Preceptorship

“Frequently Asked Questions”

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Preceptorship & Nursing Students

“Frequently Asked Questions”

1. **“Who decides if I am a preceptor and how often do I have to be a preceptor?”**
   The Clinical Nurse Manager makes the decision to have Registered Nurses trained as preceptors. Every nurse is required to be a preceptor and can be allocated to a student depending on service needs; normally in the first year of registration staff nurses are given opportunity to consolidate their own learning first. Practice-based learning forms a mandatory and essential component of the professional nursing education to enable students to develop the domains of competence to become safe, caring, competent decision-makers who are willing to accept personal and professional accountability for evidence-based nursing care (www/nmbi.ie). Hence a Registered Nurse is obliged to transmit acquired Professional knowledge, skills and attitudes……..to junior colleagues and nursing students.

2. **“What is my role as preceptor?”**
   “Teacher, Role model and Learning resource.”
   Your role as a preceptor is to act as a resource for information and guiding students through the learning experience in the clinical area. You ultimately act as a role model for the student sharing experiences with them. The role includes providing feedback in a constructive manner as to the progress of the student, and also giving direction as to how to improve, advance and maximise the learning opportunities during the clinical placement. You must, in conjunction with the student decide upon negotiated goals for achievement during the placement and also discuss how to achieve these goals with the student. As a preceptor you must at all times ensure that a quality-learning environment is maintained for the student nurse. As a preceptor or co-preceptor you are obliged to participate in the assessment process.

3. **“What’s in it for me?”**
   “Personal and Professional Development.” Students can bring alternative insight, views and information to each clinical area. Preceptorship further encourages staff to examine daily delivery of patient/client care. On a personal note working with student nurses can enhance job satisfaction and affirm your pre-existing knowledge. As a preceptor you play a significant role in developing our future nurses. This can make a difference not only for patients today, but also for patients in the future. Indeed, something to be proud of!!!

4. **“Can I do an assessment even though I’m the associate preceptor?”**
   Yes there is no operational difference between a preceptor and an associate preceptor. A fundamental issue will be the level of communication between the preceptor and the associate preceptor. It may be necessary where any doubt exists for discourse to occur between the preceptor and the associate preceptor before comment, direction or feedback is delivered to the student. It is necessary to have worked with the Rostered student for a minimum of 12 hours per week. This should equip you with sufficient knowledge to perform an assessment. The associate preceptor may assess how the student is progressing in the following ways. Review the documented interviews and the identified clinical learning outcomes before testing the student’s level of competence. Read back through the students supporting evidence and reflective practice and assess for feedback from Registered Nurses and Clinical Nurse Managers. It is recommended that you look to see what the student has recorded as their strengths and learning needs. This should equip you with sufficient knowledge to perform an assessment. Also, if in doubt, contact the Clinical Placement coordinator / Clinical Development Coordinator covering your area.
5. “When should I do a 1st, 2nd and 3rd interview?”

The 1st interview is ideally carried out on the 1st day. This interview is a getting to know each other meeting. The benefit is for both you and the student. It gives you opportunity to identify your expectations of the student, and it offers the student opportunity to discuss with you what they believe they need to gain from the placement regarding learning outcomes and competencies. If this meeting does not take place early in the placement the student does not know what is required.

The 2nd interview should be as close as possible to mid-week of placement (i.e. end of week 2 or start of week 3 in a 4 week placement. However an additional interview can be organised before this if necessary, where there may be a serious concern. This interview must include student progress with constructive feedback. Negotiated goals from the 1st interview should be discussed. It is important that constructive feedback includes both strengths and weaknesses. The goals are reviewed and new or revised goals may be set. A placement shorter than 3 weeks does not require a 2nd interview.

The following questions may be asked to assess how the student is getting on……..
E.g.
“How do you find writing progress notes?”
“Would you like to tell me about some learning experience by reflecting on a an experience or patient care that you observed?”
“Tell me how you plan to achieve a specific Clinical Learning Outcome ‘How do you find using Risk assessment tools?’

The student should be given specific direction not only on what they need to achieve but also on how they can achieve it at exposure, participation, identification or internalization level as appropriate to their year of programme.

E.g. Not ‘You need to use your initiative’ but perhaps ‘I expect you to use your initiative in the things we have agreed you can do? For instance, ‘you can go ahead and record PEWs / NEWS as long as you feedback to me afterwards’ or “If there is something you think needs to be done but are not sure if you should do it just ask, rather than waiting to be told.’

