Mt. San Antonio College

Associate Degree Nursing Program

Nursing 11: Preceptorship in Nursing

Preceptor Workbook

Introduction

The Associate Degree Nursing Faculty of Mt. San Antonio College wishes to thank you for your interest in participating in the preceptorship component of the program. The benefits of a close student association with staff in the clinical environments are many. The preceptorship rotation enables our students to experience these benefits. This workbook is a basic guide for the preceptor-preceptee relationship and we hope that it will provide you with the assistance needed to fulfill your role as a preceptor.

Part 1

Role Clarification and Guidelines

So, you have volunteered to be a preceptor. What is a preceptor and what does a preceptor do? The word preceptor has many and varied meanings depending on the institution's purpose, the individual person's concept, and the goals of the educational experience. For our purposes, the **preceptor is viewed as an experienced and prudent advisor who can coach, trust and let go of the preceptee as he/she moves from the neophyte "crawl phase" to the competent, independent "run phase."**

Obviously, it takes a special person to be a preceptor. According to preceptees who have completed the preceptorship experience, the clinical preceptors most desired were those who were:

good role models

open, honest, supportive

calm, confident, relaxed

organized, humorous, concerned,

were always professional, upheld the Nightingale oath and ate two helpings of apple pie daily.

Needless to say, there isn't one of us who can demonstrate all of these qualities every minute of each day. Student expectations are high and they may expect you to meet their expectations. However, each of you has a measure of the qualities valued by students. Most importantly, you display the qualities your supervisor and the Mt. San Antonio College Associate Degree Nursing Faculty feel are essential for a proficient and capable preceptor.

Are a competent clinician, able to apply nursing theory to nursing practice;

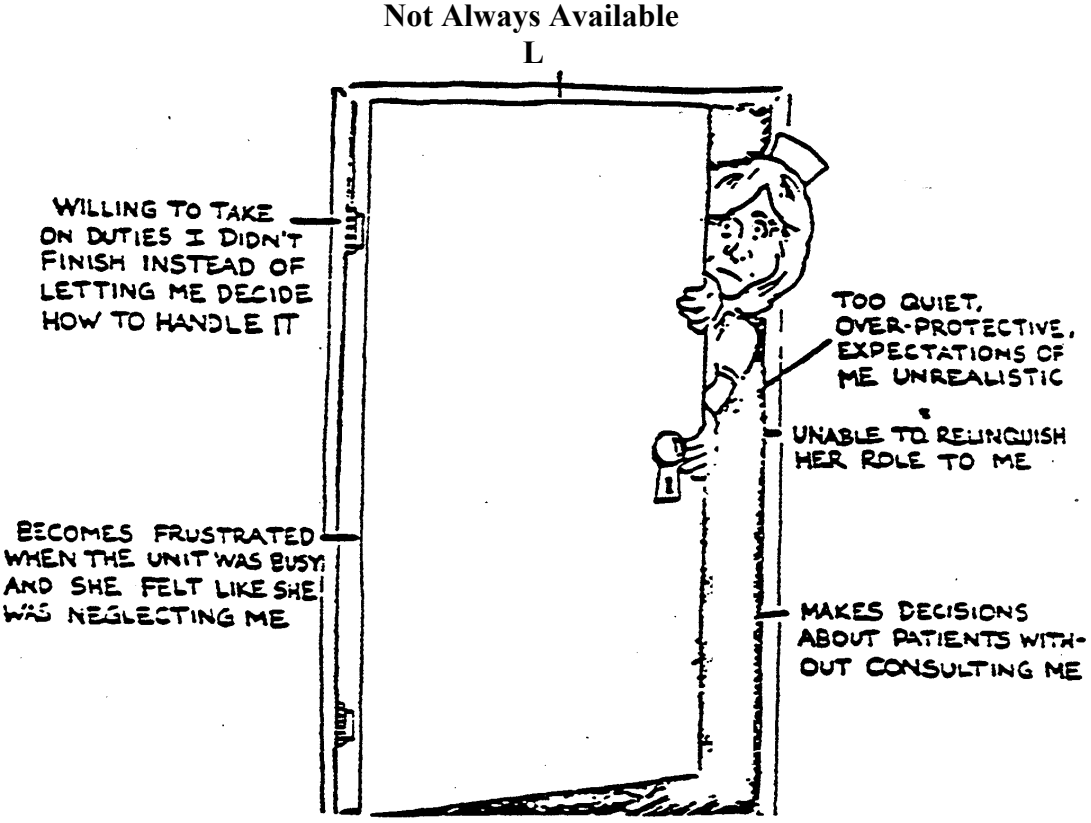
Communicate and relate effectively with patients, students, peers, and other members of health team;

Are self-confident and have a realistic perception of your own nursing performance;

Demonstrate the interest and ability to facilitate learning by students and/or new staff; and have demonstrated leadership by initiating efforts to improve patient care delivery.

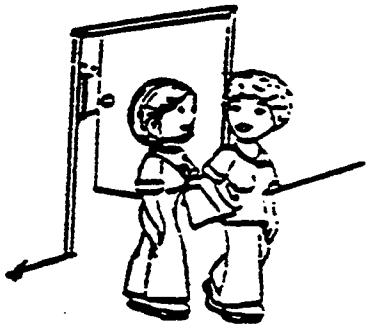
Now that your aura has been fluffed and you are floating on Cloud #__9__ enjoy it….because only too quickly reality will strike once again! As pointed out earlier, we all have measures of the qualities most desired by the student. We also have qualities least desired by students which brings us quickly to the reality that no matter how hard we try to be perfect, after all is said and done, we are only human.

Qualities Least Desired By Preceptees



Because you have volunteered to be a preceptor, we know that you are committed, enthusiastic, and desirous of guiding and taking responsibility for a preceptee's learning experience. We greatly value your participation.

Now, let's look at the roles of the three players involved in the preceptorship component; <u>preceptor, preceptee,</u> and <u>faculty liaison.</u>



Preceptor Role

The Nurse Preceptor will:

1. Attend preceptor preparation workshop.

2. Provide copy of work schedule for faculty liaison and preceptee.

3. Assume responsibility for providing an informed replacement/preceptor in the event of an unavoidable absence.

4. Schedule planned times on a daily basis to meet with preceptee and provide the faculty liaison with feedback regarding these meetings.

5. Review preceptee's weekly written objectives and guide his/her learning through selection of increasingly complex duties, in order to meet the objectives.

