A. Domains of Learning

Have you ever known a student like Ben, the CNS student? He can quote several theorists on the change process, but can’t seem to understand why staff members aren’t implementing hourly rounds after the inservice he gave on the topic. Perhaps you have known a student like NP-student Maria, who displays extraordinary technical skills, but treats the patient more like a mannequin than like a person who comes complete with feelings and concerns. Or you may have known a student like Health Systems Management-student Debra who can manipulate the databases like the whizzes in IT, but can’t turn the data into information that is meaningful for problem-solving.

Ben, Debra, and Maria each exhibit different imbalances in the three domains of learning. All three domains of learning are blended in most activities that the student performs with your guidance:

- The cognitive domain includes knowledge and thinking.
- The affective domain includes feelings, attitudes, values and beliefs.
- The psychomotor domain includes technical skills.

Most activities involve:

- a knowledge base, application of the knowledge, and knowledge-based judgment;
- an interpersonal component that requires sensitivity and respect, and
- a technical aspect that involves manipulating medical equipment or computers.

Learning in each domain is further characterized by levels of complexity. For example, the levels of the cognitive domain, in increasing order of complexity, are: knowledge, comprehension, application, analysis, synthesis, and evaluation. Sometimes the highest three levels are considered together as components of critical thinking. For more information about domains of learning, see Appendix A.
Some educators have suggested that a social or cultural domain might be considered an additional domain, or a unique combination of the other domains which represents the learning necessary for one to function in a social or cultural milieu.

**B. How to Facilitate Learning in Each Domain**

*Cognitive learning*

Refer the student to resources: books, journals, computer-assisted instruction (CAI), and online sources. What sources of information do you really use in practice? Students are often overloaded with information about references and resources from faculty. Your role is to direct the student to those resources you find most efficient and practical for the various areas of your practice.

Ask questions that will lead the student to discover the information. For example, if the student is unfamiliar with outcomes performance management principles or terminology, ask the student what she knows about evaluation. Based on the level of knowledge, you can direct to the most appropriate sources. If the student is unfamiliar with a drug, orient him to the drug information resources you use and tell him to return to you prepared to discuss the use of the drug for the particular patient. You may need to refer the student back to the faculty when the needed information is not accessible in your practice setting, or when the needed knowledge should have been mastered in previous course work.
Limit the amount of information that you supply. Although you act as a resource, you do not substitute for the student investigating, collecting, and interpreting information.

Make a habit of incorporating discovery learning on a regular basis. For the next clinical day, you might ask the student to report to you on two articles, each of which recommends a different strategy for implementing a project discussed today or for managing a patient you saw together today.

Affective learning

Explore through questions that elicit a student's attitudes, values, and beliefs. For example, when you are precepting a Health Systems Management student, suppose that an employee refuses to work overtime in a situation where the unit manager is requiring additional coverage. Ask the student to think about how she would feel if she were the manager in charge, or if she were the employee. As a first step to fully appreciating and respecting other perspectives, help the student raise awareness of his own perspectives on issues such as mandatory overtime.

Provide information on differing perspectives. Place the student in situations in which he will encounter attitudes, values, and beliefs that are different from his own. Some of these differences may reflect differing ethnic background, others may reflect differences arising from age and work experiences, the differing perspectives of various healthcare disciplines, or any host of other differences that lead to distinct attitudes and values. Chapter 5 contains more information specifically
about cultural and generational differences.

**Psychomotor learning**

Provide opportunities for demonstration and practice. This may include activities such as entering data using a data analysis software package, or using the patient electronic medical record. Recommend that the student practice with a fellow student or employee who has already mastered the technique. Psychomotor learning requires active practice. Talking through a procedure is not sufficient for learning.

In all domains, one of the preceptor’s most effective strategies is to model competent practice. Allow the student to observe you in action and point out the critical features of your practice to the student.

**C. Principles of Adult Learning**

Authorities in the field of adult learning have described numerous principles of learning. Three themes predominate: active involvement, individual differences, and relevance and motivation. These themes, represented by the acronym AIR, form a convenient frame of reference for applying adult learning principles to precepting (Case, 1996).
**Active Involvement**

Educational research has shown that as more senses are incorporated into the learning process, the learner learns and retains more. For example:

“We remember:  
10% of what we read  
20% of what we hear  
30% of what we see  
50% of what we see and hear  
80% of what we say  
90% of what we say and act.”