It is essential that the student be told if they are not meeting the required level of learning (Steinaker & Bell) and that the Clinical Nurse Manager and Clinical Placement Coordinator / Clinical Development Coordinator are informed. (See question no. 8)

The 3rd interview is at the end of the placement. The reflective piece (one per placement) and all the performance criteria is used in conjunction with the supporting evidence to make the final assessment. The Preceptor/Associate Preceptor can utilise all specs of assessment, i.e. observing the student in practice at a particular skill/interaction, by listening to a student giving advice to a patient/client/relative, or by asking the student to present patient care to him/her. To draw and explain using diagrams is also acceptable.

There should be no surprises at this point, as the student should have been given feedback on an ongoing basis. If the student is not meeting the required level of competence the preceptor needs to be present at this meeting (See next question.) If a student does not achieve due to their limitations i.e. knowledge / practice deficit, then an additional support interview should be made available to the student. A review date will be set and if no improvement a Supportive Learning Plan (SLP) is offered to the student. However it may be necessary to go straight to the SLP if necessary and all are in agreement.
6. “When should I activate a Supportive Learning Plan?”
A Supportive Learning Plan is a structured mechanism to support a student who is not achieving competencies during a practice placement. The use of a SLP may reflect either lack of achievement at a rate reasonable for that clinical area for the student’s year of practice, or apparent loss of a student’s earlier level of achievement. Please note that placement duration should have no bearing on the need to initiate a SLP. At all times during the process, each person will demonstrate respect for the dignity of others involved and maintain confidentiality. See guidelines for use of a Supportive Learning Plan on Practice Placement in the student’s UCC booklet.

7. “Where do I get time to do the paperwork?”
The student nurse should approach you and you should agree on a set time to attempt to fill in the paperwork. At this stage advise the student to consider their strengths and learning needs before the interview. It is important that they develop self-insight. Identifying the strengths and learning needs must occur at interviews and if they have not given it some consideration the interview will prove more time consuming. The assessment process can be less time consuming if there is ongoing communication re the student’s learning needs. You can then incorporate these areas into the negotiated goals. Frequent short meetings with the student throughout the placement will make the end assessment much easier to complete as well as keeping communication open between yourself and the student. It is possible to sign off some components of the assessment during a longer placement. The preceptor must liaise with the Clinical Nurse Manager if he/she foresees difficulty in getting time for the interview. The preceptor must inform the Clinical Placement Coordinator also or ask the student to do so.

8. “What should I write about in the supporting evidence and how often?”
Supporting evidence/ additional pages is available for nursing staff to highlight student’s strengths and needs in relation to achieving Learning outcomes, and to supply evidence of the student’s level of learning (Steinaker & Bell). Comments must be based on observable facts not opinion. Each written entry must be conveyed verbally to the student as part of the continuous assessment process. Feedback must be timely; given as close to the event as possible and by the people involved (i.e. not necessarily the preceptor) and based on facts so that the student can learn from the experience.

9 (a). “What level of clinical learning should the student be at?”
Clinical Learning outcomes are assessed against Steinaker and Bell’s (1979) Experiential Taxonomy levels, i.e. Exposure, Participation, Identification and Internalization. If you are unsure of how the student should be performing refer to the Steinaker and Bell’s definitions (this is incorporated in the student UCC booklet). Remember it is not what we individually think Exposure, Participation, Identification and Internalization levels of clinical learning mean, but rather what Steinaker and Bell’s definitions state. This is what enables a non-biased assessment. Further Explanations of these levels will be made available in the BSc student information folders and the Preceptor Support Group folders. Also some wards have prompt cards on student notice boards and in some wards, at the bottom of ‘Learning opportunity ‘page e.g. children’s wards. .

