PRECEPTOR DEVELOPMENT WORKBOOK
A GUIDE TO CLINICAL TEACHING AND LEARNING

This workbook is designed for use in conjunction with the Clinical Transition Framework Preceptor Course. Much of the coursework has transitioned to self-learning modules and web-based delivery, but essential discussion is needed to foster full understanding of the preceptor’s role, responsibilities and effective function. Please contact the VNIP office at office@vnip.org or sboyer@vnip.org for more information regarding use of CTF resources.

TABLE OF CONTENTS

Preceptor Roles/Responsibilities: ......................................................................................... 2
Resources for Program Success ................................................................................................. 3
  Tools: Time to teach ................................................................................................................. 3
  Tools: Program Success vs. Failure ........................................................................................ 3
  Tools: Policies & procedures that guide our practice .............................................................. 4
Engaging Communication & Diversity .................................................................................... 5
  Effective Feedback Skills ...................................................................................................... 7
Using Questions in Communication and Teaching ................................................................. 8
  Generational Issues: .............................................................................................................. 9
Personality Styles ................................................................................................................... 10
  Conflict Management .......................................................................................................... 12
Teaching and Learning ............................................................................................................ 14
  Learning preferences and Styles .......................................................................................... 14
  The Adult Learner ................................................................................................................. 16
  Critical Thinking in healthcare practice .............................................................................. 17
  Strategies to Promote Critical Thinking .............................................................................. 17
  Scoring Key based on Novice to Expert .............................................................................. 18
Clearly Defined Expectations & Competency Development .................................................. 18
  Competence vs. Confidence / Capable vs. Comfortable ..................................................... 19
Putting it all together .............................................................................................................. 24
Challenging Experiences of Precepting .................................................................................. 25
  Possible solutions for challenging experiences ................................................................... 26
Bibliography and Resource list ............................................................................................... 28
**PRECEPTOR ROLES/RESPONSIBILITIES:**

**Protector** – Protects both patient and novice from adverse outcomes
- Ensures safe learning environment for the novice to study and practice in
- Considers licensed scope of practice when assigning and delegating.
- Ensures adherence to policy and procedure (standards of practice)
- Supports developing skills while ensuring safe care, safe practice
- Protects preceptee from adverse behaviors of others
- Protects patients from errors in healthcare delivery
- Protects the novice from making errors that might threaten self/others
- Protects the profession of nursing – as the most trusted of HC professionals

**Evaluator:** Gathers evidence of safe and effective practice capability
- Observes preceptee’s clinical practice to collect evidence of capability level
- Ensures adherence to policy, procedures and standards of practice
- Discusses performance issues/concerns with preceptee & manager
- Documents observations of capability, or lack thereof
- Recognizes capability limitations in self and others
- Identifies delegation and/or accountability concerns
- Ensures that assignments are within scope of practice

**Educator:** Provides instruction and support
- Assesses learning needs & learning style
- Plans learning activities collaboratively
- Implements effective learning plan
- Develops capability of preceptee
- Fosters Critical Thinking development
- Evaluates & communicates progression
- Provides safe environment for experiential learning
- Facilitates progression of “novice towards expert”
- Documents accomplishments & concerns daily

**Facilitator:** Acts as Role Model, Socializer & Team Leader:
- Introduces preceptee to team & other staff.
- Fosters integration into workplace culture
- Provides role model of “How to access the evidence”
- Role models reflective practice, reflective learning
- Acknowledges own limitations and uses available resources
- Helps preceptee settle into new role, environment and team.
- Gives constructive feedback, Speaks for self, Listens attentively
- Resolves issues as they arise; resolves conflict in proactive manner
- Acts as role model for self-development, professional comportment and attitudes
- Supports adjustment to all the new elements that the novice faces within transition
- Ensures consistent communication between manager, novice, and/or educator
- Enlists support of full interdisciplinary team for socialization and orientation process
Resources for Program Success

TOOLS: TIME TO TEACH

Each assigned task requires some amount of time for completion, including precepting a colleague or student. It requires time to teach effectively. It also requires time to observe the practice of the new hire to determine that it is safe, effective, and adheres to agency, practice and professional protocols.

*Advocating for safe/effective care and ‘systems’ change*

*It is our Professional responsibility,* before accepting a task, role or assignment to first determine whether it can be accomplished in a safe and effective manner. At times, it is our professional responsibility to say, “No”, instead of engaging in an attempt to complete something that is unrealistic. A pro-active and professional response includes looking for solutions to accomplish the goal of the assignment. You might respond with, “If I have this full assignment, I will not have time to assess or instruct the learner. Can one or two of my patients be reassigned to allow time for developing the new hire?”

When there is a variance from optimal practice, it is our professional responsibility to document the facts of what occurred. This provides the data required to determine if the occurrence is a variance or a pattern. If it shows a pattern, the documentation reveals a “systems failure” that requires intervention – to assure safe and effective care in the future.

TOOLS: PROGRAM SUCCESS VS. FAILURE

Tools and resources that support Precepting success include the competency assessment (orientation) form, scoring key, having time to teach, time to collect evidence of capability, and having written protocols that define core aspects of both agency and individual responsibilities.

We automatically think of our coaching, preceptorship and/or program as being successful if the orientee or learner can successfully achieve the competencies. But this is only one out of four important endpoints that indicate success within your program and process. It is important to consider all aspects of success in our roles as preceptors or coaches (AACP, 2014; Childs-Kean, Ivy, Gonzales, & McIntryre, 2016; Hsu, Hsieh, Chiu, & Chen, 2014; Mann-Salinas, et al., 2014).

The four endpoints of a SUCCESSFUL program are:

1. Completion of internship or orientation program
2. Safe, competent practice of the new hire or student
3. *Early identification of a ‘mismatch’* between the learner and the clinical practice setting, with guidance to different area of practice.
4. *Early determination* that the individual might be a “threat to patient safety” and termination of their employment.

Program structure, policy statements and competency assessment forms establish the foundation for this success. Consider your own process and protocols. They should support the early identification and determinations that are key indicators of success in your program and role as a coach or preceptor (Chapman, 2014; OKBON, 2014; Omer, Suliman, & Moola, 2016).
TOOLS: POLICIES & PROCEDURES THAT GUIDE OUR PRACTICE

Documentation tools include: job description for role, self-evaluation, program evaluation, weekly planning, feedback, critical thinking development and a competency verification tool that is specific to the clinical practice of the healthcare professional (Beaver, et al., 2016; Brydges, 2016).

