PERCEPTIONS OF INTENSIVE CARE NURSE PRECEPTORS TOWARDS PRECEPTORSHIP

BY

KARLA CANDACE FARSTAD

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To the participants who shared their perceptions, I thank you.

ABSTRACT

This exploratory and descriptive qualitative research study examined the perceptions of preceptors. The participants for the study included six intensive care nurse preceptors. These nurses were presently employed within an intensive care area where the preceptorship method of orientation of students was used. The purpose of this study was to discover the intensive care nurse preceptors' attitudes, values, and beliefs regarding preceptorship.

An ethnographic research design, based on Critical Social Theory as a framework, was utilized as the strategy for data collection and analysis. The three major concepts of democracy, responsibility, and subjectivity were addressed in accordance with the preceptors' perceptions. The primary method of data collection utilized in the study was two semi-structured interviews.

Two major categories reflecting the perceptions of the preceptors were identified by means of the constant comparative method of data analysis: the preceptor role, and the preceptor-student relationship. The preceptors' perspectives of preceptorship were also identified.

The findings revealed that the participants perceived that they had no voice in the determination of their role, and in the selection and evaluation of students. Implications for nursing practice, education, and research are discussed.

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CHAPTER ONE

INTRODUCTION

Orientation of students and graduate nurses to clinical areas has long posed a concern for nursing educators and hospital administrators. Nursing students were previously taught by staff nurses in the clinical area, but their educational needs were subordinate to the needs of the institution (Myrick, 1988a). This resulted in the transfer of nursing student's education away from the hospital setting and into the classroom setting.

Centralized hospital orientation sessions have been traditionally provided to new staff members. In these sessions the institutional philosophy and hospital policies were presented, followed by an informal unit specific orientation which involved learning by trial and error (Shamian & Inhaber, 1985). This method of informal unit-based orientation was found to be inadequate. High staff turnover, reality shock syndrome, early burnout, and a lack of satisfaction with this inefficient informal method of orientation was experienced by both new graduates and senior staff nurses (Shamian & Inhaber, 1985).

As a result of continued expansion of the nurse's role and increased technology in patient care, orientation of nurses has become costly. One method identified to reduce this cost was by means of the development and implementation of preceptor programs (Giles & Moran, 1989; Myrick, 1988a). A second reason for the development of preceptor programs was to bridge the gap between nursing educational programs and the realities of the work place

(Lewis, 1986; Myrick, 1988a; Shamian & Inhaber, 1985).

Preceptorship programs first emerged within the nursing profession during the 1960s with the advent of nurse practitioner programs (Myrick, 1988a; Myrick, 1988b; Zerbe & Lachat, 1991). A preceptorship program is an individualized teaching/learning method where the preceptor and learner work in a one-to-one relationship within the clinical setting (Chickerella & Lutz, 1981). The preceptorship method of orientation differs from the "buddy method", as the buddy method constitutes an informal method of orientation. The use of preceptorship programs has spread to all areas of nursing practice within recent years. These programs were developed to provide one-to-one orientation of students and new graduates to the realities of the work place, as well as to assist with the role transition of students to that of a graduate nurse (Cox, 1988; Itano, Warren, & Ishida, 1987: Reilly & Oermann, 1985; Young, Theriault, & Collins, 1989).

Within the intensive care unit, nurses are often called to act in the role of nurse preceptors to both students and new graduates (Bizek & Oermann, 1990). This added responsibility for nurses working within an already stressful area has not been extensively studied. Several research studies have investigated the effectiveness of preceptorship programs in increasing the clinical competence of students, and assisting with their role transition from student to graduate nurse (Clayton, Broome, & Ellis, 1989; Dobbs, 1988; Giles & Moran, 1989; Itano, Warren, & Ishida, 1987; Shamian & Lemieux, 1984; Scheetz, 1989). Only one study by Bizek and Oermann (1990) looked at job satisfaction in critical care nurse preceptors.

No studies have been conducted that have researched how intensive care nurses feel about preceptorship. This is an important question, particularly in light of continual concerns over recruitment and retention of nurses within this area. High staff turnover within the intensive care area plague the effectiveness of training programs within this area (Begle & Willis, 1984). Research that explores and describes the perceptions of preceptors will provide invaluable insight into how preceptors perceive and implement their preceptor role. This information can then be incorporated into pre-existing and new preceptorship programs to enhance a program's effectiveness. Therefore, by learning how preceptors think and feel about preceptorship programs, programs can be developed to ensure that preceptors are happy and eager to participate in preceptorship programs. Motivated preceptors will result in the additional benefit of making orientation and training of nurses within the intensive care area more attractive and effective.

Statement of the Problem

In order to attain the purpose of this study, the following research problem has been identified: What are intensive care nurse preceptors' thoughts and feelings toward preceptorship?

The following three research questions have been identified to address this research problem:

1. What are the perceptions of intensive care preceptors regarding the characteristics of an ideal preceptor-learner relationship?
2. What are the perceptions of intensive care nurse preceptors in relation to

their responsibility in the preceptor-learner relationship?

3. What external and internal variables affect the intensive care nurse preceptor's perceptions of the preceptor-learner relationship?

Definition of Terms

For the purposes of this study, the following terms are to be utilized as defined:

External variables - factors that are outside the control of the preceptor. Example are administrative and institutional policies such as: scheduling, and budgetary restrictions that affect the preceptorship program.

Intensive care - an acute care setting where patients who are critically ill and require constant observation and intervention by nurses; an area designated within a hospital as either a surgical or medical intensive care unit.

Internal variables - factors that are within the individual, and make he/she react in a particular way to a social situation. These include the values, beliefs, and norms of the individual, and these in turn affect the way the individual will behave or interpret situations.

Learner - a registered nurse who is either a student or new employee within the intensive care unit setting and requires clinical teaching and/or orientation by a preceptor.

Perception - the thoughts and feelings that an individual has toward a social situation based on their experiences. The preceptor thinks and participates in a preceptorship according to their individual perceptions of this situation.

Preceptor - a clinical expert who is assigned and functions as a role model and resource person (Plasse & Lederer, 1981) for students and new employees. This individual shares his/her knowledge and skills with the learner within the clinical setting.

Preceptor-learner relationship - a preceptor and learner working together in a one-to-one relationship (Reilly & Oermann, 1985) within the intensive care unit setting. An individualized teaching/learning method where the preceptor is assigned to a learner within the clinical setting, and where the learner can experience the day -to-day practices within this setting (Chickerella & Lutz, 1981).

Assumptions

The assumptions that underlie the study are the following:

1) a relationship between the preceptor and learner is essential for learning to occur within a preceptorship;

2) preceptors' clinical teaching experiences are based on their perceptions of preceptorships;

3) preceptorships within the intensive care unit are mediated by both external and internal variables.

Conceptual Framework

Critical social theory provides the theoretical basis for the research design of this study. For the purposes of this study the critical social theory outlined by Habermas (1971, 1984, 1987, 1989) has been utilized. Critical social theory was developed to provide a reason for, and rationalization of,

society (Habermas, 1984). The second goal of critical social theory was to create a theory of modernity that analyzed and accounted for societies' redirection and enlightenment over time.

Habermas's critical social theory of communicative action is used as a framework for common understandings which include: norms, values, and situational definitions. "These background meanings are embodied in language, customs, and cultural traditions" (Habermas, 1989, p. 18). According to Habermas (1989), action is an interactive process which incorporates language as a means of communication.

The three major concepts outlined within critical social theory are democracy, responsibility, and subjectivity (Allen, 1990; Habermas, 1984; Habermas, 1987). The first concept of democracy refers to the ability of individuals to have an equal voice within their society. Responsibility refers to the commitment to nurture and assist others to learn and participate, and allow others to speak freely (Allen, 1990). Subjectivity refers to the only true reality as the meaning that an individual attaches to an event, behavior, or situation.

A critical social theory requires communicative action which includes the concepts of democracy, responsibility, and subjectivity. The concepts are not mutually exclusive, as without reason there would not be a democracy, and without traditional norms and values society would not exist. Habermas (1989) noted that the defence of reason or responsibility by an individual to act is inseparable from the project of promoting social order.

Within a preceptorship, the preceptor is responsible for orientation and clinical teaching of a learner. The intensive care nurse preceptor is required to

work within a democratic social order within the health care institution, where there are both external and internal variables that affect the preceptor's ability to work within this role. According to Allen (1990) individuals should be able to speak up without concern. Critical social theory proposes that for a democracy to occur, as in a preceptorship, individual's must feel that their subjectivity to preceptorship is attended to in order for preceptor's to be committed and responsible for the clinical teaching of a learner. Therefore, critical social theory was utilized to guide and direct data collection for this research. This was achieved through the research and interview questions which incorporated the three concepts of democracy, responsibility, and subjectivity.

Organization of the Thesis

Chapter One provides an introduction to the study. This chapter outlines the purpose and need for proceeding with the study. Chapter Two provides a literature review of current issues and research studies involving preceptors and preceptorship programs. Chapter Three describes the research design, including the research methods utilized, the sample population, the setting where the research was conducted, and ethical considerations related to the research. Chapter Four provides a description and analysis of the data obtained from the interviews with the preceptors. Chapter Five includes a discussion of the study findings. This chapter poses recommendations arising from the research findings in relation to nursing practice, education and research. Chapter Six, the final chapter, provides a summary and conclusion of the research report.

CHAPTER TWO
REVIEW OF THE LITERATURE

There are varying opinions concerning the utilization of a literature review within a qualitative research study. Fetterman (1989) identifies the need for the researcher to keep an "open mind" in regard to the group or culture under study, thereby ignoring relevant literature until after the data collection is completed. The opposite position is recommended by Morse (1989) who identifies the literature review in qualitative research as critical, as it allows the researcher to clarify the problem under study. Within qualitative research there is often little known concerning the phenomena under study (Polit & Hungler, 1991) and therefore, the literature review within this study will be somewhat limited.

Staff nurses working in all areas of nursing have developed specific expertise in their area in an effort to provide excellent care for their patient population (Piemme, Kramer, Tack, & Evans, 1986). Preceptorship programs allow for this nursing expertise to be tapped during the orientation of students and new staff members. Several benefits of preceptorship programs have been documented within the literature (Goldenberg, 1987-1988; Mooney, Diver & Schnackel, 1988; Young, Theriault, & Collins, 1989). Davis and Barham (1989) devised a preceptorship model that incorporated the benefits of the preceptorship experience which encompasses the academic program, the practice setting, and the preceptor.

The following chapter will contain a literature review of research findings

pertaining to the concept of preceptorship. The literature review includes a selective examination of the literature pertaining to preceptorship in the areas of nursing, medicine, and dentistry. The literature was screened according to the following criteria:

1) Research studies that have looked at either the student or administrative perspective concerning preceptorships, as this information is enlightening regarding the perceptions of the preceptor.

2) Research based evaluations of preceptorship programs.

3) Research studies that have examined preceptors' perspectives regarding preceptorship programs.

To allow for enhanced clarity in the presentation of these research study findings, the review of the literature is divided into three areas. These areas are derived from the theoretical framework of critical social theory and include: democracy, subjectivity, and responsibility.

Democracy

Democratic preceptorship orientation programs offer equal participation, accessibility and quality of education to all participants. Research which studied the democracy of preceptorship programs includes some which examined the benefits of preceptorship to learning and competency. The concept of democracy also entails enabling those affected by preceptor programs to have a voice in the evaluation of its effectiveness.

Preceptor programs have been praised as being both cost-effective and efficient methods of orientation, but there has been a lack of research studies

that support these assumptions (Giles & Moran, 1989). Therefore, Giles and Moran (1989) conducted a multifaceted study which compared the length of orientation of the preceptor method to the buddy method (an informal system of buddying a staff nurse with a more experienced nurse). The researchers defined the completion of orientation as the time when the orientee could practice independently. An increased length of time of five days in critical care units and six days in specialty units were noted with the preceptor program. The researchers suggested their findings were due to the fact that the buddy method was not structured to meet the individual learning needs of orientees and was often terminated because of decisions related to cost and time requirements of the program, rather than to the needs of the learners. Precepted orientees were found to be more capable of assuming full responsibilities upon completion of the preceptor program than were buddied orientees.

Two studies have investigated the effects of preceptor programs versus traditional buddy orientation programs on staff turnover (Friesen & Conahan, 1980; Giles & Moran, 1989). Friesen and Conahan (1980) found a reduced turnover of 70% in the first year followed by a 75% decrease in the second year of their preceptorship program. A similar reduction in staff turnover rates has also been noted by Giles and Moran (1989). The researchers suggested that costs of preceptorship programs can be offset by savings from decreased staff turnovers (Giles & Moran, 1989).

McGrath and Koewing (1978) conducted an evaluation of a hospital preceptorship orientation program. Towards the end of the preceptorship

program, preceptors met with new graduates in a large group and evaluation comments were requested. The new graduates stated that preceptors were available to them, allowed them to make their own judgments, and the hospital responded favorably to the preceptorship program as evidenced by their continued support of the program. The findings of this evaluation should be assessed in consideration of the fact that the preceptees were required to give their evaluation to the individuals who had functioned as their preceptors. It is questionable that the preceptees felt they could be honest with their evaluators in such a context.

Young, Theriault and Collins (1989) found that 53% of nurse preceptors in their study did not receive recognition from the employing agency for the preceptor role. This finding is consistent with Bizek and Oermann (1990) which determined that recognition and agency support are important factors to consider within the development and implementation of preceptor programs.

A survey of preceptorship programs in acute care hospitals in the Philadelphia area was conducted by Cantwell, Kahn, Lacey, and McLaughlin (1989). They utilized a nonexperimental design in the format of a 25-item questionnaire. Their findings included that only 19 of the 35 preceptor programs had a preceptorship training program for preceptors. Another finding of the study related to the termination of preceptor programs due to several factors: decreased nurses hired; lack of guidance for preceptors and lack of recognition for their efforts; inadequate staffing levels; and the inability of the preceptors to carry out their responsibilities.

The studies reviewed in this category are limited by a number of factors:

(1) they have small sample sizes (e.g., Young et al. (1989) surveyed 19 nurses); (2) lack of replication; and (3) the researchers reached conclusions unsupported by adequate data (e.g., Cantwell et al. (1989) refer to inadequate staffing as a factor determining success of the preceptorship orientation but do not elaborate as to what this means or how the data were obtained). A further limitation of this body of research is the failure of researchers to address the perceptions of other than the preceptor and preceptee regarding the outcomes of a preceptorship program. For example, the perspectives of patients in such a program have not been studied. Other staff members are seldom consulted by researchers as to the effect of a preceptorship orientation on their workload and the functioning of the clinical area. Since the inception of preceptorship programs over a decade ago, there has continued to be a paucity of research based studies conducted which have examined their effectiveness (Scheetz, 1989). Within the last couple of years, there have been an increased number of studies that have evaluated these programs.

One must consider that the nursing profession is not the only profession to have incorporated the preceptorship method or orientation. It has been utilized within the medical, social work, occupational therapy, and education professions (Paterson, 1991). Nursing may have much to learn from the experiences of other professions which have utilized preceptorship. According to Bonnabeau (1985), aspiring physicians since the early 1800s were apprenticed to a preceptor for three years in order for them to receive a medical certificate. Evaluation of medical preceptorship programs have mainly consisted of mailed questionnaires to program participants.