From Kornikau and McElroy in Pike, 1992, p. 79.

Compare the differences in recall between 3 hours later vs 3 days later:

<table>
<thead>
<tr>
<th>Method</th>
<th>3 Hours Later (%)</th>
<th>3 Days Later (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telling used alone</td>
<td>70%</td>
<td>10%</td>
</tr>
<tr>
<td>Showing used alone</td>
<td>72%</td>
<td>20%</td>
</tr>
<tr>
<td>Blend of telling and showing</td>
<td>85%</td>
<td>65%</td>
</tr>
</tbody>
</table>

From Benschoffer in Pike, 1992, p. 79.

**Active involvement** uses a variety of learning processes to engage the student: discussion, computer-assisted instruction, lab and field experiences (including data entry; leading a team meeting), individual and group projects, simulations, and role-playing. Even when the learning does not involve a psychomotor skill, learners can become active by responding to questions and organizing information instead of receiving information passively. Some active involvement strategies for preceptors include:

A. Ask questions that will help the student discover the information.
   - For the Health Systems Management student: “How do the demographics of the clients who use this state agency affect funding opportunities?”
   - For the CNS student: “Which committees and departments need to be involved in this practice change?”
   - For the NP student: “How do you help your patient answer his insurance coverage questions?”

B. When asking questions, allow the student enough time to process the question and formulate an answer. Research has shown that teachers often do not allow sufficient “wait time” before the student answers.

C. Ask questions that require students to answer with more than a “yes” or “no.” In addition to stating complete answers, encourage students to draw a diagram or picture for you when appropriate. For example, a process diagram or system flow chart for a component of an information system, or a diagram to represent pathophysiological processes or the mechanism of action of a drug.
D. Ask questions that will lead the student to constructing her own learning and connecting new learning to previous experience. For example:

- For the NP or CNS student: “How does this patient’s wound healing compare with the patient we saw last time who had a similar wound?” “What accounts for the difference?”

- For the Health Systems Management student: “How does our agency’s method for costing out care and resource allocation compare with your own work site?” “What accounts for the difference?”

E. Turn questions around. When a student asks you a question, instead of answering immediately, ask a question—a what, when, where, how, or sometimes why question—that will lead the student to answering her own question. Often a very important question of this type is “Where could you look to find that out?” A part of the process a student needs to learn from you is how to access needed information. Share important resources, including online references, URLs, and human resources, to empower the student. Refer to Chapter 6 for additional information on use of questions in coaching.

F. Share your own active learning strategies, such as your schemes for organizing data and other aspects of your practice.

G. Give the student advance organizers. Share agency forms ahead of time so that the student can be familiar with any agency-specific terms. This may include performance appraisal sheets, financial spread sheets, even organizational charts.

H. Before the student observes you in action, ask a few questions for which you will expect answers after the observation. For example:

- “How did I get the staff to volunteer to collect data on clinic ‘no-show’ rates?”
- “How did I get the project manager to select more appropriate project deliverables?”
- “How did I get the patient to tell me about his sexual orientation?”
- “How did I get the manager to give priority to implementing this new skin care standard?”

I. When you are tempted to give a mini-lecture, challenge yourself to sprinkle your comments generously with questions. This approach gives you insight into the student’s thinking and learning needs. For example:

- Instead of telling the student the most important questions to ask prior to designing an evaluation project, ask the student to tell you what is most important to consider, then offer corrective feedback.
- Instead of telling the student the most important pieces of information to collect in a patient interview, ask the student to tell you the most important.
- Instead of telling the student how to present an inservice to the staff, ask the student to tell you her plan, then offer corrective feedback.
SAMPLE QUESTIONS

Some sample questions for the **CNS student** prior to leading a committee in updating a policy:

- What is the present policy?
- What difficulties do staff nurses or others experience with the present policy?
- What is the relevant evidence?
- Who are the stakeholders in this policy? How will you involve them? Are any invested in keeping the policy in its present form?
- What is the timeline?
- What is the plan for communicating and educating about the change?