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7. Give the preceptee daily verbal feedback.

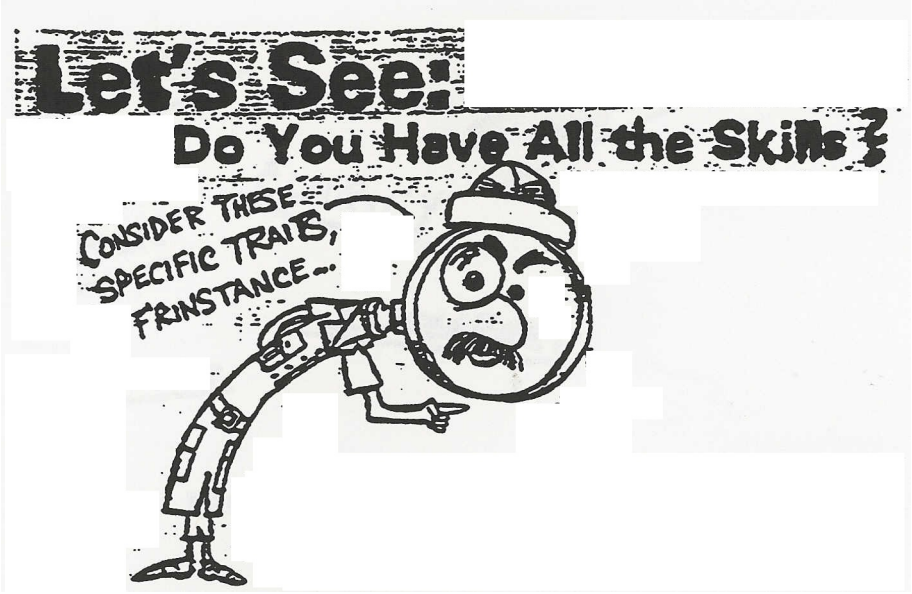
8. Supervise and teach the preceptee in the clinical area. Confer with the faculty liaison regarding the level of complexity of the nursing tasks assigned.

9. Evaluate the preceptee in writing at the end of the preceptorship experience with the assistance of the faculty liaison.

10. Attend mandatory weekly conference during working hours scheduled by the faculty liaison.

11. Utilize faculty liaison for consultation as needed or desired.

12. Complete the Preceptor Evaluation on the preceptor role and experience.



Student Preceptee Role

The Nursing Student/Preceptee will:

1. Identify in writing, specific clinical objectives each week from the designated clinical component objectives and share them with the nurse preceptor. Develop daily and weekly plans, jointly with nurse preceptor, to meet these objectives.

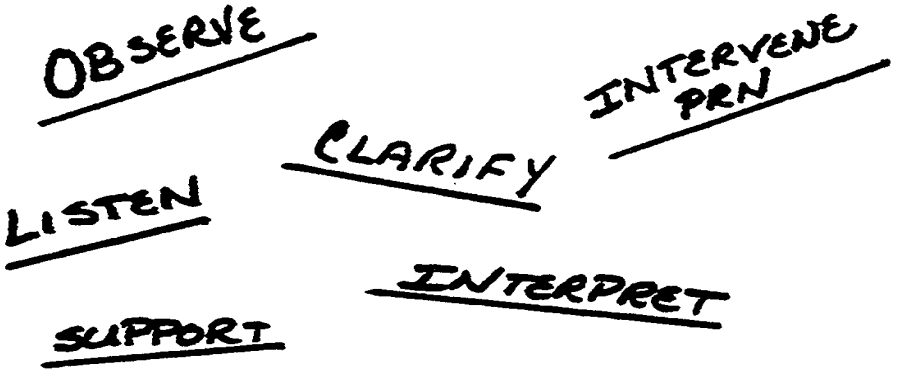
2. Work under the supervision of the nurse preceptor or her/his designee and appropriately utilize other persons in the clinical setting for supervision/ consultation; i.e., nurse manager/head nurse, registered nurses, faculty . liaison.

3. Complete a written Self-Evaluation using the Clinical Evaluation Tool at the end of the preceptorship component and share with the preceptor for feedback.

4. Achieve the clinical objectives at a satisfactory level which will be jointly determined by the preceptee, preceptor and faculty liaison.

5. Maintain a diary and submit to the faculty liaison on a weekly basis.

6. Attend weekly conference at a time that is mutually agreed upon by preceptor, preceptee and faculty liaison.



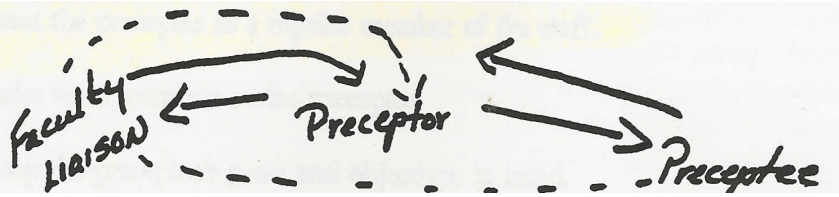
Faculty Liaison Role

The Faculty Liaison will:

1. Participate by teaching nursing content and assume related responsibilities.
2. Assist preceptor by:
    A. Participating in preceptor preparation and orientation.
    B. Helping to identify learning experiences needed for the individual preceptee.
    C. Reviewing preceptee's written weekly goals.
    D. Meeting on a regularly scheduled basis to communicate needs and/or student/preceptee's progress.
    E. Being available by phone or in the facility for consultation during preceptor and preceptee's scheduled times.
    F. Assisting with the evaluation of the preceptee and being available for discussion of the evaluation process at the end of the preceptorship component.
    G. Being a resource and support person.
    H. Guiding the preceptor in her/his role.
3. Organize and conduct weekly meetings to discuss experiences, problems and feelings. The faculty liaison will assist the preceptors in problem-solving with regard to planning, implementing and evaluating the preceptee's learning experiences.

4. Conduct weekly conference with preceptee, focusing on her/his experiences, problems and feelings.

5. Collect and review preceptee's diaries weekly.



With the duties of the three players in focus, you have many questions about your responsibilities and how to meet them. This next section will deal with tips on how to make the experience work for you and your preceptee.

