Most schools of nursing rely on preceptors and Clinical Faculty, or adjunct faculty, to teach undergraduate students in the clinical setting. The practice has become universal. The American Association of Colleges of Nursing (AACN) has stated expectations with respect to preceptors and clinical instructors:

- “Clinical instructors, at minimum, are master’s-prepared with a practice focus and may be full or part-time (joint, adjunct, etc). They may coach and mentor preceptors to facilitate critical thinking and clinical decision-making.”
- “Preceptors whose primary role is direct or indirect patient care (not faculty) serve as role models for the design, organization, and implementation of patient care. They also work with clinical course faculty, work at least part-time in the role in which they are precepting students, and, at minimum, hold a baccalaureate degree in nursing” (AACN, 2007 p. 2).

AACN acknowledges that “some schools may find it difficult to achieve these goals in the short-term,” but establishes these expectations in the belief that “it is important to identify a uniform set of expectations for academic nurses in higher education that all member institutions can work toward accomplishing” (AACN, 2007, p.1).

You may be working with a school that offers a distance learning option for the clinical experience you are precepting or teaching and supervising. If you are working with distance learning students, you may find Chapter 7. Precepting and Distance Learning helpful.

**A. The Preceptor Role**

Many schools of nursing require a capstone course – the final course before graduation from the undergraduate program. In the course, students synthesize their
learning throughout the curriculum. Over the duration of the course, they practice in a way that gradually approximates the new graduate’s practice. The student takes these steps to the brink of RN practice with the guidance, assistance, and support of an assigned preceptor. The preceptor helps the student to learn and practice new skills and introduces the student to the staff nurse role in a very personal and realistic fashion. At the conclusion of the course, the student’s competencies have advanced to the point at which the student may manage and care for a substantial patient assignment, using the preceptor as a resource.

Schools differ in the qualifications they require of preceptors. In most situations, the preceptor is not compensated financially, but may be offered access to some of the resources of the college or university. Many states and certifying organizations offer credit for precepting as an option to meet professional development requirements for re-licensure or re-certification. Find out about rewards that the school offers you as a preceptor, and clarify license and certification renewal requirements that may apply to you.

The preceptor usually precepts one student at a time. Often students choose a specialty of particular interest to them for their clinical experiences in the capstone course. Some schools require the student to establish and accomplish certain of his own objectives in addition to the course objectives determined by the faculty.

Research has identified preceptor behaviors of role modeling, facilitating, guiding, and prioritizing as integral to baccalaureate students’ development of critical thinking ability (Myrick & Yonge, 2002). Research has also identified stress among preceptors – specifically related to the preceptor’s workload, preceptee’s skill level, organizational support, and preceptor confidence (Hautala, Saylor, & O’Leary-Kelly, 2007). Hautala et al. recommended that the preceptor’s workload be adjusted to accommodate precepting, and that preceptors receive training and organizational support in their preceptor roles. These findings validate findings of an earlier study (Henderson, Fox, & Malko-Nyhan, 2006) which identified that preceptors experience intrinsic rewards for precepting and require adequate preparation and organizational support to function effectively. These researchers recommended preceptor support in the form of continuing education, effective scheduling, and adequate time for learning and feedback in the clinical environment.

B. The Clinical Faculty Role

Most schools of nursing rely on the services of Clinical Faculty or Adjunct Faculty to teach undergraduate students in clinical experiences. Faculty respect the skills and experience that Clinical Faculty bring and find them indispensable – especially in light of the shortage of full-time nursing faculty.

Though arrangements vary with different schools and different healthcare organizations, most often the Clinical Faculty member is a practicing nurse who
contracts with a school of nursing to devote a specified number of days or hours each week to working with a group of undergraduate students during their clinical experience. The Clinical Faculty role is usually a part-time job. In most situations, the students have limited, if any, opportunity to establish their own objectives in undergraduate clinical courses.

Schools differ in the qualifications they require of clinical faculty. Compensation arrangements and job descriptions also vary among schools and healthcare facilities which work together in Clinical Faculty arrangements. Assure that you have clarified the conditions of your employment, compensation, and other matters related to your service to both employers.

Values and culture differ between nursing academia and nursing clinical practice (Schriner, 2007). As Clinical Faculty you are not fully transitioning into an academic role, but nevertheless will experience differences between the academic culture and the practice culture. In Schriner's study, new Clinical Faculty experienced stress related to unclear expectations, lack of preparation for the role, the changing student culture, taking responsibility for care given by students, and disparities between their expectations and the reality of the teaching role and reward system. You can prevent some of the stress by asking for a thorough orientation to expectations and a faculty resource person for ongoing support. Guide your faculty resource person in providing you with the information that is most relevant to you – perhaps in the form of examples specific to your clinical setting, rather than in the form of detailed written information about the curriculum.

C. Graduate and Undergraduate Students: The Same Thing Only Different?

Previous chapters of this book have presented numerous clinical teaching approaches in the context of graduate student practica. Most of these strategies and techniques apply equally well to undergraduate students: assessing the student, planning experiences, asking questions, listening actively, coaching, giving corrective feedback, evaluating performance. With little difficulty, you can translate these recommendations into your experience with undergraduates. Although there are many similarities, there are some important differences to address when working with undergraduates and some of the suggestions in previous chapters deserve special emphasis with undergraduates.