Some sample patient-management questions for the **CNS or NP student**:

- Is there a problem here? Sometimes, let the correct answer be “no.”
- What is important? Irrelevant?
- Is a pattern developing?
- What additional information do you need? How will you get the additional information?
- What will you do first? Why?
- Is there a conflict between your perspective and the patient’s? If so, how will you resolve it?
- What is the patient goal or outcome? What is the timeline for goals?

Some sample questions for the **Health Systems Management student** prior to designing an evaluation project:

- How would you describe the current program?
- Who are the stakeholders?
- Who wants the evaluation?
- What type of evaluation is appropriate?
- Why is an evaluation wanted?
- When is the evaluation needed?
- What resources are available to support an evaluation?
J. Ask questions that require students to reflect on their own practice experiences, to identify ways to improve and to plan for a more successful next encounter.

K. Use questions, such as the sentence completions below, to optimize the precepting process and guide the student toward assuming some accountability for the effectiveness of the relationship. Some of these questions might be particularly useful at the time of midterm evaluation, or at a time when you perceive that the student is having difficulty.

Some Precepting Sentence Completions for the Student
One thing I wish my preceptor knew about me is ______________.
I wish my preceptor would stop (or start) ___________________.
One thing that is like (or different from) my previous clinical experience is __.
One thing I still need more practice with is _________________________.
The most important thing I’ve learned so far is ________________________.

John W. Newburn wrote:  “People can be divided into three groups:
Those who make things happen
Those who watch things happen
And those who wonder what happened.

Newburn notwithstanding, an active learning process includes some watching and some wondering or reflecting about what happened.

Some Precepting Sentence Completions for the Preceptor
One thing I wish my student knew about me is ______________.
I wish my student would stop (start) _____________________.
One thing that is like (or different from) my previous clinical experience is __.
One thing my student still needs more practice with is ________________________.
The most important thing my student has learned so far is ________________________.
How will you respond to this precepting situation?

This situation involves a Health Systems Management student, but the behaviors observed might also be observed with a CNS or NP student regarding the knowledge base you expect of the student based on course materials you have received.

You think that your student, Julie, lacks the knowledge base she should have. The course syllabus shows previous class sessions, resources, and projects related to regulatory compliance – specifically to TJC standards and National Patient Safety Goals (NPSG). Yet, Julie appears very unfamiliar with the intent of programs you are designing to address NPSGs – she even gave you a blank look when you mentioned “NPSGs.” She’s very enthusiastic about designing the details of the program and communicating about the programs with nursing leadership, but she doesn’t seem to understand the bigger picture.

You challenged Julie with your observation of the discrepancy between her practice and your expectation. She offered a variety of inadequate explanations: “I’ve been so busy at work I haven’t had time to devote to readings – I can’t even always make it to class.” “I don’t learn that much from class anyway. I’d rather learn it on my own, but I just haven’t had time.” “I’m really competent in my real nursing life and I certainly can’t afford to lose my job.”

Questions for the Preceptor

1. Which of the AIR categories predominate in Julie’s situation?
2. What actions will you take?

Sound Approaches for the Preceptor

1. Which of the AIR categories predominate in Julie’s situation?
   - Relevance and motivation. Julie is giving priority to her job because of financial and professional needs. She’s finding class irrelevant. She may also have feelings of insecurity as she steps outside her familiar knowledge base and practice.
   - Active involvement and individual differences are also evident in that Julie seems to prefer the active involvement in the organization to the more passive learning situation of classroom lectures or studying on her own.