Policy statements and protocols provide guidance for our healthcare practice and establish the expectations for both individuals and process within a facility. Preceptees are called upon to work with students, orientees, new graduates and allied healthcare team members in various capacities and the policy statements can provide a road map for the ‘how tos’ (Chapman, 2014; Childs-Kean, Ivy, Gonzales, & McIntryre, 2016; CLN, 2015; Coates & Fraser, 2014; Windey, et al., 2015; Goss, 2015; McClure & Black, 2013).

Reflection: Find and read your agency policies for student management, competency assessment, orientation, and coaching or preceptor program. You may need to look in job descriptions for details regarding role expectations and responsibilities of various team members. (Whitehead, Owen, Henshaw, Beddingham, & Simmons, 2016; Wruble Hakim, et al., 2014; Zittel, Moss, O'Sullivan, & Siek, 2016)

What other roles are outlined and defined?
Are there defined expectations and requirements for students in your agency?
In your opinion, what are the most important guidelines within these protocols?

Taking care of the Clinical Preceptor

Clinical coaches/preceptors need help too. They require basic instruction in the challenging roles that they fulfill; they need resources for teaching, time to evaluate the preceptee, and tools that allow them to complete this work in an effective, practical manner.

Self-Care Realities: There will always be multiple obstacles to self-care.

- Not caring for oneself is not an option if you are going to continue to grow!
- The key to self-care is making an informed choice and accepting responsibility for that choice.
- In your precepting role, you must take care of yourself before you can care for your preceptee.
- You need to role model good self-care practices.
Engaging Communication & Diversity

On completion of this section, participants will be able to:

- List at least 3 communication factors that impact precepting
- Identify potential cultural and diversity issues faced in the workplace and detail solutions for two
- Describe situations that require different conflict resolution approaches within the workplace
- What does appropriate assertiveness look like in the clinical setting – please give an example

Listening

Listening is the most important component of communication. It is hard work. For effective listening we must concentrate and focus on the other person. When we are truly listening – our pulse and BP rise, we may start sweating!

**Speed** - our brain works much faster than we can speak!

Our speech is at an average of 150 words per minute, whereas we think at 400-500 words per minute. What happens in the gap?

We tend to:
- Jump to conclusions
- Daydream
- Plan a reply
- Mentally argue with the speaker

*It is better to remain quiet and be thought a fool then to speak and remove all doubt.*
- Mark Twain

There are two parts to every message:

**Words + Feeling = Full Meaning**

You need to pay attention and respond to both!

The Coach or Preceptor’s ability to listen is crucial. Listen to understand rather than to simply hear, because listening is one of the most powerful and effective behaviors to establish, maintain and nurture any relationship. Those moments when someone truly listens to us are rare and wonderful. There is a reason why we have two ears and one mouth!
Keys to Clear, Effective Communication

- Use clear concise words
- Use language that the listener understands
- Focus on the present
- Choose the right environment
- Choose the right time
- Evaluate your stress level and that of the New Employee
- Be aware of perceptions, both yours and theirs
- Consider cultural differences and preferences in communication

Reflection: Which of these “Keys” to communication offer you the most challenge?

How and why?

Importance of Feedback
Both development and completion of a coaching or teaching plan requires discussion between the preceptor and coachee. This discussion ensures that there are clearly defined expectations, questions are answered, and needed support and assessment of effectiveness is provided.

Feedback is a key part of Managing Performance, Teamwork & Communication. It lets people know how they’re doing and it gets and keeps them on track.

Feedback is most useful when:
- The timing is close
- You describe the behaviors (what you saw/heard)
- You maintain a posture of CURIOSITY and refrain from interpreting
- You balance positives and negatives
- You check for understanding and offer practical ideas and suggestions
EFFECTIVE FEEDBACK SKILLS

Focus on the problem, **NOT** the Person

Be specific, **NOT** general

Emphasize change/improvement, **NOT** BLAME

BUILDS THE RELATIONSHIP

**ACTIVITY:** here is a list of messages that we use in communication

First mark each statement with either “**O**” (Obstructive) or “**F**” (Facilitative) or Use a ? mark to identify the ones you have the most trouble categorizing.

Mark: **O** for Obstructive; **F** for Facilitative; or a ? for unsure

- I want statements
- Communication cut-off
- You should statement
- I feel statement . . . .
- Expressing dissatisfaction through a third party
- Reflective statements . . .
- Agreeing with a criticism
- I intend statement
- Communication postponement
- You are bad or you did something bad statement
- Defending oneself
- I like and don’t like
- Sarcasm
- Open-ended . . .
- Commanding
- Premature advice
- Asking for feedback
- You are good, you did something that was good . . .
- Assuming rather than checking out
- Asking for more specific criticism
- Interrupting statements

**Answer Key:**

Facilitative Messages: I want, I feel statements... I like and don’t like... Reflective statements... Open-ended statements... Agreeing with a criticism... Asking for more specific criticism... Asking for feedback You are good You did something that was good... I intend statement... Communications postponement
Obstructive messages: You are bad or you did something bad  Expressing dissatisfaction thru a third party  Assuming rather than checking out  Communication cut-off  Put-down question  Should, could, would  Sarcasm  Commanding  Premature advice

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**USING QUESTIONS IN COMMUNICATION AND TEACHING**

**We ask questions to:**

- Gain information
- Stimulate conversation
- Gain the others views
- Check agreement / understanding
- Build trust and rapport
- Stimulate thinking

**There are many ways to ask questions.** The way you ask, will bring about different results:

- OPEN ENDED- Helps people think for themselves and gets additional information
- CLOSED: Focuses on specific facts and might limit conversation
- CLARIFYING: Checks for understanding and may help speaker say what they mean
- FOCUSING: zooms in and helps person develop ideas or thoughts in a particular area

**Examples of Effective Questions**

1. What options do you have?
2. What will the outcome be if you do that?
3. What are the pros and cons of your idea?
4. What problems or obstacles are you facing?
5. What are some ways you’ve could deal with them? What else could you do?
6. What assumptions do you have about this problem? How can you test them?
7. How else might you look at this?
8. What worked well? What did not work well?
9. How can you use this knowledge?
10. What did you learn from this experience?
11. How does this relate to _________?
12. What would you do differently next time?
13. How have you drawn these conclusions?
14. What was your reasoning?
15. Where would you find that information, nursing standard, or resources?

**Reflection:** Which of these three steps do you find the most difficult?
If the United States is a melting pot, the cultural stew still has a lot of lumps
- Caring for Patients from Different Cultures, by Geri-Ann Galanti

GENERATIONAL ISSUES:

What do we expect of the novice coming to our area of expertise and what do they expect of us? Times have changed but we do not always recognize the changes and their impact (Weston, 2006).