Subjectivity

Subjectivity within this review of the literature focuses on the experiences of the learner and those of the preceptor as they pertain to their participation within a preceptorship program. The meanings that both the preceptor and preceptee attach to the experience of participating in a preceptorship program is explored.

Increased job satisfaction of the preceptor through participation in a preceptorship program has been documented as a benefit of these programs (Goldenberg, 1987-1988; Young, Theriault, & Collins, 1989). Studies have also shown that nurses who have been oriented by the preceptor method have increased satisfaction with their orientation as compared to other nurses who have not been preceptored (Giles & Moran, 1989; McGrath & Princeton, 1987; Mooney, Diver, & Schnackel, 1988).

In the study by Giles and Moran (1989) comparing the buddy method and preceptor method of orientation, 85% of the 37 preceptors expressed increased satisfaction with the preceptor method. The preceptors commented that the preceptorship method of orientation was better organized, monitored and progressed in a logical sequence. Participation by means of the preceptor role stimulated their continued learning and self-development. It has been reported in the literature that preceptors report their preceptor role to be a challenge and an opportunity to share their experiences, opinions, and knowledge (Goldenberg, 1987-1988; Young, Theriault, & Collins, 1989).

Bizek and Oermann (1990) measured job satisfaction in 73 critical care nurse preceptors utilizing a 48-item Likert scale. They found a weak but

significant correlation between level of job satisfaction and amount of perceived support from the agency for the preceptor role (r= 0.265, p= 0.013). They also noted a negative correlation between level of job satisfaction and the number of years of experience in critical care nursing (r= 0.210, p= 0.041). Greatest levels of job satisfaction occurred in intermediate care and emergency units as compared to intensive care units but no rationale for this finding was suggested by the researchers. This is the only preceptor study that has addressed the importance of agency support as a factor in promoting and enhancing job satisfaction.

Young, Theriault and Collins (1989) surveyed 30 nurse preceptors. A total of 19 nurses responded to the interview and survey questions. Utilizing a 21-item questionnaire which utilized a four-point Likert scale, they found that 73% of respondents experienced job enrichment and personal growth as a result of the preceptorship experience. Respondents also felt that the preceptor role increased their knowledge base in the areas of institutional policies and procedures, and provided them with an opportunity to prepare them for future leadership and teaching roles (Young, Theriault, & Collins, 1989). The researchers did not discuss the implications of the low response rate to the validity and reliability of their findings.

An evaluation of a critical care nursing internship program that included 33 new graduates was undertaken by Hartshorn (1992). Data were collected by means of five instruments at the initiation of the program, end of the program, and at four months after completion of the program. The major finding of this study was that the new graduates experienced problems with burnout during

their first year of employment. However, the graduates' reported job satisfaction improved with the length of time of employment (Hartshorn, 1992). This is the only study that investigated the relationship of burnout and preceptorship programs. There was no reported attempt by the researchers to identify variables which may have influences the graduates' job satisfaction (e.g., type of clinical area; staffing in the workplace; acuity in the workplace). There was no comparison made between this group that was preceptored and a group that had not been preceptored.

Giles and Moran (1989) asked nurse managers to respond to a 17-item Likert-type questionnaire designed to measure outcomes of a preceptorship orientation program for newly hired nursing staff. A total of 86% of the respondents reported that they experienced greater satisfaction with the preceptor method compared to the buddy method. They identified that the preceptor program provided more individualized orientation and the new graduates experienced less stress during this transitional period. Staff nurses were surveyed in the Giles and Moran research. One important finding to note from the study was that 84% of staff nurses not acting in the role of a preceptor preferred the preceptor method. They stated that they were interrupted less by the new graduates during the course of the day because of the preceptorship program. Some preceptors in this study were not entirely satisfied with the preceptorship program. Some nurses felt frustrated because they were expected to assume usual workloads while at the same time assume responsibility for precepting. However, in general, nurses have been found to be satisfied with the preceptor role.

Shamian and Lemieux (1984) conducted a study which evaluated a preceptor model compared to a formal teaching model with nurses. Of the entire sample, 130 subjects were enrolled in the preceptor group while 186 subjects were in the formal teaching group. Two self-administered questionnaires, three months apart, were completed by all participants. This questionnaire surveyed the nurses' knowledge of policies and procedures and assessment skills. Findings from this study demonstrated that the learners had an increased acquisition of assessment skills three months following completion of the preceptorship. The researchers considered the effect of extraneous and confounding variables (e.g., previous clinical experience; age; education) on the research findings; they noted that the two groups were homogeneous in their description of the demographic data.

The results of Shamian and Lemieux's study were echoed by Scheetz (1989) who studied the effectiveness of preceptorship programs on the development of clinical competence. Scheetz utilized a nonequivalent comparison group pretest-posttest design in a program where 36 students were preceptored and a control group of 36 students were not. A Clinical Competence Rating Scale (CCRS) was used which revealed that the preceptored group showed a significantly greater gain in clinical competence in all three domains of problem solving, psychomotor skill performance, and application of theory to practice upon completion of the preceptorship program. Reliability and validity measures were provided for the CCRS scale.

A recent study by Oermann and Navin (1991) utilized the CCRS scale. The researchers conducted a descriptive correlational study of nursing

graduates and 24 preceptors. Findings showed that new graduates rated themselves higher on all competencies than did their preceptors in the areas of problem solving, applying theory to practice, and psychomotor performance. A significant negative correlation between age and the nurses' self-ratings was identified. The researchers provided possible rationale for the incongruence in the assessments of the graduates and the preceptors. They identified that the preceptor's evaluations of new graduates may reflect a negative bias in evaluating the performance of new graduates. Further studies comparing preceptor to new graduates must be undertaken to identify the reasons for this discrepancy in order to validate these findings.

Jairath, Costello, Wallace, and Rudy (1991) conducted a quasi-experimental study which involved 22 nursing students immediately prior to their graduation. Of these students, nine took part in a 17-week preceptorship program, while the remaining 13 received the standard pregraduate experience. Schwirian's 6 Dimensional Scale of Nursing Performance was used. Improvements in nursing performance in the preceptorship program occurred within both the teaching/collaboration and planning/evaluation dimensions. Student self-appraisals of professional development after 17 weeks were significantly higher for the experimental/preceptor group than the control group (Jairath, Costello, Wallace, & Rudy, 1991).

According to Giles' and Moran's (1989) research, improvement in preceptor's skills occurs with preceptorship. The researchers utilized a Self-Diagnostic Preceptor Inventory questionnaire and determined that both specialty and critical care nurses experienced an increase in their ability to

precept nurses after attending a preceptorship workshop. The mean score of 129 out of a possible 200 was noted for preceptors prior to the workshop and increased to a mean score of 151 following the workshop. Giles and Moran also noted that critical care nurse preceptors skill levels continued to increase after the workshop, but levelled off for nurses who worked in other areas. The possibility of the Hawthorne effect occurring in this research was not acknowledged by the researchers.

An early study by Friesen and Conahan (1980) found in the questionnaire responses from 26 new graduate nurses that the preceptor system was perceived as beneficial to them and that their only concern was the inconsistent contact with their preceptors due to scheduling differences. These findings were reflected by Pietroni (1981). He found in his evaluation of seven third-year medical residents, rated on a 10 point Likert Scale, that the residents gave an average score of 8.1 when asked about their experience gained from the preceptor program. Only on one occasion did the resident complain about insufficient contact with his preceptor, although another felt that he was imposing on his preceptor. These findings may represent what residents have come to expect in medical education.

In a study of 36 medical students, Coombs, Perell, and Ruckh (1990) found that 81.7% of respondents perceived the preceptor experience to be favorable, exposing them to pertinent and worthwhile experiences. Another study by Jaffe, Friedman and Ritchen (1985) utilized mailed questionnaires to sample both students and preceptors. The findings from both groups were similar: 14 out of 24 students found the program to be positive, as compared to

15 out of the 24 preceptors. These findings present a positive response but at a lesser percentage than the previous study. However, a smaller sample size has been used.

One study by Keenan, Seim, Bland, and Altemeier (1990) investigated a community preceptor program that was a six week elective offered to third and fourth year medical students. The 165 students who participated in this course rated the program as a mean score of 1.358, based on a five point rating scale with "1" being rated as excellent. Over a three year period in which the preceptorship program had been provided, there has been a 97% retention of the 60 preceptors. The researchers suggest that this finding indicates that the preceptors are satisfied with this role. The authors do not state whether or not the preceptors receive any monetary rewards or other rewards that may account for the high retention rate of preceptors.

A larger retrospective study compared 696 surgical medical students in a community preceptorship program with 683 students in a university-based rotation. The findings showed no significant differences in their performance, knowledge, and in departmental examination scores (Rambo, Sosnowski, Othersen, & Lancaster, 1989). These findings are similar to Ressler, Kruger, and Herb (1991) who evaluated a critical care nursing internship program and found that there was no statistical difference between those that had been preceptored and those that had not in the area of job knowledge and clinical performance.

Only one study by Allanach and Jennings (1990) examined anxiety, hostility, and depression among preceptees experienced during the

preceptorship period. Data were collected over 2.5 years from 52 preceptees and they found no statistically significant change in the affective state of the preceptees. This was the only study that looked at the affective states of preceptees or preceptors.

Ferguson and Calder (1993) conducted a study which compared nurse preceptors' and nurse educators' valuing of student clinical performance criteria. The researchers surveyed 126 preceptors and 17 nurse educators. A response rate of 77.7% was reported. The Clinical Competence Criteria Valuing Scale (CCCVS) was utilized which incorporated a six point Likert scale. The researchers determined that educators and preceptors were similar in their valuing of selected performance criteria. However, educators had a higher expectation of student performance than preceptors in the formulation of nursing diagnoses, and incorporation of theoretical knowledge and scientific principles into nursing care. Preceptors expressed higher expectations on organization of equipment and supplies, reflecting a bureaucratic role conception, working cooperatively with others, and adopting skills to client situations. The researchers utilized the entire population of preceptors and educators for their sample, and therefore, the disparity in the sample size was due to this population size.

McGrath and Princeton (1987) evaluated a preceptor program by tape recorded interviews with 21 nurses who completed a preceptor program between 1975 and 1982. One of the research questions asked was, "What are the feelings and attitudes of new graduates toward their preceptors?" (McGrath & Princeton, 1987, p. 134). The researchers found that preceptors were viewed

positively as persons who were readily available to guide, support, and teach them. A qualitative descriptive study was also conducted by Peirce (1991) which utilized open-ended questionnaires to ascertain how undergraduate preceptorial students viewed their clinical experience. Of 44 students, 50% responded to the questionnaire. Major findings from this study included the perceived benefits of students having the opportunity to care for patients in a supportive environment with preceptors who are receptive, and willing to teach and share their knowledge.

Responsibility

Responsibility in preceptorship was investigated by research studies which examined the roles and responsibilities of both the preceptor and preceptee. McGrath and Princeton (1987) stressed the importance of the preceptor role as a teacher and mentor, allowing for the student or new staff member to increase their knowledge base, and at the same time socialize them into their role as a staff member. The role of the preceptor according to Shamian and Inhaber (1985) decreases as the new nurse is socialized into their new environment and the preceptor takes on the role of a resource person. Several studies have been undertaken that examine the socialization of new graduates and students, and the effect preceptorship programs have on their knowledge base (Clayton, Broome, & Ellis, 1989; Dobbs, 1988; Giles & Moran, 1989; Itano, Warren, & Ishida, 1987; Shamian & Lemieux, 1984; Scheetz, 1989).

Socialization of new graduates and students has been noted to be an

important component of preceptor programs (Davis & Barham, 1989; Dobbs, 1988; Hill, 1989; Itano, Warren, & Ishida, 1987; Shamian & Inhaber, 1989). Dobbs (1989) conducted a study of 103 generic baccalaureate nursing students before and after their final course which involved preceptorship. Corwin's Nursing Conception Scale was used in this study. It showed a significant decrease in the total role deprivation score. This decreased total deprivation score refers to the preceptorship method as being a more positive method of orientation where the socialization of nursing students to their new work environment occurs.

Clayton, Broome, and Ellis (1989) performed a quasi-experimental study which researched the effect preceptorship had on the socialization of baccalaureate graduate nurses into the role of a professional nurse. Their sample size consisted of 33 students in the control or traditional group, with 33 students in the treatment or experimental group. Both groups were given the Schwirian Six Dimension Scale of Nursing Performance prior to the course, immediately following the course, and six months after graduation. Findings of the six month follow-up showed significantly higher scores on leadership, teaching/collaboration, interpersonal relations and communication, and planning and evaluation subscales. Although a different scale was used than in Dobbs' (1988) study, the findings are similar. When evaluating the study by Clayton, Broome, and Ellis (1989), it is important to note that there are several problems associated with the Schwirian scale. Mason (1992) noted that high scores may represent the unwillingness by participants to assign low ratings, or that the questionnaire was not sensitive enough to differentiate levels of

competencies.

Although studies by Dobbs (1988) and Clayton, Broome, and Ellis (1989) showed a positive effect of preceptorship programs on socialization of new graduates, Itano, Warren, and Ishida (1987) found no difference. The study by Itano, Warren, and Ishida compared role conceptions and role deprivation of baccalaureate nursing students in a preceptorship program with those in a traditional program. A multiple time series design was utilized with assignment of students into a preceptor program and a non-preceptor control group. The findings indicated no difference in role conceptions or role deprivation in students participating in the preceptorship program and those who did not participate. These studies have exhibited that there is some inconsistency within present research regarding the effect of preceptorship in the socialization of students and nurses. However, the most recent studies demonstrate that preceptorship improve socialization of graduate nurses (Clayton, Broome, & Ellis, 1989; Dobbs, 1988).

A recent study by Shah and Polifroni (1992) explored the responsibilities and perceptions of preceptors. This was the first study that researched preceptors' perceptions regarding their responsibilities. Preceptor responsibilities which were identified included commitment, inclusion in all activities, and accessibility to the students. Examples of these responsibilities included being a facilitator, change agent, teacher, resource, nurturer, director, organizer, monitor, role model and socializer (Shah & Polifroni, 1992, p. 44). Rewards for preceptors were identified as consisting of three levels which include professional, organizational and personal. The professional benefit

included a personal investment in the preparation of the next generation of nurses. Institutional rewards entailed improved community ties. Personal rewards included both intellectual growth and recognition of the preceptor.

The research which examined responsibility in preceptorship has been limited by the failure of researchers to provide information about the scales and survey tools they utilized. As well, the studies have focused on the experience of preceptors, rather than of preceptees.

Summary

Although much of the research in this area is severely limited by its design and small sample size, preceptorship as a method of orientation has been shown to increase job satisfaction, increase clinical competence, promote socialization, and to be an effective means of orientation. Small sample sizes and inconsistent reports within the literature have been noted. Only one study examined the intensive care nurse preceptor population in relation to job satisfaction. Studies have consisted predominantly of quantitative research in relation to clinical competence and socialization of preceptored students, and therefore, the need for qualitative research to explore previously unstudied areas (e.g., perceptions of preceptors regarding their role) are necessary. Research has addressed the importance of preceptorship programs to the students, but few have addressed the perspectives of the preceptor, while none have investigated the perceptions of the intensive care nurse preceptor. Therefore, a descriptive qualitative study focusing on the intensive care nurse's thoughts and feeling toward preceptorship is mandated. This study provided

invaluable information that will assist in improving existing and new preceptorship programs within this area incorporating the preceptors' perspective.