2. What actions will you take?
   - Clarify expectations with Julie. She cannot be excused from preparation for clinical practice because of her job. She needs to accept that she must have a baseline knowledge in order to benefit from clinical practice. Require her to gain the information she lacked and report it to you or demonstrate it for you the next time.
   - If the pattern persists, share your observations with the faculty member.
   - Ask Julie to identify ways to create study time in her schedule. She is the only one who can do this, but she first must accept the need to create time to study. Who can help her? What can she delegate? What can she do differently or not at all for the duration of the course?
Individually Differences

Each of our students presents as a unique constellation of individual differences. Some of the ways students differ from one another and from you as preceptor may include:

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Disability status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience as a healthcare consumer</td>
<td>Learning styles</td>
</tr>
<tr>
<td>Race</td>
<td>Personality type</td>
</tr>
<tr>
<td>Professional expertise</td>
<td>Conflict management style</td>
</tr>
<tr>
<td>Religion</td>
<td>Aptitudes</td>
</tr>
<tr>
<td>Practice specialty</td>
<td>Achievements</td>
</tr>
<tr>
<td>Formal education</td>
<td>Talents</td>
</tr>
<tr>
<td>Gender</td>
<td>Interests</td>
</tr>
<tr>
<td>Workplace culture</td>
<td>Family roles</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>Age and generation</td>
</tr>
</tbody>
</table>

Some precepting strategies based on individual differences include:

A. Ask questions to assess the student. In addition to establishing rapport, knowledge about the student gives you insight into ways to connect new learning with prior knowledge and experiences. Chapter 5 provides in-depth information about precepting ethnically diverse students.

B. Assess your student’s learning style and other dispositions. Most students will not have completed formal learning style inventories. However, people do have insight into how they learn best. So for practical purposes:

- Ask the student about previous learning and what techniques have worked best in the past.
- Observe how the student goes about learning new information.
- Note the activities toward which the student gravitates.
- Review learning styles in Section E. on page 34.

C. At times you will be teaching the student a way of doing something that differs from the way the student has performed it in the past. Emphasize how the new way differs and discuss your rationale. Acknowledge that there may be several ways to accomplish the same end. This learning experience serves to broaden the student’s repertoire of skills, not downgrade them.

D. Recognize that your own individual characteristics contribute to the effectiveness of the preceptorship. Certain of your characteristics promote successful precepting better than others. In addition, your own characteristics will create more positive chemistry with some students than with others. Explore some of your own characteristics using the Myers-Briggs Type Inventory (MBTI™) at http://www.personalitypathways.com/type_inventory.html, or in a Thumbnail Sketch of the MBTI™ and precepting implications in Appendix B.
Alternatively, you might choose to identify your behavioral type and personality style using the DiSC model. This model explores behavior across four primary dimensions, each of which is associated with certain characteristics:

- Dominance – independent, results-driven, strong-willed, action-oriented, risk-taking
- Influence – optimistic, outgoing, team-oriented, energizing, entertaining
- Steadiness – empathetic, cooperative, consistent, predictable, change-averse, good listener
- Conscientiousness – concerned, cautious, correct, detail-oriented, quality-conscious, planner


E. Disclose some of your own characteristics. This is especially important if you place special value upon certain elements of a student’s behavior. For example, if you value taking the initiative by the student, let the student know your value, and also describe some examples of taking initiative in the student role. Without such clarification, you and your student may each translate initiative into different behaviors. It is important to come to a mutual understanding of expectations and interpretations.

Relevance and Motivation

You can’t motivate anyone.
You can only connect with and use the person’s own motivators.

Hopefully the student views the practicum experience as an opportunity to practice the theory mastered in class or to learn strategies that will enhance opportunities for hire into a desired position, and not simply as a required course that must be completed as painlessly as possible. Robert Pike (1992) makes the following motivational suggestions.

A. Offer choices. Activate the learner by letting her select from a range of possible experiences and projects. Work closely with faculty in finding a mutually rewarding experience for both preceptor and student.

B. Link learning to a problem that the student will be able to prevent or solve by knowing the information or process. Clearly describe problems that can arise
when a student does not master the learning at hand. Or, for a more active approach, ask the student to identify problems that might arise for a manager, a CNS, or an NP who did not know how to….

C. Hold the student accountable for performing tasks, duties, and assignments that make a helpful contribution to your practice. When nurses are in the learner role, they often feel motivated when they believe that what they already know and know how to do can contribute to the situation.

D. Get excited yourself about the student's project. Give praise for work done. Protect and enhance the learner's self-esteem.

