Keeping the Center of Nursing Alive: A Framework for Preceptor Discernment and Accountability

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Given the documented challenges of the aging population, the aging nursing workforce, and the predicted shortage of health professionals, there are concerns related to undergraduate nursing students’ readiness for practice as safe and competent registered nurses (Baltimore, 2004; Jackson, Clare, & Mannix, 2002). Furthermore, nurse scholars have voiced concerns related to students’ and new graduates’ taking on a professional identity reflective of the caring ideals of respect, dignity, and accountability in their everyday practice (Flint, 2006; Paton, Martín, McClunie-Trust, & Weir, 2004). The role modeling and professional accountability presented by the registered nurse preceptor has been identified as crucial in nurturing the new graduate’s sense of accountability and respect toward patients, families, colleagues, and other health professionals (Stockhausen, 2005). In addition, Stockhausen contends that the registered nurse in the preceptor role is essential to the student learner’s acquisition of sense of personal identity as a nurse.

BACKGROUND

The ability of the registered nurse preceptor to discern the student’s clinical judgment in relation to prioritizing, intervening, and evaluating care is central to ensuring practice readiness of the student and safe patient care. Preceptor discernment is a complex process of attuning to and assessing the student’s ease and accuracy in clinical decision making and evaluating the student’s ability to practice safely, ethically, and responsibly with patients and their families (Paton, Thompson-Isherwood, & Thirsk, 2009). It is contended that preceptor discernment is experientially acquired through an intentional process of thinking, reflecting, debating, and questioning students’ behaviors in relation to their understandings and intentions within clinical situations.

Registered nurses are most commonly asked to take on the preceptor role as a consequence of their demonstrated clinical expertise, skill, and excellence. Through the process of assessing, watching, guiding, prompting, and evaluating student competence, preceptors acquire knowledge, experience, and wisdom that contribute to unique teaching expertise. This distinctive proficiency is understood as a combination of both educational and clinical discernment. Accurate preceptor discernment is essential not only to ensure competent nursing practice and safe patient care, but also to determine successful
accomplishment of academic courses’ goals. It is argued through the findings of this research, and within the context of this article, that to precept effectively, nurses need to develop additional high-level educational discernment and teaching expertise not acknowledged, understood, supported, or appraised in academic and service institutions.

**RESEARCH**

A substantial body of research-based literature supports the benefits of preceptorship in student learning (Baltimore, 2004; Charleston & Happell, 2005; Hartigan-Rogers, Cobbett, Amirault, & Muise-Davis, 2007; McCarthy, 2006; Myrick & Yonge, 2002). However, minimal research-based literature describes the knowledge, expertise, and wisdom preceptors acquire as they work through challenging, complex, and unpredictable situations with students in everyday practice. This article offers an overview of a triangulated research project, focusing on the unique skill set, expertise, and wisdom of nurse preceptors; the dissemination of the findings of this research through the development of a Southern Alberta Collaborative; and the creation of an educational framework and website to support, extend, and legitimize the nurse preceptor role.

In acknowledging the relationship among preceptor discernment, patient safety, and experiential learning, a Southern Alberta Collaborative encompassing academic, service, and professional regulating bodies was developed, and evolved into the Centralized Preceptor Education Project. The purpose of the collaborative was to create a profile of nurse preceptors and explicate the knowledge acquired and integrated in preceptors’ everyday work life. Two funded research studies were conducted, both as descriptive surveys and interpretive inquiries, exploring and articulating the professional practice of the preceptor. The first phase of the research process involved sending descriptive surveys to approximately 800 preceptors. The second phase involved qualitative interviews with 16 focus groups consisting of three to five preceptors, and 5 individual interviews.