CHAPTER THREE
THE RESEARCH DESIGN

The research method utilized in this research study was selected to identify the perceptions of the subjects in regards to preceptorships in the intensive care unit. An ethnographic research design, based on critical social theory as a framework, was utilized as the strategy for data collection and analysis. Ethnography has its roots in cultural anthropology for the purposes of conducting field research (Spradley, 1979). It allows for the researcher to establish a systematic understanding of the culture under study from the perspective of the subject.

According to Spradley (1979), the core of ethnography is to understand another way of life from the native point of view. Fetterman (1989) also identifies ethnography as the art and science that pertains to describing a culture or group. Ethnography pertains to the every day lives of the individuals under study. "The end product of doing an ethnography is a verbal description of the cultural scenes studied" (Spradley, 1979, p. 21). Ethnographic research provides a holistic perspective of a social group that provides a comprehensive and complete picture of the culture under study (Fetterman, 1989). The major aim of this research was to study the perceptions of intensive care nurse preceptors of preceptorship and therefore, ethnographic research was appropriate to provide the richness of data required to describe these perceptions.

Interviews

The primary method of data collection utilized in the study was through interviews. Fetterman (1989) identifies interviewing as the most important data gathering technique in ethnographic research. According to Wilson (1987) interviews rely on the subject's verbal responses pertaining to their perceptions, experiences, and feelings in regards to the phenomena under study. "Ethnographers use interviews to help classify and organize individual's perception of reality" (Fetterman, 1989, p. 50). The purpose of this study was to discover the intensive care preceptors' attitudes, values, and beliefs regarding preceptorship.

Semi-structured interviews were undertaken as the primary method of data collection for the study. The semi-structured portion of the interview encompassed an exploration of subjects' responses. According to Polit and Hungler (1991) the purpose of the interviewer in semi-structured interviews is to encourage informants to talk freely and allow them the initiative in directing the flow of information. "A structured or semi structured interview is most valuable when the fieldworker comprehends the fundamentals of a community from the 'insider's perspective' " (Fetterman, 1989, p. 48).

According to Spradley (1979), ethnographers must consider the language of the participants when developing interview questions and conducting interviews. As the researcher is an intensive care nurse herself (i.e., an "insider"), the researcher is cognizant of the participants' language and was able to utilize this language within the interview process. A limitation of this insider role is that the researcher may assume too much and not seek

clarification concerning the participants' statements. Another limitation may occur if the participants view the researcher's insider role as that of an expert in nursing education. If the participants view the researcher in this manner, they perceive that she is testing their knowledge or questioning their competence. Strategies to minimize the effect of these limitations are discussed later in this report.

The researcher contacted the individuals who had agreed to participate in the study. A mutually agreed upon time and location was set up for the interviews to take place. Interviews were tape recorded after informed consent (Appendix A) had been obtained from the participant. Interviews were conducted privately in the informants' home. This was identified by Rather (1992) as conducive to the interview process. This allowed for a comfortable and familiar surrounding for the participant which assisted the participant in being more at ease and relaxed during the interviewing process.

Two interviews were conducted with each informant. The first interview took approximately one hour and involved interviewing the participant according to the semi-structured interview guide (Appendix B). The interview was then transcribed by the researcher and a copy of the transcript was sent to the participant for review. The researcher noted statements or terms in the first interview which required further validation and/or clarification. The second interview, following the participant receiving a written transcript of the first interview, involved validating and clarifying the participant's responses made in the first interview. An interview guide provided an outline for the second interview (see Appendix C). At this time, the participant was able to add, delete,

or revise statements made in the first interview. This interview took approximately thirty minutes.

Field notes were taken during and immediately following the interview. The field notes encompassed observations made by the researcher during the interview as well as ideas, mistakes, breakthroughs, and problems that occurred during the fieldwork (Lipson, 1989). This strategy assisted the researcher to remain reflective about her interview style and allowed her to make necessary improvements in the research process during the study. It also assisted her to identify participant's verbal and nonverbal reactions during the interviews which required further clarification or were incongruous to other statements.

The Sample

The participants for the study included six intensive care nurse preceptors. These nurses were presently employed as nurses within an intensive care area where the preceptorship method of orientation of students and new graduates is employed. The Health Sciences Centre and the St. Boniface Hospitals were selected. Applications requesting access were sent to both hospitals. Although due to time restrictions placed on the study, the application for access to Health Sciences centre was withdrawn. Approval for the study was received from St. Boniface Hospital. (See Appendix D).

Upon receiving access to the hospital, the director of nursing for the intensive care area was contacted and permission to request volunteers to participate in the research was received from her. The head nurses of the intensive care units were then contacted by the researcher and asked to list

nurse preceptors who met the study criteria. Head nurses were asked to identify nurse preceptors who met the following criteria for participation in the study:

1) have previously functioned in the role of preceptor within the intensive care area at least twice (i.e., they have precepted at least two nurses)

2) speak English

The head nurses were requested not to discuss the study with their staff. The head nurses referred the researcher to the intensive care nursing (ICU) program, as they did not have the information readily available to them, and they felt that the ICU program would be able to provide the researcher with this information. Names, addresses and telephone numbers of nurses meeting the study criteria were provided to the researcher by the ICU program.

The potential research participants identified on the list were then contacted by the researcher through a letter of explanation (Appendix E) which was mailed to them. The letter of explanation invited them to participate in the study. The letter also provided a description of the study. Potential participants were then contacted by telephone by the researcher after three to five days. A discussion of the nature of the study, and any questions that they may have concerning the study were answered at this time. The participants were then asked if they were willing to participate in the study.

Ethical Considerations

Prior to implementing the research study the proposal for the research study was first reviewed and approved by the Ethical Review Committee of the Faculty of Nursing at the University of Manitoba (see Appendix F). Spradley

(1987) outlined the following ethical considerations pertaining to ethnographic research. These considerations include: 1) consider the participants first; 2) safeguard participant's rights, interests, and sensitivities; 3) communicate research objectives to the participants; 4) protect the privacy of the participants; 5) do not exploit participants (ensure that there is value for participants); and 6) make reports of research available to the participants. These considerations identified by Spradley were utilized within the study. For example, the consent for the study (Appendix A) outlines how the confidentiality of the participants was ensured. The nurses who were identified as meeting the selection criteria for the study received a written description of the study that included the purpose of the research. Prospective participants were made aware of their right to stop the interview process at any time as well as their ability to ask questions of the researcher at any time throughout the interview process.

Privacy and confidentiality of the participants was maintained throughout the research process. The identity of the participants was known only by the researcher. Research committee members were only given the code number assigned to each participant. They did not know the identity of the person that was interviewed in the transcripts. No obvious threats to the participants was experienced. A value to the participants according to Spradley (1979) is that they are provided with the opportunity to assist a student in learning, to contribute to the field of knowledge, and to participate in a research study. Participants who participated in the study were provided with a summary of the study findings.

Data Analysis

Data analysis for the purposes of the research study entailed the utilization of the constant comparative method in the tradition of Glaser and Strauss (1967). The constant comparative method outlined by Glaser and Strauss (1967) encompasses four distinct stages which include: 1) comparing data to each category; 2) integrating categories and their properties; 3) delimiting the developing theory; and 4) writing the theory. Tape recorded interviews were transcribed and the data obtained from these transcriptions underwent the constant comparative method of data analysis. The meanings derived from the interviews were integrated into categories that described the participants' experiences. According to Fetterman (1989) data analysis and data collection within an ethnographic study occur simultaneously. The researcher is the human instrument and must identify the relative worth of the data at every stage of the research prior to any formalized analysis.

Standard methods of measuring external validity are inappropriate in ethnographic research according to Glaser and Strauss (1967). Within an ethnographic study, the participant's validation of emerging categories is a more appropriate measure of validity within this method of research. According to Omery (1988) validity in ethnographic research is achieved through the lengthy stay within the observed culture, the verification of the observations, and the narrative reports of as many participants as possible. The second interview within this study will check the validity of the responses from the first interview and insure the validity of the research findings. Fetterman (1989) states that when the researcher looks for patterns pertaining to the participant's thoughts

and behaviors, they are addressing the issue of reliability within ethnographic research.

Study Limitations

The major limitations of the study related to the nature of the sample population. The six participants for the study were volunteers. Preceptors who volunteered for the study may have different perceptions regarding preceptorship than those who chose not to participate. The preceptors who were willing to participate in the study may have been eager to learn more about preceptorship as compared to those who chose not to participate.

Two tertiary care institutions were initially selected as potential sites for the study. Although due to time restrictions placed on the study, only one site was used for data collection. Therefore, as only one site was used, the perceptions of the preceptors reported in the study may be unique to this one institution.

Another limitation of the study was due to the method of data collection. Interviews were tape recorded. This method of data collection may have made the participants self-conscious and therefore, they may have edited their comments during the interview. One participant repeatedly asked the researcher during the second interview if the tape recorder was on. This participant preferred to make changes to the first interview transcript with the tape recorder off.

Two of the limitations of the study were directly related to the researcher's status. As an ICU nurse and preceptor (i.e., an "insider"), the participants may

have viewed the researcher as an expert in preceptorship. If the participants viewed the researcher in this manner, they may have perceived that she was testing their knowledge. One strategy used by the researcher to minimize the effect of this limitation was through a statement on the letter of explanation and consent form which stated that the researcher did not hold a supervisory position. The researcher made it clear during the interviews that she was only concerned with their perceptions of preceptorship and was not testing their knowledge. As the researcher is an insider, the researcher may have assumed too much and not clarified participants' statements. However, the second interview provided the researcher with an opportunity to clarify participants' statements.

Summary

This chapter has presented the methods of data collection and analysis procedures utilized within the study. An ethnographic study was selected as the research methodology. The constant comparative method of data analysis was undertaken to elicit the meanings derived from the data collected. Ethical considerations have also been presented that were considered within the implementation of the research study. Limitations of the study were also addressed.

CHAPTER FOUR

FINDINGS

The research study entailed an exploration of the experiences of nurse preceptor's within the intensive care area and their perceptions of preceptoring. Two major categories were identified in the research findings: the preceptor role, and the preceptor-student relationship. In this chapter, a number of subcategories will be discussed in relation to these two major categories. This chapter includes a discussion of the preceptors' perspectives regarding their clinical teaching. The preceptor's perspective is defined as the attitudes, values, and beliefs of the participants in regard to precepting. The preceptor's perspectives affected how she implemented teaching within the clinical area, and how she assessed her own performance.

The predominant category in the research findings refers to the way in which the participants perceived their preceptor role. Although many similarities in the participants' perceptions are noted, differences exist in the way in which each preceptor interpreted how this role is to be enacted. Table 1 describes the demographic characteristics of the research participants. All of the participants in this study were female in gender. Five of the participants' educational background was that of a RN diploma. One participant had earned a baccalaureate degree in nursing. Preceptor #2 who had received her BN ascribed to a similar perspective regarding precepting as did Preceptor #4 who had an RN diploma. Primary practice area (e.g., surgical or medical ICU) did not attribute to a difference in the participants' perspectives.

The Preceptor's Perspectives

Perspectives of the six intensive care preceptors regarding their clinical teaching were identified by means of two interviews with each participant. The interviewer explored their thoughts and feelings regarding preceptorship. According to Ames and Ames (1984), the perspectives of teachers regarding their role encompass a system of teacher motivation in which teachers ascribe to different value and goal orientations which result in particular perceptions, attributions, and behaviors in their teaching. These differences in turn affect how the preceptor perceives student success and /or failure, how they attend to the preceptorship of students, and how they evaluate their own performance as a preceptor. The authors have identified three systems of teacher motivation: ability-evaluative, moral responsibility, and task mastery.

The classification system outlined by Ames and Ames (1984) has been utilized for categorizing the preceptor's motivational orientation to clinical teaching within a preceptorship. The perspectives of the six clinical teachers are compared in Appendix G. Five of the six preceptors were classified according to the classification system of Ames and Ames. One of the preceptors did not fit into the aforementioned categories. Preceptor #6 adopted a mentoring-professional identity as outlined by Paterson (1991). Preceptor #3 who ascribed to the ability-evaluative goal orientation had the most years of total nursing experience and intensive care nursing experience. Paterson (1991) has suggested that the ability-evaluative perspective may be indicative of a beginning teacher. However, Preceptor #3 was not a beginning preceptor. Preceptor #6 had one year less total nursing experience than Preceptor #3, but

she ascribed to the mentoring-professional identity goal orientation. Therefore, the participants' perspective was not correlated with education or years of nursing experience.

Central beliefs

Although the six preceptors articulated different goal orientations, they shared some central beliefs regarding the preceptor role. These central beliefs included: being there, presencing, not the final evaluator, and patient as primary focus.

Being There

All preceptors believed that "being there" for students was an integral component of the preceptor role.

> I like to be in control of the situation and I like to feel as if they feel that I am being there for them.

Being there for the student consisted of the preceptor being available for the student when assistance was warranted. Preceptor #6 referred to her view of the preceptor role as "somebody that you (the learner) can look to for guidance." The preceptors in the study also identified the importance of their being available to answer students questions, and being a resource for the students.

"Being there" for students was revealed in the participants' perception of students as their possession. The six participants referred to students that they were precepting as "my student." The participants stated that other staff members recognized their owning of students.

> Staff members are quick to approach me if they have a concern about my student.

Presencing

The six participants expressed the importance of physical presence as a key element within the preceptor role. The preceptors provided several examples where they were not physically able to be with the student and their preceptor role was compromised.

> One of the most negative preceptor experiences that I had was being assigned a patient who was quite sick at the other end of the room from my student. She also had a patient who required a little bit of work. I was just not able to get down and see her all day long. We were on opposite breaks. It worked out very badly.

All examples that identified the lack of physical presence by the preceptor evoked a negative response as the participants felt that they could not assist or evaluate the student effectively when this type of situation occurred.

Not The Final Evaluator

The six participants in the study felt that an important distinction in their role was that they were not to be the final evaluator of the student. Their role was seen as being there to assist the student with their learning within the clinical setting. The advisor was perceived as the one responsible for student evaluations.

> I don't think you as a preceptor should have that control whether a student passes or fails.

> It's not my decision to say if she passes or fails. I'm there to help her as much as possible in my area. It's the instructor's choice to say that she can continue or not. I sort of got comments, "it's up to you to get her out of here." That isn't my role. My role is to help her as much as possible, not to make it hard on her.

Patient as Primary Focus

The participants identified that their first responsibility was to the patient and then to the student. Preceptors were primarily concerned with patient care and patient safety. Preceptor #3 expressed the need for intervention from her superiors if patient wellbeing was jeopardized by a student she was precepting.

> If it was something that was occurring with a patient in the unit that was unsafe or detrimental or something, I would approach my head nurse about it. If it's detrimental to the patient, that's my cutoff point.

