Nurse Preceptor Self-Efficacy: Best Practices for Professional Development

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Abstract

Title of Dissertation:	Nurse Preceptor Self-Efficacy: Best Practices for Professional Development
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Nurses assume preceptor responsibilities in addition to usual nursing duties and most have minimal pedagogical preparation for the role. However, preceptors influence the competence of new staff through their instruction. The development of self-efficacy is vital to patient outcomes and safety. Using Bandura's (1997) framework of self-efficacy, ten proficient preceptors participated in an action research study that included individual interviews and focus groups related to the research question: What do proficient nurse preceptors report about the development of their preceptor self-efficacy for the purpose of recommending ongoing professional development and best practices within a hospital setting?

Preceptors identified thirteen best practices for ongoing professional development within their hospital. These practices include areas of Instruction, Preceptor Support and Professionalism. The largest number of findings were within Instruction. Preceptors are the first teachers of new hires within hospitals. Effective instruction was predicated upon the existence of role support and inculcation of professionalism within the preceptor culture. Recommendations for practice include adoption of these best practices into ongoing professional development curricula. A monthly preceptor forum, to facilitate preceptor networking and sharing, is recommended. Future research might examine teaching strategies utilized by preceptors and the timing of these strategies when engaged in precepting. A comparative study

using a self-efficacy tool for assessment could be conducted to ascertain whether the preceptor forum was building self-efficacy among the preceptors in comparison to another non-participating group of preceptors.

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EDUCATION

Doctor of Education, Educational Leadership **2014**
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Bachelor of Science, Nursing **1977**
University of Lowell, Lowell, MA
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PROFESSIONAL EXPERIENCE

Current Employment

1998-present **HOSPITAL FOR SPECIAL CARE**
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Clinical Resource Consultant: Nursing

Responsibilities: Clinical orientation, inservice, continuing education; competence assessment of nursing staff; regulatory agency survey readiness; support of organizational initiatives; coordinate nursing student affiliations, oversight of nursing continuing education provider unit. Past chair, Nursing Practice Committee. Past Healthcare Consultant for hospital's Child Care Center/Youth Camp (1999-2006).

2004-present ***Adjunct Clinical Faculty (Pediatric Nursing)***

Central Connecticut State University: BSN	Spring 2011-2013
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Past Employment

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Wallingford, CT
Instructor: First Aid/CPR, & Medication Administration for Child Care Providers; Medication Administration for Staff in Residential Care Homes.

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Child Care Nurse Healthcare Consultant

1987-2012 **CONNECTICUT CHILDREN'S MEDICAL CENTER/ NEWINGTON CHILDREN'S HOSPITAL**
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Staff Nurse*, (Per Diem)*

- Neurology Ambulatory Care (1998-2012)
- MS6 (school age and adolescent) medical surgical unit (1996-1998)
- School Nurse (substitute) CCMC School (1998-2009)
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1983-1987 **MOUNT SINAI HOSPITAL**
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Primary Nurse, Acute Behavioral Crisis Program

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Staff Nurse, Hartford Hospital, Pediatrics

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PROFESSIONAL AFFILIATIONS/MEMBERSHIPS

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- CHA Conference of Healthcare Educators (1993-2014)
  - 2008-2009 Chairperson, Healthcare Educators Forum
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  - 2002-2003 Medication Administration Proficiency Exam Task Force member
  - 1999-2000 Competency Task Force member
  - 1994-1997 Member Continuing Education Project Subcommittee
- Connecticut League for Nursing Member, (1994-5, 1999-present)
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- Connecticut Nurses' Association Member (2010-present)

CERTIFICATIONS

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AWARDS

Sigma Theta Tau Research Award (1994) for Master's thesis entitled, "*Heparin vs. Saline Flush in Peripheral I.V. Locks in Pediatrics"*

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"Building by Bridging Self-Efficacy in Nurse Preceptors".

May 2014: Hospital for Special Care Research Day CME presentation, New Britain, CT,
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Dedication

This dissertation is dedicated to my father, Samuel A. Thomas, who passed away just prior to being able to witness his daughter's achievement of this milestone. My father was a proud supporter of my academic pursuits, and I am grateful for the values, work ethic and love that he transmitted to his children. Thanks dad for your love and support!

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Very special thanks to my son, Thomas Slaney, who taught me about the doctoral journey as he shared his own experiences of the dissertation process. I valued the words of encouragement, honest critique and proof-reading of my work. Thanks son!

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I would be remiss if I did not thank my special friend and mentor, Teresa Twomey, whose persuasion convinced me to apply for doctoral studies. Since she started a year ahead of

me, I was able to learn vicariously from her experiences of the previous year and to benefit from her stories of various academic challenges.

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Another person to whom words of gratitude are owed is Amy Frey, medical librarian at my current work site. Amy helped to launch this research study through her assistance with my literature search and in obtaining the necessary journal articles. Thank you, Amy, for your assistance and help.

And finally, I am grateful for the coaching of my daughter, Heidi Slaney, relevant to writing strategies. Since her mom's skills had become rusty with dis-use, Heidi offered helpful tips about how to plan and structure a paper that have served me well. Thanks to my special daughter!

And now, lest these acknowledgements turn into another dissertation, it is time to summarize: Thanks for the special part that each of you has contributed towards the accomplishment of this goal!

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CHAPTER ONE: INTRODUCTION TO THE STUDY

Introduction to the Chapter

Nursing has relied on practicing staff or preceptors to serve as the orientors of new hires or internal transfers among units or specialties in healthcare facilities (Hyrkäs & Shoemaker, 2007; Ulrich, 2011). While it is generally agreed that preceptors should receive an initial day of training in preparation for this role, there is little consensus about the type and amount of ongoing support and education that is necessary (DeWolfe, Perkin, Harrison, Laschinger, Oakley, Peterson & Seaton, 2010), and limited research exists that engages preceptors in sharing their ideas in light of their own professional development needs (Forneris & Peden-McAlpine, 2009, Horton, DePaoli, Hertach & Bower, 2012; Sandau, Cheng, Pan, Gaillard & Hammer, 2011). This is ironic given the number of preceptors operating in hospital settings throughout the United States. Since experienced, proficient preceptors have been identified as significant contributors to an effective workforce (Henderson, Fox, & Malko-Nyhan, 2006), it would be important to understand what factors influenced their growth as a preceptor and what they relay as essential for professional development.

Because nursing is a practice discipline, pre-licensure education has focused on caring for patients at the bedside rather than the pedagogies associated with precepting newly graduated nurses (GNs) or new hires. However, when nurses assume the responsibilities of preceptor, they must learn a new skillset (Boyer, 2008) and within healthcare settings, proficient preceptors have been able to bridge this gap. While much is written about the need for excellent preceptors and ongoing support (Henderson & Eaton, 2013; Hyrkäs & Shoemaker, 2007; Sandau et al., 2011), little is written from the preceptor perspective about their attainment of self-efficacy and the relevant competencies.

Self-efficacy refers to the beliefs that people hold about their capabilities to perform in given situations and their ability to achieve or effect desired outcomes (Bandura, 1997). Bandura's social cognitive theory describes four sources of self-efficacy, three of which were chosen to frame this study of proficient nurse preceptors in a hospital setting. These sources include: enactive mastery experiences and active participation to achieve success at desired goals, vicarious experiences, and verbal persuasion or spoken encouragement from respected individuals related to the capabilities of the learner. The fourth source, emotional or physiologic states, relates to the emotional interpretations and somatic responses to stress-producing situations. Each source contributes to the development of self-efficacy throughout an individual's lifetime.

Since higher levels of self-efficacy have been related to positive outcomes including increased employee productivity, job satisfaction and personal wellness (Caprara, Barbaranelli, Steca, & Malone, 2006; Grau, Salanova, & Peiró, 2001; Jex, Bliese, Buzzell, & Primeau, 2001; Schwarzer & Hallum, 2008), it was expected that proficient preceptors would likewise report greater job-specific self-efficacy than new or less effective preceptors. Swihart (2007) suggested that since higher self-efficacy has been associated with job perseverance and was a good predictor of motivation, enhancing the self-efficacy of preceptors related to their role is important. Learning from the professional experiences of proficient nurse preceptors and enlisting their expertise has furnished insights that will be helpful in developing curriculum strategies to promote preceptor self-efficacy.

This action research study engaged proficient nurse preceptors in exploring the development of their preceptor self-efficacy for the purpose of recommending ongoing professional development within a hospital setting. In collaboration and partnership with these

stakeholders, the researcher synthesized best practices to support the advancement of preceptor self-efficacy. This chapter contains the context of the study, problem statement, conceptual framework, research questions and significance of the study.

Context of the Study

Within healthcare facilities, selection as a preceptor is often based on clinical competence or longevity rather than teaching excellence. Nurse preceptors are partnered with orientees for a designated period of time that varies based on the prior experience of the new nurse and the complexity of the clinical skills that are needed in the work environment (Gavlak, 2007). Initial preparation for the preceptor position usually involves attendance at a one-day educational program before assuming orientor duties (Benner, 1984; Sandau, et al., 2011). Clinically skilled bedside nurses, who understand the complexities of care, may "lack skills in areas such as educational theories…teaching strategies, teaching with technology, and evaluation" (Bonnel & Starling, 2003, p. 2), and must learn a new set of competencies as a preceptor. Proficient nurse preceptors have acquired these special competencies, however, preceptor engagement in the exploration of the formative experiences and supports that enabled their growth has only recently begun to be addressed in the literature (Horton et al., 2012; Sandau et al., 2011) and was the focus of this action research study.

Although a sequential pattern of development for nurse preceptors has not been described in the literature, as it has been for practicing nurses (Benner, 1984), the need for ongoing professional development of preceptors, which implies growth to a higher level of competence, has been recommended (Boyer, 2008; Henderson & Eaton, 2013). There is recognition within the profession that being a preceptor calls for the attainment of new skills (Boyer, 2008; Swihart, 2007; Ulrich, 2011). One study described expert staff nurses, who assumed the clinical educator

or preceptor position with students, as going from "expert [bedside nurse] to novice [preceptor]" (Cangelosi, Crocker & Sorrell, 2009). Within hospital settings, proficient preceptors have successfully survived this metamorphosis and gained the necessary preceptor competencies to emerge as exemplary orientors of new hires to their work unit (Boyer, 2008). Hearing what proficient preceptors, who were engaged in an action research study, reported about the acquisition of self-efficacy has provided critical information relevant to increasing the capabilities and self-efficacy of new preceptors.

Self-efficacy describes a person's beliefs about his/her abilities to perform in a certain capacity and to effect desired changes. "Expectations of personal efficacy are derived from four principal sources of information: performance accomplishments, vicarious experiences, verbal persuasion, and physiologic states" (Bandura, 1977, p. 191). Since people with low outcome or job-related self-efficacy have been associated with less perseverance and tolerance of stressors (Bandura, 1977; Grau et al., 2001), discovering ways to increase the self-efficacy of valuable human resources, such as the preceptor group, was important. Asking preceptors with high self-efficacy what sources enabled their development as a preceptor was helpful in identifying educational approaches to aid less efficacious colleagues.

While considerable attention has been paid in the nursing literature to the support needs of novice nurses in acute care hospital settings (Nelson et al., 2012), less attention has been paid to the ongoing needs of their preceptors (Horton et al., 2012). It has been acknowledged that preceptors are entrusted with enormous responsibilities: role modeling, teaching, socializing, protecting and evaluating the competence of orientees (Ulrich, 2011). The first impression and success of a new nurse is impacted greatly by how well prepared the preceptor is for his/her role. Proficient preceptors have been able to assimilate the necessary knowledge, skills and attitudes

to effectively fulfill this role. This action research study provided an opportunity for proficient preceptors to share insights and recommend ongoing strategies that would benefit their peers, as well as their consumers, the nurse orientees.

Oversight by proficient preceptors and an accurate evaluation of the new nurse's competence during the orientation period is essential to maintain the safety of the nurse and the patient during the learning period (Boyer, 2008). Whether or not an orientee gets off on a solid foundation may be dependent on the first weeks with their preceptor (Casey, Fink, Krugman, & Propst, 2004; Sandau & Halm, 2011). Since inadequate training of staff has been associated with compromised patient safety and increased medical errors, promotion of preceptor competency and support for the role has been recommended (Baggot, Hensinger, Parry, Valdes, & Zaim, 2005). Hearing the perspective of preceptors with higher self-efficacy was instructive for devising pedagogies related to effective supervision and shepherding new staff. Having a well-prepared and efficacious preceptor workforce has the potential to significantly impact the caliber of patient care provided on that work unit.

The need to have preceptors with high self-efficacy is particularly urgent in light of the realities of today's workplace, which can frequently be described as demanding and resource deficient (AHRQ, 2004). This environment may require the preceptor to simultaneously juggle charge duties, a heavy patient assignment and their orientee's needs. Preceptors in acute care hospital settings have reported increased stress related to the challenges of orienting new staff in addition to their other nursing responsibilities (Griffin, Hanley, & Saniuk, 2002; Hautala, Saylor, & O'Leary-Kelley, 2007). Since ongoing stress can contribute to burnout, dissatisfaction with orientation and turnover of nursing staff, discovering ways to mitigate these effects and preceptors during the orientation process would be critical (Haggerty, Holloway & Wilson, 2012).

Knowledge of what high-performing preceptors reported in this study as relevant to the development of higher self-efficacy has shed new light on strategies that could prevent these adverse outcomes and turnover.

Resilient and efficacious preceptors, able to persevere and thrive in today's value-driven environment, have become increasingly important, given the fact that healthcare administrators must reduce expenses (Conway, 2009), and at the same time continually improve patient safety (IOM, 2001) and outcomes (Craig, Eby, & Whittington, 2011). Hospital reimbursement has also been linked to patient satisfaction with nursing care and positive outcomes, with the Centers for Medicare and Medicaid Services (CMS) penalizing underperforming facilities by reducing payments (HCAHPS, 2013). To achieve safety and quality goals, hospitals employers need proficient preceptors, able to effectively cultivate the next cadre of nurses, and these preceptors have shared the pedagogical strategies that enabled their preceptor expertise in this action research study.

The need to develop proficient preceptors, as well as retain outstanding staff, is especially critical since the turnover of nurses within an organization is detrimental in terms of lost human resources and risks to patient safety. Because nurse replacement costs have been estimated at between $62,000 and $88,000 (Jones & Gates, 2007), employers can ill afford to lose competent preceptors, have poorly prepared new hires or chance reduced compensation due to poor consumer satisfaction and outcomes. Administrators at the University of Michigan Health System (UMHS) identified their preceptors as a key to reversing these potentially harmful trends (Axelrod, Handfield-Jones, & Michaels, 2002). UMHS categorized preceptors as "A players" within their organization, a terminology used in the business world to describe employees who directly affect the bottom line through their contributions. Their investment in professional

development activities for nurse preceptors proved beneficial, as positive and significant impacts were reported in preceptor and orientee satisfaction, as well as improved retention rates (Hensinger et al., 2004). Scant research to date has engaged proficient preceptors in exploring the development of their self-efficacy (Forneris & Peden-McAlpine, 2009, Horton et al., 2012; Sandau et al., 2011), which has been linked to increased job satisfaction and turnover reduction (Grau et al., 2001; Jex et al., 2001), and this action research study afforded this opportunity. More than ever, healthcare administrators may be reliant on the contributions of proficient preceptors to reduce turnover and ensure quality patient outcomes.

Although various instructional strategies and support mechanisms have been suggested towards the goal of professional development of preceptors, there has been little consensus or research to recommend one method over another (Henderson & Eaton, 2013), and few have solicited the knowledge and discernment of proficient preceptors relevant to this topic. While studies have been published proposing professional development in the form of on-line education (Harmon, 2013), self-learning packets (Riley-Doucet, 2008), workshops (Boyer, 2008; Swihart, 2007), blended learning (Bradley et al., 2007), and simulation (Wilson, Acuna, Ast & Bodas, 2013), few engaged the preceptors as collaborators in the process and may have overlooked valuable insights and innovations that their learners might have offered. However, a notable exception was described by educators at a Midwestern medical center, who engaged preceptors via a Preceptor Committee and charged the group with identifying and planning strategies to meet their educational needs (Nelson et al., 2012). Committee members examined the literature relevant to novice nurse orientation, interviewed newly minted nurses about their experiences, and subsequently participated in planning and implementing a preceptor forum relevant to these identified needs (Nelson et al.). Similarly, this study collaboratively engaged proficient

preceptors in active dialogue and examination of their growth as a vehicle to recommend best practices for preceptor development within a hospital setting.

Because preceptors are significant contributors to a competent workforce that directly impacts patient satisfaction, outcomes and reimbursement, it is important for healthcare administrators to support the development of their nurse preceptors. Inviting high-performing preceptors to reflect on their attainment of preceptor competence, and involving them in solutions to help other preceptors grow has uncovered new perspectives and insights that would benefit and develop their colleagues within the organization. This action research study attempted to provide that information by engaging proficient preceptors in exploring the following research question: What do proficient nurse preceptors report about the development of their preceptor self-efficacy for the purpose of recommending ongoing professional development and best practices within a hospital setting?

Statement of the Problem

Nurse preceptors in healthcare organizations face a myriad of challenges as they try to enact this expanded role within today's value-driven health system (Conway, 2009). Preceptors are entrusted with guiding new staff through the vulnerable first weeks to months of employment and serve as coach, teacher, protector and evaluator (Ulrich, 2011). To effectively perform as a preceptor, the nurse must acquire additional competencies that are not typically emphasized in most pre-licensure nursing curriculums (Boyer, 2008). Also, the role involves added work responsibilities on top of usual nursing duties, which can contribute to job stress, burnout and increased attrition (Griffin et al., 2002; Hautala et al., 2007). Therefore, finding ways to cultivate the preceptor group and mitigate the effects of stress associated with the role would be important for both professional development and the health of the organization.

Within hospital settings, managers and educators rely on their high-performing preceptors to acculturate and mold subsequent generations of staff to the work unit (Biggs & Schriner, 2010), yet few studies report tapping into this group as a potentially rich source of information. Listening to proficient preceptors has revealed new insights that were helpful in determining what ongoing preceptor development would be most beneficial and energizing. This action research study attempted to bridge this gap by engaging proficient nurse preceptors in exploring the development of their preceptor self-efficacy for the purpose of recommending ongoing professional development and best practices in a hospital setting.

Self-efficacy, a construct identified in social cognitive theory, is a measure of how humans perceive their capabilities in general and job-related contexts (Bandura, 1977). Outcome self-efficacy refers to people's perceptions of possessing competencies essential to their employment (Grau et al., 2001). Because highly efficacious people are more likely to take on new responsibilities, rate their job satisfaction and commitment higher, and enjoy better health states (Grau et al., 2001; Jex et al., 2001; Schwarzer & Hallum, 2008), it would be advantageous for hospital preceptors to possess this attribute. Proficient preceptors are expected to report a greater level of self-efficacy than new preceptors who, despite excellence in bedside nursing, may lack the requisite skill-set for precepting.