<u>How can I help the student preceptee feel a part of the unit where I work? What is the best way to let my co-workers know what the student preceptee is doing and how my role has changed?</u>

After much brainstorming and discussion, preceptors have agreed that the best way to avoid this confusion would be to hold a staff meeting approximately a week or two before the student preceptee arrives on the unit for the preceptorship experience. At this meeting, you should:

1. Explain the preceptorship;

2. Discuss your new role as a preceptor;

3. Discuss the student's role as a preceptee and how it differs from the traditional student role;

4. Discuss the staff's role in helping the student preceptee to assume the leadership role and responsibilities. At this time, role descriptions should be posted on the unit information board along with the name of the student preceptee and the dates of the preceptorship rotation.

By clearly informing the staff about the role of the student preceptee, you will have taken the first step in helping the student to feel a part of the unit. According to past preceptee experiences, other actions that you can take to help the student preceptee to feel a part of the unit is to:

1. Introduce the preceptee to the entire staff.

2. Make rounds with the preceptee.

3. Give the preceptee a tour of the unit.

4. Include the preceptee in all aspects of your job and decision-making.

5. Treat the preceptee as a regular member of the staff.

6. Refer team members to the preceptee.

7. Keep the preceptee's goals and objectives in mind.

8. Let the preceptee set her/his own pace as much as possible.

9. Give the preceptee responsibility.

10. Give the preceptee feedback on a regular basis.

11. Provide the preceptee with someone to answer questions when it is necessary for you to be off the unit.

W*hy do I have to set up a conference with the preceptee on a daily basis? How can I possibly fit this into my busy schedule?*

Recognizing that there never seems to be enough hours in the day, planning is the key to establishing, fostering and maintaining the preceptor/preceptee relationship. Without rapport, it is impossible to establish an environment where trust, learning, growth, and evaluation can occur. Therefore, it is important that you and your preceptee agree on a daily time to discuss the events of the day, future plans, review objectives and share feelings. These meetings may take approximately thirty minutes in the beginning of the preceptorship while you are establishing rapport, and only five or ten minutes in the end when your trust has been established.

Like you, the preceptee is anxious. Unlike you, the preceptee is unsure of her/his abilities and is conditioned in school to expect positive and/or negative feedback on a daily basis. Although the hospital work world provides feedback on a regular basis (six month to yearly evaluations), the intervals are too long for a preceptee. At this point in the preceptee's growth and development, he/she needs daily feedback from you as the preceptor. This feedback provides the preceptee with a clear picture of how he/she is doing, what area(s) need improvement, and what area(s) are strong.

Because we are human, we always pick up on things we don't like initially. That is o.k., but it is really important to relate not only the negative things, but to give some positive strokes for even the insignificant things the preceptee is doing correctly. Obviously, we all need positive strokes from time to time. This is particularly true of the preceptee in the first week of the preceptorship. Later on, as the preceptee feels more confident and begins to spread her/his wings, he/she will not require as much positive or negative feedback from you, because he/she will be better able to evaluate her/his own performance.

Beside providing for feedback and a dose of positive stroking, daily conferences allow time for you to counsel the preceptee regarding personal and course objectives. Counseling the preceptee regarding her/his personal weekly goals and the program's course objectives, is of prime importance in planning a successful experience and determining the preceptee's assignments. Because students tend to be idealistic, it is not uncommon for the preceptee to develop unrealistic expectations of themselves and others. One of your responsibilities is to help them to evaluate their personal objectives in relationship to their skill level, opportunities available on the unit, and time limitations of the overall experience. By doing this you can almost always assure a positive experience.

Are you saying that I make out the preceptee's daily assignments?

Absolutely, you are the boss! Although this may seem like a mammoth job, it is essentially the same process you use in making out client care assignments. What we are asking you to do, with the help of the preceptee, is to review the goals and objectives, assess the preceptee's strengths and weaknesses and jointly plan an assignment which will assist the preceptee in meeting her/his personal goals and the course objectives. Keep in mind that the preceptee's abilities vary as do staff members. You know that assignments will take on increasing levels of difficulty as the preceptee masters each skill. It is anticipated that by the end of the last week of the preceptorship component, the preceptee will be able to safely function as a beginning nurse in a team leading position.

Remember that you will not be making all these decisions alone. The faculty liaison assists you in assessing the preceptee, identifying the learning needs and planning learning experiences. This is particularly true in the first few days of the experience when you and the preceptee are both feeling anxious about your new roles.

Besides giving daily feedback what other things can I do to let the preceptee know that I have confidence in her/his abilities?

According to past preceptee, daily feedback is at the top of the list, but other things that you can do include:

1. Once you are reasonably sure he/she can function safely, you can discontinue checking on everything the preceptee does. When the preceptor no longer checked every medication, each time, preeptees interpreted this as a big vote of confidence.

2. Let the preceptee take on responsibilities that he/she feels capable of handling.

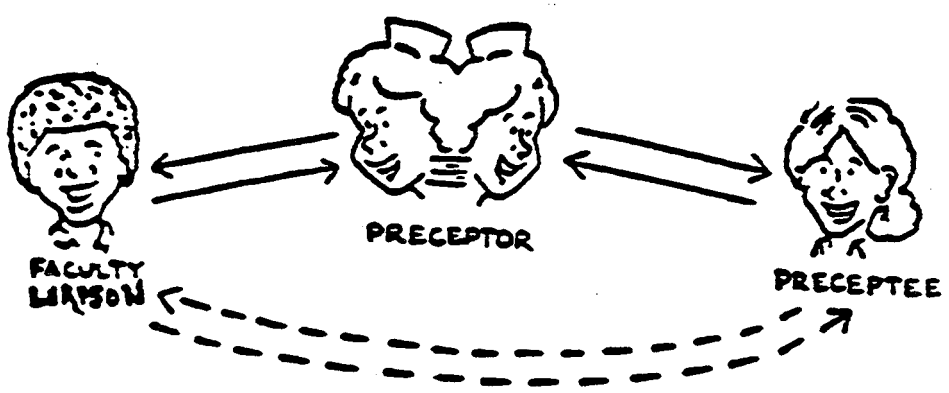
3. Leave the preceptee in charge of the team when you are off the unit.