Remember the hierarchy of basic needs. Comfort, safety and belonging come first. Research with new graduates has shown that comfort with skills, with staff, and with patients are precursors to confidence and to clinical judgment (Duchsch, 2001; Duchsch, 2003; Secrest, Norwood, & Keatley, 2003; Thomka, 2001; White, 2003; Winter-Collins & McDaniel, 2000).

If students are made to feel “different” from the culture of the organization, perceive a threat or have a compelling personal or family need, not much learning will occur until those basic needs can be addressed. It is not realistic, nor is it the preceptor's role, to resolve the student's personal or family issues, but it might be helpful to acknowledge an issue and ask the student what needs to happen in order to benefit from the learning experience. For example, a brief phone call to a baby-sitter might put the student at sufficient ease to gain from the experience. If the student perceives a threat to his person, competence, or relationships with colleagues and patients, explore the student's concern and offer some suggestions for building confidence and comfort level.

E. Selected Models of Individual Differences

1. Learning Styles
2. Novice to Expert
3. Leadership Styles

Amongst the individual differences that people exhibit, some are more salient than others in the preceptor-student relationship. For the purposes of preceptorship, three of the most relevant individual differences are differences in learning style, differences along the novice-to-expert continuum, and differences in leadership styles. Cultural differences and generational differences are also highly significant and are discussed in Chapter 5.

1. Learning Styles
One of the most used formulations of learning style was developed by Kolb. He identified four modes of learning and some characteristics that accompany each mode:
Concrete Experience = Learning by feeling and intuition
Active Experimentation = Learning by doing
Reflective Observation = Learning by observing and perceiving
Abstract Conceptualization = Learning by feeling and intuition

Kolb’s model consists of four learning styles and characteristics that accompany each learning style. Each style combines two of the four modes of learning:

Accommodator = Concrete Experience + Active Experimentation
Diverger = Concrete Experience + Reflective Observation
Converger = Abstract Conceptualization + Active Experimentation
Assimilator = Abstract Conceptualization + Reflective Observation

In practice, it is helpful to identify your student’s preferred learning style. For example, the student who is a converger will benefit from hands-on, practical, problem-solver type of activities. However, this learner tends to be more pragmatic, preferring learning situations where there is only one correct answer or solution. Since today’s healthcare environment does not offer such a limited choice of solutions, the preceptor can expect to focus much of the learning experience on why alternative approaches must be considered and often adopted.

Some authorities believe that the learning process is really a cycle that incorporates all four of the modes of learning. According to this viewpoint, a learner’s preferred mode will be the approach taken first. Then as learning proceeds, other modes are brought into play. For example, you may be teaching data entry skills to a student who prefers to learn by doing (Active Experimentation). This student will connect best with the new learning by practicing with the computer and psychomotor skills involved. However, to use the advanced skills competently, the student will need to learn via other modes as well:

- Reflective Observation, by observing you when you enter data and by reflecting on your performance;
- Abstract Conceptualization, by thinking about the process of data entry and interpreting it, and
- Concrete Experience, by incorporating your coaching feedback and by considering his feelings and responses to the behavior learned.

Kolb’s formulation is one of many learning style models (Kolb, 1985). Appendix C contains further information about Kolb’s model. Here are some links to other learning style inventories that may be of interest; most offer a free inventory.

http://gregorc.com/books.html
Gregorc’s Adult Guide to Style; a free test is not offered at this site.

http://www.engr.ncsu.edu/learningstyles/ilsweb.html
Index of Learning Styles Questionnaire
In a recent study (Brunt & Kopp, 2007), researchers measured learning styles of a small sample (22 pairs) of preceptors and orientees using Kolb’s Learning Style Inventory and Gregorc’s Style Delineator. They compared satisfaction of preceptor and orientee pairs who had styles in common with those whose styles differed. Results revealed no significant differences in satisfaction with orientation and preceptorship between those pairs whose styles matched and those pairs whose styles differed. Both groups reported high satisfaction scores. All participants received an interpretation of their learning style results. Perhaps insight into one’s own learning style as a preceptor and investigation of the learning style of the person precepted helps promote effective learning even when learning styles of the two parties are not the same.

