section of the guide that addresses giving feedback and evaluating student performance.

25. What if I have to fail a student? How do I manage to do that? Will the faculty be able to help me? Will it mean the end of the student's career?
First, it is important to remember that neither a preceptor nor the faculty advisor fails the student. It is the student who fails to meet expectations. It is important to be continually assessing a student's progress so any concerns can be addressed early in the experience. If you have any concerns or questions, contact the clinical faculty advisor who ultimately is the one who assumes responsibility for communicating the final decisions. Due process is always observed and students will be offered additional opportunity to succeed.

Reasons to be concerned:
- *Unsafe behavior or demonstrated potential for causing harm.*
- *Lack of progress in clinical competence.*
- *Lack of improvement in response to feedback from preceptor and/or faculty advisor.*
- *Ineffective self-evaluation to improve clinical behaviours.*

26. How are the evaluations to be filled out if I am sharing the student with another preceptor?
Sometimes both preceptors independently fill out the evaluation forms and other times they discuss the progress and fill one form out together. The faculty advisor can also share strategies that have worked in other situations.

27. Will I receive feedback on my role as a preceptor from the student and the faculty advisor?
Ask for feedback from the student and the faculty advisor. It is important to assess your role and discover how you might be even more effective than you are. Students will be encouraged to provide written feedback to preceptors at the end of the rotation.

28. What happens if I (the preceptor) am ill for a shift?
Please check with your manager to see whether the student should also stay home or if the manager is comfortable assigning the student with another RN. It is helpful to discuss this possible scenario with the manager prior to the preceptorship.

29. What do I do if I don't have enough hours in my schedule/rotation for the student to acquire 320 hours?
Please discuss this occurrence with your manager and the faulty advisor. This does occur frequently and usually managers will ask another RN to assume preceptorship responsibilities. There may also be a limited number of alternate experiences for the student to observe/participate that you could help arrange. (e.g., attending a breast feeding clinic, observing in the OR, attending a clinically relevant workshop, etc.)

FAQS—QUESTIONS FACULTY ADVISORS FREQUENTLY ASK

1. How does the faculty advisor role differ from that of the clinical instructor?
   Unlike the traditional clinical instructor, the faculty advisor is not actively involved in the actual clinical teaching of the student. In other words, the preceptor assumes responsibility for facilitating, guiding and teaching the student in the provision of nursing care in the clinical practice set- ting while the faculty advisor acts as a resource to the preceptor and the student and is essentially the custodian of the teaching and learning process.

2. Why is it important that the faculty advisor be connected to the clinical area?
   Key to the preceptorship experience is faculty advisor presence and the perception of faculty advisor presence. One of the key concerns of preceptors is the lack of accessibility to faculty advisors. It is important, therefore, that the faculty advisor, if within proximity to the clinical practice site, make routine visits to those sites. It is recommended that the faculty advisor visit the nursing units, at minimum, at the beginning of the preceptorship experience, midway through the preceptorship experience, and towards the completion. The faculty advisor may make additional visits as deemed necessary and indeed is encouraged to so. Although the faculty advisor is not actively involved in the actual clinical teaching of the student, he/she is encouraged to be actively involved in the experience. It is important, therefore, that faculty advisors be easily accessible to the preceptor and the student via telephone, email, Skype etc.

3. How does the faculty advisor facilitate the teaching and learning process?
   As custodian of the teaching and learning process, it is the faculty advisor's responsibility to ensure that there is congruency between preceptor expectations and the learning objectives of the student and that the goals and objectives of the academic program are met. The faculty advisor needs to keep the lines of communication open between themselves, the preceptor and the student at all times for the purpose of clarifying any questions or concerns that may arise throughout the preceptorship experience, if required consult with the preceptor on issues related to student assignments in the clinical setting and discuss any potential teaching strategies that may help to facilitate the preceptorship experience.

4. Does the preceptor expect the faculty advisor to provide feedback on his/her teaching process?
   Presently, there is no formal mechanism for the faculty advisor to provide feedback to the preceptor. It is important, however, that the faculty advisor provide ongoing feedback to the preceptor regarding their performance as clinical teachers.

5. How important is it to respond immediately to preceptor concerns regarding a student's performance?
   This is an important question. It is critical that the faculty advisor respond to preceptor concerns immediately, otherwise, it may be perceived that the faculty advisor is inaccessible or unavailable. Such a perception can leave the preceptor feeling unsupported in their role.

6. What steps should be taken if the faculty advisor recognizes that the unit is not a safe learning environment for the student?
   If the faculty advisor feels that the unit is not a safe learning environment for the student, it is important that he/she immediately discuss her/his concerns with the Course Coordinator.

7. What role does the faculty advisor play in the evaluation process?
   The faculty advisor is responsible for evaluation of the overall preceptorship experience and where appropriate provides input regarding student performance. The faculty advisor also assumes responsibility for grading all written assignments for his/her student group.

8. What is the faculty advisor's responsibility if the preceptor or student raises concerns about performance?
   Whenever the preceptor or student raises concerns about performance, it is important that the faculty advisor act on that feedback immediately. The faculty advisor should not allow it to go unchecked. He/she must be proactive rather than reactive in his/her involvement in the evaluation process.