The nursing discipline commonly refers to five levels of nursing skill acquisition, described by Benner (1984), to identify the characteristics and stage of a nurse's development: novice, advanced beginner, competent, proficient and expert. Borrowing from this language, Boyer (2008) devised a "Preceptor Expertise Evaluation" instrument, where preceptors were rated on specific competencies using a "novice=1" to "expert=5" rating system. In addition, Boyer clustered the preceptor competencies according to Lenburg's (1999) Competence

Outcomes and Performance Assessment (COPA) model. The COPA model identified eight core practice competencies with which these preceptor competencies were aligned, including: assessment and intervention, communication, critical thinking, human caring and relationship skills, teaching, management, leadership and knowledge integration. Beginning preceptors would be expected to score lower expertise scores than seasoned preceptors when using Boyer's evaluation instrument (VNIP, 2009). In like fashion to the scholarship of nurse professionalization, this action research study of preceptors used the term "proficient" to describe high-performing or outstanding preceptors. For most nurses, becoming a proficient preceptor requires time, job-related experiences and ongoing professional development (Swihart, 2007).

Proficient preceptors have both clinical acumen and precepting know-how, including goal-setting, coaching, promoting critical thinking and evaluating performance. They ensure that new hires develop into competent team members (Ulrich, 2011). Less efficacious preceptors could learn much from proficient preceptors about managing challenging preceptor responsibilities such as conflict resolution, working with diverse learners and communicating effectively. Since most nurses have had little preparation in instructional methodologies as part of their basic nursing education (Bonnel & Starling, 2003; Yonge, Hagler, Cox & Drefs, 2008), and the preceptor role is often assumed after only a day of training, it is not surprising that new preceptors have reported decreased self-confidence and knowledge related to teaching pedagogies (Haggerty et al., 2012; Sandau et al., 2011).

The literature has identified a need to provide ongoing support to preceptors (Baggot et al., 2005; Henderson et al., 2006; Yonge et al., 2008). However, this researcher, upon conducting a recent poll of educators at Connecticut hospitals, found that only four of the twenty

responding hospitals had provided any formal ongoing preceptor professional development during the past year, and among those that did, there was great variation in the delivery and content of the professional development material that was offered (Thomas, 2013, see Appendix A).

While diverse formats for education and support have been suggested in the literature, no consensus exists to endorse one method over another (DeWolfe et al., 2010). The input of proficient preceptors has been, prior to this study, a relatively unexplored resource. Their participation has provided invaluable evidence which could be used by administrators in making choices as to which supportive and pedagogical activities would be most efficacious to implement. Also, involvement of the in-house experts to identify and recommend solutions to preceptor development has built capacity within the group and has increased the commitment of the preceptor group towards this effort.

Because the current environment in hospitals calls for nurses who are able to care for challenging patients with multiple co-morbidities (AHA, 2012), healthy and committed preceptors are needed in the workplace. However, these same nurses who assume preceptor responsibilities are also juggling a myriad of competing tasks. Besides orienting new staff, preceptors often simultaneously manage full patient assignments, committee projects, or the role of charge nurse (Griffin et al., 2002; Hautala et al., 2007). The multiple demands on preceptor time have been reported as stressful (Hyrkäs & Shoemaker, 2007; Yonge et al., 2008). Ongoing exposure to stressors has been associated with worker perceptions of overwork, cynicism and burnout (Grau et al., 2001; Jex et al., 2001). Burnout may contribute to what has been called the "turnover intention" of nursing staff (Grau et al, 2001; Günüsen & Üstün, 2010). Preceptor stress and a chaotic environment can also compromise orientee satisfaction (Baggot et al., 2005).

Since higher self-efficacy in employees has been associated with moderation of stress, better work performance, job commitment and health states (Grau et al., 2001; Jex et al., 2001; Caprara et al., 2006), proficient preceptors reports about the development of their self-efficacy might be taken as instructive for preceptors and employers to proactively try to prevent negative consequences.

Healthcare financiers today must maintain a robust and vibrant workforce as they deal with government regulations to improve patient satisfaction and outcomes, or face reductions in reimbursement from Medicare and Medicaid sources (CMS, 2013; Craig et al., 2011). Simultaneously, the costs of providing care and the acuity of patients in hospitals settings have increased dramatically (AHA, 2013). Having a competent workforce to provide effective care is integral to achieving high quality outcomes. Hospitals cannot afford to lose experienced preceptors as a casualty of burnout or have poorly trained staff due to ineffective precepting. Since replacing an experienced nurse costs thousands of dollars, it would behoove hospital employers, in this value-driven economy (Conway, 2009), to act upon findings about ways to support and increase the self-efficacy of their preceptor group (Hensinger et al., 2004; Hyrkäs & Shoemaker, 2007). The social sciences literature has indicated that workers who reported higher self-efficacy were less likely to look for alternative employment elsewhere (Grau et al., 2001; Günüsen & Üstün, 2010).

Because excellent preceptors train the next generation of staff and ensure the competence of new hires to care for an increasingly complex patient population, planning organizational supports for preceptors is important. Listening to the perspectives expressed by proficient preceptors and involving them in solutions to organizational challenges could serve to empower and energize a group that traditionally has been unheard. This action research study has added

significant data needed by hospital administrators to support resource allocation for preceptor development. The purpose of this action research study was to engage proficient nurse preceptors in exploring the development of their preceptor self-efficacy for the purpose of recommending ongoing professional development and best practices in a hospital setting.

Conceptual Framework

The conceptual framework that guided this study drew on the work of Bandura's (1997) social cognitive theory of self-efficacy. Self-efficacy refers to the beliefs that people have about their capabilities to perform in given situations and their ability to achieve desired outcomes. Studies within the literature have demonstrated a positive relationship between levels of individual self-efficacy and job productivity, wellness states, satisfaction, and organizational commitment (Grau et al., 2001; Jex et al., 2001; Caprara et al., 2006; Schwarzer & Hallum, 2008). In addition, workers with high self-efficacy may be more likely to continue their education, request additional responsibilities and expend greater effort on the job (Schwarzer & Hallum, 2008). One study reported that teachers who were highly self-efficacious had higher achieving students and better interpersonal co-worker networks (Caprara et al., 2006). The association between higher self-efficacy and desired positive worker characteristics was a significant reason for healthcare employers to engage proficient nurse preceptors in exploring the development of their self-efficacy in the role for the purpose of recommending best practices for ongoing professional development within a hospital setting.

Bandura (1997) hypothesized that self-efficacy is shaped by four sources of information throughout a person's life: *enactive mastery experiences, vicarious experiences, verbal persuasion, and emotional or physiologic states*. Social, personal and situational factors influence how people interpret and integrate perceptions of self-efficacy. People judge their self-

efficacy based on these factors and a combination of "rules or heuristics that people use to weight and integrate efficacy information from different sources in constructing beliefs about their personal efficacy" (Bandura, p. 79). In this study, Bandura's (1997) sources of self-efficacy were used as the lens through which to explore the developmental experiences of proficient nurse preceptors and guided the collaborative recommendations for ongoing preceptor development and best practices. Each source of self-efficacy is outlined in Table 1 and briefly described in the following paragraphs.

Enactive mastery experiences.

While each of the four sources contributes to self-efficacy, Bandura (1997) identified the strongest influencer as enactive mastery experiences, which involves active participation of the learner and performance accomplishments. Dividing learning into manageable chunks with realistic goals for attainment allows an individual to achieve mastery within a reasonable amount of time. Goals should be sufficiently challenging, as a degree of difficulty and overcoming past failures can convince learners they are able to persist in the face of adversity. Upon experiencing success with graduated learning, progress may be made towards increasingly higher levels of competency. The most salient source of self-efficacy comes from active experimentation. Self-correction may occur based on timely, effective feedback.

Enactive mastery experiences alone, however, do not produce increased self-efficacy. A person could perform skills successfully, but still possess a lower sense of self-efficacy. Rather, it is the value that is placed on these activities regarding "these performances" that contributes to whether individuals change their sense of self-efficacy (Bandura, 1997, p. 81). In addition to mastery experiences, people's perception of self-efficacy is influenced by the degree of difficulty, amount of effort expended to achieve the goal, social value and amount of external aid

Table 1 Sources of Self-Efficacy (Bandura, 1997)	
Source	**Brief Description**
Enactive mastery experiences	The strongest source of efficacy information. Involves active participation of the learner. Accomplished by breaking down complex skills into easily mastered smaller skills which can be tackled hierarchically.
Vicarious experiences	Comparison of self with the attainments of others. Visualizing or listening to the experiences of people similar to oneself; noting that if others can do it, the learner feels able to do it.
Verbal persuasion	Social influencing and encouragement by respected sources to influence the learner regarding personal capabilities that previously were unthinkable. Is effective if the outcome is realistic for the learner to accomplish.
Emotional or physiologic states	Targeted strategies to reduce people's somatic and emotional responses to stressful situations (e.g. enhancement of well-being to decrease stress levels; desensitization; correction of negative interpretations of bodily responses).

received. Applied to nurse preceptors, this might include such aspects as difficulty of position expectations, employer/peer support and recognition, and temporal or work conditions. The other three sources of self-efficacy, vicarious experience, verbal persuasion, and emotional or physiologic states also contribute to the self-assessment of one's efficacy.

Vicarious experiences.

Though not as strong a source of self-efficacy as mastery experiences, vicarious experiences involves the use of modeled attainments (Bandura, 1977). Seeing or visualizing people in action who are similar to them enable humans to imagine achieving a similar level of accomplishment. When people have not been exposed to life experiences in a particular arena, they may have little idea of potential capabilities. Hearing stories of others' attainments permits envisioning the performance of an activity. The verbalization of thought processes related to

decision-making and the testing of alternative solutions allows learners to comprehend the rationale behind actions and to consider other ways of thinking.

Modeled performances by competent persons represent an example of the use of vicarious experiences, and can provide predictability and situational control. Predictability reduces stress by helping people anticipate events and coping strategies (Bandura, 1997). The model might demonstrate effective coping strategies for handling an expected aversive situation or illustrate failure via deficient strategies. This would permit the learner to predict what might occur, and thus, decide whether to use the modeled strategy or choose an effective alternative. For example, proficient preceptors may provide novice preceptors with examples from their own experiences about how to react when encountering a challenging situation.

The use of vicarious experiences also allows individuals to compare themselves in relation to their peers: "The attainments of others who are similar to oneself are judged to be diagnostic of one's own capabilities" (Bandura, 1997, p. 87), and knowledge of best practices relating to role performance can contribute to an individual's self-appraisal of efficacy. For nurse preceptors, having knowledge of the competencies relating to precepting would be helpful in judging and improving self-efficacy.

Verbal persuasion.

Verbal or social persuasion involves the use of spoken encouragement by respected sources or persons significant to the learner. Bandura (1977) felt that people could be influenced by the suggestions of others into attempting activities that they may have previously feared or avoided. When delivered by a credible source, the message would more likely be heeded and not dismissed. Although the effect of verbal persuasion tends to diminish over time, it has been found to be particularly effective for the person struggling to reach challenging, but attainable

goals. In such a case, the person is more likely to expend additional energy and effort to reach these goals (Bandura, 1997).

Verbal feedback delivered during an evaluation of performance can contribute to or detract from self-efficacy (Bandura, 1997). The ways in which the feedback is framed can produce a positive or negative effect. Focusing on deficiencies or shortfalls versus achieved progress can have decidedly different impacts on the recipient. Conversely, while focusing on positives might promote self-efficacy, falsely inflating capabilities and achievement when mastery experiences indicate otherwise can have the opposite effect. Proficient preceptors provide ongoing, effectual feedback that focuses on progress and self-gains. Hearing how verbal persuasion contributed to the growth of proficient preceptors, as well as exploring their use of this approach with orientees or peers has proven instructive for ongoing professional development of newer preceptors.

Emotional or physiologic states.

Emotional or physiologic states refers to the affective or somatic responses that a person may experience in association with a particular activity (Bandura, 1997). When dealing with a struggling orientee and a busy assignment, a nurse preceptor might experience physiologic responses such as an increased heart rate, blood pressure, sweating, and fatigue, as well as affective responses of anxiety, defensiveness, or anger. A preceptor with low self-efficacy could internalize these symptoms as evidence of a lack of capability and powerlessness. However, a seasoned preceptor would more likely blame his/her symptoms on the challenging work situation rather than low preceptor self-efficacy. In addition, the mood state that a person is experiencing at the time of a learning activity also impacts perceived self-efficacy. When a person feels happy at the time of an activity, their perception of self-efficacy is usually higher on recall of the event.

Thus, a highly efficacious preceptor might recall a challenging experience of precepting in the hospital as a stimulating or growth producing emotional state.

Since self-efficacy is influenced by context and continually shaped by the sources of information identified by Bandura (1997), and is critical to preceptor effectiveness, a hospital setting presents a unique opportunity to learn about the self-efficacy development of proficient preceptors. According to Bandura, "Billions are spent annually on occupational training, but there is a paucity of reliable evidence about the effectiveness of the methods used" (p. 440). Understanding what contributed to higher self-efficacy has provided solutions beneficial within this organization and may be applicable to other healthcare settings. The purpose of this action research study was to engage proficient nurse preceptors in exploring the development of their preceptor self-efficacy for the purpose of recommending ongoing professional development and best practices within a hospital setting.

Research Questions

The primary research question that guided this action research study was: What do proficient nurse preceptors report about the development of their preceptor self-efficacy for the purpose of recommending ongoing professional development and best practices within a hospital setting?

There were four sub-questions:

1. What do proficient nurse preceptors report about the development of their self-efficacy related to enactive mastery experiences?
2. What do proficient nurse preceptors report about the development of their self-efficacy related to vicarious experiences?

3. What do proficient nurse preceptors report about the development of their self-efficacy related to verbal persuasion?
4. What do proficient nurse preceptors recommend regarding best practices for ongoing preceptor professional development?

Operational Definitions

Emotional States: Affective response to a given situation with associated self-efficacy interpretations (Bandura, 1997).

Enactive Mastery Experiences: The strongest source of efficacy information that involves active participation of the learner. Learning may be structured by breaking down the learning into achievable and hierarchically structured learning chunks (Bandura, 1977).

Modeling: Seeing or visualizing the attainments of others or of the self through specially arranged situations to demonstrate what the learners are capable of (Bandura, 1997).

Novice Nurse Preceptor: An experienced nurse who assumes new responsibilities as a preceptor and must learn additional preceptor competencies (Boyer, 2008).

Nurses: Registered nurses (RN) or licensed practical (vocational) nurses (LPN, LVN); designation is dependent on their education and passing score on the RN or LPN pre-licensure examination (NCSBN, 2013).

Orientee: A newly hired nurse or transferee to another unit or specialty who is participating in an orientation program. Includes novice or newly graduated nurses as well as experienced nurses.

Physiologic States: Somatic or bodily responses to a given situation or stimulus; Targeted strategies would seek to reduce or replace negative responses with positive coping strategies and associations to increase self-efficacy related to the given situation (Bandura, 1997).

Preceptee: A newly hired nurse or transferee to another unit or specialty whose orientation is being guided by one or more preceptors.

Preceptor: A practicing nurse who is selected by an employer to serve as the orientor of a new hire for a designated period of time. Preceptor responsibilities include serving as a role model, coach, teacher, influencer, socializer, and protector of the orientee (Ulrich, 2011).

Proficient preceptors: In this study, a descriptor for preceptors who possess clinical acumen and achieve above-average ratings on the Preceptor Effectiveness Evaluation (VNIP, 2007) by their manager or clinical educator.

Self-Efficacy: The beliefs that people hold about their capabilities to perform in a given situation and their ability to achieve or effect desired outcomes (Bandura, 1977).

Verbal Persuasion: Source of self-efficacy involving spoken encouragement or verbal feedback related to a person's capabilities to achieve a desired goal or objective (Bandura, 1997).

Vicarious Experiences: Comparison of self with the attainments of people similar to oneself. Involves listening to varied experiences or visualization to imagine performing an activity or achieving a goal or objective (Bandura, 1997).

Significance of the Study

Within healthcare organizations, proficient preceptors are relied upon as the key to the successful orientation and acculturation of new nurses to the work unit (Horton et al., 2012; Ulrich, 2011). By virtue of being the orientee's first interface with the work environment, preceptors influence the confidence and competence of new hires (Biggs & Schreiner, 2010). This study was significant because retaining effective preceptors and growing new preceptors are fundamental concerns of nursing managers and administrators as a vehicle to train new staff to meet the demands of patient care. This section will describe the preceptors' need for ongoing

preceptor professional development; identification of the need for supports to mitigate the stressors inherent in the preceptor role; the association of high self-efficacy with moderation of stressors; the need to prevent preceptor/staff turnover and adverse effects on patient outcomes and costs; and the benefits of building high self-efficacy in preceptors.

Preceptors Need Ongoing Professional Development

Despite the reliance on preceptors, the literature has indicated that most nurses lack skills related to the complexities of teaching and evaluation (Bonnel & Starling, 2003; Luhanga, Dickieson & Mossey, 2010; Yonge et al., 2008), and most hospital employers expect preceptors to fulfill the requirements of the role with little more than a day of instruction (Sandau et al., 2011). The findings of this researcher's recent survey of Connecticut hospitals (Thomas, 2013, see Appendix A) indicated that while all respondents required an initial preparatory preceptor class, only 21% of the hospitals had provided ongoing professional development for their preceptors within the past year, which could be related to the faltering state economy and reduced reimbursement, that had impacted resources for hospital education and staffing (CHA, 2013).

In the midst of this current austere fiscal climate, seeking out the expertise of in-house resources, namely excellent preceptors within the hospital was found to be a powerful resource for information and help. This action research study engaged proficient preceptors in exploring the development of their self-efficacy as a preceptor as a means to recommend effectual and cost-effective ongoing professional development strategies.

Since attainment of skill in precepting requires ongoing education, job experiences, and organizational supports (Hyrkäs & Shoemaker, 2007; Luhanga et al., 2010; Sandau et al., 2011), proficient preceptors within the hospital setting, who have been able to master the intricacies of

this role, provided a wealth of information that was instructive for preceptors struggling with their responsibilities. Newer preceptors might benefit from using the information shared by the high-quality preceptors relevant to navigating preceptor challenges. Accessing the expertise of preceptors within hospital settings would seem to be in line with the Institute of Medicine's (IOM) admonition to utilize nurses within the full scope of their practice and potential (IOM, 2011), and this group has traditionally been unheard or underutilized as knowledge workers (Nelson et al., 2012). This study provided a voice for proficient preceptors to explore their process of self-efficacy attainment as a preceptor and engaged their participation in recommending solutions for ongoing development and support.