4. Refer team members to the preceptee for direction, assistance and/or consultation.

5. Step back and let the preceptee handle the team, particularly when things get a little hectic.

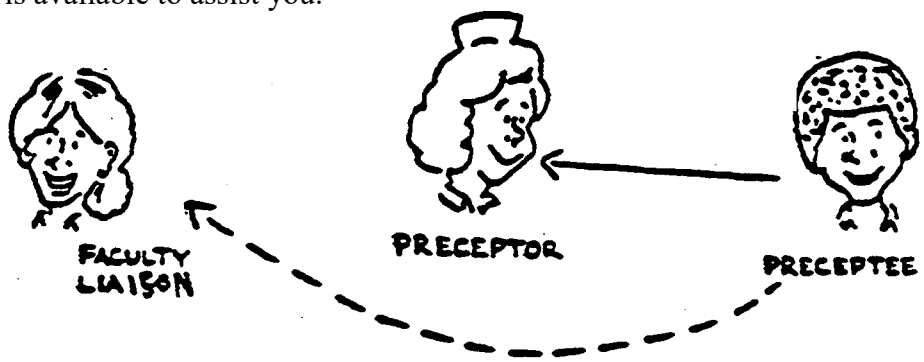
It seems like I have all the responsibility. Can this be?

If you will take a minute to re-read the role descriptions of the other two players, you will see that most responsibilities are jointly shared by all three players. You may perceive that you have most of the responsibility, but this is partly because of the change in everyone's role. You have the familiar nursing student, the instructor, the staff nurse whose pattern of communication is significantly changed. Previously, the instructor assumed all responsibility for the student and communicated with her/him directly. The student reported directly to the instructor and felt little or no responsibility to the unit staff. As a staff nurse, you functioned primarily as a consultant to faculty and students on unit policy and specific patient care needs. Now, the responsibility is divided among the three players and the communication pattern has changed. As the preceptor (staff nurse), you communicate directly with the preceptee (student) and the faculty liaison (instructor).

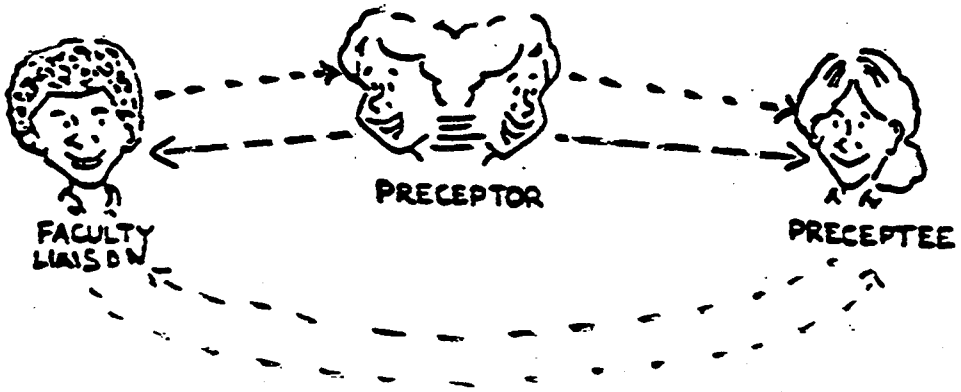


On a daily basis, the preceptee communicates directly with you as preceptor but only indirectly with the faculty liaison. This change has been made to encourage the preceptee to begin to give up the security blanket inherent in the traditional faculty-student relationship, and to begin to develop a peer support system within the hospital setting.

The faculty liaison communicates directly with you as preceptor and indirectly with the preceptee. If a situation occurs that you feel unsure about, the faculty liaison is available to assist you.



So because you are the middle person, it may seem that the greatest burden is on you. Just keep reminding yourself that it is still a three-way operation with equal responsibility for all.



Your responsibilities as a preceptor are to:

1. Attend the preceptor orientation, work with the faculty liaison and submit evaluation forms.

2. Select one or two nurses who could act as a substitute preceptor in the event you are ill or absent. It is your responsibility to tell them about the preceptor role, and the specific preceptee objectives to be accomplished on the day of your absence. Sharing your preceptor workbook with the substitute, will probably be very helpful.

By now, you should understand the roles of the three players. Until you actually practice your new role, you probably won't have a feel for it, so expect that uncomfortable, jittery feeling for a while…the unknown is always a little scary, even when we have been told what is going to happen.

As a preceptor, particularly if this is your first time in this role, you may feel a bit uneasy. The following are questions that preceptors commonly have. We hope the answers will serve to relieve some of your ansiety as you take on this new role.

Question	**Answer**

What have I gotten myself into? I'm not sure I have the knowledge or the skill to teach preceptees.

I have the feeling the student is going to be watching every move I make. What if I don't look good? I bet the preceptee will be secretly critical of me.

Well, maybe the preceptee won't be critical… but silly as it may sound, I think if the preceptee follows me around and watches every move I make, it will drive me crazy.

I am not sure I'm a very good teacher.

What if I don't do something exactly the way the preceptee has been taught.

You may not believe you are "smart" enough or "good" enough, but your nurse manager and the faculty believe you are. That is why we picked you. We aren't looking for a Super Nurse no one can stand someone who is perfect anyway.

Yes and No. How is that for a definite answer? There isn't much doubt that the students will be watching you pretty closely, especially at first. But our experience has been that preceptees are very rarely critical of preceptor's skills and expertise. Most commonly we hear precptors remark, "I'll never be able to be efficient as he/she is."

That is understandable. Fortunately, the preceptee is going to be far too busy to follow you around and watch every move that you make. He/she has objectives to meet each week so he/she will be doing client care, medications, treatments, charting and team leading.

You may be surprised. You have practical, day-to-day knowledge and expertise to function effectively as a registered nurse. Watching you and working with you gives the preceptee a chance to see "real nursing" in action. Be yourself. You don't have to know sophisticated teaching techniques. Preceptees will learn from watching you whether you are doing a mundane daily task, delivering client care, or making a complex nursing judgment. That is something they don't see in the classroom or clinical in the traditional student role.

Good! In most situations, there is more than one ways to do things right. Showing the preceptee alternatives can be effective in increasing overall learning. You have always known the correct underlying principles that are still taught in school.

What if I make a mistake?

What if I just can't work with the preceptee?

I'm concerned about the quality of client care. Can the preceptee handle the responsibility without making a mess of things?

How closely do I have to watch the preceptee?

let go. It's also difficult to let the preceptee struggle with a problem when you can easily come up with a solution. You may find that her/his anxiety level is going down while yours is going up! Hang in there. The outcome of the struggle can be a positive learning experience.

What if something comes up with the preceptee and I don't know what to do?