Preceptors in general made certain that patient safety was ensured, especially when the student was caring for a critically ill patient. The patient was viewed by all preceptors as being the major focus of their nursing role. Preceptors were hired as staff nurses within the intensive care setting, and participated in the preceptoring of nursing students in addition to their nursing responsibilities. Therefore, their primary role, even while precepting, was that of nurse.

Ability - evaluative

The teacher who ascribed to an ability-evaluative goal orientation attempts to maintain a sense of self-worth of his/her ability to teach (Ames & Ames, 1984). The student is blamed for negative outcomes or student failure, and the teacher is credited with student success. Preceptor #3 identified many of the behaviors associated with the ability-evaluative category. She described her primary role as being responsible to the student that she was assigned to.

> Well, how I see it being a preceptor is primarily being there for the student; one specific person that she feels comfortable going to ask questions; kind of being a student's friend.

In addition, Preceptor #3 also stated that she had a "great deal of responsibility

towards that student and the patient that she is looking after."

Preceptor #3 described that in her role as a preceptor she was allotted control of the preceptor-student relationship. She demonstrated this by her active involvement in "keeping track along with the student of what kind of experiences they haven't had," and arranging the assignment of students to patients in which they needed the experience. Nursing staff in the unit were viewed as bearers of information about the student to Preceptor #3. However, they were not expected to directly intervene with students.

She regularly attempted to seek out learning experiences for students, and offered her expertise and knowledge to the student to assist in the student's learning. Her major premise was that students needed her presence and intervention in order to avoid making mistakes.

> Several times I've said why don't you keep the patient to one side of me. My patient isn't too heavy, and we really haven't been situated close by. I won't let you do anything bad with this patient. Nothing is going to happen. The student has had a very good experience.

Having students assigned to patients close to her enabled her to demonstrate her own ability to students and to protect them from errors.

Preceptor #3 stated she played an active role in the learning experiences of students, but would "step in" if she felt the care that was being provided was not sufficient.

> If I identify a problem and it's not a life threatening situation I will not interrupt the student or embarrass the student in front of the patient or another nurse or whatever. If it was going to be detrimental to the patient I would actually put my hand out and stop the student from doing it. Usually because we have such good rapport she'll know that I'm not doing that to embarrass her or something. She'll stop what she's doing and I'll say lets do it this way. I try not to take control of the student's

patient unless there's really good reason for it.

Situations which involved the learner not progressing well, despite her interventions, resulted in Preceptor #3 questioning the student's ability to be a ICU nurse. However, one situation involving a student who had failed the program resulted in her questioning her ability as a preceptor. She referred to a precepting situation in which the end result was that the student was asked to leave the program. The student had threatened to involve a lawyer.

> I'm just kind of precepting out of the goodness of my heart here. Do I really want to get involved with things like this?
>
> That was very frustrating and scary, and it made me doubt my own worth as a nurse and a preceptor.

Moral Responsibility

The teacher with the moral responsibility orientation blames negative outcomes on herself/himself, and the student is credited for positive outcomes (Ames & Ames, 1984). The major focus within this system is the welfare of the student, and the facilitation of their learning. Two participants (#2 and #4) attested to this goal orientation. Preceptor #2 viewed her role as a preceptor in relation to students as "helping them to attain a higher level of function." She revealed her thoughts concerning the preceptor role.

> In my perception, the preceptor role is mainly a role of mentorship; primary function is to socialize the student, and make them comfortable in the setting first and foremost.

Preceptor #2 made decisions independently, but decisions were usually made in consultation with the student.

> Tomorrow if you have a choice of this patient or a patient in CCU. Do you

have any preference as to where you would like to be?

Preceptors #2 and #4 expressed the need to stay "in touch with the comfort level" of the student within the clinical area.

> Sometimes you have to push them a little bit and say I"m sure you can do this and why don't you do this.
> Be in touch with them. Because if you are not in touch with their level of comfort you push them into a bad situation.

In addition, Preceptor #4 reflected on the importance to students of the promotion of their comfort within the intensive care unit.

> It sort of made me stop and realise how important we are to the student sometimes. That us just being there and maybe not that we are not actually really doing anything, how much more comfortable when we are there.

Unlike Preceptor #3, Preceptor #2 and #4 both asked for collaborative support from other staff members in evaluating student progress when they were physically apart from the student.

> Often times I will ask those people that I feel confident about their judgment, if they're working side by side with the student, I will ask them what kinds of things went on during the day, if I've been really busy and unable to observe myself. Or the head nurse if she's been around, she can give me an idea of how the student did with their head to toe at rounds.

The preceptor was perceived by Preceptor #2 and #4 as being responsible for student errors.

> I felt firstly, as if should I have been over there, or should I have spoken to her about this. Secondly, it was deciding who would speak to the student whether me or the nurse who had identified the problem. You took it as a personal reflection upon yourself because you are this student's preceptor and was almost a reflection upon you and your role as a preceptor. I took it to be my problem too.

This perception by preceptors of being responsible for student errors is indicative of the moral responsibility goal orientation.

Task Mastery

The teacher who ascribes to the task mastery orientation has his/her values externally oriented toward the task undertaken (Ames & Ames, 1984). The major concern within this orientation is what the educational goals are, and how these goals should be met for the students. Preceptor #1 and #5 demonstrated a task-mastery goal orientation in their preceptoring of students in the clinical area. Their primary focus was to provide students with learning experiences that would achieve the learning goals of the intensive care program. They perceived student performance as "everything."

> Any concerns that I ever had would be related to performance or clinical. Other than that it is not important. If they're doing their job it doesn't matter.

Preceptor #1 saw herself as having a "high degree of control" in the preceptor-learner relationship. She ensured that students were providing patients with safe and quality care at all times.

> If I see that a student is struggling, I'll step in. I make sure that I keep tabs on the student either directly or indirectly. I would never let a situation get out of control especially when there's going to be patient involvement.

Preceptor #1 and #5 promoted student learning experiences through the arrangement of patient assignments in accordance with the needs of the student.

> I had identified one student that had required a little more work. She hadn't had much experience admitting a fresh heart. I thought she should get more experience. It worked out okay. I had a better idea after seeing her in action.

Preceptor #5 described her role as a preceptor as a facilitator of student learning.

> The way I approach it is I am there to help the student adjust to the clinical area; give them guidance when required. I am not there in a teaching role, that's the teacher's position. I help them with the day to day things, and I will ensure that they are giving safe care. A facilitator, and just to be there as a resource person for the student. To make sure if they have questions that there is someone they can go to.

Nursing staff were viewed by Preceptor #1 as bearers of information about the student to the preceptor.

> If I had a real concern about someone (student) then I would approach that preceptor and to ask her what her perceptions are, and if she has noticed this as well.

Preceptor #5 envisioned the staff nurses' role as assisting the preceptor to provide students with sufficient learning opportunities, and to observe the student in her absence.

Preceptor #1 attributed student success and mastery in relation to her participation in the student's learning.

> I like to see people excel, not just pass but really learn something. If I can participate that makes me feel wonderful.

Mentoring - Professional Identity

Although the categories of goal orientation outlined by Ames and Ames have been used to represent the perspectives of five of the preceptors, the perspective of Preceptor #6 was not represented by these categories. She adopted a mentoring-professional perspective similar to that identified by Paterson (1991). In this perspective, the teacher's primary concern is to enable students to develop their own personal and professional identity. Preceptor #6

provided the student with the opportunity to specify what type of learning experience he/she would like.

> I found it's important near the beginning to get your learner to sit down and talk about the kinds of things that are detrimental to their learning experience. How they like to be taught. Do you want somebody there asking you questions, challenging you? Do you want to come to me as a resource; come to me when you have problems?

Preceptor #6 identified her primary role as a preceptor as being a "mentor" as compared to a teacher.

> I guess a preceptorship role I've always seen it as being a mentor because in fact you are both nurses. More peers than a student-teacher role. Somebody there for guidance. Not standing over their shoulder and checking everything they do. More as somebody to come to when you have problems. Check this out or you don't quite understand. I see it more like a buddy than a sort of student-teacher role.

She also saw her role as a promoter of student learning. This was evidenced by her assignment of patients within the clinical area. She would examine the assignment sheet to see what patients were being admitted that day. When students admitted a patient undergoing open heart surgery one day, she would arrange for the student to follow through their care of the patient on the next day. As well, she described the importance of negotiating with other nurses to enhance student learning.

> Just make sure that the person is assigned to patients that are going to give them a good learning experience.
>
> If there is something going on that is very interesting, I will go out of my way to get them involved with that particular experience. On the other hand, if there's a nurse at that bedside who doesn't want that particular person involved, I think you'd have to negotiate a bit.

Preceptor #6 utilized a collaborative approach with the advisors in the

ICU program to discuss problems that she was having with a student in order to discover the underlying cause.

> If there's problems you talk about what the problem was; various things that could have affected, influenced the problem whatever it was. Example: Having a bad day. Patients just very difficult. They haven't had that kind of a patient before. There are lots of things that influence what people do.

Her collaborative approach to identifying student problems involved the identification of the underlying problem, and not just evaluating the end result of a particular situation.

Preceptor #6 attributed student performance and failure as a direct reflection on her. She described her perception of student failure.

> I think they're significant because you feel, um, how the learner does is a direct reflection on your ability to precept somebody.

All of the behaviors demonstrated by Preceptor #6 were indicative of the mentoring-professional identity goal orientation.

The perspectives of six preceptors have been discussed within this section according to the categories outlined by Ames and Ames (1984). Not all of the interview data fit neatly into the categories (e.g., Preceptor #3 demonstrated some task mastery too). In addition, Preceptor #6 did not ascribe to the goal orientations outlined by Ames and Ames. The perspective of each preceptor appeared to have a direct influence on their clinical teaching within the intensive care unit. The attributes of each perspective promote specific learning within the preceptor-student relationship. Therefore, one cannot say that there is only one exemplary perspective of clinical teaching.

Professional Identity

The professional identity of the nurse influences how the preceptor teaches within the clinical area. The primary focus of a nurse is to care for the patient, and to be responsible to them. The teacher's primary concern is to the student. According to Paterson (1991), when one is a clinical teacher in nursing there may be a conflict of primary focus because one is both a nurse and a teacher. All six preceptors in the study ascribed to a nurse-teacher identity within the preceptor role.

The nurse-teacher role in clinical teaching involves the student learning through observing and participating in the care of patients with the preceptor. Preceptors are often assigned their own patient, and at the same time, participate in the direct patient care being provided by the student. The preceptors indicated that they worked with the student to ensure the student's learning experiences.

> If there was a situation happening I would grab both students and say 'come on over there'. The situation was a 99 and I grabbed both students to come over and I happen to be on 99's that day. I stood at the head of the bed and suggested what each of them do very calmly. I think it worked really well. I was able to direct the situation. The students were both able to defibrillate. They were both able to monitor rhythms and check pulse, able to administer drugs.

The Preceptor - Student Relationship

Although the participants perceived the preceptor role in certain ways, they identified several factors that influenced their relationship with students. This section will describe the perceptions of the participants as they relate to the

preceptor-student relationship. How preceptors interact with students is determined to a significant degree by how they perceive their preceptor role: i.e., their goal orientation. Within this section, the following subcategories will be described: enacting the relationship, and mediating variables.

Enacting the Relationship

Setting the Stage

The participants identified the importance of setting the stage for the preceptor-student relationship. Setting the stage entailed forming a relationship with the student and providing the student with basic knowledge as a foundation for their performance in the unit. Preceptor #2 who ascribed to the moral responsibility goal orientation described the importance of forming a relationship with the student.

> I usually start the relationship by contracting with the student as to what their needs, concerns, wants, priority needs they have for their learning, skills, etc. They identify for me their goals, and I tell them in return what I perceive my role to be. We set the basis there for our relationship.

The need for starting the relationship on the "right foot" was echoed by Preceptor #1.

> It is right at the beginning when the students are their most insecure and don't know where anything is and those kinds of things. So if you can really get off on the right foot it makes it so much easier for them.

In addition, Preceptor #5 also identified the importance of knowing the student's educational and nursing background prior to starting the preceptor-learner relationship in order that she could identify the student's learning needs.

Expectations for Helping

Certain student characteristics were identified by the participants as

necessary to effect a preceptor-student relationship which would result in student success. According to Preceptor #3, students should be truthful, trustworthy, and not defensive. Preceptor #6 further added that students should be highly motivated and extroverts. These characteristics were seen as potentiating the preceptor-student relationship. The helping behaviors of the preceptors in regards to the students were determined by the presence or absence of these characteristics.

Preceptor #1 reported an incident in which the student did not demonstrate help seeking behavior. Not seeking help from the preceptor was regarded as evidence of the student's lack of motivation. In addition to the help seeking behavior of students, Preceptor #1 expressed the expectation that students would follow her advice, and that she should only have to correct something once.

> Well, usually I just have to diplomatically point something like this out once, and it takes 99% of the time because students are very insecure and you know you just have to mention something to them once and that's all it takes.

Preceptor #1 stated she would encourage learning experiences for students, but if they did not demonstrate help seeking behavior or exhibited avoidance or lack of effort, the preceptor would withdraw her help. In the following incident, a patient in the unit was on an intra-aortic balloon pump (IABP) and the student was asked by Preceptor #1 if she would like to review the balloon pump with the preceptor. The IABP is a mechanical device which provides circulatory assistance to the heart.

> The student answered, "oh yeah, well if I get to it." That's how she spoke to me. She never did approach me to go over the balloon pump so I

> wasn't particularly impressed with that , and after that I didn't approach her with new situations. I was more hesitant to do so because of the response that I got.

Preceptor #4 stated that students are expected to possess the ability to communicate with staff, either verbally or non-verbally. A student with a language barrier posed considerable difficulty for this participant.

> Not really certain how much she is confabulating about what she knows and how much she is really perceiving. Not asking questions. She's just nodding that she understands.

Another situation demonstrates the importance of nonverbal cues for Preceptor #4.

> You would say something to her, but she never showed any expression. Example: Like is she angry or is she mad at me or is she taking this in the right sort of way. You sort of have to ask her what do you feel.

Stepping In

Stepping in was identified by Preceptor #1, #3 and #5 as intervening when the student was experiencing problems in the clinical area. Often this intervention occurred in the form of increased supervision and feedback.

> She just couldn't function without someone being there. She let things slide or not do things, and whoever covered her on her break, they just ended up doing all her work for her. I spoke with her instructor and it was sort of taken care of and she was watched.

When a student is experiencing difficulties in the clinical area, Preceptor #1 stated that she utilizes a method of separating the student from the clinical area to help the student to review their performance.

> Only couple of times I would say to a student that I want to get them out of the unit into a less stressful environment. I'll offer to take them for coffee. I just let them know what I see as happening. I ask them how they feel

> about what is happening, and I just give them some guidance and some suggestions about what I would like to see changed.

This separation of student from the location of the intensive care unit allows the student to reflect on their performance away from the stressors of the clinical area. This method of helping was only reported by Preceptor #1.

Mediating Variables

Several mediating variables were described by the participants as having a direct influence on the preceptor-student relationship. The following variables were identified: culture, nature of student, age and experience, and gender.

Culture

Preceptors #3, #4, #5, and #6 described instances when culture was a mediating factor in the preceptor-student relationship.

