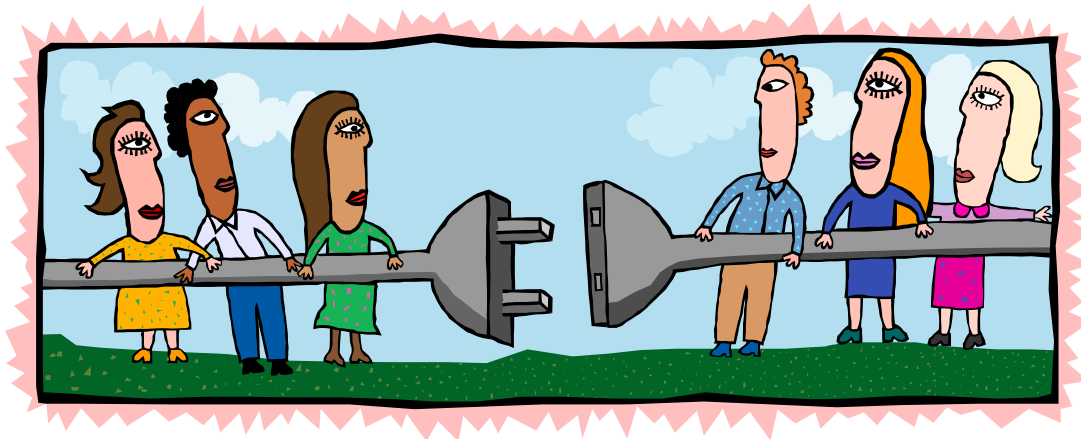


# Preceptor Program Workbook



*This work is a collaboration between:*

- Regional Health Occupations Resource Center
- Economic and Workforce Development funds awarded to Saddleback College by the Chancellor's Office, California Community Colleges
- Carl D. Perkins Vocational and Technical Education Act of 1998 through grant agreement number 02-161-001, awarded to Los Rios Community College District by the California Community College Chancellor's Office
- The Orange County Ethnic Workforce Initiative (funded by a grant from The Healthcare Foundation for Orange County)

Copyright © 2003 Chancellor's Office California Community Colleges. Permission is hereby granted to reproduce this work, in whole or part, for classroom use only.

*March 2004*

## **Acknowledgements**

A special thanks to all the professionals who assisted with the development of the Preceptor Workbook and their contributions to this program.

### **DACUM Committee**

Karen Gottlieb, RN, MSN, CCRN  
Clinical Educator  
UCI Medical Center - Orange

Laura Greico, BE, RT (RN)  
Clinical Coordinator  
Cypress College - Cypress

Janet Henderson  
Asst. Director Health Info Management  
UCI Medical Center - Orange

Darcie Peterson, RN  
Medical Surgical Certified  
St. Joseph Hospital - Orange

Michael Lopez  
Education Coordinator/Lead Tech  
Kaiser Permanente - Riverside

Gregory A. Pate, EMT  
Training Coordinator  
Schaefer Ambulance Serv. - Santa Ana

Surinder Patel  
Critical Nurse III  
Saddleback Memorial - Laguna Hills

### **DACUM Facilitator**

Joanne Gray, RN, MSN  
Regional Health Occupational Resource  
Center  
Saddleback College  
Mission Viejo

### **Work Committee**

#### **Orange County Ethnic Workforce Initiative**

Lisa Armstrong, RN, MSN  
Clinical Nurse Specialist  
Children's Hospital of Orange County -  
Orange

Ann Centeno, MS, PhD  
Education Director  
Kaiser Permanente - Orange

Karen Gottlieb, RN, MSN, CCRN  
Clinical Educator  
UCI Medical Center - Orange

Elyse McClean, RNC, MSN, CNS  
Children's Hospital of Orange County  
Orange

Mary O'Connor, RN, MSN  
Consultant  
Anaheim

Joyce Olson, RN, BSN  
Education Department  
Anaheim Memorial Medical Center

Sharon Saenz  
Kaiser Permanente of Orange County  
Anaheim

Kathy Saunders, RN, MSN  
Critical Nurse Specialist  
UCI Medical Center - Orange

**Work Committee**  
**Orange County Ethnic Workforce**  
**(continued)**

Teri Thompson, RN, BSN, MS  
Clinical Educator  
St. Joseph Hospital - Orange

**Reviewed, Edited & Revisions by:**

Gail Dodge, RN, BSN  
Education Coordinator  
San Antonio Hospital - Upland

Mary O'Connor, RN, MSN  
Consultant  
Anaheim

Tracy Ladbury, RN, MSN  
Clinical Nurse Specialist  
Miller Children's Hospital - Long Beach

Flora Tomoyasu, RN, MSN  
Clinical Nurse Specialist  
Fountain Valley Hospital

Stephanie Lowry, RN  
Riverside Community College

Trisha Tutor, RN, MSN  
Faculty  
Riverside Community College

Sally Morgan, RN, MSN  
Director of Nursing Education  
Golden West College - Huntington  
Beach

**Project Director**

**Model Curriculum Format by:**

Joanne Gray, RN, MSN  
Regional Health Occupations Resource  
Center - Orange County Region  
Saddleback College  
Mission Viejo

Linda Zorn, MA, RD, FAWHP  
Director Far North/North  
Regional Health Occupations Resource  
Center

**Project Coordinator**

Kathy Creed, RN, MS  
Director Bay Area  
Regional Health Occupations Resource  
Center

Gisela Nily  
Orange County Ethnic Workforce  
Initiative - Anaheim

Mary O'Connor, RN, MSN  
Director Orange/Inland Empire  
Regional Health Occupations Resource  
Center

**Administrative Assistant**

Katherine Murray, BRE  
Orange County Ethnic Workforce  
Initiative, Anaheim, CA

## **Table of Contents**

<b>Page 2</b>	<b>Introduction</b>
<b>Page 6</b>	<b>Module 1: Preceptor Role</b>
<b>Page 24</b>	<b>Module 2: Role Model</b>
<b>Page 29</b>	<b>Module 3: Educator</b>
<b>Page 67</b>	<b>Module 4: Facilitator</b>
<b>Page 98</b>	<b>Module 5: Evaluator</b>
<b>Page 134</b>	<b>References</b>

## **Goals, Objectives and Definitions**

### **Program Goal:**

To provide information and experiences that will develop a preceptor who:

- Demonstrates a high level of knowledge, clinical proficiency, professionalism and serves as a clinical instructor to new employees and students in the clinical setting.
- Assists with the transition to the clinical environment in order to insure quality patient services, maintains organizational standards, and continuity of patient care in a cost-effective manner.

### **Program Objectives:**

#### **Core Behavioral Objectives**

By the end of the program, the learner will be able to:

1. Describe the roles and responsibilities of the preceptor and preceptee.
2. Describe the attributes of a preceptor as role model.
3. Demonstrate the educational process for assessment, planning and implementation of learning experiences.
4. Apply strategies to facilitate socialization of employee/student into work environment and foster critical thinking.
5. Utilize techniques in formative and summative evaluation processes.

## Traffic Jam Activity

**Goal:**

To move both teams forward so they are standing on the other teams' squares. They must face the same direction as they started and in the same order.

**Guidelines / Rules:**

- Only one person can move at a time
- You can only move one square at a time
- Only one person can stand on a square at a time
- You cannot pass any member of your team
- You will, of course, have to pass members of the other team
- Once you make a move, you cannot move back

If your teams get stuck, all members return to original positions, then rotate the front person to the back square and the next person in line moves to the front square.

**Processing:**

When the teams are successful in the activity, you need to ask them how this activity relates to the purpose of the workshop. For teachers, you could ask questions like:

- How does this activity relate to our team in this building?
- How does this activity relate to the profession of teaching?
- How does this activity relate to the needs of our students?
- How does this activity relate to our responsibility to each other?
- How does this activity relate to our interaction with parents?
- How does this activity relate to what we need to do to become a better or more effective team?
- How does this activity relate to what I, as an individual, need to do to make my team better or more effective?
- Etc.

### Introduction

**Part 1:** On this sheet, please list four facts about yourself. Three of them should be true. One of them should be false.

- 1.
- 2.
- 3.
- 4.

**Part 2:** Now, as a group, do the following steps, in order, one at a time.

1. List, in the spaces provided below, the name of each person in your group.
2. Have each person read his/her statements out loud.
3. As each person reads the four statements, list next to his or her name the number of the statement you think is false and why.
4. Once each person has completed sharing the statements, take one person at a time and have each of the people in the group tell which statement is false and why. Then the person who has shared his/her own four statements can reveal which one was really false.
5. Do this for each of the people in your group:

1. Name \_\_\_\_\_ Statement # \_\_\_\_\_ is false because:

\_\_\_\_\_.

2. Name \_\_\_\_\_ Statement # \_\_\_\_\_ is false because:

\_\_\_\_\_.

3. Name \_\_\_\_\_ Statement # \_\_\_\_\_ is false because:

\_\_\_\_\_.

4. Name \_\_\_\_\_ Statement # \_\_\_\_\_ is false because:

\_\_\_\_\_.

5. Name \_\_\_\_\_ Statement # \_\_\_\_\_ is false because:

\_\_\_\_\_.

## Personal Objectives

### Exercise 1.3

**Identify your personal objectives for this program** (be sure that they are measurable and written in an active format):

**As a result of attending this program, I will be able to:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_



## **Module One:**

### Preceptor Role

## **Module I Preceptor Role**

### **Learning Objectives**

**Goal Statement – The goal of this module is to introduce the participant to the roles and responsibilities of the preceptor and preceptee.**

**Behavioral Objectives – At the completion of this area of content, the participant will be able to:**

1. Orient the class participants to the overall program.
2. Define the terms and job functions of preceptor and preceptee.
3. Identify the knowledge, attitudes, and skills needed to be an effective preceptor.
4. Identify the rights and responsibilities of a preceptor and preceptee within an organization.
5. Discuss ways of managing the emotion aspects of both the preceptor and preceptee roles.

## Handout 1.1

### Definitions

#### **Preceptor:**

- For the person who is a novice to the area (newly hired/transferred) a preceptor serves as a role model with:
  - Competence
  - Experience.
- The novice to the area is guided by the preceptor to the roles and responsibilities, as well as:
  - formal and informal rules.
  - customs
  - culture
  - workplace norms.

#### **Preceptee:**

- The preceptee, who may also be called the “orientee”, is new to a facility, department, and/or unit and participates in a planned orientation program.

#### **Preceptorship:**

- The planned orientation program that helps to introduce and integrate the preceptee into the work setting.

#### **Orientation:**

- This is a method used by an employing agency to introduce a new employee to an organization's:
  - Philosophy
  - Role expectations
  - Physical facilities.

#### **Competence:**

- Is determined by the measurement of an employee's knowledge, attitude and skill in a specific role.

## What is DACUM?

The term DACUM is taken from three words:

**Develop A Curriculum.**

- It is a relatively new and innovative approach to occupational analysis (copyrighted in 1990 by the Center for Education and Training for Employment at The Ohio State University in Columbus Ohio). It has proven to be a very effective method of quickly determining, at relatively low cost, the competencies or tasks that must be performed by persons employed in a given job or occupational area. It is a process for analysis of:
  - A job
  - An occupation
  - A process
  - A function.
- **Philosophy of DACUM:**
  - Expert workers can describe and define their job more accurately than anyone else.
  - An effective way to define a job is to precisely identify the tasks that expert workers perform.
  - In order to perform tasks, certain knowledge, skills, tools and worker behaviors are required.
- **Task:**
  - Smallest unit of work with a useful outcome.
  - Outcome is a product, service, or decision.
  - An assignable unit of work.
  - Has a definite beginning and ending point.
  - Can be observed and measured.
  - Can be performed independent of other task.
  - Consists of two or more steps.
  - Usually 6 – 20 tasks per duty.
- **Duty:**
  - Describes a large area of work in performance terms.
  - Serves as a title for a cluster of related tasks
  - Is a generally, not specific, statement of work that is performed.
  - Is a meaningful, stand-alone statement without reference to a job.
  - Usually 6 – 12 duties per job.
- **An Example:**
  - **Job:** Homeowner
  - **Duty:** Maintain the yard
  - **Task:** Mow the lawn
  - **Step:** Start the mower

## The DACUM Competency Profile for the Preceptor

The Preceptor is one who demonstrates a high level of knowledge, clinical proficiency, professionalism and serves as a clinical instructor to a new employee and students in a clinical setting. Assists with the transition into the clinical environment in order to insure quality patient services, maintains organizational standards and continuity of patient care in a cost-effective manner.

(Developed on March 7, 2001 by the Regional Health Occupations Resource Center, Saddleback College; used with permission.)

Duties	Tasks						
<b>A:</b> Serve as a role model	<b>A-1:</b> Maintain current practice	<b>A-2:</b> Serve as a resource person	<b>A-3:</b> Participate in developing performance standards	<b>A-4:</b> Assist in defining the role of the Preceptor/Preceptee			
<b>B:</b> Provide education	<b>B-1:</b> Assess learning needs	<b>B-2:</b> Assess personal/professional needs	<b>B-3:</b> Establish performance objectives/evaluation criteria	<b>B-4:</b> Orient learner to organizational documentation	<b>B-5:</b> Teach how to locate resources	<b>B-6:</b> Review procedures/policies for standard of care	<b>B-7:</b> Plan educational experiences
	<b>B-8:</b> Review theory and the procedure steps	<b>B-9:</b> Demonstrate clinical skills	<b>B-10:</b> Oversee return demonstration	<b>B-11:</b> Provide emotional support and coaching			
<b>C:</b> Serve as a facilitator*	<b>C-1:</b> Orient to physical environment	<b>C-2:</b> Arrange clinical experiences	<b>C-3:</b> Introduce employees/students to corporate culture <ul style="list-style-type: none"> <li>Unwritten rules**</li> <li>Social norms**</li> </ul>	<b>C-4:</b> Integrate employee/students to staff	<b>C-5:</b> Introduce to organizational resources	<b>C-6:</b> Communicate mutual objectives with dissimilar organizations/departments	<b>C-7:</b> Facilitate communication with other departments
<b>D:</b> Perform preceptor evaluation	<b>D-1:</b> Communicate progress to student	<b>D-2:</b> Provide constructive feedback	<b>D-3:</b> Communicate progress to management/instructor	<b>D-4:</b> Document evaluation	<b>D-5:</b> Perform competency-based evaluation.		
* Facilitator role term substituted for the original "liaison." ** Added to this section.							
<b>Tools, Equipment, Supplies and Materials</b>	<ul style="list-style-type: none"> <li>Reference resources</li> <li>Access to continuing education</li> <li>Student curriculum/teaching manual</li> <li>Calendar for planning</li> <li>Patient bill of rights</li> <li>Peer reporting mechanism</li> <li>Check off list</li> <li>Rotation list</li> <li>Policy/procedure manual</li> <li>Medical equipment</li> <li>Evaluation tools</li> </ul>						
<b>Traits and Behaviors</b>	<ul style="list-style-type: none"> <li>Ability to establish rapport</li> <li>Initiative</li> <li>Punctual</li> <li>Communication – good skills</li> <li>Dependable</li> <li>Efficient</li> <li>Loyal</li> <li>Enthusiastic</li> <li>Professional</li> <li>Common sense</li> <li>Intrinsically motivated</li> <li>Level headed</li> <li>Logical</li> <li>Thorough</li> <li>Patience</li> <li>Calm</li> <li>Intuitive</li> <li>Tact</li> <li>Team player</li> <li>Flexible</li> <li>Advocate</li> <li>Interpersonal skills</li> <li>Responsible</li> <li>Sense of humor</li> <li>Dependable</li> <li>Empathic</li> <li>Motivated</li> </ul>						
<b>Knowledge and Skills</b>	<ul style="list-style-type: none"> <li>Possess academic and licensure/certification requirements</li> <li>Serve as a resource to colleagues</li> <li>Organizational skills</li> <li>Excellent needs assessment skills</li> <li>Knowledge of learning styles</li> <li>Cultural diversity</li> <li>Excellent communication skills, verbal and written</li> <li>Time management skills</li> <li>Job experience in field</li> <li>Demonstrate excellence in field</li> <li>Desire to teach</li> <li>Ability to develop learning objectives</li> <li>Growth and development</li> <li>Objective evaluation skills</li> <li>People skills/customer relations</li> <li>Listener and leadership skills</li> </ul>						

## **Role Transition**

How are the roles of the Staff Nurse and Preceptor different?

Role of Staff Nurse

Role of Preceptor

Differences in responsibilities

Ways to make a smooth transition

## Sharks & Dolphins

### Exercise 1.4

Take a few minutes and list the positive (dolphin) and negative (shark) experience you have had with preceptor(s):

[illegible]

Qualities of an Effective Preceptor

Knowledge	Attitudes	Skills

## **Preceptor's Expectations**

In addition the responsibilities that the preceptor carries, the preceptor also has expectations or "rights" that need to be supported by the preceptor's employer and manager. When these rights are supported, problems and pitfalls are avoided and the experience is one, which is rewarding to both the preceptor and preceptee.

### **Preceptors must have:**

1. A job description that includes the role of the preceptor.  
*Question for the preceptor: Do you have a written job description that defines the nature and scope of your responsibilities?*
2. A structured program to prepare the preceptor for the role.  
*Question: Were you a willing participant in this process or were you "assigned" to be a preceptor?*
3. An understanding of expected outcomes for the orientation program.  
*Question: Are you and your preceptee clear on the goals to be attained?*
4. Access to preceptee evaluation tools that are valid and reliable.  
*Question: What tools are you using? Has their validity and reliability been established? By what body?*
5. A measurement of the preceptor's performance expectations.  
*Question for the preceptor: How are you going to receive feedback on your performance?*
6. A description of the preceptor's responsibilities in relation to others who are involved in the orientation program.  
*Question: Are you responsible for your preceptee's potential inability meet established performance criteria? Or are they professionals who are responsible for their own performance?*

7. A description of the preceptor's responsibilities in relation to others who are involved in the orientation program.  
*Question: Has it been established that you are the only preceptor or are others involved in this process? Is there a written plan?*
  
8. Resources to help in the enactment of the role of preceptor.  
*Question: What resources are available to assist you in achieving your responsibilities, e.g. administrative and material support, time, teaching aides, access to patient experiences and work situations?*
  
9. A facility support system that helps the preceptor to enact the role.  
*Question: To whom can you turn for help?*

**Responsibilities of the Preceptee**

- Identifies his/her own learning needs.
- Is an active participant in the learning process.
- Participates in regularly scheduled progress meetings.
- Identifies daily and weekly goals and objectives.
- Utilizes resources, library and department resources.
- Readily asks questions regarding any job related or department issues.
- Reads and follows policy and procedure manuals.
- Completes all competencies by the end of the program.
- Reports concerns to preceptor or manager as appropriate.
- Evaluates the preceptorship program, preceptor and self.