Gaining insight into your own learning style and that of your student can assist you in making the preceptorship most effective. You may not choose to explore various learning style inventories, but at least reflect upon your own preferred ways of learning and inquire of the student about previous learning experiences and preferences in learning.

2. Novice to Expert

The most widely used model of development of nursing expertise was proposed by Benner (1984) and continues to be used extensively as a framework for nursing education and research. Based upon the Dreyfus model of decision-making and derived from exemplars of clinical practice in acute care, the model also applies well in primary care and administrative practice. The table that follows displays characteristics of each level of expertise along the novice-to-expert continuum, and implications for precept.
<table>
<thead>
<tr>
<th>Characteristics</th>
<th>STAGE</th>
<th>Preceptor Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Has no experience with situations in which asked to perform tasks</td>
<td>NOVICE</td>
<td>• Teach rules to guide actions that can be recognized without situational experience</td>
</tr>
<tr>
<td>• Lacks discretionary judgment</td>
<td></td>
<td>• Must be backed up by a competent practitioner</td>
</tr>
<tr>
<td>• Relies on abstract principles and context-free rules instead of past experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Practices by the rules learned</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Doesn’t know when an exception to the rule is relevant or which tasks are most relevant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Has some minimal past experience to draw from</td>
<td>ADVANCED BEGINNER</td>
<td>• Shift from teaching rules to guidelines</td>
</tr>
<tr>
<td>• Demonstrates marginally acceptable performance</td>
<td></td>
<td>• Help to recognize patterns and their meanings</td>
</tr>
<tr>
<td>• Has global, not specific experience</td>
<td></td>
<td>• Assist in prioritizing</td>
</tr>
<tr>
<td>• Begins to recognize patterns and attributes, maybe with preceptor’s help</td>
<td></td>
<td>• Must be backed up by a competent nurse</td>
</tr>
<tr>
<td>• Sees all aspects as equally important, has difficulty differentiating importance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Takes in little of the situation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Concentrates on the task at hand and remembering the rules</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Can identify which aspects of the task are important and which can be ignored</td>
<td>COMPETENT</td>
<td>• Focus on improving decision-making skills and ways to improve coordination of multiple, complicated needs of patients or of the organization</td>
</tr>
<tr>
<td>• Is organized, but lacks speed and flexibility of the proficient stage</td>
<td></td>
<td>• A good preceptor for a nurse who is at the novice stage</td>
</tr>
<tr>
<td>• Knows what needs to be done</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Feels able to cope and manage unforeseen events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sees their actions in terms of long-range goals or overall plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sees the situation as a whole, not focusing on the parts</td>
<td>PROFICIENT</td>
<td>• Use complex case studies to facilitate learning.</td>
</tr>
<tr>
<td>• Uses experience rather than rules to guide practice</td>
<td></td>
<td>• Use of context-free situations will cause focus on exceptions to the rules</td>
</tr>
<tr>
<td>• Can recognize when the expected, normal picture is absent</td>
<td></td>
<td>• A good preceptor for a nurse who is at the competent stage</td>
</tr>
<tr>
<td>• Has a holistic understanding that facilitates decision-making</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Considers fewer options, narrows down the problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Has an intuitive grasp of the situation</td>
<td>EXPERT</td>
<td>• Often not possible to recapture mental processes</td>
</tr>
<tr>
<td>• Manages clinical problems extraordinarily well</td>
<td></td>
<td>• Encourage exemplars and descriptions of excellent practice</td>
</tr>
<tr>
<td>• Practices holistically rather than fractionated</td>
<td></td>
<td>• A good preceptor for a nurse who is at the proficient stage</td>
</tr>
<tr>
<td>• Zeroes in on the accurate range of the problem, correctly identifies solutions efficiently</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Is considered an expert by others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Has difficulty articulating rationale for interventions; may just know “I’m right”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Adapted from Baltimore, 2004. *Orienteer Characteristics and Preceptor Implications.*
ties in their own work setting, they may not be able to transfer this competence to a new setting. If the student is a novice in a specific skill, then you need to focus on the characteristics of the student at the corresponding stage and plan appropriate learning experiences to match their decision-making ability.

