

Positive Precepting: Preparation Can Reduce the Stress

Preceptors are critical participants in the education of student nurses. They establish role expectations and evaluate performance based on faculty input and student responses. When guidance is provided to establish realistic expectations, positive clinical experiences that proactively deal with potentially significant issues can result.

A faculty member and graduate student rounded the hospital corridor, coming face-to-face with a clinical preceptor standing next to the bustling nurses' station of a critical care unit. Without prelude, an exasperated look on her face, the preceptor launched into her story. "I tell my students I'm not usually in the business of ratting them out, but *this one...*!" This student claimed to have seen and done it all, showed no desire to do anything more than once, and reported nothing of personal benefit was taking place on the assigned unit. Yet when questioned by the preceptor, the student had little understanding of the nursing care needed for the assigned patients. The preceptor's frustration was shared by the faculty member when conversation turned to burn out and this valuable nurse's desire to give up the responsibility of precepting for a semester or two.

All faculty know preceptors, those exceptional staff nurses who make unique contributions to a student nurse's ability to bridge the gap between theory and practice, are worth their weight in gold. Preceptors make the role of nursing tangible for future members of the profession, are excellent recruiters for hospital units, and often enjoy rewarding relationships with students. Precepting also involves hard work, interactions that try patience, and encounters that steal time and energy.

What planning should take place before a preceptor embarks on a clinical relationship with a student nurse? What steps at the outset of the clinical experience can reduce the likelihood of a negative experience for the preceptor and the student? Can concern about a student's performance be provided to students and faculty in a constructive way? In this article, effective performance in the preceptor role is described and some practical strategies for making preceptorship a positive experience are identified.

The Numbers in Nursing

Nursing is the largest health-related occupation and employment opportunities for registered nurses are growing faster than all others, with projections for almost 1 million new and replacement openings by 2014 (U.S. Department of Labor, Bureau of Labor Statistics, 2006). As student enrollment rapidly increases to develop an adequate health care workforce for tomorrow, nursing programs struggle to find enough faculty. Competition for available student clinical placements in many geographic areas has become critical as patient numbers and length of stay decline steadily. As Baby Boomers begin to retire, a reported 3 of 10 nurses under age 30 plan to leave the profession within a year (Aiken et al., 2001).

These trends contribute to an increasing need for creative approaches to providing quality clinical experiences for student nurses. Immersion in the role of the nurse, particularly as a student, provides significant groundwork for the individual's early socialization, easing reality shock and increasing retention as new graduates enter the workforce

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Note: A related article on this topic, "Preceptor Training: A Vital Component to Reducing First-Year Turnover," can be found in the May/June 2008 issue of *Medsurg Matters*, the official journal of the Academy of Medical-Surgical Nurses (www.medsurgnurse.org).

(Diefenbeck, Plowfield, & Herrman, 2006; Nelson, Godfrey, & Purdy, 2004).

Nothing compares to the remarkable influence of a staff nurse preceptor on the professional development of a student nurse. This approach to clinical management typically is part of the final phase of nursing education, designed to provide an in-depth experience in the patient care setting. The preceptor serves as a role model, mentor, and coach to the assigned student in ways that can not be duplicated by nursing faculty. Precepting can be less stressful for staff nurses and more effective for students if a few steps are followed to set the stage for success, recognize impending problems, and explore ways to make meaningful contributions to a student's growth.

To Be or Not to Be a Preceptor

Willing and *able* are frequent labels used to describe preceptors in the hectic, challenging hospital environment. Qualifications for preceptors may be described in a state's nurse practice act, including level of licenser and length of experience, but other characteristics may be more critical to this role (Oklahoma Board of Nursing, 2008). In addition to nursing expertise, important attributes include a positive attitude, patience, and comfort with thinking out loud (Greene & Puetzer, 2002; Kupferman, 2005; Wilkes, 2006). Excitement is contagious, and passion for the profession of nursing is critical for effective role modeling. These attributes are observable through a positive attitude. Enthusiasm, approachability, self-respect, and the respect of peers are important in a preceptor (Baltimore, 2004). A personal commitment to learning and an interest in teaching, tempered with a dash of humor, contribute to success. Humor can be used as a teaching tool, especially when mistakes occur, to relieve anxiety and promote growth in the relationship between the student and preceptor (Fawcett, 2002).