(b). “Is the BSc Children and General Integrated Nursing student and BSc General Nursing Student expected to be at the same level when in General wards?”
Preceptoring and teaching is the same, but assessment criteria depends on what stage each student is at. The general theoretical component of the BSc Children & General Integrated Nursing Student’s programme is the same. You must however be cognisant that the Children & General Integrated Student is completing Two programmes at the same time, so therefore they receive theory at different times and therefore a second year general student is not comparable to a second year Children and General Integrated Nursing Student. The general nursing students may have covered more general nursing in UCC while their C/G student colleagues may have been receiving children’s lectures. So it is always important to ask the student what they have covered in UCC if unsure, and if required cross check with CPC/CDC /link lecturer. On completion of both programmes, both programme graduates will be at the same basic level of competence and function as a safe practitioner – in order to pass their respective programmes and be eligible to apply for registration as a RN in General Nursing.
10. “What can and can’t a student do?”
This is where the delegation aspect of the ‘Scope of Practice’ & ‘Code of Conduct’ documents guides you. See also the Absolute Restrictions in nursing student’s Practice Placement Guidelines and Intern’s guidelines. Before delegating you must ensure that the student has adequate knowledge and skills to carry out the task. This will be influenced somewhat by the stage of the educational programme the student is currently at. You must reinforce with the student that they too have a responsibility to ensure they practice safely within the limits of their own scope/ ability. Ability is determined by knowledge, understanding and learned skill. Students must be supervised and supported in the clinical areas throughout the entire course.

Medication administration without the supervision of a RN remains an absolute restriction even during Internship. Medication management student guideline is clearly outlined in the Interns CUH guide/information book. There is a unique Double checking Competency assessment document that must be completed by intern and RN in the children’s wards. The interns receive this document at the start of internship.

11. “Can I mark a student up to higher than the expected level?”
Yes, it is possible that the student is performing above the required level of competence in some criteria. The CLO and Competency booklets advise the level of clinical Learning Outcomes that the student is expected to achieve over the various Clinical placements throughout the course. The time frame examples will also be made available in the BSc student information folders and the Preceptor Support Group folders. When evaluating competence the assessor must apply the criteria for differing levels of competence as identified by Steinaker and Bell. Although it is important to acknowledge students’ strengths we must reinforce to each student nurse that it is essential that they work within his/her scope of practice.

12. “The student isn’t performing well… Will the Clinical Placement Coordinator / Clinical Development Coordinator speak to the student about this?”
The CPC/CDC would have no problem discussing these issues with the student. However, have you relayed your concerns to the student? It is much more effective and relevant if the staff member involved gives the feedback directly to the student themselves. It is also vital that the problem is communicated with the Clinical Nurse Manager or more senior preceptor before involvement of additional personnel. The CPC/CDC would ask to be kept informed, although action on their behalf may not be required. See next question - how you can best deliver the feedback?

13. “How do I tell a student they are not doing well?”
Be honest and supportive towards the student, as it can prove difficult for any of us to accept feedback in a positive manner. Ensure privacy and dignity for the student in this situation. Students often say that they would prefer to be told directly if there is something they need to improve on and be given guidance on how to achieve this. Be compassionate and direct when giving feedback. Ensure adequate documentation of the discussion is noted in the student’s UCC booklet.

14. “What happens if a student does not achieve?”
We try not to use the word fail. Instead we would say that the student did not reach his/her level of clinical learning in the clinical area. Keep in mind that you are not helping the student in the long term by deeming them competent if in fact there were areas where the student was not at the required level. You must promptly liaise with the CPC/CDC if you feel the student is not progressing, (See guidelines for use of a Supportive Learning Plan on Practice Placement in the Student’s UCC book).
15. “Who looks at these documents?”
All documents have to be returned to UCC by the students and are processed by UCC. The booklets are submitted for each year of the programme and reviewed ahead of the Examination Board.

16. “Are there implications for me as a preceptor if I sign off clinical learning outcomes for a student and it is identified at a later stage that this student is not performing?”
Your entry on the register automatically implies a duty of care to protect the people you care for directly or indirectly. Where the Fitness to Practice Committee is of opinion that there is a prima facie case for holding an inquiry into the incompetence of a newly qualified nurse, you may be called upon to give evidence on oath. Hence the answer is yes. However, if you have given due consideration to this important issue, there will be no further implications for you following the inquiry.

17. “Are there consequences for the profession if I sign off learning outcomes for a student that is not achieving?”
Best quality care would not be implemented and subsequently the reputation of the profession and the public’s confidence in us would be damaged. If in doubt, consider the following:
- Would we want to be cared for by this nurse? If not, why not and if it isn’t good enough for you, why should that be good enough for the patients?
- Would we want this nurse on our team, could we rely on them when the work load is excessive, or are they a liability in times of crisis, or your backup on night duty?