It is also true that a student may be quite expert in certain aspects of the role such as certain clinical skills, and at the same time be a novice in other aspects such as the organizations/systems sphere of CNS practice.

Davis, Sawin, and Dunn (1993) believe that NP students enter the graduate program at the advanced beginner stage with respect to the NP role and graduate at the competent-proficient level. Their research identified teaching strategies which preceptors used to facilitate learning with NP students, shown in the table that follows. Although this example focuses on patient assessment, the strategies apply readily to students preparing for the CNS role or the management role.
### Strategies for Different Levels of Learners: A Patient Assessment Example

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Advanced Beginner</th>
<th>Transition</th>
<th>Competent-Proficient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Needs much help to focus assessment</td>
<td>Needs less assistance to focus; forms assessment and sets priorities with minimal assistance</td>
<td>Analyzes assessment data; states alternative plans; develops own caseload</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Conferencing</th>
<th>• Emphasize chart review in pre- and post-conference</th>
<th>• Expect student to come up with more alternatives</th>
<th>• Focus on plan and pattern development</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Begin to expect student to pick up on subtle clues</td>
<td>• Focus on subtle changes</td>
<td>• Focus on critical aspects</td>
</tr>
<tr>
<td></td>
<td>• Emphasize putting the physical and psychological together</td>
<td>• Emphasize putting the physical and psychological together</td>
<td>• Focus on precision</td>
</tr>
<tr>
<td></td>
<td>• Focus on critical aspects</td>
<td>• Focus on precision</td>
<td>• Plan for more postvisit-only conferences</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Timing</th>
<th>• Do not limit time</th>
<th>• Focus more on time efficiency</th>
<th>• Increase time constraints</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Role modeling</th>
<th>• Role model</th>
<th>• Reduce role modeling</th>
<th>• Continue to reduce role modeling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Continue to increase review questioning</td>
<td>• Continue to increase review questioning</td>
<td>• Continue to increase review questioning</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Charting</th>
<th>• Use preliminary charting to teach logical thinking and completeness</th>
<th>• Expect student to write the plan as a mechanism to increase clarity and comprehensiveness</th>
<th>• Expect integrated charting in a timely manner</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Questioning</th>
<th>• Use lots of guiding and direct questions to help student organize thinking</th>
<th>• Begin analytic approach to questioning</th>
<th>• Focus on refining skills</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Challenge student for alternate plans</td>
<td>• Analyze information given by student</td>
<td>• Focus questions on self-evaluation of visit</td>
</tr>
<tr>
<td></td>
<td>• Ask “What if?” and “What else?” questions</td>
<td></td>
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</table>
As a final example of the novice-to-expert continuum, consider the Learning Vector concept developed for medical education (Bowling, 1993). The following diagram represents the concept and an explanation follows.

The Learning Vector concept describes four learning styles that support the student’s need for greater independence in learning as the student matures professionally.

- In the early phases of professional development when the student is first exposed to and is acquiring practice expertise, the student responds best to a more authoritarian and teacher-centered approach. In this exposure phase, the preceptor assumes a directive role and communicates facts and principles.
- As the student acquires knowledge, develops expertise, and enters the acquisition stage, the preceptor employs the Socratic approach by raising questions with the student and encouraging the student to formulate questions. As the student continues to mature, the preceptor invites the student to engage in clinical problem-solving with the preceptor and assume a more collegial role. Bowling names this approach the heuristic teaching style, or “let’s-solve-it-together” attitude. When the preceptor employs the heuristic approach, the student incorporates some of the preceptor’s problem-solving strategies through dialogue with the preceptor.
- When the student has matured to the integration stage, the student has developed a reasoning approach to problem-solving and is ready for independence. The preceptor supports the student’s independence. The preceptor also counsels and stimulates the student’s motivation to pursue further learning. Bowling calls this teaching style behavioral.

The Learning Vector as it applies to Nursing Preceptorship

Because the student does not mature in all aspects of practice simultaneously, you will identify a need to be directive with some aspects and grant more independence in areas of proficiency.

These stages apply to your development as a preceptor as well. Make use of this book to guide you in the aspects of the preceptor role which are less familiar to you.