Important Considerations When Working with Undergraduate Students:

• Make Contact with Your Facility’s Resource Person
Most facilities have designated someone, often a Staff Educator, to coordinate student clinical experiences. This individual will probably have helpful suggestions about working with students in your facility.
• Get Off to a Good Start

The first day sets the tone. Make and communicate ground rules, such as when the student must contact you before beginning a particular procedure. If feasible, it may be helpful to require students to do a self-directed orientation to the unit before the first experience. This may allow the student to introduce himself to some of the personnel and become acquainted with the physical setting in a more personal way. If you decide to do this, prepare a guideline or checklist for the student's use.

• Remember that Undergrads Lack the RN License and RN Experience

The graduate student comes to the clinical practicum with a valid RN license and usually with work experience as an RN. Because undergraduate students are in the process of working toward these credentials, the clinical teacher of undergraduates must focus even more intensely on patient safety.

Most state nurse practice acts specifically provide that nursing students may perform RN activities under the supervision of a qualified, designated instructor. Unlicensed students do not “practice on your license” as such, but you are legally responsible for assessing the student’s competencies, making appropriate assignments, and providing the student with the necessary guidance and assistance to practice safely. Students are responsible for their own actions. In a lawsuit, a student’s actions would be compared with the conduct of an ordinary, reasonable, and prudent student nurse in the same or similar situation. Explore the legal implications of your clinical teaching role with both faculty and your supervisor in the practice setting. For a complete discussion of the legal responsibilities of nursing faculty, consult Brent (2004).

• Recognize that the Clinical Setting is Highly Stressful for Undergrads

Undergraduate students find clinical practice settings particularly stressful. In addition to the stresses of working with acutely ill patients and unfamiliar equipment, systems, and personnel, the undergraduate student is keenly aware that you are evaluating her performance. You can help relieve some of the stress by reassuring the student that you are not constantly evaluating — at times you are simply teaching or offering corrective feedback.

Demonstrating caring behaviors toward the student may help to alleviate stress. Schumacher (2007) identified caring preceptor behaviors including advocating, welcoming, including, autonomy with appropriate preceptor presence, making human connections and genuine feedback. Noncaring preceptor behaviors included unwelcoming, autonomy with preceptor overpresence or underpresence, and nongenuine feedback.

Situations may arise in which you must decide whether to protect the student or allow the student to struggle through a difficult situation — whether to hold the student’s feet to the fire, or act as a shielding firewall. Think through in advance how such situations might occur in your setting.

There is not one right answer that covers all such situations. Certainly you will protect the safety of the patient and the student's physical safety. When you need to intervene
to prevent stress or embarrassment for the student, role model professional behavior for the student, explain to the student how you have managed the situation, and ask the student to tell you her perceptions of the situation and how she might act differently in similar situations in the future.

For a more advanced student, you may decide that a situation presents a valuable learning experience; support the student in working through it, and process the situation and the student’s actions afterward. To whatever extent you decide to assist the student in such situations, it is never desirable to manage the situation completely behind the scenes in a way invisible to the student. Your role is to introduce the student to the realities of nursing practice – as gently and supportively as possible. Students will learn valuable lessons from your actions and the rationale for your actions in difficult situations.

- **Assess the Student's Previous Experience**

As a group, undergraduate students exhibit great diversity in clinical and life experiences. Many have worked as nurse externs or as nursing assistants. However, you may be working with a student who is entering a clinical setting for the first time. Assess the student’s previous experience in healthcare settings. Since nursing assistant, volunteer, and nurse extern roles may differ considerably from one facility to another, find out specifically what the student has done during previous experiences. Students’ non-clinical work experiences and life experiences also influence their perspectives on clinical practice and how quickly they master certain objectives.

Information you obtain when you assess the student will help you to alleviate stress and unfamiliarity for the student who is new to the setting and will allow you to use time efficiently with the student who has experience. When you assess the student, find out which courses and clinical experiences the student has completed, so that you can plan to build on previous learning and seek new experiences for the student.

- **Expect Less Independence and Flexibility than with Graduate Students**

It is absolutely critical that you operationalize the objectives of the course in your clinical setting – that is, think through exactly what the student will be doing in your clinical setting when he has accomplished each objective of the course. If you are uncertain about example behaviors that match the objectives, consult with the course faculty.

The purpose of the clinical experience is for the student to practice, receive corrective feedback and approximate the behaviors which indicate successful completion of the course. So, these specific behaviors serve as an important reference point throughout the experience and as criteria for evaluation at the conclusion of the course.

Because the objectives and the behaviors that describe them are the focal point for learning and achievement in the course, it is essential that you, the student, and the faculty share a common understanding of expectations. Clarifying expectations at the outset will facilitate a more effective clinical experience for all concerned.
Although undergraduate students’ objectives are more standardized than graduate students’ objectives, undergraduate students are nevertheless adult learners and will appreciate the opportunity to make choices when appropriate.

**Diagnosis:**

Part-timer’s Disease, a disorder similar to Alzheimer’s Disease.
Defining characteristic: Did I forget? Or, did the faculty not tell me?