Preceptors Need Support: Precepting Can Be Stressful

While the literature suggests that ongoing support of preceptors was needed (Haggerty et al., 2012; Henderson et al., 2006), there has been little consensus regarding the type and quantity of ongoing supports. Being a preceptor can be stressful due to the added job responsibilities of orienting new staff on top of a complex patient assignment, charge role or committee responsibilities (Griffin et al., 2002; Haggerty et al., 2012; Hautala et al., 2007; Sandau et al., 2011; Yonge et al., 2008). Because human service professionals [and preceptors] frequently work in emotionally charged and demanding environments, they could be particularly vulnerable to fatigue, stress, job disillusionment and burnout (Schwarzer & Hallum, 2008). Self-efficacious preceptors have encountered job stressors, and exploring their responses and support recommendations to manage preceptor challenges has proven useful.

Promotion of Self-efficacy to Moderate Stressors and Adverse Effects

One employee characteristic that has been associated with moderation of stressors in the workplace was high self-efficacy (Grau et al., 2001; Jex et al., 2001), and it could be predicted

that proficient, self-efficacious preceptors would report a similar moderating experience of stressors related to precepting responsibilities as compared to novice preceptors. Also, increased worker self-efficacy has been associated with other positive attributes desirable in preceptors: better wellness states (Grau et al., 2001; Jex et al., 2001), willingness to take on challenging endeavors (Bandura, 1977), pursuit of additional education (Caprara et al., 2006; Grau et al., 2001) and commitment to the job (Grau et al., 2001; Jex et al., 2001). Since higher self-efficacy has been correlated with a healthier workforce (Caprara et al., 2006; Grau et al., 2001; Jex et al, 2001), finding ways to increase self-efficacy was vital. Inviting preceptors to share their sources of self-efficacy during the course of this study provided beneficial information relevant to stress management, job learning and personal well-being.

Increasing the self-efficacy of preceptors was also important because preceptors with lower self-efficacy might negatively affect learners through cynicism or other manifestations of stress (Schwarzer & Hallum, 2008). This could contribute to orientee dissatisfaction with orientation and result in turnover of staff. The literature has demonstrated that educators with higher self-efficacy ratings had better performing students and were more likely to create social supports that encouraged professional growth (Caprara et al., 2006). Likewise, it was expected that preceptors who reported higher self-efficacy would demonstrate positive role modeling to enable their orientees' successful acculturation and satisfaction with the orientation experience. Prevention of employee dissatisfaction that could result in turnover, by raising the self-efficacy of preceptors, was an important goal, as replacing even one nurse costs thousands of dollars (Jones, 2008). Involving proficient preceptors in a study such as this helped to identify sources that promoted self-efficacy and which could be used to energize and motivate other staff.

Preventing Turnover and Its Negative Effect on Patient Outcomes

Because replacement of experienced staff nurses and preceptors, particularly on specialty units, has often been difficult to obtain, loss of valued staff could compromise patient outcomes. For this reason, maintaining a healthy workforce has become increasingly important as hospitals strive to maintain financial viability (CDC, 2013). At the same time that hospitals were required to decrease hospital readmissions and costs (Craig, et al., 2011), they were simultaneously challenged to improve patient outcomes (Conway, 2009). Data to validate the funneling of resources towards preceptor development activities, as a solution to maintenance of a competent workforce, would be helpful for managers. Using information gleaned from this study relevant to best practices for preceptor development might prevent turnover and indirectly impact patient safety and quality outcomes.

Benefits of Building High Self-efficacy Preceptors

Since hospital reimbursement has now been linked to patient outcomes and satisfaction (Conway, 2009; HCAHPS, 2013), it is even more urgent to invest in proficient, self-efficacious preceptors who are able to help grow a competent, qualified staff (Yonge, Krahn, Trojan, Reid, & Haase, 2002). As high self-efficacy has been related to better teaching and learning (Caprara et al., 2006), as well as better role modeling and increased organizational commitment (Grau et al., 2001; Hensinger et al., 2004), this research that has demonstrated methods to increase the self-efficacy of preceptors could represent important innovations for healthcare employers. While preceptors can be at risk for increased stress (Haggerty et al., 2012; Henderson et al., 2006), and burnout as a result of the demands of the job (Bégat, Ellefsen & Severinson, 2005), and may have knowledge deficits relevant to teaching (Bonnel & Starling, 2003), proactive planning and actions can be implemented to mitigate these issues. A myriad of sources from the

social sciences (Grau et al., 2001; Jex et al., 2001; Bandura, 1997), education (Caprara et al., 2006; Schwarzer & Hallum, 2008) and nursing (Hautala et al., 2007; Henderson et al., 2006; Hensinger et al., 2004; Hyrkäs & Shoemaker, 2006) suggest that self-efficacy is a fundamental concept for establishing a professional workforce and can be acquired (Bandura, 1997). Proficient preceptor participants in this study may have been the optimal individuals available within the hospital setting to provide these suggestions and best practices for the incorporation into ongoing professional development.

In a time when hospitals are competing with each other for resources and are required to provide evidence of improved patient care outcomes, the use of proficient preceptors has represented an untapped resource within the hospital setting. Engaging proficient preceptors in the exploration of the development of preceptor self-efficacy for the purpose of developing best practices for ongoing professional development represented a significant and unique avenue of study.

CHAPTER TWO: REVIEW OF THE RELATED LITERATURE

Introduction to the Chapter

The purpose of this action research study was to engage proficient nurse preceptors in exploring the development of their self-efficacy for the purpose of recommending ongoing professional development within a hospital setting. High self-efficacy has been associated with better job performance and health states of workers (Bandura, 1997) and having employees with this characteristic is desirable (Grau et al., 2001; Jex et al., 2001) and essential in light of the current austere fiscal climate (AHRQ, 2004; CMS, 2013). Proficient preceptors, who provide valuable services as the orientors of new nurses to the hospital, represented a relatively untapped source of information about best practices for preceptor development within this economic environment.

This literature review includes information gleaned from scholarly sources such as empirical studies, peer-reviewed journals and government websites. Chapter Two is organized into a broad review of the literature from three relevant subject areas: (a) preceptor professional development and support needs; (b) self-efficacy and job performance; and (c) changes in hospital reimbursement to a value-driven health system.

Preceptor Professional Development and Support Needs

Nursing preceptors are practicing staff that serve as the orientors of new hires or internal transfers to other units within the hospital setting (Hyrkäs & Shoemaker, 2007; Ulrich, 2011). While selection as a preceptor is primarily based on clinical excellence, this designation also requires the acquisition of teaching competencies integral to the role and for which most nurses have had little preparation through their pre-licensure nursing curricula (Bonnel & Starling, 2003; Hillman & Foster, 2011). Despite this lack, hospital educators and managers would be

able to identify within their work units those nurses who have become proficient at precepting and who have attained the necessary pedagogical skills to enact this role successfully (VNIP, 2009). Although some preceptors have reported feeling inadequately prepared and struggle with the complexities of the position (Bonnel & Starling, 2003; Luhanga et al., 2010; Yonge et al., 2008), proficient preceptors have been able to bridge this knowledge gap. Since ongoing development and support of preceptors has been recommended in the nursing literature (Hyrkäs & Shoemaker, 2007; Luhanga et al., 2010; Sandau et al., 2011), enlisting the active participation of proficient preceptors was a helpful source for ideas relevant to innovations and best practices for developing newer or less efficacious preceptors.

This first section of this literature review outlines the responsibilities ascribed to nurse preceptors, typical preparation of nurse preceptors for the role, and recommendations from empirical studies regarding ongoing professional development for this group. In addition, the specific knowledge gaps identified by the literature will be outlined, as well as ways that experienced or proficient preceptors were engaged to meet educational needs and provide education at exemplar institutions.

Responsibilities of nurse preceptors.

Capable and proficient nurse preceptors are heavily relied up to perform essential functions in hospitals that are critical to the maintenance of a competent workforce (Walker, Cooke, Henderson & Creedy, 2013). Ulrich (2011) has categorized these functions as follows: teacher/coach, leader/influencer, facilitator, evaluator, socializer, protector and role model of the orientee, towards the ultimate goal of staff competence in provision of care that ensures patient safety. Preceptors assess their orientees' learning needs, select appropriate educational activities,

encourage critical thinking, and accurately evaluate competence (Swihart, 2007), and they are expected to assume these professional and leadership activities in addition to their clinical duties.

As twenty-first century nurses find themselves practicing in an increasingly complex and stressful healthcare environment (Hyrkäs & Shoemaker, 2007; Sandau et al., 2011), the need to have highly efficacious and proficient preceptors is especially significant. Preceptors, who are entrusted with guiding neophytes during the orientation period, impact every new nurse that enters the work unit, and they have been identified as a key human resource asset (Hensinger et al., 2004; Hyrkäs & Shoemaker, 2007, Ulrich, 2011). Many schools of nursing have adopted the preceptor concept and may also utilize the same pool of staff nurses for role models and clinical educators of senior or capstone students (Myrick & Yonge, 2004). While precepting during the orientee's vulnerable first weeks, the preceptor may encounter a myriad of challenges from various sources including: the learning environment, preceptor role expectations and workload (Griffin et al., 2002; Hautala et al., 2007), as well as the orientee (Biggs & Schriner, 2010). A proficient preceptor could be expected to successfully weather these adversities, however, a less efficacious preceptor, who may have had little more than a day of preparation for the role, may lack the precepting acumen to navigate such circumstances. Since preceptors carry such weighty responsibilities, identifying essential ongoing educational ingredients to grow a cadre of proficient preceptors within hospitals is crucial.

Preparation of nurses for the preceptor role.

It is noteworthy that nurses are chosen to become preceptors based on their clinical rather than teaching abilities, and most have had little exposure to the rigors of teaching (Bonnel & Starling, 2003; Hillman & Foster, 2011). In addition to competence with the population served, managers select preceptors who have achieved a satisfactory rating on their performance

evaluation and who might be interested and willing to serve in this capacity (Ulrich, 2011). Attention to educational theories and instructional strategies to promote critical thinking in novices and new hires have traditionally received scant mention in undergraduate nursing courses (Beres, 2006). Since it has been acknowledged that clinical competence and precepting are separate skill sets, it is logical that preceptors would require professional development, peer support and mentoring related to managing the challenges of this role (Henderson & Eaton, 2013) and as a vehicle to increase preceptor proficiency.

Initiation into the preceptor role and responsibilities usually includes participation in a foundational educational activity prior to assumption of duties, such as a one-day workshop (Sandau & Halm, 2011; Swihart, 2007; Ulrich, 2011). However, within the United States, variation exists as to the length, content and delivery of these activities among healthcare entities. Within some states, professional organizations and Boards of Nursing have attempted to establish requirements for attendance at a preceptor education day and a standard curriculum (VNIP, 2009, Sandau et al., 2011). For example, the Minnesota Nurses Association, in 2004, endorsed a paid, 8-hour preceptor workshop as necessary to becoming a preceptor (Sandau & Halm, 2011). However, other states have no preceptor training requirements, as in the state of Connecticut, where hospital employers may offer their own class or send staff to an outside venue like the Connecticut Hospital Association (CHA). CHA hosts a one-day Preceptor Class twice a year for new preceptors for a fee; the curriculum was developed through the collaboration of hospital-based educators within the state (Connecticut Hospital Association, 2013). Currently no "advanced" preceptor workshop is offered to build on or reinforce the concepts introduced during the basic class.

Recommendation for ongoing professional development.

After attending an initial class, additional support of preceptors has been recommended to enable their growth (Boyer, 2008; Cangelosi et al., 2009). New preceptors require time and experience to develop proficiency in the role, similar to the acquisition of skills by new nurses along a continuum of novice to expert practitioner (Benner, Sutphen, Leonard, & Day, 2010; Haggerty et al., 2012; Hyrkäs & Shoemaker, 2007). Preceptors should not be presumed to have obtained skill in teaching by virtue of their competence as clinicians (Bratt, 2009; Paton & Binding, 2009; Ulrich, 2011). Shortsightedly, much of the resources expended by healthcare organizations for preceptor development have related to provision of an initial educational workshop and have stopped short of providing ongoing professional development and support to this group (see Appendix A). It is fortuitous that despite this lack, proficient preceptors have found other sources to enable their growth or have learned through trial and error. While continuing education has been suggested (Henderson et al., 2006), implementation and venues to encourage social networking and sharing of best practices has been inconsistent.

The need for continued support of the preceptor beyond this initial education has been cited in the nursing literature, with education identified as a key component (Forneris & Peden-McAlpine, 2009; Haggerty et al., 2012; Hautala et al., 2007; Henderson & Eaton, 2013; Myrick & Yonge, 2004; Sandau et al., 2011). As preceptors have been expected to assimilate a volume of knowledge and skills within a compressed amount of time, they may have not received adequate education to be effective (Baltimore, 2004: Sandau et al., 2011). This was borne out by a study of novice nurse preceptors in New Zealand, where a precepting model similar to the USA's exists. Less than half of those surveyed reported they felt confident in their abilities to perform this role (Haggerty et al., 2012). The data from follow-up focus groups revealed

recurrent themes: a perceived need for ongoing preceptor education and feedback related to the preceptor's effectiveness. In addition, system problems, such as staffing patterns that did not afford nurses time to perform necessary preceptor responsibilities, lack of replacements to enable attendance at educational activities and oversubscription to planned preceptor classes served to block preceptor participation in professional development activities. Similar frustrations have been substantiated by other researchers (Henderson & Eaton, 2013) and underline the importance of examining and supporting preceptor development.

Improvements in quality and satisfaction of employees were noted when one Midwestern acute care hospital's administrators overhauled their orientation and preceptor program (Hillman & Foster, 2011). Pre-reforms, a high turnover rate was reported, and "the preceptors varied on their experience, training, willingness to participate and ability to organize orientation" (p. 51). The researcher concluded that ongoing preceptor support and education was necessary to prevent inconsistencies in preceptor quality and to improve the orientation process.

While preceptor professional development has been recommended, the optimal content, methodology, delivery and sequencing to achieve this objective are still subjects for debate (DeWolfe et al., 2010). In addition, much of the nursing research has related to precepting pre-licensure students by staff nurses rather than precepting of practicing nurses (Henderson & Eaton, 2013; Sandau et al., 2011). Proficient preceptors have assisted with uncovering effective ways of tackling this quandary through an exploration of their own journeys and through participation in this action research study.

Specific preceptor knowledge gaps.

As mentioned previously, there is great variability as to the frequency, content and context of professional development support for preceptors nationally, and it has often has been

left to happenstance (Henderson & Eaton, 2013). A systematic review of empirical studies related to preceptor supports found no consensus related to structure, process or outcomes (DeWolfe et al., 2010). Specific problematic areas for preceptor education that have been identified include: feedback and communication skills (Foy, Carlson & White, 2013; Myrick & Yonge, 2004); coaching for critical thinking (Forneris & Peden-McAlpine, 2009; Foy et al., 2013; Myrick & Yonge, 2004), working with non-traditional and diverse learners (Haggerty et al., 2012; Hyrkäs & Shoemaker, 2007; Sandau et al., 2011), role modeling (Myrick & Yonge, 2004), and facilitating social integration of new employees (Myrick & Yonge, 2004; Sandau et al., 2011). Conflict resolution and appropriate handling of performance issues have also been areas of concern (Haggerty et al., 2012; Luhanga, Yonge & Myrick, 2008). However, when educational activities were offered to address these needs, follow-up participant surveys indicated increased satisfaction, self-confidence and/or knowledge related to precepting (Günüsen & Üstüm, 2010; Henderson et al., 2006; Hensinger et al., 2004; Horton et al., 2012). However, whether the activities correlated with change in preceptor behavior has been largely unexplored in the literature (Sandau et al., 2011). Discoveries about what proficient preceptors within one hospital felt had contributed to their growth and self-efficacy has assisted educators and administrators in making choices for development, and will continue to do so in the upcoming year.

A common complaint of healthcare managers has been a perceived lack of critical thinking among novice nurses (Benner et al., 2010; Fero, Witsberger, Weismiller, Zullo & Hoffman, 2009; Myrick & Yonge, 2004). Proficient preceptors who have been successful as a coach and facilitator of critical thinking for new hires, have found a way to cultivate this attribute among their protégés. However, newer preceptors may have not been provided with effective

tools or teaching pedagogies for encouraging critical thinking (Forneris & Peden-McAlpine, 2009; Sandau et al., 2011), and hence may struggle with this responsibility. Often, critical thinking has been considered a skill to check off rather than a process that can be employed to promote reflective thinking in practice. Forneris and Peden-McAlpine (2009) studied the effect of a contextual learning intervention on preceptors' perceptions of critical thinking. Pre-intervention, preceptors described critical thinking in terms of task completion and time management. During the activity, preceptors were engaged in activities that encouraged reflection: seeing the "big picture", "thinking out loud" to increase understanding, and using past experience to inform current decisions. They were instructed to try these techniques with orientees. Follow-up data from surveys at six-month's post-intervention found that preceptors' perception of critical thinking had changed; critical thinking was now defined as "a dialogue to share thinking and understand rationale" (Forneris & Peden-McAlpine, p. 1720). The preceptors reported increased dialogue that enhanced critical thinking with orientees.

Sandau et al. (2011) studied the effects of an eight-hour professional development workshop on preceptor variables that included frequency of coaching for critical thinking and use of constructive feedback with orientees. Preceptors in attendance were employed at a facility without consistent preceptor education for several years prior to this class. As a memory aid for preceptors in promoting critical thinking, a practical mnemonic, termed the "MAP" was distributed on a laminated card. This information could guide the construction of preceptor questions to promote inquiry in novices. A key goal of the educational experience was helping preceptors understand critical thinking as an approach to learning and clinical decision-making. Preceptor self-reports at three to six months post-workshop indicated a significant increase in comfort with coaching new nurses to think critically.

Preceptors of graduate level nursing students also verbalized discomfort and lack of skill in promoting critical thinking with graduate-level nursing students in the clinical setting (Myrick & Yonge, 2004). Graduate nursing education uses a preceptor model as well, with graduate students typically working one-on-one alongside a preceptor for a designated time period. Although these preceptors hold a graduate degree in nursing, they also may have received little education regarding teaching or precepting. Myrick and Yonge examined the perceptions of graduate student preceptors and their preceptees related to critical thinking using a grounded theory approach. Their research identified two processes that affected the development of critical thinking in the learner: "the relational process" and another dynamic interaction, "moving forward/keeping back". Preceptors that established a baseline of respect and trust showed receptiveness to student contributions and encouraged healthy skepticism and questioning, which enabled the growth of critical thinking. Two approaches were identified, "cultivating critical thinking" and the opposite, "curtailing critical thinking" that occurred when "preceptors were unable to entertain different ways of thinking about situations" (Myrick & Yonge, p. 377). Additional ways to promote critical thinking in orientees were considered when proficient preceptors engaged in dialogue with the researcher around the development of their own self-efficacy related to precepting.

Proficient preceptors serve as role models for their orientees relevant to their practice as competent clinicians. Since role modeling has been identified as an area for development by newer preceptors (Myrick & Yonge, 2002), hearing how proficient preceptors learned the importance of this function effectively could help in growing new preceptors. Myrick and Yonge (2004) identified role modeling as an important preceptor function that could enhance critical thinking. Because preceptors are the subject matter experts, their preceptees will likely

emulate their values and behaviors "which ultimately results in behavior modification that is usually permanent (Bidwell & Brasler, as cited in Myrick & Yonge, 2004, p. 375). It has been suggested that the quality of preceptor modeling in healthcare organizations can have long-lasting positive or negative effects on the nursing workforce (Hensinger et al., 2004), hence the need to understand proficient preceptors' development as role models.