I'm glad you asked that! That is where your faculty liaison person comes in. Give her/him a call. This person is almost always available to assist you in anyway he/she can.

Ah, Ha! You said "almost always" available! What if I can't reach he/she?

Then go ahead and use your own judgment and talk it over with the faculty liaison person as soon as he/she is available.

What if the preceptee doesn't make it?

In spite of how good you are and how hard you try, occasionally a preceptee may fail. Remember, you have the faculty liaison person to support and help in making this decision. The fact that a preceptee fails does Not mean that You have failed as a preceptor.

As much as we dislike thinking about it, everyone makes mistakes from time to time. By acknowledging mistakes and taking corrective action, you can serve as an effective role model to the preceptee.

Occasionally, personality differences occur. If you experience difficulty working with your assigned preceptee, talk with your faculty liaison. He/she may be able to help pinpoint and resolve the difficulty. If not, it is possible to rearrange preceptee assignments so that both the preceptee and the preceptor can get the most out of this experience.

Remember, the preceptee doesn't have to lead a team the first day. You will be working closely together as he/she gradually assumes more responsibility so you will have a pretty good idea about what the preceptee is able to do.

That is a tough one. As you get to know the preceptee and her/his capabilities, he/she will require less and less supervision. But it's hard to

Characteristic of the Student Preceptee

If you think that you feel a bit anxious in your new role as preceptor, it's a pretty good guess hat the preceptees may be nervous wrecks. Here they are in their last medical-surgical experience as a student, soon to become practitioners and expected to function in a variety of settings. They have a great many expectations for this preceptorship experiences; unfortunately they may not all be realistic.

It is not uncommon for the preceptee to feel frightened, overwhelmed and confused the first few days of the preceptorship experience. Since excessive anxiety inhibits learning and problem solving, the following suggestions are offered to aid you in helping the preceptee deal with her/his anxiety.

1. **Be aware that the preceptee is anxious and try to let her/him know that you are supportive.**

   A simple statement such as "I'll bet starting a new experience like this is a little scary," conveys not only that you understand, but gives the preceptee an opportunity to talk about some of her/his fears.

2. **What good does it do to let the preceptee talk about her/his fears?**

   Frequently, the anticipation of an event is far worse than the reality. Getting one's fears out into the open, permits an objective look at them. Expressing a fear aloud, can sometimes be sufficient to expose how unrealistic it is or can serve as a basis from which problem- solving can begin.

3. **If you are feeling a bit anxious about your role as a preceptor or have experienced similar feelings in a specific situation:**

   Why not share that with your preceptee? Knowing that you are human and have anxieties or have had similar experiences can be a great relief for the preceptee.

Let's see how this might work for the preceptee:

When your preceptee is feeling overwhelmed, you can relieve some of the anxiety by helping her/him to focus on one thing at a time. Objectives can be very useful. Before a child can run, he/she must first learn to crawl, stand and walk.

Crawl Phase; Stand Phase:

The preceptee arrives on your unit with anxiety level registering somewhere between pretty scared and terrified.
He/she knows that he/she is expected to lead a team during this clinical experience.

How can he/she accomplish this? Is he/she going to lead a team the first week? In the first two days, help the preceptee to focus on what he/she needs to learn. Who are the people working on the unit? What do they do? How does the unit work? Do the objectives reflect a realistic appraisal of what should be learned?

***Walk Phase-Week II*:**

By the second day, the preceptee has learned where the bathrooms are located and can find her/his way from one end of the unit to the other without getting lost more than once. Now what? Is it time for the preceptee to assume a bit more responsibility? By now the anxiety level should be down to somewhere around Pretty Scared and our preceptee is ready to learn. By the second day, you should involve the preceptee in the dynamics of organizing the assignment for the shift.

Where is our preceptee this week on the Anxiety Scale? With a little luck, he/she should able to be down to the Sweaty Palms Level and be able to master more complex tasks and additional responsibility. You may even feel comfortable enough to leave the unit for 30 minutes without living in fear that the preceptee will injure a client or get the unit in a complete uproar in your absence. Hurrah? On to Week III.

Run Phase-Week III:

At last the big moment arrives! It is time for the preceptee to lead a team. Can he/she do it? Will the Anxiety Scale go off the end of the register? If the preceptee has met appropriate objectives each week, gradually mastered increasingly complex responsibilities, and has not become overwhelmed, he/she is ready! Team leading may elicit no more than a jittery feeling. At last! The preceptee is ready to run! How did this miracle occure? In part, it happened because you helped the preceptee to take one step at a time, which kept her/his anxiety level within a range that allows learning to occur.

Of course, not all preceptees are going to progress at exactly the rate described above. Some may be ready to team lead by the end of the first week, while others must wait until the third week. Using the faculty liaison as a consultant, you will be working with the preceptee to gradually take on more complex task and assume more responsibility, as he/she is ready for them. The weekly clinical objectives given to you by the preceptee, will assist you in determining her/his readiness to assume more responsibility.

Part II: Objectives

Guidelines for Writing Weekly Clinical Performance Objectives

The preceptee will write weekly performance objectives and submit them to you on the first work-day each week. These objectives must be behaviorally stated and should reflect the preceptee's goals for the week. You should evaluate the appropriateness of these goals and discuss them with the preceptee. You should discuss with the faculty liaison, methods for the preceptee to meet these objectives. The pre-ceptee must be encouraged to make these objectives measurable and attainable.

Examples:

Correct

1. I will locate supplies and emergency equipment on the unit.
2. I will check each intravenous infusion every hour.
3. I will have all IV piggybacks infusing within thirty minutes of the specified time.
4. I will call all doctors that must be called.
5. I will review and post all lab reports and discuss their relevance with my preceptor.

Incorrect

1. Become more organized…
   (Not specific. Must state behaviors)
2. Assume entire team leading role…
   (Not specific)

Caution!

Do not allow the preceptee to set her/himself up for failure by writing goals that are too broad and unattainable.

Part III- Counseling and Communication Skills

Although the counseling process is generally referred to as a relationship between the counselor and client rather than a set of techniques, there are some techniques that you can use to help the preceptee understand the environment and make effective decisions. These techniques basically have to do with your skill in communicating. In other words: How well do you listen? How helpful are your responses? Are you demonstrating verbally and nonverbally that you are interested?