- **Meet Today’s Undergrad: A Different Kind of Animal**

Your previous experiences may lead you to faulty assumptions. You will probably find that most students are quite different from you as an undergrad. Some of these differences may be generational, as discussed in Chapter 5.

The undergraduate student is also different from new graduates or experienced nurses you may have precepted. Some of your own student experiences and previous precepting experiences will prove very useful when working with undergrads. However, most important are your assessment of the student and a clear understanding of the course expectations so that you expect neither too much nor too little of the student.

Regardless of previous experience, the objectives and expectations are the same for all students in the course. The difference will lie in the type of experiences and the amount of practice the student will need to meet the objectives. Though all students must reach the same destination or outcomes, they may travel at different speeds and by different routes. For those students who meet objectives readily, it may be appropriate to offer more advanced or enriching experiences. If you think that the student’s performance shows readiness for more challenging situations, share your perceptions with the course faculty.

Hopefully, you will not experience incivility on the part of your students. Unfortunately, these problem behaviors have been noted among some nursing students. For further information or advice, consult the Luparell resources recommended at the end of the book.

- **Help the Student Formulate Meaningful Plans of Care**

The student may be required to prepare plans of care in a particular format. Remember that for beginning students the nursing care plan is a tool to help them structure their thinking and planning process – it is not intended to be a practical tool that a practicing RN would find useful. Required format and structure vary with the level of student.

Most undergraduate students need a more structured process of planning in advance than practicing RNs use. Develop for your own use an efficient and effective method of planning care with the student. McVey (2006, in Jackson et al., pp. 126 – 126)
recommends a series of practical questions to help the student organize care:

1. **Who?** The relevant specifics about this particular client
2. **What and Why?** Client assessment and focused chart review
3. **So what?** Bottom line implications of assessment findings
4. **Now What?** Priority actions
5. **When?** Timing and sequence of nurse actions
6. **What before?** Prep and collaboration before implementing the plan

**Make Purposeful, Realistic Assignments**

Use the objectives and your assessment of the student’s competencies and learning needs as a guide to making assignments. Clinical time and clinical resources are limited and it is important that each assignment serve a purpose in the student’s progression toward accomplishing the objectives. Staff nurse colleagues may offer input and it may be very useful. However, your colleagues probably do not have your insight into the objectives of the course. Though well-intentioned, their suggestions may not match the student’s learning needs. When making assignments, consider the amount of support and assistance that the student will need to complete the assignment. Avoid creating an overwhelming assignment for YOURSELF when you have responsibilities for other students, other patients, or both.

**Teach Priority Setting**

Students learn priorities from the questions you ask. Direct your questions with priorities in mind. **Ask questions such as:**

1. “What is most urgent?”
2. “What is the most important observation?”
3. “What are the most important precautions associated with this particular procedure (or medication)?”
4. “Of all the information you read about this patient’s condition, what will be your focus today?”

**Avoid Giving THE Answer**

You can expect to hear the student ask, “What should I do now?” Whenever it is safe to do so, turn the question back to the student: “What alternatives have you thought of?” “What does the procedure say?” “Did you check that on our Intranet?” “What is the patient’s preference?” Or other questions that will help the student think through the situation.

Duchscher (2003) found that new graduate’s initial critical thinking in unfamiliar situations could be described in a dialogue that the new grad carried out:

- “What shall I do?”
- “I’ll call the RN.”
- “What will the RN do?”
- “Can I do that?”

Of course some competencies required to act in unfamiliar situations may indeed be beyond the capability of the student, and the student may need you to intervene.
Nevertheless, thinking through what the RN will do and what additional learning the student needs to act similarly is a learning experience.

- **Deal with Questionable or Poor Practices by Staff Members**
Each situation is different. It is important to help students differentiate between safe alternatives and unsafe practices. Do not ignore these situations. Use them as learning opportunities. Raise questions with the student about what should have happened and why. Ask the student to identify the risks inherent in the practices they observed. Help the student to identify factors that contributed to the situation and how to address these factors. Explore follow up on the incident with the student. Does the incident need to be reported? If so, to whom? Should the student follow up with the staff member involved, or with someone else? How should you follow up, if at all? These situations call for your best professional judgment. Do your best to model ethical, professional behavior. Take approaches that will not alarm the patient, compromise the patient’s confidence in the staff, or embarrass a staff member. Naturally, patient safety has priority over avoiding embarrassing a staff member, but whenever possible, allow the staff member to save face.

- **Use Observational Experiences Constructively**
When thoughtfully planned and designed to promote student’s engagement with the observation, observational experiences can enrich a student’s clinical experience. Faculty may have assigned or suggested observational experiences as a part of your student’s experience. Or, you may identify an opportunity in your facility. Effective observational experiences include some preparation on the part of the student, perhaps reading an article, a protocol, or other pertinent material. The student should also make specific observations that will allow her to respond to specific questions about the experience. Depending upon the type of care being observed, questions might include:

1. “What protective equipment were staff members wearing? Why?”
2. “What infection control measures did you observe?”
3. “How did the patient perceive this procedure?”
4. “What was the purpose of . . .?”
5. “What were the roles of the various staff members present?”
6. “What equipment was in use? By whom?”
7. “How was the patient’s status and progress monitored?”
8. “How would you prepare a patient for this procedure?”

