EDUCATION

Becoming a super preceptor: A practical guide to preceptorship in today's clinical climate

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Abstract

Purpose: To provide both potential and active preceptors with practical information that will help with the decision to become a preceptor, and to develop the preceptor partnership among the preceptor, the faculty, the student, and the patient. The article suggests ways to apply realistic techniques to assure that the preceptorship is successful in today's fast-paced practice climate. The article also presents successful evaluation strategies for the experience.

Data sources: Evidence-based reports, anecdotal experiences, personal conversations, and reports of proven preceptorship techniques.

Conclusions: Through a review of available literature and the authors' experience as preceptors and faculty, it is clear that it is possible to implement a mutually beneficial preceptor experience even in today's productivity-based practice models. Preplanning and use of suggested strategies can make precepting an enjoyable and rewarding experience.

Implications for practice: The education of tomorrow's practitioners is a mutual professional partnership among the stakeholders in the educational process. Application of practical strategies for enhancing this partnership will make the experience realistic and rewarding.

The need for excellence in the preceptor role has been well documented in the literature over the past two decades. However, there is little that is current and few contributions that present practical tips on being a preceptor in today's ''productivity'' environment. Furthermore, there is little in the current literature that prepares the newer preceptor to ask the right questions and plan the appropriate experiences for students. This article is designed to help the faculty and the preceptor build a professional partnership that will result in a positive learning experience for today's nurse practitioner (NP) student.

The preparation of nursing students for successful transition to real world role implementation has always been a challenge in nursing education. The use of preceptors as role models and teachers in the clinical setting has been employed for many years. Indeed, with the expansion of programs in advanced practice to encompass distance learning, and the need to place students in clinical experiences where it is not possible for the academic faculty to observe the students on a first hand basis during the clinical portion of the courses, the role of the preceptor has become essential in the educational process (Burns, Beauchesne, Ryan-Krause, & Swain, 2006). A preceptorship is usually a time-defined relationship with externally defined objectives, and has as its goal the instruction of a neophyte in the proficiencies of a new role (Barker, 2006). Within this relationship, the preceptor models the realities of practice for the student and helps guide the student to organize behaviors and strategies for effective and efficient patient care. In addition, a preceptorship provides the student with the opportunity to experience the pressures of day-to-day relationships with patients, other professionals, the referral system, local, state, and federal rules and regulations, and the realities of productivity-based

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practice. Preceptors are the vital link between the concepts and evidence-based approaches to care and the realities of actual practice.

Being a preceptor is a valued professional activity and is rewarded by the certification authorities by giving credit for recertification in advanced practice by the American Nurses Credentialing Center (ANCC, 2008). The impact of the preceptor on the student's formation has been cited repeatedly in the literature (Lyon, 2001; Hayes, 1994, 1998; Yonge, 2005). Each of these authors describes ways in which the preceptor's unique position influences the way in which the student forms a basic framework for practice. As important as the preceptor's experience is on the formation of the student's professional development, the relationship is forged in the crucible of a clinical environment that is not designed to allow for the time it takes to implement the teaching process.

Preceptorships are frequently short term and dependent on the length of the student's course. The time that students spend with the preceptor is determined by overall clinical hour requirements rather than the student's individualized learning needs. The availability of the preceptor and the student for mutually convenient hours and the structure of the clinic's patient care hours are also essential ingredients in the equation. This reality demands that the preceptor quickly identify the student's learning needs and select patient encounters to meet those needs and then fit them into the available time constraints. This is a difficult and often frustrating activity.

Students often present themselves to the preceptor with few, if any, formal objectives for the experience aside from the requirements of the course. Most often, the preceptor is still expected to maintain the level of productivity that existed before the preceptorship and assure that all regulations and policies are followed. This presents an environment that is not conducive to the development of self-efficacy in the student (Hayes, 1998) or enthusiasm on the part of the preceptor. In a recent meeting at a large advanced practice symposium in 2008, many preceptors reported that a lack of communication between the professors and the preceptor, a lack of relationship building efforts on the part of the faculty, and a general sense that the professors are not clinically current were identified in group discussion as barriers to the faculty–preceptor relationship.

In spite of all the pitfalls in the preceptorship experience, it is possible to construct a rewarding experience for all participants: the student, the clinical preceptor, the patient, the practice, and the faculty. This article will describe practical and effective tips for enhancing the outcomes of the precepted experience and forging mutually beneficial relationships among the people engaged in the process.