> You could tell she was in culture shock and the whole bit. Just dealing with all that so you couldn't just jump on her for the way she would talk or whatever. Her mannerisms were very different from ours.

The knowledge of students' cultural background influenced how these participants engaged in their relationship with the students throughout the preceptorship. Preceptor #4 attempted to learn about the culture, and the students' experiences within their own countries. She reflected upon this in her assessments of the student's performance.

> I couldn't imagine doing what she had done leaving her kids at home and coming over for four years. It blew my mind to think of that. It sort of made me stop and think of what she was going through and I sort of put myself in her position and sort of kind of understand what she was going through and understand the cultural differences.

Nature of Student

One of the factors that was viewed by Preceptor #3 as a mediating factor in the preceptor-student relationship was the nature of the student. Particularly significant was whether the student would be working in a tertiary care hospital ICU after graduation.

> A girl from a very far away country. That was a real real challenge for her preceptor and actually for all of us in the group because she didn't do too well at all. The course office was trying to put this girl through. Get her through the course in any way that they could. Number one she wasn't going to be nursing in Canada. She came from a third world country, and her country very badly needed her back. Some of the skills that she had learned would certainly help, and so maybe she didn't know how to insert a swan properly, but she probably never see a swan again. That was very challenging for all of us.

> Alot of the kind of patients she was looking after were not the kinds of patients she would be looking after at the Grace (Hospital). Like open heart surgery patients. She (the student) said she "was doing fine, she doesn't expect to be a keener and she didn't want to because she was expecting to go back to the Grace, and she wouldn't be looking after these kinds of patients anyways."

Age and Experience

Age and experience were reported to influence the preceptor-student relationship. Students who were young and lacked experience were reported to be a concern for Preceptor #3. Preceptor #5 and #6 agreed that maturity is integral to the preceptor-student relationship.

> Some of the people coming through seem younger and younger. Their maturity level is, they have to buckle down pretty fast. It's a tough course, and you can't be fooling around.

Gender

Preceptor #3 was the only preceptor that viewed gender as having

affected the preceptor-student relationship. She determined this in one experience with a male student.

> It is very challenging and I felt really bad for this fellow. He had been nursing for a number of years. I think he was just so threatened by the whole thing. I don't know if it was like a male dominance issue or that he should be able to pass this if 12 other women are passing it. He kind of had an attitude like that.

This example was the only one provided by any of the six preceptors that identified the gender of a student having been an issue in the preceptor-student relationship.

The Preceptor Role

A predominant category identified in the research was the participants' perceptions of their preceptor role. The perspectives of the participants and their goal orientation have already been discussed. In addition to the participants' goal orientation, there are variables that affect their participation and execution of the preceptor role. Within this section, the following subcategories will be described: preparation, needs, rewards, and problems.

Preparation

The six preceptors identified the importance of preparation for the preceptor role. All of the preceptors except Preceptor #3 had participated in some form of a preceptorship workshop. Preceptor #3 stated that she had met with a teacher in the ICU program for two hours and had reviewed the evaluation process. Experience and maturity were identified by the participants as factors which primarily prepared them for the preceptor role.

Experience

"Experience" was identified as the major factor in the participant's growth as a preceptor by all of the participants. The preceptor's experience allowed her to increase her focus on the student rather than on her own ability as a preceptor. It also increased her confidence in her intuition and skill as a preceptor.

> Initially you are more focused on your own insecurities instead of functioning in the preceptor role.
>
> I'm a little more aware of what to look for and notice problems. I'm just a little more aware of their learning needs, and the whole situation.
>
> I guess initially I was more concerned about assessing their knowledge level and sort of trying to be more of a teacher. I still do alot of teaching, but I sort of go over and see how they are doing and try to help them get more organized. Doing more assessing from a distance and relying on other staff to give you feedback about what's going on and how they're doing.

Several participants recognized that they had evolved with experience from an ability-evaluative orientation to a more learning focus in their precepting.

Preceptor #6 identified how she had grown in her role as a preceptor from her initial preceptoring experiences because of her reflections about her own learning as a student within the intensive care program. She also was the only participant who noted that students are individuals and that they learn differently.

> In the beginning I think I expected people to be quick, do things immediately, and do them right, and there must be something wrong with you if you can't do it that way. Learn to give people some space. I think that came with taking the course myself, I learned all kinds of things that were effective when you had preceptors and weren't effective. I also learned from my own preceptors the kinds of things that I didn't like, but

people are different and learn differently.

In addition, Preceptor #6 noted that she had learned about precepting through "trial and error" and that "you learn from your mistakes." Preceptor #3 attributed her preparation for the preceptor role over the years to increased confidence in her nursing ability. She also referred to her experiences working with students and "knowing that none of them has ever killed a patient yet."

Maturity

One participant reported that her age has contributed to her ability as a preceptor in providing students with constructive criticism.

> Another thing that I think has helped is my age. I've only had a couple of people that have been older than me. I think it might be easier to take a reprimand from a nurse with more years experience than you.

Preceptor #2 identified her young age and relatively small amount of ICU experience as a factor affecting her ability to enact the role of preceptor. She expressed concern as to whether at times "my background is extensive enough."

Needs

The preceptors who participated in the study identified several needs associated with the preceptor role. This section will describe the following: advisor support, team work, physical proximity, compensation, autonomy, affirming feedback, and breaks from precepting.

Advisor Support

One of the most commonly referred to need was support from advisors in decision making. Preceptors #1, #3, #4, and #5 identified the importance of

advisor support in the preceptor-learner relationship.

> Just having the support of the instructor was very positive working together with her. She would come every day and talk with me and say this is what's going on and this is what I'm going to talk to her about and I think this going well. And how are you doing?

In addition, when the preceptor was preceptoring a student who was having difficulties, the preceptor sought the help of the instructor.

> I'd never had to do that before and it was nice to know that they were there and sort of step in and be that much of a resource. Which was really good because I think that is what she needed because she didn't know me from a hole in the ground and she knew the instructor for at least a while. Sort of know that you'd be there. And she's very scared to make a mistake, and not making it through the course.
>
> It was because of her that I think made everything go as well as it did. If I didn't have the support and the instructor hadn't been there I don't know if she would have made it through. The teacher said to me if she didn't have such an understanding preceptor she wouldn't have made it through. It was a combined effort between the two of us.

Team Work

One of the needs identified by the participants was team work within a preceptorship. Team members included other staff, the advisors from the ICU program, and the student. Preceptors #2, #4, #5, and #6 described the importance of communication and collaboration with other health team members.

> She (the student) wanted to learn so badly. It was good that we could be there and be that support to her. The whole teamwork. My whole group of staff that had worked, that I work with normally, were all very supportive of her which was good to see.
>
> Preceptor #2 conveyed the need for utilizing other nurses to supervise

students when the preceptor is unavailable.

> Often times I will ask those people that I feel confident about their judgment, if they're working side by side with the student, I will ask them what kinds of things went on during the day if I've been really busy and unable to observe myself. Or the head nurse if she's been around, she can give me an idea of how the student did with their head to toe at rounds.

Preceptor #3 noted that when she is supervising a student whose preceptor is ill that it is important to know "where the student is at." An example was provided that involved a student who had failed to report a low urine output.

> One night I was preceptoring her and her preceptor was sick. One specific incident that I had questioned her. It wasn't unsafe. She got very defensive. In the end I learned that it was getting near the end of the program and it was kind of like she had one more reprimand and she would be out. As I was not her real preceptor I wasn't aware of that. It was kind of a communication thing.

Physical Proximity

The need for being visible and in close proximity to the student was noted as being a priority need by all preceptors. This was particularly true for those participants who viewed student success as largely due to their interventions.

> When you are far away from your student it's very difficult to observe what is going on and assist them if they are caring for a level five to six patient that they are having difficulty with. It's really hard to be there and to observe what is going on.

Preceptor #2 reported that she felt that she had not been in control when she was physically apart from her student.

> The charge nurse at the time had assigned breaks so that my student was alone by herself in a corner with three other patients, and she had only been in our unit for 3 or 4 shifts. I wasn't there, so I wasn't able to be apart of that decision. Fortunately another nurse spoke up and noted that

> these breaks were unfair to the student. I felt bad after the fact to hear what was going on, and not being in control.

Compensation

All of the participants agreed to the need for some form of compensation for their role as a preceptor. They perceived that the added demands of precepting while at the same time caring for patients was beyond the mandate of their staff nurse job description. Compensation was described as monetary or in the form of continuing education.

> I think it would be appropriate if we did get some monetary compensation besides a thank you.

> There is recognition for performing in this role, but I think most of it is internal gratification. That is really the only recognition you are receiving aside from perhaps a review that you have functioned in this role and it's good for a resume etc., etc. Some of the other preceptors working in our unit have requested retribution in the forms of monetary etc. They feel that a lot of time and effort is spent in precepting and other rewards aside from the feelings of gratification are just not there.

> If they (institution or even the ICU instructors) were able to inservice us perhaps once a year if there was some little workshop on preceptorship and learning needs, and teaching adults. It would be nice to have a type of continuing education forum of some sorts. Even a bulletin board in which they could post an article monthly or something like that. It would improve our abilities as well. I think it is really an important role.

Autonomy

All the participants concurred regarding the need for autonomy in their role as a preceptor. This was particularly an issue in regard to preceptors' role in determining the nature and structure of their role. The participants perceived that their role was defined by others, specifically administrative and educational

staff, without their input.

> As far as the preceptor course is I feel I have very little control in that and what is expected of us. For many years we have tried to have workshops and have more input into it and it kind of seems to fall by the wayside.
>
> I think it would be nice to have a bit more input as to our function.

Affirming Feedback

Preceptor #2 described affirming feedback as a necessary aspect of the preceptor role. The lack of affirming feedback, or any feedback, was identified by Preceptor #1 as a deterrent in the current precepting system.

> How we are evaluated is that the students evaluate us. I think that's pretty well the only form of evaluation.

Breaks From Precepting

One of the participants identified the need for breaks from precepting, especially after experiencing a negative experience with a student.

> Over exposure and just tired of having to explain everything and not just doing it myself.

In addition, another participant identified the need for a readily available supply of preceptors to prevent overextension of the preceptor pool.

> I think that you need to make sure there are a lot of preceptors around. It can add to their stress. It is important to maybe precept every second rotation or every third just to give them a break.

Rewards

All of the preceptors associated specific rewards with the preceptor role. Identified rewards varied from a simple thank you to the awareness that the preceptor had contributed positively to a student's learning experience within

the intensive care unit.

Acknowledgement

Three of the preceptors attributed acknowledgement in the form of 'thank you's' as a reward for their participation in the preceptor role. Verbal and written acknowledgements of their work by students were particularly treasured.

> I've had some lovely thank you's from the students. That's very rewarding. I've kept some of the notes that they have given me.

Five of the six preceptors expressed that receiving affirming feedback was a reward for the preceptor role. Preceptor #5 recalled an incident involving a former student when the student had become a preceptor herself.

> When she became a preceptor and came to talk to me afterwards and said: I don't know how you put up with me as a student. The student I got right now is exactly like I was. She thanked me for my patience. I don't believe that you put up with me.

Preceptor #3 also indicated the hiring of a student by the ICU upon graduation was a means of affirming feedback, and a reward for her participation in the preceptor role.

> If one of the students that I had was hired, that was very rewarding to me because obviously their kind of skills or whatever, they were desirable enough to be hired.

In addition, she identified former students who emulated her behaviors when they were preceptoring themselves as providing her with affirmation of her ability to precept.

> I kind of chuckle sometimes because I hear my words coming out of their mouth. Like certain things I teach and deal with in a certain way and I hear the way that I would deal with it coming out of my ex-student's mouth with their own students now. That's very encouraging and makes me feel

really good that they think my techniques are good enough to pass on.

Self -Learning

The identification of one's own learning needs, and reinforcement of one's own learning was identified by Preceptor #1 and #3 as a reward for participation in the preceptor role.

> I look at it as a challenge, and I enjoy it, and I enjoy teaching. It also reinforces my own learning needs. Students ask really good questions. Sometimes I have to go to the library to look up the answers. Reminds me of my own deficits.

> One of the best things I get out of being a preceptor is that I don't get as stagnant as far as my own learning needs.

Positive preceptoring experiences or preceptoring students that were independent were not the only means by which the preceptors learned from their experiences. Self-learning was also recognized by Preceptor #1 and #4 as resulting from one's negative experiences associated with the preceptoring of students.

> I guess we must have just been miscommunicating on some levels or something, but I really tried. I did make an honest effort. I tried my best not to be threatening etc., and um, it just I don't know, it just didn't work out. It wasn't a positive experience for her, nor was it particularly for me, but I think I did learn from it. After that, that's when I really ensured that I tried to establish a good relationship at the beginning and not wait for the relationship to develop because you really don't have the time.

Student Learning

Preceptor #6 stated that student learning is a rewarding experience for her participation in this role.

> I think that's the really positive parts because you have a sense that you can influence their learning experience. Not just sitting around transferring patients to CVT every shift. They're getting a good

experience.

Preceptors' #1, #3, and #6 stated that when students performed well in the unit, it affirmed their ability as a preceptor. Preceptor #6 also identified that growth of students in a positive way was more affirming to her than a student who was stronger in the beginning of the preceptorship but did not demonstrate growth.

The ability to make independent decisions that contributed to student learning within the intensive care unit was also perceived. Preceptor #3 described her participation in the preceptor role as "helping out the nursing profession in general" and "perpetuating intensive care nurses."

Problems

There were several problems that were reported by the participants as affecting their role as a preceptor. Affirming feedback, breaks from precepting, and physical proximity have already been addressed within the needs section of this chapter. In addition to these problems, there are other difficulties associated with the preceptor role. These additional problems include: evaluating students, inexperienced students, perceptions of unfairness, and differences of opinion among staff.

Evaluating Students

The evaluation of students was viewed by Preceptors #1, #2, #3, and #4 as a major problem in preceptorship. The participants in the study felt they were unprepared to assess students' clinical performance in the ICU. Providing a critical appraisal of a student's clinical performance was perceived as a distasteful and awkward task.

> Ah, very rarely have I had to really criticize. I don't like to do it, but I realize that if I am going to be in this role that there may come a time when I have to do that.

Preceptor #3 described an incident with a student in which there was disagreement over what should be written on the anecdotal record.

> She must have ragged at me for like for five hours that she wanted this off the anecdotal record. Gave me a new one that I could completely fill out so that this wouldn't be crossed off. I refused to do it. I don't know if it was just because she came from a different country or because she was the type of person that she was. I saw that as a problem.

Inexperienced Students

Preceptor #5 identified a major problem as the clinical inexperience of students being admitted to the ICU program. She perceived that this problem existed as the direct result of inadequate entrance requirements of the program.

> I find a real problem with the entrance requirements for taking the ICU course. The ICU course used to require a couple of years of nursing experience prior to taking the ICU course. Not required now. It was really showing. Some people could cope with it and some people just can't. It's unreasonable to expect them to.

Preceptor #6 agreed that improved entrance educational standards for the ICU program were necessary. She offered some suggestions for improvement.

> I think that now they are letting people come into the course as an RN graduate or BN graduate. I don't think that's appropriate. I think you should have at least two years of general duty nursing surgical/medical.