Proficient preceptors can serve as role models for vulnerable new staff in responding to bullying behaviors. While hospitals have made strides towards eliminating lateral violence among workers, role modeling by proficient preceptors of communication strategies to prevent or deflect this activity is important (Sandau et al., 2011). Protecting novices from inadvertent social missteps and demonstrating appropriate responses to inappropriate communications can be crucial to successful integration and retention of new staff (Ulrich, 2011). One study engaged preceptors around use of cognitive rehearsal and sentence prompts: "Preceptors were asked to coach their orientees …[that] verbal and non-verbal violence directed at them was unacceptable and gave directions for confronting this behavior" (Sandau et al., 2011, p. 120). Proficient preceptors within the study hospital identified preceptor behaviors that could protect preceptees during their vulnerable first days, and sharing these strategies as part of ongoing preceptor development may aid newer preceptors.

While proficient preceptors communicated and provided feedback effectively, the literature demonstrated that newer preceptors needed help in these areas (Hyrkäs & Shoemaker, 2007). Also, since performance appraisals fell outside the purview of most nurse preceptors, providing constructive feedback and evaluating achievement of goals was uncomfortable (Luhanga et al., 2008; Paton & Binding, 2009). When confronted with a struggling learner, less efficacious preceptors needed support from managers, educators, or faculty to help script the

session with the person. Novice preceptors could fail to access these resources and might feel reticent about the power differential between themselves and their orientees (Forneris & Peden-McAlpine, 2009; Myrick & Yonge, 2004). Acknowledging this discomfort, and learning how proficient preceptors within this study had developed self-efficacy relevant to power and providing constructive feedback was especially helpful for preceptor development.

Another area for preceptor development, noted by other nurse researchers, was working with diverse learners (Alspach, 2008; Hyrkäs & Shoemaker, 2007; Sandau et al., 2011). Education of preceptors about aspects of diversity and potential impacts on learning has surfaced in the literature (Walker et al., 2012). Proficient preceptors in this study had developed competence in meeting the needs of different types of learners. Demographic changes within the United States and elsewhere indicates that the population of nurses is becoming increasingly diverse (U.S. Census Bureau, 2010). More nurses list English as a second language than previous generations (Haggerty et al., 2012). Hyrkäs and Shoemaker (2007) indicated that 11% of the preceptors from their study site had been educated outside of the United States. Traditionally educated nurses, defined as those attending a nursing program immediately after completion of their secondary education, are no longer the norm, and more are pursuing nursing as a second career at an older age (National League for Nursing [NLN], 2011). In addition, healthcare organizations within the U.S.A. are required to promote a culturally diverse and competent workforce (OMS website, 2013). The National Standards for Culturally and Linguistically Appropriate Services (CLAS) recommend that healthcare organizations "implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area" (OMS, Standard II). These societal changes have implications for educating preceptors.

Working with diverse learners was mentioned by proficient preceptors relevant to the changes in their preceptees' demographics and ways to promote preceptor self-efficacy were identified relevant to increasing learner success.

Preceptor engagement in shaping professional development.

An exemplar of preceptor engagement in finding solutions for professional development was found at a large academic medical center in the Midwest (Nelson et al., 2012). A Preceptor Committee was established and charged with soliciting feedback from newly graduated nurses who had recently completed orientation. Additionally, the Committee was asked to plan and implement an educational program to assist preceptors in meeting new nurses' needs. To prepare, committee members reviewed the literature relevant to the concerns of novice nurses. Focus groups allowed novices who recently completed orientation to share perceptions of orientation struggles and successes. This information provided a springboard that guided the creation of a preceptor development workshop.

The unique aspect of this study (Nelson et al., 2012) was the engagement of experienced preceptors in educating themselves, identifying their own and constituents' learning needs, and participation in the development of teaching and learning activities. In constructing the workshop, seasoned preceptors were used as teachers to invoke discussion, facilitate role-plays, provide tips and tools to promote critical thinking, and emphasize the importance of positive feedback. Participants of this preceptor-led event unanimously rated the program as very good or excellent, and recommended an encore the following year to build on this knowledge. Proficient preceptors, who often represent an unheard voice within hospital settings, were in this example, provided a role as partner and provider of education for their peers.

The previous example illustrated how a group of like-minded peers and clinical educators working together could lend their expertise and experience to make professional development recommendations and solutions that benefited colleagues and their organization (Nelson et al., 2012). The nursing literature has identified a need for ongoing development of preceptors and aspects of the role in which preceptors may lack efficacy (Benner et al., 2010; Fero et al., 2009; Forneris & Peden-McAlpine, 2009; Hyrkäs & Shoemaker, 2007; Myrick & Yonge, 2004; Sandau et al., 2011). As part of this study, proficient preceptors have had the opportunity to reflect on their own self-efficacy experiences, and their recommendations for best practices will guide innovations about the education of preceptors. This, in turn, could impact the orientation experience of new hires. The next section of this literature review will examine the theoretical framework of self-efficacy and its relationship to job performance.

Self-Efficacy and Job Performance

Self-efficacy refers to the beliefs that people hold about their capabilities to perform in given situations and their ability to achieve or effect desired outcomes. Within healthcare and education disciplines, research has demonstrated that the level of self-efficacy is related to the level of job performance (Caprara et al., 2006; Grau et al., 2001; Jex et al., 2001; Schwarzer & Hallum, 2008). Social scientist Albert Bandura (1997) postulated that people with greater self-efficacy would be more likely to persevere towards achievement of goals in the face of job stressors. In the current challenging healthcare environment, proficient preceptors, who may possess a higher level of self-efficacy related to role responsibilities, represent a valuable asset. Discovering what fosters the growth of this group's self-efficacy and how to elevate that of all preceptors has been beneficial.

According to Bandura (1977), self-efficacy develops throughout a person's life, varies based on the situation and context, and "derives from four principal sources of information: performance accomplishments, vicarious experiences, verbal persuasion, and physiologic states" (p. 191). Much of a person's self-efficacy is shaped by performance accomplishments or enactive mastery experiences using modeling, active participation and experimentation.

Although all four sources of information serve to shape self-efficacy and are necessary, the strongest influencer was believed by Albert Bandura (1997) to be performance accomplishments. This was especially true when a supportive environment was created and learning activities were divided into manageable chunks or increments so that the person could reasonably achieve and experience mastery. The learner would then be able to move on to achieve higher levels of competence. Provided with increasing amounts of independence and a reasonable time frame for accomplishment, the learner could make self-corrected adjustments to performance (Bandura, 1977, p. 192). By diversifying the modeling or learning experiences, the likelihood that the person would generalize the learning to other situations was increased (Bandura, 1977). Accomplishment of goals was also positively related to higher self-efficacy perceptions. Although proficient preceptors may have indicated that they learned the craft of their job through on-the-job learning, having an experienced preceptor as a resource and mentor has been recommended (Ulrich, 2011).

Although not as compelling a source of self-efficacy as enactive mastery experiences, vicarious experiences, verbal persuasion and physiologic states or emotional arousal were also listed as significant contributors to goal achievement (Bandura, 1997). Proficient preceptors who participated in this action research study likewise indicated that the three sources that were examined had contributed to their development as efficacious preceptors. Through hearing and

observing the experiences of others, preceptors could conceive of themselves in similar situations. Vicarious learning, according to Bandura (1997) involved the use of symbolic modeling, listening to stories of success and envisioning the desired performance. Verbal persuasion referred to spoken encouragement provided by significant others that prompted desired actions. Bandura (1977) asserted that: "People are led through suggestions into believing they can cope successfully with what has overwhelmed them in the past" (p. 198). This effect was increased when these suggestions were made by respected sources, such as teachers, managers and co-workers, who through positive reinforcement could profoundly encourage and motivate a person to persevere (Bandura, 1997). Proficient preceptors, likewise, described being encouraged to develop by a significant mentor or manager in ways that had impacted their preceptor self-efficacy.

The fourth source of self-efficacy, physiologic states or emotional arousal, involved using targeted strategies to reduce negative physiologic responses elicited in the face of a challenging activity (Bandura, 1977). Self-efficacy was increased when previously dreaded activities were experienced within a safe learning environment using biofeedback and gradual desensitization to reduce fight or flight responses. Avoidant behaviors resulted in the opposite effect and lowered self-efficacy, reinforcing fears. Since this action research study related to the experiences of proficient and efficacious preceptors, the researcher had chosen to narrow the focus to the first three sources of self-efficacy in exploring preceptor self-efficacy development.

Although achievement of goals might raise self-efficacy, learners also needed reasons or inducements that provided motivation to continue in an activity (Bandura, 1997). These included social and material supports for an activity, as well knowledge of the standards by which one was judged. The social context in which the activities occurred impacted self-efficacy

development: Requisite resources and supports were essential ingredients of motivation, indicative of the value ascribed to preceptor responsibilities and role within a given context. Also, people who were successful and believed that future activities would likewise be rewarded were more likely to report increased self-efficacy and persist in the face of challenging situations (Bandura 1977). Another essential ingredient of learner support was performance standards that enabled knowledge of expectations and how they measured up. When people understood what was required of them, personal self-efficacy and job effectiveness were increased (Bandura, 1997). In the absence of standards and social support, people would likely fall prey to futility and give up. This action research study listened to the experience of proficient preceptors relevant to the influence of these factors on self-efficacy and was able to recommend supports and strategies beneficial to preceptors within the practice setting.

Since newer preceptors have reported knowledge deficiencies related to teaching pedagogies (Haggerty et al., 2012; Sandau et al., 2011), this group of preceptors might also be predicted to report lower instructional self-efficacy than proficient preceptors. Preceptors with lower self-efficacy could have serious implications for acute care hospital employers. Unsatisfactory precepting could jeopardize the retention of new staff, who may feel ill prepared to care for their patients and unhappy with their orientation experience (Hillman & Foster, 2011; Twibell et al., 2012). Since the inadequate training of staff has been linked to compromised patient safety and increased medical errors (Baggot et al., 2005), learning how proficient preceptors enacted their role to ensure positive orientee outcomes proved to be valuable information. The first impression and success of a novice nurse is greatly impacted by the efficacy of the preceptor and is integral to preventing adverse patient outcomes. Whether or not

an orientee gets off on a solid foundation is largely dependent on the initial weeks with their preceptor (Casey et al., 2004; Sandau & Halm, 2010).

For new nurses to receive the support they need to grow, a staffing model that allows time for the performance of clinical teaching responsibilities by their preceptors is necessary (Henderson & Eaton, 2013; Trepanier, Early, Ulrich & Cherry, 2012; Ulrich, 2011). In addition, allocation of resources to give preceptors time away to attend education regarding the role is essential to promote professional development and self-efficacy (Hyrkäs & Shoemaker, 2007; Sandau et al., 2011). When there was a higher perception of workplace rewards and benefits, preceptors reported increased commitment to role (Hyrkäs & Shoemaker, 2007). Thus, for healthcare institutions serious about creating a stimulating and appreciative workplace, engaging the input of proficient preceptors related to self-efficacy development in research such as this could be an important first step towards identifying best practices.

Unfortunately, preceptors in hospital settings have reported that instructing and guiding new co-workers can be stressful, as these responsibilities are added onto existing nursing duties (Yonge et al., 2002a; Yonge et al., 2008). Surveys of preceptor perceptions of stressors indicated that increased stress was directly related to the workload and added preceptor responsibilities (Griffin et al., 2002; Hautala et al., 2007). Complaints related to "overwhelming workloads [that] have the potential to lead to preceptor burnout" (Haggerty, 2012, p. 33) have been echoed by nurses from New Zealand, Canada and the United States (Sandau et al., 2011; Yonge et al., 2002a). In addition, limited staffing resources have required preceptors, at times, to assume leadership or charge nurse duties in the absence of other qualified staff members (Richards & Bowles, 2012). Although the literature recommends that preceptors of newly graduated nurses

receive a lesser assignment during the early orientation period, reality demonstrates that this is not always feasible (Hautala et al., 2007; Henderson et al., 2006).

Exposure to repeated occupational stressors has been associated with depression, anxiety, physical illness and emotional exhaustion (Grau et al.; Jex et al., 2001). These untoward health effects or strains could lead to burnout. Symptoms of employee burnout have included cynicism about the job, lack of commitment to the organization, and expression of intent to leave (Jex et al., 2001). Workers in human service professions were found to be particularly vulnerable due to their work with people in highly charged social situations (Schwarzer & Hallum, 2008). Burnout for these professionals included depersonalization characterized by negative or callous responses to people, loss of idealism and inability to cope with job demands. While people with higher self-efficacy were not immune to stress, they were found to be associated with fewer reports of burnout and adverse health effects (Grau et al., 2001).

Because ongoing stress in the workplace has been linked with negative effects such as fatigue, burnout, health problems, orientee dissatisfaction, and turnover (Grau et al., 2001; Jex et al., 2001; Yonge et al., 2002a), uncovering mechanisms to moderate stress and increase the capabilities of all preceptors is needed. Possession of high job-related self-efficacy has been associated with moderation of stress in the work environment (Grau et al., 2001; Jex et al., 2001), and proficient preceptors have offered insights about effective management of stressors in performing their role despite the pressures of a frequently unpredictable work environment and high acuity of patient populations.

Teacher self-efficacy as a mediator of job stress and burnout was the focus of a study of teachers in Germany and Syria (Schwarzer & Hallum, 2008). Although these two different groups of teachers may have had cultural and national differences, this study demonstrated

remarkably similar findings of self-efficacy as a protective resource against job stress and burnout. The researchers employed a self-efficacy scale that measured job accomplishment, skill development on the job, social interactions, and coping with job stress. While lower self-efficacy was found to be a precursor of burnout, higher self-efficacy predicted moderation of the effect of job stress. Age was noted to be a significant variable, with younger teachers and those with lower self-efficacy more at risk for burnout. Schwarzer and Hallum (2008) observed that, "strengthening teachers' optimistic self-beliefs along with improved teaching skills should be a preventative measure to avoid this downward spiral" (p. 169).

Higher self-efficacy has also been associated with greater likelihood that a person would complete tasks and progress to other more challenging endeavors (Bandura, 1977; Grau et al., 2001; Jex et al., 2001). "Efficacy expectations determine how much effort people will expend, and how long they will persist in the face of obstacles and aversive experiences" (Bandura, p. 194). Provided conditions and resources to support desired activities were present, workers with high self-efficacy were more likely to request additional responsibilities, continue their academic education and persevere (Grau et al., 2001). In addition to perseverance and better job performance, high employee self-efficacy has also been correlated with increased organizational commitment, as well as enhanced personal welfare and health states (Bandura, 1977; Grau et al., 2001; Jex et al., 2001).

Jex et al. (2001) examined the effect of coping style and self-efficacy on stressor-strain relationships using a Likert-type survey on a sample of United States infantry soldiers. Coping was defined as behavior undertaken to moderate effects of workplace stressors and adverse health effects of stress. Active coping activities included problem solving, confronting situations, education, or exercise, while avoidant coping strategies employed denial,

procrastination, disengagement or substance usage. Participants were queried about work stressors (e.g. overload and role clarity), self-efficacy, coping strategies, and adverse effects or strains (Jex et al.). Study results demonstrated a negative correlation between self-efficacy and psychological strain (Jex et al.), and an interaction was noted between role clarity, self-efficacy and active coping. "Efficacy moderated the stressor-strain relationship when active coping was high" (p. 404). Also, the choice of coping methods in combination with self-efficacy impacted the degree to which the stressors and strains were moderated. Using avoidant coping strategies to handle stressful situations increased the report of strain for all individuals, regardless of their self-efficacy level. Engaging proficient preceptors in interviews and focus group discussions during this action research study has recommended active coping strategies to reinforce preceptor self-efficacy and promote preceptor health.

Besides better health and organizational commitment, employees with higher self-efficacy also performed better and valued jobs characterized by ambiguous role requirements, increased autonomy, and high-stakes responsibilities (Grau et al., 2001; Jex et al., 2001; Schwarzer & Hallum, 2008). In addition, these workers were more likely to continue their education and take on academic challenges, while the opposite effect was noted for those with low self-efficacy. Lower self-efficacy employees reported job autonomy that involved initiative, independent decision-making and challenges to be emotionally exhausting and, "a demand rather than a resource, [and they] displayed greater emotional exhaustion as levels of autonomy in their job increased" (Grau et al., p. 72). Since proficient preceptors are able to practice efficaciously amidst a healthcare environment full of ambiguities, sharing the forces that influenced their self-efficacy could help newer preceptors.

Another positive characteristic of employees with high levels of self-efficacy was better social integration (Grau et al., 2001), which might be expected regarding proficient preceptors. A study of middle school educators in Italy demonstrated a positive relationship between teachers' perceived self-efficacy, student achievement and job satisfaction (Caprara et al., 2006). An analysis of the data led researchers to hypothesize that teachers influenced each other via their level of self-efficacy, and in these settings, teachers reported greater job satisfaction. Better student achievement correlated with the number of high self-efficacy teachers. The researchers concluded that "teachers with high levels of self-efficacy beliefs were more likely to be able to create the conditions and promote interpersonal networks that would nourish and sustain their work satisfaction" (Caprara et al., 2006, p. 485). Furthermore, efficacious teachers promoted learning, radiated enthusiasm and pursued professional development, which served as role models for other staff members. Learning from proficient preceptors how to develop self-efficacy among newer preceptors could have a positive influence on the culture of an organization.

This literature review has demonstrated a relationship between self-efficacy and job performance: Workers with high self-efficacy were more satisfied with their jobs, desired challenging work assignments, and expressed commitment to their organization (Caprara et al., 2006; Grau et al. 2001; Jex et al., 2001; Schwarzer & Hallum, 2008). The students of teachers with high self-efficacy demonstrated greater achievement (Caprara et al., 2006). Highly efficacious staff created social supports to meet their needs and positively impacted colleagues (Caprara et al.). High self-efficacy also moderated the effects of job stressors such as increased responsibilities and role conflicts that could result in burnout and job turnover (Caprara et al., 2006; Grau et al., 2001; Jex et al., 2001; Schwarzer & Hallum, 2008). These positive attributes

associated with high self-efficacy are particularly necessary for preceptors, who orient the next generation of hospital staff. Since high self-efficacy has been associated with better job performance and health states in the workplace, articulating best practices to bolster the self-efficacy of preceptors in the face of an austere economic climate is desirable.

Changes in Healthcare Reimbursement by Value-Driven Health Care

The practice of nursing has become increasingly demanding as advances in science and technology, the aging of the Baby Boomer generation, and a resulting increase in patients with complex and chronic conditions have become the norm (AHA, December 2012). Although proficient preceptors play an integral role in the on-boarding and socialization of new staff within the hospital setting (Baltimore, 2004; Luhanga et al., 2010), assisting nurses to become better preceptors has often been pushed aside due to other organizational priorities, and preceptors are often stretched thin due to workload and limited resources to support their role (Alspach, 2008).