Generational Cohorts are groups of people with the same birth years and shared core values. These values are shaped by early life influences and significant events within their experience. This includes parents, media, social ‘climate’, and world events.

The generational cohort groupings are getting shorter as our world changes at a faster pace! Along with ‘challenging characteristics’, each brings positives to our workplace:

Reflection: Search out and review an article related to generational issues such as: Integrating Generational Perspectives in Nursing Weston, Maria J. 2006 OJIN Vol. # 11 No. #2, Manuscript 1. available: http://www.nursingworld.org/mods/mod982/generationfull.htm

What concepts within generational cohorts impact your role as a coach or preceptor?

For Americans coming of age now:
Their defining experience is the advent of the Internet. They are coming of age in a time of instant information that is technologically transmitted – which makes them:

- More impersonal in their social relations
- Reliant on e-mail, instant messaging, & pagers.
- Ethnically and racially diverse
- Idealistic and social-cause oriented without being cynical

Communication Tips for Generational Cohorts

<table>
<thead>
<tr>
<th>Traditionalist</th>
<th>Generation X</th>
</tr>
</thead>
<tbody>
<tr>
<td>Show respect for their experience</td>
<td>Talk with them, not to them</td>
</tr>
<tr>
<td>Use more formal language – avoid cursing and slang</td>
<td>Listen to them. You might learn something</td>
</tr>
<tr>
<td>Respect their attention to formality</td>
<td>Provide immediate answers and feedback</td>
</tr>
<tr>
<td>Don’t rush or pressure them</td>
<td>Give them challenges, not “busy work”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Baby Boomer</th>
<th>Generation Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>Honor their experience</td>
<td>Emphasize positives of doing right rather than the negatives of doing wrong</td>
</tr>
<tr>
<td>Ask for their advise</td>
<td>Be positive, simple, rational, factual, and friendly</td>
</tr>
<tr>
<td>Speak in an open, personal style</td>
<td>Mentor them and be realistic</td>
</tr>
<tr>
<td>Offer to partner and get the job done, don’t wait to be asked</td>
<td>Be prepared to offer flexible scheduling</td>
</tr>
</tbody>
</table>
PERSONALITY STYLES impact our communication styles. Personality styles are the characteristics which are most visible and easily identifiable. They describe preferences for our worldview, energy recharging, decision-making and life style choices. Select between the choices on the same line from columns 1 or 2 for each row, then determine which box holds the most checks. This provides a broad impression of your style (CAPT, 2014).

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gather our Energy Source:</strong> Do you prefer to focus on the outer world or on your own inner world?</td>
<td><strong>This is called</strong></td>
</tr>
<tr>
<td>○ Easily distracted</td>
<td><strong>Extraverts (E) or Introverts (I)</strong></td>
</tr>
<tr>
<td>○ Tolerate noise and crowds.</td>
<td>○ Concentrate easily.</td>
</tr>
<tr>
<td>○ Talk more than listen.</td>
<td>○ Avoid crowds, seek peace and quiet.</td>
</tr>
<tr>
<td>○ Meet people readily – join in many activities</td>
<td>○ Listen more than talk.</td>
</tr>
<tr>
<td>○ Blurt things out without thinking</td>
<td>○ Proceed cautiously in meeting people</td>
</tr>
<tr>
<td>○ Parties recharge your batteries</td>
<td>○ Think carefully before speaking.</td>
</tr>
<tr>
<td>○ Hates to do nothing. Always on the go</td>
<td>○ Time alone recharges batteries</td>
</tr>
<tr>
<td>○ Likes working or talking in groups.</td>
<td>○ Loves quiet time, reflective</td>
</tr>
<tr>
<td>○ Seeks the center of attention and/or action.</td>
<td>○ Would prefer to socialize with 1-2 at a time</td>
</tr>
<tr>
<td><strong>Perceiving Function:</strong> Do you prefer to focus on the basic information you take in or would you rather interpret and add meaning?</td>
<td><strong>This is called</strong></td>
</tr>
<tr>
<td>○ Learn new things by imitation &amp; observation</td>
<td><strong>Sensing (S) or iNtuition (N)</strong></td>
</tr>
<tr>
<td>○ Focus on actual experience.</td>
<td>○ Have truth as an objective.</td>
</tr>
<tr>
<td>○ Tend to be specific and literal</td>
<td>○ Decide more with my head.</td>
</tr>
<tr>
<td>○ Give detailed descriptions.</td>
<td>○ Have harmony as a goal.</td>
</tr>
<tr>
<td>○ Behave practically.</td>
<td>○ Decide more with my heart.</td>
</tr>
<tr>
<td>○ Rely on past experiences.</td>
<td>○ Agree with others - people are worth listening to</td>
</tr>
<tr>
<td>○ Likes predictable relationships.</td>
<td>○ Choose tactfulness over truthfulness.</td>
</tr>
<tr>
<td>○ Value standard ways to solve problems.</td>
<td>○ Deal with people compassionately.</td>
</tr>
<tr>
<td>○ Methodical.</td>
<td>○ Expect the world to recognize individual differences</td>
</tr>
<tr>
<td>○ Value realism and common sense.</td>
<td>○ Note how an option has value &amp; affects people</td>
</tr>
<tr>
<td><strong>Judging Function:</strong> When making decisions, do you prefer to first look at logic and consistency or first look at the people and special circumstances?</td>
<td><strong>This is called</strong></td>
</tr>
<tr>
<td>○ Have truth as an objective.</td>
<td><strong>Thinking (T) or Feeling (F)</strong></td>
</tr>
<tr>
<td>○ Decide more with my head.</td>
<td>○ Seek to adapt my life &amp; experience what comes up</td>
</tr>
<tr>
<td>○ Question findings - others may be wrong.</td>
<td>○ Like adapting to new situations.</td>
</tr>
<tr>
<td>○ Choose truthfulness over tactfulness</td>
<td>○ Enjoy starting things</td>
</tr>
<tr>
<td>○ Deal with people firmly, as needed</td>
<td>○ Keep life as flexible as possible - nothing missed</td>
</tr>
<tr>
<td>○ Expect world to run on logical principles</td>
<td>○ Enjoy surprises, like adapting to frequent changes</td>
</tr>
<tr>
<td>○ Note pros &amp; cons of each option</td>
<td>○ See time as a renewable resource</td>
</tr>
<tr>
<td>○ See others' flaws...critical</td>
<td>○ See deadlines as elastic.</td>
</tr>
<tr>
<td>○ May tolerate queries as to emotional state</td>
<td>○ Ignore &quot;to do&quot; list even if made one</td>
</tr>
<tr>
<td>○ Feelings are valid if they're logical.</td>
<td>○ Would rather do whatever comes along</td>
</tr>
<tr>
<td><strong>Life Style Choices:</strong> In dealing with the outside world, do you prefer to get things decided and adhere to the schedule; or do you prefer to stay open to new information and options?</td>
<td><strong>This is called</strong></td>
</tr>
<tr>
<td>○ Prefer life to be decisive, imposing will on it.</td>
<td><strong>Judging (J) or Perceiving (P)</strong></td>
</tr>
<tr>
<td>○ Prefer knowing what they’re getting into</td>
<td>○ Seeks to adapt my life &amp; experience what comes up</td>
</tr>
<tr>
<td>○ Enjoy finishing things</td>
<td>○ Like adapting to new situations.</td>
</tr>
<tr>
<td>○ Work for a settled life, with plans in order.</td>
<td>○ Enjoy starting things</td>
</tr>
<tr>
<td>○ Dislike surprises &amp; want advance warnings.</td>
<td>○ Keep life as flexible as possible - nothing missed</td>
</tr>
<tr>
<td>○ See time as a finite resource</td>
<td>○ Enjoy surprises, like adapting to frequent changes</td>
</tr>
<tr>
<td>○ Take deadlines seriously.</td>
<td>○ See time as a renewable resource</td>
</tr>
<tr>
<td>○ Like checking off &quot;to do&quot; list.</td>
<td>○ See deadlines as elastic.</td>
</tr>
<tr>
<td>○ Feel better with things planned.</td>
<td>○ Ignore &quot;to do&quot; list even if made one</td>
</tr>
<tr>
<td>○ Settled. Organized.</td>
<td>○ Would rather do whatever comes along</td>
</tr>
</tbody>
</table>