Lack of clinical experience in students was perceived by Preceptor #5 to be an added responsibility for her in her role as a preceptor.

> I was real worried about the amount of responsibility that was being placed upon me because she was so inexperienced. I still had a patient load of my own. It was a little more than I thought I could handle. The fact that she needed extra guidance, and I just didn't have the time to give her

what she needed.

Perceptions of Unfairness

Perceptions of unfairness were viewed by Preceptors #2, #3, #4, and #5 as a problem in the preceptor role. They concurred that students should be treated and assessed according to clearly defined and consistently fair expectations and processes. Preceptor #5 described a situation in which the student was not being evaluated by universal standards.

> I found that this student in particular was being treated by different standards than other students. She was being watched more closely in the way she interacted with the family and the patient, and was criticised for her method, the way she was doing it. It was different standards for her. What would've gone unnoticed in somebody else she was criticised for.

Preceptor #4 reported that students who were at a lower level were treated differently by the nursing staff than those who were near graduation.

> Say you have a student who is not as advanced as another student, but still meeting the minimal requirements, everyone is advanced beyond that. Other staff have a tendency to judge that student by the others' standards and not by the minimum standards. You don't have control over what other people do or say.

Differences of Opinion Among Staff

One of the most commonly reported problem among the six preceptors was differences of opinion among staff, and the resultant negative comments made to them by other staff members regarding the student they were precepting. These participants noted that they were required at times to advocate for students who others in the ICU staff regarded as incompetent or unworthy. Preceptor #1, #2, and #6 noted that any concerns regarding their

students were brought to their attention by other staff nurses.

> Picking on the students. Nitpicking I guess more than picking on them. Things that they would never talk to their coworkers about. They would go and tell the preceptor that your student did this this way. Didn't titrate the drugs fast enough, or didn't tell me until two hours after the urine output was less than thirty.

Preceptor #4 attributed differences of opinion between a student and a nurse that was preceptoring the student in her absence as the reason a lack of communication ensued between them.

> My student had gotten really upset with this comment on the anecdote about the urine output, and it was just like why this is coming out of the blue. I guess what had happened in the other unit was that the instructor had given her royal shit for not reporting a low urine output on somebody. So she thought she was going to be kicked out of the course because this was on her anecdote. This is what I heard from the instructor afterwards. They thought they had dealt with it and it was over and done with. The girl that had preceptored for me didn't see it as a problem. I didn't see it as a problem, but I didn't know of that incident.

Other problems in addition to the previously mentioned problems were identified by Preceptor #3. These problems included the inaccessibility of preceptors during the night, not being able to participate in the assigning of preceptors to students, and not being able to see anecdotal records written by the student. She also pointed out that filling out a student's anecdotal record at the end of the shift can take up to one half hour or so, adding to the preceptor's workload. Preceptor #5 stated that her views did not seem to be heard by the administrators of the ICU program. This added to her stress in the preceptor role.

> If they want me to be a preceptor they at least should listen to what I have to say.

Summary

In this chapter the perceptions of six participants regarding preceptorship have been presented. The central themes that emerged from the research findings were: 1) Ames and Ames' classifications were not inclusive of all orientations. Preceptor #6 ascribed to the mentoring-professional identity goal orientation outlined by Paterson (1991), 2) The perspectives of the participants regarding precepting were not correlated with education or years of experience of the participants, 3) Although not the evaluator of the student's clinical performance, the major role of the preceptor is assessor. This role is one in which they felt unprepared, 4) Being a preceptor is taxing. Many needs of preceptors were identified particularly having a voice, and needing acknowledgement, and 5) The perspectives of the preceptors are what they intend to do. The study did not examine how they actually precept. However, it is apparent that participants' perspectives determined to a significant extent how they enacted their role as preceptor.

Table 1

Demographic Characteristics - Nurse Participants

Characteristics	Number of Participants
Number of Participants	6
Age	
Mean (years)	30.8
Range (Years)	28 - 35
Primary Practice Area	
Surgical ICU	5
Medical ICU	1
Highest Level of Education	
R.N. Diploma	5
B.N. Degree	1
Number of Times Precepted in ICU	
Mean	9
Range	2 - 20
Percentage Employed	
part - time	4
full - time	2
Number of Years Nursing	
Mean	10.7
Range	5 - 16
Number of Years Employed in ICU	
Mean	4.5
Range	2 - 9

CHAPTER FIVE
DISCUSSION

In this chapter, an analysis of the research findings presented in Chapter Four are discussed. The analysis is informed by and structured according to the conceptual framework of Critical Social Theory based on the three major concepts of democracy, subjectivity, and responsibility. Implications for nursing practice and education are detailed in the body of this chapter. Recommendations for future research imperatives are presented in a separate section at the end of the chapter.

Democracy

This section of the chapter which refers to the concept of democracy includes a discussion of those elements which were determined to be within the rights of preceptors. These include having a voice, access to information, fairness of process, and acknowledgement and affirmation. It should be noted that this research did not investigate the accuracy of the participants' perceptions. It may be that preceptors are indeed granted a voice in the determination of their role and in the selection and evaluation of students. However, what is of concern is that none of the participants perceived they have a voice in these elements of preceptorship. It is this reality which is true for them.

Having a Voice

The right to an equal voice as a partner in the preceptorship relationship

has been identified by such authors as Allen (1990) and Davis and Barham (1989). Having a voice in the role description of preceptors and in decisions about students was perceived by the participants to be a necessary but lacking element in their current preceptorship experience.

Not having a voice in determining what it is that preceptors are to do has resulted in the participants being unable to clearly identify the expectations of their role. The consequences of this have been uncertainty about how well they are performing the role, a diversity of interpretations as to how much autonomy should be granted students, a variety of interpretations of how much supervision is desired and valuable for students, confusion about the role of the other nursing staff in relation to the student's learning, and bewilderment about how to juggle a patient assignment while at the same time precepting the student. The preceptor role as interpreted by the participants entails a multitude of identities; caregiver; team member; assessor; supervisor; gatekeeper; teacher; coach; and advocate. However, as preceptors perceive that they have no voice in determining the mandate of their preceptor role, the participants attempted to fulfil all obligations equally. Fatigue and burn out were predictable consequences.

Preceptors must be able to engage in active dialogue with the faculty of ICU programs to clearly identify the roles and responsibilities of preceptors. This discussion should centre not only on what it is that preceptors should do but how they are to do it. What, for example, should be the primary focus of a preceptor when he/she must engage in patient care as well as in facilitating student learning? What are the preceptor's rights regarding feedback about

their performance as a preceptor and continuing education to prepare them to fulfil their role effectively?

The participants stated that they had little if any voice in determining which students should be placed with individual preceptors and in making decisions about students' performance in the ICU program. However, once assigned to a student, they were granted a major role in coaching and assessing the student. Not having a voice in selection and evaluatory decisions about students entails responsibility without authority. Responsibility without authority ultimately leads to the experience of powerlessness (Erlen & Frost, 1991). Powerlessness in turn results in feelings of worthlessness, cynicism, negativism, and apathy (Erlen & Frost, 1991). These hardly seem to be the necessary ingredients for successful preceptorship. An additional concern in this regard is that those who currently make decisions regarding the preceptor role (i.e., educators in the ICU program) may not interpret priorities within the role in the same way as would preceptors. Ferguson and Calder (1993) determined in their research that preceptors place a higher priority than educators on elements of preceptorship such as organization, teamwork, bureaucratic role conception, and adapting skills to a client's situation. However, the educators in their sample emphasized the formulation of nursing diagnosis and the incorporation of theoretical knowledge and scientific principles. It would appear that preceptors require a formal mechanism which facilitates their input in the selection and evaluation of students.

Although the preceptor is expected to assess and communicate to the student's advisor the quality of the student's clinical performance, they have little

voice in the final decision made about the student's progress in the program. Because the participants perceived that they had little or no access to relevant information about students, they were frequently at a loss to understand decisions made by educators in the ICU program to pass or fail students. Their lack of voice in decisions about students was reflected in situations in which they perceived that these decisions had been unfair but they were powerless to influence the decision. If the responsibility for assessment is primarily the role of the preceptor, they must have a role in the summative evaluation of students. As well, the rationale for decisions to pass or fail students should be clearly communicated to preceptors. Preceptors should be given the opportunity to voice in writing their objection to decisions about students' progress in the ICU program.

Another aspect of having a voice was in determining the admission policy for the ICU program. The participants indicated that they had major concerns about the lack of clinical experience of some students prior to the preceptorship experience. These concerns need to be heard by the educators in the ICU program. As well, the educators should consider ways to inform preceptors of the rationale behind their decisions in regard to admission criteria. Participation should be fostered of preceptors on program committees which consider admission decisions .

Access to Information

Closely related to having a voice is the preceptor's access to information which is needed for the enactment of the preceptor role. Because the participants were granted access to only part of the documentation about the

student's performance and experience, they perceived that they did not have sufficient information at times to effectively function as the student's preceptor. The participants were forced to rely on their communication with students to determine the rationale for student's clinical difficulties and the student's learning needs. This poses a difficulty when the student has not established a rapport with the preceptor and is not able to verbally disclose details regarding their learning experience. Another concern in this regard is that all the preceptors stated that it is difficult to find time and space in the ICU to speak frankly and openly with students. It would appear that if preceptors are to be given the ongoing responsibility for teaching and assessing students, they must also have access to the student's written comments about their experience.

Forming a relationship with students takes time and effort. The participants stated that often they knew students only superficially until the end of their preceptorship. Because the preceptors are not given information other than academic performance, much of what they learn about the student's clinical learning needs occurs by trial and error. As well, the preceptors may not have the personal and experiential resources to help certain students to succeed. Because the participants perceived that they had no say in who was assigned to them, they were required to "muddle through" relationships with students with whom they were incompatible or ineffective.

The selection of preceptors and the assignment of students has, according to the participants, been largely based on who is available. Obviously, a planned and conscious process to choose which preceptors are best suited to work with specific students is in order. Educators should consider

asking students prior to the preceptorship experience about their usual learning style, their preference as to supervisory style, and their learning needs. As the educators in the ICU program know the students prior to the preceptorship experience, perhaps they could interview both available preceptors and the students, matching the preceptor's skills, experience, and teaching style to the student's identified needs.

Acknowledgement and Affirmation

When one performs a job well, one expects to be acknowledged for having done so. The need for recognition and agency support was perceived as a right, not merely a benefit, by the participants. Feeling that one is not alone in the preceptorship experience and that one is valued for their contribution to the student's learning has been noted by researchers to be integral to the preceptor's motivation to participate in this role (Bizek & Oermann, 1990; Young, Theriault, & Collins, 1989). A study conducted by Cantwell, Kahn, Lacey, and McLaughlin (1989) identified reasons for termination of preceptor programs which include lack of guidance for preceptors, and lack of recognition for their efforts. It would appear that, if preceptor burnout is a current concern, (Mooney, Diver, & Schnackel, 1988) educators in ICU programs must attempt to discover tangible and effective ways of acknowledging the significant contribution that preceptors have made. Continuing education for the role was perceived by the participants as one such means. As continuing education appears to be imperative to assist preceptors to fully understand and enact their role, it would appear that this reward of precepting may accomplish two things: affirmation and education.

As well as affirmation, preceptors have a right to know how they are performing in their role. The participants reported that at present their only form of formal feedback was written evaluations by students. However, these are not required and many preceptors do not receive them, particularly if their relationship with the student had been problematic. Student ratings of preceptors should be a requirement of the program. It may be argued that a student could write a negative evaluation of a preceptor which may reflect badly on the preceptor's ability. This eventuality may be countered by giving a copy of the student's evaluation to the preceptor and permitting the preceptor to append a written response if it is required. One participant cited a situation in which the educators had protected her by not showing her a negative evaluation. This protectionism resulted in her feeling that the evaluation must be scathing to require such intervention from the educators. Preceptors have a right to see what students have written about them.

Responsibility

The preceptor's responsibility refers to his/her commitment to nurture and assist students to learn. The participants described this commitment in terms of their ownership of the experience, the resources they required, and the elements of the preceptor role. This section discusses the following in relation to the preceptor's responsibility: student as territory; need for proximity of assignment; preparation for preceptor role; and helping.

Student as Territory

The assignment of a student to a preceptor results in a definition of

territory. The participants referred to "my student" as an indication that the preceptor assumed the role of the student's primary teacher and protector. Although some participants encouraged other nursing staff in the unit to supplement the preceptor's role, it was understood that it was the preceptor who had final say in everyday decisions about the student.

The well-defined tasks and roles of the clinical practice arena are blurred when a nurse assumes both a preceptor and a clinician identity. They must juggle the needs of patients and the student, while at the same time having no clear idea of what it is that they should do as a preceptor. A factor which exacerbates this situation is that, according to the participants, preceptors receive minimal feedback as to how they are accomplishing their role as preceptor. However, they must rely on such feedback in order to define the expectations of the role. The experience of preceptors causes them to seek a sense of belonging and being in control of the situations they encounter. One consequence of this is that preceptors establish the student as their territory exclusive from that of the nursing staff (Bennis & Slater, 1968). Territoriality in preceptorship is exhibited largely by semantics (e.g., "my student") and by the structuring of learning experiences, away from other nursing staff and close to the preceptor.

The outcomes of territoriality have not been investigated in this research study. However, one might surmise that the student would have limited access to the skills and attributes of other nursing staff if the preceptor tightly controlled the student's access to other nurses. As well, nursing staff may not be able to give the preceptor the appraisal support and guidance the preceptor may

require because they are not permitted to work with and access students. The issue of territoriality will be resolved by implementing the recommendations previously detailed in regard to access to information, having a voice, and the need for affirmation and acknowledgement.

Need for Proximity of Assignment

Selection of patient assignments in the ICU has, according to the participants, been largely based on patient and senior nurse availability in the ICU. The participants stated that they were often assigned to patients who were located across the room from the student and his/her patient. It would appear that this present practice defeats the premise of preceptorship. The lack of physical presence between the preceptor and student results in the inability of the preceptor to offer support, share his/her knowledge, and effectively assess and evaluate student performance. As a result of this present practice, preceptors must rely on other nursing staff to provide the student with necessary information and feedback that the preceptors perceive as part of their preceptor role. This is complicated by the preceptor's territoriality which prohibits the nursing staff from having direct communication with a student about what the nurse observes. Inconsistent contact between preceptor and student has previously been identified as a problem within preceptorship (Friesen & Conahan, 1980).

Proximity of patient assignment was perceived by the participants to include the notion of "being there" for the student. This was perceived by the participants as an integral component of the preceptor role. Being there for the student constitutes both a physical and spiritual presence where there is an

overall intunement with the student's situation (Karl, 1993). Preceptors who are physically apart from their student are not cognizant of the needs of the student. Therefore, they are unable to assist the student with providing patient care, and to identify specific learning experiences which are required in the future to meet the student's identified learning needs.

It would appear that a process is required when determining patient assignments to consider the proximity of the preceptor and the student. As well, an open dialogue with the preceptor and the student would allow for the assignment to incorporate the student's learning needs, and at the same time, facilitate the development of the preceptor-learner relationship.