In a value-driven payment system, hospital financiers are increasingly challenged to find ways to cut costs while at the same time produce high-quality patient care outcomes or face cuts in reimbursement by third-party payers (HHS, 2013). Towards this end, proficient preceptors who possess excellent clinical skills and impact the next generation of nurses within hospitals should be recognized as a valuable human resource asset. Administrators at one healthcare institution identified this bonanza within their walls, noting preceptors' contributions were integral to the fiscal success of the institution (Axelrod et al., 2002), and a subsequent study validated their investment in nurse preceptor education with significantly improved satisfaction and retention statistics (Hensinger et al., 2004). This intervention was calculated to have saved

the hospital thousands of dollars, when costs related to of loss of talent, recruitment and risks to patient safety were considered.

Turnover of nurses is costly, amounting to thousands of dollars, with impacts to morale and stress on the remaining staff (Hyrkäs & Shoemaker, 2007; Jones, 2008). Some organizational leaders have concluded that investing in the development of preceptors is beneficial to their bottom line. Replacement of a nurse has been calculated at between $62,000 and $88,000 (Jones & Gates, 2007). As reimbursement in the United States is increasingly being linked to patient safety and quality outcomes, institutions that do not measure up will face reductions in reimbursement, while organizations with better outcomes will receive increases (Conway, 2009). Hence, planning resources to support the development of preceptors towards achievement of a higher level of self-efficacy, to improve new hire competence, and to minimize turnover rates would be pro-active on the part of employers (Hensinger et al., 2004; Jones, 2008; Jones & Gates, 2007).

Because vital functions involving the development and acculturation of new staffs hinge upon the work of proficient preceptors, ongoing support and education are essential. Sub-par preceptor performance risks perpetuation of a culture of mediocrity that could result in adverse patient outcomes (Haggerty et al., 2012; Hyrkäs & Shoemaker, 2007; Sandau et al., 2011). Ineffective preceptor teaching strategies could inhibit critical thinking and delay the professional development of new nurses (Sandau et al., 2011), which could also impact employee satisfaction and increase turnover intention (Twibell et al., 2012).

A lament of hospital administrators and managers has been a perceived deficiency in the critical thinking of their new hires (Fero et al., 2009). As healthcare has become increasingly specialized and information and technology has exploded, students have emerged from colleges

and universities as generalists. Benner et al., (2010) wrote that "a significant gap exists between today's nursing practice and the education for that practice" (p. 4). Because critical thinking and sound clinical judgment are essential to patient satisfaction and outcomes, which are now tied with reimbursement, hospitals have responded by prolonging orientation for novices (Greene, 2010). This translates into increased costs and a burden for the hiring entity. Proficient preceptors are crucial players in the promotion of critical thinking in novice nurses in hospitals, and an effective and efficient orientation could potentially reduce expenses associated with a prolonged orientation or ineffective training (Hillman & Foster, 2011).

Ulrich (2011) noted that organizational supports that publicly recognize preceptors' worth were necessary and suggested a variety of institutional retention strategies including financial and non-financial incentives. Benefits valued by preceptors included paid time off to attend training, schedule flexibility, and acknowledgement of their contributions from employers. Regular connection with clinical nurse educators was desired, particularly in dealing with challenging learners (Hyrkäs & Shoemaker, 2007). Hyrkäs and Shoemaker reported preceptors who felt supported remained loyal to their institutions and persevered in their job. Involving proficient preceptors in an action research project has served as a mechanism to recognize the contributions of proficient preceptors through seeking their help in defining cost-effective solutions and identifying best practices for preceptor self-efficacy development.

It was previously noted that workers reporting higher self-efficacy were associated with better wellness states (Grau et al., 2001; Jex et al., 2001). In the face of skyrocketing health insurance costs and increased emphasis on employee wellness (Baicker, Cutler & Song, 2010) having a cadre of proficient preceptors could only be beneficial. Applying what proficient

preceptors have learned about management of stressors in the work environment would be advantageous to nurse preceptors and their employers.

With healthcare reform looming on the horizon, the picture has been painted of an increasingly cost-conscious and value-driven reimbursement system. Data gleaned from this action research study has offered insights and solutions that could have implications related to staff competence, which can impact patient outcomes and ultimately reimbursement. Since workers with high self-efficacy have been identified as healthier, more committed, persevering and goal-oriented, capitalizing on ways to increase this attribute would be desirable. Proficient preceptors have much to contribute to the growth of workers within health systems, and using their wisdom about preceptor self-efficacy development is valuable information for their employers. This action research study has essayed to accomplish this through engagement of proficient nurse preceptors in exploring the development of their self-efficacy for the purpose of recommending ongoing professional development and best practices within a hospital setting.

Summary of the Literature Review

This chapter summarized the literature of three themes germane to the topic of proficient preceptor self-efficacy development: the professional development and support needs of nurse preceptors, self-efficacy and job performance, and changes in healthcare reimbursement to a value-driven payment system necessitating an efficacious and competent workforce. The literature indicated that preceptors provide vital services in healthcare organizations as the orientors of novice nurses, new hires, and transferees (Bratt, 2009; Luhanga et al., 2010; Ulrich, 2011). Preceptors facilitate the successful transition of orientees into the workplace and ensure new staffs provide safe care for complex and challenging patients. Newer preceptors, who may be skilled at the bedside, require support and professional development to learn teaching

competencies required of the role (Foy et al., 2013; Hyrkäs & Shoemaker, 2007; Sandau et al., 2011). Proficient preceptors have mastered the craft of precepting and have represented a relatively untapped resource from which information about attainment of self-efficacy has been gleaned.

Increasing preceptor self-efficacy is important since employees with higher self-efficacy report greater wellness states, perform better at work, create positive social networks and have better performing students (Jex et al., 2001; Grau et al., 2001; Schwarzer & Hallum, 2008). Also, these workers manage workplace stressors better and are less likely to experience burnout (Schwarzer & Hallum, 2008). Since precepting presents unique stressors related to the added duties of orientation, identifying best practices to enable self-efficacy development of preceptors is needed. Proficient preceptors within this action research study have shared information that might benefit newer preceptors by increasing self-efficacy and preventing burnout, turnover and loss of competent staff.

Because healthcare administrators are continually pushed to improve patient outcomes, reduce costs, yet maintain a healthy workplace, an awareness of the value that preceptors add to healthcare organizations must be recognized. Proficient preceptors who have attained a high level of self-efficacy and competence in their role have insights that would help to grow the next generation of preceptors. The purpose of this study was to engage proficient nurse preceptors in exploring the development of their self-efficacy for the purpose of recommending ongoing professional development within a hospital setting. The next chapter will describe the research design and methodology.

CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY

Introduction to the Chapter

This chapter discusses the research design and methodology that was used in the conduct of this study. The purpose of this study was to engage proficient nurse preceptors in exploring the development of their self-efficacy for the purpose of recommending ongoing professional development within a hospital setting. This action research study was framed using Bandura's (1997) social cognitive theory of self-efficacy. Based on the reports of the participants in this action research study, this researcher has compiled best practices relevant to preceptor development within a hospital setting.

This section is organized into seven sections: (a) a statement of the problem, (b) research questions and definition of terms, (c) design of the study (d) population and sample (e) data collection and analysis procedures, (f) human subjects protection (g) study materials and informed consent procedures (h) and limitations of the study.

Re-Statement of the Problem

Nurse preceptors in healthcare organizations face a myriad of challenges as they try to enact this expanded role within today's value-driven health system (Conway, 2009). Preceptors are entrusted with guiding new staff through the vulnerable first weeks to months of employment and serve as coach, teacher, protector and evaluator (Ulrich, 2011). To effectively perform as a preceptor, the nurse must acquire additional competencies that are not typically emphasized in most pre-licensure nursing curriculums (Boyer, 2008). Also, the role involves added work responsibilities on top of usual nursing duties, which can contribute to job stress, burnout and increased attrition (Griffin et al., 2002; Hautala et al., 2007). Therefore, finding ways to

cultivate the preceptor group and mitigate the effects of stress associated with the role is important for both professional development and the health of the organization.

Within hospital settings, managers and educators rely on their high-performing preceptors to acculturate and mold subsequent generations of staff to the work unit (Biggs & Schriner, 2010), yet few studies report tapping into this group as a potentially rich source of information. Listening to proficient preceptors has revealed new insights that will be helpful in determining what ongoing preceptor development would be most beneficial and energizing within the research hospital. This action research study attempted to bridge this gap by engaging proficient nurse preceptors in exploring the development of their preceptor self-efficacy for the purpose of recommending ongoing professional development and best practices in a hospital setting.

Self-efficacy, a construct identified in social cognitive theory, is a measure of how humans perceive their capabilities in general and job-related contexts (Bandura, 1977). Outcome self-efficacy refers to people's perceptions of possessing competencies essential to their employment (Grau et al., 2001). Because highly efficacious people are more likely to take on new responsibilities, rate their job satisfaction and commitment higher, and enjoy better health states (Grau et al., 2001; Jex et al., 2001; Schwarzer & Hallum, 2008), it would be advantageous for hospital preceptors to possess this attribute. Proficient preceptors would be expected to report a greater level of self-efficacy than new preceptors who, despite excellence in bedside nursing, may lack the requisite skill-set for precepting.

The nursing discipline commonly refers to five levels of nursing skill acquisition, described by Benner (1984), to identify the characteristics and stage of a nurse's development: novice, advanced beginner, competent, proficient and expert. Borrowing from this language, Boyer (2008) devised a "Preceptor Expertise Evaluation" instrument, where preceptors were

rated on specific competencies using a “novice=1” to “expert=5” rating system. In addition, Boyer clustered the preceptor competencies according to Lenburg’s (1999) Competence Outcomes and Performance Assessment (COPA) model. The COPA model identified eight core practice competencies with which these preceptor competencies were aligned, including: assessment and intervention, communication, critical thinking, human caring and relationship skills, teaching, management, leadership and knowledge integration. Beginning preceptors would be expected to score lower expertise scores than seasoned preceptors when using Boyer’s evaluation instrument (VNIP, 2009). Commensurate to the scholarship of nurse professionalization, this proposed action research study of preceptors uses the term “proficient” to describe high-performing or outstanding preceptors. For most nurses, becoming a proficient preceptor requires time, job-related experiences and ongoing professional development (Swihart, 2007).

Proficient preceptors have both clinical acumen and precepting know-how, including goal-setting, coaching, promoting critical thinking and evaluating performance. They ensure that new hires develop into competent team members (Ulrich, 2011). Less efficacious preceptors could learn much from proficient preceptors about managing challenging preceptor responsibilities such as conflict resolution, working with diverse learners and communicating effectively. Since most nurses have had little preparation in instructional methodologies as part of their basic nursing education (Bonnel & Starling, 2003; Yonge et al., 2008), and the preceptor role is often assumed after only a day of training, it is not surprising that new preceptors have reported decreased self-confidence and knowledge related to teaching pedagogies (Haggerty et al., 2012; Sandau et al., 2011).

The literature has identified a need to provide ongoing support to preceptors (Baggot et al., 2005; Henderson et al., 2006; Yonge et al., 2008). However, this researcher, upon conducting a recent poll of educators at Connecticut hospitals, found that only four of the twenty responding hospitals had provided any formal ongoing preceptor professional development during the past year, and among those that did, there was great variation in the delivery and content of the professional development material that was offered (see Appendix A).

While diverse formats for education and support have been suggested in the literature, no consensus exists to endorse one method over another (DeWolfe et al., 2010). The input of proficient preceptors has been, until now, a relatively unexplored resource and has provided invaluable evidence that might be employed by their administrators as to which supportive and pedagogical activities would be most efficacious to implement. Also, involvement of the in-house experts to identify and recommend solutions to preceptor development has built capacity within the group and has increased the commitment of the preceptor group towards this effort.

Because the current environment in hospitals calls for nurses who are able to care for challenging patients with multiple co-morbidities (AHA, 2012), healthy and committed preceptors are needed in the workplace. However, these same nurses who assume preceptor responsibilities are also juggling a myriad of competing tasks. Besides orienting new staff, preceptors often simultaneously manage full patient assignments, committee projects, or the role of charge nurse (Griffin et al., 2002; Hautala et al., 2007). The multiple demands on preceptor time have been reported as stressful (Hyrkäs & Shoemaker, 2007; Yonge et al., 2008). Ongoing exposure to stressors has been associated with worker perceptions of overwork, cynicism and burnout (Grau et al., 2001; Jex et al., 2001). Burnout may contribute to what has been called the "turnover intention" of nursing staff (Grau et al., 2001; Günüsen & Üstün, 2010). Preceptor

stress and a chaotic environment can also compromise orientee satisfaction (Baggot et al., 2005). Since higher self-efficacy in employees has been associated with moderation of stress, better work performance, job commitment and health states (Grau et al., 2001; Jex et al., 2001; Caprara et al., 2006), learning what proficient preceptors report about the development of their self-efficacy has proved instructive for preceptors and employers as a means to proactively prevent negative consequences.

Healthcare financiers today must maintain a robust and vibrant workforce as they deal with government regulations to improve patient satisfaction and outcomes, or face reductions in reimbursement from Medicare and Medicaid sources (CMS, 2013; Craig et al., 2011). Simultaneously, the costs of providing care and the acuity of patients in hospitals settings have increased dramatically (AHA, 2013). Having a competent workforce to provide effective care is integral to achieving high quality outcomes. Hospitals cannot afford to lose experienced preceptors as a casualty of burnout or have poorly trained staff due to ineffective precepting. Since replacing an experienced nurse costs thousands of dollars, it has behooved hospital employers, in this value-driven economy (Conway, 2009), to investigate ways to support and increase the self-efficacy of their preceptor group (Hensinger et al., 2004; Hyrkäs & Shoemaker, 2007). The social sciences literature has indicated that workers who reported higher self-efficacy were less likely to look for alternative employment elsewhere (Grau et al, 2001; Günüsen & Üstün, 2010).

Because excellent preceptors train the next generation of staff and ensure the competence of new hires to care for an increasingly complex patient population, planning organizational supports for preceptors is important. Listening to the perspectives of proficient preceptors and involving them in solutions to organizational challenges has served to empower and energize a

group that traditionally has been unheard. This action research study has added significant data needed by hospital administrators to support resource allocation for preceptor development. The purpose of this action research study was to engage proficient nurse preceptors in exploring the development of their preceptor self-efficacy for the purpose of recommending ongoing professional development and best practices in a hospital setting.

Research Questions

The primary research question that has guided this action research study was: What do proficient nurse preceptors report about the development of their preceptor self-efficacy for the purpose of recommending ongoing professional development and best practices within a hospital setting?

There are four sub-questions:

1. What do proficient nurse preceptors report about the development of their self-efficacy related to enactive mastery experiences?
2. What do proficient nurse preceptors report about the development of their self-efficacy related to vicarious experiences?
3. What do proficient nurse preceptors report about the development of their self-efficacy related to verbal persuasion?
4. What do proficient nurse preceptors recommend regarding best practices for ongoing preceptor professional development?

Definition of Terms

Emotional States: Affective response to a given situation with associated self-efficacy interpretations (Bandura, 1997).

Enactive Mastery Experiences: The strongest source of efficacy information that involves active participation of the learner. Learning may be structured by breaking down the learning into achievable and hierarchically structured learning chunks (Bandura, 1977).

Modeling: Seeing or visualizing the attainments of others or of the self through specially arranged situations to demonstrate what the learners are capable of (Bandura, 1997).

Novice Nurse Preceptor: An experienced nurse who assumes new responsibilities as a preceptor and must learn additional preceptor competencies (Boyer, 2008).

Nurses: Registered nurses (RN) or licensed practical (vocational) nurses (LPN, LVN); designation is dependent on their education and passing score on the RN or LPN pre-licensure examination (NCSBN, 2013).

Orientee: A newly hired nurse or transferee to another unit or specialty who is participating in an orientation program. Includes novice or newly graduated nurses as well as experienced nurses. Term used interchangeably with preceptee.

Physiologic States: Somatic or bodily responses to a given situation or stimulus; Targeted strategies would seek to reduce or replace negative responses with positive coping strategies and associations to increase self-efficacy related to the given situation (Bandura, 1997).

Preceptee: A newly hired nurse or transferee to another unit or specialty whose orientation is being guided by one or more preceptors.

Preceptor: A practicing nurse who is selected by an employer to serve as the orientor of a new hire for a designated period of time. Preceptor responsibilities include serving as a role model, coach, teacher, influencer, socializer, and protector of the orientee (Ulrich, 2011).

Proficient preceptors: In this study, a descriptor for preceptors who possess clinical acumen and achieve above-average ratings on the Preceptor Effectiveness Evaluation (VNIP, 2007) by their manager or clinical educator.

Self-Efficacy: The beliefs that people hold about their capabilities to perform in a given situation and their ability to achieve or effect desired outcomes (Bandura, 1977).

Verbal Persuasion: Source of self-efficacy involving spoken encouragement or verbal feedback related to a person's capabilities to achieve a desired goal or objective (Bandura, 1997).

Vicarious Experiences: Comparison of self with the attainments of people similar to oneself. Involves listening to varied experiences or visualization to imagine performing an activity or achieving a goal or objective (Bandura, 1997).

Research Design

This study employed an action research design inclusive of individual interviews and focus groups of study participants. The primary unit of analysis was proficient preceptors within one hospital setting. The research questions were framed using Bandura's (1997) theory of self-efficacy. This section of the chapter will describe the design, methods and the rationale for these choices, as well as a discussion of the methods selected for ensuring reliability and validity of the study.

Action Research Design

This study employed an action research design as a means of uncovering and recommending best practices relevant to the development of preceptor self-efficacy within a hospital setting. Grounded in a qualitative research paradigm, it been utilized by researchers from the education, social sciences and healthcare disciplines as a means of identifying solutions,

initiating actions, evaluating the effect of these actions with the purpose of "making a difference" within the sphere of interest (Herr & Anderson, 2005; Stringer, 2007).

Stringer (2007) defined action research as "a collaborative approach to inquiry or investigation that provides people with the means to take systematic action to resolve specific problems" (p. 8) or to "gain greater clarity and understanding of a question, problem or issue" (p. 19). Since proficient preceptors are actively involved in the process of precepting, using a methodology described as "research in action rather than research about action" (Coghlan & Brannick, 2010) was apropos. Whereas traditional research methodologies have viewed the researcher as a disengaged observer or manipulator as in an experimental study seeking to find universal truths, the action researcher recognizes that there are variances inherent to each culture, context and situation, as well as differences in the meanings that the participants ascribe to their situation. It considers the environment, politics and other social factors that are often discounted or ignored in traditional research methods (Stringer, 2007). It is a participatory process whereby the community of interest is invited to participate as equals in a systematic research process towards a goal of improving processes and outcomes. Indeed, it has been said that "action research is best done in collaboration with others who have a stake in the problem under investigation" (Herr & Anderson, 2005, p. 4), and who was better to involve than proficient preceptors.