- **Plan Learning for All Domains of Learning: Facts, Principles, Skills, Affective Behaviors, and Critical Thinking**
In the cognitive domain, undergraduate students need to learn many facts, principles, and rules during their clinical experiences. They also need to develop critical thinking skills. Chapter 3 suggests some approaches to foster critical thinking.

When working with undergraduates, it is important to remember that what constitutes critical thinking depends upon the level of the student. For example, a more advanced student will recall as facts the important assessment and monitoring aspects associated with particular medications. Students at all levels should come to the clinical
setting prepared with pertinent knowledge about any medications they will administer and should use unit-based references for newly ordered medications. But suppose that a patient who is receiving a diuretic is nevertheless exhibiting signs and symptoms of fluid retention and so now has a new order for an additional diuretic of a different class which is unfamiliar to the student. If you supply a simple description of the action of the drug, the student can apply critical thinking skills to identify the signs and symptoms that indicated the new order and the related important observations and precautions. A student who had knowledge of the drug could simply recall the factual information, but the student who had no knowledge of the drug would have to figure it out, based on information about the action of the drug.

In the **psychomotor domain**, look for as many opportunities as possible for students to perform their skills. They need practice! If you identify a student who has deficits in skill performance, find out what resources the school can provide to help the student strengthen skills. Most schools have learning labs, many of which include sophisticated simulators.

In the **affective domain**, model respectful relationships with others. Give the student feedback on how well he demonstrates caring, respectful, professional behavior.

Some have suggested that there is a **fourth domain of learning** – a **social and cultural domain** that combines some of the features of the other domains. Social learning is very important for the undergraduate student. Research findings suggest that beginning nurses must find a level of comfort in relationships with patients and staff members, as well as with their skills, before they are capable of understanding the clinical picture and exercising clinical judgment (Secrest et al., 2003; White, 2003). Support the student in developing the beginnings of these relationships. Often students and their clinical teachers function as somewhat of a parallel system to the unit culture and lose the opportunity to assist the student with these social aspects of the RN role.

- **Address Student Concerns About Feedback and Evaluation**
  Undergraduate students are often extremely sensitive to the specter of evaluation that they perceive as haunting their clinical experiences. Make a point of reassuring the student that you don’t expect perfection, especially at the beginning of the term. Let
the student know that you will give corrective feedback throughout the term, but that it is only at the conclusion of the course that you make a final judgment about whether the student has met the objectives.

Be sure to include validating, affirming feedback as well as corrective feedback. The students need to know what they are doing right. It is easy to forget this important ingredient, particularly when managing a group of students as Clinical Faculty.

Remember that each observation of the student’s performance is only a snapshot. Your judgments about performance require a series of observations that can be summed to indicate patterns of behavior.

**Beware of biases** – either a halo effect or a reverse halo effect. Your expectations can color what you observe. A student may need to improve certain aspects of care, and at the same time, perform quite well in other aspects.

Encourage students to evaluate their own performance, using the objectives as measures. Ask the students to state examples of evidence that they are progressing toward, or have accomplished, an objective.

Find out how the faculty grades students’ clinical practice. Some schools use an A,B,C,D,F system and others use Pass/Fail. There are advantages to both methods. Advocates of letter grades argue that the method encourages students to excel and to put forth more effort in the clinical setting. Proponents of the Pass/Fail approach believe that clinical performance is either competent or not competent and should be graded as such. Your role may or may not include actually assigning a grade. You will present evidence to the faculty that supports a particular grade, and so it is important to ask faculty for examples of the behaviors that typify the levels of grading that they use.

When you plan clinical experiences, plan the observations you will make so that you can assure you will see the student’s performance of particular objectives.

- **Keep Anecdotal Notes**

  Whether you work with one student or a group of students, anecdotal records will help you recall the particulars of student performance. The school may have a policy and a required or recommended format for anecdotal records. Record enough information about the patient so that you can recall the patient care needs. Protect the identity of the patient. Make notes to capture your observations of the student’s performance. Think of that part of the anecdotal note as the equivalent of a video recording. Keep your interpretation or judgments about what you observed separate from the description of your observations. Share your notes with the student at intervals as a means of sharing perceptions.

  If you are managing a group of students, review your anecdotal notes of the previous experience before the next experience. This will help you direct your attention toward students whom you may not have observed to the same extent as some of their peers.
• **Conduct Meaningful Pre- and Post-conferences**

As Clinical Faculty you will be conducting pre- and post-conferences. As a preceptor, you may develop a routine of the equivalent of a pre- and post-conference as a one-on-one interaction with your student.

The pre-conference is an opportunity to briefly touch base with the student before the day’s experience begins to identify priorities, review the student’s plan, and clarify as needed. It is your opportunity to assure yourself that the student is prepared to provide safe care and to identify the times when you plan to be with the student.

Post-conferences are most effective when focused on a particular topic or aspect of care. It is very important to keep the focus on the clinical experience of that particular day and not use the time as additional class time.