Preparation for Preceptor Role

When a person volunteers to take on a new role, they expect to receive adequate preparation for it. Although adequate preparation for the preceptor role is an expectation, this was not perceived by the participants to have occurred. The participants were provided with a one day workshop to prepare them for the preceptor role. Giles and Moran (1989) identified preceptorship workshops as increasing a preceptor's ability to preceptor students. However, the participants in this study perceived that the preceptorship workshop did not provide them with the necessary information to define their role expectations, or the knowledge which they perceived was imperative to implement the preceptor role. This resulted in inconsistency in the way in which each preceptor perceived and defined the preceptor role. Lack of direction and specific expectations inherent within one's role lead to uncertainty in meeting one's role expectations (Paterson, 1991). The participants were forced to rely on their own

experiences within the ICU to prepare for the preceptor role. Therefore, much of their role was defined by their identity as a clinician. They transferred their role as caregiver of patients to that of students. This resulted in role conflict when the needs of both patients and students were equally demanding. Preceptoring through trial and error were the predictable consequences of lack of preparation for the preceptor role. This method often resulted in fatigue and preceptor burn out.

A one day workshop is unlikely to adequately prepare a nurse to effectively implement the preceptor role. Continuing education is required to provide preceptors with information (e.g., providing constructive criticism, assessing student performance) to enable them to enact the expectations of the preceptor role. It would appear that preceptors should be consulted during the development of preceptorship workshops and continuing education forums regarding preceptorship to allow for their specific learning needs to be considered and incorporated into these programs. An additional requirement is for preceptors to be provided with specific role expectations of the preceptor role prior to participating in a preceptorship. Preceptors should be encouraged to regularly meet and discuss their preceptoring experiences to provide each other with alternative methods of assisting and evaluating students within the ICU.

Helping

Another responsibility inherent within the preceptor role is that of student helper. Participants referred to helping behavior as their facilitation of student learning in the ICU setting. Although helping behavior was initially provided to

all students, continuation of this helping behavior was dependent on certain student attributes. Preceptors in the study stated that students should be highly motivated and extroverted. Helping behaviors were offered to students when the preceptor perceived the students exhibited these attributes. When students were perceived by the preceptor to exhibit lack of effort or exhibited a decreased willingness to learn, the preceptor would withdraw helping behaviors to these students. This finding is similar to Paterson's (1991) study of clinical teachers. The similarity appears to arise because of the lack of preparation for both the clinical teaching and preceptor role. Because clinical teachers and preceptors lack a theoretical understanding of student difficulties in clinical area, they rely on emotive, intuitive clues to determine their response to these situations.

Within a preceptorship, there is a great reliance on students to be able to communicate their needs either verbally or nonverbally to the preceptor when they are experiencing difficulty within the clinical area. Students who are unable to do so are disabled within the preceptorship system. The students who were perceived by the preceptor as not seeking help or not heeding the advice of the preceptor to seek new learning experiences were perceived as lacking motivation. Helping behaviors were then withdrawn from these students. It does not appear that the participants considered alternative reasons for the student's behavior (e.g., anxiety, learned helplessness). A major consequence of this removal of helping behavior is the student is left to fend for him or herself until the completion of the preceptorship. Continuing education is needed which specifically addresses possible reasons for students' problematic behavior and measures to address these. Preceptors should be encouraged to

foster helping behaviors throughout the preceptorship. As well, educators should inform preceptors in preceptorship workshops of the rationale for providing helping behaviors to students.

Subjectivity

The preceptor's subjectivity refers to his/her perception of the preceptor role, and the preceptorship in general. The participants described this in terms of their own perspective of precepting, and the student's background. This section discusses the following in relation to the preceptor's subjectivity: preceptor attributional style, and nature of student.

Preceptor Attributional Style

The attributional style of the preceptor directly influenced how the preceptor perceived student success or failure in a preceptorship. Preceptors who attribute themselves as responsible for student failure assume personal responsibility when a student does not perform well. They attempt to work with students to identify the underlying cause of the student's poor performance. However, the preceptor who attributes student failure to the student does not consider an underlying cause for the student's poor performance. Experience was not correlated with attributional style in the study as the participant who ascribed to the ability-evaluative perspective had the most ICU nursing experience. However, this finding may be due to this preceptor's inability to reflect on his/her previous experiences. Paterson (1991) and others (Munroe, 1988; Rovegno, 1992) have suggested that it is the individual's ability to reflect on their teaching experience, rather than duration of experience, which

determines their perspective of teaching.

The varying preceptor attributions result in inconsistency between preceptors in their assessment of student performance in the ICU. Paterson (1993) described perspectives as either a narrow (ability-evaluative; task mastery) or a broad (moral responsibility; mentoring-professional identity) applied science. The preceptors who ascribed to the task mastery goal orientation were primarily concerned with the student's ability to master the learning goals established by the preceptor and the ICU program. The ability-evaluative preceptor's primary concern was to demonstrate her own teaching ability. This is compared to the preceptors who ascribed to the moral responsibility and mentoring-professional identities who were primarily concerned with student learning, and the development of the student's personal and professional identity. Although all the perspectives contributed to student learning within the ICU setting, the mentoring-professional identity goal orientation contributed to the student's ownership of their learning experiences rather than the preceptor directing the student's learning experiences. It would appear that the preceptors' perspective determined to a significant extent how they perceived and enacted their preceptor role.

A preceptor's perspective can be used as a diagnostic tool (Munroe, 1988) to determine where further education is needed about the preceptor role. Therefore, educators should consider ways in which they can inform preceptors that these varying perspectives exist. Preceptors can then learn to reflect on their own attributional style when participating in the preceptor role.

Nature of Student

Although the preceptor is expected to treat all students equally, the participants described incidents in which their enactment of the preceptor role, and their perceived responsibility to the student varied with the nature of the student (i.e. from community hospital; foreign student). Students who were formerly from a community hospital or from a foreign country were not expected by the preceptors to care for the same high acuity level of patients upon their return to their previous clinical setting. These students were perceived as requiring less experience and challenge. This perception led to preceptors adapting their preceptoring of the student to incorporate their revised expectations of the student's individual learning needs. Lack of communication between the nursing staff and the ICU program regarding the nature of the student (e.g., student background, culture) resulted initially in frustration for all of the nursing staff. Therefore, educators from the ICU program should inform preceptors about the student's background prior to the preceptorship.

Preceptors indicated that they had to seek information from the student regarding their past experiences, and the work area to which the student was expecting to return. This poses a concern when the student does not readily offer pertinent information about themself and their learning needs. Precious time and energy is exerted by the preceptor to understand the student's culture and work background. As the educators in the ICU program know the student's professional background and clinical experience, perhaps they could meet with the preceptor and the student to discuss this prior to the preceptorship. The preceptor would therefore be cognizant of this information prior to the

preceptorship, and he/she could spend more time and effort in assisting the student to meet their learning needs, instead of searching for this information during the preceptorship. As well, the preceptor would then be able to share this information with other nursing staff so that they would not be continually questioning the student during the course of the preceptorship. Continuing education for preceptors is warranted in the area of precepting students from different cultures.

Future Research Imperatives

The following section identifies research imperatives, and recommendations that have emerged in the analysis of the research findings. The findings of this study have identified the need for additional research to be undertaken in the area of precepting. A replication of this study is mandated to compare perceptions of preceptors in other health care settings (e.g., community health, psychiatry). This study would be able to identify whether the perceptions of preceptors in an ICU setting are unique, or if they are reflective of all preceptors in varying clinical settings.

A qualitative study is needed to explore how other staff can best assist the precepting process. This study has shown that the support and collaboration of nursing staff is a necessary component of preceptorship. A study of this nature would be able to identify how other staff can best be utilized and incorporated in a preceptorship program.

Another study that describes how expectations of the preceptorship are communicated to the students is necessitated. A comparative study between

the expectations of preceptors, educators, and students regarding the preceptor's role would reveal the unique perspective of each of the players in the preceptor relationship. A study of this nature would enable preceptors an increased ability to precept students in the clinical area.

A study involving participant observation is needed that asks: "How do preceptors who attest to different perspectives make decisions about their role? This study showed that perspectives of preceptors may be used as a diagnostic tool to identify values and beliefs of preceptors. Further research would enable preceptors to consider and reflect on their own perspective when making a decision in the preceptor role.

There is a need for future research to be undertaken to determine if any additional perspectives regarding preceptorship exist. As was found in this study, an additional goal orientation first identified by Paterson (1991) was present within one preceptor. The presence of additional perspectives may be evident in preceptors and influence their enactment of the preceptor role.

In addition, there is a need to identify what internal and external variables result in specific perspectives. This study has suggested specific internal and external variables that influence the preceptor-learner relationship. Examples of these variables include: age and experience of preceptor; lack of preparation for preceptor role; and preceptors' perspectives. A number of research questions arise from this research study. How does age of preceptor affect perspective? How does length of precepting experience affect perspective? How does education of preceptor affect perspective? Through an increased understanding of the variables which influence a preceptor's

perspective, changes or improvements can be made within the education of preceptors to encompass these variables.

More studies are warranted that compare perspectives of clinical teachers to preceptors. Through comparisons between clinical teachers and preceptors more can be learned of what the educational needs and supports are necessitated for these vital roles in nursing education.

Summary

The analysis of the research findings suggest that there are several dimensions to the preceptor role and the preceptor-student relationship. Several needs associated with the preceptor role need to be addressed to ensure that these vital participants in the precepting of ICU nurses are supported and maintained in this role. Through preparing preceptors for their role, providing preceptors with continuing education, and acknowledging preceptors for their participation in preceptorship programs, this goal can be achieved. With health care reform underway, and the associated budgetary restrictions that ensue, there is an increased need to utilize resources that are already in place. Preceptors are one of these vital resources.

This chapter has presented an analysis of the findings of the research identified in Chapter Four. The analysis was informed and structured according to the three major concepts of Critical Social Theory. Critical Social Theory provided a helpful structure which allowed for clarity in the presentation of the analysis of the research findings. Implications for nursing education, practice, and research were identified based on the research findings.

CHAPTER SIX
SUMMARY AND CONCLUSION

The research presented in this report was an exploratory and descriptive qualitative research study which examined the perceptions of six intensive care nurse preceptors. The purpose of the study was to discover their attitudes, values, and beliefs regarding preceptorship. The literature review revealed that previous studies have consisted predominantly of quantitative research in relation to clinical competence and socialization of preceptored students, and therefore, the need for qualitative research to explore previously unstudied areas (e.g., perceptions of preceptors regarding preceptorship) was necessary. An ethnographic research design, based on Critical Social Theory as a framework, was utilized for data collection and analysis. Two semi-structured interviews were conducted with each participant. The constant comparative method of data analysis revealed two categories: the preceptor role, and the preceptor-student relationship. The preceptors' perspectives of preceptorship were also identified. The summary of the preceptors' perceptions is presented according to the three major concepts of Critical Social Theory: democracy, responsibility, and subjectivity.

Democracy

According to Allen (1990), there is a need for preceptors to have an equal voice within a preceptorship relationship. Being able to have a say in his/her job description was seen as an integral component of the participants'

role. The ability of preceptors to be able to share their concerns about their role, and knowing that what they say will be listened to and considered was essential to the preceptor role. The preceptors in this study communicated the need for their assessment of student performance to be attended to by the administrators of the ICU program. It was felt that this information should be taken into consideration during the summative evaluation process.

Autonomy in the preceptor role was perceived as a need by all of the study participants. Preceptors were often unclear about what constituted their preceptor role. They identified the need to be active in formulating a definition and structuring of their role. The participants revealed that students required individualized learning based on the students' learning needs. Therefore, the preceptors needed autonomy in scheduling patient assignments and learning experiences.

Team work and the ability to communicate with all levels of staff involved with the preceptorship (e.g., head nurse, advisor, program coordinator) were seen as vital components of ensuring successful student outcomes. Negative staff comments about the student and his/her ability were seen by the participants as hampering the preceptorship. The participants communicated that support from other members of the staff and ICU program provides assistance to fulfil their role as preceptor and enhanced their positive perceptions of preceptorship.

The participants identified the need for access to information (e.g., student anecdotals) as a means by which they could improve their own precepting ability and improve student experiences within the ICU setting. The

lack of access to the entire student anecdotal form was seen as holding back pertinent information regarding their own performance as a preceptor, and that of the student. In turn, this hampered their ability to precept.

Preceptors revealed that the past experience of the student was information that was necessary in formulating their relationship with the student. The student who had ICU experience, as compared to a new graduate who had never worked in an ICU would require a different approach to the formulation of the preceptor-student relationship. Students who had one or less years of general medical/surgical nursing experience were perceived as too inexperienced to be admitted to the ICU program. Therefore, preceptors felt that these students required an increased amount of preceptor time which added to their responsibility in the preceptor role.

There was some concern and disillusionment with the fairness of the preceptorship process expressed by the participants. Preceptors indicated that there was disparity in the standards for the evaluation of students. Several participants indicated that students whom they thought should have passed the program were asked to leave the program, while other students were allowed to carry on.

Acknowledgement was identified as an integral motivation to participate in the preceptor role. Affirmation of his/her performance in the preceptor role fostered continued participation by the preceptors. Knowing that one has made a difference in students' learning within the clinical area provided an impetus for preceptors to participate in future preceptorships.

Responsibility

According to Allen (1990), responsibility refers to the preceptors commitment to nurture and assist the student to learn the new role they are undertaking. Inherent within the preceptor role was the perceived ownership of the student by the preceptor. This perceived responsibility to "my student" was communicated by the participants as a need to be in close physical proximity to the student that they were precepting. Other staff members seek out the preceptor to tell them concerns they had about the preceptor's student. In doing so, the student was seen as the territory of the preceptor throughout the preceptorship.

All of the participants in the study identified the lack of physical proximity between themself and the student as hampering their enactment of the preceptor role. They felt that they were compromising their role as a preceptor if they were unable to assess or evaluate student performance effectively. Preceptors described the importance of their being available to the students to answer questions or offer assistance to them. "Being there" for the student was deemed an integral component of the preceptor role.

In addition to formal preparation for the preceptor role, (e.g., preceptor workshop), the participants identified experience and maturity as contributing factors to their ability to enact the preceptor role effectively. Lack of preparation for the preceptor role was identified by the participants of the study. Although the preceptorship workshop did provide necessary information to the participants to enable them to precept, it did not meet all the preceptors' learning needs, particularly in relation to evaluation techniques in the clinical

area.

Helping students to learn in the ICU was deemed part of the preceptor job description. Although helping was initially provided to students, continuation of this helping behavior was dependent on certain student attributes (i.e., motivation; extroversion). Students who were viewed by the preceptor as not seeking help or not heeding the advice of the preceptor were perceived as lacking motivation. Helping behaviors were then withdrawn from these students.

Subjectivity

Subjectivity was identified by Allen (1990) as the meaning that an individual attaches to an event, behavior, or situation. The perspectives of the participants in the study affected how they precepted in the ICU. How the preceptor perceived student success or failure was directly attributed to the preceptors' perspective.

The six participants in the study ascribed to the nurse-teacher role identification. Their primary role was that of a nurse who was directly responsible for providing patient care. Their secondary role was that of preceptor who was responsible to facilitate student learning within an ICU setting. Therefore, the patient came first throughout the preceptorship.