**Preceptee Expectations**

1. Knowledge as to the specific work assignment.  
*Question: Do you have a copy of your job description?*
2. Knowledge as to what is expected in the specific work assignment.  
*Question: Do you know what you are to achieve?*
3. Knowledge as to how to interact with the preceptor.  
*Question: What is it that your preceptor expects of you?*
4. Knowledge as to how to interact with the staff of the unit, department, and institution.  
*Question: Who is responsible for each aspect of your orientation?*
5. Knowledge as to what is expected at the end of the orientation program.

*Question: How is the preceptor going to measure that you have achieved your goals and objectives?*

6. Knowledge regarding the evaluation tools to be used to appraise their performance.

*Question: What measurement tools are to be used? Are they current, clear, and accurately developed?*

7. Use of the unit, department, institution's resources.

*Question: Is there enough time? Are there adequate reference materials? Are there enough hands-on experiences?*

8. Knowledge at to the unit, department and institution's support systems.

*Question: To whom can I go for help?*

9. Evaluation of the effectiveness of the preceptor program.

*Question: Has the preceptor program been tested? Is it effective?*

**Stress****Internal Stress****Emotional Responses:**

Fear	Self-doubt, insecurity	Isolation
Anxiety, nervousness	Excitement	Loneliness
Guilt over mistakes	Need to prove self	Competitiveness
Peer's expectations of tough, non-emotional response to stress	Emotional crisis	

**Physical Responses:**

Fatigue, exhaustion	Working when ill	Sore muscles
Lack of sleep	Working against circadian rhythm	Working through breaks, mealtime
Body not accustomed to heavy workload or fast pace		

**Mental Responses:**

Worry about performance	Inadequate education	Criticism of performance
Unclear priorities	Forgetting information used in school	Expecting perfection in self
Lack of clear job description	Lack of knowledge about organizational policies and procedures	

**External Stress****Environmental Sources:**

High noise level	Unattractive or disorganized work site	Interruptions
Exposure to pain, suffering or death	Unpleasant odors	Inability to find supplies or information
Hot/cold working area	Accents interfering with communication	

**Interpersonal Sources:**

Loss of patient	Patients' knowledge level	Working overtime
Inflicting pain on patients	Working holidays	Patients' manifestation of stress
Staff conflicts	Large number of assignments	Being evaluated
Expectations of manager	Level of responsibility	New peer group – lack of trust
New leadership role	Lack of performance feedback	Work short staffed
Problems with physicians	Pressure to document	Academic standards vs “real life”
Missing old friendships	Interdepartmental conflicts	Lack of support or help from peers
Intimidation by co-workers from a previous work experience		

## Reality Shock

In her work on reality shock in nursing, Marlene Kramer describes two concepts that are useful to preceptors who work with new graduates: reality shock and biculturalism.

**Reality Shock** is the shock-like reaction of new graduate nurses when they find that the work situation for which they have prepared does not operate with the values and ideals they had anticipated. This reaction is caused by a discrepancy between the culture the nurse was educated for and the one that actually exists in the work setting.

**Biculturalism** is the desired form of resolution to differences between the value systems of nursing students and staff nurses wherein the new nurse retains the best values and practices of both the school and work cultures.

There are four distinct phases to reality shock:

1. **Honeymoon**

Characterized by a euphoric feeling. The new employee is eager to master new skills. Tasks are concrete and results are easily seen. Everything is great.

2. **Shock**

Suddenly the job isn't so great, the managers are difficult and cynical, and the patients are demanding and ungrateful. If an employee remains at this phase, it can prove fatal. This phase includes;

Outrage	=	you should have done...
Hypocrisy	=	people saying one thing and doing the other
Rejection	=	loss of interest in work related issues
Fatigue	=	feeling of negativity

3. **Recovery**

Characterized by a general feeling of accepting things because they will not change.

4. **Resolution**

The world does not seem so bleak, a sense of well being.

**Strategies for coping with Reality Shock:**

<b>Phases of Reality Shock</b>	<b>Characteristics of Phase</b>	<b>Strategies to Lessen Reality Shock</b>
1. Honeymoon	<ul style="list-style-type: none"> <li>• Everything is wonderful</li> <li>• Excited</li> <li>• Looking at the world through rose-colored glasses</li> <li>• Enthusiastic</li> <li>• High energy level</li> <li>• Co-workers “helpful”</li> <li>• Pleased with being a “real nurse”</li> <li>• Focus is on learning routines and perfecting skills</li> <li>• Wants to learn everything at once.</li> </ul>	<ul style="list-style-type: none"> <li>• Take an interest in the preceptee</li> <li>• Help to set realistic expectations</li> <li>• Encourage to ask questions about the history of the organization</li> <li>• Assist to focus on developing a reputation for competence in skills and interpersonal relationships</li> </ul>
2. Shock	<ul style="list-style-type: none"> <li>• Anger, moral outrage</li> <li>• Frustration, rejection</li> <li>• Confusion</li> <li>• Disappointment</li> <li>• Disillusionment</li> <li>• Realizing that the values are not the same</li> <li>• Discouraged because they are not grasping all the information as fast as they thought they would</li> <li>• S/S: Excessive fatigue, superficial criticisms and a tendency to have a negative view of all things</li> </ul>	<ul style="list-style-type: none"> <li>• Be a good listener</li> <li>• Encourage preceptee to look at things they have learned so far and tasks they are able to do independently</li> <li>• Focus on the good things that have happened during the shift rather than on the frustrating events</li> <li>• Create a climate for learning where less than perfect behavior at new skills is acceptable</li> <li>• Communicate to preceptee that it is all right to be learners and that they are not expected to be proficient at performing every clinical skill</li> <li>• Prevent preceptee from feeling abandoned</li> <li>• Encourage the preceptee to write down things they think should be changed. These ideas can be used later in their career when the preceptee has earned the respect of their colleagues.</li> </ul>

Phases of Reality Shock	Characteristics of Phase	Strategies to Lessen Reality Shock
3. Recovery	<ul style="list-style-type: none"> <li>• Stress is reduced</li> <li>• Able to grasp the role</li> <li>• Realized the truth and more than one perspective exists</li> <li>• Sense of humor begins to return</li> </ul>	<ul style="list-style-type: none"> <li>• Nurture the ability to see humor in a situation</li> <li>• Give positive feedback about progress and share stories about the preceptor's own first work experiences</li> <li>• Assist to turn disappointments and unpleasant situations into learning experiences</li> </ul>
4. Resolution and Bicultural Adaptation	<ul style="list-style-type: none"> <li>• Adjustment begins by job-hopping, fleeing work by returning to school, quitting or withdrawing from nursing, burnout (the result of unresolved conflict; characterized by chronic complaining)</li> <li>• Bicultural Adaptation, the only constructive type of resolution</li> <li>• Biculturalism is the integration of two conflicting value systems, e.g. school vs. work, balancing between the academic ideals with work realities.</li> </ul>	<ul style="list-style-type: none"> <li>• Assist to evaluate work situation objectively and effectively predict the actions and reactions of other staff</li> <li>• Help identify appropriate and obtainable goals</li> <li>• Discuss constructive problem-solving, including how to go about positive change</li> </ul>
<b>Other strategies that a preceptee can adopt to reduce reality shock include:</b> <ul style="list-style-type: none"> <li>• Being flexible</li> <li>• Getting organized</li> <li>• Asking questions</li> <li>• Staying healthy</li> <li>• Finding a mentor</li> <li>• Having some fun</li> <li>• Knowing what is expected</li> <li>• Being aware of self and job</li> <li>• Knowing the job description and expectations</li> <li>• Knowing what is expected</li> <li>• Time management and keeping a time log</li> <li>• Talking to other recent graduates, sharing feelings and experiences</li> <li>• Peer teaching; reflecting on one's nursing practice</li> <li>• Having adequate knowledge to provide safe care</li> <li>• Knowing own strengths and weaknesses</li> <li>• Seeking feedback constantly</li> </ul>		

Implementing a Preceptor Program					
Nurse Manager	Charge Nurse/Assistant	CNS/Clinical Instructor	Staff Development Instructor	Preceptor	Preceptee (Orientee)
Interviews and hires applicant	Functions as a preceptor to new preceptors	Identifies candidate for preceptor selection	Conducts centralized orientation	Meets selection criteria	Attends centralized orientation program
Participates in preceptor selection	Participates in preceptor selection	Develops role performance criteria	Monitors orientee's progress and provides feedback to orientee and clinical instructor	Attends preceptor program	Identifies learning needs and seeks appropriate resources
Supports preceptor attendance at educational activities on work time by "covering assignment"	Assists in development of role performance criteria	Assigns preceptor to new orientee	Collaborates with clinical instructor to identify preceptor candidates	Completes preceptor program	Participates in mutual goal setting
Reminds staff at weekly meetings of the need for flexibility and patience during orientation of new staff	Completes time schedule to facilitate preceptor/orientee relationship	Communicates orientation outcomes to new nurse	Conducts preceptor development program and communicates results to the nurse in charge	Completes preceptor practicum	Completes unit-based specialty orientation programs
Assists in development of preceptor role and performance criteria		Conducts feedback sessions with preceptor and orientee to further identify learning needs and assess orientation progress	Assesses preceptor learning needs annually	Assesses orientee learning needs and provides appropriate educational opportunities	Evaluates orientation program
Collaborates with clinical instructor and preceptor to discuss orientee's progress		Serves as a consultant to the preceptor for problem solving	Presents preceptor courses	Plans and monitors individual orientation in conjunction with clinical instructor and charge/head nurse	Evaluates preceptor
Rewards preceptors for performance via attendance at educational conferences time off, office time, monetary		Facilitates preceptor development via monthly preceptor forums	Provides for clinical instructor development by conducting educational programs	Provides feedback to the new nurse via conferences	
Evaluates preceptors		Evaluates preceptor	Updates charge/ head nurses on socialization issues related to orientation	Documents progress via anecdotal notes and orientation progress records	
		Evaluates orientee		Attends educational offerings per year	
				Facilitates orientee's socialization to the workplace	
				Serves as a role model and clinical resource to orientee and other staff members	
				Contributes to the orientees' day evaluations	
		Evaluates orientation curriculum and assists in revision annually			



## **Module Two:**

### **Role Model**

## **Module II Role Model**

### **Learning Objectives**

**Goal Statement – The goal of this module is to introduce the participant to the attributes of a preceptor as a role model.**

**Behavioral Objectives – At the completion of this area of content, the participant will be able to:**

1. Define role modeling and specific attributes for modeling professional attitudes and behaviors.
2. Demonstrates role model activities.
3. Identify aspects of effective communication.

## **Definition**

Role Modeling is a process in which an individual identifies with and assumes the values and behaviors of another person that ultimately results in behavior modification that is usually permanent. (Bidwell & Braswell)

## **Role Model Attributes**

- A. Clarity
- B. Consistency
- C. Openness
- D. Communicativeness
- E. Specificity
- F. Accessibility

Adapted from: Myrick, F & Younge, O. (2002) "Preceptor behaviors integral to the promotion of student critical thinking." *Journal of Nurses in Staff Development*. 18:3, May/June, 2002.

**Role Model Activities**

- A. Provides competent patient care
- B. Maintain current practice
- C. Participate in Unit Governance
- D. Serve as resource person
- E. Demonstrate time management and organizational skills
- F. Promote effective communication

Adapted from: Myrick, F & Younge, O. (2002) "Preceptor behaviors integral to the promotion of student critical thinking." *Journal of Nurses in Staff Development*. 18:3, May/June, 2002.

[illegible]



## **Module Three:**

### **Educator**

## **Module III Educator Role:**

### **Learning Objectives**

**Goal Statement** – The goal of this module is to introduce the participant to the educational process for assessment, planning and implementation of learning experiences.

**Behavioral Objectives** – At the completion of this area of content, the participant will be able to:

1. Describe the learning process.
2. Explore various learning styles and stages of learning.
3. Apply adult learning principles in teaching psychomotor skills.
4. Formulate a learning plan using a variety of educational experiences.
5. Establish performance goals/evaluation criteria including timelines.

## **The Learning Process**

- I. Higher mental process
  - A. Factors that influence the learning process
    1. Environment
      - Mental
      - Physical
    2. Culture
    3. Intellectual ability
    4. Primary language
    5. Philosophy of education
      - Liberal
      - Progressive
      - Behaviorist
      - Humanistic
      - Radical
  - B. Memory related to learning
    1. Learning through association
    2. Learning through contextualism

## II. Transfer of Learning

### A. Factors that influence transfer of learning

1. Program participants
2. Program Design and delivery
3. Program content
4. Changes required to apply learning
5. Organizational context
6. Community/Societal forces

### B. Motivating Factors or Enhancers

### C. Barriers

## III. Categories of Learning

### A. Knowledge

### B. Attitudes

### C. Skills

### III. Learning Styles

Assessment of the learner is the first step in the education process. A useful tool has been developed by Kolb - called the "Learning-Style Inventory." The Learning-Style Inventory describes the way a person learns and how they deal with ideas and day-to-day situations in their life.

The Learning-Style Inventory uses 12 sentences with a choice of endings. These endings are ranked according to how a person would go about learning something.

Following the completion of the inventory, the learner then inserts the rankings into a "Cycle of Learning" and a "Learning-Style Grid." The results are correlated to four points:

- Concrete Experience (**CE**). The number on this part of the continuum related to a person's strength of preference for learning things that have personal meaning in their life today. That is, **a person likes to learn things that are useable in current situations.** We all use CE at some level.
- Reflective Observation (**RO**). The number on this part of the continuum relates to a person's strength of preference for wanting some time to reflect and think about the things that they are learning. **This person likes to plan things out and take time to make sure that they have it correct.** We all use RO at some level.
- Abstract Conceptualizations (**AC**). The number on this part of the continuum relates to a person's strength of preference for learning lots of facts and figures. **This person likes to learn lots of new concepts and information on about any topic.** We all use AC at some level.
- Active Experimentation (**AE**). The number on this part of the continuum relates to a person's strength of preference for applying and practicing what has been learned. **This person enjoys hands-on activities.** We all use AE at some level.

The profile on the Cycle of Learning gives an indication as to a person's best part in the learning cycle. A discussion of the common profiles follows. Remember, a person is all four styles and operate in all four stages of quadrants. However, a person probably has a stage in which they do very well and a stage in which they do poorly. We need to learn to take advantage of the things we do well and increase in our abilities in the areas of concern.

## **Assessing the Learning Profile:**

### **Profiles 1 and 2 The Reflector**

- Favor perceiving or learning new information through concrete experience (CE) and tend to process or internalize this new learning through reflective observation (RO).
- View situations from many different points of view.
- Skilled in situations that generate a variety of ideas and perspectives.
- Need to know why it is important to learn a new concept, strategy, idea, technique or method.
- Spend time observing others learning rather than taking action quickly.
- Need to have a plan before acting.
- Enjoy the personal connection of working together with other students.
- Enhance learning, by asking questions that help to understand why it is so important to learn a specific topic and where this new learning will be used.

### **Profiles 3 and 4 The Theorist**

- Favor perceiving or learning new information through abstract conceptualization (AC) and tend to process or internalize this new learning through reflective observation (RO).
- Best at understanding a wide range of information and are able to put it into concise, logical form.
- Interested in abstract ideas and concepts and less focused on people.
- Prefer that a theory have logical soundness than practical value.
- Thorough, industrious, goal-oriented, and prefer principles and procedures to open-ended situations.
- Excel in traditional learning situations because the lecture and reading modes suit them.
- Enjoy solitary time, not fond of working in groups.
- Enhance learning by asking questions that help gather enough information to understand what you are being asked to learn.

### **Profiles 5 and 6 The Pragmatist**

- Favor perception or learning new information through abstract conceptualization (AC) and tend to process or internalize this new learning through active experimentation (AE).
- Take information learned and try it out to see if it works.
- Want to know if what is learned makes sense and can use it to make life more effective, productive, and applicable.
- Best at finding practical uses for ideas and theories.
- Excel in problem-solving and decision-making based on finding solutions to questions.
- Prefer technical tasks to social or interpersonal issues.
- Good at working with their hands and at lab stations.
- Enjoy working mainly alone or with a small group.
- Need to know how things work.

- Enhance learning by using what is learned and asking questions that help to understand how something works.

### **Profiles 7 and 8 The Activist**

- Favor perception or learning new information through concrete experience (CE) and tend to process or internalize this new learning through active experimentation (AE).
- Interested in applying or using what they are learning in their everyday life.
- Learn best from “hands-on” experiences.
- Interested in knowing where else this newly learned information can be used.
- Take what was learned and find other uses for it.
- Enjoy carrying out plans and getting involved in new or challenging experiences.
- Risk takers and are at ease with new people and situations.
- Often use their intuition to reach conclusions to logical problems.
- Good at teaching others what they have learned and helping others see the importance of this new learning.
- Enjoy working with others and often have an expansive social circle.
- Enhance learning by asking questions that help determine where this information can be used.

### **Profile 9**

- This profile could be rotated around all for continuums. Each different profile simply represents a very strong preference for one pole of a continuum over another and a balance between the other poles on a continuum.

### **Profile 10**

- This profile is characterized by a learner who is focused primarily on gathering information. Lots of information! They are more interested in and spend more time gathering information than they need time to process or understand. They are always asking for more information from the instructor or where they can go to find additional information about the subject they are learning.