Purposes of the post-conference include (Oermann & Gaberson, 1998):

1. Develop students’ problem-solving skills
2. Build students’ decision-making and critical thinking skills
3. Debrief the clinical experience
4. Develop cooperative learning and group process skills
5. Allow students to assess their own learning
6. Develop oral communication skills

Your role in the conference is to guide discussion and not to present information. If you plan a theme in advance based on your knowledge of the patients and events that you anticipate will occur, be sure to guide the students to connect the theme with each student’s experience. During the experience, make rounds on the students’ patients to identify possible themes for the conference that would be pertinent to the day’s experience of each student.

Avoid the temptation to lecture and interpret. Make most of your statements into questions – and allow time for the question to “land.” That is, allow students time to process the question and construct a response before answering yourself or moving on to another topic.

Each student should have an opportunity, perhaps the requirement, to speak during the post-conference. Avoid a simple series of reports, one by each student, in which no questions are asked or comments made. Each student need not necessarily give a full report of her activities during the experience. Instead, the theme might be assessment, or communicating with patients and family, communicating with staff, technology, documentation, or some other pertinent aspect of care. If you choose a format of a different student giving a more indepth presentation of a patient at each session, require that each student ask a question of the presenting student. Or, that all students take notes and that each student restate one point made by the presenting student.

Students may be reluctant to critique one another’s plans or actions, but you might ask each student to add one additional consideration in the care of a patient whom another student has presented. Or perhaps, ask students to identify how the needs of another student’s patient differed from the needs of his patient.
If you elect to invite guests, perhaps representatives of other disciplines or unit staff, prepare the guest in advance that this is not a guest lecture for the entire duration of the conference, but rather an opportunity for the students to place the expertise of this individual in the context of the day’s experiences.

You may find it necessary to enforce some discipline about on-time arrival at the post-conference. Encourage students to signal you if they need assistance to complete their assignments on time. You may direct students to help one another, which will add to their learning and importantly to recognize the need to ask for help in patient care. Emphasizing on-time arrival at post-conference also helps students develop time management skills – a great challenge for most new graduates.

- **For Clinical Faculty, Work Effectively with a Group of Students**

Clinical Faculty usually work with a group of students on a clinical unit. Managing the needs of so many patients and students can prove chaotic, and planning ahead is essential. When making assignments, take care not to overwhelm yourself. If you have 10 students and assign two patients to each student, you will make yourself accountable for 30 people – 31 including yourself! At times, assigning two students to work together in the care of a complex patient may provide an excellent learning experience. Plan in advance your priorities for specific observations and supervision during each experience.

It is acceptable to assign different activities to different students in the group. Naturally, the students need patient care experience and should receive as many patient care assignments as possible. But there are times when a student’s patient is discharged or transferred unexpectedly and no suitable patient care assignment is available. Prepare for these occasions by developing a list of activities that will permit students to make constructive use of the time on the unit. Perhaps list each activity on a card, creating for yourself a pocketful of cards from which you can pull self-explanatory assignments for students. Having instructions written will help you avoid taking time away from supervision of care to explain some alternative assignment.

**Alternative assignments** should make use of the clinical resources available. This does not include activities such as reading texts, preparing class assignments, or other activities that do not make use of the clinical setting. Possibilities might include:

1. Reviewing medical records of selected patients on the unit. Identify the indications for the medications they are receiving and assessing the patient’s response – and to include talking with the patient about his response.
2. Reviewing a medical record and talking with a patient to determine priorities in his care.
3. Reviewing the laboratory reports in the medical record and relating results to pathophysiology and therapies that are documented in the record.
4. Asking a nurse specific questions about her care of a particular patient.
5. Using reference material on the facility’s Intranet to answer certain questions related to care of patients on the unit.
Give some thought to what types of assignments on your unit make use of the resources there and provide a learning experience for students that addresses the course objectives.

For further development of these suggestions and additional recommendations for teaching undergraduates in the clinical setting, see Case & Oermann (2004).

**D. Studies Have Shown: Some Research-Based Guides for Preceptors** by Virginia McMahon Keatley, DNSc, RN

Keatley (1998) identified the presence of critical incident stress among baccalaureate nursing students practicing in clinical areas. The students identified trauma from intrapersonal threats (fear, feelings of inadequacy, worry), interpersonal dilemmas (feeling unwelcome on units, experiencing lack of support from faculty and staff), and extra-personal challenges (lack of time and control, feeling lonely). One recommendation of this study was to strengthen student confidence and comfort through the use of a consistent nurse preceptor.

In a subsequent study, Secrest, Norwood, and Keatley (2003) explored nursing students’ experiences of **feeling professional**. In a phenomenological study, students (n=64) were asked to reflect upon a clinical event during which they felt professional and share it in detail.

The themes which emerged from this study were: belonging (being part of the team), knowing (being able to answer questions from patients and families), and affirmation (seeing results of own action, no longer feeling like a student).

Based, in part, upon these 2 studies, a formal preceptorship experience was planned and implemented at a small state school in the southeastern United States. This 120-hour clinical, accompanied by a 3-hour didactic course in Nursing Theory, Research, and Practice, became the culminating course of the baccalaureate program.