Statistical analysis of the descriptive survey highlighted the demographics, educational preparation, support, challenges, and reasons registered nurses accepted the preceptor role. Although this article’s focus is on the qualitative phase, 66% of preceptors had received basic education from a college or university program, and 34% gained qualifications from a hospital school of nursing. Preceptors in Southern Alberta predominately had 20 to 34 years of clinical nursing experience, whereas the larger urban areas were characterized by two main groups of clinical experience. Analysis showed one group with a high number of preceptors with 2 to 4 years of clinical experience and another group with 30 to 32 years of experience. Although most preceptors had attended a 1-day workshop as preparation for the role within the past 3 years, 69% of preceptors stated they felt unprepared for their role as preceptor. This percentage was even greater in rural areas, where 80% of nurse preceptors reported they were not adequately prepared for the preceptor role. Nurses felt unprepared for assessing and evaluating the competence of student nurses, and often called on colleagues to validate perceptions on student progress. When preceptors were concerned about student progress, they called on their peers to clarify their understandings, seeking faculty advice in less than 25% of these situations (Paton, Robertson, Thirsk, & McKiel, 2006).

Interpretive analysis of the focus groups and individual interviews conducted by the primary investigator and two research assistants involved a process of reading and re-reading the text with the goal of increasing understanding of the challenges and teaching expertise of preceptors. The interpretive analysis, informed by the work of Heidegger (1927/1962), revealed understandings of accountability and professional discernment and accountability in the preceptor role and, ultimately, patient safety (Figure).

**FINDINGS**

Accountable preceptor practice is represented in preceptors’ awareness of their role as a crucial link among academic learning, practical skill acquisition, and student competence in assessment, intervention, and evaluation of patient care. In discovering the responsibilities of the preceptor role, these nurses described the process they went through to find out the basic rules of the “who, what, and how” and the available guidelines for taking on the role. Many preceptors spoke with their work colleagues and faculty advisors to clarify the expectations of the role. Discovering the expectations and lines of communication was essential for the preceptor to accept the request of guiding, assessing, and evaluating undergraduate students during this final practicum.

Preceptors learn about the significance of their actions to student learning, the relevance of discussions with students, colleagues, and other disciplines, and how they reveal caring actions in diverse situations, defining the profession as a practice requiring contextual knowledge. In watching students, preceptors determine not only whether a standard of care is upheld, but also the parameters of safe practice that can be tolerated. If students display practice that is on the border of safe care,
Accountable practice for nurse preceptors is demonstrated by their thinking, challenging, and even agonizing over whether the student’s practice upholds the ideals of respectful, safe, and competent practice. The responsibility of evaluating and reviewing the student’s patient care cannot be overlooked, as one preceptor described: “I think part of it is realizing what our job . . . as a preceptor and as a nurse is . . . that’s a big responsibility.”

In learning to precept, nurses determine whether the student’s practice predominately represents a level of care that is consistent with safe practice. Given that students’ practice is often characterized by fluctuations and hesitation in assessing, intervening, and evaluating patients, patient care, and even standards of care (Patton et al., 2004), assessing it is not an easy task. Furthermore, a student may exhibit little promise or desire for upholding high standards of care (Scanlan, Care, & Gessler, 2001), posing more extensive demands on the preceptor’s ability to negotiate goals, assess learning, and evaluate competence with the student. In the current study, preceptors felt responsible not only for the student successfully meeting the academic requirements, but also for the future professional practices of nurses as reflected in the student’s standard of care. Conserving the relational aspect of the preceptorship, identified as central to effective precepting, requires a high level of educational discernment, clinical expertise, and professional accountability.

The teaching approach a preceptor takes with a student is reflective of how the preceptor perceives the student to learn “best,” the student’s comfort and safety level within the context, and the clinical demands. For example, some students require their preceptor to be at their side, whereas others prefer more independence. Although assumptions exist as to where students should be at particular points in their program, preceptors take on the responsibility of determining where students actually are within the given context and adjust or compromise their own time line to fit students’ needs. Learning to discern where students are and where they should be is time consuming and challenging, particularly when students do not agree or do not demonstrate the expected behaviors.