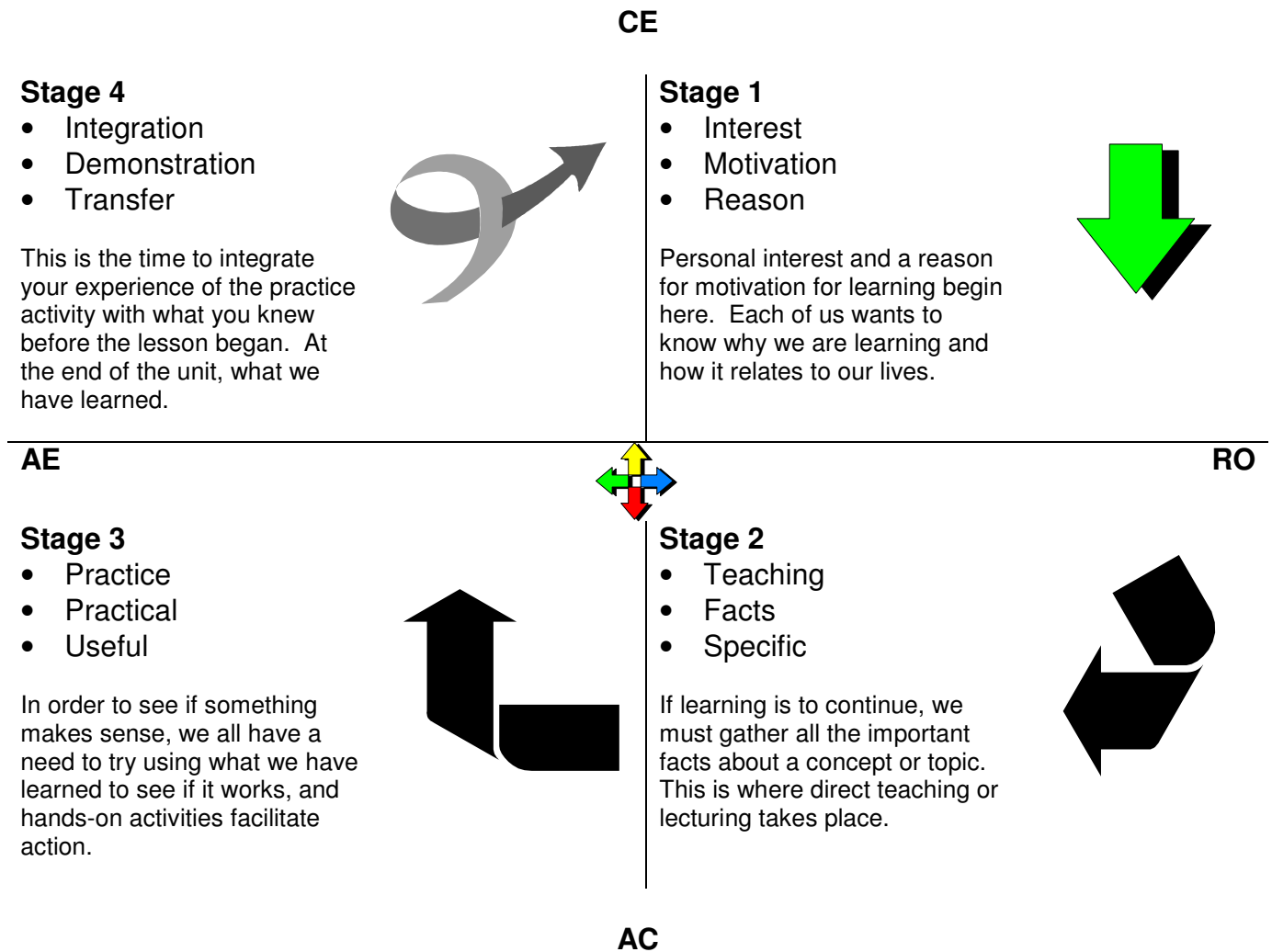
### **Profile 11**

- This profile is characterized by a learner who is focused more on having time to understand what they have learned and less focused on lots of information. In fact, they often like smaller chunks of information with plenty of time to understand it. Long lectures are extremely difficult for the learner with a profile like this.

### **Profile 12**

- This profile is a fairly well-balanced learner in the learning environment. It probably doesn't matter what the instructor does in the classroom, this learner is very adaptable. They generally enjoy school and do well with their work in school.

### Stages of Learning - Follow the Arrows



**Stage 1:**

Some people favor perceiving or learning new information through concrete experience and tend to process or internalize this new learning through reflective observation (RO).

- These individuals are best at viewing situations from many points of view.
- They approach events as an observer and would prefer to reflect on the situation rather than take action.
- They generally enjoy and are skilled in situations that ask them to generate a wide range of ideas.
- They are interested in harmony and create supportive cultures.
- They demonstrate concern for people and trust through personal interactions.
- They are interested in being involved in communal issues.
- They are usually asking: "Why do I need to learn this information, why should I stay awake in this class and/or why is it important to my life?"

**Stage 2:**

Some people favor perceiving or learning new information through abstract conceptualization and tend to process or internalize this new learning through reflective observation.

- These individuals are best at understanding a wide range of information and are able to put it into concise, logical form.
- They are more interested in abstract ideas and concepts and less focused on people.
- They would prefer that a theory have logical soundness than practical value.
- They are thorough, industrious, goal-oriented, and prefer principles and procedures to open-ended situations.
- They excel in traditional learning situations because the lecture and reading modes suit them.
- They excel at detail work.
- They are usually asking: "What do I need to learn from this class session and what facts do you want me to know?"

**Stage 3:**

Some people favor perception or learning new information through abstract conceptualization and tend to process or internalize this new learning through active experimentation:




- These individuals are best at finding practical uses for ideas and theories.
- They excel in problem-solving and decision-making based on finding solutions to questions.
- They prefer technical tasks to social or interpersonal issues.
- They experiment and tinker with things because they need to know how things work.
- They believe: "If it works, use it."
- Their goals are to make everything usable in their lives.
- They are usually asking: "How can I use what I'm learning to make my life more effective, productive, and applicable?"



**Stage 4:**



Some people favor perception or learning new information through concrete experience and tend to process or internalize this new learning through active experimentation.

- These individuals learn best from "hands-on" experiences.
- They usually enjoy carrying out plans and getting involved in new or challenging experiences.
- They may also tend to rely more heavily on "gut" feelings than on logical analysis.
- They are risk takers and are at ease with new people and situations.
- They encourage people to think for themselves.
- They often use their intuition to reach conclusions to logical problems.
- They are usually asking: "If all this information I'm learning is accurate, what else could it become or how else does it play a role in my world?"

## Multiple Intelligence

Additional Discussion of Learning Styles and Needs (examples)		
Logical/ Mathematical		<p>Often called scientific thinking. This learning style deals with deductive thinking/reasoning, numbers, and the recognition of abstract patterns.</p> <p>This person learns best when you've provided opportunities to classify, categorize, and work with abstractions and their relationship to one another.</p>
Verbal/Linguistic		<p>This learning style deals with words and language, both written and spoken. This teaching/learning style dominates most Western educational systems.</p> <p>An aural learner:</p> <ul style="list-style-type: none"> <li>• Tends to remember and repeat ideas that are verbally presented</li> <li>• Learns well through lectures</li> <li>• Is an excellent listener</li> <li>• Likes to talk</li> <li>• Enjoys plays, dialogues, dramas</li> </ul>
Intrapersonal		<p>This learning style deals with inner states of being, self-reflection, metacognition, and awareness of spiritual realities.</p> <p>This person really does better alone, pursuing self-defined interests. New information is absorbed best when the projects are individual-self-paced, and singularly oriented.</p>









Additional Discussion of Learning Styles and Needs (examples)		
Interpersonal		<p>This learning style operates primarily through person-to-person relationships and communication. It relies on all the other learning styles.</p> <p>An interactive learner:</p> <ul style="list-style-type: none"> <li>• Learns best through verbalization</li> <li>• Often hums and talks to self or others</li> <li>• Usually is not quiet for great lengths of time</li> <li>• Enjoys question/answer sessions</li> <li>• Finds small group discussions stimulating and informative</li> </ul> <p>Impart information to this person by giving opportunities to compare and contrast, interview others, sharing ideas, and cooperating to accomplish any given task.</p>
Visual/spatial		<p>This learning style deals with the sense of sight and being able to visualize an object and create internal mental images/pictures.</p> <p>The visual learner:</p> <ul style="list-style-type: none"> <li>• Learns by seeing and watching demonstrations.</li> <li>• Likes visual stimuli such as picture, slides, graphs</li> <li>• Sees the image in the “mind’s eye”</li> <li>• Often stares</li> <li>• Needs something to watch</li> <li>• Becomes impatient when extensive listening is required</li> </ul>

Additional Discussion of Learning Styles and Needs (examples)		
Body/kinesthetic		<p>This learning style deals with physical movement and the knowings/wisdom of the body, including the brain's motor cortex, which controls bodily motion.</p> <p>The kinesthetic learner:</p> <ul style="list-style-type: none"> <li>• Learns by doing, direct involvement</li> <li>• Often fidgets or finds reasons to move</li> <li>• Is not very attentive to visual or auditory presentation</li> <li>• Tries things out</li> <li>• Responds to music by physical movement</li> <li>• Likes to move hands (doodling, tapping) while learning</li> <li>• Uses movement to help concentrate</li> </ul>
Musical/rhythmic		<p>This learning style deals with the recognition of tonal patterns, including various environmental sounds, and a sensitivity to rhythm and beats.</p> <p>This learner gets information via melodies, musical notation, or rhythm as a critical aspect of the delivery system.</p>

Adapted from: Kagan, S. and Kagan, M. (1998) *Multiple Intelligences*. Kagan Cooperative Learning.

**Principles of Adult Learning—Malcolm Knowles**

1. After maturity is reached, learning ability remains practically constant. (Kolb - 4)
2. Learning results from stimulation through the senses. It is estimated that 75% of what is heard is forgotten after 2 days. It has been said that learners remember: (Kolb - 3)
  - 10% of what is read
  - 20% of what is heard
  - 30% of what is seen
  - 50% of what is heard and seen
  - 80% of what is heard, seen and done

Learning Retention Illustration			
<b>10%</b> of what is read			
<b>20%</b> of what is heard			
<b>30%</b> of what is seen			
<b>50%</b> of what is heard and seen			
<b>80%</b> of what is read, heard, and seen			

3. When we learn, connections are made to what we've learned before. (Kolb - 1)
4. Activity is needed when the adult learns. (Kolb - 3)



5. It is hard to learn when we're under stress. (Kolb - 1)



6. When we learn – we learn more than just what is presented. (Kolb - 2)
7. In order to have the learning be effective, the adult learner must be interested in the learning. (Kolb - 1)
8. It helps when the learner feels successful. (Kolb - 3)



9. Competitive activities may stimulate the adult to learn. (Kolb - 3)



10. Learning is enhanced when the problems are challenging. (Kolb - 3)

11. The adult learner likes to know the why, how and “what to do with it” of learning activities.(Kolb - 2)



12. Understanding the expected standards helps the learner to know the “why” of learning activities. (Kolb - 2)

13. The adult learner likes to know that they are succeeding. (Kolb - 4)

14. The adult learner is motivated by recognition and credit. (Kolb - 4)



15. Vivid and intense learning experiences increase the likelihood of remembering information. (Kolb - 2)



16. Adult learners like the learning to be reality-based; to be useful. (Kolb - 2)

17. Identifying logical relationships helps to make a more effective learning experience. (Kolb - 2)



18. Learning should be immediately followed by application. (Kolb - 3)

19. Skill repetition enhances skill development. (Kolb - 3)

20. Adult learners who feel responsible for learning will learn more. (Kolb - 3 and 4)

21. Each person's speed and ease of learning will be different. (Kolb - 1)

22. Grades are not the greatest motivator for the adult learner; guidance is of greater importance. (Kolb - 3 and 4)

23. A relaxed and informal atmosphere is the most conducive environment for adult learners. (Kolb - 2 and 3)



24. Small group interactions are enjoyed by adult learners. (Kolb - 2 and 3)



25. Adults do not like to have their time wasted. (Kolb - 4)

26. Lecture is not the preferred method of learning for all adults. (Kolb - 2)



27. Because of their years of experience, it is not always easy for the adult learner to change. (Kolb - 1)

28. Food and drinks help to create a relaxed atmosphere and reflect consideration of the learner. (Kolb - 2)



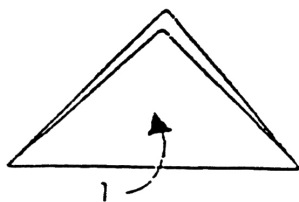
29. It is logical to move from “simple to complex” and “known to the unknown.” (Kolb - 2 and 3)
30. Trying out learning activities is helpful to the adult learner. (Kolb - 3)
31. The adult learner likes to be able to move the learning into principles and concepts. (Kolb 2 and 3)
32. The adult learner likes to see themselves as a self-directed; they like others to see them that way. (Kolb - 1)
34. For the adult, learning is a part of effective problem-solving. (Kolb - 1)
35. Goal achievement is important for the adult learner. (Kolb - 1)



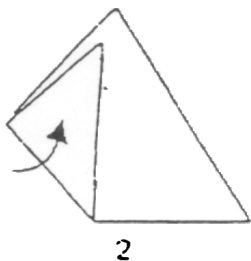
Adapted from: Alspach, J. (2000) *From Staff Nurse to Preceptor: A Preceptor Development Program*. 2<sup>nd</sup> edition. American Association of Critical-Care Nurses.

Elias, J.L and Merriam, S. (1980) *Philosophical foundations of adult learning*. Florida: Krieger Publisher Co.

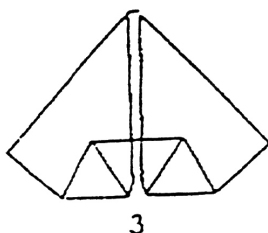
Knowles, M.S. (1980) *The Modern Practice of Adult Education*. Cambridge.



Fold napkin in half diagonally to form a triangle



Bring right and left points to the center point to form a diamond



Fold bottom point up to about one inch from top

Then fold halfway back onto itself



Turn napkin over bringing corners together, tucking one into the other



Turn napkin back over

Peel down the right and left sides from the top center to make petals

Open base to stand upright

### **How to Fold a Napkin Fleur de Lis**

1. Fold napkin in half diagonally to form a triangle
2. Bring right and left points to the center point to form a diamond
3. Fold bottom points up to about one inch from top and fold it back on itself
4. Turn napkin over bringing corners together, one into the other
5. Turn napkin back over
6. Peel down the right and left side from the top center to make petals
7. Open base to stand

## **How Do You Teach Psychomotor Skills**

### **What Is Psychomotor Learning?**

#### **The Four-Step Job Training Method (Psychomotor Learning):**

In preparing to use the four-step method you should:

- Have a time table
- Break down the job (task detailing)
- Rehearse the training session
- Have tools and materials ready
- Arrange the work/training place



#### **STEP ONE: PREPARE** (Promotes learner motivation)

- Put learner at ease
- Find out what the learner already knows and can do
- Arouse learner's interest in acquiring more knowledge and/or skill
- Place learner in the proper learning position and location

#### **STEP TWO: PRESENT** (Promotes learner understanding)

- Tell the learner what he/she is expected to do
- Show the learner each step of the task
- Explain how the learner is expected to do it
- Demonstrate the task, explaining what you are doing as you are doing it

#### **STEP THREE: TRY-OUT** (Provides learner participation)

- Have learner tell you what he/she is going to do to perform the task
- Have the learner perform, explaining how he/she is doing it
- Correct performance as needed
- Reinstruct if necessary

#### **STEP FOUR: FOLLOW-UP** (Allows learner to apply new knowledge)

- Have learner practice alone
- Encourage questions
- Model desired behavior
- Check frequently
- Taper off

Adapted from: St. Joseph Hospital, Clinical Education Department (2001) "Preceptorship: A creative approach to quality performance (Preceptor Handbook)." March, 2001. Orange, California.

## Step 1: Prepare

How do I prepare myself to give job instruction?

- 1). Do a training plan.
  - Who, what, when, where, how...
- 2). Do a job breakdown (e.g. DACUM).
  - Main steps
  - Task statements
  - Equipment and materials
  - Safety factors

How do I prepare for receiving job instruction?

- 1). How would I put them at ease?
  - Ask them something they feel positive about and give a positive response.
  - Don't overload/overwhelm them.
  - Let them know you understand a new task can be difficult.
  - Make eye contact.
- 2). Why give them the big picture?
  - People work more effectively and are more motivated when they know why things are done certain ways and where their work fits in the overall picture.
- 3). What kind of reactions do I look for?
  - Sudden changes in facial expression
  - Stiffing in posture
  - Attentiveness
  - Do they look at you when they talk?
  - Do they watch what you do?
  - Do they ask questions?

## Step 2: Present

- 1). Tell them about the job.
  - Give brief overview of entire job.
  - Start with "Main Steps" column of Job Breakdown.
  - Give trainee a copy of Job Breakdown.
- 2). Place them correctly.
  - In actual place of doing job.
  - In relationship to equipment/materials used.

- 3). Show them the job.
  - Run through the whole process before concentrating on components.
  - Keep details to a minimum.
- 4). Demonstrate how to do it.
  - One step at a time. If it's complex, repeat it a few times. (You might want to demonstrate incorrect method and discuss results/effects.)
- 5). Explain why it's done this way.
  - Connect proper methods to good results.
  - Focus on details.
  - Give it meaning.
- 6). Emphasize safe work methods.
  - Point out hazards- where they are, how they're dangerous.
  - What can happen if precautions aren't taken? What should be done if emergency occurs?
- 7). Summarize key points.
- 8). Ask for questions.
  - Let them know you'll be glad to answer any questions.
  - It's O.K. to have questions.

### **Step 3: Tryout**

- 1). Have them tell you the main steps.
  - Do they have the general picture?
  - Make corrections when necessary to avoid misunderstandings.
  - Ask questions.
- 2). Have them instruct you.
  - You follow the directions.
  - Are all the key steps correct?
- 3). Have them explain how each step is done.
  - Also, explain why it's done this way.
  - Check emergency procedure, if any.
  - Ask if they have any concerns.
- 4). Let them try.
  - Watch closely.
  - REINFORCE what's done correctly.
  - If they make mistakes, ask them to examine what they did and correct it themselves.

## Step 4: Follow-up

- 1). Check their familiarity with the area.
  - Location of departments, materials, equipment, helpful co-workers.
- 2). Check their knowledge of key procedures.
  - Ask for review of main tasks.
- 3). Let them know how to find you.
  - Encourage this when necessary.
- 4). Encourage them to continue asking questions.
  - Provide answers, or refer them to written procedures.
- 5). Model the desired behavior in daily practice.
  - Reinforce the proper techniques.
- 6). Taper off your supervision.
  - Check frequently at first, then taper off.
  - As employee competence improves, direction from you can decrease.
- 7). Always tell them how they are doing.
  - Reinforce desirable learning.
  - Correct undesirable performance.
- 8). Watch on new assignments.
  - Show how it's done and ask how it differs from old.
  - Ask how employee would handle this new situation.

## Summary

### How to be effective when teaching psychomotor skills

1. Preparation
  - Adequate time
  - Materials
2. Motivation
  - Build on previous learning experiences that were successful.
  - Why?
3. Create a safe learning environment.
4. Develop a trusting relationship with the preceptee.

Adapted from: St. Joseph Hospital, Clinical Education Department (2001) "Preceptorship: A creative approach to quality performance (Preceptor Handbook)." March, 2001. Orange, California.

## **Learning Needs**

**Definition:** A learning need is demonstrated when a person's performance does not achieve the desired level.

### **Step 1: Discover the learner's current level of performance.**

As a preceptor, you will need to do each of the following to determine the preceptee's learning needs:

1. Compare the preceptee's present knowledge, attitudes, and skills with the expected outcomes
2. for orientation
3. Record whether the preceptee currently meets each expectation
4. Focus the preceptorship on areas that have to be attained

### **Step 2: Identify what needs to be learned.**

True learning needs are based on the outcome expectations of the orientation program.