In a phenomenological study, Keatley, Norwood, and Secrest (2004) sought to determine the meaning of preceptorship as described by the students. Graduating
seniors (n=19) were asked to describe specific clinical experiences that were meaningful to them. The data were analyzed using Polio’s interpretive framework (Polio, Henley, & Thompson, 1977). As the researchers worked with the data, a thematic structure evolved. Against a backdrop of awe about nursing, three themes emerged: competence, connection, and rewards. Exemplars for each theme were identified. Each theme supported the thematic structure.

This study strongly suggested that the preceptor made the experience for good or bad. The extended time (120 hours) spent on the same unit with the same nurse allowed the student to become familiar with routines, medications, and procedures leading to a feeling of competence, “I can do this.” In turn, this perceived competence ameliorated the feelings of fear, inadequacy and worry reported in the earlier study. The extended time and consistency also facilitated a connection for the students. They became part of the nursing team, valued for their part in providing care. This connection banished the perception that they were not wanted or welcome on the unit and not supported by the staff. Indeed, the connection worked both ways. The preceptor served as an entree to the whole staff. Preceptors helped students become part of the whole group and most staff members also viewed the student as “one of them.” Finally, a sense of reward emerged as students reported excitement from the affirmation they received from patients, families, and staff.

As a final component to preceptor studies, Keatley is conducting research to identify what preceptors find meaningful in a preceptorship. Preliminary data suggests that the consistency of working with one student for an extended period of time, seeing that student grow in comfort and ability, and feeling they have made a contribution to the profession play a large part in the satisfaction preceptors receive from the experience. Thus, it appears that a good experience is not a one-way street. All parties gain from the experience. This is borne out anecdotally by the number of preceptors who request to work with students multiple times.

A well-developed preceptor experience can exert a powerful impact upon a nursing student. Over the years, certain components of such a program have become very clear to faculty implementing our course. Keatley makes recommendations for successful preceptorship for the preceptor, student and faculty.

**Preceptor:**

1. The **single most important element** for preceptor selection must be a **real desire on the part of the preceptor to work with a nursing student.** The desire should be to foster student growth. Preceptors who are subtly coerced or assigned the responsibility as part of the job should not be selected. A preceptor who does not truly want to precept can be detrimental to student development.

2. Preceptors must feel secure in their role as a nurse. Preceptors leave themselves open to scrutiny by the students. They must feel comfortable with students’ questioning and occasionally disagreeing with them.

3. Preceptors must understand the role of the professional nurse. Preceptorship goes beyond the technical and managerial skills of a nurse.
and enters the realm of leadership, committee assignments, outside professional continuing education, and advocacy. In our program, we require preceptors to have a BSN, believing that a broad educational background is essential in a leader.

**Students:**

1. The student must **initiate contact** with and **meet the preceptor prior** to starting the clinical experience. This lessens first day anxiety considerably.
2. Students must **complete a self-assessment of skills** and share this with the preceptor prior to starting the first work day. This delineates the student's scope of practice for the preceptor.
3. Students keep a recording of thoughts, feelings, and content learned. This journal is submitted to the faculty member weekly. It is extremely important that student confidentiality be maintained, as students share some very personal feelings in these journals.
4. Students must adhere to the requirements of the unit: work hours, break time, uniform. They set up the schedule with the preceptor, working whatever days and shift the preceptor works.
5. Students must inform faculty and preceptor of any change in work schedule.
6. Accountability for clinical preparation is strictly enforced.

**Faculty:**

1. Faculty selects and meets with prospective preceptors prior to assigning a student.
2. The faculty maintains responsibility for grading the student. Preceptor input is always obtained, but the relationship between preceptor and student should not be overshadowed by grading.
3. Faculty must be on call at all times and remain very visible on the unit. Our faculty visit at least every other time the student works.
4. The faculty member does not supersede the preceptor in hands-on care. The faculty role is to work with and support the preceptor and troubleshoot when needed. Clinical experience and hands-on care is provided by the preceptor.
5. Feedback for both the preceptor and student is essential.
E. Questions and Answers for Clinical Faculty
by Gayle Roux PhD, RN, CNS, NP-C

As Associate Professor and Associate Dean of Faculty at the Marcella Niehoff School of Nursing, Gayle Roux is intimately involved in negotiating clinical experiences and clinical faculty assignments. Dr. Roux shared her thoughts in response to questions frequently asked by new clinical faculty.

Question I. As a brand new Clinical Faculty member or preceptor, what do I need to learn?

We acknowledge and respect that preceptors and clinical faculty come with many talents. You bring clinical expertise, communication skills, safety-focused approaches – there’s really not much catch up work to do. You primarily need to refashion and mold your skill set to focus on pedagogy and addressing students’ learning needs. Your role as Clinical Faculty or preceptor complements what you already do very well.

Question II. What are some of the specifics about pedagogy and learning needs?

One thing that may be a bit different is working with a student who has a problem – whether it is performance, interpersonal interactions, attitude, attendance, personal situations, or some other problem. Don’t hesitate to consult with your faculty contact - even if you just want to verify that what you perceive is a problem. Your faculty contact can validate your perceptions and offer suggestions. Your faculty contact can offer perspective about student norms and help you determine the seriousness of the matter. There is a multi-layered communication line for student problems. That’s one reason why it is important to identify problems early and begin the communication process. Your faculty contact person can help you determine when communication with the course director and others may be needed. Ask your faculty contact about the process before you perceive a problem.