Becoming a preceptor

Making the decision to become a preceptor is not an easy one. Trying to squeeze extra time out of an already packed schedule often seems to be an impossible task. Remuneration for the time and energy expended is usually low or not offered. What then, would motivate one to become a preceptor? Research has supported the notion that that for NPs a powerful influence on the decision is personal satisfaction and a desire to ''give back'' to the students to repay those who invested in their education. Another factor is the perception of the quality of the communication between the faculty and the preceptor. Open dialogue between the preceptor and the faculty not only enhances the preceptee's experience but also provides the preceptor with much needed peer support and a narrowing of the theory–practice gap (Kaviani & Stillwell, 2000; Lyon & Peach, 2001; Hayes, 1994, 1998). Students and recent graduates have also indicated that the decision to be a preceptor in their careers is also based on the experience that they had while being precepted (E. Koenig, personal communication, January 5, 2008). Some recent graduates have considered the preceptor role because they ''remember how it feels to be a student'' and how helpful a great preceptor had been in their formation.

Negative experiences as a preceptor can also influence decision making. Being ''responsible'' for the success or failure of a student is a heavy burden. Many potential preceptors are reluctant to undertake the role because of a perceived lack of skill in techniques to manage conflictual situations with a student who is not performing well. A past history of unsuccessful preceptorships is also a powerful influence on the decision. Situations in which the preceptor's input was either not solicited or not used to make progression decisions have a negative impact on the decision to repeat the experience. The authors have had the experience of being exhausted at the end of a preceptorship because the student could not be trusted to see a patient safely, discussions with the student were not fruitful, and repeated attempts to contact the instructor were unacknowledged. When the student passed the course in spite of documented lack of achievement, discouragement and anger were powerful ''demotivators.'' In the stressful world of primary care, one less stressor is a welcome respite. How, then, does one become a successful preceptor? What does it take to have interactions with students that bring a sense of achievement to both parties?

Precursors of successful preceptorships

First, it is essential that before a clinician agrees to be a preceptor, he or she should have some indication of the expectations of the program for the precepted experience. These expectations should include the level of practice expertise the student has achieved (Are they beginners or on their last rotation? Are they experienced nurses or new to the profession?). The clinician should ask for the objectives for the course, the course syllabus, and the number of hours over a specific time frame the student is expected to spend with the preceptor. This will provide the focus of the course and help the preceptor plan the time the student spends in the practice more effectively. It is quite appropriate for the preceptor to expect that the student display professional behaviors, be mentally and physically prepared for the experience, and be willing to supplement the time in clinic with specific readings to improve his or her ability to manage the patient's conditions.

Second, the preceptor should have some sort of communication, either face to face, telephonically, or electronically, with the student before the onset of the preceptorship. Some areas of discussion might include mutual expectations for the conduct of the preceptorship including dress code, charting parameters, and urgent contact information in case either party cannot be available for an agreed-upon meeting. Additionally, a brief description of the practice routines and a general sense of the patient population will give the student a better sense of how to prepare for the experience. If the preceptor is specific about these basics, it can eliminate poor first impressions and save instructional time in the long run.

Third, it is helpful if the preceptor has some understanding of generational differences in learning patterns. Research indicates that the length of experience as a nurse is not correlated with level of competency in NP students (Rich, 2005). The combination of a younger student with limited or no experience in nursing with an experienced NP who is a new preceptor can often lead to frustration on the part of both parties. This frustration can be diminished by open communication of expectations, mutual willingness to offer constructive feedback, and the formation of a good partnership with the faculty member. It is suggested that the faculty member make at least one visit per precepting period, either in person (the best strategy) or via telephone. This improves the sense of a teaching partnership and allows for a more satisfying experience.

Table 1 Barriers to precepting success

Detrimental effect on productivity
Practice not designed to include students
Patients' expectations for care provider's attention
Discomfort with the teaching role
Short duration of the precepting experience

Barriers to precepting

The most common perceptions of barriers to precepting are listed in Table 1. The literature does not have many current economic analyses of these factors; however, one study indicated that community physicians who were precepting third year medical students actually saw 1.4 fewer patients and spent 51 min longer at work than physicians who did not have students with them (Levy, Gjerde, & Albrecht, 1997). Another study of rural clinics indicated that there was no difference in the billing charges that were generated between sites that had students and those that did not (Amella, 2001). The question of productivity often is largely dependent on the level of the student and the fit between the student and the preceptor. This area needs further research, particularly in today's practice climate.