A preceptor encourages a student to be self-directed. This enhances the development of clinical

Table 1.
Precepting in a Pinch – Guidelines for Stress Reduction

P	PREPARE <ul style="list-style-type: none"> • Know clinical skill level of the student. • Who is doing what for each patient? • When does the day end for the student? • Do student goals and objectives match faculty input?
R	RIGHT EXPERIENCE <ul style="list-style-type: none"> • Is the goal multiple skills or total care of patients? • How many patients? • Is observation appropriate or is skill performance expected?
E	ENGAGE <ul style="list-style-type: none"> • Require written, personal objectives from each student. • Is this unit new for the student? Are roles clear? • Introduce yourself <i>and</i> your team members.
C	COMMUNICATION <ul style="list-style-type: none"> • Do you have a cell phone or pager number for faculty? • Do you know the faculty member's location for the assigned time period?
E	ENERGIZE <ul style="list-style-type: none"> • Share your enthusiasm and knowledge. • Include observation/learning outside routine activities. • Keep safety as the first priority; intervene when necessary, but allow the student to learn from experience.
P	PROGRESS <ul style="list-style-type: none"> • Require reports on achievement of personal goals/objectives. • Is the student appropriately engaged? • If little or no progress is being made, call faculty immediately!
T	TALK OUT LOUD <ul style="list-style-type: none"> • Have the student talk out loud when making clinical decisions. • Require frequent patient updates.

decision-making skills. Students must know the preceptor will not rush them or bypass their more deliberate efforts, thinking only of expediency (Fawcett, 2002). At the same time, students must realize their preceptor will not jeopardize the safety of patient or nurse for the sake of learning (Baltimore, 2004). Nothing escapes a student when it comes to the preceptor's commitment to this role. The student is invested emotionally in the experience and expects the preceptor to be as well (Gray & Smith, 2000).

Faculty Contributions to the Preceptor Role

Adequate preparation and support are critical for the staff nurse assuming the role of preceptor (Yonge, Krahn, Trojan, Reid, & Haase, 2002). With a little time for planning, the preceptor controls the groundwork for a more effective working relationship with faculty members. Practical guidelines

(see Table 1) can help when planning time is shortened.

The preceptor should encourage the unit manager to include faculty in staff meetings prior to the beginning of the student's clinical rotation (Palmer, Cox, Callister, Johnsen, & Matsumura, 2005). Early contact establishes a collegial relationship and the team receives critical details about the student's current educational level, prior clinical experience, and specific outcome expectations. This establishes lines of communication with faculty and introduces the student to the entire team, whose support will be critical in coming weeks. All staff members must know the student's level of performance and limitations to ensure safe practice.

After the staff meeting, the faculty member should clarify how often he or she plans to visit the unit. Depending on level of competence and how near the student is to graduation, faculty may continu-

ally round or visit intermittently while remaining available by pager. The preceptor may ask for scheduled faculty visits to the unit, supplementing unannounced rounds, to enable students to anticipate faculty arrival and plan meaningful reports. Also, the preceptor is assured of time to speak promptly and privately with faculty regarding questions or concerns. Pager or cell phone numbers should be confirmed and course documents provided to describe expectations and evaluation for this clinical experience. The faculty member should discuss any documents or areas of responsibility that are not absolutely clear, including college, faculty, and preceptor expectations of the student. What number of patients should be assigned? How is the student's prioritization assessed? How soon should the student accomplish course goals?

The evaluation form serves as an ongoing reference to be discussed in precise terms to clarify the role the preceptor is expected to play in contributing to evaluation of the student's performance. The student must be aware of the preceptor's role in performance evaluation. In addition to other data sources used to evaluate the student's progress, such as patient contributions, the preceptor will provide the student with daily verbal feedback (Smith, McKoy, & Richardson, 2001).