Another new experience will be keeping anecdotal records and documenting student performance. Review the summative and formative evaluation process that you will follow to document the student’s performance. Ask your faculty contact for suggestions and a sample of the evaluation tool that will be required for completion with each student.

Question III. I’m accustomed to managing a heavy patient load, but I am a bit concerned about taking on 10 students at a time. What advice can you give me?

First and foremost, never put yourself in a situation in which you feel unsafe. Use your judgment to create assignments that you can supervise comfortably. Set safety
parameters for yourself.

Keep safe and sane by limiting some of the students’ patient care activities. For example, on a medical-surgical unit, all 10 students do not need to give medications to their patients during each clinical experience. Assign 5 to give meds and the other 5 to look up their patients’ meds so that they can expand their knowledge base in pharmacology and be prepared to administer the drugs in the future. Even out the assignments over the term so that all have an equal number of opportunities to administer the medications. You might give a post-conference assignment to those who did not administer the meds to report about the meds ordered for their patients and associated nursing responsibilities.

On a pediatric unit, you might assign the students to administer oral medications only for the first three weeks, and progress to IV meds for a time, and then finally to IV piggybacks.

Administration of medications is one aspect of practice in which we hold the student accountable for the same safe practice standard as the RN each time the student administers a medication. In other aspects of practice, we of course insist on safe practice, but allow for a learning curve and some cushion as the student develops competency.

**Question IV. How do you set the points on that learning curve?**

Clarify with your faculty contact the appropriate expectations for the student’s scope and level of practice. Ask for examples that are specific to your practice setting.

One practice pearl I can offer is to get a sense of the group’s performance norm. When you see that a student is lagging behind her peers, it’s a red flag.

**Question V. I’m excited about the opportunity to work for the school as a faculty member. I know I’m not really employed by the setting where I’ll be with the students, but I’m not used to being a guest on a nursing unit. What do I need to know?**

As soon as you receive your assignment, go to work on meeting the requirements of the clinical practice setting. This is critical because all of the requirements cannot necessarily be satisfied quickly. There will be orientation related to a variety of aspects of care and practice, depending upon your assignment. Some settings have required courses related to the special needs of their patient population, such as a course concerning child abuse or elder abuse. Certainly you will need to receive access to the computerized documentation and information systems, learn the policies and procedures most pertinent on your unit, and introduce yourself to unit staff. Unfortunately, we often have to accomplish these requirements in an extremely short timeframe.

It is wise to meet with the unit manager and staff to discuss their expectations for the students at the initiation of the clinical rotation. These expectations can then be
shared with the students and translated into their clinical experience. For example, some units like the students to do walking rounds for change-of-shift report. Students may be asked to notify the primary nurse when the patient requests analgesia so the nurse is apprised of the situation. It is important for the faculty and students to know the expectations and follow the variations in practice for that specific unit.

It’s a great insight to view yourself as a guest and to extend courtesies. But, do your best to integrate yourself and your students into the unit milieu. You can make valuable contributions to patient care and the students benefit from a more realistic experience when you and the students integrate with unit staff and practices.

**Question VI.** I’ve precepted undergrads in the past and that was not a paid position. I’m excited about the Clinical Faculty role, but honestly I could make more money picking up extra shifts. Students are so important to our profession. Why aren’t the dollars there?

You’re learning to think like a faculty member already! We do not claim that the work of nursing faculty is compensated commensurate with its value. Nursing education is an extremely expensive enterprise. Just as an example, we have 140 students in our Medical-Surgical course. That’s 14 groups of 10 students, each with its own Clinical Faculty, and we’re accounting for just one course out of the 53 clinical courses we run concurrently.

We have limited resources with which to compensate our faculty. However, in your role as clinical faculty it is wise to inquire about your salary before your teaching assignment is confirmed. You should know the salary comparison for your teaching position versus clinical practice before you accept the assignment. Potential faculty can then make an informed decision if the teaching position is the right step. Universities are continuing to propose salary increases for nursing faculty to compete with the market demand for nurses. We are aware that salary is one of the many variables that contribute to the faculty shortages. Professional discussions on salary issues with school of nursing administrators will assist the discipline of nursing education to progress with budget requests and salary increases.

It’s difficult to arrive at a fair and commensurate standard. One approach that some university medical centers have implemented is the joint appointment, in which the master’s-prepared nurse is on salary for a designated number of clinical practice hours and a designated number of hours teaching students. However, with the current high acuity, short stays, and need to focus on outcomes, many healthcare facilities do not find themselves in a position to entertain joint appointments. This contribution to the future of nursing can not always be measured in salary expenditures. Many nurses and faculty believe the current faculty and nursing shortage requires a collaborative commitment from universities, agencies, hospitals, legislators, and the state and federal government to create innovative programs to educate more nurses to meet the health demands of the public.

**Question VII.** I’m quite accustomed to all the computer and Web-enhanced tools available to us in practice, but I don’t know that much about what’s going on in schools
of nursing. I’ve heard about SimMan® - do I need to learn all about what the students are doing with technology at the School of Nursing?