Another perceived barrier is the requirements that Medicare place on the structure of the visit. The regulations state: ''Any contribution and participation of a billable service must be performed in the physical presence of a teaching (physician or resident) in a service that meets teaching (physician) billing requirements'' (Centers for Medicare and Medicaid Services, 2007). (Note that the guidelines do not discuss NPs, the brackets are the authors' notation.)

The Center for Medicare Services (2007) rules for documentation by students indicate that a student can document only the review of systems, and the past medical, social, and family history. The preceptor must document the history of present illness and the physical examination. Initialling the student's charting is not sufficient to meet the requirements. Following these rules does increase the time and complexity of the visit.

Another barrier is the perception that ''the patients do not want to have a student.'' This is certainly true in some cases, particularly when there is a strong emotional or intimate problem overlay to the visit. Having a student see the patient can often extend the duration of the visit and the patient may have to endure a second history or physical examination session. If the patient refuses to have a student, the patient's wishes must always be respected. This can be an excellent topic for the reflection portion of the student's day. It is an excellent learning experience to assure that students do not take the rejection personally or as a reflection of their expertise.

The authors have often had success in these cases when the patient is told that he or she was specifically chosen as an important example of a skill or condition about which the student needs to learn and that the preceptor will be with the student every step of the way. Another helpful approach is that the student is providing fresh eyes and a possible new tactic for a problem that has been difficult, and that students are excellent sources of the ''latest and greatest.'' Furthermore, the authors have often had the experience of the patient being happy that there is a student because that implies that the preceptor is so well respected that he or she is chosen as a preceptor by the academic community. This often gives enhanced status to the preceptor and to the practice.

Preceptor fatigue is another barrier to effective preceptorships. If a potential preceptor is asked to precept by medical schools, allied health programs, and nursing programs, the amount of personal satisfaction for patient contact and the experience that one is ''always on'' can lead to burnout and frustration (S. Hatem, personal communication, January 15, 2008). It is a reality that advanced practice programs are experiencing increases in enrollment and the number of precepted experiences has increased as well. Individual tracks within a program as well as multiple programs within a University or College or within a geographic area often place the potential preceptor in the middle of a cacophony of requests for the service. This is frustrating and can lead to a desire for ''them all to go away and leave me alone'' (L. Sedlock, personal communication, May 15, 2008).

Practical strategies for successful precepting

It is human nature to often apply the same strategies that were used ''on us,'' even if they were not particularly helpful. It is important to realize that different techniques for different learners should be selected depending on the student's and preceptor's personality and level of experience, as well as the pace of the practice. A constellation of techniques is summarized in Table 2. In order to meet Medicare guidelines, a successful approach is for the student to do the history and physical exam (H&P) while the preceptor sees another patient. When the preceptor returns to the room, the student presents the H&P and the preceptor and student develop the plan together based on findings from the observed examination. Points for improvement can be discussed after the visit, but the preceptor can amend the pattern of the examination as it occurs. This demonstrates a collaborative approach and eliminates the patient having to have the same exam twice.

Another technique is the so-called ''One Minute Preceptor'' model (Neher, Gordon, Meyer, & Stevens, 1992). The authors' experience is that it takes longer than one minute, but it is an effective approach. In this classic model, there are five microskills used.

> *What do you think is going on?* (get a commitment)
> *What led you to that conclusion?* (probe for supporting evidence)
> *Many times when . . . . .* (teach general rules)
> *You did an excellent job of . . . . .* (reinforce what was right)
> *Next time this happens, try . . . . .* (correct mistakes) (p. 419)

The advantages of this model are that it allows the preceptor to undertand student's critical thinking pattern, it communicates general rules of encounter with patients and it provides for immediate feedback about what was good and what needed improvement in the encounter.