9. What is the faculty advisor's role with regard to the preceptored student?
   While the faculty advisor acts as advisers to the preceptor, he/she also must provide input to the student regarding how best they can achieve their learning objectives and perform within the expectations of the academic program or agency. Open communication, as previously discussed, is important for all players at all times.

10. How can I support students with feelings of anxiety regarding the clinical placement?
    The best way to support students with feelings of anxiety regarding clinical placement is to create a good and trusting rapport with them prior to entering the clinical setting. The student needs to know that the faculty advisor is there to support them in their learning experience and that they are available and accessible to them throughout the preceptorship experience.

FAQS—QUESTIONS STUDENTS FREQUENTLY ASK

1. I don't know if I am progressing as I should in this preceptorship. How do I go about asking my preceptor for feedback?
   Ask your preceptor if he/she can set aside some time to discuss your progress. If sharing feedback is difficult for her/him—perhaps sharing some specific questions will help. It is always helpful to use 'I' statements such as: "I really appreciate frequent feedback, it helps me understand how I am doing and what I still need to work on". Establish regular opportunities to chat i.e. after each shift, after each stretch or at coffee break. Try to be specific when you ask for feedback. Share your opinion of your successes and your challenges and then ask for her/ his feedback. Or, ask about a particular area of your nursing practice. You can also ask your faculty advisor for help and support. Acquiring feedback is important for your growth as a learner.

2. What do I do if I am sick?
   Call your unit, your preceptor and email or contact your faculty advisor. It is important not to work while sick. Do your best to keep healthy.

3. I want to attend a friend's wedding but it is on a day I am scheduled to work with my preceptor. What do I do?
   Discuss the matter with your faculty advisor and your preceptor. It is acceptable to ask for a day off for a special event. You will have to make up the shift as the 320 hours is non-negotiable.

4. I feel like my preceptor and I got off on the wrong foot. I'm not sure if she likes me.
   These are common feelings and usually part of the 'getting to know each other' phase. Try to bring your best positive attitude and your best work ethic to your unit every day. If things do not improve it is important to ask your preceptor to set aside time to discuss your relationship. Both of you need to be invested in your learning and your relationship in a positive and respectful way. It is important to keep in mind that a preceptor-student relationship is not a friendship but a professional one focused on helping you make the transition to a graduate nurse. Again, your faculty advisor can help guide in this matter. If you feel unfairly treated in any way, please share these feelings with your preceptor and faculty advisor as soon as possible.

5. I feel overwhelmed in this placement. I'm not sure if I can be successful.
   This is also a common feeling as the preceptorship pushes you to learn and accomplish at a fast pace. Share your concerns with your preceptor and faculty advisor right away so you can explore these feelings and set in place the best plan for you to move forward.

6. Do I need to make up my sick days?
   Yes, you are expected to complete 320 clinical hours.

7. How do I know which day I am supposed to start the rotation?
   Call the unit a week or two prior to the clinical start date and leave a message for your preceptor asking him/her to call you. Do not forget to provide your contact information.

8. What should I do if my preceptor is ill and I am due to come in to work?
   Have this discussion at the beginning of your preceptorship and establish a plan before you start. Some preceptors would prefer you work only with them, others will arrange for an alternate preceptor for that day.

9. What should I do if I have a needle stick injury or any other type of injury at clinical?
   After taking appropriate first aid measures, report your injury to your preceptor and charge nurse and follow agency guidelines for documentation of needle stick injury. Also notify your faculty advisor who will inform you of the necessary documentation from the School of Nursing perspective.

10. My preceptor is not giving me the independence I would like, how can I discuss this with her/him?
    Communication is important, speak with your preceptor about your progress and discuss your aspirations for assuming more responsibility. You can negotiate this transition ensuring both parties are comfortable with your increased independence. The ultimate goal is for you to be able to assume a graduate nurse patient assignment. Your faculty advisor can help you with this discussion.

11. I'm on a varsity sports team and need some time off in order to compete with my team, is this possible?
    The School of Nursing wants to support our varsity athletes, so speak with the Course Coordinator prior to coming to NURS 402 or 402X. This course is challenging and has a specific requirement of hours. She/he can assist you in determining if this is the right time for you to enroll in this course based on your team responsibilities. When you are enrolled, your faculty advisor can work with you and your preceptor in negotiating time off for your team events. You are still required to complete 320 hours to complete the course.

12. My preceptor has been offered overtime shifts, can I work them and finish up earlier?
    We discourage you from taking on extra hours through overtime shifts. Your preceptorship is a challenging time in your nursing career. You need time to complete course work and stay healthy. You are expected to work the equivalent of full time working hours. In some circumstances, students may be granted permission to work an overtime shift(s). Please contact your faculty advisor and Course Coordinator to discuss this.

13. My preceptor has invited me to attend a staff party/social event, is it OK if I attend? What if I am invited to my preceptor's home for dinner?
    Remember this is a professional relationship and so safe boundaries must be established very early in your relationship. Your preceptor and staff are colleagues, but also your evaluators. Consider this power differential before you engage in any social activities outside of the work environment.

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