18. “Can I ever give a student the benefit of the doubt?”
If factual objective feedback has been given with clear direction during the placement, a case of “benefit of the doubt” should not arise.
You may consider how your decision to give the “benefit of the doubt” feels when you consider every preceptor that the student has encountered has taken that option. You could also consider the public disgrace that this student might face if dismissed from duty on grounds of incompetence or worse, the loss of their registration and livelihood. Indeed, it would be kinder not to give the “benefit of the doubt”!

19. “What considerations would facilitate students in achieving learning outcomes?”
- Is the clinical placement adequate to support learning? (Auditing is vital)
- Are there adequate clinical placements available to students to assist learning?
- In my role as a preceptor did I facilitate learning for the student? (E.g. prompt the student regarding the learning resources in the ward or clinical area; allow the student to partake in care planning and implementation of care; facilitate interviews with the student and plan how learning outcomes could be achieved etc.)
- Is the student lacking academic or practical ability? (Consider a SLP)
- Has the student worked sufficient hours with his/her preceptor or associate preceptor during their allocation?
- Refer to questions 2, 4, 5, 6, 7, 8, 9; 10 & 11.

20. “Where can I get more information / advice regarding my role as a preceptor and/or issues involving nursing students?”
You may contact the CPC/CDC /link lecturer linked with your ward and he/she will gladly give you any additional information you require or source this information for you. There is information & sample documentation available in the ‘Nursing’ section of the Staff Directory – in the Information for Preceptors and the Nurse Documentation folders. Also some wards have hard copy preceptor / student’s information folders.
21 “Why do students have different UCC booklets”?

In 2018 a new undergraduate nursing student curriculum was launched by NMBI, and with curriculum changes NMBI produced a standardized nursing student booklet document that all colleges have adopted. The 2018 nursing student intake have these new standardized university books. All Nursing students who commenced their course before 2018 will complete their programmes with the college books with which they commenced their programme.

22. “Is there a difference in the new and old nursing students’ assessment process”?  

All Nursing students commencing their programme in 2018 and in future years will have to achieve all the indicators in each performance criteria in each placement, i.e. all domains will be assessed using the two week assessment or three week or over assessment tool. Therefore the student consistently maintains a holistic level of competence including all domains, to progress from one year to the next in the programme.

In the old system, the nursing student had to achieve a specified individual number of CLOs / competencies and therefore all domains were not achieved until the book was due for submission to the exam boards. The CLOs and competencies hence had many more indicators included in the old system.

Both systems are similar in that they use ‘Steinaker and Bell Taxonomy’ levels (exposure, participation, identification or internalization) in the assessment process.

The new system is more reliant on ward specific outcomes to guide learning and does not have a skills section included in the college booklets.

23 “Is there a difference in the scope of nursing students undertaking the new standardized NMBI assessment process?”

The student’s scope remains the same based on - the procedures, actions and processes that all nursing students are allowed to perform when they have adequate knowledge, are assessed as competent and supervised appropriately by a RN.

24. “How long will there be two assessment processes for nursing students?”

The old system will remain until 2017 Nursing students have completed their nurse training.

25. “Who do I contact if I have further questions?”

Any member of the NPDU (CPC/ALO/NPDC) or UCC link lecturer assigned to the ward /clinical area.

Thank You for the support, care and compassion extended to Nursing students as well as CUH patients. You are the student’s role model and their key to connecting Practice to Education...SUCCESS.
CUH Poster Displayed during Preceptor Week

‘Celebrating Nursing Preceptors’
Help Nursing Students Build Clinical Competence, Patient & Family Care

Nurse Preceptor
Experience / Role model

Clinical Role
In Education

Nursing Student
Knowledge /Skill

Supervision
Assessment

New Graduate
Confidence / Competence

“Inspire, Innovate, Influence”

“Care, Compassion, Competence”

Bridging the Gap in Nurse Education

Preceptor

Unique Family
Interdependence
Pride

Problem Solving
Resourceful
Innovative & Creative

Trust, Honesty
Communication
Connection

Patient First
Patient Flow
Patient Advocate

Knowledgeable
Challenged, Skilled
Capable, Effective
Leaders

Child & Family / Patient & Family Centred care

Professional & Composed
Resilience, Reflective Learning
Evidence Based Practice

Nursing Care
Patient Care
Self Care
Team Care

Kindness
Friendship
Loyalty
Teamwork

Futuristic & Modern
Caring & Compassionate
Diversity & Inclusion

Key to
Connecting Practice to Education

C/G Team NPDU - CUH