There still remains the problem of productivity and how to get through a busy schedule with a student and not be at the clinic until midnight. Table 3 summarizes some suggestions that have worked for the authors. One approach is a focused half day. The preceptor can see the projected schedule and select one or two patients on whom the student can concentrate. The focus can be related to age, condition, assessment skills, or aligned with the objectives for the course the student is taking. In this strategy, students will have time to review necessary information from the chart and/or from the evidence base so that they will be prepared to ask the patient appropriate questions and perform a focused examination. While the student is preparing or while the student is in the initial encounter, the preceptor can be seeing other patients and keeping the schedule on track. Although this only provides for the student to see one or two patients, it gives the student the opportunity to have an in-depth experience and learn approaches that can be used in subsequent encounters (Taylor, 1998). This technique can

Table 2 Techniques for precepting students

Case discussions
Matching patients and the student for a specific learning experience
Direct questioning
Think aloud sessions
Assignment of directed readings
Coaching and cheerleading
Direct observation

Table 3 Scheduling strategies for precepting

Focused half days
Focused observation
Wave-scheduling
Appointment modification

increase confidence in the student, is less overwhelming to the neophyte, and keeps the preceptor on course for the day's schedule.

In the initial part of the precepting experience, the focused observation is often helpful. During this time, the student adopts a ''fly on the wall'' approach with the patient encounters. This gives the student the opportunity to observe you as a role model for specific aspects of the patient visit and provides material for a period of reflection at the end of the day in which the student may understand how the preceptor introduces variations depending on the patient's needs, and identify what the preceptor believes is important in every encounter. This technique is excellent for the beginning student or it can be useful on a day when there is not a lot of time for teaching because of a heavy schedule. This technique is not appropriate for a student's entire rotation. A third useful technique is ''wave-scheduling.'' In this pattern, two or three patients are scheduled at the same time and then that time slot is followed by a 10 or 15 min break. The student can see one patient while the preceptor sees the others. There is time for the preceptor to see the student's patient and not fall behind. This allows for the full complement of patients to be seen during the day, and it eliminates the back-up that occurs with the more usual 15 min/patient pattern.

Another variation on the above technique is to remove one appointment from the morning session and one or two from the afternoon session so that the preceptor and the student have ''catch up'' time. This pattern can potentially decrease the productivity of the day's schedule and so the preceptor needs to have support from the practice management to allow for this kind of flexibility. In some practices where the authors have worked, there is constructive ''preceptor'' time that is built into the productivity analysis that allows for the clinician to precept twice a year for 10–15 weeks. This eliminates the problem with productivity bonuses, as precepting is considered part of the productivity equation.

Student evaluation

This area is often a stressful one for preceptors, particularly when there is a necessity to give negative feedback. Hayes (1994) reported that feedback, no matter how well intentioned, may batter the self-esteem of the student. Responses of the student may range from appreciation and acceptance to tearful anger accompanied by defensiveness or passivity. In spite of these expected responses, honest feedback is essential in the precepting process. A summary of tips for giving feedback is found in Table 4.

Table 4 Evaluation tips

Base on performance not personality
Understand student's response to the feedback
Put the behavior in the context of the patient's outcomes
Assure privacy for evaluations
Be honest and constructive in your intent
Communicate feedback to faculty in a timely manner
Mutually devise a strategy for improvement
Do not generalize to an entire group of students

Evaluation should be specific, timely, include the student's assessment of the problem areas, positive as well as negative and give the student the opportunity to participate in the amelioration of the problem (Benzie, 1998). The focus should be on behavior and not personality. The authors have found that putting the behavior in the context of how it affects the patient's outcomes is often most helpful. Evaluative comments can come at any time in the day's schedule, but should be performed privately, gently, honestly, and in the spirit of producing growth. The authors cannot think of a time when negative evaluation comments are appropriate in front of the patient or practice staff.

Evaluation comments should be communicated to the faculty member in a timely manner. This report should include a description of the problem, the approaches to rectification and the progress that has been achieved. Positive feedback should be communicated in a similar manner. If the preceptor is having difficulty with the student or the experience is not going well, it is essential that the faculty member be apprised of the problem promptly so that a mutually beneficial solution can be designed. In addition, generalizing one student's problems to an entire group of students is neither helpful nor appropriate.

Conclusion

Effective precepting is a partnership of the skilled practitioner, the nurse practitioner faculty, and the focused student. While it takes time, it is a rewarding experience for all parties. Students learn best by being given the opportunity to practice in a supportive and realistic environment. The skills of NP graduates are often directly attributable to the quality of the precepted experiences students had while in their program. It is essential for all of us as skilled professionals to take time to prepare the next generation of NPs. In today's productivity-based practice environment, it is often a challenge to provide an effective learning atmosphere; however, implementation of some of these strategies and a bit of planning can produce amazing results.

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