Based on this assessment tool, I believe that my personality style is __________________________
Please Hear What I’m saying!”
We tend to hear and communicate from our own Personality style, but to understand each other we need to recognize their style. You can’t change who you are but you can use language in a manner that helps others to understand from their perspective.

There are 16 different Personality Styles:

<table>
<thead>
<tr>
<th>ISTJ</th>
<th>ISFJ</th>
<th>INFJ</th>
<th>INTJ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doing What Should Be done</td>
<td>High Sense of Duty</td>
<td>Inspiration to others</td>
<td>Everything has room for improvement</td>
</tr>
<tr>
<td>ISTP</td>
<td>ISFP</td>
<td>INFP</td>
<td>INTP</td>
</tr>
<tr>
<td>Ready to try anything</td>
<td>Sees much but shares little</td>
<td>Performing noble service to other</td>
<td>A love of problem solving</td>
</tr>
<tr>
<td>ESTP</td>
<td>ESFP</td>
<td>ENFP</td>
<td>ENTP</td>
</tr>
<tr>
<td>The ultimate realists</td>
<td>You only go around once</td>
<td>Giving life a little extra squeeze</td>
<td>Life is full of many challenges</td>
</tr>
<tr>
<td>ESTJ</td>
<td>ESFJ</td>
<td>ENFJ</td>
<td>ENTJ</td>
</tr>
<tr>
<td>Life’s administrator</td>
<td>Hosts and hostesses of the world</td>
<td>Smooth talking persuaders</td>
<td>Natural Born Leaders</td>
</tr>
</tbody>
</table>

WEB RESOURCES FOR LEARNING MORE ABOUT THE PERSONALITY TYPES

Internet web links can be accessed from the VNIP web site: [http://www.vnip.org/links.html](http://www.vnip.org/links.html)
Scroll down on the page and explore the links that take you to further info about personality, conflict management, and learning styles.

What information surprised you regarding your personality and conflict management styles?

How might your learning style impact the instruction that you provide to others?

How do you prefer to communicate with others?
CONFLICT MANAGEMENT

Conflict is an opportunity for resolution, for developing new directions, ideas or expectations!

Many fear conflict, or at the very least, dislike conflict very much. Due to this fear or dislike, many avoid conflict as a negative or detrimental influence. Instead, research shows us that embracing conflict can be valuable to the collaborative process and the human interactions that occur within groups.

Conflict is a common phenomenon, conflict accompanies human interactions. Simmel (1955), insisted that conflict, if regarded comprehensively, is valuable and can be managed to promote positive change. Conflict can be viewed as merely a difference of opinion, ideas or solutions to an issue, problem or situation. But as it intensifies it becomes personalized, emotionalized and complex. Effective conflict management is a vital skill that can be learned.

Conflict style preferences often relate to personality characteristics. There have been more recent efforts to link the Myers-Briggs Type Indicators with conflict management styles (Marion, 1995). Some studies suggest a need for more research on the work culture of health care organizations to better explain nurse’s conflict handling Where is the balancing point for your conflict resolution style?

This matrix looks at two elements of conflict, cooperation and assertiveness. Determine your level of cooperation or assertiveness from high to low in each category you will fit in one of five positions.

Cooperation: how much you are concerned about the needs of others

Assertiveness: how much you will focus on meeting your goals and your needs

Knowing one’s predisposition toward conflict is the first step towards resolution and provides an opportunity to manage conflict creatively. There is no one perfect style. Different situations call for different approaches.
Steps to Managing Diversity or Conflict

**Step One: Treat the Other Person With Respect.**

Respect for another person is an attitude conveyed by specific behaviors such as:

- Article I. How you listen to another
- Article II. How you look at him/her
- Article III. Tone of voice
- Article IV. Selection of words
- Article V. Launder your language. Avoid wording that make it hard for the listener to hear your message.

**Respect** - For many of us, an act of willpower is needed to fight the gravitational pull into disrespect.

A conscious effort must be made to convey respect and instill a sense of worth to all concerned parties. If you find yourself judging you probably are communicating that judgment.

**Step two: Listen**  Listen Until You Have “Experienced the Other Side”

You listen and say back the other person’s ideas or proposals as heard the other person.

- To show that you understand, make a sentence or two which shows the meaning this person wants to put across.
- Concentrate especially on reflecting feelings.
- It is not enough to just hear the other’s emotions.
- They need to be understood and accepted.

When the other person feels heard, you have earned the right to speak and share your point of view and your feelings.