Preceptor and faculty also should discuss how to address special issues, such as a lack of fit due to personality, attitude, or situations on the unit, or questionable clinical competence. Although precepted students typically are near the end of their education, clinical expertise varies dramatically among students. Students with skills inadequate to meet objectives, including those lacking confidence, require extra time and attention the preceptor may not have (Yonge et al., 2002). The preceptor should identify potential deficiencies, but it is not necessarily his or her responsibility to address or correct them. Because faculty members are the best resource, it is critical to relay any of these issues promptly for immediate help. The health care

institution probably has a protocol, as does the student's nursing program, for addressing these issues. It is important for the preceptor to know precisely how and where his or her input fits in this process.

A Positive Start to the Preceptor: Student Relationship

Preceptors have control over the initial tone of the clinical experience (Thomas & Thompson, 2003). It is critically important that students believe they belong on the assigned unit and are considered valued members of the team from the beginning of the clinical experience (Fawcett, 2002; Watson, 2002). Early, open lines of communication should be established by the preceptor to create a climate of trust, and questions encouraged. Introduction of all team members and their responsibilities is important so the student can become familiar with unit function.

The student's personal objectives for this clinical assignment are as important as course objectives and faculty expectations. When a student is unable to articulate personal objectives, the preceptor may need to coax the timid student, cue the nervous one, and alert the faculty to the incapable one. The combined information enables the preceptor to identify unit personnel and resources that will help the student meet learning objectives (Baltimore, 2004). Daily goals should be discussed with the student at the outset of each shift, progress reviewed at the end of the shift, and revisions encouraged for the next clinical day. Armed with information provided by the faculty member, the preceptor can review the student's planned progress through the rotation. The student needs specific but realistic time frames to accomplish goals, and faculty should be informed if the timeline is not met (Freiburger, 2001).

Precepting Priorities: Setting Professional Boundaries

The preceptor may transition rapidly through the many roles of the position, from coach to advocate, role model to negotiator, lis-

tener to supervisor, and evaluator to "opener of doors" (Yoder as cited in Nelson, Godfrey, & Purdy, 2004). A common denominator in a smooth transition between these roles is establishing personal and professional boundaries.

As the nurse develops a precepting persona, he or she should consider the use of professional titles when working with a student. A casual, first-name approach to this relationship can hinder communication later (Wilkes, 2006). The use of titles may feel uncomfortable or even foreign to the preceptor and student born to the Baby Boomer generation. However, this differential can be important when the preceptor has to review the student's performance objectively and deliver constructive feedback. It also can be beneficial when a student has to give weight to critical feedback, such as ways to improve time management, organization, or priority setting.

The preceptor and student may be part of any generational groups. However, Siela (2006) indicated the majority of current nursing students are Generation Xers and Generation Next or Millennials, while most registered nurses are Baby Boomers. Used as reference points, these generational groups view power structures and hierarchy differently. GenXers (born after 1964) may seem abrupt, abrasive, and strongly independent, while Millennials are more open to supervision and structure. Both groups tend to be willing listeners when preceptors share insights (Duchscher & Cowin, 2004). GenXers may view everyone on the health care team as a member on equal footing (Watson, 2002), so setting initial ground rules that include title differentials emphasizes a necessary difference in status (Luparell, 2007; Wilkes, 2006).

Discussion about titles as forms of address can serve as an opening to identify the role of the staff nurse at the facility and familiarize the student with the prevailing standard of care (Fawcett, 2002). These activities are part of socializing the student to the role of the nurse. Role scope and limita-

tions also are established by the state board and the agency. Clarifying the student's awareness of regulations and policies also can reinforce the role difference that exists between the student and licensed nurses.