In order to communicate to the preceptee that you are interested and attentive, you will want to "attend" both physically and psychologically. PHYSICAL ATTENDING means paying attention to the physical needs and surrounding of the preceptee. Included would be such things as offering coffee or tea, having a comfortable environment temperature wise, and being about two to three from each other. If there were such a place on the nursing unit, a room with comfortable lighting and chairs, quiet colors, and plants would be ideal. In lieu of such, aim for that place which the preceptee will associate with being relaxed and comfortable.

Psychological Attending involves body language. A person who is interested in what the other is saying tends to sit up and lean slightly forward in the chair rather than slouch and lean back. The arms and hand rest comfortably, the fingers do not drum (indicating nervousness wishing to be somewhere else), and the arms are not folded across the chest (implies a closed attitude). Particularly important, is the use of good eye contact. You communicate the intent to try to understand the person but you also can take in cues about behavior through the person's mannerisms and expressions.

In addition to paying attention to the physical environment and your own body language, you will need to engage in **Active Listening**. In active listening, you will be attempting to understand both the content and feeling of what is being said. Although this sounds easy, we often are thinking instead of listening. We tend to do three kinds of thinking.

First, we <u>think about</u> what is being said. As the other person talks, you speculate about the motivation, you wonder about the intent, or you judge what is being said.

Another kind of thinking is *thinking for* the other person-when you mentally direct what the other person should be doing or feeling. "It would be better for you to change," The best thing to do in that circumstance is…," and "You shouldn't feel that way."

A third kind of thinking is *thinking ahead* – where you complete the thought of the other person. Hopefully, this will facilitate true understanding of what someone is saying.

Moustakes says, "Listening is a magnetic and strange thing, a creative force… The friends that listen to us are the ones we move toward; and we want to sit in their radium ad though it did us good, like ultraviolet rays… When are listened to, it creates us, makes us unfold and expand…Ideas actually begin to grow within us and come to life… It makes people happy and free when they are listened to."

Effective listening requires paying
Attention to both the content and tone of
What is said plus other nonverbal cues such
As gestures and facial expressions.

It is more a process of listening to main thoughts and ideas rather than to every word spoken. Try to recall the main content of the entire message. Look for important themes; these are the ones that are repeated many times and usually with intensity.

As the interaction which you have with the preceptees progress, it will obviously be necessary for you to respond to what is being said. Your responses should be such that communication is not blocked, that you demonstrate that you understand, care, are interested, and are willing to help, if necessary.

Probably the best way to insure that you have understood the real message that someone has sent would be to restate it-in your own words. This is called ***Reflection*** **w**hich will not only clarify what you have understood, but it allows the preceptee to continue to talk if he/she would like to. For example, a new nurse says to you, "How in the world am I supposed to maintain sterile technique when we keep running out of suction catheters?" A reflection response might be, "You are feeling frustrated because there do not seem to be enough suction catheters?" By responding in this way, you would be refraining from the use of a response which could bring your discussion to a halt. Some responses which you should avoid are discussed as follows:

1. *A judge mental or evaluative response:*
   "You should not let the supply of catheters get so low!" Depending on your tone of voice, the person could become defensive and "hold back." He/she might feel that you are not a safe person with whom to ventilate frustrations or anger.

2. *Advice-giving responses:*
   "Perhaps you could order the catheters that you'll need when you first come on shift." With this comeback, you are giving as yet unasked-for advice. Although the preceptee may need help and suggestions for preventing the problem in the future, you should withhold the advice until it is asked for until the end of your conversation. It is possible that the problem the preceptee is experiencing is larger than this issue of suction catheters would suggest. You would need to find this out by allowing her/him to continue verbalizing.

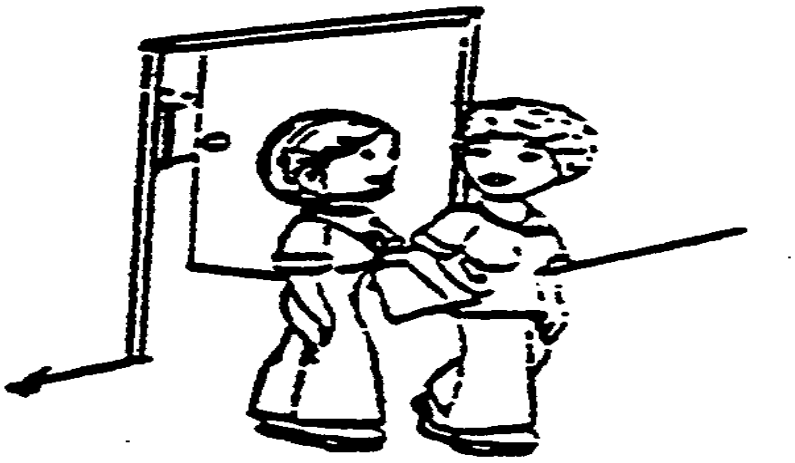
3. *A topping response:*
   "Out of suction catheters again? That's nothing! Last week, I had to cover the pillows with hospital gowns because we ran out of all the other linen!"
   This kind of response is like one-upmanship where you describe a situation which is definitely more dramatic than the present problem. The message is, "I was worse off than you, so what are you complaining about?"

4. *A reassuring response:*
   "Don't worry about it. The patient will be all right."
   In this situation, your message to the person is not usually reassuring. Instead, you have told the preceptee that her/his feelings are unwarranted. Although, we sometimes need to assist the preceptee in putting crises into perspective, we need to be careful not to communicate non-acceptance of the feelings that get expressed. It is similar to telling someone not to cry when he/she is bursting with emotions.

Sometimes the responses that block communication come to us too easily. Try to get into the habit of not responding immediately but pause momentarily. Then, respond with the use of a reflection response.

Another skill to develop is the use of ***Open-Ended Questions***. Depending on how the questions are used, they could either facilitate communication or be threatening and cut off communication. Some guidelines for using open-ended questions follow:

1. Think about the questions you want to ask so that you will get the information you need. For instance, if you ask the preceptee, "How are things going?" and he/she always says, "Fine," but looks distressed, then perhaps your question needs to be refocused.



"How did it feel to be doing four patients by yourself today?"

2. Try to avoid asking questions which can be answered with "yes" or "no."

3. Questions which start with "Who," "What," "Why,""Where," "How," and "When," tend to keep the other person talking.

4. Ask the questions in such a way that the answer will not make the person feel stupid or wrong.

If a conversation lags, it doesn't necessarily mean that a question needs to be asked to get things going. In those situations, the use of silence might be helpful or a phrase such as, "Take your time. There is no rush."