1. Learning interests are ideas or activities that the preceptee would like to learn about, but which are not included in the list of expected outcomes for the orientation program.
2. Non-learning needs exist when discrepancies between the present and desired performance are caused by something other than a need for instruction.

### **Step 3: Identify priority of learning needs with the preceptor**

Why might some learning needs take priority over others?

1. Preceptees will likely perceive some of their learning needs as more important than others.
2. Preceptors may view the importance of these needs differently from how preceptees view them.
3. To work together successfully, the preceptor and preceptee will need to reach a consensus on which needs will take priority over others.

### **Step 4: Learning needs are agreed-upon by both preceptor and preceptee:**

The learning needs assessment helps preceptors distinguish between orientation expectations that the preceptee already meets (no learning need exists) and those the preceptee has not yet achieved (learning needs still exist). The preceptorship will focus on helping the preceptee to meet those learning needs.

1. Because the entire list of learning needs cannot be attained simultaneously, it is necessary to begin dividing this list into smaller sets that can be achieved over a specified period of time.
2. Validation is needed in some areas of the self-assessment.

Adapted from: Alspach, J. (2000) *From Staff Nurse to Preceptor: A Preceptor Development Program*. 2<sup>nd</sup> edition. American Association of Critical-Care Nurses.

# ORIENTATION COMPETENCY CHECKLIST MEDICAL-SURGICAL SKILLS INVENTORY

Self-Assessment			Competencies				Validator			Education Process			Competent	
0	1	2					1	2	3	4	Date	Code	Initial	Y/N
<b>Patient Assessment/Care Planning</b>														
Perform and document physical assessment findings for the following systems:														
			1. neurological											
			2. integumentary											
			3. cardiovascular											
			4. respiratory											
			5. gastrointestinal											
			6. genitourinary											
			7. musculoskeletal											
Identify nursing care problems in the functional health patterns of:														
			1. health perception/health management											
			2. activity/exercise											
			3. cognitive/perceptual											
			4. pain											
			5. nutritional/metabolic											
			6. elimination											
			7. sleep/rest											
			8. coping/stress											
			9. sexuality											
			10. values/beliefs											
			11.											
<b>Develop and implement:</b>														
			1. a nursing plan of care											
Delegate nursing activities to:														
			1. licensed nursing personnel											
			2. unlicensed nursing personnel											

**Self-Assessment**  
0 = no experience  
1 = limited experience  
2 = experienced

A:IMSSKL

## Validator Assessment

1. no skills
2. limited skills
3. competent
4. competent, able to teach

## Education Process

- P&P = read policy/procedure  
E = attend class  
V = video/self-learning  
D = demo/discussion

Self-Assessment		Competencies		Validator				Education Process			Competent
0	1	2		1	2	3	4	Date	Code	Initial	Y/N
Collaborate:											
			1. with other health-care providers.								
<b>Medication Administration</b>											
Safely administer/perform:											
			1. oral medications								
			2. sublingual medications								
			3. intramuscular injections								
			4. subcutaneous injections								
			5. eye medications								
			6. genitourinary irrigants								
			7. rectal medications								
			8. Mantoux testing								
Evaluate medication action(s) for:											
			1. effectiveness								
			2. adverse effects								
Provide patient teaching regarding:											
			1. expected effects								
			2. side effects								
			3. discharge instructions for medications								
<b>Intravenous Therapy (IV)</b>											
Manage activities related to intravenous therapy, specifically:											
			1. patient teaching regarding intravenous therapy								
			2. starting IV lines								
			3. regulating IVs								
			4. maintaining IV sites								
			5. mixing IV infusion using additives								
			6. discontinuing peripheral IVs								
			7. using IV infusion pumps								
			8. heparin locks								
			9. blood/blood products								
			10. drawing of blood for lab studies								
			11. ortho (Stryker) transfusion equipment								
			12. piggy-back medications								

<b>Self-Assessment</b> 0 = no experience 1 = limited experience 2 = experienced	<b>Validator Assessment</b> 1. no skills 2. limited skills 3. competent 4. competent, able to teach	<b>Education Process</b> P&P = read policy/procedure E = attend class V = video/self-learning D = demo/discussion
--	---	---

A:IMSSKL

Self-Assessment		Competencies	Validator				Education Process			Competent Y/N	
0	1		2	1	2	3	4	Date	Code		Initial
		13. maintaining central lines									
		14. managing TPN/PPN									
		a. observing for signs of hyperglycemia									
		b. monitoring urine glucose levels									
		15. managing cancer chemotherapy									
		a. implementing patient instruction									
		b. observing for side effects									
		c. providing patient protection									
		<b>Airway Maintenance</b>									
		1. provide patient teaching regarding airway maintenance activities									
		2. set-up and maintenance of suctioning equipment									
		3. assessment for correct placement of an endotracheal tube									
		4. monitor ventilator function									
		5. suctioning of trachea using aseptic technique									
		6. suctioning of mouth and nose									
		7. placement and reading of pulse oximeter									
		8. set-up and maintenance of oxygen-administration equipment									
		9. administration of oxygen via:									
		a. mask									
		b. nasal cannula									
		c. endotracheal tube									
		d. tracheostomy									
		Be able to state the value of the following nursing actions related to airway maintenance:									
		1. cough and deep breathe									
		2. pain management									
		3. position change									
		4. elevation of the head and chest									

**Self-Assessment**  
 0 = no experience  
 1 = limited experience  
 2 = experienced

**Validator Assessment**  
 1. no skills  
 2. limited skills  
 3. competent  
 4. competent, able to teach

**Education Process**  
 P&P = read policy/procedure  
 E = attend class  
 V = video/self-learning  
 D = demo/discussion

A:MSSKL

[illegible]

**Signature of Orientee**

**Initials**

**Signature of Validator**

Initials

**Signature of Validator**

Initials

Signature of Validator

Initials

**Signature of Validator**

**Self-Assessment**  
0 = no experience  
1 = limited experience  
2 = experienced

<u>Validator Assessment</u>	<u>Education Process</u>
1. no skills	P&P = read policy/procedure
2. limited skills	E = attend class
3. competent	V = video/self-learning
4. competent, able to teach	D = demo/discussion

**Levels of Competency:**

To assess levels of competence, understanding a person's professional growth and development is critical. The Dreyfus Skill Acquisition Model applied to nursing practice describes a progression of skill acquisition:

- **A novice:**
  - A new graduate nurse with no nursing experience
  - Requires close supervision, assistance and education
  - Needs rules (i.e. policies and procedures) to guide actions
- **Advanced beginner:**
  - Independent in some aspects of practice, yet not in all situations
  - Needs assistance in setting priorities
  - Needs frequent monitoring and education
- **Competent:**
  - Applies experience and judgment to new patient situations
  - Sets priorities to achieve long-term goals
  - Manages most complex situations
  - Decision-making is logical and deliberate
  - Requires ongoing education to remain current
- **Proficient:**
  - Nursing practice is efficient, flexible
  - Decision-making is less labored
  - Mentors other nurses
  - Manages all situations effectively
  - Requires ongoing education to remain current
- **Expert:**
  - Has intuitive grasp of patient care situations
  - Masterful at problem-solving
  - Anticipates complications
  - Assists other nurses in becoming mentors
  - Requires ongoing education to remain current

Adapted from: Benner, P. (1982) From novice to expert. *American Journal of Nursing*. 82:403-407.

**Applying Competency Level Information:** The following two tables illustrate three competency levels and their use in the areas of medication administration and coordination of patient care.

Adapted from: Robinson, S. and Barberis-Ryan, C. (1995) "Competency Assessment: A Systematic Approach. *Nursing Management*. 26:2

Medication Administration			
Level	Technical Skills	Interpersonal Skills	Critical Thinking Skills
Novice Practitioner	<ul style="list-style-type: none"> <li>Applies the 5 rights:               <ul style="list-style-type: none"> <li>right dose</li> <li>right drug</li> <li>right time</li> <li>right patient</li> <li>right route</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Identifies drug, if asked</li> <li>Greets patient</li> <li>Introduces self to patient</li> </ul>	<ul style="list-style-type: none"> <li>Looks up drugs if unknown</li> <li>Follows written parameters (e.g. BP, pulse, glucose)</li> <li>Recognizes documented allergies</li> </ul>
Advanced Beginner	<ul style="list-style-type: none"> <li>Organizes delivery to improve efficiency and minimizes interruptions (e.g. having the cart stocked, no need to run for supplies)</li> <li>Knows adverse effects and contraindications</li> </ul>	<ul style="list-style-type: none"> <li>Answers specific questions about medications (e.g. action, indication) to patient, family, MD, pharmacy and other nurses</li> </ul>	<ul style="list-style-type: none"> <li>Seeks resource for direction to meet 5 rights, if necessary</li> <li>Identifies situations requiring modification in medication administration</li> </ul>
Competent Practitioner	<ul style="list-style-type: none"> <li>Prioritizes meds for a group of patients (e.g. pre-ops, insulin's, stats, prns)</li> <li>Knows nursing implications (food-drug interactions, therapeutic drug levels, lab values)</li> <li>Delegates tasks to minimize distractions</li> </ul>	<ul style="list-style-type: none"> <li>Initiates patient/family teaching while administering meds (e.g. action, indications, side effects)</li> <li>Communicates nursing assessments to appropriate people (e.g. labs, drug levels, adverse effects)</li> <li>Does discharge planning/teaching (e.g. IV antibiotics)</li> <li>Resource to novice and advanced beginner</li> </ul>	<ul style="list-style-type: none"> <li>Recognizes adverse effects and contraindications</li> <li>Recognizes appropriate resources to resolve problems</li> <li>Independent problem solving</li> <li>Decision-making is logical deliberate</li> <li>Assesses/manages emergent situations</li> </ul>

Coordination of Patient Care			
Level	Technical Skills	Interpersonal Skills	Critical Thinking Skills
Novice Practitioner	<ul style="list-style-type: none"> <li>Assigns all patients and unit activities on a timely basis</li> <li>Enters orders into the appropriate document</li> <li>Completes patient classification reports and sends to nursing office each shift</li> <li>Sees that discharge summary/instructions are done for all potential discharges.</li> </ul>	<ul style="list-style-type: none"> <li>Communicates changes in medical/nursing orders</li> <li>Reports objective data to MD, other shift, and nurse managers</li> </ul>	<ul style="list-style-type: none"> <li>Sees that all assignments are completed for shift</li> <li>Recognizes significant changes in patient status and seeks appropriate resources</li> </ul>
Advanced Beginner	<ul style="list-style-type: none"> <li>Completes patient care assignment based on acuity of needs, job description and level of caregiver skill</li> <li>Revises and updates nursing orders as needed</li> <li>Organizes work load to maximize efficiency</li> <li>Participates in and follows up with established plan of care</li> </ul>	<ul style="list-style-type: none"> <li>Initiates contacts with other departments to ensure that patient care needs are met</li> <li>Communicates with MD and other caregivers, giving complete and accurate information regarding patient condition</li> </ul>	<ul style="list-style-type: none"> <li>Begins to evaluate quality of care delivered by others</li> <li>Evaluates change in patient status and reports complete and accurate information to appropriate resources.</li> <li>Delegates activities in routine situations and some urgent situations.</li> </ul>
Competent Practitioner	<ul style="list-style-type: none"> <li>Accepts responsibility as dictated by unit needs</li> <li>Plans for continuity in each patients' care over all shifts and over sustained periods of time</li> <li>Facilitates resourceful use of organization's policies and procedures by all unit members</li> <li>Adapts to changing workloads with flexibility, reprioritizing need and guiding other staff in adjusting workloads</li> </ul>	<ul style="list-style-type: none"> <li>Actively initiates effective communication patterns among team members</li> <li>Coordinates and cooperates with other care providers for productive problem-solving to meet patient needs</li> <li>Resource for staff members; communicating appropriate knowledge, skills and conduct</li> <li>Creates a practice environment that maximizes individual performance</li> </ul>	<ul style="list-style-type: none"> <li>Aware of staff weakness and utilizes staff strengths in coordinating patient care</li> <li>Uses sound clinical judgment when delegating responsibilities during emergency situations</li> <li>Identifies conflicting medical/nursing orders and takes appropriate action</li> <li>Recognizes opportunities to change patient care delivery or nursing care practices that will improve quality of patient care</li> </ul>

## Selecting Teaching Methods:

The **knowledge** component of competence may be taught using:

- Hospital, department, and unit policy/procedure manuals
- Books and journal articles
- Lectures, discussions, seminars
- Case presentations.

The **attitude** component of competence may be taught using the following approaches:

- Role-playing to distinguish effects of positive and negative work attitudes, including performing duties in a careless manner; providing incomplete, tardy, or otherwise marginal work quality; failing to tailor services to patient and family needs; or displaying disrespectful, judgment, or culturally insensitive behaviors.
- Written or videotaped scenarios that illustrate positive and negative work attitudes.
- Case presentations to actual job situations that illustrate effects of positive versus negative work attitudes.
- Role modeling or desired affective traits by preceptor.
- Values clarification exercises.

The **skills** component of competence may be taught using:

- Reading procedure manuals and manufacturers' instruction books.
- Viewing audiovisual media.
- Observation of skill demonstration with return demonstration.
- Practice with actual equipment.

Review the following learning activities and check either knowledge, attitude, or skill - and indicate where each fits into Kolb's Learning Styles (Stages 1, 2, 3, 4).				
Knowledge	Attitudes	Skills	Kolb	Learning Activities
				Reading articles, books, or hospital procedures.
				Completing self-learning packages and modules
				Listening to audiotapes
				Using computer-assisted instruction
				Watching videotapes
				Practicing in a skills laboratory
				Completing worksheets
				Observing others perform a procedure
				Participating in role plays
				Practicing procedures with a preceptor
				Participating in rounds
				Return demonstration of a procedure or skill
				Listening to lectures
				Independently providing patient care services
				Participating in small-group discussions
				Asking questions
				Playing instructional videos
				Completing written exercises
				Participating in a patient care conference
				Practicing skills with teaching aids such as mannequins

Adapted from: Alspach, J. (2000) *From Staff Nurse to Preceptor: A Preceptor Development Program*. 2<sup>nd</sup> edition. American Association of Critical-Care Nurses.

**Creating a Plan:**

Ask yourself:

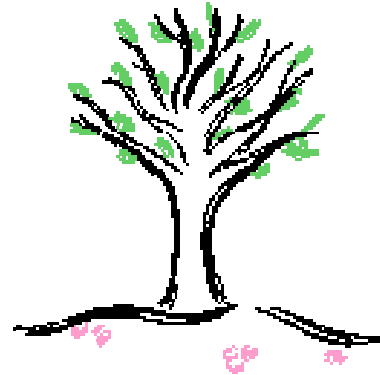
1. Who does your other tasks while you are performing your training role?
  - a. Discuss with your supervisor.
  - b. Can you delegate some tasks or adjust deadlines.
2. What will you cover?
  - a. Find out what they already know and what they still need to learn.
  - b. Collaborate to make plan
3. What do you expect of him/her?
  - a. Tell him/her your expectations and your measurement methods.
  - b. What tools are available?
4. What are the specific requirements?
  - a. Are requirements being met?
  - b. If not, what is not met, e.g. speed, accuracy, safety?
5. When will you train?
  - a. Full-time or sporadic
  - b. How will this effect learning?
6. Where will you train?
  - a. Noise level - will you be disturbing others/others disturbing you?
  - b. Can the employee learn the task correctly away from the work area?
7. How will you teach?
  - a. Locate available resources
  - b. Determine which learning activity is appropriate to the content
8. How will you determine how well he/she is doing?
  - a. Estimate satisfactory rate of progress to use as a measurement.
  - b. What tools are available?

Adapted from: St. Joseph Hospital, Clinical Education Department (2001) "Preceptorship: A creative approach to quality performance (Preceptor Handbook)." March, 2001. Orange, California.

## **Goal Setting**

### **I. Purpose**

- A. Growth
- B. A way of accomplishing tasks
- C. A means to an end



### **II. Benefits of goal setting**

- A. Goal setting can improve self-esteem.
- B. The preceptee can see progress immediately.
- C. It helps the preceptee see their strengths.
- D. It makes the preceptee aware of their growth areas. They begin setting new goals to improve in these areas and in turn make them strengths.
- E. Goals give a person confidence.
- F. The feeling of successes and of satisfaction comes from achieving goals. It makes life much more interesting when one has something to strive for.
- G. Frustration levels are lowered when vagueness and doubt are replaced by structure and direction.
- H. Goals allow the preceptee to look at completed goals as success stories, which in turn stimulate them to achieve future goals.
- I. Written goals help them visualize, actionize and then actualize.
- J. Goal setting keeps them on track.
- K. Goal setting forces prioritization.
- L. Goal setting makes them accountable for completing the goals.

### III. Barriers to Goal Setting

- A. **Predictability** – People in general are threatened by change. Goal setting may be uncomfortable.
- B. **Conditioning** – People are creatures of habit. It is very difficult to break old habits. Goals can be seen as a threat when it comes to breaking old habits.
- C. **Miracles** – Some people wait for a miracle to happen, instead of taking the steps necessary to ensure that goals will be accomplished.
- D. **Fear of losing** – None of us want to be a failure. Many people will not set goals because they are afraid of being unable to attain that goal.
- E. **Fear of winning** – The irony of this is that some individuals will not set a goal because they are afraid of being able to attain that goal. How will they need to change?
- F. **Over expectations** – Setting goals too high can reinforce the behavior of not being able to reach goals.

### IV. Characteristics of a model goal

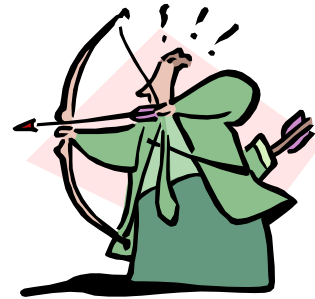
- A. They must be mutually set.
- B. Goals should be relevant.
  - Recommendations from the program facilitator, nurse manager and preceptor.
  - Competency lists
- C. Goals must be stated positively.
- D. Goals must be realistic and obtainable.
- E. Goals must be measurable.
- F. Goals must be written.
- G. Goals must be specific, including timeframes for achievement.

An example of a mutually set goal with the above characteristic might be:

“The preceptee will have successfully started three intravenous lines within the first week.”