Unlike traditional research methodologies where the persons being studied are classified as "subjects", this current research study used terminology in the genre of action research, namely "participants", who were invited from among people or stakeholders directly involved in the subject being researched (Coghlan & Brannick, 2010). Action research views the researcher role as that of facilitator and collaborator, while the proficient preceptor participants of this study

were the subject matter experts operating within this context and environment (Stringer, 2007). Stakeholders, who in the case of this study were proficient preceptors, shared their knowledge and professional lived experiences to identify and create solutions aimed at the development of other preceptors within their organization.

One of the purposes of action research is the involvement and empowerment of the participants of the research, in this case proficient preceptors within a hospital setting, in the quest for understanding and improved outcomes. Action research, is "done in collaboration with others who have a stake in the problem under investigation" (Herr & Anderson, 2005). It is a democratic, egalitarian process: The researcher is an equal partner to the stakeholders collaborating in the study and has been likened to a catalyst for change. The proficient preceptor participants who were involved in identifying sustainable solutions to improve their practice also were able to establish collaborative relationships and links with others within their organization (Stringer, 2007).

Action research purports to make a difference by "systematically investigating issues in diverse contexts and to discover effective and efficient applications of more generalized practices" (Stringer, 2007, p. 6). He describes a simple framework labeled, "look, think, act", which continually repeats in a spiraling interaction. The steps involve (1) the gathering of data and defining/describing the situation; (2) reflecting, analyzing and interpreting the actions; and (3) acting by reporting, implementing and evaluating. Other researchers have described similar variations of this framework such as: "Construct, plan actions, take actions and evaluate actions" (Coghlan & Brannick, 2010). Since the actions are continually under reflection and modification, action research can be a complex and dynamic process (Stringer, 2007).

This study applied Stringer's framework to the design of the study. During the "Look" phase, proficient preceptors, identified for their expertise by their clinical educators and managers, were invited to participate. During the individual interview, proficient preceptors shared reflections about their journey to becoming a highly self-efficacious preceptor. Each participant identified, using Bandura's theory of self-efficacy attainment as a focus, the influence of the sources of self-efficacy upon their personal growth as a preceptor. During the "Think" phase, the researcher transcribed and coded participant responses using Bandura as a lens. The themes were shared with the participants during a subsequent focus group discussion. During this group, participants reflected further on the topic of preceptor self-efficacy and, as part of the "Act" phase of the study, contributed to the recommendations for best practices related to preceptor development within their institution. This study has made available important data which may assist hospital administrators in making difficult choices regarding allocation of funds related to preceptor professional development activities. Such information may also inform decisions based on best practices that may prove efficacious and energizing for learners and positively impact patient outcomes.

Reliability and Validity

Action research differs from quantitative studies in that rigor is established not on the traditional understanding of reliability and validity, but on checks for trustworthiness. These checks are designed to ensure that the research does not merely reflect the opinion and worldview of the researcher and are "not based solely on superficial or simplistic analyses of the issues investigated" (Stringer, 2007, p. 57). Lincoln and Guba, 1985, (as cited in Stringer, 2007), felt that trustworthiness could be established through procedures that assessed credibility,

transferability, dependability, and confirmability. This study ensured trustworthiness by using the approaches described in the following paragraphs.

Credibility.

Three tests for credibility were employed: triangulation, member checking and participant debriefing. Triangulation refers to using multiple sources of information to verify the accuracy and interpretation of the phenomena being reported (Creswell, 2009). Managers identified proficient preceptors using the Preceptor Expertise Evaluation-Revised tool. Using the same instrument, the preceptors were asked to complete an assessment of their own self-efficacy. After completion of the survey, each proficient preceptor participated in an individual interview with the researcher, as well as a subsequent focus group related to the identification of best practices related to preceptor professional development and self-efficacy.

Member checking allowed participants to review the data and reports that were derived from the research procedures. Themes that were generated by the researcher were shared with the members, which allowed participants a chance to correct or clarify their experiences (Creswell, 2009; Stringer, 2007). During this action research study, the participant viewed his/her typed transcript, and themes that were identified related to the sources of self-efficacy were shared, and open for discussion at the focus group. Additional data from the focus group conversation were also collected. Anonymity within a focus group could not be assured, however, the group was requested to maintain confidentiality via the establishment of ground rules for group process.

Participant debriefing "focuses on the feelings and responses of the participants rather than the information that they have provided" (Stringer, 2007, p. 58). This was accomplished via

the focus groups where the members had a chance to articulate feelings related to the topic and the recall of events related to their own preceptor development.

Transferability.

Because this was an action research study, the findings of this study apply to this context and hospital (Stringer, 2007) will not be generalizable to other hospital settings. The use of rich, thick description or a detailed accounting of participant responses was used for the purpose of allowing the reader to better understand the information shared by participants (Creswell, 2009). This type of vivid description would permit the reader to determine the trustworthiness and applicability of the research to other milieus (Bryman, 2008) as well as contribute to a better understanding of preceptor self-efficacy and professional development within the research setting.

Dependability and Confirmability.

Dependability of the results were established through use of detailed field notes during the interviews and focus groups, as well as tape recording of the proceedings (Bryman, 2008). Complete records were kept of the entire research proceedings, including the interview and focus group transcripts, and of field notes scribed by the researcher. Relevant notes regarding how and what decisions the researcher made regarding the study will be retained through the course of the study. These elements of data will be maintained so that other researchers could review the results and determine if the conclusions were accurate; they will be retained securely for seven years after the conclusion of the study by the researcher and then will be destroyed.

Authenticity.

The authenticity of the results will be determined based on the effect that the action research had on the participants (Bryman, 2008). The purposes of this action research are to

explore the experiences of proficient preceptors relevant to their development of self-efficacy and to recommend best practices. It is anticipated that participation in this research journey will enable proficient preceptors to feel empowered to recommend and enact changes that will increase the self-efficacy of other preceptors.

Population and Sample

The population for this action research study was nurse preceptors within one hospital setting in Connecticut, specifically at the Hospital for Special Care. A purposeful sample of proficient nurse preceptors from within this setting served as the participants. This hospital was selected because it had recently implemented a preceptor development program. Because an active preceptor program had existed at this organization for several years, the clinical educators and managers would be able to identify a group that could be classified as proficient preceptors.

The researcher asked the clinical educator or nurse managers to identify potential candidates for the study who would qualify as proficient preceptors. Proficient nurse preceptors were defined in this study as nurses who had served as a preceptor for three years or more, who engendered the professional respect of their colleagues and manager as a preceptor, and who rated above average when evaluated using the Preceptor Expertise Evaluation-Revised instrument. Individuals meeting these criteria were invited to participate, following approval by human subjects committee at both the University of Hartford and the hospital. The sample consisted of 8-10 proficient nurses from a variety of patient care units and specialties within the facility (See Appendices G, H, I). Sampling nurses from heterogeneous specialty units would allow maximal variation sampling of preceptors, who might report divergent experiences (Stringer, 2007). However, because these preceptors worked within the same hospital setting and may have had similar developmental experiences, they may also have represented a typical

sample of proficient preceptors. Since nurses staff hospital settings around the clock in shifts (e.g. 8-hours, days or nights), it was anticipated that the researcher would have to be flexible in scheduling time to meet with the participants at a private location within or outside the facility.

Instruments

This study used the following instruments: the Preceptor Expertise Evaluation-Revised, adapted from the Preceptor Expertise Evaluation instrument from the Vermont Nurse Internship Project (VNIP), 2007; the Preceptor Self-Efficacy Evaluation, adapted from VNIP (2007); a Preceptor Individual Interview Protocol and a Focus Group Protocol. The variety of instruments provided a diverse source of data in order to increase the validity of the research design. Each was described in this section and how they were used.

Preceptor Expertise Evaluation-Revised

To identify which nurses qualified as "proficient" preceptors, the Preceptor Expertise Evaluation Tool-Revised (see Appendix B) was utilized. Preceptor competency was rated using this tool, which was adapted by the researcher from an instrument developed by Susan Boyer (VNIP, 2007). Boyer identified and aligned preceptor competencies with categories established through Lenburg's (1999) Competence Outcomes and Performance Assessment (COPA) model. The COPA model identified eight core practice competencies: assessment and intervention, communication, critical thinking, human caring and relationship skills, teaching, management, leadership and knowledge integration.

The rater evaluated preceptor expertise with this tool, using a "novice-1" to "expert-5" to score the candidate. The rating terminology employed in this instrument borrowed from the work of Benner (1984), who described five levels of nursing skill acquisition and development: novice, advanced beginner, competent, proficient and expert. Benner tied the growth of nurses

from novice to expert to their job-related experiences, time, and ongoing professional development (Swihart, 2007). Based on this theory of skill acquisition, this study made the assumption that development into a proficient preceptor also required these components. Thus, in the genre of nursing scholarship, this study assigned the term "proficient" to describe nurses with three to five years of experience in precepting and who scored above average (e.g. "4" or "5" ratings) on the Preceptor Expertise Evaluation-Revised. It was also expected that beginning preceptors would score lower expertise scores using this rating instrument. In addition to experience as a criteria, this instrument was used by clinical educators or unit managers to determine whether the preceptor qualified as "proficient" as described in this study. This instrument was piloted by subject matter experts, namely clinical educators who worked within a hospital setting with preceptors and minor edits were made to the wording to increase clarity.

Preceptor Self-Efficacy Evaluation

The Preceptor Self-Efficacy Evaluation tool (see Appendix C) was used to compare the evaluation of the clinical educator or unit manager with the self-efficacy evaluation of preceptor relevant to his/herself. Prior to commencing the individual interview, the proficient preceptor was asked to complete the instrument. The competencies and rating scheme were the same as that used by the clinical educator or unit manager. The directions for the tool were amended to reflect Bandura's (2006) suggestions for wording a self-efficacy instrument. In addition, directions were changed to address preceptors' self-assessment of their capability to perform duties. This instrument was piloted using preceptors within a hospital setting, and minor edits were made to the wording to make the competency statements easier to understand. This instrument was used as a point of comparison with the manager/clinical educator evaluation of preceptor competence, and was expected to be congruent.

Preceptor Individual Interview Protocol

After completion of the self-assessment instrument described previously, the proficient preceptor participated in an individual interview with the researcher, following the Preceptor Individual Interview Protocol as a guide for the interaction (see Appendix D). The function of this protocol was to promote the researcher's consistency in explaining the purpose and theoretical framework of the interview. The protocol consisted of open-ended interview questions developed by the researcher that were posed to each individual. Proficient preceptors' reflections of their professional development and of their precepting capabilities comprised the interview questions. Three sources of self-efficacy were explored: enactive mastery experiences, vicarious experiences and verbal persuasion. In addition, proficient preceptors were asked to share examples of how to use these constructs as a vehicle to develop self-efficacy with orientees. Table 2 on the following page presents the relationship between the interview protocol questions and the conceptual framework.

Focus Group Protocol

A focus group is essentially a group interview that "emphasizes a specific theme or topic that is explored in depth" (Byman, 2008, p. 473). Focus groups are comprised of more than one participant, with most having four to eight participants (Bryman, 2008; Creswell, 2009). The purpose of this focus group was to examine, via a group milieu, the self-efficacy development of proficient preceptors. The final task of the focus group meeting was to identify best practices related to the professional development of preceptors within their hospital setting.

Table 2

Self-Efficacy Preceptor Interview Question Matrix

Question #1- Demographic information about the preceptor related to precepting.

Question #2-13	Enactive Mastery Experiences	Vicarious Experiences	Verbal Persuasion
2. How were you prepared for the preceptor role?	X	X	X
3. Describe people who helped you to learn the role of preceptor (e.g. a role model or mentor).	X	X	X
a. How did you see them develop self-efficacy or use self-efficacy		X	
4. How do you think you could develop self-efficacy in others?	X	X	X
5. What elements of the self-efficacy framework that I have described were influential to your own development as a preceptor?	X	X	X
6. Vicarious experiences are described as hearing about the experiences of others like you and how they behaved and thought in a given situation. Can you think of an example of how you learned through a vicarious experience to grow as a preceptor?		X	
7. What have you shared regarding your own clinical experiences *(vicarious experiences)* with your orientees to help them understand a different way of looking at or doing something?		X	
8. What life experiences taught you or helped you to know how to teach critical thinking?	X	X	
a. How do you get your orientee to develop his/her critical thinking, in a way that will leads to a different understanding of the problem?	X	X	X

9. Thinking back on your history as a preceptor, tell me about the moment that you felt, "I am finally getting good at this"? a. What were the events surrounding this realization? b. How long did it take to achieve this level of expertise? c. How many orientees did you have to precept before you felt you did it well?	X X X X		
10. Tell me a time that you felt you were verbally persuaded you were good at your job?			X
11. How did you think through a problem related to precepting? a. What was most difficult about being a preceptor and how did you think your way through it?		X	X
12. What could we do to better develop new preceptors within this hospital and at other hospitals?	X	X	X
13. What do we do well in developing new preceptors within this hospital and other hospitals? (and that we should continue or do more of?)	X	X	X
14. What could we do to better develop experienced preceptors within this hospital and at other hospitals	X	X	X
15. What do we do well in developing experienced preceptors within this hospital and other hospitals? (and that we should continue or do more of?)	X	X	X

Given the fact that nurses provided 24-hour coverage and work in an unpredictable and demanding healthcare work environment, it was anticipated that the researcher needed to be flexible with scheduling. More than one focus group was conducted to enable participation of the preceptors.

The Focus Group Protocol was a guide to assist the researcher in conducting the focus group in a consistent manner (see Appendix E). The Protocol contained a description of the purpose of the study, the theoretical framework that underpinned the self-efficacy discussion, as well as questions designed to elicit proficient preceptor reflection and sharing related to the topic. A focus group methodology was chosen because of the increased likelihood that divergent opinions and viewpoints about preceptor self-efficacy would be expressed (Bryman, 2008). Participants would be more likely to respond to the comments of other participants in this setting, which could trigger additional ideas or discussion. In addition, the researcher was able to observe the interaction of members within the group in their work setting.

To ensure consistency and prevent over involvement of the research facilitator, the protocol provided a uniform approach by the facilitator, and general questions to focus the discussion on the desired topic (Bryman, 2008). For example, the focus group began with (a) introductions and disclosure regarding the voice recording of the group to ensure accuracy of the transcription; (b) small group activity with pairing of the proficient preceptors (5-10 minutes) to allow time to discuss; (c) sharing small group observations with the larger group, and (d) full discussion of the use of enactive mastery experiences, vicarious experience, and verbal persuasion relevant to preceptor professional development will follow. The final culminating activity and the ultimate purpose of this focus group (e) was recommending best practices for developing preceptor self-efficacy. These recommendations will be included in the final action plan. Table 3 on the next page presents the relationship between the Focus Group questions and the conceptual framework.

Table 3

Focus Group Interview Question Matrix

Question	Enactive Mastery Experiences	Vicarious Experiences	Verbal Persuasion
4. How do you think you could develop self-efficacy in others? (Describe development broadly).	X	X	X
16. Active participation or enactive mastery experiences is described as when a person is actively engaged in doing the learning; and the learning activities consist of incrementally more difficult, but achievable goals; and the person is able to self-correct along the way towards achievement of a goal. • Can you think of an example of how you could develop self-efficacy in a novice preceptor via active participation?	X		
17. Vicarious experiences are described as hearing about the experiences of others like yourselves and how they behaved and thought in a given situation. • Can you think of an example of how you might develop self-efficacy in a novice preceptor using vicarious experiences?		X	

Focus Group Interview Matrix (continued)

18. Verbal persuasion is described as when another person, particularly one in authority or that you respect, provides encouragement about your capabilities, tells you that you have ability and that you are capable of achieving a desired goal. • Can you think of an example of how you could develop self-efficacy in a novice preceptor using verbal persuasion?	X

Data Collection Procedures

Prior to initiation of the data collection for this action research study, the clinical educator or unit manager identified proficient preceptors as possible research participants. To qualify as a candidate for this study, an evaluation of the preceptor using the Preceptor Expertise Evaluation-Revised was conducted, and the preceptor scored above average, (e.g. score "4" or "5"), on the overall ratings. Once proficient preceptors had been verified as meeting the criteria for participation, they were invited to participate in the study and completed the requisite informed consent. All preceptors completed a self-self-efficacy evaluation of their capabilities relevant to preceptor responsibilities. Data was collected from participants during individual interviews and subsequently during the focus groups. The data source table is presented in Table 4 on the next page. This action research study uses data from multiple data sources, (e.g. individual interviews and focus groups) to increase the rigor and trustworthiness of the study. To minimize the influence of researcher bias, semi-structured interview guides were developed by the researcher for use during individual interviews and focus groups. Open-

Table 4

Data Source Table

Research Questions	Sources of Self-Efficacy (Bandura, 1997)	Individual Interview Protocol Item	Focus Group Protocol Item
1. What do proficient nurse preceptors report about the development of their self-efficacy related to enactive mastery experiences?	Enactive mastery experiences or active participation	2, 3, 4, 5, 8, 8a, 9, 9a, 9b, 9c, 12, 13, 14, 15	4, 16, 19
2. What do proficient nurse preceptors report about the development of their self-efficacy related to vicarious experiences?	Vicarious experiences	2, 3, 4, 5, 6, 7, 8, 8a, 11, 12, 13, 14, 15	4, 17, 19
3. What do proficient nurse preceptors report about the development of their self-efficacy related to verbal persuasion?	Verbal Persuasion	2, 3, 4, 5, 8a, 10, 11, 12, 13, 14, 15	4, 18, 19
4. What do proficient nurse preceptors recommend regarding best practices for ongoing preceptor professional development?	Enactive mastery experiences or active participation; vicarious experiences; verbal persuasion	12, 13, 14, 15	4, 19

ended questions relating to the research questions framed the discussion about proficient preceptor's development of self-efficacy as a preceptor.

The researcher arranged individual interviews at a time and place convenient to participants. The length of time for each interview was estimated at 45-60 minutes. To ensure the accuracy of data, the researcher used a voice recording of the proceedings and transcribed the interviews. A recorder permitted a detailed analysis of the contents after transcription. In addition, the researcher took field notes that included observations that may have

eluded the voice recording, such as information about the context of the interview, non-verbal communication, and proxemics. Stringer (2007) recommends that interviews be transcribed as quickly as possible after completion of the interview to enhance recall. Participants were contacted following the interview by the researcher to validate the accuracy of their individual transcript. In addition, the themes and best practices that derived from the focus group were shared with the members for verification prior to research dissemination and sharing. Recordings were confidential and reviewed only by the researcher and the researcher's advisor and would not be shared without the participant's permission. Seven years after the conclusion of the study, transcripts will be destroyed.