Getting It Done by Thinking Out Loud

One of the greatest challenges for the student bridging the gap between nursing theory and nursing practice is setting priorities. The nurse can show a commitment to the early tone established for the relationship by using a few minutes at the beginning of each shift to discuss and establish a tentative plan for the day, thinking out loud as he or she prioritizes activities for the upcoming day. This establishes a mental frame of reference for the student to stretch clinical decision-making skills (Myrick & Yonge, 2002). The student also can think out loud to plan, prioritize, and perform nursing interventions, using these opportunities to refine decision-making skills.

A preceptor can narrow or widen the student's exposure to common errors in judgment by subtly guiding priority setting and time management. The decision to intervene or allow the student to learn from non-harmful mistakes can be made more readily when the student verbalizes thoughts. Feedback on the student's plan is best offered after the preceptor determines if the approach is different, ineffective, or unsafe. Flexibility may be a consideration if the student's way is simply different from what the preceptor would have chosen, and the preceptor should guard against hyper-vigilance if no harm will come from a student's novel approach (Baltimore, 2004). The student is blending faculty, institutional, and preceptor preferences with theoretical knowledge acquired in the classroom, an activity that requires a great deal of coordination for the novice practitioner.

Keeping safety foremost, the preceptor may choose to allow the student to make a "controlled mistake" (Lichtman et al., 2003, p. 457). For example, the student prepares for a dressing change but

has not gathered all the appropriate materials, or schedules the morning activities without consideration for a patient's temporary absence from the unit. Rather than correcting the student or providing observation about the experience, the preceptor should allow the student to recognize the mistake even if it means mild disruption or confusion. The student may have to re-equip or reorganize, but learns the value of reviewing a procedure manual or cushioning time frames. These teachable moments encourage self-reliance and provide an opportunity to refer students to on-site references, a decided change when compared to getting assignments the day before providing patient care in order to allow for advance preparation.

What Is Reasonable and What Is Not

As the student progresses through the clinical rotation, the preceptor should provide daily, direct, honest feedback based on the student's written objectives, course materials provided by the faculty, and consideration for the student's current skill level. Giving specific examples of decisions that could have been handled more efficiently or effectively would be helpful, with discussion of what might have resulted from a different approach. Privacy for these conversations is important if the preceptor anticipates the student may feel embarrassed or uncomfortable addressing clinical decisions or actions in public. The student is in a vulnerable position, learning from a wide variety of virtual strangers in a public setting (Myrick, 2002), and may feel unexpectedly insecure transitioning from direct supervision by a familiar faculty member to greater independence and membership on a new professional team.

Words of praise from a preceptor impact the student differently from feedback given by a faculty member because the preceptor is viewed as an active participant in the real world of working nurses. Change is more palatable when strengths are the basis for improvement; the student's ability should be praised often and sin-

cerely, incorporating strengths into steps for improvement, and including constructive suggestions from other practitioners (Baltimore, 2004; Seldomridge & Walsh, 2006). A passable and exemplary performance should be distinguished clearly. Differentiation between proficient or capable practice will help a student understand what is needed to do a superior job (Seldomridge & Walsh, 2006).

My teaching experience has shown that rehearsing feedback before delivery to a student will help the preceptor select specific words of encouragement to allow the student to identify tangible steps toward change. For example, an eager student may be adept at connecting emotionally with patients, but requires direction on how to incorporate appropriate patient teaching succinctly into limited available time. The preceptor can provide the student with multiple opportunities to conduct successive teaching sessions during one shift. A student with strong assessment skills may have difficulty focusing his or her time on performing frequent priority system checks for a postoperative patient rather than a lengthy head-to-toe examination. The preceptor should praise the student's thorough approach and level of skill while quizzing him or her about priority systems (such as respiratory or circulatory) to be included in the more frequent evaluations.

Bumpy Road Ahead: Warning Signs

One of the most difficult and stressful responsibilities of a preceptor is contributing performance-related feedback to the student's evaluation. Giving feedback is even more uncomfortable when the input has to be negative (Yonge et al., 2002). The preceptor who feels demoralized, frustrated, or anxious when this happens is not alone. In their survey of preceptors working with unsuccessful nursing students, Hrobsky and Kersbergen (2002) reported a preceptor's feeling that he or she had "killed somebody's career" (p. 552).