Like many of the answers you’ll give to students, the answer is both yes and no. In our lab, we welcome Clinical Faculty. I think it helps you to know the resources we have to support and remediate students. That doesn’t mean that you need to know how to operate SimMan®. It does help you to know that for a student who lacks confidence and proficiency with skills, there is a place for practice.

Computer applications and Web-based resources open a new world for all of us. In fact, in placing students for clinical experiences, some pilot work is ongoing to explore the possibilities of letting the computer do the work of figuring out how to accommodate and coordinate the requests of numerous schools for clinical rotations at the many facilities at which they seek for student placements – at the graduate level as well as the undergraduate. Here in Chicago, we are one of 22 schools which place students in the few facilities devoted to pediatric care. Proponents of Web-based placements cite the efficiency of the process – the saving of time on the part of faculty and facility professionals and the opportunity for earlier finalizing of placements. Skeptics worry that the impersonalizing may result in failure to look after the interests and objectives of participating schools.

**Question VIII.** We both have limited time to continue our conversation – where do we leave it for now?

Well that’s certainly true. The shortages of nurses, nursing faculty, APNs, nursing managers, and so many other of our valiant colleagues affects us all. We all have fewer hours to devote to each one of our accountabilities – something we all need to remember when we collaborate with others.

I think the best place to leave it is with the invitation for ongoing communication. I hope that you’ll be in touch with your faculty contact at any time a question or concern arises. And, we’ll reciprocate with information that we think will help you.

My sincerest thanks for the expertise you bring to our students!

**F. Conclusion**

Preceptors and Clinical Faculty who work with undergraduate students make an invaluable contribution to students’ progress and to the nursing profession. This chapter has highlighted these two important roles and recognized that much of the information in preceding chapters applies to their practice. The chapter has also focused on some aspects of clinical teaching of the undergraduate student that differ from working with graduate students. The chapter featured contributions by a nursing faculty member who has conducted and continues to conduct research related to precepting and by the Associate Dean of Faculty at Loyola University Chicago Marcella Niehoff School of Nursing.
When precepting puzzles you…
or you have a question, just

Ask the Preceptor’s Preceptor

The other day one of the patients I had assigned decided he didn’t want a student – despite the fact that I had explained all of this to him the day before – my role, the student’s role. When the student and I walked into his room, he said, “Look, I’m too sick for this. You’re going to have to find someone else to practice on.” I was really taken aback. I said, “Well, we’re both disappointed to hear that because we really plan to give you excellent care this morning. However, we won’t cause you any additional stress, we’ll work with someone else this morning.” Then we left the room and readjusted the assignment, which didn’t make the staff very happy. In retrospect, I think I reacted too quickly and too severely. But I was so shocked and so influenced by this hospital’s tremendous emphasis on customer service. How could I have handled it better?

A. You were right on target. The patient is always right. What if the patient or family complained about the student’s care, or your insistence that the student give care? Patient satisfaction and customer service are very important imperatives.

B. He was really off base. When patients sign the consent on admission to teaching hospitals they accept student involvement in their care. You shouldn’t have caved to that. What a poor advocate and role model for the student! You should have told him that he had already consented and that you’d be sure the student didn’t make any mistakes.

C. You should have explored this further with him, just as you would if he were refusing a medication. The outcome might be the same, but at least you could have clarified things and modeled that process for the student.

C. is the best answer. Your idea about exploring it with him as you would if he refused a medication or treatment is a good insight. What are his concerns? You don’t want to be a salesman, with an answer for every objection. You don’t want to coerce or persuade him, or embarrass the student. But, it is important to clarify his concerns, the student’s role, and your role.

It is a delicate situation. It is also an opportunity to role model for the student how to explore the patient’s concerns. If the student is his nurse this morning he will probably receive closer attention than he would from a staff nurse – not only because he is the student’s only patient, but because you – a highly qualified, experienced nurse – are also monitoring his care. Be careful how you present that piece of information – you don’t want to undermine the staff! It’s enough to say that the student will give him her full attention since she has no other patient care responsibilities, that she is competent to do the activities that his care requires, and that you will be overseeing his care. Telling him this will not only reassure him, but will also affirm the student.

Nevertheless, you must respect his wishes. If he remains reluctant or becomes agitated, tell

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Ask the Preceptor’s Preceptor

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him that you will arrange for another nurse to care for him, and do so. Whether or not he accepts the student, it is a great opportunity for the student to see the value of exploring and clarifying concerns.

Consider this particular student as well. Is this student someone who will be threatened and stressed by caring for a patient who initially rejected her? If this is a beginning student, perhaps another assignment would be best. But, for a more advanced student, working through it might be beneficial.

Then there’s the staff. If you change the assignment, you will be altering another nurse’s assignment. Be sure that the nurse involved and the charge nurse know that you did in fact talk with the patient about the student assignment previously and at that time he was comfortable with it. Is there a reasonable way to compensate the nurse for the inconvenience of the changed assignment – such as assisting the nurse in some way?

And finally, it’s understandable that you responded as you did. As my comments indicate, there’s a lot to consider here and you resolved the situation efficiently and effectively. Still, take advantage of the learning opportunity that this situation presented. Explore with this student, or perhaps with your group of students in conference, the various alternatives and implications in this situation.