3. Leadership styles

Depending upon your leadership style, you may work best with a student who needs a great deal of direction, or a student with whom you can work on a more collegial level, or a student who is at some point between those two extremes. One popular measure of leadership styles, based upon the Situational Leadership model, is the Leadership Behavior Analysis (LBAII). One of the developers of the LBAII is Ken Blanchard, co-author of the management classic, *The One-Minute Manager*.

The LBAII identifies four different leadership styles. Each style is a different combination of directive and supportive behaviors.

**Leadership Styles in Situational Leadership**

<table>
<thead>
<tr>
<th>Style</th>
<th>Directive/Supportive</th>
<th>Student who most benefits from the style</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coaching</td>
<td>High Directive; High Support</td>
<td>Lacks competence and commitment</td>
</tr>
<tr>
<td>Directing</td>
<td>High Directive; Low Support</td>
<td>Lacks competence; has commitment</td>
</tr>
<tr>
<td>Supporting</td>
<td>Low Directive; High Support</td>
<td>Has competence; lacks commitment</td>
</tr>
<tr>
<td>Delegating</td>
<td>Low Directive; Low Support</td>
<td>Has confidence and commitment</td>
</tr>
</tbody>
</table>

Lockwood-Rayermann (2003) recommends the use of the leadership styles to create effective matches of student needs and preceptor strengths. The Situational Leadership model identifies primary and secondary leadership styles using the LBAII. The model also suggests that based upon your assessment of a student’s levels of competence and commitment, you might vary your style for best results.

It may not be practical or possible for you and your students to identify and compare your styles with any of the tools named in this chapter. On the other hand, you and your student might spend a few minutes with a free online assessment – many of the learning style Websites recommended earlier in this chapter offer free online assessments. Or, you might each complete the thumbnail MBTI™ found in Appendix B.
Whether or not you use formal tools to assess behavioral, learning, and leadership styles, you will forge a more effective preceptorship relationship if you dialogue about your styles and preferences. Students may have completed some of these assessments independently or as a part of course work and may have results to share with you.

Share with faculty your own characteristics that have implications for precepting. Let the faculty member know if you think you work best with a student who is at a particular level of competence and commitment as defined in Situational Leadership.

F. Conclusion

Chapter 2 has explored domains of learning: cognitive, affective, and psychomotor. The chapter has also described learning principles using the acronym AIR to represent Active Learning, Individual Differences, and Relevance and Motivation. And, the chapter has presented implications of these adult learning concepts for precepting.
When precepting puzzles you...
or you have a question, just

**Ask the Preceptor’s Preceptor**

I haven’t had that much experience precepting graduate students and so I’ve been more than happy to supply information when my student asks questions. After all, his questions show interest and that he wants to do a good job. And, it makes me feel like I have something to offer and that I really am teaching. But after working with him for a few weeks, I see a pattern developing. I’m beginning to feel like a reference book or a search engine. Should I just tell him to go look it up himself or ask his course faculty?

A. Give him the information. That’s what you’re there for. The practicum is action-oriented, so you need to give him whatever information he needs to function.

B. Help him identify the best sources of the information he needs to practice — whether it’s information about your organization, policies and procedures, standards, regulations, drugs, equipment, or other relevant aspects.

C. Tell him that you expect him to come prepared with the information he needs to function. Let the faculty member know that he is not adequately prepared and that you really wonder what he learned in his previous course work.

B. is the best answer. Unless the situation is urgent, tell him where to find the information. Better yet, ask him where he could find out or ask him to look in more than one source and tell you which source had information that is more useful and why. It’s true that the practicum is action-oriented and your major role is to guide the student in applying information to practice. However, another important aspect of your role is helping the student identify and use the most appropriate credible sources of information. He should not be spending excessive amounts of his time with you looking up information at the expense of time for active involvement; he needs to accomplish most of it before arriving for time that is scheduled with you. Applying the adult learning principle of active involvement, he will be more likely to remember information that he has sought out for himself and will also learn how to identify and use sources of information. If you believe that he has a significant knowledge deficit related to information that the faculty has told you was included in prerequisite courses, bring it to the attention of the faculty member.