Preceptors consistently voiced the burden of being responsible for a “weak student.” Inherent to these situations is a tension between helping versus correcting, and guiding versus stopping unsafe practice. One preceptor stated:

I was doing a learning contract with one of my students, and . . . processing (that) was tough stuff. And what was tough about it was correcting, rather than my approach of always being supportive and coaching. Correcting wasn’t in (my) repertoire at the time.

Preceptors are required to adjust not only their timeline, but also their envisioned way of being with students to get them through the rotation and ensure safe practice. The focus on correcting students required different preceptor proficiencies, initially unknown or unfamiliar.

And so I did my own reflections on how does that really support student growth and learning. . . . It was a challenge for me to be challenging them. (Teaching) in this corrective manner was challenging for me. I realized that actually the students learn a lot when we correct them. That’s a good thing . . . . I realized that their liking me wasn’t contingent on my being super nice to them and not challenging them in that way.

Through a process of self-reflection and intentional internal debating, preceptors learned what accountability in this role meant. Ultimately, preceptor accountability involves noticing both the expected and the unexpected, making sound judgments, and ensuring students take on the responsibility of assessing their skills and level of practice. In doing this, preceptors felt they had the chance to “give back to the profession” by upholding standards of care and preventing unsafe practice. Preserving the ideals of ethical, competent, and respectful practice was at the crux of safe practice. Preceptors learned how to conserve the relational aspect of the preceptorship, while getting students to accept this responsibility.

Preceptors talked about the relational challenges that occurred when students could not meet the expectations of the clinical course. A fragmented relationship often resulted in the preceptor withdrawing from the role. As one preceptor described:

I had one challenge, one student in particular . . . on the first day of clinical she’s out there . . . wants to get there with her nursing skills. . . . There was a patient with a walker, and the patient was delusional, and he said that he wanted to walk without his walker. So she took the walker away. And I . . . gasp . . . So we had to have a discussion around patient safety, number one, and around nursing roles. . . . And then later, within a week or so, she went off the unit with a patient who was not allowed off . . . took this patient off the unit, didn’t tell
anybody that she was off unit with this patient. So again we had to have that conversation about safety.

This preceptor described the challenges and the sense of exasperation she experienced in getting the student to “think” about the consequences of her actions and be accountable for her decisions. The assumption that more time would correlate with an increase in the student’s learning and skill acquisition was challenged. Learning happened as the preceptor concluded that the student was not ready to move on as a newly registered nurse, and that this was not a reflection of her clinical or teaching expertise. The challenges, time commitment, and emotional turmoil due to student progression not being as expected cannot be overlooked, particularly in relation to sustaining the nurse in this role.

Preceptors identified the process of evaluating a student, particularly one who is not progressing as expected, as extremely challenging and harmful to their self-esteem. Another preceptor described a situation in which she experienced a sense of disregard, at both the clinical and the teaching discernment levels. The result was a feeling of total loss of self-esteem and a negative perception of her clinical credibility:

The first time I precepted, there was a language barrier. . . . and later it came up that it wasn’t really as much a language barrier as a knowledge barrier. . . . he just hadn’t progressed, and he was making big medication errors and big problems and wasn’t . . . taking feedback . . . wasn’t taking me seriously. . . . He’d go to the faculty and say, ‘Well, it’s her, it’s not me. She doesn’t know what she’s doing . . .’ And so that would make me second guess my practice and my knowledge. And then . . . having heard that from the faculty and having to deal with him one on one again . . . it was very uncomfortable and there was tension. . . . and he was on a learning plan, so in the end I had to say, ‘I’m not going to do this anymore. He’s not progressing anymore.’ So . . . the faculty made the decision not to keep him going after midterm. That [whole experience] really, really turned me off [teaching students]. Like [he] . . . second guessed my knowledge. I’d only been nursing for 3 years. But I thought . . . I was kind of at the point where I can still remember my being a student, so I thought that was an advantage, and I thought I could really bring something to it. . . . and it totally shot me down, pounded me to the ground . . . and it really came up that it wasn’t really as much a language barrier as a knowledge barrier. . . . he just hadn’t progressed, and he was making big medication errors and big problems and wasn’t . . . taking feedback . . . wasn’t taking me seriously. . . . He’d go to the faculty and say, ‘Well, it’s her, it’s not me. She doesn’t know what she’s doing . . .’ And so that would make me second guess my practice and my knowledge. And then . . . having heard that from the faculty and having to deal with him one on one again . . . it was very uncomfortable and there was tension. . . . and he was on a learning plan, so in the end I had to say, ‘I’m not going to do this anymore. He’s not progressing anymore.’ So . . . the faculty made the decision not to keep him going after midterm. That [whole experience] really, really turned me off [teaching students]. Like [he] . . . second guessed my knowledge. I’d only been nursing for 3 years. But I thought . . . I was kind of at the point where I can still remember my being a student, so I thought that was an advantage, and I thought I could really bring something to it. . . . and it totally shot me down, pounded me to the ground . . . and having found (that) the other nurses around me kind of second guessed me as well, because . . . ‘Why isn’t your student doing very well? And why isn’t he progressing?’ Like, it was horrible. I don’t think I would do it again.

Speaking with colleagues and engaging in dialogue about student practice was described as essential for upholding standards of practice, academic understandings, student assessment, and evaluation and, most importantly, for sustaining the nurse in this role. Through engaging with self and others (e.g., colleagues, preceptors, faculty, and health professionals), preceptors re-created them- selves, keeping the center of nursing alive. The faculty advisor responded to the preceptor’s call by respectfully hearing her concerns about herself, her student, and professional practice. Although the faculty advisor e-mailed the preceptor regarding student progress and meeting times, there was a time lapse before a face-to-face conversation occurred.

Engaging with others enabled a deeper level of self-analysis, as expressed by several other preceptors:

. . . then you start taking a step back and you’re like, ‘Well, what do I know? . . . I am young . . . maybe they have a point.’ But then I think, talk with others . . . and consider, ‘No, I’ve had 2 years’ experience. I know what I’m doing. I do a good job.’ And so it took me a while in the beginning, but now . . . youth doesn’t have as much to do with it as knowledge.

Another preceptor said:

And I do a lot of reflection on what’s going on. And then I get my students at the end of every semester to write what’s been helpful, do my own self-evaluation, what’s been helpful, what’s been least helpful, and how did they get challenged? What are they going to walk away with most? So I did my own reflections on how does that really support student growth and learning? What do I want my students to know? What is that whole nursing role? What does nursing mean? That’s how we’re challenging them . . . . That’s how I believe I’m challenging them . . . . And really it comes from last semester when I had to develop my own self-awareness. . . . I really had some challenging students last semester and I spoke with others . . . and that was the most reflective part for me . . . . So it was quite a shift for me in my own thinking. And I think that’s what led into this semester, with my own self-awareness. . . . I encouraged the students to start reflecting on their self-awareness.

Preceptors strive to reveal the ideals of best practice for undergraduate nurses, keeping the center of nursing alive. They are deeply troubled when the ideals of nursing are being, or have been, eroded. Although these situations highlight the challenge of re-creating one’s self after a shattering experience, they also bring forward the importance of the advisor role in the preceptor-advisor-student triad. The advisor needs to be available, to listen to the experience of each preceptor, and to observe the student in the learning experience. The re-creation is a transformation, a re-assembling of the parts, that gives preceptors an opportunity to be reminded of the challenges of learning and the skills of teaching and evaluating students. Through this preceptor transformation, a new creation of self as teacher, assessor, and evaluator is revealed from an old situation.