As mentioned earlier, when you begin to respond to the concerns that the preceptee shares with you, don't be afraid to wait a few seconds before you respond in order to think about what was said. By giving yourself time to think about what you will say, chances are that you will say something different than if you responded immediately.

Part IV

Handling Problem Behavior

Occasionally, you will find yourself in a position to handle problem behavior on the part of your preceptee. Depending on the behavior involved, it might be more appropriate for some problems to be handled by the faculty liaison (eg,, absenteeism). However, since you will be working so closely with the individual, you might find yourself counseling the preceptee to change the behavior involved.

Prior to entering this kind of counseling, you might find it helpful to examine your belief system as it relates to the motivations of others. Fournies says,". . . if you believe the wrong things about your subordinates, those beliefs will be the basis for you to do the wrong things to solve problems…" So ask yourself: Are you a Theory X or a Theory Y person? Theory X people assume that most individuals find work distasteful, have no responsibility, lack ambition, and prefer to be directed.

Theory X

"If I don't keep after her, she'll probably not ambulate the patient."

Theory Y

"She knows what needs to be done and I feel sure she'll do her best."

On the other hand, Theory Y people believe that individuals will be self-directed in the accomplishment of objectives. They will work as hard as they play or rest. Under the proper conditions, the average person not only seeks but accepts responsibility. If you enter the counseling session with the belief that this preceptee really will not improve unless you "sit on her /him," then you would be doing both yourself and the preceptee a disservice. On the other hand, if you believe that this person can change and wants to learn, you will probably approach the person in a more helpful fashion.

In addition to examining your beliefs prior to counseling, you should do a problem analysis. By going through such a process, you may find the solution to handling the problem is other than counseling.

In analyzing the problem, you must first identify- as specifically as possible- what the performance problem is.

"**Is this important or not?"**

Once you have identified the problem, consider its importance. if the problem is not important, ignore it.

This may sound like a simple step, but sometimes we have very strong feelings about relatively minor things.

Once you have identified that the problem is important, you should decide if there is a skill deficiency or not. If there is a skill deficiency, examine the situation from three sides:

1. Has the preceptee ever done the skill before? If not, the solution is to show her/him how. There may be skills which will be new to the preceptee.

2. Has the preceptee forgotten how to do something because the skill is not used frequently? Did he/she change only one dressing in the past? Practice might take care of this situation. Perhaps he/she could change all the dressings on your team for a period of time.

3. Is the skill done regularly but not correctly? The probable cause of the problem then is that the preceptee is lacking feedback on how to do it correctly.

It is interesting to note that 50% of non-performance problems are due to lack of feedback. If people are not permitted to know the results of their actions, they cannot make effective changes.

If you decide that the performance problem is not a skill deficiency, then something other than instruction is required. Again, examine the situation from three sides:

1. Is the preceptee being punished in some way for doing the right behavior? Is there an undesirable consequence? When asking this question, keep in mind that the consequence is undesireable to the preceptee. For example, you may be working with her/him getting organized in the morning routines of the unit. If becoming organized means that he/she will get to care for even more clients tomorrow, then getting organized might not be what he/she really wants to do or work toward!

2. Does the preceptee get favorable consequences from non-performance or other performance?

3. Is the behavior that you want to occur being rewarded? In other words, is there a favorable consequence for the desired performance? If the preceptee is doing something well or correctly, is it acknowledge and/or reinforced?

As you continue to analyze the situation there are other questions to consider such as:

-Are there obstacles preventing the preceptee from functioning? Perhaps the reason the client's beds were not made this morning is lack of linen as opposed to lack of organization?

-Does the preceptee know that the behavior is a problem? If change-of-shift report always gets started fifteen minutes late, he/she may not see the need for being to work on time just to sit around for fifteen minutes. The preceptee knows being late to work is not good, but the lateness has not caused any difficulties.
-Does the preceptee know what is expected? Or are we assuming that he/she should know something just because he/she has been there for several days now?

If analyzing the problem, you decide that the preceptee could do it if he/she wanted to, then you need to redirect the preceptee's behavior by using a coaching discussion.

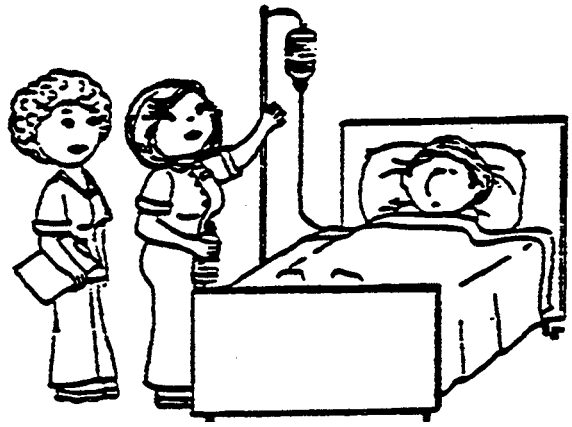
As you begin a coaching discussion, ***You Must First Get The Preceptee to Agree That a Problem Exists*****.** **A**s mentioned before, sometimes people know that their behavior is wrong but are not aware that it causes a problem. The only way that you will know if you have achieved this initial step is for the preceptee to actually verbalize that a problem exists. This initial step will possibly take up fifty percent of your counceling/coaching time but it is essential to accomplish before proceeding with your discussion. In coaching the preceptee to recognize the existence of a problem, you would identify the specific behaviors involved as well as how often the behavior takes place and the consequences of the behavior (to you, the other nurses, the patients, etc.)

The second step is to ***Mutually Discuss Alternate Solutions*****.** This could be much like a brainstorming session where as many ideas as possible are generated without any attempts to argue the merits of one idea over the other. It is preferable that the ideas be generated by the preceptee. Specific ideas will be more helpful and constructive rather than simple statements such as, "I'll try harder."

The next step is to ***Mutually Agree On The Action to be Taken.*** Although several ideas may have been generated, the preceptee will probably prefer some of the solutions more than others. Together, you should decide what will be done and when.
As with the second step, the preceptee should be the one to verbalize what will be done and by whom.

Once there is a commitment on the part of the preceptee to change her/his behavior by certain means, it is up to her/him to do this. Your responsibility, however, also continues. You will have to continue to demonstrate the importance of your discussion by **Follow Up With the Preceptee.** If the preceptee made the change but you did not follow up and, therefore, recognize the change, then no reinforcement can be given. Chances are that the undesirable behavior will recur.