**Step Three: State Your Views, Needs and Feelings**

- State your point of view briefly.
- Use “I” Statements
- State the truth as it really is for you
- Launder your language. Avoid loaded words.
- Don’t make more extreme statements than you really believe.
- Disclose your feelings.
- Until the emotional issues are resolved, the substantive issues probably can’t be settled.
**Crucial Conversations** - We need to engage in ‘crucial conversations’ to ensure safe and effective care of patients. This may require some guidance for some of us and the Vital Smarts website offers excellent advice on how to manage difficult conversations. It is very easy to sign up for the free Crucial Skills Newsletter. “Each week, the Crucial Skills Newsletter brings tips, experiences, and additional instruction to your e-mail inbox from the authors and experts of Change Anything, Crucial Conversations, Crucial Confrontations, and Influencer.” More information can be found at: [http://www.vitalsmarts.com/newsletter.aspx](http://www.vitalsmarts.com/newsletter.aspx)

**TEACHING AND LEARNING**

**Teaching:** You know that learning has occurred when there is a change in behavior or performance.

A fundamental aim of instruction is to facilitate growth in critical thinking, problem solving, and learning to learn. Learners have differing degrees of self-efficacy and awareness of their own learning styles.

**Reflection:** From your own experience as a student, what affects your ability to learn?

**LEARNING PREFERENCES AND STYLES**

As people with different preferences, we all have styles and ways of learning and teaching. We will tend to teach the way we like to learn unless we are aware of the learners’ styles and preferences – and make a conscious effort to present information in a manner that suits the learner’s style, rather than our own.

**VARK** represents several of the ways that we prefer or like to learn. No one person only ever uses just one approach to learning. We use a combination of styles, but we all have preferences.

**Visual learners** - learn best when they have something to look at. Adding pictures, using graphics, and use of color enhances their learning. A book without pictures will lose them quickly.

**Auditory learners** - get more out of lecture, tapes, radio and find it distracting to see things. They are good listeners

**Read/write learners** - love books, taking notes, case studies, journaling and often write in the book.

**Kinesthetic learners** – prefer to be up and doing: experiential learning is a favorite way to learn. They need “to do it” to learn.

The more we understand the style of our preceptee, the more we can tailor our teaching to meet their needs and preferences. We also need to realize that our own preferred style influences the way in which we deliver instruction.

**For example:** Auditory learners tend to assume that the lecture component is very valuable and that everyone wants to hear the words spoken to them.
One style is not better than the other, but each requires different methods to maximize the ease and effectiveness of teaching and learning methods. When instructing someone, the more we vary our teaching methods the more we will engage a variety of learners. Instruction that serves all learning styles is teaching that incorporates multiple delivery methods and allows the learner to choose the methodology that best suits their learning needs and styles.

"Education is what remains after one has forgotten everything one learned in school." - Albert Einstein

Inventory of Learning Styles – Richard Felder (Kolb, 2017; Forehand, 2012; ICES, 2014)

<table>
<thead>
<tr>
<th>Active learners:</th>
<th>Reflective learners:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Understand new information by doing something with it</td>
<td>• Prefer to think about new information before acting on it.</td>
</tr>
<tr>
<td>• Like to try out and experiment with new information</td>
<td>• Need to think through problems before discussing it in groups.</td>
</tr>
<tr>
<td>• Do not like sitting through lectures</td>
<td>• Like to have some ‘time out’ to process and consider new information</td>
</tr>
<tr>
<td>• like interaction and dealing in groups</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Sensing learners:</th>
<th>Intuitive Learners:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Like learning facts and solving problems WITH established methods.</td>
<td>• prefer discovering new relationships</td>
</tr>
<tr>
<td>• process information through the 5 senses</td>
<td>• can be innovative in their approach to problem solving</td>
</tr>
<tr>
<td>• are generally careful, practical and patient</td>
<td>• tend to work faster and dislike repetition</td>
</tr>
<tr>
<td>• Like new knowledge to be practical and connected to the real world.</td>
<td>• Dislike work which involves a lot of memorization and routine calculations.</td>
</tr>
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<table>
<thead>
<tr>
<th>Visual Learners:</th>
<th>Verbal Learners</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Understand new information best by seeing it in the form of pictures, demonstrations, diagrams, charts, films and so on.</td>
<td>• Understand new information best through written and spoken words.</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Sequential Learners:</th>
<th>Global Learners:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• understand new information in linear steps, logical sequence</td>
<td>• Tend to learn in large jumps by absorbing material in a random order without necessarily seeing any connections until they have grasped the whole concept.</td>
</tr>
</tbody>
</table>
THE ADULT LEARNER

Adult learners vary widely among ages, abilities, job experiences, cultural backgrounds and personal goals. They range in educational backgrounds in the amount of basic and advanced education. They have well-developed personal identities and they have a range of personal experiences which are learning resources (Brydges, 2016; Forehand, 2012; Kolb, 2017).

Adult learners tend to be pragmatic learners. They study to improve their performance in other social roles. They let school work take a back seat to other responsibilities; such as family. They expect learning time to be well spent. They hope that learning will help them solve problems in their daily lives.

**Adult learners focus on what they WANT to learn!**
- Are diverse and bring a wealth of experiences to the situation
- Prefer to have some degree of control over their learning
- Experience learning as an active process of construction of meaning
- Need to connect the content to their own meaning structures
- Are influenced in the learning situation by their sense of self

**We learn best when we...**
- Have input into the planning
- Engage in social learning
- Learn from peers as well as from an instructor
- Use various sensory modalities
- Use a variety of ways of thinking
- Experience both individual and group learning
- Associate new learning with prior experiences
- Use prior experiences while further learning occurs
- Have opportunity to apply new info to practical situations in our lives.
- Analyze & expand our needs and learning
- Have a variety of options related to learning styles
  - Receive positive feedback
  - Move from simple to complex
  - Feel comfortable and safe
  - Attempt tasks that allow success
CRITICAL THINKING IN HEALTHCARE PRACTICE

Development of clinical care providers requires moving from textbooks to clinical practice. Experiential learning is essential for the growth of critical thinking skills, as the new care provider needs to experience the individual responses to concepts and skills that are applied in context of actual patient situations.

To support critical thinking development within this experiential learning, you need to know what critical thinking is, what it “looks like” in your practice setting, and how it is developed.

**Reflection:** Find and read at least two articles specific to critical thinking found in health care publications or web sites. (a few quick links can be found at [www.vnip.org/links.html](http://www.vnip.org/links.html))

What was unique, striking, informing within the articles about critical thinking?

What does critical thinking look like in your work setting?

How do we foster critical thinking development when coaching or precepting?