## V. Using goals to improve the preceptoring experience.

- A. Meet with preceptee each week to set goals and review achievement from previous week.
- B. Encourage preceptee to come prepared with a list and self-evaluation.
- C. Limit number of goals.
- D. Do not duplicate competency lists.
- E. Share ideas regarding how goals can be met.
- F. If a goal was not achieved, reevaluate to see why and try again.  
Was the goal realistic? relevant?
- G. Role model goal setting by setting goals for yourself as a preceptor.



## VI. Goal setting principles for long-term goals

- A. Each goal should describe a specific end result.
- B. A goal should make you stretch but still be attainable.
- C. Identify why you want to accomplish this goal.
- D. Remember goals can be changed.
- E. You create most of your obstacles.
- F. Goals should require you to do more of something or do it better or differently.
- G. If the goals are attainable, this reinforces self-esteem and keeps us motivated.
- H. Visualize what you will be when you reach your goal

### **Exercise**

Write one goal you might set for your preceptee during the first week in your work setting. Remember to include the above characteristics.

**WEEKLY LEARNING PLAN PROGRESS TRACKER**

Preceptee: \_\_\_\_\_

Preceptor(s): \_\_\_\_\_

Date: \_\_\_\_\_ Week#: \_\_\_\_\_ Patient Load: \_\_\_\_\_

**Preceptee's Goals for the Week:**

Goal	Met	Not Met	Evaluation

Progress on competency/equipment checklist(s):

Learning needs identified:

Comments:



## **Module Four:**

### Facilitator

## **Module IV      Facilitator Role:**

### **Learning Objectives**

**Goal Statement** – The goal of this module is to introduce the participant to strategies that facilitate socialization of employee/student into work environment and foster critical thinking.

**Behavioral Objectives** – **At the completion of this area of content, the participant will be able to:**

1. Discuss strategies to maximize the integration of the employee/student into the clinical environment.
2. Utilize a process that encourages critical thinking and problem solving in case study situations.
3. Apply conflict management strategies.

**Facilitator Activities:**

- A. Familiarize preceptee with physical environment
  
  
  
  
  
  
  
  
  
  
- B. Promote sense of belonging
  
  
  
  
  
  
  
  
  
  
- C. Arrange clinical assignments
  
  
  
  
  
  
  
  
  
  
- D. Encourage systematic thinking and problem solving
  
  
  
  
  
  
  
  
  
  
- E. Negotiate with staff members to improve experience

**“Find and Name the People” Tool (Example):**

✓	Name	Position	Information
	<b>Nurses</b>		
	<b>Case manager</b>		
	<b>Physicians</b>		
	<b>Housekeeping</b>		
	<b>Central Service</b>		
	<b>Lab</b>		
	<b>Radiology</b>		
	<b>Social Services</b>		
	<b>Other departments</b>		
	<b>Contacts Outside Facility</b>		

## Self-Orientation to Medical-Surgical/Rehabilitation "Scavenger Hunt"

**Student**
**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

<b>Safety-Related:</b>	<b>Hospital Areas:</b>	<b>Unit Telephone Number:</b>
Fire Extinguishers Fire Alarm Code Cart Code Blue Code _____ Biohazard trash can Needle disposal container(s) Infection control manual Fire/disaster manual Soiled linen disposal (e.g.: chute, hamper)	Lobby Administration Cafeteria Library Other (list):  <b>R.A.C.E.: Fire Management:</b> <b>R = Rescue</b> <b>A = Alarm</b> <b>C = Contain</b> <b>E = Extinguish</b>	To report anticipated absence, lateness, call:
<b>Supplies/Equipment:</b>		<b>Unit-Related Areas:</b>
Admission kits Personal care items (e.g. soaps, lotions, toothpaste, comb, slippers) Pillows, blankets Bedpan, urinal Stool specimen containers Urine specimen container Tissues, toilet paper Lubricant Bath basins <div style="margin-left: 150px;">Emesis basin</div> <div style="margin-left: 50px;">Bedside trash (paper) bags</div> <div style="margin-left: 150px;">Chux</div> <div style="margin-left: 100px;">Denture cups</div> Drinking cups Alcohol pads Adhesive tape IV solutions IV stands/poles IVAC/termometers Wheelchairs Sphygmomanometer/stethoscope Tongue blades Wound dressing equipment (e.g.: 4x4's, ABDs, q-tips)	Bed scale Portable scale Irrigation solutions Irrigation trays Bedside commodes Medication cups Syringes Needles Restraints Paperwork, e.g.: <div style="margin-left: 150px;">I&amp;O</div> <div style="margin-left: 50px;">Vital sign flow sheets</div> <div style="margin-left: 50px;">Addressograph</div> <div style="margin-left: 50px;">plate and stamp machine</div>	Clean utility room Linen closet(s) Nurses' lounge Staff restroom Treatment room(s) Medication room Dirty utility room Conference room Ice machine Nourishment refrigerator <div style="margin-left: 150px;">Medication refrigerator</div> <div style="margin-left: 150px;">Shower room</div> <div style="margin-left: 150px;">Tub room</div> <div style="margin-left: 150px;">Microwave</div> Staff assignment bulletin board Reference materials, e.g.: manuals <div style="margin-left: 150px;">PDR, etc.</div> Telephone directory
<b>Emergency Codes (dial 55 to report all codes):</b>		
Fire: Code Red Cardiac Arrest: Code Blue	Disaster: Code Triage Hazardous Material: Code Orange	Infant Resuscitation: Code Pink Infant Abduction: Code ABC

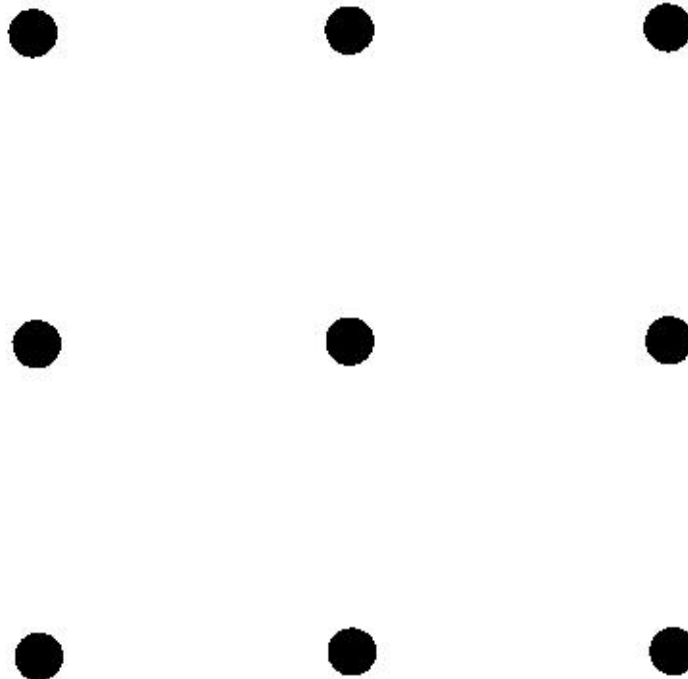
**Systematic Thinking and Problem Solving**

Focusing on thinking allows you to become more aware of personal attitudes and values and how they affect your perceptions. Often we do not recognize how our own attitudes and values shape the way we perceive situations – and how our perceptions affect the way we interact with our preceptees.

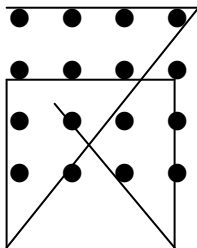
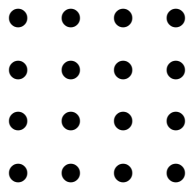
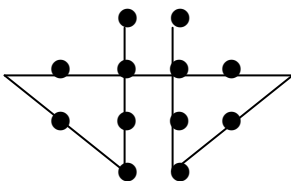
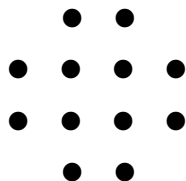
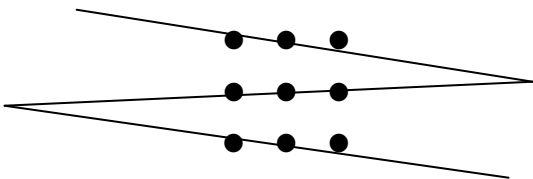
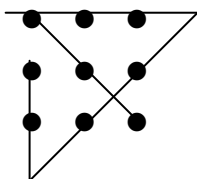
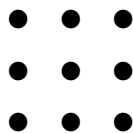
The inferences we make about the data we perceive influence our response to the situation. The next two pages contain aspects of our thinking, attitudes and values – in pleasant applications (Brain Teasers and Riddles):

**Exercise 1: Join the dots**

You have 2 minutes to join the dots with 4 consecutive straight lines. You may not lift your pen off the paper or repeat a line.

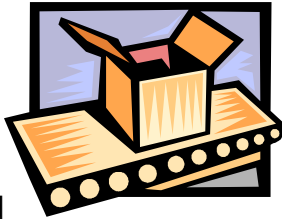


***Solution***



Adapted from: Kroehnert, G. (1991) *100 Training Games*. McGraw-Hill.

# Brain Teasers :



1. Sand

2. MAN  
BOARD

3. STAND  
I

4. | R | E | A | D | I | N | G |

5. WEAR  
LONG

6. R  
ROAD  
A  
D

7. T  
O  
W  
N  
▽

8. CYCLE  
CYCLE  
CYCLE

9. LE  
VEL

10. \_ O \_  
M.D.  
B.A.  
Ph.D

11. KNEE  
LIGHT

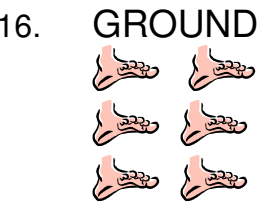
12. i i  
O O  
O O  
O O

13. CHAIR



14.

15. T  
O  
U  
C  
H  
▽



17. MIND  
MATTER

18. HE'S / HIMSELF

19. ECNALG

20. DEATH LIFE

- 1. \_\_\_\_\_
- 3. \_\_\_\_\_
- 5. \_\_\_\_\_
- 7. \_\_\_\_\_
- 9. \_\_\_\_\_
- 11. \_\_\_\_\_
- 13. \_\_\_\_\_
- 15. \_\_\_\_\_
- 17. \_\_\_\_\_
- 19. \_\_\_\_\_

- 2. \_\_\_\_\_
- 4. \_\_\_\_\_
- 6. \_\_\_\_\_
- 8. \_\_\_\_\_
- 10. \_\_\_\_\_
- 12. \_\_\_\_\_
- 14. \_\_\_\_\_
- 16. \_\_\_\_\_
- 18. \_\_\_\_\_
- 20. \_\_\_\_\_

**Listening Test: Riddles**

1. Is there any federal law against a man marrying his widow's sister?
2. Do they have a fourth of July in England?
3. If you had only one match and entered a cold room that had a kerosene lamp, an oil heater and a wood stove, which would you light first for maximum heat?
4. How many animals of each species did Moses take aboard the Ark with him during the great flood?
5. The Yankees and Tigers play 5 baseball games. They each win 3 games. No ties or disputed games are involved. How come?
6. How many birthdays does the average man have? The average woman?
7. According to international law, if an airplane should crash on the exact border between two countries, would unidentified survivors be buried in the country they were traveling to or the country they were traveling from?
8. An archeologist claims he has dug up a coin that is clearly dated 46 B.C. Why is he a liar?
9. A man builds an ordinary house with 4 sides, except that each side has a southern exposure. A bear comes to the door and rings the doorbell. What color is the bear?

**Answers: Brain Teasers**

1. Sandbox
2. Man overboard
3. I understand
4. Reading between the lines
5. Long underwear
6. Crossroads
7. Downtown
8. Tricycle
9. Split level
10. Three degrees below zero
11. Neon light
12. Circles under the eyes
13. Highchair
14. Paradise
15. Touchdown
16. Six feet underground
17. Mind over matter
18. He's beside himself
19. Glance Backwards
20. Life after death

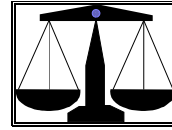
**Answers: Riddles**

1. There is no law against a man's marrying his widow's sister, but it would be the neatest trick of the week – to have a widow, he would have to be dead.
2. Yes, and 5<sup>th</sup> and a 6<sup>th</sup>, etc.
3. The match.
4. Moses took no animals at all; it was Noah who took two of each.
5. Who said the Yankees and the Tigers were playing against each other in those games?
6. The average man has one birthday, so does the average woman. The rest are birthday anniversaries.
7. You can't bury survivors under any law – especially if they still have enough strength to object!
8. The archeologist is a liar because B.C. means "Before Christ" and who could have guessed in advance that Christ would be born?
9. The bear that rang the doorbell would have to be a white bear. The only place you could build a house with four southern exposures is at the North Pole where every direction is south.

## **Critical Thinking Dispositions**

**Truth seeking:**

A courageous desire for the best knowledge, even if such knowledge fails to support or undermine one's preconceptions, beliefs or self-interests.

**Open-Mindedness:**

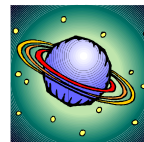
Tolerance to divergent views, self-monitoring for possible bias.

**Analyticity:**

Demanding the application of reason and evidence, alert to problematic situations, inclined to anticipate consequences.

**Systematicity:**

Valuing organization, focus and diligence to approach problems of all levels of complexity.

**Self Confidence:**

Trusting of one's own reasoning skills and seeing oneself as a good thinker.

**Inquisitiveness:**

Curious and eager to acquire knowledge and learn explanations even when the applications of the knowledge are not immediately apparent.

**Maturity:**

Prudence in making, suspending, or revising judgment. An awareness that multiple solutions can be acceptable. An appreciation of the need to reach closure even in the absence of complete knowledge.

**Systematic Approach to Thinking and Problem Solving:****A. Definitions****1. Decision making**

- a. A systematic sequential process of choosing among alternatives and putting the choice into action. (W. Lancaster & J. Lancaster, 1982)
- b. Analyzing alternative courses of action, their potential effects, and selecting the best course of action
- c. Implementing the selected action, monitoring the effects and reevaluating the decision in light of the effects

**2. Problem Solving**

- a. Problem solving is cognitive processing directed at achieving a goal when no solution method is obvious to the problem solver. (Mayer & Wittrock, 1996)
- b. Rational, analytical thinking, an investigative action
- c. Use of the nursing process
  - 1) Assess
  - 2) Plan
  - 3) Implement
  - 4) Evaluate

**3. Critical thinking**

- a. A composite of the attitudes, knowledge, and skills. (Watson & Glaser, 1980)
- b. Of process, the goal of which is to make reasonable decisions about what to believe in what to do. (Enis, 1996)
- c. A dynamic cognitive process
- d. The art of thinking about your thinking while you are thinking in order to make your thinking better: more clear, more accurate, or more defensible. (Paul, Binker, Adamson, and Martin (1989)

**4. Critical Thinking Steps**

- a. Interpretation
- b. Analysis
- c. Inference
- d. Explanation
- e. Evaluation
- f. Self regulation

## **B. Critical Thinking Steps**

### **1. Interpretation**

#### **a. Components**

- Categorizing
- Decoding
- Clarifying meaning

#### **b. Application**

- Distinguish facts, assumptions, and inferences
- Knowledge component
- Interpreting data



#### **c. Clinical Example**

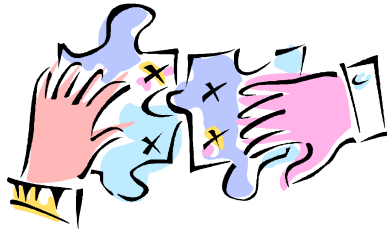
### **2. Analysis**

#### **a. Components**

- Prioritizing
- Making relationships/connections
- Defining various courses of action

b. Application

- Recognize the existence of problems
- Distinguish between relevant and irrelevant information
- Begin to analyze nursing problems and define the possible courses of action



c. Clinical Examples

d. Case scenario

A MVA patient, age 13, had an open reduction of a right tibial fracture three days ago and is also in pelvic traction. She is complaining of pain in her right leg. She states that her pain level is an 8/10 and that it is worse than yesterday. The patient has Vicodin and MS ordered for pain. The preceptee prepares to medicate the patient with morphine.

**3. Inference**

a. Components

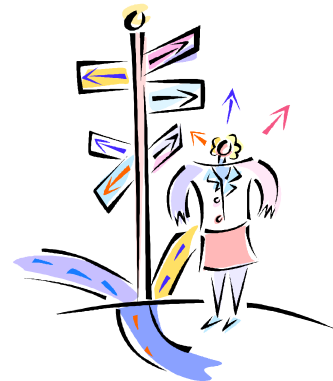
- Drawing conclusions based on evidence/data
- Comprehending the meaning of subjective and objective data

b. Application

- Weighing risks and benefits of various courses of actions
- Identifying gaps in information
- Making sound decisions



c. Clinical Example



#### 4. Explanation

##### a. Components

- Explaining
- Providing rationales for conclusions

##### b. Application

- Explaining in verbal or written format, sound reasons for actions taken or conclusions drawn
- Explaining relationships between data



##### c. Clinical Example

##### d. Case Study

The patient is admitted for atrial fibrillation, has CHF and is on bed rest. The patient's medications include Heparin SQ bid and Digoxin daily. In discussing the patient's medications with the preceptee, she tells you that heparin is given because the patient is on bed rest.

## 5. Evaluation

### a. Components

- Continuously assessing the data for relevancy to the situation
- Ensuring that the data supports the conclusion

### b. Application

- Questioning the data, signs and symptoms for relevancy
- Evaluating appropriateness of care
- Cost effectiveness
- Anticipating, thinking ahead
- Looking at the big picture



### c. Clinical Example

## 6. Self Regulation

### a. Components

- Continuously questioning, examining and monitoring one's thinking for accuracy

### b. Application



- Asking questions
- Comparing and contrasting situations
- Seeking further data to support and validate conclusions

### c. Clinical Example

### C. **Putting it all together**

1. Frame the question
  - a. Use the critical thinking components.
  - b. Pose questions that encourage thinking and problem solving
  - c. Encourage the preceptee to come to you with questions/problems but also possible solutions
  - d. Why? What if? So what? What now?
2. Use case examples

The physician leaves the following order for the patient who is one day post-op appendectomy:

  1. DAT
  2. d/c IV fluids when taking fluids well

What are the facts?

What are the alternatives/choices?

What other assessments should be made?

What factors will influence the choice?

How will know if I made the correct choice?

What am I overlooking?

3. Build Confidence
  - a. Give feedback that tells the preceptee that you trust their ability.
  - b. Acknowledge when the preceptee has made an appropriate decision.
  - c. Validate the preceptee's assessments/findings/conclusions.
  - d. Collaborate with the preceptee in making out assignments
  - e. When setbacks or "bad" days occur, remind preceptee of their progress and successes.