A preceptor may doubt his or her ability to conclude that a student is not performing satisfactori-

ly, or feel more responsible for the student's shortcomings than is reasonable (Seldomridge & Walsh, 2006; Wilkes, 2006). One key to avoiding the devastation that students, preceptors, and faculty feel when a nursing student is unsuccessful is prompt identification of competency issues (Hrobsky & Kersbergen, 2002). A student may attempt to forge an unhealthy alliance with a preceptor, especially when dealing with fears about competency. The student should be reminded that preceptors and faculty members share a commitment and desire to see students succeed.

The preceptor contributes critical and unique input on the student's ability to apply conceptual knowledge to clinical practice, in part because he or she may have more direct contact with the student in the final clinical rotation than the faculty member (Seldomridge & Walsh, 2006). Meanwhile, the faculty member has the background to develop strategic objectives that can increase the student's likelihood of success, as well as many resources to supplement what is occurring in the clinical setting. A team approach increases the likelihood that interventions can be developed to help a student overcome obstacles to learning and meet clinical objectives. This requires prompt collaboration between faculty and preceptors (Freiburger, 2001; Öhrling & Hallberg, 2001). Some common warning signs have been identified among unsuccessful students (Hrobsky & Kersbergen, 2002). The preceptor should be alert if a student does not ask questions or is reluctant to answer them. Does a student appear to go through the motion of being on the unit without fully engaging in learning opportunities, or lack enthusiasm for assuming the role of the nurse? A poor attitude or unprofessional behavior, such as chatting at the desk, or taking personal phone calls or lengthy lunches, may be critical issues that require confrontation.

The preceptor should not wait until he or she witnesses unsafe skill performance or patience is exhausted before contacting the

faculty member. An inability to fill in critical gaps when discussing anticipated care or asking questions about clinical decisions may reflect a serious deficit in a student's learning that should be discussed promptly with the faculty member. Progress should be demonstrated during planning and prioritizing at the beginning of the shift as student learning results from the preceptor's wealth of experience (Öhrling & Hallberg, 2001). Based on his or her level of education, a student should be able to address "what if" or "why are we concerned" questions posed throughout the clinical day (Baltimore, 2004). Simple, factual, and non-judgmental language should be used to explore the student's thought processes. When questions go unanswered despite cues and clues, the preceptor should give the faculty member feedback and enlist support to provide the student with additional guidance (Hrobsky & Kersbergen, 2002).

The Value of Collaboration

Faculty and preceptor are a formidable team when they collaborate to increase the quality of the clinical experience, enhance learning opportunities, and prepare the student for the real world of practice. Preceptors report feelings of great personal satisfaction, self-enrichment, and energy as a result of participating in the education of future nurses (Baltimore, 2004; Kupferman, 2005). Precepting plays an active role in reducing reality shock for new graduates and strengthens the ranks of the profession (Butler & Felts, 2006; Greene & Puetzer, 2002). The stress of the additional responsibility of preceptorship can be reduced and personal satisfaction enhanced through clarification of responsibilities, a collegial relationship with the faculty member, and clearly conveyed student expectations.

The situation of the preceptor described at the beginning of this article demonstrated the need for prompt identification of the student who is not achieving clinical objectives and early notification of faculty so intervention can occur

to impact a student's clinical practicum in a positive way. The harried preceptor in the scenario, so frustrated with the student's negative attitude and lack of preparation, addressed the concerns very late in the semester, but these critical remarks were taken seriously and precipitated intense interventions. Supplemental on-campus lab work was developed for the student, along with behavior-specific learning objectives related to identified areas of weakness. Goals were reviewed multiple times each clinical day by faculty and preceptor for the final weeks of the practicum. Everyone was informed and comfortable with the student's level of competency prior to completion of the clinical experience. ■

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