___________________________________________________________________________________________

**STRATEGIES TO PROMOTE CRITICAL THINKING**

It is vitally important that the coach or preceptor focus time, teaching and energy on fostering the development of critical thinking capability in the novice with whom they are working.

One key principle: “Do not answer their questions if you can avoid it”. When we answer their questions, we do their critical thinking for them. It is much more beneficial for the learner if you can ask a question that assists them in finding the answer for themselves.

Here are many tools, techniques and processes that foster the development of critical thinking.

**Discuss**
- What did I miss?
- How could this be made better?
- Why are we doing it this way?

**Case Presentations**
- Reflect & explore practice situations
- Turn errors into opportunities
- What if's?

**Thinking out loud**
- Did you notice…?
- I could do x, y or z but for this patient, I think this is best…?
- What am I missing?
- Put it down on paper.

**Develop and incorporate good habits of inquiry**
- Keep an open mind
- Verify information
- Take enough time to explore situation
- Replace “I don’t know” with “How can we find out?”

**Explore Alternatives**
Replace “I don’t know” with “How can we find out?”
Put it in writing!
Create a concept or mind map.

**Questioning**
- Anticipate questions that others may ask.
- Explore possible consequences. What if we try this?
- Focus on outcome. What is the goal?
- Try to focus on the rationale. Why?
- Explore other alternatives. What else?
If we want them to see how we are thinking, we must practice, “thinking out loud”.

If we want to see how they are thinking, we need to ask questions and foster discussion that reveals and develops their thought process.

*Questions are not judgmental; instead they can foster reflection, encourage new ways of thinking, invite us to tell stories, and expand possibilities.*

The transition from Novice to Expert requires:

- **Belief in their own ability** to perform tasks and procedures
- The ability to **integrate theory and principles in clinical experiences**
- Ability to **determine what the most important aspects** of the situation are
- Movement **from a task-oriented focus to seeing the patient** holistically
  
  *Changing from a detached observer into an involved performer*

### SCORING KEY BASED ON NOVICE TO EXPERT

VNIP applies the concepts of ‘novice to expert’ theory in evaluating competence.

**Performance Scoring**

- Identified Limitation (Novice)
- Capable (Advanced Beginner)
- Performs Independently (Competent)
- Proficient
- Expert

### CLEARLY DEFINED EXPECTATIONS & COMPETENCY DEVELOPMENT

**What is Competence?**

**Reflection:** *What does competence look like in your clinical practice setting?*

*How would you word a definition of competence for your agency’s policy statement?*

Effective healthcare providers require complex combinations of knowledge, performance, skills and attitudes, which makes defining the term more important, but also much more difficult.

You need competence before you can expect to achieve competency. Your competence indicates that you are capable of fulfilling your job responsibilities (Delfino, Williams, Wegener, & Homel, 2014). Competency, however, means that you actually fulfill your job as expected (Lenburg, Abdur-Rahman, Spencer, Boyer, & Klein, 2011; Robbins, et al., 2017).
Competency can be defined as the formal exhibition of a skill, ability, or aptitude of a professional (Beaver, et al., 2016; Kavanagh & Szveda, 2017).

**Self-reporting and self-testing are the least reliable assessments. Conversely, the most reliable assessment is observing actual performance.** (Hawkins & Exstrom, 2014; McDonald, 2014)

**The Gold Standard for Competence validation is observation of actual performance in the clinical setting.**

A SAMPLING OF DEFINITIONS FOR COMPETENCE:

- The quality of being competent or capable of performing an allotted function.
- The quality of being competent; adequacy; possession of required skill, knowledge, qualification, or capacity.
- The individual’s capacity to perform job functions – possession of knowledge, skills, and ability to function in a given field. (Battle Creek Health Systems)
- The effective application of knowledge and skill in the work setting.
- The ability to perform a task with desirable outcomes under the varied circumstances of the real world.

(Benner, 2015; Hsu, Hsieh, Chiu, & Chen, 2014; Lenburg, Abdur-Rahman, Spencer, Boyer, & Klein, 2011; Toth & Ritchey, 2014; Joint Commission, 2016; CLN, 2015; NCSBN, 2015; VT SBON, 2014)

**COMPETENCE VS. CONFIDENCE / CAPABLE VS. COMFORTABLE**

*The new graduate is ‘capable’ long before they are comfortable or confident!*  

Each of these terms shows up in conversations with preceptors and clinical coaches. Without a clear definition of ‘competence’ for your agency, the goals of working with students or orientees remains vague and open for individual interpretation. We may get sidetracked by the issues of confidence, capability, and comfort. During an orientation or limited internship experience, there is rarely time enough to achieve confidence or comfort.

**Success builds success** and lays the foundation for growth in both confidence and comfort with any aspect of care that is being ‘practiced’.

**Comfort and confidence in clinical practice come with experience.** These are not the objectives for the preceptor. The preceptor seeks to observe, and collect evidence of, patient care that is capable, effective, safe, and in adherence to specific protocols.

*The National Council State Boards of Nursing (NCSBN) defines competence as the application of knowledge and the interpersonal, decision-making, and psychomotor skills expected for the nurse’s practice role, within the context of public health, welfare and safety* (NCSBN, 2015).
Assessing Competence requires identifying clearly defined expectations

**Clearly defined expectations** will plainly state the performance expectations for the individual working on a specific unit.

One of the keys to clarity in identifying clearly defined expectations is adhering to the ‘KISS principle’. **KISS stands for – Keep It Short & Simple!**

**Critical behaviors** are the supporting structures of the competency assessment and are the essential actions that one must demonstrate to validate competency.

**They must**: be measurable and specific; applicable for initial and ongoing assessment; define the entire role, but remain realistic & achievable for a new graduate

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**Clearly defined expectations:**

- A competency focus is the primary target of the preceptor
- Documentation of performance is needed for performance appraisal
- Critical thinking component should be evident & integrated into the process
- Interpersonal issues must also be addressed
- Evaluation is based on performance expectations
- Documentation tools provide evidence of meeting actual performance criteria
- The instruction page clearly states the meaning of terms, process for accurate data collection, and the minimum requirements for completion of both the form and the competency assessment.

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**FORM AND PROCESS DIRECTIONS:**

The directions for completing your documentation tool will be found either in policy or on a page of directions that is filed with the form. These must clearly state definitions of words, what is required, by whom, when, what is meant by abbreviations or initials, and what the minimum requirements are for meeting competency expectations.

