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## Coaching for Competence

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

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

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

### The Coaching Concept Model Overview

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

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

### Model Implementation

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

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

### Preparation of Unit Coaches

Unit preceptors were invited to apply to become coaches. These nurses had proven histories of nurturing young staff in the orientation process. They had a firm commitment to finding the special talents of every novice and encouraging the growth of each nurse. As preceptors, they demonstrated sound clinical expertise, but more impor-

tantly, they were also trusted advocates of novice development. They knew that all of the essential territory mapped out for orientation had been covered in the 6 weeks of double-assigned support from a preceptor. Central orientation classes and specialty education laid the groundwork upon which the unit preceptors built the core of the program. Every skill had been itemized and each orientee assessed for need for instruction, practice, or demonstrated competency. These experienced preceptors recognized that prioritizing, pacing, and reorganizing the workload were areas for improvement.

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

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

The coaches proposed the fol-

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

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

### Launching the Program

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

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

**Table 1.**  
**Activities of the Unit Coach**

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

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

### Evolution Over Time

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

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

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

**Table 2.**  
**Questions to Help with Reflective Practice**

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

upon the prompting of the experienced coach.

### Evaluation

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

When the summer included the welcoming of 19 new staff, in addition to the 10 added from January

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

shop, and preceptor newsletter served to propagate the elements of the program.

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

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