The enactment of the preceptor role and the perceived responsibility to the student varied with the nature of the student (e.g., from community hospital; foreign student). The preceptors adapted their precepting of these students to include an expectation that the students would not care for the same high acuity

level of patients upon return to their previous clinical setting. These students were perceived as requiring less experience and challenge during the preceptorship experience.

The participants indicated that there was a lack of communication between the nursing staff and the ICU program regarding the nature of the student. Therefore, preceptors had to seek out information from the student regarding their past experiences, and the work area to which the student was expecting to return. Precious time and energy was exerted by the participants to understand the student's culture and work background.

Conclusion

The findings and analysis of this research study investigating the perceptions of intensive care nurse preceptors regarding preceptorship have been addressed within this report. Critical Social Theory has been utilized as a framework for data collection and analysis. Implications for nursing practice, education, and research have been discussed.

The research has provided invaluable insight into preceptor goal orientations and preceptors' perceptions of preceptorship. The findings of the study may be utilized in the development of preceptorship programs to clearly define the preceptor role. If preceptors are to participate in the preceptor role, they should be treated as true partners in preceptorship. Preceptors need to have autonomy in the determination of the preceptor role. Preceptors should not only be responsible for student learning in the ICU, they should also be provided with some authority in the evaluation of student performance.

Preceptors need to have an active voice in preceptorship. This study has contributed to an understanding of not only what it is that preceptors do but what preceptors require to enact their role.

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APPENDIX A

CONSENT FORM

I, _____ agree to participate in the study conducted by Karla Farstad who is a Registered Nurse and a student in the Master of Nursing Program at the University of Manitoba. I am aware that Karla works part-time as an ICU nurse at HSC. She does not hold a supervisory position at that institution.

I understand that the purpose of this research is to investigate the perceptions of intensive care nurse preceptors regarding preceptorship.

I agree to participate in two interviews to discuss my perceptions. The interviews will take place at a location mutually convenient to the researcher and myself. I understand that during the interviews I will be asked questions about myself: practice area, educational background, and extent of my nursing experience with precepting within the intensive care area. I understand that my participation in the first interview will involve one to one and one-half hours of my time, and that the second interview will involve approximately one hour of my time. The interviews will be tape recorded. The tapes will be transcribed by the researcher. I understand that I have the right to refuse to have taped all or part of the interview.

I understand that participation in this study is completely voluntary and that even after the interview begins I can refuse to answer any questions or decide to terminate at any time. Whether or not I decide to participate, my position as a nurse will not be affected in any way. If I decide to participate and then later withdraw, I am free to do so without penalty.

A maximum number of six participants is required for the purposes of this study. If more than six volunteers are obtained, the researcher will randomly select six names from the list of volunteers. This selection will take place by placing the names in a box and requesting that one of the committee members be blindfolded and select six names. All volunteers for the study will be notified by the researcher if they have or have not been selected for the project.

I have been assured that my involvement in the study will remain strictly confidential. I will be assigned a code number by the researcher. My identity will be known only by the researcher. The researcher and the committee members (see below) will be the only persons who will have access to the

transcripts. The committee members will be given only the code number assigned to each participant: they will not know the identity of the person being interviewed in the transcripts. I understand that the written report and any further publication coming out of this study will describe only group information and will not identify me in any way. Tapes will be kept in a locked container, and destroyed within seven years following completion of this study. The key to this container will only be kept by Karla Farstad.

I understand that participation in this study will result in no direct benefits.

If necessary, I am aware that I may contact Karla Farstad at or her advisor, Dr. Barbara Paterson, at 474-8240 at the Faculty of Nursing, University of Manitoba.

Thesis Committee Members:

Dr. Barbara Paterson, Chair
Assistant Professor, Faculty of Nursing, University of Manitoba

Dr. Ina Bramadat, Internal member
Associate Dean
Undergraduate Program
Faculty of Nursing, University of Manitoba

Mrs. Judy Kaprowy, External member
Director of Medical Nursing
St. Boniface General Hospital

My signature below indicates my willingness to participate in the study.

Date: _____ _____ _____
(Participant) (Investigator)

I would like a summary of the results of this study:

yes ___ no ___

Mail to:

APPENDIX B

INTERVIEW GUIDE

Demographics

1. Where is your primary practice area?
2. What is the highest level of education you have completed? (RN., BN.)
3. How many times have you precepted within the intensive care area?
4. What is your age?
5. What percentage are you employed? (ie. full-time or part-time).
6. How many years have you been nursing?
7. How many years have you been employed in an intensive care unit?

Guide for Interview Questions

1. What are your perceptions about your ability to control what occurs in the preceptor-learner relationship?
2. Give me an example of a time in which you were able to make a decision independently in the preceptor-learner relationship? How did it make you feel about precepting?
3. Give me an example of a time in which you were not able to make a decision independently in the preceptor-learner relationship? How did this incident make you feel about precepting?
4. Tell me about a time in which a student would not or did not function independently in the preceptor-learner relationship? How did this incident make you feel about precepting?

5. Describe the preceptor role to me? Who do you communicate to about what occurs in the preceptor-learner relationship and what kinds of things do you tell them?

6. What differences have you noticed in the preceptor-learner relationship when the learner is different from you in gender, ethnicity, or age? How do you explain these differences?

7. Give me an example of an incident in which the learner perceived their performance differently from your assessment? Why was this incident significant to you? How did the incident influence your preceptor role in later situations?

8. How has the way in which you precept changed from your beginning experiences? How do you account for these changes?

9. What was the most positive precepting experience you have had to date? What made it positive?

10. What was the most negative precepting experience you have had to date? What made it negative?

APPENDIX C

INTERVIEW GUIDE FOR SECOND INTERVIEW

1. Did you have any questions or concerns regarding the transcripts?
2. Do you wish to clarify anything further at this time?

APPENDIX D

February 10, 1993

Karla Farstad

Re: Recruitment of ICU Nurse Preceptors from
St. Boniface General Hospital for the research study:

Perceptions of Intensive Care Nurse Preceptors Towards Preceptorship

Dear Ms. Farstad:

I am pleased to inform you that your access has been approved. You may proceed with your study on the understanding that:

1) you speak with Jo-Ann Sawatzky, a fellow graduate student, to ensure that you are not asking the same ICU nurses to participate simultaneously in you two studies;
2) any significant changes in the proposal will be submitted to my attention, prior to implementation;
3) you review the enclosed policy on confidential information and then sign and return the enclosed Pledge of Confidentiality.

The communication of nursing research to staff at SBGH is an important activity. We encourage you to make presentations to hospital staff about your research. Also, please consider writing a short story about some aspect of your research for our Nursing Division newsletter, **Nursing Dialogue**. Upon completion of your study, we request that you provide us with a brief summary of your final report.

Thank you for selecting St. Boniface General Hospital as one of the sites for recruiting participants for your study. Please feel free to contact me with your questions or concerns. Should you encounter any site-related difficulties during the course of your study, I would appreciate being notified of these.

Sincerely,

Kaaren Neufeld R.N. M.N.
Assistant Director, Program Evaluation
Department of Nursing Research
Tel. 235-3480

409 Taché, Winnipeg, Manitoba, Canada R2H 2A6
Tel (204) 233-8563 Fax (204) 231-0640

A Grey Nun Corporation/Une corporation des Soeurs Grises
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APPENDIX E

LETTER OF EXPLANATION FOR NURSE PARTICIPANTS

My name is Karla Farstad. I am a Registered Nurse and a student at the University of Manitoba in the Master's of Nursing Program. I am conducting a study to learn about the perceptions of intensive care nurse preceptors regarding preceptorship as part of my nursing program. I am a part-time nurse in ICU at HSC. I do not have a supervisory position at HSC and do not anticipate having one in the immediate future.

Your head nurse has suggested your name as someone who might be interested in learning more about this study. I would like to ask you at this time to participate in this study. A maximum number of six participants is required for the purposes of this study. If more than six volunteers are obtained, the researcher will randomly select six names from the list of volunteers. This selection will take place by placing the names in a box and requesting that one of the committee members be blindfolded and select six names. All volunteers for the study will be notified in writing by the researcher if they have or have not been selected for the project.

If you participate in this study, I will interview you on two separate occasions. The first interview will involve one to one and one-half hours of your time. The second interview will involve approximately one hour of your time. During the interviews I will ask you to discuss your perceptions of preceptorship. I will ask you some questions about yourself: practice area, educational background, and extent of your nursing experience with precepting in the intensive care unit. The interviews will take place at a location and time mutually convenient to the researcher and yourself. I would like to have your permission to tape record the interview. The tape of the interview will be transcribed by myself. Following the first interview, I will review the tape recording, and telephone you to arrange a second interview to share my findings with you and to determine if the information I have taken from the tape recording accurately reflects what has been said during the first interview. You will be provided with a copy of the transcript from the tape recording for you to review prior to our second interview.

If you participate in this study, your involvement in the study will be strictly

confidential. You will be assigned a code number by the researcher. Your identity will be known only by the researcher. The researcher and the committee members will be the only persons who will have access to the transcripts. The committee members will be given the code number assigned to each participant; they will not know the identity of the person being interviewed in the transcripts.

The tapes of the interviews will be transcribed by the researcher. The transcripts and tapes will be kept in a locked container to which the investigator will have the only key. All audio tapes and written material, excluding the final written report, will be destroyed within seven years following completion of the study. The written report and any further publication coming out of this study will describe only group information and will not identify you in any way.

Participation in this study is completely voluntary. Your decision whether or not to participate in this study will not affect your position as a nurse in any way. If you participate in this study, you have the right to refuse any question that you do not wish to answer.

Participation in this study will result in no direct benefits to you but it may provide you with the opportunity to share your thoughts and feelings about preceptorship.

If you choose to participate, I will read a consent form to you. I will answer any questions that you may have concerning this study. Your signature on the consent form indicates your willingness to participate in the study. You are free to withdraw from this study at any time without any harm to you.

I will be telephoning you in three to five days to discuss the nature of the study and any questions you may have. If you are willing to participate in the study, you will be asked to sign a consent form immediately before the first interview begins. You will be given a copy of the signed Consent Form to keep. I can be reached at 255-1975. If you wish to speak with my advisor, Dr. Barbara Paterson, she may be reached at 474-8240 at the Faculty of Nursing, University of Manitoba. Thank you for your time and consideration.

Researcher: Karla Farstad, BN., Student in Masters of Nursing program, University of Manitoba and part-time (20%) staff nurse in ICU at HSC.

Thesis Committee Members:

Dr. Barbara Paterson, Chair
Assistant Professor, Faculty of Nursing, University of Manitoba

Dr. Ina Bramadat, Internal member
Associate Dean
Undergraduate Program
Faculty of Nursing, University of Manitoba

Mrs. Judy Kaprowy, External member
Director of Medical Nursing
St. Boniface General Hospital

APPENDIX F

The University of Manitoba

FACULTY OF NURSING
ETHICAL REVIEW COMMITTEE

APPROVAL FORM

Proposal Number N#92/42

Proposal Title: "Perceptions of Intensive Care Nurse Preceptors Towards Preceptorship."

Name and Title of Researcher(s): Karla Farstad, RN, BN
Master of Nursing Graduate Student
Faculty of Nursing, University of Manitoba

Date of Review: December 07, 1992, and January 04, 1993

APPROVED BY THE COMMITTEE: January 04, 1993.

Comments: APPROVED with submitted clarifications/revisions received December 18, 1992, and Chair's correspondence dated January 6, 1993.

Date: January 11/93

Karen I. Chalmers, PhD, RN — Chairperson
Associate Professor
University of Manitoba Faculty of Nursing

Position

NOTE:
Any significant changes in the proposal should be reported to the Chairperson for the Ethical Review Committee's consideration, in advance of implementation of such changes.

Revised: 92/05/08/se

A COMPARISON OF PRECEPTOR PERSPECTIVES

Criterion Variable	Preceptor #1	Preceptor #2	Preceptor #3	Preceptor #4	Preceptor #5	Preceptor #6
Goal structure	Task Mastery	Moral Responsibility	Ability - Evaluative	Moral Responsibility	Task Mastery	Mentoring - Professional Identity
Primary focus	Student's ability to master learning goals established by preceptor and curriculum	Student learning and welfare	Preceptor's ability	Student learning and welfare	Student's ability to master learning goals established by preceptor and curriculum	Development of students' personal identity
Role Identification	Nurse-Teacher	Nurse-Teacher	Nurse-Teacher	Nurse-Teacher	Nurse-Teacher	Nurse-Teacher
Preceptor's Role	Gatekeeper to the profession; to provide learning experiences which result in student mastery	To form a partnership with students; to assist students to attain a higher level of function	Gatekeeper to the profession; to maintain control and demonstrate their own teaching and clinical ability	To assist students to sort out and assimilate their knowledge	Gatekeeper to the profession; to provide learning experiences which result in student mastery	To allow students to make decisions independently
Perception of students	Individuals who need the assistance of the preceptor to integrate and learn new information	Individuals who need the support of the preceptor	Individuals who are overwhelmed and need the preceptor's knowledge and expertise	Individuals who are learning and need support of the preceptor	Individuals who require expansion of basic skills in a new area	Owners of their learning experience

Criterion Variable	Preceptor #1	Preceptor #2	Preceptor #3	Preceptor #4	Preceptor #5	Preceptor #6
Attributional focus	Student success due to diligent monitoring by preceptor, appropriate assignment, and effort of student.	Student success due to student's ability and the provision of appropriate learning resources.	Student success due to preceptor's ability to teach.	Student success due to student's ability.	Student success due to preceptor's ability to provide learning experiences and promote confidence.	Student success due to student's ability.
	Student failure the result of lack of effort by student or failure to heed preceptor's advice.	Student failure due to preceptor's inability to intervene effectively.	Student failure due to student inadequacies (eg. dishonesty, defensiveness).	Student failure due to preceptor's inability to intervene effectively	Student failure due to program's inability to provide sufficient time for mastery or one-to-one teaching.	Student failure due to preceptor's inability to provide suitable learning or unfair evaluation practices.
Role of the nursing staff.	To communicate concerns about student directly to preceptor.	To actively participate in teaching and assessing student performance.	To provide appraisal support; to initiate disciplinary action (head nurse).	Partners in provision of learning experience. Members of the teaching team.	Assist the preceptor to provide sufficient learning opportunities.	Assist the preceptor to provide sufficient learning opportunities.
Role of advisor	To support preceptor's decision's; to monitor the student's progress	A partner in the decision making re students.	A partner in the decision making re students.	The final evaluator. Partners in the learning experience.	The teacher. To ensure appropriate pre-entrance requirements and performance standards	Problem solver. Monitor of student's progress.

Criterion Variable	Preceptor #1	Preceptor #2	Preceptor #3	Preceptor #4	Preceptor #5	Preceptor #6
Self-evaluation focus	Negative feedback performance viewed as miscommunication and student problem.	Student's unhappiness with preceptor's assessment viewed as evidence of role inadequacy.	Threat of appeal viewed as evidence of role inadequacy.	Staff negativity re student viewed as evidence of role inadequacy.	Problems of students viewed as due to inadequacies in program or entrance requirements.	Negative feedback re students from staff viewed as personal inadequacy.