The individual interviews provided data relevant to three of the sources of self-efficacy relating to preceptor development, including enactive mastery experiences, vicarious experiences and verbal persuasion. Following completion of the individual interviews, the researcher arranged and conducted the focus groups. The proficient preceptors from the individual interviews were invited to participate and comprised the focus groups. Informed consent was obtained prior to participation in the individual interviews. Focus groups were held at a time and location convenient to the participants, and the duration was expected to be no more than two hours.

At the start of the focus group, members were introduced and ground rules established (Stringer, 2007). The researcher explained the procedures and time frame of the group. Members were asked to respect the views of others, to allow each person an opportunity to express his/her opinion, and to maintain confidentiality related to disclosures within the group. Anonymity could not be assured within focus groups. During the focus group, participants were

provided with questions relating to the research questions. The researcher acted as a facilitator to keep discussion focused on the topic at hand and served as the timekeeper.

The focus group was voice recorded and transcribed verbatim following the meeting. Transcripts were reviewed by the researcher and the researcher's advisor and after study completion. Relevant notes regarding how and what decisions the researcher made regarding the study were retained through the course of the study. These elements of data will be maintained so that other researchers could review the results and determine if the conclusions were accurate; they will be retained securely for seven years after the conclusion of the study by the researcher and then will be destroyed. To allow replication of this study by other researchers, an Action Research Protocol with estimated timeline for completion follows in Table 5 on the next page.

Data Analysis

This section describes the analysis of data obtained from individual interviews and focus groups. Following each interview and focus group, data was transcribed verbatim from the recorded transcripts to promote accurate representation of stakeholder thoughts and ideas. The themes identified in the individual interviews were shared with focus group members for the purpose of discussion. Sharing divergent viewpoints permitted a group examination and collaborative recommendations that were contextually specific and relevant.

Stringer (2007) describes two major processes to analyze the data from an action research study, both of which will be employed to illuminate this research topic of the development of preceptor self-efficacy. He terms the first process, "categorizing and coding the data", and the second "key experiences" or transformational moments that have changed the perspective of people. This analytic activity involves unpacking the events "to identify the elements that

compose them, thus illuminating the nature of these experiences" (Stringer, p. 98). This action research study employed both types of analysis.

Coding and Categorizing the Data

To categorize and code the data, the Stringer (2007) describes six steps in the process: (a) reviewing the collected data, (b) unitizing the data, (c) categorizing and coding, (d) identifying themes, (e) organizing a category system, and (f) developing a report framework. In this action research study, results were first transcribed and were read over by the researcher to get a better understanding of the major ideas presented and a global sense of the information that was shared. To prevent researcher bias in interpreting the data, a process called bracketing was used in which the researcher's understandings, intuitions and interpretations were identified (Stringer, 2007). For this reason, transcriptions were done "verbatim" and the proficient preceptors' words and descriptions were used when possible. This assisted the researcher with the next step, which was to unitizing the data.

When unitizing the data, the researcher identified "units of meaning-statements that have discrete meaning when isolated from other information" (Stringer, 2007, p. 101). Specific ideas, concept and events that were relevant to the development of preceptor self-efficacy were broken out from participants' transcripts.

In the third stage, the researcher categorized and coded data. Coding is a process whereby data is broken apart and categorized. Strauss and Corbin (as cited in Bryman, 2008) identified three types of coding practice: open coding, axial coding and selective coding. This study used axial coding, which referred to the process of "selecting a category and positioning it within a theoretical model" (Creswell, 2009, p. 184). During this activity, a large number of

Table 5

Action Research Study Protocol

Timeline	Events/Descriptors
December 2013-January 2014	Pilot instruments with preceptors. Complete documentation required by University of Hartford and affiliating hospital's IRB. Defend Dissertation Proposal Chapters 1, 2, 3, including protocols.
February-April 2014	Recruit study participants for individual and focus groups. Obtain informed consent for study participation. Schedule individual interviews and focus groups, and secure locations. Contact and arrangements will be done via phone, e-mail or post-office mail. Conduct the individual interviews (one hour) followed by focus groups (two hours) in length. Transcribe verbatim after each interview and focus group. Ensure confidentiality of the data.
May-June 2014	Conduct analysis of the data according to Interview and Focus Group Protocol. Interpret data and develop conclusions in light of the conceptual framework.
July-September 2014	Complete Chapters 4 & 5 according to University of Hartford standards set by the Educational Leadership Doctoral Program at the University of Hartford. Final dissertation defense.

categories emerged related to preceptor self-efficacy development and were broadly grouped. The fourth step involves identifying themes from the groupings of the data. The researcher identified themes that were held in common across participants as well as those that were divergent.

The fifth step involved invoking a category system to "provide a clear picture of the categories and subcategories of information related to the topic investigated" (Stringer, 2007, p. 102). The researcher clustered categories to invoke a logical order relevant to the research topic. Finally, when these steps of the data analysis were completed, results were translated using this system via reports and presentations related to recommendations for best practices for preceptor development (See Appendix M).

Analyzing Key Experiences

Key experience analysis as a research strategy was also employed. Memorable or high-impact moments related by participants provided deeper and richer understanding of the phenomena of preceptor self-efficacy development. Participants in this study were asked open-ended questions that may have elicited stories of success or failure that led preceptors to new understandings, insights and self-efficacy.

The steps followed in this analytical process involved analysis of the transcription to identify relevant events and experiences of proficient preceptors. Next, major features of the experiences were identified, and salient elements comprising the event detailed. The researcher organized these features, elements and experiences in categories to clarify and organize the preceptor development experiences by themes. Key experience analysis proved beneficial in understanding the process and impact of formative experiences on preceptor development, and contributed to the knowledge of best practices within this context.

The researcher and her advisor analyzed data from the focus groups, and a report of best practices related to the development of preceptor proficient development at this site was completed. It is anticipated that the findings of this study will be shared within the nursing professional community as well as via poster presentations and nurse educator forums.

Protection of Human Subjects

Before initiating this action research study and recruiting volunteers, researchers must "take steps to ensure that participants come to no harm as a result of their participation in the research project" (Stringer, 2007, p. 54). To this purpose, this proposal was submitted for review and approval to the Institutional Review Board (IRB) of the University of Hartford and the data collection site.

Once approved by the IRB's, proficient preceptors were invited to participate. The researcher explained the purpose of this study: to engage proficient preceptors in an exploration of the development of preceptor self-efficacy for the purpose of recommending best practices. Procedures such as participation in an individual interview and focus group were explained, as well as the time commitment involved. If candidates expressed interest, they were asked to sign an informed consent form prior to engaging in the study (see Appendix F). Participants were not coerced to participate, nor offered material benefits for taking part in the study.

Participants were asked to maintain confidentiality of information that was shared within the individual interview and the focus group. Because this study involved a group, confidentiality was maximized but could not be guaranteed. The transcripts were kept confidential, and only the researcher and her advisor had access to the transcripts. Any reports that was generated from an analysis of the data reported findings in aggregate and/or protected

the identity of the participants through the use of aliases and disguised work units. All transcripts and tapes were destroyed seven years after completion of the study.

The researcher fully explained potential risks and/or discomforts of engaging in this study. In the event that a participant were to become uncomfortable with the conduct of the study, or wished to withdraw from the study, he/she were informed of their right to refuse and withdraw from the study at any time without fear of reprisal from the hospital management or the researcher. In the event that discussion about precepting experiences triggered psychological distress, the participant could opt out of the study and would have been referred to professional counseling services, such as the hospital's Employee Assistance Program [EAP]. This study did not use language biased against people based on gender, race, sexual orientation, race, disability or age (Creswell, 2009). In addition, participants were allowed to view the recommendations of the study prior to completion of the study.

Study Materials Inclusive of Informed Consent

Copies of the study materials, including the research instruments, interview and focus group protocols and informed consent form are found in the Appendices section of this proposal.

Limitations of the study

Limitations of this study included the lack of generalizability due to methodology chosen, the small sample size (Coghlan & Brannick, 2010; Herr & Anderson, 2005), and researcher bias related to the need for ongoing preceptor development. This study was conducted at one type of hospital in a given context, which may not apply within another healthcare environment. In addition, time constraints prevented this researcher from fully evaluating the fruits of this project and continuing on to the next cycle of action research.

A limitation of focus groups is the fact that the researcher has less control over the group and its direction than the individual interview (Bryman, 2008). In addition, it was challenging to schedule the focus groups, since nurses were often unable to break away, and data collection activities required a commitment to participate when off duty. Since the participants' reports were from memory and self-perception, the story of their activities might have been colored by their own perception or a desire to be accepted within the group. In addition, "group think" can be a drawback of groups: Reticent members often defer to dominant members, culturally preferred opinions might only have been expressed, and members may have been uncomfortable with topics raised. The researcher attempted to mitigate these potential limitations by establishing ground rules and intervening to draw out reticent members.

One final limitation was the conceptual framework of this study, which limited the constructs under examination to the development of preceptor self-efficacy. One source of self-efficacy, physiologic or emotional states, was not included in the scope of this study, since after discussion amongst the advisor and researcher, it was felt to be not applicable.

Summary of the Chapter

This chapter provided a description of the design and methodology of this action research study, including a statement of the problem, research questions, operational definitions, design of the study, sample, data collection and analysis procedures, human subjects protection, and limitations of the study.

This study used an action research design to engage proficient nurse preceptors in exploring the development of their preceptor self-efficacy for the purpose of recommending ongoing professional development and best practices in a hospital setting.

CHAPTER FOUR: PRESENTATION OF THE FINDINGS

Introduction to the Chapter

Chapter Four presents the findings of this action research study. The purpose of this study was to engage proficient nurse preceptors in exploring the development of their self-efficacy for the purpose of recommending ongoing professional development within a hospital setting. This action research study was framed using Bandura's (1997) social cognitive theory of self-efficacy. Based on the reports of the participants within this action research study, best practices were identified relevant to ongoing preceptor professional development within the hospital setting.

Data Collection Review

This section provides a brief overview of the data collection and analysis methods employed in the course of this study. This study employed an action research design inclusive of individual interviews and focus groups of study participants. The primary unit of analysis was ten proficient preceptors within one hospital setting. The research questions were framed using Bandura's (1997) theory of self-efficacy.

First, the researcher conducted individual interviews with each proficient preceptor, using an interview protocol (Bryman, 2008). The protocol consisted of open-ended interview questions based on Bandura's (1997) conceptual framework, constructed by the researcher, which were posed to each participant. The interview questions explored proficient preceptors' reflections about their development in the preceptor role and precepting capabilities. Three sources of self-efficacy were explored: enactive mastery experiences, vicarious experiences and verbal persuasion. The relationship between the interview protocol questions and the conceptual framework was illustrated in Table 2. The interviews were audiotaped and transcribed by the

researcher. Pseudonyms were assigned to interview participants to protect their identity in the reporting of all data.

Following participation in the individual interview, participants were invited to take part in a focus group. The purpose of the focus group was to examine, via a group milieu, the self-efficacy development of proficient preceptors. A focus group protocol (Bryman, 2008), created by the researcher and based on Bandura's (1997) conceptual framework, was employed (see Table 3). All ten of the proficient preceptors, who participated in the individual interviews, also participated in one of two focus groups. The culminating task of the focus group meetings was to identify best practices related to the professional development of preceptors within their hospital setting. The focus groups were audiotaped and transcribed by the researcher, and pseudonyms were assigned to each participant in the reporting of data to protect the proficient preceptors' identity.

Data Analysis Review

This section will provide a short review of the data analysis procedures used to analyze the data from the individual interviews and focus groups. Action research methods described by Stringer (2007) were employed in analyzing the data.

To categorize and code the data, the Stringer (2007) describes six steps in the process: (a) reviewing the collected data, (b) unitizing the data, (c) categorizing and coding, (d) identifying themes, (e) organizing a category system, and (f) developing a report framework.

Reviewing the collected data

After completion of the individual interviews and focus groups, the results were transcribed and re-read by the researcher to get a better understanding of the major ideas presented, as well as obtain a global sense of the information that was shared. To prevent

researcher bias in interpreting the data, a process called bracketing was used, in which the researcher's understandings, intuitions and interpretations were identified (Stringer, 2007) and put to the side. For accuracy in reporting, transcriptions were done "verbatim", and the proficient preceptors' literal words and descriptions were used. This assisted the researcher with completion of the next step, which was to unitize the data.

Unitizing the data

To unitize the data, the researcher identified "units of meaning-statements that have discrete meaning when isolated from other information" (Stringer, 2007, p. 101). Specific ideas, concepts and events that were relevant to the development of preceptor self-efficacy were broken out from participants' transcripts.

Categorizing and coding data

In this step, data could be categorized and coded. Coding described the process whereby data was broken apart and placed into groupings or categories. Strauss and Corbin (as cited in Bryman, 2008) identified three types of coding practice: open coding, axial coding and selective coding. This study employed axial coding, which referred to the process of "selecting a category and positioning it within a theoretical model" (Creswell, 2009, p. 184). During this activity, categories that emerged relating to preceptor self-efficacy development were broadly grouped.

Identifying themes

Themes emerged from the groupings of the data. The researcher identified themes that were held in common across proficient preceptors as well as those that were divergent.

Organizing a category system

The fifth step involved devising a category system to "provide a clear picture of the categories and subcategories of information related to the topic investigated" (Stringer, 2007, p.

102). The researcher clustered categories to invoke a logical order relevant to the research topic (see Appendices J, K, L & M). During each step of this process, the researcher and research advisor engaged in dialogue about the findings.

Developing a report framework

Finally, after completing steps one through five of the data analyses, results were translated, via reports and presentations, in the form of recommendations for best practices for preceptor development within this hospital setting Following completion of this study, a curriculum for ongoing preceptor professional development will be constructed to benefit preceptors within this facility.

Qualitative Findings

Research Question 1.0 What do proficient nurse preceptors report about the development of their self-efficacy related to enactive mastery experiences?

Finding 1.1 Ten out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on an ability to *model the occupational skills/clinical competencies of their unit of work.*

Because Nursing is a practice discipline, nurses must first be able to model clinical competence relevant to the population and skills required within the work unit to be an effective preceptor. Obtaining this level of nursing competence requires time and experience. Possession of clinical know-how helped preceptors feel confidence, even when faced with perplexing new patient situations while precepting. Preceptors reported this was a foundational requirement for advancing self-efficacy in the preceptor role.

Eduardo described his personal experience of becoming a nurse and preceptor, and it was through the modeling of his preceptors that he garnered the clinical knowledge, skills and

attitude that were necessary to develop self-efficacy. Eduardo felt that preceptors should first be knowledgeable and able to safely care for their patients. He explained,

> I try to show that to them. You should have the knowledge, otherwise you will not be able to impart properly, which is right, which is not. And if they see these things in me, they might actually copy what I am showing.

During the Focus Group, Georgia, also spoke to the need for preceptors to demonstrate clinical competence. She said that preceptees "look to see how you perform, how you carry it through, how you make your assessment, and then they internalize what you are doing and will perform in the same way".

Three proficient preceptors commented on the importance of clinical experience during their formative years that had contributed to preceptor effectiveness. Eduardo noted the value of clinical knowledge and experiences gained throughout his career, and that he was able to draw from and share with preceptees. Regarding this, he said, "Those things you started remembering and keeping them in your memory bank". Donna stated that she had become a preceptor after about two years of experience as a registered nurse. Having this basic clinical competence elevated her self-efficacy as a preceptor. She reported always feeling like she was "clinically competent while precepting", and believed her orientees "felt like they were learning from me". Billie reported having a large background of clinical experiences that were helpful to share with preceptees. She related, "I've seen a lot of things and when they're doing something, I can tell they are nervous because they have never done it before, but to me, it isn't a big deal". Billie shared a personal insight about the learning process, saying, "It takes me about six months to feel like I am doing good at something, at a new job or any new responsibilities."

Carol talked in detail about her own experience of becoming a competent nurse before she assumed a preceptor role, and how the lack of self-efficacy of preceptors she was supposed to be learning from could have negatively impacted the safety of her patients through ineffective precepting. "The senior nurse on my unit was there six months before us. She's like [*sic*], 'Why are you asking me?' There were some nights none of us knew what was going on". When Carol later transferred to another unit, she related a better experience of having seasoned nurse preceptors that she was able to learn from, and her knowledge increased, contributing to her self-efficacy as a nurse and later as a preceptor.

Henrietta, Frances, Georgia and Ingrid cited competent bedside nurse preceptors as instrumental to their basic competence as nurses and self-efficacious preceptors, and whose example they all tried to emulate. Henrietta reported that she relied on her preceptors for help as a novice practitioner: "They were confident and basically knew A to Z [*sic*] how to get the job done." Frances said of her preceptor, "She could get an I.V. into this chair. She remembered all those little things about patients, and was your resource." In describing their preceptors, Georgia and Ingrid both used the word "knowledgeable". Georgia reported that her preceptors "reinforced what we learned in nursing school, why you do things, when you do things…all the interventions and the rationales why [*sic*]". Ingrid also described her preceptor as being "hard-working and tuned in to her patients". Ingrid attributed her successful transition into a competent nurse, who could identify and access necessary resources, to the modeling of her preceptor.

Ingrid felt that she was ready to be a preceptor when she "knew enough of the time management, the organization, to share it with other people." She stated, "My self-efficacy developed over time; learning on the unit and being there so long, I became competent and I knew who my resources were." When she became a preceptor she said, "I knew what

experiences I could pull and give to somebody, having had the knowledge of providing care for the patients."

Ingrid felt that in general there should be a way of determining when a nurse was ready to take on the preceptor role. She suggested assessing whether the nurse had the knowledge and the skills in some way, "like a pre-test or some assessment, and make sure the nurse is strong in her skills, talk to the staff, the manager, and the nursing assistants." Adele and Jane reflected along a similar vein regarding readiness to take on the preceptor role. Adele maintained, "With the core [skills] they should be competent." Jane stated that as a requirement to precept, nurses should be "up-to-date on all their clinical skills".

Since nursing is a practice discipline, participants of this study strongly agreed that having clinical competence should be a prerequisite for the role of preceptor. Preceptors who did not have the necessary knowledge and skills might demonstrate inappropriate modeling, which could be detrimental to patient care within a hospital setting.

Finding 1.2 Eight out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on their ability to *provide effective feedback in ways that enhanced preceptee performance.*

Preceptors must be able provide feedback in ways to that enhanced the performance of their preceptees and was felt to be an important aspect of preceptor self-efficacy. Proficient preceptors indicated that effective preceptor feedback was specific, relevant to the knowledge and skills to be learned, and offered in a manner that was ongoing, timely, consistent, sensitive and encouraging.

Two proficient preceptors mentioned ongoing feedback as necessary aspects of their role. Georgia learned to give continual feedback through the examples of her preceptor and head

nurse, who regularly checked in with her as she was learning. She remembered them as checking in and saying, "Come here and tell me something about your patients". She said it served to give her a sense of her organization, "It was a check-in: What did you do? What could you have done differently? Let's go and do this." In addition, they noted her what she had done well during that day. Eduardo also recalled his preceptor providing continual feedback about his performance, strengths and weaknesses when he was new. He said, "There is [*sic*] a constant verbal encouragement." As a new preceptor, Eduardo reported using feedback to determine whether his preceptee comprehended and learned the competencies necessary to successfully perform patient-based skills. He did this by debriefing with his preceptee at the end of the shift. "So there was constant talk at the end of the day, what happened….There should be feedback, if they are learning something or not." He reported, "Through the years you actually started mastering that, becoming more and more comfortable."