Adapted from: De Castillo, S. (1999) *Strategies, Techniques, and Approaches to Thinking: Case Studies in Clinical Nursing*. W.B. Saunders.

**Practice Critical Thinking Case Studies****#1: Crisis Intervention Scenario**

The client is a 20-year-old student who lives in the university dormitory. He tends to be a loner who does not make friends readily, even though he is frequently seen on campus and around the dormitory. On Wednesday the hall monitor tells the residential advisor that he has not seen the client for a couple of days. The residential advisor knocks on the client's door several times but does not get a response. The door is locked.

Campus security is notified. When the security guard arrives, the residential advisor asks all of the students in the area to return to their rooms. The security guard unlocks the door and enters the room. They find the client sitting on the floor in the corner of the room. He is dirty and the room is a mess. There is a strong smell of urine. When the security guard speaks to the client, he quietly tells the guard to leave or he will be sorry. The client looks away and refuses to answer any of the guard's questions. The university nurse is summoned to the room.

1. What are the facts in this case that you need to consider?
2. What do you need to do first?
3. What conclusions can you make about this client?
4. What action might you take? Why?
5. Upon what assumptions did you base your conclusions?
6. What information (data) do you need to verify your conclusions?
7. How will you know if your conclusions/actions were correct?
8. What biases are apparent in this case?
9. What attitudes influenced your thinking about this client?
10. What skills did you use when considering the client's situation?
11. What other questions would you want to use with this case?

## **#2: Pediatric Scenario**

A 6-year-old girl is admitted to the PACU following a lacrimal duct probing. She has a history of asthma and is receiving humidified oxygen through a nebulizer mask. Suddenly her respiratory status changes. She is struggling for air and has sternal retraction. Her respirations become loud and “crowing.”

1. What are the facts in this case that you need to consider?
2. What do you need to do first?
3. What conclusions can you make about this client?
4. What action might you take? Why?
5. Upon what assumptions did you base your conclusions?
6. What information (data) do you need to verify your conclusions?
7. How will you know if your conclusions/actions were correct?
8. What biases are apparent in this case?
9. What attitudes influenced your thinking about this client?
10. What skills did you use when considering the client’s situation?
11. What other questions would you want to use with this case?

### **#3: Step Down Unit Scenario**

Mr. Graves was admitted two weeks ago with right lower lobe pneumonia. With severe chronic obstructive pulmonary disease (COPD) as his underlying disease, he has been deteriorating since admission. Although he is given albuteral breathing treatments every 3 hours round the clock, his respiratory rate is 30/min., and he is constantly using his accessory muscles to breathe. His latest blood gases indicate his CO<sub>2</sub> is up to 75. The physician orders a morphine drip. The nurse expresses her concern about the order and refuses to give the medication.

1. What are the facts in this case that you need to consider?
2. What do you need to do first
3. What conclusions can you make about this client?
4. What action might you take? Why?
5. Upon what assumptions did you base your conclusions?
6. What information (data) do you need to verify your conclusions?
7. How will you know if your conclusions/actions were correct?
8. What biases are apparent in this case?
9. What attitudes influenced your thinking about this client?
10. What skills did you use when considering the client's situation?
11. Do you agree or disagree with the nurse's decision? Why?

<b>#4: Home Health Care Scenario</b>
--------------------------------------

On your second home visit with Mrs. Bravo, she tells you, "Being in this much pain isn't worth it anymore. I am just getting worse every day. I can hardly do anything for myself. I would be better off dead!"

1. What are the facts in this case that you need to consider?
2. What conclusions can you make about this client?
3. Upon what assumptions did you base your conclusions?
4. Describe three possible responses you could make to Mrs. Bravo. Provide a rationale for each.
5. Which response would you choose and why?
6. What actions do you need to take?
7. How will you know if your conclusions/actions were correct?
8. What attitudes influenced your thinking about this client?
9. What skills did you use when considering the client's situation?
10. What other questions would you want to use with this case?

<b>#5: Medical Unit Scenario</b>
----------------------------------

Mr. Kaplan, a patient with asthma, was admitted yesterday morning. He has an order for albuterol treatments to be given every 4 hours around the clock. You enter his room at 4:00 a.m. and find him sleeping soundly.

1. What are the facts in this case that you need to consider?
2. What conclusions can you make about this client?
3. What action might you take? Why?
4. Upon what assumptions did you base your conclusions?
5. What information (data) do you need to verify your conclusions?
6. How will you know if your conclusions/actions were correct?
7. What attitudes influenced your thinking about this client?
8. What skills did you use when considering the client's situation?
9. What other questions would you want to use with this case?

<b>#6: Pre-op Admission Scenario</b>
--------------------------------------

You are working on pre-admission testing. Ms Albert is a 56-year-old scheduled for transurethral resection of a bladder tumor. Her symptoms include frequency and burning on urination. Ms Albert's medical history is complicated by COPD as a result of smoking cigarettes for nearly 40 years. On physical examination, her breath sounds are diminished with wheezes and rhonchi throughout all lung fields. Ms Albert has a chronic productive cough, is dyspneic on exertion (one flight of stairs) and sleeps on three pillows.

1. What are the facts in this case that you need to consider?
2. What conclusions can you make about this client?
3. Upon what assumptions did you base your conclusions?
4. Describe three important nursing interventions for Ms Albert. Provide a rationale for each.
5. What information (data) do you need to verify your conclusions?
6. How would you evaluate the effectiveness of each of these interventions?
7. What attitudes influenced your thinking about this client?
8. What skills did you use when considering the client's situation?
9. What other questions would you want to use with this case?

## **#7: Pediatric Surgery Scenario**

You are discharging a 4-month-old baby who has had a cleft lip and palate repair. You find that the baby has Down's Syndrome as well as other physical anomalies. The baby is crying and in obvious pain. When you realize there are no medications ordered for postoperative pain relief, you call the surgeon who tells you, "I don't like to order narcotics for babies, especially this type of child. He'll settle down after a while."

1. What are the facts in this case that you need to consider?
2. What conclusions can you make about this situation?
3. Upon what assumptions did you base your conclusions?
4. What information (data) do you need to verify your conclusions?
5. Describe possible responses you could make to the physician. Provide a rationale for each.
6. Which response would you choose and why?
7. What action might you take? Why?
8. What biases are apparent in this case?
9. What attitudes influenced your thinking about this client?
10. What skills did you use when considering the client's situation?
11. What other questions would you want to use with this case?

**Conflict: A Part of the Orientation Process:**

Adapted from: Thomas, K.W. and Kilmann, R.H. (1974) *Conflict Mode Instrument*. Xicom, Incorporated, USA.

1. What conflict exists for the preceptee?

2. What conflict exists for the preceptor?



3. What conflict exists for the staff in the area or field?

4. What conflict exists for the manager?



**Conflict is:**

- When what you have and what you want are different.
- A pattern of energy.
- Nature's primary motivation for change.

**Conflict Myths:****Myth #1:** "Conflict is Negative"

Conflict is natural, neither positive nor negative, it just is. It is the outcome of conflict that can be good or bad. In nature, friction between elements (wind, sand, and water) acts as its primary motivator for change, creating beaches and canyons, mountains, and pearls. It is not the situation that causes upset and bad feelings, but how we handle it. A disagreement between friends can lead to an end of the friendship or a chance to gain a better understanding of how the other person views things.

**Myth #2:** "Conflict is a Contest"

Conflict is not a contest. Conflict just is. We choose whether to make it a contest, a game in which there are winners and losers. There doesn't always have to be a winner and a loser. That's great for a game, which we decide to play that way, but to be a loser at work or in your family or community doesn't feel great for anyone. The ideal is to create solutions in which everyone's needs are met and we're all winners. Resolving conflict is rarely about who is right. It is about acknowledgement and appreciation of differences.



**Myth #3:** “The Presence of Conflict is a Sign of Poor Management”

An effective leader anticipates conflict when possible, deals with conflict when it arises and enjoys its absence when possible. Conflict, in itself will not affect the way other people feel about you. If however, you choose to ignore the conflict and allow it to continue, your employees will see you as a less-than-effective leader. On the other hand, if you address the conflict and motivate the staff, you will win their support and respect. You may avoid future conflicts as well.

**Myth #4:** “Conflict, if Left Alone, Will Take Care of Itself”

This is a half-truth. You can avoid conflict – it is a valid coping strategy, but not the only strategy. The intensity of the conflict varies. Left unchecked, conflict can escalate as easily as dissipate.



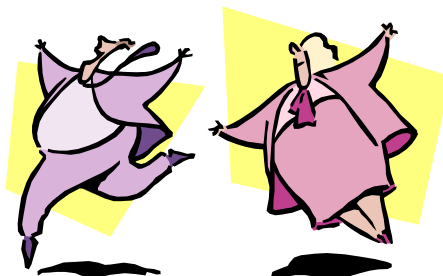
**Myth #5:** “Conflict Must be Resolved”

This myth stifles creativity, causing the leader to become solution-oriented. Some conflict is best managed by endurance, while other events require multiple solutions. Quick movement toward resolution can limit success.



## **The Five Conflict-Handling Modes**

- ❑ Competing
- ❑ Accommodating
- ❑ Avoiding
- ❑ Collaborating
- ❑ Compromising



### **Competing:**

- ❑ Assertive and uncooperative
- ❑ Power-oriented
- ❑ Useful for:
  - Standing up for rights
  - Defending an important position
  - Trying to win

### **Accommodating:**

- ❑ Unassertive and cooperative
- ❑ Involves self-sacrifice
- ❑ Useful for:
  - Charitable causes/generosity
  - Obeying orders
  - Yielding to another point of view

### **Avoiding:**

- ❑ Unassertive and uncooperative
- ❑ Does not address the conflict
- ❑ Useful for:
  - Diplomatic sidestepping
  - Avoiding until a better time
  - Withdrawing from a threatening situation

### **Collaborating:**

- ❑ Assertive and cooperative
- ❑ Seeks to satisfy both sides
- ❑ Useful for:
  - Gaining additional insights
  - Avoiding negative competition for resources
  - Solving interpersonal problems

### **Compromising:**

- ❑ Somewhat assertive and somewhat cooperative
- ❑ Solutions are mutually satisfying; acceptable to all
- ❑ Middle ground mode
- ❑ Useful for:
  - Splitting the difference
  - Making concessions
  - Finding a quick middle-ground position



## **Module Five:**

### Evaluator

## **Module V Evaluator Role**

### **Learning Objectives:**

**Goal Statement – The goal of this module is to utilize techniques in formative and summative evaluation processes.**

**Behavioral Objectives – At the completion of this area of content, the participant will be able to:**

1. Define formative and summative evaluation.
2. Recognize the impact of non-verbal communication.
3. Demonstrate constructive feedback and coaching skills.
4. Implement the evaluation process.
5. Develop an individual preceptee program.

**Evaluation:**

A person needs to evaluate observable and measurable behavior, because learning cannot be directly observed. Learning is inferred on the basis of **a change in behavior**. Unless the evaluator has some basis for comparison of the behavior, the behavior cannot be judged as acceptable or not.

Learning objectives and criteria should be written so that the **standard** for satisfactory performance is evident. Without consistent standards for evaluation of performance, each preceptor might judge performances differently because each could be using different standards to rate the performance.

**Formative evaluation** measures intermediate outcomes. Negative comments at this level are positive, because they promote a satisfactory **summative** evaluation.

**Summative evaluation** measures the **final outcome(s)** and emphasizes the total experience, the effectiveness of the whole, as well as each part of the experience.

**WEEKLY LEARNING PLAN PROGRESS TRACKER**

Preceptee: \_\_\_\_\_

Preceptor(s): \_\_\_\_\_

Date: \_\_\_\_\_ Week#: \_\_\_\_\_ Patient Load: \_\_\_\_\_

**Preceptee's Goals for the Week:**

Goal	Met	Not Met	Evaluation

Progress on competency/equipment checklist(s):

Learning needs identified:

Comments:

## **Performance Evaluation:**

This type of evaluation is considered to be a participative form of assessment aimed at increasing the autonomy of the learner in his/her own learning process. The effectiveness of a preceptor's evaluation during a preceptorship experience depends upon the following characteristics:

- Recognizes the individual difference and competencies of each preceptee.
- Plans specific patient assignments and learning activities that develop the identified learning gaps.
- Gradually increases the workload and patient responsibilities depending upon the specific documentation of progress.
- Remains available to assist and evaluate the preceptee's ability to care for patients and make clinical judgments.
- Meets with the preceptee throughout the day to answer questions and assesses the progress.
- Holds debriefing sessions at the end of the day denoting progress or the need to progress.

### **I. Using goals to improve the preceptoring experience.**

- A. Meet with preceptee each week to set goals and review achievement from previous week
- B. Encourage preceptee to come prepared with a list and self-evaluation.
- C. Limit number of goals.
- D. Do not duplicate competency lists.
- E. Share ideas regarding how goals can be met.
- F. If a goal was not achieved, reevaluate to see why and try again.  
Was the goal realistic? relevant?
- G. Role model goal setting by setting goals for yourself as a preceptor.



### **II. Goal setting principles for long-term goals**

- A. Each goal should describe a specific end result.
- B. A goal should make you stretch but still be attainable.
- C. Identify why you want to accomplish this goal.
- D. Remember goals can be changed.
- E. You create most of your obstacles.
- F. Goals should require you to do more of something or do it better or differently.
- G. If the goals are attainable, this reinforces self-esteem and keeps us motivated.
- H. Visualize what you will be when you reach your goal

**Adapted from:** *Developing Preceptor Expertise in the Clinical Setting.* A workshop presented by Cerritos Community College, East Los Angeles College, Glendale Community College, and Mount San Antonio Community College. 5/30-31/02, Palm Springs, California.

**COMMUNICATION**

**Communication is both verbal and non-verbal.**

**Perceptions may or may not give the true picture.**

**Perceptions need to be validated.**

**Unvalidated perceptions can lead to misunderstandings.**

<b>Body Language Signals</b>		
<b>Nonassertive</b>	<b>Assertive</b>	<b>Aggressive</b>
<b>Posture</b>		
Slumped Shoulders forward Shifting often Chin down Sitting: legs entwined	Erect, but relaxed Shoulders straight Few shifts, comfortable Head straight or slight tilt Sitting: legs together or crossed	Erect, tense, rigid Shoulders back Jerky shifts or planted in place Chin up or thrust forward Sitting: heels on desk, hands behind head or tensely leaning forward
<b>Gestures</b>		
Fluttering hands Twisting motions Shoulder shrugs Frequent head nodding	Casual hand movements Relaxed hands Hands open, palms out Occasional head nodding	Chopping or jabbing with hands Clenched hands or pointing Sweeping arms Sharp, quick nods
<b>Facial Expression</b>		
Lifted eyebrows, pleading look, wide-eyed, rapid blinking Nervous or guilty smile Chewing lower lip Shows anger with averted eyes, blushing, guilty look	Relaxed, thoughtful, caring or concerned look few blinks Genuine smile Relaxed mouth Shows anger with flashing eyes, serious look, slight flush of color	Furrowed brow, tight jaw, tense look, unblinking glare Patronizing or sarcastic smile Tight lips Shows anger with disapproving scowl, very firm mouth or bared teeth, extreme flush
<b>Voice</b>		
Quiet, soft, higher pitch Uhs, ahs, hesitations Stopping in "midstream" Nervous laughter Statements sound like questions with voice tone rising at the end	Resonant, firm, pleasant Smooth, even-flowing Comfortable delivery Laughter only with humor Voice tones stay even when making statement	Steely quiet or loud, harsh "biting off" words, precise measured delivery Sarcastic laughter Statements sound like orders or pronouncements
Adapted from: Potter, P. and Perry, A. (2001) <i>Fundamentals of Nursing</i> . Mosby		

**Changing the “Message”:**

Adapted from: Brounstein, M. (2000) *Coaching and Mentoring for Dummies*. IDG Books Worldwide.

- “I” messages (“I think,” “I feel that”) are more effective than “you” messages (“you should,” “You are wrong”) because they minimize the other person’s defensiveness and resistance to further communication.
- Give two examples of recent communication in which an “I” message would have been more helpful than a “you” message.

1.

2.

## **"I – MESSAGE"**

### **Purpose:**

The primary purpose of an "I-Message" is to state a personal concern or discomfort in a descriptive manner, not a judgmental one, so that it is possible for the listener to hear and understand the problem that his/her behavior is causing for the speaker.

The intent is to have the other person modify his/her behavior, to preserve the person's self-esteem, and to maintain a functional relationship.

### **Benefits:**

1. It provides a format for expressing the effects of a person's behavior on you.
2. All parties retain responsibility for their own behavior.
3. It increases the chance of the user getting his/her needs met.
4. Change can take place out of a sincere concern for others.
5. This method minimizes the potential for resistance and a perception of "high treat" interaction.

### **Model:**

- I feel/think (*feeling, emotion*)
- When (*non-blameful description of other's behavior*)
- Because (*concrete, tangible effect on me now or into the future*)
- Therefore I need (*request for what you would like to have happen*)

### **Example:**

**"I feel angry when staff members are late for meetings, because I feel my time is not being valued therefore, I would request that we begin all meetings on time."**

### **Things to avoid:**

Using "I – Messages" to express dissatisfaction with recurring behavior.  
Using the "I – Message" to punish or get revenge.  
Failure to recognize the depth of one's own feelings.  
Unrealistic expectations about the outcome.

### **Ineffective words:**

You should, always, never, I can't, why.

## **Coaching the Preceptee**

Adapted from: St. Joseph Hospital, Clinical Education Department (2001) "Preceptorship: A creative approach to quality performance (Preceptor Handbook)." March, 2001. Orange, California.

### **Definition**

Coaching is a conversation wherein one person (the coach) instructs, counsels and tutors another (the coachee/preceptee) in how to improve performance. Effective coaching yields more than improved performance; it also increases personal satisfaction, inspires a commitment to excellence and fosters the coachee's development as a leader.

### **Coaching Conversations**

Coaching conversations occur in a variety of situations:

- before a challenging event, in the midst of action
- after a triumph or defeat
- during the pause between assignments

There are three general types of coaching conversations:

- feedback
- problem-solving
- developmental.

Type	Coaching Conversations: Purpose
<b>Feedback</b>	To reinforce or change a specific pattern of behavior.
<b>Problem-Solving</b>	To figure out the best approach for solving a problem, pursuing an opportunity or producing a specific result.
<b>Developmental</b>	To define the coachee's professional or personal aspirations and explore alternative pathways for realizing those aspirations.



### **4 E's of Giving Constructive Feedback**

#### **Engage:**

Set the stage to convey your positive intent in the spirit of mutual respect and learning.