**DISCUSSION**

In discovering the role of the preceptor, registered nurses identified the need to know what is expected of them, how long the experience will last, and how to de-
termine whether a student meets the requirements of the academic institution. In moving into preceptorship, preceptors described their learning about teaching in practice and their ability to attune to student thinking, notice hesitation, question, comfort, guide, and offer evaluations in a manner that conserves the relational aspect of the preceptor-student encounter. Preceptors discussed talking with colleagues and each other. Regular opportunities to engage with others were seen as paramount in clarifying practice and extending learning for students, as well as improving confidence and teaching expertise for preceptors. Faculty support and the ability to engage with other preceptors during preceptorship are not only comforting, but also essential in relation to future sustainability (Figure).

Through discovering, learning, and engaging, preceptors advanced their teaching expertise in practice. The following framework (Figure) describes the preceptors’ perceptions of learning and advancing in this role in a manner that recognizes the value of basic knowledge, the extension and consolidation through experience, and the wisdom acquired through critical reflection. One preceptor described this as:

So I guess . . . it makes you kind of think, so you develop a higher level of critical thinking, as you do this role, that enables you to zero in . . . right away, and to start probing . . . in different ways.

Preceptors attune to and discern student realities, evaluate student learning, and ensure that safe and competent practice prevails in everyday patient care situations. To precept effectively, registered nurses acquire knowledge, experience, and wisdom that currently are not offered as expounded knowledge. Preceptors take on high levels of accountability to ensure that safe practice prevails. This requires an understanding of academic goals, student behaviors, and practice-based collegiality to discern student thinking and competence.

Standards of nursing evolve and, alternatively, may be eroded. Beneath the call for preceptors to offer something back to the profession is the need to preserve the ideals of respect, dignity, and accountability in everyday practice. At the crux of what really matters for preceptors is the preservation of ideals—the call to a shared humanity that is respectful of caring, yet inclusive of academic goals and professional ethics. Ideals of respect, dignity, and professional accountability in ensuring safe and competent care are unequivocal in preceptor discernment.

The role of the nurse preceptor is challenging. Preceptors are caught between academic goals—often viewed as unrealistic and disconnected from the real world of nursing—and practice policy, guidelines, and timelines. Ultimately, the patient and family are the lodestar guiding the process, as safe and ethical practice overrides all other goals. Challenges are expected in the preceptor role, even when students easily connect theoretical understandings with practical applications; it is, however, proposed that a higher level of attunement, discernment, and accountability is required for nurses to effectively precept and evaluate undergraduate students.

CONCLUSION

Registered nurse preceptors are challenged conceptually, practically, ethically, professionally, academically, and generationally to discern the standards of practice and competence of undergraduate students. Often called on for their clinical expertise, they are now required to help determine whether a student is “fit for practice,” usually with minimal understanding of the undergraduate curriculum, teaching expertise, evaluation criteria, and clinical or academic support.

In speaking with these preceptors, the authors learned of their compassion for nursing, desire to give “something back” to the profession, goals to ensure high-quality care, and need to do well. However, preceptors were often caught in challenging situations, experiencing high levels of inner turmoil before asking for assistance or making a judgment call on student performance. They needed support, clarity, and understanding of their new role, which was distinct from their role as a clinical expert.
This research has highlighted some of the challenges that registered nurse preceptors encounter, the inner turmoil they experience, and the need to support, extend, acknowledge, and legitimize their role. The educational framework (Figure) that the authors have developed is a beginning to this legitimization. The Southern Alberta Collaborative: Centralized Preceptor Education Project (www.cpep-net.ca) is an important step of acknowledgement. It is an intentional act of recognizing the accountability and wisdom these leaders embrace in preserving the ideals of best practice and keeping the center of nursing alive.

key points

Precepting

1 The relational aspect of preceptorship requires a high level of educational discernment, clinical expertise, and professional accountability.

2 Preserving the ideals of ethical, competent, and respectful practice is at the crux of safe practice.

3 Through engaging with self and others (e.g., colleagues, other preceptors, and faculty), preceptors re-create themselves, keeping the center of nursing alive.

4 In discovering, learning, and engaging, preceptors advance their teaching expertise in practice.

REFERENCES