The **Recognition of Achievement** is extremely important in correcting the problem. The sooner the reinforcement occurs following the behavior, the greater its influence. For example, if the preceptee takes care of the tardiness problem, it is better to acknowledge the behavior change early rather than wait.



"You have been much better about keeping your I.V.'S labeled and running on time."

You have just reviewed a process for analyzing problems and handling problem behavior.

Part V

Formal and Informal Feedback

During the time span that you are a preceptor to a preceptee, you will find yourself in numerous situations in which feedback can be given. There are two ways to go about giving this feedback to the preceptee: formally or informally. You will be involved in both.

The key to informal feedback is spontaneity; giving information about performance during or immediately following some behavior. Formal feedback is delayed. It is usually associated with large events such as evaluation time or the weekly meetings you will be having to review the preceptee's progress.

Advantages of spontaneous, informal Feedback: Problems are handled as they occur, support is given at the time it is most needed, and anxiety can be alleviated by knowing the job is being done correctly. People tend to place more trust in informal feedback because they feel the communication is spontaneous and is given without the pressure of organizational policy.

Although there are definite advantages to informal feedback, formal feedback should be given on a systematic basis. This will certainly occur for the preceptee upon completion of this component of the program. Since you have followed and observed the preceptee most closely during this period, your participation in the evaluation process will be most important. This form of evaluation which is in writing, should include documentation of the preceptee's status in relation to the performance criteria and evaluation of progress made on other personal goals which the preceptee has established. You may want to consult with the faculty liaison for guidelines in the evaluation process.

Principles for Giving Feedback

In order to feedback to be useful to someone, the person must understand the feedback, accept it, and be able to do something with it. In addition to using the counseling skills described earlier, the following principles should guide you in giving useful feedback.

To facilitate someone's being able to understand your feedback, ***Avoid generalizations about Behaviors.*** Instead, give specific examples to preceptee. For instance, don'ts just say, "You're doing a good job." Try to be as specific as possible about what is being done well! Use recent examples of the behavior that you are commenting on so that the circumstances will be clear.

"You seemed more comfortable doing that catheterization just now. Your sterile technique was correct, you seemed more familiar with the equipment, and you were able to keep the patient informed of what was happening."

In order for someone to accept feedback from you, particularly if it is on the negative side, this person must believe that you care for her/him and that your motives are in her/his best interest. Furthermore, negative feedback is easier to accept if you ***Describe What you Have Seen and the Effect It had on You or the Client.*** By using "I" statements, you ***Help Prevent Defensive Behavior*** from occurring. For example, "I feel upset when you behave like…"

In deciding when to give a person feedback, ***Consider the Present Circumstances.*** If the person has just experienced an emotionally upsetting episode, then it would probably be more appropriate to delay feedback. If the preceptee is extremely busy with client care, he/she might not be able to really hear your message.

On the other hand, if the preceptee is seeking feedback from you about a specific situation, the likelihood that your feedback will be accepted is great.

Not only is the timing of your feedback a consideration, but ***Privacy*** is an important factor also. It may be difficult to find a quiet, private place on the nursing unit but care should be taken to insure that the preceptee will not be embarrassed in the presence of others.

Feedback Should Be Validated. To do this, you can describe the behaviors, then check out your assessment of the situation for accuracy before offering suggestions for improvement. For example; to the preceptee orienting to team leading:

> "There were five clients scheduled to go to surgery today. The operating room nurse reported that two of the client's charts were incomplete and the pre-op medication was 45 minutes late for one of them. It seems that your are experiencing some difficulty with surgical preparation routines. Could you tell me what happened?

Lastly, in order for the feedback to be useful, the ***Preceptee Needs To Be Able to Change the Behavior Involved.*** If what you are focusing on has to do with physical characteristic or personality quirks that someone has had for years, probably little change can take place. If you think that an attitude should change, be prepared for the fact that it will take time. Attitude rarely change as a result of verbal feedback. Changing the behavior surrounding the attitude may be all that is possible. For example: Suppose that the preceptee has the opinion that all nursing assistants are lazy. This is demonstrated by speaking to them in a demeaning manner. In this situation, it would be easier and faster to change the manner of speaking rather than trying to change the attitude behind it.

Several principles have been presented for your consideration. If you could implement all of them all of the time, you might stifle the preceptee.

Part VI

Evaluation

Evaluation is a form of feedback which can reinforce learning. When you give the preceptee feedback regarding achievement of an objective, he/she feels successful and motivated to continue learning. Positive reinforcement lets the preceptee know what he/she is doing right, and increases the probability that the preceptee will maintain the behavior or level of performance.

Evaluation is also a form of feedback that can help correct misinformation. If the preceptee is not performing as well as you expect, evaluation can help to pinpoint weaknesses and areas in which the preceptee needs to improve. Thus, evaluation can be an effective teaching tool.

Another important purpose of evaluation is to provide feedback to the nursing faculty on their teaching effectiveness. Nursing faculty may feel that a student has been successful in their learning but unless her/his ***Behavior*** demonstrates this learning, the message has not gotten across. Nursing faculty evaluate learning in the classroom by using tests and application of that learning in the clinical setting. ***The Terminal Objective In The Nursing Program Is To Produce a Graduate Who Can Function in the Health-Care World***. The behavior you observe during this experience assists in evaluating the learning which has occurred.

Methods of Evaluation

The preceptee evaluation form you will be using can be found in your folder. The faculty liaison will assist you in completing this form. Feel free to call her/him.

When to Evaluate

In keeping with departmental policy, students are evaluated weekly through a clinical experience and again at the end of the rotation. Evaluation is an on-going process that begins the first day of the rotation and ends when the preceptee leaves.

Sometimes a preceptee might seem to be doing poorly at first. Try not to be overly alarmed abouth this. Some struggles and failures along the way are expected; this does ***Not*** mean the preceptee won't meet the ***Terminal Objectives of the Experienc*****e.** While evaluation is more or less a continuous process, it is more objective to look at overall performance rather than individual, specific events on a day-to-day basis.

Unfortunately, sometimes a preceptee's overall performance seems to be unsatisfactory. If your preceptee's performance remains unsatistactory in spite of all your efforts, you should not wait until the formal evaluation time but contact the faculty liaison. He/she will help you.

Notes