- Preparation:
  - Think about the positive outcome you want to achieve. Even if you are giving feedback “on the spot,” frame it in terms of what behavior, issue, and situation you want to improve. Don’t give feedback unless there is a constructive outcome you wish to achieve. Have that outcome in mind when you give the feedback.
- Link Feedback to Common Goals:
  - How will the feedback improve processes, meet deadlines, enhance the work environment.
- State What You Want to Discuss
  - “I have a concern about...”
  - “We need to talk about...”
  - “I have some thought on...”

#### **Empathize:**

Determine the best time and place to convey the message, focus on facts and feelings, utilize active listening.

- Environment and Timing
  - Think about distractions, other people that may be around, or whether or not the person is upset.
  - Address feelings that may emerge to enable you to move on to the point of the discussion.
  - If “on the spot” feedback is necessary, move to a private area.

#### **Educate:**

Describe observation and impact of behavior; focus on the situation, issue or behavior, not the person.

- Descriptive Observation
  - State the facts and avoid judgment, evaluation or interpretation.
  - Be specific and to the point.
  - Convey respect and support
  - Stay focused on the issue at hand; avoid past or unrelated situations.
  - Don’t let issues go unaddressed or you run the risk of unleashing stored up concerns.
- Impact of behavior
  - Describing the impact of the behavior helps to keep the discussion objective and will help minimize defensive responses.
  - Link behavior to business goals or challenges:

- Improved patient care
  - Customer satisfaction
  - Better access to patient information
  - Improved work environment
- Point out one or two of the most significant consequences
- Remain objective
  - Avoid getting caught up in your own emotions.
  - If this may be a “hot button” issue for you, practice ahead of time – role-play with a colleague.



### **Enlist:**

Set the stage for the person to respond; focus the discussion on solutions and promotes open discussion.

- Elicit the Person's Response
  - Use feedback as a tool to ascertain what the person thinks.
  - Use questions to probe, such as:
    - “What are your thoughts about...?”
    - “How do you think we can improve this situation?”
    - “What do you suggest can be done?”
  - Listen and summarize what you heard. This will let you validate what you heard and demonstrate that you are interested in what the person has to say.
  - Proceed based on the person's response.
- Guide Toward a Solution
  - Move the discussion toward a solution based on standard practice and/or your expectations. Avoid tell the person exactly what to do.
  - Guide and assist the person in development of solutions to promote their ownership of the problem and creating a solution.

**What To Do When... (Small Group Exercise)**

Adapted from: Alspach, J. (2000) *From Staff Nurse to Preceptor: A Preceptor Development Program*. 2<sup>nd</sup> edition. American Association of Critical-Care Nurses.

Each of the following descriptions represents a preceptee that you might encounter. Selected examples are given that demonstrate how you would attempt to relate effectively with each of the preceptees.

1. A preceptee whose work is disorganized and slow, for example the preceptor may:
2. A preceptee who performs unfamiliar skills without seeking the preceptor's supervision.
3. A "know-it-all" preceptee who ignores the preceptor's direction.
4. A preceptee who has been shown repeatedly how to perform the same skill, but who continues to do it incorrectly.
5. A preceptee who continually remarks that a former place of employment had higher and better standards of nursing care.
6. A preceptee who expects to be spoon-fed and resents having to assume any responsibility for learning.
7. A preceptee who cries when you critique his or her performance.
8. A preceptee who shows no concern after making a serious medication error.
9. A preceptee who complains about the preceptor's poor clinical skills.
10. A preceptee who is hesitant and flusters easily, fearing he or she may make a mistake.

**What To Do When...**

Each of the following descriptions represents a preceptee that you might encounter. Selected examples are given that demonstrate how you would attempt to relate effectively with each of the preceptees.

1. An orientee (preceptee) whose work is disorganized and slow, for example the preceptor may:

- Review the target date specified on the learning contract.
- Solicit the orientee's impressions regarding reasons for slow progress.
- Ask how he or she determines the order in which assignments are.
- Ask how he or she determines the priority of work activities.
- Share your observations.
- Reach consensus on ways to facilitate completion.

2. An orientee who performs unfamiliar skills without seeking the preceptor's supervision.

- Identify one or two concrete examples of situations in which capabilities were overestimated.
- Solicit the preceptee's opinions regarding his or her readiness to manage the situations.
- Perhaps review the orientation checklist items to distinguish between items that may be independently.
- And those that might require supervision or assistance.

3. A "know-it-all" orientee who ignores the preceptor's direction.

- Openly acknowledge and commend orientees for areas where they have demonstrated excellent performance.
- Minimize any perceived threats to their professional integrity by maintaining a colleague-to-colleague relationship, rather than teacher-to-student relationship.

4. An orientee who has been shown repeatedly how to perform the same skill, but who continues to do it incorrectly.

- There may be a lack of knowledge about what needs to be done, how to do what needs to be done, and/or lack of motivation to perform the skill correctly.
- Analyzing this performance problem entails investigation and attempting to resolve each potential cause.

5. An orientee who continually remarks that a former place of employment had higher and better standards of nursing care.

- This may be similar to #3 above.
- Attempt to channel orientee's valid and constructive input by suggesting they keep a record of areas where improvements seem needed; make plans for you and the orientee to mutually present these proposals at a future staff meeting.

6. An orientee who expects to be spoon-fed and resents having to assume any responsibility for learning.

- Ensure that the interviewer, in the hiring process, relates the employer's expectations regarding the orientee's responsibility to complete the orientation; ensure that the unit manager reinforces this expectation.
- Monitor the orientee's completion of their responsibility on a regular basis.
- If necessary, counsel the orientee regarding the observations.

7. An orientee who cries when you critique his or her performance.

- Share your observations related to the orientee's responses to critique of his or her performance and attempt to elicit the cause(s) of those responses.
- Make every attempt to defuse unwarranted emotional responses by avoiding the use of negative feedback, emphasizing accomplishments, conveying confidence in the orientee's ability to successfully complete all requirements; care use of humor.

8. An orientee who shows no concern after making a serious medication error.

- Similar to #4 above; in addition a potentially serious situation.
- Orientees may not comprehend the nature of their error, and may have little or no appreciation for its potential consequences.
- Counseling these orientees will involve more instruction than admonishment.
- Rarely, when orientees fully comprehend their error and its consequence and still display no apparent concern, the preceptor may request clarification of this problem, explain the necessary follow-up activities and their likely outcomes.
- Although potentially dangerous errors cannot be concealed, over-reacting is not in proportion to the situation and also needs to be avoided.

9. An orientee who complains about the preceptor's poor clinical skills.

- The preceptor should arrange for a private meeting location to share what has been communicated and to request clarification of the nature and extent of the perceived problems.
- Make every attempt to avoid becoming reactive or defensive to these complaints. Try to work with the orientee to clarify areas of misunderstanding and to identify ways in which the preceptor can more effectively work with the orientee.

10. An orientee who is hesitant and flusters easily, fearing he or she may make a mistake.

- This orientee may benefit from a more extended instructional practice time in a quiet, simulated setting where fewer variables exist to increase their fears and anxieties.
- May benefit from a more self-directed approach to instruction, such as viewing videotapes and practice by themselves before a preceptor observes their performance.

**Constructive Feedback: Application to Clinical Situations**

1. The doctor orders digoxin (Lanoxin) to be given IV push. The orientee volunteers to do it, but says, "I've never done this before." The preceptor raises her eyebrows and states, "You've never done that before?" The preceptor has had an extremely busy morning with no break and is trying to get away for lunch.

*Questions:* If you were the preceptor, how would you feel? Identify your feelings.

If you were the orientee, how would you feel? Identify your feelings.

How would you change this situation? List the steps:

## **Constructive Feedback: Application to Clinical Situations (continued)**

2. The orientee has received an a.m. admission scheduled for surgery at 11:00 a.m. It is now 9:30 a.m. and the orientee comes to the preceptor three times within 30 minutes on how to fill out the preoperative checklist. It is discovered that the patient has not taken his cardiac medications prior to admission. The orientee again comes to the preceptor and asks whether to give the cardiac medications. This is the orientee's 5<sup>th</sup> patient that has not been sent to surgery in a timely fashion.

The orientee has the following characteristics:

- Trouble with priority setting.
- Frequent overtime.
- Repeatedly asks the same basic questions, especially in hectic situations.
- Tested well on the orientation examinations.
- Has excellent communication and psychosocial skills.
- Is very insecure about her technical skills, which are limited
- Is in her third week of orientation.

*Questions:*

How are you, as a preceptor, feeling?

Given the above characteristics, how do you think that the orientee is feeling?

How would you approach the situation regarding the cardiac medications?

What goals would you set with the orientee for future situations?

### **Constructive Feedback: Application to Clinical Situations (continued)**

3. The patient has not voided since surgery 8 hours ago; her intake has consisted of 1000cc IV and p.o. After notifying the surgeon, he orders a foley catheter to be inserted. Even though the orientee is an experienced RN, the preceptor accompanies the orientee to validate proficiency and sign off the generic skills check list. The orientee tells the preceptor that she has inserted many foley catheters at other institutions and verbally reviews the steps generally followed.

Upon entering the room, the preceptor introduces herself and the orientee and tells the patient what will be done. She then tells the orientee to wash her hands, screen the patient, and arrange the linen to protect modesty, and open the foley tray. As the orientee begins to open the foley try, the preceptor tells the orientee to put on the sterile gloves, open the soap and the lubricant packs, and to check the foley balloon before she begins.

This instruction continues throughout the procedure and with each direction given, the orientee responds, "Yes, I know that."

After the procedure the preceptor and orientee return to the nurses station. The orientee says to the preceptor, "I told you before we went in there that I knew how to insert a foley," and walks away.

#### *Questions:*

If you were the orientee, how would you feel as you walked out of the patient's room?

If you were the preceptor, how would you feel about the orientee's comment to you?

If you were the preceptor, how would you respond to the orientee's comment?

How could the situation be changed?

### **Constructive Feedback: Application to Clinical Situations (continued)**

4. You meet your orientee for the first time, and according to her checklists and what she tells you, she is fairly experienced. However, when she has the opportunity to perform clinically she is either unable and/or unwilling to carry out nursing procedures, e.g. starting IVs.

When you attempt to instruct the orientee on a specific procedure, she is impatient and displays expressions of boredom. When you advise her to call for pre-op laboratory results, which should have been drawn an hour ago, she says, "I put it in the computer and sent the requisition, so I've done my part."

When you go on a break with her, she tells you that her general orientation was a waste of time and no one showed her how things were to be done.

#### *Questions:*

What action might you take at this point?

What things might be causing the orientee to behave in this way?

5. You sit in on a meeting with the instructor and your supervisor to discuss the orientee's progress. The meeting has been called because the orientee told the instructor that she has not been receiving a good orientation because her preceptor was too busy to show her anything.

#### *Questions:*

What would your recommendations be for dealing with this orientee?

What issues require attention?

If this scenario involved a male orientee, how might your reaction differ?

## CRITERIA FOR EVALUATING PERFORMANCE

The Performance Evaluation tool is designed to measure orientee's student performance in relation to the objectives of the preceptorship experience. Each category has several performance levels identified.

The orientee/student should strive to demonstrate a satisfactory rating on all critical performance behaviors by the end of the preceptorship experience. **Orientee/students may receive a rating of less than satisfactory during the preceptorship, but must improve to a satisfactory level by the end of the preceptorship experience.**

Orientee/student is evaluated by preceptor on an **on-going** basis. The orientee/student is assisted to assess his/her performance and to identify learning needs. A **written** evaluation is reviewed with the student at the **beginning, mid-way, and at the end** of the preceptorship. Written documentation must accompany ratings below the satisfactory level of performance.

Any orientee/student who is unable to show consistency in preparation for clinical performance or who places a patient in physical or psychological jeopardy may jeopardize the continuance of the preceptorship experience.

**There are three categories to evaluate the orientee/student's performance.**

**Consistently** demonstrates behavior is satisfactory progress. A satisfactory evaluation is the performance standard to indicate the level of expertise that orientee/students much achieve by the end of the preceptorship experience.

Demonstrates behavior with **minimal prompting** denotes that there is a need to improve performance in identified areas. These areas should be documented by way of Anecdotal Notes, Progress Report describing actions in which the orientee/student may improve in their performance.

Demonstrates behavior with **repeated prompting** is a serious potential of an unsatisfactory evaluation of clinical performance evaluation. This assessment is derived when an orientee/student continues to not show improvement after verbal warnings or Progress Reports of a identified areas that need improvement. The orientee/student does not show evidence of continued progress in improving in their clinical performance. As a result, the continuance of their preceptorship may be in jeopardy.

## **Integrating Formative and Summative Evaluation into Overall Performance Evaluation**

### **FORMATIVE EVALUATION**

- Ongoing process and documentation
- Weekly updates with preceptee
- Multiple preceptors must communicate
- Written goals and follow-up
- No surprises at end of orientation

### **SUMMATIVE EVALUATION**

- Collaboration with Manager
  - Meet with manager before preceptorship begins
  - Work with manager to refine questions to be answered by the evaluation
  - Decide what data must be collected to answer evaluation questions
  - Develop methods to collect the data, including instruments and time frames
  - Ongoing formative evaluation
- Final Evaluation
  - Manager's responsibility
  - Clarify preceptor responsibility
  - Analyze and interpret data
  - Write final report
  - Share with preceptee

## Performance Evaluation

**Orientee/Student** \_\_\_\_\_

Direction to the preceptor: This form is intended to summarize the ability of the orientee/student at the end of the formal preceptorship experience and to provide direction for further development. Please evaluate the orientee/student on each of the listed behaviors.

	Consistently demonstrates behavior	Demonstrates behavior with minimal prompting	Demonstrates behavior with repeated prompting
<b>Professionalism</b>			
Identifies self-learning needs			
Develops a plan to meet self-learning needs			
Orients to preceptor and staff			
Orients to layout of unit, medication, charts, utility rooms, supplies			
Locates the crash cart, IV's meds, defibrillator, and intubations supplies and reviews appropriate application of leads/defrillation pads			
Reviews charts fro new orders frequently			
Demonstrates personal and professional accountability			
Maintains patient confidentiality			
Acts as a patient advocate			
Performs within ethical, legal, and regulatory frameworks of nursing and standards of professional nursing practice			
<b>COMMENTS:</b>			
<b>Critical Thinking</b>			
Identifies changes in patient status and reports to health care provider			
Makes decisions about the administration of specific medications based on assessed findings			
Supports learning needs and available resources to the patient's clinical presentation			
Intervene safely for patients synthesizing knowledge of underlying principles to perform therapeutic nursing interventions			
<b>COMMENTS:</b>			
<b>Outcome Identification and Care Planning</b>			
Identifies expected outcomes individualized to the patients			
Develops a plan of care (Map) that prescribes interventions to attain expected outcomes			
Identifies appropriate interventions and modifies Map as needed			
Establishes reasonable priorities			
Communicates plan appropriately to patient and other health team members			
<b>COMMENTS:</b>			
<b>Communication</b>			
Documents patient care problems and interventions in the medical record			

Utilizes organizational strategies to assist in planning and organizing patient care (worksheets, report sheets, colored markers, etc.)	Consistently demonstrates behavior	Demonstrates behavior with minimal prompting	Demonstrates behavior with repeated prompting
Takes report on patient care assignment from off going RN			
Organizes end of shift report with preceptors input			
Gives end of shift report with preceptor guidance			
Participates in MD's rounds on patients			
Communicates with RN regarding patient care needs			
Initiates communication with MD regarding patient care needs			
Takes a telephone or verbal order from MD with preceptor support (listening)			
Implements new orders from MD's in a timely fashion throughout shift			

<b>COMMENTS:</b>			
<b>Leadership</b>			
Evaluates the patient's progress toward outcomes			
Delegates specific instructions to CNA's/PCA's to assist the RN in caring for and monitoring patients			
Follows up with CNA's/PCA's on the aspects of patient care that were delegated to them			
Follow up and reprioritizes with the aspects of patient care that were delegated to them			
Supervises and evaluates the activities of or other assistive personnel			
Informs and educates patient and family			
<b>COMMENTS:</b>			

<b>Comments:</b>	
<b>Focus for Further Development:</b>	

---

Orientee
Date

---

Educator
Date

---

Preceptor
Date

Reviewed (date):

Orienteer \_\_\_\_\_

Coordinator \_\_\_\_\_

Shift partner \_\_\_\_\_

---

Preceptor
Date

## PERFORMANCE EVALUATION/MEASURING OUTCOMES

### Preceptorship Progress Report

Oreintee/Student: \_\_\_\_\_ Date: \_\_\_\_\_

Preceptor: \_\_\_\_\_ Unit: \_\_\_\_\_

#### PROBLEM AND INFORMATION:

#### ACTIONS TAKEN:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Oreintee/Student)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Assessment: Clinical Skills	DATE MET	INITIALS
Interventions safely for patients synthesizing knowledge of underlying principles to perform the following:		
<b>IV Therapy</b>		
Inserts an IV		
Discontinues an IV		
Monitors IV sites and documents site assessments		
Demonstrates ability to use IV pump for primary and secondary IV infusions		
Converts IV to saline lock		
Manages IV therapy for patients with preceptor as backup including management of:		
• TPN		
• Blood		
• Medicated infusions		
Demonstrates ability to use syringe pump/PCA pumps as indicated		
<b>Sterile/Aseptic Procedures</b>		
Inserts Foley catheters		
Discontinues Foley Care		
Performs sterile dressing change		
Removes staples		
Obtains sterile specimens		
Obtains specimen for lab via		
• Phlebotomy		
• Central IV Line		
Performs Trach care		
Suctions patient		
Performs Blood Glucose Monitoring		
<b>Nasogastric/Gastric Feeding Tubes</b>		
Inserts nasogastric tube		
Administers medications via (nasogastric) tube		
Administers (nasogastric) feedings		
<b>Tubes/Drains</b>		
Cares for a patient with a chest tube		
Cares for patient who post-operative drain (specific type)		
<b>Other Skills:</b>		

COMMENTS

## PERFORMANCE EVALUATION/MEASURING OUTCOMES

### ANECDOTAL NOTE

Date:\_\_\_\_\_ Orientee/Student:\_\_\_\_\_

Unit:\_\_\_\_\_ Preceptor:\_\_\_\_\_

**Sample Form: RN Orientation**  
**Acute Care Services – Medical/Surgical Unit**  
**Outcomes and Objectives**

Outcome/Objectives for:	Target Date	Completion Date	Signature
<b>1. Outcome: New team member is acquainted with the unit</b>			
<b>Objectives:</b>			
1. States that he/she feels a level of comfort with the location of critical rooms and equipment (see List "A")			
2. Correctly using telecommunications equipment (see List "B")			
3. Demonstrates knowledge of work-hour requirements.			
<b>2. Outcome: New team member is acquainted with the unit's computer systems (see List "C")</b>			
<b>Objectives:</b>			
1. Demonstrates the ability to order laboratory tests and retrieve results.			
2. Correctly uses telemetry system.			
3. Outcome: New team member is familiar with unit-specific policies and procedures.			
<b>Objectives (reviews):</b>			
1. Conscious sedation			
2. Wound Care/Decubitus Care			
3. TPN/PPN			
4. Patient acuity			
5. Safety manual			
6. Restraint			
<b>4. Outcome: New team member is familiar with unit recording and reporting forms.</b>			
<b>Objectives</b>			
1. Correctly locates and completes essential forms.			
2. States correct disposition of each form.			
3. Assembles and dismantles a patient chart.			
<b>5. Outcome: The new team member achieves a level of competence in identified areas of the skills checklist.</b>			
<b>Objectives:</b>			
1. Discusses past educational and work experiences with the preceptor.			
2. Completes the skills checklist assessment-identifying areas for which the preceptee has no experience (score of "0") or minimal experience (score of "1").			
3. Devises (with the assistance of the preceptor) an individual plan to attain skills identified on the skills checklist assessment.			
4. Works in concert with the preceptor to allow for observation of work performance and response to patient needs.			