**The preceptor or coach will gather evidence that the orientee consistently:**

1. Provides safe and effective care according to all applicable protocols
2. Adapts the plan of care to the changing needs and condition of the patient
3. Identifies the limits of their own capability
4. Seeks assistance and/or resources when faced with gap in capability

As you observe the new hire, student, or orientee, you are watching to ensure the last two items in this list. These are the essential items make the difference between safe vs. unsafe practice. It is the individual that will go ahead and act when they are unsure of themselves or the task that may pose a serious threat to patient wellbeing.

It is essential that you are able to answer the question: **Does the new person recognize the limits of their own capability and seek assistance, resources, and/or information accordingly?**
Sampling - A valid and reliable research technique
A valid and reliable approach to competency assessment (Brydges, 2016)

In sampling - specific skills, tasks or aspects of care delivery are selected for evaluation; if the individual is determined to be competent within that sample, it can be extrapolated that they are competent overall. You do not need to see the new person perform every skill, task, procedure or assessment, but if you are using sampling within your process, it must be identified and defined within the protocols and/or directions for the form.

The full identified sample is required for initial competence assessment and is the entry level or baseline for advanced beginner practice. The orientation, internship, residency or transition program documentation should also communicate the entire expectations of their role as a care provider.

Example: You observe the new PT aide assisting a patient with transfer from bed to wheelchair. They complete the task according to all applicable protocols (policies, procedures, standards of practice, etc.); they stop and seek help when questions arise; they look up info appropriately.

This observation is the “evidence of safe and effective clinical practice” in that situation and setting. This will be documented on your competency form as observed performance and the policy or instructions for the form will identify which observations comprise a sufficient sample for concluding overall competence.

Within this example, you have observed the learner transfer a patient in a safe and effective manner. You may extrapolate that they can safely complete other, similar transfers based on this evidence.

Clearly Defined Expectations are essential:
Once the clinical expectations are clarified, assessment of capability can occur. Self-evaluation of expectations starts with the preceptee identifying their capability in the self-evaluation section. The self-assessment is used only for identifying learning needs, not for competence validation. This self-reported capability is verified by observation of clinical practice to validate that the reported capability can be put into action in a safe and consistent manner.

Items that are identified as new or unused skills are the learning needs of the individual. Once these are identified, the learner sets goals for achieving mastery of these skills. You can help them establish realistic goals, but the learner must have the drive to meet the goals and to participate in both the learning and assessment processes.

The clinical coach or preceptor validates performance, measures progress, and identifies the preceptee who may need a different setting for success in practice.

Remember, your number one job is to PROTECT - Your role protects the preceptor, patient, family, agency and colleagues. Communication is required to protect all parties, so provide clear messages or instructions, repeat them, write it down and give on-going feedback (VNIP, 2016).

Competency development includes WRITTEN PLANS for ‘identified limitations’

- Identify the problem
- Create the Action Plan in a collaborative manner
- Achieve team agreement with the plan
- Implement the plan
- Evaluate effectiveness and performance
- Continuously evaluate and communicate
CLINICAL COACHING OR TEACHING PLANS
Engaging in precepting without a plan is like traveling without a road map. You will get somewhere, but there is little to predict where that might be.

Clinical coaching or teaching plans assist the coach or preceptor in organizing the steps and process within the experiential learning program. These written plans provide concrete guidelines for the experiential learning and reflection that occurs during a successful transition program (Delfino, Williams, Wegener, & Homel, 2014; Miraglia & Asselin, 2015; Smith & Pilling, 2007).

Two vital elements of a teaching or precepting plan include:

1) Clearly and concretely defining the expectations and
2) Clarifying the learning resources and process for using them. The learning resources can outline the standardized knowledge that is unique to a specialty area while also identifying assessment tools that may be used by the agency or individual (Toth & Ritchey, 2014).

When creating these written plans, coaches and coachees need to keep key principles of effective teaching and learning in mind. Your success is greater when you:

- **Plan for Success - Remember that success builds success**
- **Progress from simple to complex**
- **Establish clearly defined expectations – put it in writing!**
- **Discuss in advance all expectations for both final performance requirements and the learning strategies for achieving them.**
- **Use story-telling, ‘case scenarios, what-ifs’, questions, & specific discussion time as tools for critical thinking development – leading towards clinical reasoning**

“Field Trips” When developing your instructional or teaching/learning strategies, please consider the “field trips” that might support orientation competencies, holistic care, specialty services, and a better understanding of the continuum of care. This aspect of teaching/learning is where we send the learner or new hire to work with a colleague in another service specialty or to experience a portion of holistic care that is provided in a different location.

**Building a teaching or clinical coaching plan** - The components of a teaching or clinical coaching plan include:

- Directions for completion
- Goal statement
- List of Teaching/Learning Activities that provide directions for the preceptor and the new staff member, student or learner.
- List of performance outcomes statements that provide evidence of meeting the stated goal.
- Space for documentation of meeting the performance criteria
- Determine methodology and/or questions for supporting Critical Thinking development
- Space for documentation of discussion, planning, issues, and success.

**Documentation as a communication issue**
We must document what we observe and do. That means all that we observe and do, as we may be questioned later as to “What happened?”, “What did you see?”
Documentation as a legal issue
We must keep in mind that these principles of communication and documentation apply for both patient care charting and the tracking of progress with the new hire, orientee, or colleague with whom we are working. Having a solid documentation trail can answer all the questions thrown at you at later date when questions about someone practice arise. (Omer, Suliman, & Moola, 2016)

Accountability Statement:
Acceptance of individual responsibility for:

- what is done
- what is not done
- acknowledging limits of capability or knowledge
- seeking assistance, information, or guidance
- personal growth and learning to serve patient & specialty needs  (Whitehead, Owen, Henshaw, Beddingham, & Simmons, 2016; Zittel, Moss, O'Sullivan, & Siek, 2016)

Accountability  As a Preceptor, you are accountable for making appropriate assignments/delegations and for providing appropriate supervision of performance, tasks, skills, assessment and care.

  It takes a whole village to raise a child    - African proverb

Coaching Self-Assessment
Print and complete the ASTD Coaching Self-Assessment Form that can be retrieved at: http://www.ahrq.gov/teamsteppstools/instructor/fundamentals/module9/coachselfasfm.pdf or found via a web search for the title: ASTD Coaching Self-Assessment Form

Reflection:  Complete the Coach’s Plan for Self-Improvement.
Which, if any, of these competencies are especially relevant to your particular coaching role (guide, teacher, motivator, and mentor)?