**Sample Form: RN Orientation**

Acute Care Services – Medical/Surgical Unit  
Outcomes and Objectives

**Signature Page:**

The outcomes and objective have been reviewed:

\_\_\_\_\_  
Preceptee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Preceptee

\_\_\_\_\_  
Date

The outcomes and objectives have been satisfactorily achieved:

\_\_\_\_\_  
Preceptee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Preceptee

\_\_\_\_\_  
Date

**List "A":**

Fire extinguishers  
Crash cart  
Clean/dirty utility rooms  
Clean/dirty linen  
Staff/family lounges  
Supplies  
Medications  
Charts, other forms  
Manuals, reference books

**List "B":**

Emergency codes  
Transferring calls  
Using pagers  
Entry door  
Security cameras

**List "C":**

Password  
Login/logout  
Admit a patient  
Printing  
Discharging/transferring

**Conducting the Program: Putting it All Together**

Adapted from: St. Joseph Hospital, Clinical Education Department (2001) "Preceptorship: A creative approach to quality performance (Preceptor Handbook)." March, 2001. Orange, California.

The following provides a guide to executing your preceptorship program. Each preceptee is different and you will use your judgment to modify the program.

**Week 1**

This week consists of hospital, nursing and department orientation.

**Week 2**  
**FOCUS****1. *Structure and Routine***

This allows the preceptee to adapt to the new environment. The preceptee learns the structure of the department as well as develop a routine to organize themselves. A solid foundation is needed to build skills.

**2. *Socialization to the Unit and Staff***

Giving the preceptee and staff an opportunity to bond can make a big difference in making this a pleasurable experience that enhances the work environment and aids in employee retention.

**DAILY TASKS**

1. On the first day your preceptee will follow you throughout the day and become familiar with your daily routine. You will be primarily role modeling. Routines may be altered due to unexpected events. This is a good opportunity to demonstrate how we need to remain flexible, prioritize and adapt to change.
2. The second and third day the preceptor will guide the preceptee through the daily routine. You will guide the preceptee through assessments, labs, medications, procedures and charting. The preceptee should not be expected to handle the full load. It is strongly recommended that you avoid giving the preceptee a partial assignment while you care for some patients. A preceptor cannot be two places at once. You and your preceptee should be together at all times.
3. When an opportunity arises to perform a procedure you will want to demonstrate the procedure. The next time you will guide the preceptee through it. When the preceptee demonstrates competence he/she may perform it independently.
4. Review all documentation daily. If you have an IP (interim permit) preceptee, you will need to co-sign all documentation.
5. Introduce the preceptee to the staff, physicians and ancillary staff.

**FORMATIVE EVALUATION**

1. Discuss the preceptee's development of routines and organization.
2. Evaluate last week's goals.

3. Identify daily and weekly goals.
4. Document competencies attained.

### **Week 3**

#### **FOCUS**

##### **1. *Prioritizing Skills***

As we continue to build on our foundation, we start to develop the ability to assess changing situations and prioritize their order. This is a very important skill that is crucial to the preceptee's success.

##### **2. *Critical Thinking***

What makes a highly skilled staff stand out is their ability to assess and problem solve quickly. We call this critical thinking. Challenge your preceptor daily to develop these skills. This is at the heart of a preceptor program, to bring tasks together with the ability to think critically.

#### **DAILY TASKS**

1. The preceptee will assume care of the whole assignment for routine care under the constant guidance of the preceptor. The preceptee will start to tackle more challenging clinical situation including calling the physician to report changes in condition and receive orders.
2. After shift report discuss how the preceptee will prioritize their assessments and the rationale involved.
3. When the day becomes hectic, have the preceptee stop and describe what needs to be done, how they are prioritizing and why. This will give him/her a few minutes to clear their head and focus.
4. To begin the development of critical thinking skills, discuss the assessments findings and state why the patient may display these signs and symptoms. You may use the same process to discuss disease processes and medications. Please assist the preceptee in these discussions rather than questioning him/her. We do not want the preceptee to feel like they are being interrogated (see Principles of Adult Learning).
5. Continue to review documentation.

#### **FORMATIVE EVALUATION**

1. Discuss the development of prioritizing and critical thinking skills.
2. Participate in progress meetings as assigned.
3. Evaluate last week's goals.
4. Identify daily and weekly goals.
5. Document competencies attained.

## **Week 4**

### **FOCUS**

#### **1. *Decision Making Skills***

This skill is an extension of the critical thinking skill. Making a decision based on the critical thinking process is a big step for the preceptee. He/she needs assistance and support in developing this skill and becoming confident in its use.

#### **2. *Delegation***

This is the beginning of building leadership skills. The preceptee will learn how to be more effective in their role by delegating to his/her aide. What to delegate and how to delegate are the skills to be developed.

### **DAILY TASKS**

1. Assist the preceptee in adapting his/her routine to working with and delegating to other members of the health care team, especially the aide.
2. Observe and guide the preceptee with the communication and process of delegation.
3. Assist the preceptee in assessing his/her decision-making skills by having the preceptee conducting the critique of clinical situations.
4. The preceptee should be gaining some independence while you still maintain guidance and support.
5. Pursue the discussions of clinical situations to develop more complex critical thinking skills.
6. Continue to review documentation.

### **FORMATIVE EVALUATION**

1. Discuss decision-making skills.
2. Discuss team leading and delegation skills.
3. Continue with daily evaluations and progress meetings.
4. Evaluate last week's goals, identify next week's goals.
5. Document competencies attained,

## **Weeks 5 - 10**

### **FOCUS**

1. *Socialization to new shift* and staff (if hired for the night shift)  
For the night shift preceptee, the move to the night shift represents another change to adapt to and adds a level of stress. Be prepared to support the preceptee in this time of transition.
2. *Continue to develop skills - prioritization, critical thinking and team leading*  
The preceptee should be gaining in their confidence and competence. Continue to challenge the preceptee to new heights. The early successes should pay off here where you will start to see the preceptee blossom.
3. *Independence*  
The “letting go” process has its beginnings here. The preceptee is now gaining independence and is eager to show you how well they are doing. **Remember** you must still guide, support and oversee their work. This is a gradual process, which may be difficult for both the preceptee and preceptor. The preceptor may have a sense of a loss of control and may find it difficult to resist the impulse to step in and help. The preceptee may feel insecure about gaining independence and feel like they are losing their security net. This is an important transition for the preceptee as they enter the real world of nursing.
4. *Self - Confidence*  
As they preceptee gains independence his/her confidence level should also rise. This is important to their function as a professional. If this is stunted alert your manager/educator right away. A part of developing confidence is to trust one’s instincts and judgments. As the preceptee approaches the end of the program and for the next 6 to 9 months, this will be a focus of growth.

### **DAILY TASKS**

1. Orient the preceptee to the new shift’s routines and tasks.
2. Introduce the preceptee to the new staff.
3. The competencies (documentation) communicate preceptee’s progress.
4. Preceptee manages entire assignment with preceptor serving as safety net and teaching advanced clinical concepts.
5. Identify competencies not accomplished and plan for their coverage.

### **FORMATIVE EVALUATION**

1. Discuss progress of all skills learned in previous weeks.
2. Discuss progress of independence and confidence.
3. Continue with daily evaluations and weekly progress meetings.
4. Evaluate the previous week’s goals and identify the next week’s goals.
5. Document competencies attained.

## Preceptorship Contract/Conferences

Name: \_\_\_\_\_ Date of Hire: \_\_\_\_\_  
License: \_\_\_\_\_ Date of Expiration: \_\_\_\_\_

I, \_\_\_\_\_ have been oriented to the Nursing Preceptorship  
Program for \_\_\_\_\_ and agree to act as a preceptor for

\_\_\_\_\_ during the \_\_\_\_\_  
(Name) (Date)

Preceptor: \_\_\_\_\_ Date: \_\_\_\_\_

---

Beginning Conference

Date

Initials

---

Mid Conference

Date

Initials

---

Final Conference

Date

Initials

## PERFORMANCE EVALUATION/MEASURING OUTCOMES

### **PRECEPTEE'S PREASSESSMENT NEEDS**

Submit this to your preceptor on your first clinical day. Submit a copy to preceptor on the first meeting.

Orientee/Student: \_\_\_\_\_

Date: \_\_\_\_\_

Preceptor: \_\_\_\_\_

Hospital: \_\_\_\_\_

Skills Never Completed:

Skills Needing Mastery:

Time Management:

**PRECEPTORSHIP CALENDAR**

Orientee/Student: \_\_\_\_\_ Preceptor \_\_\_\_\_

Phone: \_\_\_\_\_ Unit: \_\_\_\_\_

Hospital: \_\_\_\_\_ Phone \_\_\_\_\_

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Sunday

Please date this calendar. A calendar indicating shifts and days assigned to work must be developed, reviewed, and adhered to each month during the Preceptorship. Provide a copy of this calendar for yourself as well as your Preceptor.

## **Beyond Preceptoring: Letting Go and Mentoring**

Adapted from: St. Joseph Hospital, Clinical Education Department (2001) "Preceptorship: A creative approach to quality performance (Preceptor Handbook)." March, 2001. Orange, California.

### **Letting Go**

Part of the purpose of the preceptorship process is to assist the preceptee in making the transition to staff personnel. They must begin to stand-alone and function as a coworker. The process of letting go and allowing the preceptor to function more independently is sometimes difficult. We encourage you to let the preceptee take on responsibilities that they express comfort with and to let them handle their workload during slow and hectic times. It is counterproductive to clean up a situation that they might well be able to solve and complete. We also encourage you to refer the other team members to the preceptee regarding questions or problems in patient care. As you let go, always remember that you are functioning as the preceptee's safety net when it comes to patient care and other disciplines.

How long does it take a new employee to make it through the 4 phases of reality shock and become an effective team member? It can take up to a year - at least 6 months on the average. Adjust your expectations and those of the other team members to the true realities of the "orientation" process as you guide and support the new employee to excellence.

### **The Mentor Relationship**

After completion of the preceptorship, the new staff person ideally enters a mentoring relationship. The mentor may be the preceptor however any qualified staff may become a mentor. The purpose of this program is to always have a lifeline to the new staff. Completing the preceptorship is only the beginning and we do not want the new staff to think that they are "cut free" and on their own to sink or swim.

The mentorship is meant to serve as a support system. The mentor is not responsible for the new staff's performance. This is an informal relationship that allows the new staff to have someone to go to in confidence to review challenging clinical situations or other work related issues they may be having difficulties with. The mentoring relationship may continue as long as needed to assist in supporting the new staff through the transition from preceptee to experienced staff.

# References



## **References**

- Alspach, J. (2000) *From Staff Nurse to Preceptor: A Preceptor Development Program*. 2<sup>nd</sup> edition. American Association of Critical-Care Nurses.
- Benner, P. (1982) From novice to expert. *American Journal of Nursing*. 82:403-407.
- Benner, P. (1984) *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. Addison-Wesley.
- Bidwell, A. S. & Brasler, M. L. (1989) Role modeling vs mentoring in nursing education. *Image: Journal of Nursing Scholarship*, 21(1), 23-25.
- Bloom, B. (1956) *Taxonomy of educational objectives: Book 1: Cognitive Domain*. New York: Longman.
- Board of Registered Nursing. (1999) *Components of a prelicensure preceptorship*. Consumer Affairs, State of California.
- Brink, K. (2000) *Conflict Management*. Kaiser Permanente Medical Center, Riverside, CA
- Brookfield, S. (1987) *Developing Critical Thinkers*. San Francisco: Jossey-Bass
- Brounstein, M. (2000) *Coaching and Mentoring for Dummies*. IDG Books Worldwide.
- Caffarella, R.S. (1994) *Planning programs for adult learners*. San Francisco: Jossey-Bass
- Conley, V.C. (1973) *Curriculum and instruction in nursing*. Little, Brown & Company, Inc.
- De Castillo, S. (1999) *Strategies, Techniques, and Approaches to Thinking: Case Studies in Clinical Nursing*. W.B. Saunders.
- Developing Preceptor Expertise in the Clinical Setting*. A workshop presented by Cerritos Community College, East Los Angeles College, Glendale Community College, and Mount San Antonio Community College. 5/30-31/02, Palm Springs, California.
- Dexter, P., et al (1997) Proposed framework for teaching and evaluating critical thinking in nursing. *Journal of Professional Nursing*. 13(3): 160-167
- Elias, J.L and Merriam, S. (1980) *Philosophical foundations of adult learning*. Florida: Krieger Publisher Co.
- Ennis, R.H. (1985) A logical basis for measuring critical thinking. *Educational Leadership*. 43:44-48.
- Everson, S., Panoc, K., Pratt, P. (1981) "Precepting as an entry method for newly hired staff." *Journal of Continuing Education in Nursing*. 12:5, 22-26.
- Fahje, C., McMyler, E., and Mateo, M. (2001). "When New Employee Orientation Doesn't Go as Planned." *Journal for Nurses in Staff Development*. 17:3, May/June, 2001.

- Flynn, J.P. (1997) *The role of the preceptor: A guide for nurse educator and clinicians*. Springer Publishing Company.
- Gardner, H. (1993) *Multiple intelligences: The theory in practice*. New York: Basic Books
- Haggard, A. (1984) *A Hospital Orientation Handbook*. Aspen
- Hinshaw, A.S. (1982) "Socialization and resocialization of nurses for professional nursing practice." In Hein, E., and Nicholson, M.J. (eds) *Contemporary Leadership Behavior*. Little, Brown.
- Kagan, S. and Kagan, M. (1998) *Multiple Intelligences*. Kagan Cooperative Learning.
- Knowles, M.S. (1980) *The Modern Practice of Adult Education*. Cambridge.
- Kolb, D.A. (1976) *Learning style inventory, technical manual*. Boston: McBer and Company
- Kramer, M. (1974) *Reality Shock: Why Nurses Leave Nursing*. CV Mosby.
- Kroehnert, G. (1991) *100 Training Games*. McGraw-Hill.
- Lancaster, W. and Lancaster, J. (1982) Rational decision making: Managing uncertainty. *Journal of Nursing Administration*. September, 23-28.
- Magill, R A. (1989) *Motor Learning: Concepts and Applications*. 3rd Ed. Wm C Brown, Dubuque, Iowa,
- McBeath, R.( 1992) *Instructing and Evaluating in Higher Education.*, Educational Technology Publications, Englewood Cliffs
- McGee, C. (2001) "When the golden rule does not apply: starting nurses on the journey to cultural competence." *Journal of Nurses in Staff Development*. 17:3, May/June, 2001.
- Miller, M. and Babcock, D. (1996) *Critical Thinking Applied to Nursing*. Mosby.
- Murray, Josh, "Learning Styles Assignment", Algonquin College, Ottawa, Canada, <http://www.algonquinc.on.ca/~murr0060/index.html>, accessed on 7/17/01.
- Myrick, F & Younge, O. (2002) "Preceptor behaviors integral to the promotion of student critical thinking." *Journal of Nurses in Staff Development*. 18:3, May/June, 2002.
- Oermann, M., Truesdell, S. & Ziolkowski, L.(2000) "Strategy to assess, develop, and evaluate critical thinking." *Journal of Continuing Education in Nursing*. 31:4, July/August, 2000.
- Piemme, J. Tack, B. and Kramer, W. (1986) "Developing the nurse preceptor." *Journal of Continuing Education in Nursing*.
- Potter, P. and Perry, A. (2001) *Fundamentals of Nursing*. Mosby.
- "Preparing the Preceptor for the Educator Role" (2001) The Sixth Annual Health Occupations Education Institute, presented by the Regional Health Occupations Resource Center of Orange County.
- Redman, B. (1997) *The Practice of Patient Education*. 8<sup>th</sup> edition. Mosby.

Regional Health Occupations Resource Center, Saddleback College (2001) *Dacum Competency Profile for the Preceptor*. Mission Viejo, CA

Robinson, S. and Barberis-Ryan, C. (1995) "Competency Assessment: A Systematic Approach." 26:2, February 1995, *Nursing Management*.

Rodriguez, L. (et al) (1996) *Manual of Staff Development*. MosbyYear Book

Sirski-Martin, K. (2001) *Conflict Management: Preparing the Preceptor for the Educator Role*. Presented by the Regional Health Occupations Resource Center, Saddleback College, Mission Viejo, CA (April 22-25, 2001).

*Standards for Continuing Education in Nursing*. (1986) American Nurses Association.

Stone, C. & Rowles, C. (2002). "What rewards do clinical preceptors in nursing think are important?" *Journal of Nurses in Staff Development*. 18:3, May/June, 2002.

Strader, M. and Decker, P. (1995) *Role Transition to Patient Care Management*. Appleton and Lange.

Stuart-Siddall, S. and Haberlin, J.M. (1983) *Preceptorships in Nursing Education*. Aspen.

St. Joseph Hospital, Clinical Education Department (2001) "Preceptorship: A creative approach to quality performance (Preceptor Handbook)." March, 2001. Orange, California.

Thomas, K.W. and Kilmann, R.H. (1974) *Conflict Mode Instrument*. Xicom, Incorporated, USA.

Watson, G. and Glaser, E.M. (1980) *Watson-Glaser Critical Thinking Appraisal Manual*. New York: Harcourt Brace Jovanovich.

Zwoski, K. (1982) "Preceptors for Critical Care Areas. *Focus on Critical Care*. 9:5, 7-11.

<http://www.ndsu.nodak.edu/instruct/stammen/uswest/aboutgrant/html/dacum.htm> (basic information about DACUM - accessed 7/27/01)