Which two or three competency areas do you need to improve most?
What steps can you take personally to improve in these areas?
What support do you need to improve in these competencies?
Read through and consider the implications of the case discussion found at: http://webmm.ahrq.gov/case.aspx?caseID=238
PUTTING IT ALL TOGETHER

The Clinical Transition Framework (CTF) engages core theories and concepts to establish a comprehensive, evidence-based approach for supporting students, new graduates and experienced nurses as they experience transitions within healthcare.

Preceptor education and support is a crucial element of the successful transition system. Preceptors apply concepts pertaining to communication skills, giving feedback, conflict management, teamwork, competency validation, sampling theory, accountability, novice to expert, and fostering critical thinking development.

Specifically, the CTF engages universal and unit specific competency tools to detail the clinical performance requirements. Sampling theory is engaged to gather evidence of capability. Transitional evaluation is not complete until an accountability statement summarizes the professional responsibilities and ongoing learning needs of each care provider.

Discussion points and concepts include:

Competence vs. Comfortable

Sampling

What evidence is collected?

Accountability

Professional formation

Clearly defined expectations

Universal vs. Unit specific performance requirements

Tools and resources for precepting

Effective feedback

Roles and responsibilities

Program success factors

Critical thinking development
CHALLENGING EXPERIENCES OF PRECEPTING

POTENTIAL PROBLEMS - An Orientee.....

1. . . . whose performance is progressing too slowly.

2. . . . who overestimates his/her capabilities

3. . . . who underestimates his/her capabilities.

4. . . . who is disorganized or has poor time management skills.

5. . . . who does not seek assistance with unfamiliar skills.

6. . . . that is a “know it all”-ignores coach’s suggestions or direction.

7. . . . that has been shown repeatedly how to perform the skill but continue to perform it incorrectly

8. . . . who continually remarks that a former place of employment had higher/better standards

9. . . . who won’t take any personal responsibility for learning and wants to be spoon fed.

10. . . . who becomes visibly upset when his or her performance is critiqued.

11. . . . who shows no concern after making a grievous or dangerous error.

12. . . . who complains about the quality of the coach’s job skills.

13. . . . who is hesitant and flusters easily, fearing that he/she may make a mistake.

14. . . . who seems preoccupied with his/her personal situation. (takes home to work.)

15. . . . who is experiencing difficulty in relating to his/her co-workers.
POSSIBLE SOLUTIONS FOR CHALLENGING EXPERIENCES . . .

1. . . . whose performance is progressing too slowly.
   - Review target dates
   - Ask orientee what obstacles or reasons progress is slowed
   - Are they aware they are moving slowly? Compare your observations to theirs.
   - Agree on factors that would assist in facilitating completion of orientation.
   - See if you can renegotiate target dates.

2. . . . who overestimates his/her capabilities
   - identify concrete examples in which you think the orientee overestimated his/her abilities.
   - Ask orientee whether they felt they were able to manage these situations or what they thought was expected of them.
   - Why didn’t they request assistance? Anxiety, embarrassment, felt coach was too busy?
   - Have discussion to agree upon when orientee should/should not ask for assistance.
   - Review orientation checklist to see what that person HAS been deemed competent to perform.

3. . . . who underestimates his/her capabilities.
   - Same as above
   - In addition offer generous verbal support.

4. . . . who is disorganized or has poor time management skills.
   - Give 2 examples of this.
   - Ask orientee how he or she determines order of priorities and what factors are considered.
   - Have orientee survey other staff for how they organization and prioritize their work.
   - Reach consensus on how he or she can improve work organization-tools.
   - Assist orientee in planning and prioritizing and see how they do sticking to the plan.

5. . . . who does not seek assistance with unfamiliar skills.
   - Same as those who overestimate their capability

6. . . . that is a “know it all”-ignores the preceptor’s suggestions or direction.
   - This is a difficult one because you are now dealing with EGO.
   - Commend them for what they do know.
   - Minimize threats to their integrity by validating as a colleague instead of teacher/student.
   - Describe a situation where orientee ignored suggestions and discuss possible adverse outcomes.
   - Reach an agreement whereby you could “learn from each other”.

7. . . . that has been shown repeatedly how to perform the skill but continues to perform it incorrectly.
   - Focus on the cause of the problem—WHY AREN’T THEY GETTING IT?
   - Lack of knowledge or motivation, what obstacles may be in place? (physical, operational, attitudes, other?)
   - Ask them to verbalize how to perform the skill step by step.
   - Have them do a mock demonstration.
   - Use alternative teaching method-videotape, computer.
   - Have another instructor review it with them

8. . . . who continually remarks that a former place of employment had higher/better standards
9. **who won’t take any personal responsibility for learning and wants to be spoon fed.**
- Reiterate expectations of orientation including time frame.
- Have unit manager do the same.
- Review completion of responsibilities on a regular basis.
- Identify when goals are not being met.
- Make sure you have benchmarks and have the orientee agree to them.

10. **who becomes visibly upset when his or her performance is critiqued.**
- Find out why they are upset.
- Ask how else it could have been addressed that would not have elicited this response.
- Don’t use negative feedback or personalized criticism; instead emphasize accomplishments and strengths to instill confidence; then target areas that could be improved.
- Keep a box of Kleenex handy and move forward with discussion.

11. **who shows no concern after making a grievous or dangerous error.**
- SERIOUS SITUATION! May pose threat to patient safety – which requires action plan!
- Identify cause of lack of concern.
- Confirm that your perception of lack of concern is accurate (are you reading body language correctly, etc.)
- Maybe they don’t comprehend the nature of the seriousness.
- Have them involved in identifying ways to prevent the error in the future.
- Have them involved in critiquing the error.

12. **who complains about the quality of the coach’s job skills.**
- Private meeting with coach first and if that doesn’t work get third party involved – manager/coordinator.
- What are their complaints, personal, professional, with regard to teaching or nursing skills?
- Don’t get defensive!
- Maybe they need a different coach?

13. **who is hesitant and flusters easily, fearing that he/she may make a mistake.**
- Same as those who underestimates abilities and who become visibly upset when critiqued.
- May need more or alternative instruction.
- Be available.
- Reassure them that you are willing to help them alleviate their fears.
- Assure them of your confidence in them and detail the evidence that shows capability.

14. **who seems preoccupied with his/her personal situation. (takes home to work.)**
- If it’s not affecting work performance then maybe you can just refer them for help.
- If it is affecting performance then may need discussion with manager &/or EAP referral.

15. **who is experiencing difficulty in relating to his/her co-workers.**
- This requires discussion and confrontation with both parties.
- Should be done openly not in private while excluding one party.
- Identify specific issues related to nursing performance not personality.
BIBLIOGRAPHY AND RESOURCE LIST