During the Focus Group, several participants addressed provision of timely and ongoing feedback as a requisite of efficacious precepting. On a daily basis, Adele would ask her preceptee, "How did your day go today", to get the person's perspective about their experiences. Then she would say, "Let's look back on all the events that we have done together", and address specific concerns right then, "How could we fix that so it won't reoccur again?" She continued, "I am not going to wait, I'll address it with the person." Donna and Henrietta also verbalized that timely feedback was beneficial. Donna asserted, "They're more receptive to feedback if it's right on the spot", and the preceptee could "ask questions" or seek clarification if needed. Henrietta concurred, "If you have to correct something that's not done the way it should be done, it's better to say something right away rather than waiting".

Ingrid reported that part of her growth as a preceptor included developing an ease of communication over time regarding what needed to be done in a learning situation. Ingrid discovered that to provide constructive feedback, she had to "listen as much as not just telling [*sic*]; not this is the way, and that's it." This meant being attuned to the non-verbal feedback from the preceptee as well. Ingrid tried to "find specific examples and frame it in a way that was a constructive criticism, not a wrong, but you can do this quicker or easier [*sic*]." Jane indicated that she found she had greater success with precepting orientees when she framed feedback in a positive way. "My style is kind. I'm quick to redirect people, but in a positive way" and "for most people that is rewarding."

Proficient preceptors reported that orientees needed specific feedback about the expectations and correct way to perform skills. Jane informed preceptees from the beginning that she would not assume anything about what they knew, that she would ask questions and ensure that what they knew was "correct". Carol reported that after explaining something or telling a story to illustrate a point, she would seek feedback from her preceptees. "Does this make sense? Because if it doesn't make sense, then you're not understanding it, or I'm not". Ingrid validated the comprehension of preceptees by seeking verbal feedback, as well as checking in with them throughout the orientation period. She said she would ask, "What do you think, what would you do?" Ingrid then would give pointers or provide more information as needed, saying, "You could do this", or "Another way is this".

Billie reported a need to provide encouraging feedback when precepting novice nurses, who often had unrealistic expectations about their accomplishments. She felt these misperceptions became apparent after about a month on the job, stating, "They dipped down in their performance, feeling bad about themselves, and that's where you build them back up." She

told them, “I don’t expect you to be as far along as you think”. Over time, when they were feeling more comfortable, she would point out their progress to them, “Look at how good [*sic*] you are doing”. Donna learned the importance of encouraging feedback as a preceptee, and the lessons learned were applied when she precepted others. When she had been a nurse for several years, Donna changed jobs to a new specialty unit. Of this she recalled, “The first time I changed a G-Tube [*sic*], I was so nervous.” Her preceptor’s feedback helped her survive this, “My preceptor was very calm and non-judgmental….She validated all of my concerns and understood that this is a very new experience,…and it is normal to be nervous, and encouraged me to make me feel more comfortable.”

Carol reported that as a new nurse, she inferred positive feedback by the actions as well as the words of her preceptor, and she has followed this modeling as she developed in preceptor self-efficacy. For example, when her preceptor told her, “I think you can do this by yourself, I’ll be in the next room”, she interpreted this as indicative of progress and that her preceptor now trusted her to perform safely and independently without direct oversight.

Frances offered feedback in the form of hints and humor to push her preceptees to the next level. “Depending on the patient and the situation, you can give them helpful hints to give them a bit of their own chops to be able to say, I can’t do this right now”. She also used humor to convey a point about a lack of decision-making. Frances would say to her preceptee, “You don’t have to look at me for the check mark every single time”. Sometimes she might add, using a joking voice, “Okay, I’m the mom now”, to illustrate her point about making a decision. If the situation did not proceed as planned, Frances would, “clue them along the way [*sic*]”.

Two proficient preceptors, Billie and Carol mentioned the location where feedback was delivered and sensitivity to the feelings of the preceptees as important. These were learned

elements in providing feedback and contributed to their self-efficacy. Billie cited use of a "quiet area" to deliver corrective feedback. Carol would provide explanations of practice related to a scary new procedure in a private place, like the Medication (Med) Room. She stated, "I don't want to ever have them in the patient room and be embarrassed at not knowing what to do." Also, Carol said that she would not disclose to the patient that this was the first time the preceptee might be doing the new procedure.

Preceptor self-efficacy was promoted when preceptors learned how to step away from certain challenging or frustrating situations with a preceptee. In order to provide objectivity and gain a clearer perspective of the situation, preceptors could choose to halt the interaction or situation in which the preceptee was acting so they could be constructive. To avoid showing impatience, Frances stated, "Sometimes you have to just walk out of the room." After taking a deep breath and collecting herself, she would return with a clearer directive. Billie stopped giving corrective feedback when her preceptee became emotional and angry. She said, "I had to talk to myself in my head while she was doing that to stay very calm and not feed into it, just remain professional, calm." She told the preceptee, "Let's take a break, this isn't productive; another day we will do it". In this example, Billie noted that when the orientee returned the following day, she was more receptive to feedback, and they were able to move forward with her learning. Carol reported that the preceptor "could offer suggestions, but the person has to be open to that". Learning this intricate feedback balance was part of preceptors' development of self-efficacy.

Preceptors indicated that the development of their self-efficacy in the role was related to their ability to use effective feedback strategies. These skills included being specific and relevant to the knowledge and tasks to be learned. Preceptors also recognized that feedback

needed to be offered in an ongoing manner and was timely, consistent, sensitive and encouraging.

Finding 1.3 Six out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on their ability to *provide constructive feedback to preceptees.*

Constructive feedback represented a necessary requirement for the development of preceptor self-efficacy, as it was a particularly important skill that assisted in the redirection of preceptee learning. Successfully navigating difficult communications helped preceptors to manage conversations and confrontations that could create discomfort.

Proficient preceptor Georgia identified a difficult aspect of communication that stemmed from providing oversight to an adult learner. She related an example of precepting an older experienced nurse who had changed positions within the organization from a leadership to a staff role and had been accustomed to being the provider of feedback rather than recipient. However, this person was new to the unit and routines. The orientee acted uncomfortable when the preceptor tried to provide oversight, telling her, "Don't hover." Georgia said, "I didn't want to step on toes, I didn't want to belittle", and that "this was a little intimidating for me". Georgia shared another example of working with a challenging older preceptee who would "literally freeze" when she approached. Precepting in these situations was described as "very challenging" and required preceptor self-efficacy to change behaviors.

Giving constructive feedback to preceptees who did not want to hear the message was reported as difficult. Ingrid stated that, "the hardest part is the negative feedback", especially "if they don't take any of that feedback". She related the experience of precepting an orientee who had been resistant to constructive criticism. Ingrid had tried different approaches with limited

success. During the Focus Group, she reflected, "How far do you go with that? How do you get through to somebody that feels that they know everything? It was still frustrating and I worried about safety and things." Jane had also dealt with a similar situation with an orientee who "just didn't want to listen to anything I had to say. That can be frustrating, and then I needed help." She continued, "You can't teach someone what's right if they don't want to listen".

Providing negative feedback to orientees who became defensive or emotional was considered stressful. Billie stated, "It's always difficult to tell somebody they're not up to snuff, and she maintained that the hardest thing to say was, "You're not where you need to be". She related a stressful experience of having an orientee who needed corrective feedback, but who responded emotionally, and she said, "You never want to tell somebody, 'You're not doing good [*sic*].' It's a hard pill to swallow. So that's probably the biggest challenge". However, Billie suggested that these difficult conversations don't happen often enough, and learning how to manage these feedback situations were vital becoming an efficacious preceptor.

Proficient preceptors worried about how the constructive feedback would be received and impact relationships with their preceptees, however, they reported that addressing issues promptly could improve communications. In discussing this issue, Donna stated that she found, in particular, that confronting preceptees about unprofessional behaviors was the most uncomfortable for her. She gave the example of catching a young orientee using her cell phone in a prohibited area on the unit and told her to "put the cell phone away". On reflecting why this felt so difficult, Donna said, "Because I don't like confrontation". Frances commented, "It's a really hard process to feel comfortable enough to say, this isn't what you learned. Nobody wants to hurt anybody's feelings." She explained this reluctance as, "Sometimes we're just too nice, because we have to work with each other afterwards". However, Frances did maintain that

immediate and constructive feedback could actually provide for ease of communication. She gave the example, "If we have a situation that didn't go as planned, I would ask them after we got out of the room: 'How do you think that went?'" After the preceptee answered, she might say, "Could I give you my opinion, because it was this and this should have happened [*sic*]?" Georgia supported this finding as well in her dialogue, describing how it was helpful to immediately address problem areas with preceptees.

Constructive feedback was identified as crucial in the high stakes hospital environment where patient safety was paramount. While provision of such feedback could be uncomfortable for both preceptor and preceptee, they were also necessary to correct inappropriate behaviors. Preceptors reported the development of preceptor self-efficacy hinged on an ability to effectively manage difficult conversations and constructive feedback.

Finding 1.4 Seven out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on the ability to *utilize feedback as a mechanism for growth relevant to precepting.*

Proficient preceptors reported that feedback information received through formal, informal, direct and indirect sources contributed to their growth as a preceptor. Such feedback served to reinforce and validate their perceptions of self-efficacy and motivated them to persevere as a preceptor. Specific types of feedback that were mentioned included the following: formal feedback using written evaluation forms and direct face-to-face progress meetings, informal feedback obtained through orientee or staff comments, and indirect feedback inferred from observations of successful performances, recommendations of former orientees, or overheard comments. When receiving constructive feedback, preceptors desired feedback that was timely, relevant, respectful, and allowed the chance for dialogue. These elements, when

present were cited as contributory to preceptor growth and were instrumental to the self-efficacy development of preceptors.

Feedback from preceptees was seen as a powerful indicator of preceptor efficacy by preceptors. Jane and Adele talked about the direct verbal feedback they had received from new nurses which served to increase their preceptor self-efficacy. Jane reported, "They thought I did a good job. That's rewarding for me and it feels like the next time it is easier, it comes easier…It makes me feel good about that so I enjoy doing it." Adele shared an example of receiving positive verbal feedback from an orientee relevant to a new technique she had reviewed with her. The orientee, who she had precepted for the first time, complimented her by saying, "Where were you when I was orienting? Why weren't you here to precept me?"

Preceptors interpreted positive verbal feedback and observations of successful performance as indicative of their efficacy in the role both during and after completion of the orientation program. Preceptors said that they heard feedback about their instruction from others second-hand or through overheard comments. Ingrid reported that a preceptee had said, "Ask for Ingrid, she's a good preceptor, you'll learn a lot". Eduardo related hearing preceptees tell co-workers and other orientees, "He is a good one", which served to increase his self-efficacy. Additionally, Eduardo reported positive feedback that he had heard emanated from senior staff members or other co-workers. He stated, "They don't usually tell *me* [emphasis added], but they have no reservations when they are giving hand-overs [*sic*] or try to introduce me to one of the other nurses." On hearing feedback like this, Eduardo said he interpreted it as, "I must be doing something right. So I just keep doing what I could do [*sic*]". This indirect positive feedback had the effect of validating the self-efficacy of preceptors.

After her preceptees had completed orientation, Ingrid related how she understood her their behavior and comments as indicative of her successful precepting. Although no longer serving as their preceptor, they still viewed her as a resource. "They would tell me that I was a good preceptor, and they were ready to fulfill their role". Also, she believed she had fulfilled her responsibilities well when she observed preceptees able to "demonstrate everything they needed to do or performing a skill independently because they had been taught it". These positive preceptee comments, as well as observations of preceptee progress, reinforced the self-efficacy perceptions of preceptors relevant to their precepting capabilities.

Frances found receiving verbal feedback from her co-workers as affirming. After watching Frances precept a particularly challenging new hire, colleagues on the unit complimented her patience and said, "I don't know if I could stand there and do that like you do. How do you get through it?"

Besides positive feedback, during the Focus Group, preceptors indicated that they wanted to hear constructive feedback. This would help to clarify the orientee's perceptions, identify problem areas, make changes or suggest alternatives. Georgia stated that getting more input from orientees about her performance would be helpful. "I'd like more feedback on what the orientee thought of you as a preceptor…Constructive feedback for the nurses for him or herself to grow". Frances suggested formalizing the meeting between the manager, preceptor and preceptee as a vehicle to "discuss how they are doing, so maybe that time could be a time the orientee could say, 'Frances is driving me crazy', or 'She's doing a great job'…face to face". Carol felt that if the negative feedback from the preceptee involved "a big thing, it should be addressed right away". Also, Carol wanted to hear constructive feedback when it occurred, "I would want to know then. Then if they need to change, they could have a different preceptor".

Jane agreed that she would want feedback proximal to the unhappiness, "I would want to know then" and to be told "in private".

Five proficient preceptors identified discussion of dissatisfactions face-to-face as helpful to clarifying problems and seeking mutually agreeable solutions. To facilitate communication, Ingrid recommended saying to the preceptee, "Are there any issues, is there anything at all?" Carol would ask "questions as to how" the orientee perceived his/her needs were not being met. Frances would inquire as to "the way they perceive what you are explaining to them." She continued, "They might think you are micromanaging when in fact your goals is to help them manage time better." Georgia added that the preceptor might have intervene to "prevent a disaster", which could be explained to the preceptee at a face-to-face meeting.

Formal written feedback from orientees was seen as helpful in development of self-efficacy. Ingrid reported that when students or nurses she had precepted completed written evaluations about how she did as a preceptor, it "made me feel better, more comfortable and made me extend myself a little further." Georgia mused, "I'd like more feedback on what the preceptee thought of me as a preceptor, constructive feedback for the nurse for him or herself to grow. Feedback like, 'I wish I had more time for computer entry', or 'I wish I had more time to do SP [*sic*] tubes', or 'I wish I had'…"

Henrietta noted that she had received written feedback intermittently from the Clinical Education staff about her performance as a preceptor, which aided her growth as a preceptor. "Getting feedback kind of validated me [*sic*]. I was reassured that the preceptees are receiving what they need to learn. It validated what I was doing was correct. For me it took a few years, and the feedback helped". Henrietta requested more consistent feedback post-orientation from her orientees. She noted that feedback from nurses assigned to float between units was often

informal. After completing an orientation to her unit, float preceptees would move on to another unit, and she wondered how they were managing. She said, "I will run into them in the cafeteria or just passing in the hallway, and I informally ask them, 'How did it go?'" Structuring consistent written feedback was suggested as a mechanism for validating the preceptor's self-efficacy evaluation.

Two proficient preceptors identified formalizing feedback mechanisms as a means of validating their self-efficacy. Henrietta wanted the manager to address her enactment of the preceptor role during the yearly performance evaluation, recognizing the things she did well, as well as opportunities for growth. "Feeling good about your practice and feedback is always the best". Ingrid also indicated that preceptors could benefit from manager feedback, "using evaluations and changing your practice" as a means for growth.

Proficient preceptors reported that feedback about their precepting acumen was important to professional development and growth in the role. Such feedback was derived from formal, informal, direct and indirect sources and served to reinforce and validate perceptions of self-efficacy. Genres of feedback received by preceptors included formal written or verbal preceptor evaluations from orientees, face-to-face, second-hand comments or commendations, and inferred via observations of successful performances of preceptees. Preceptors desired constructive and effective feedback about preceptee dissatisfactions to ensure prompt adjustments and resolution. Formalizing feedback processes to ensure consistent collection and sharing this information was suggested as a means to enhance preceptor self-efficacy.

Finding 1.5 Eight out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on an ability to *use knowledge of learning styles to engage learners.*

Preceptors reported that being able to utilize knowledge about learning styles to engage the preceptee was an important component of their preceptor self-efficacy. This included understanding their own learning preferences as well as assessing preceptee needs. An important component of preceptor self-efficacy was the application of this knowledge to preceptor-preceptee relationships to encourage positive learning outcomes and learner satisfaction.

To give preceptors a foundation to draw upon, content about learning styles was mentioned as a basic component of their role-specific preparation curricula. Georgia recalled that her initial preceptor education had addressed content relating to learning styles, inclusive of self-analysis and exploration of the type of learners in her class. She remembered discussing, "What learning style does best with what type of preceptor, making you look at yourself to see how you respond and would problem solve things".

Billie commented that insights about her own learning style had facilitated her development as a preceptor. She described herself as an active, hands-on learner. "If you talk to me, I will process a little bit of it, but I have to actually do it." To increase her recall during explanations or lectures, Billie would record copious notes, adding diagrams to illustrate key points. Throughout her experience of orientation as a novice nurse, Billie found herself paired with preceptors whose learning style differed from hers, but she made it work using note taking. "When I started working, I had a little notebook on me to write everything down, because when people talk to me, it doesn't always stick". When learning about a new piece of equipment, she said she "wrote down all the parts and copied little pictures." Henrietta was a self-described

active learner, who preferred a visual and hands-on approach. She reported a tendency to "lose a lot through auditory. You are listening to someone, but then your mind wanders away."

In addition to self-awareness of their learning styles, being able to assess how their preceptees learned was considered necessary for preceptor self-efficacy in constructing learning experiences. Frances tried to discover how her preceptees learned from the beginning of the orientation. She stated, "For me, the biggest challenge is trying to find out what kind of learner the person is. Until you know something about them, you're not sure what direction you should go in". However, she said that once she figured out what kind of learner they were, "you can move along the road". Billie felt she needed to "get a gauge of how they learned", and Donna stated that she needed to "understand their learning style and what they needed". Ingrid, Jane, Frances, Carol, and Henrietta commented how each preceptee presented a new learning experience. Ingrid and Jane mentioned their different learning styles. Carol reflected, "Some take longer to put it all together", and Henrietta stated, "Some learn quickly, some by steps…I try to assess the preceptee who I am teaching". Frances noted, "Some pick up on their skills better, they recall what they learned in school". Georgia suggested that devising a check-off list about preceptee learning preferences might prove helpful, such as, "How do you learn best, is it visual, auditory, lecture?" She continued by saying, "That should be page one on your new person's list [referring to the orientation checklist used by preceptors at her hospital]." Georgia felt that knowing how preceptees learned would allow her to seek out a variety of teaching tools and methods to meet their needs.

Self-knowledge about learning styles was identified by Georgia as helpful to both preceptees and preceptors. When her preceptees had insight into how they learned, she found it easier to select teaching methods and learning experiences that were effective. "It is so much

more helpful when the new person says, 'I don't learn well like that. I need to see it'. I find that if they are a young person, maybe they don't have that knowledge about themselves." Billie tried to give her new nurses small tasks at first to determine how they learned best. She explained, "You learn how they learn. I think that's important, because I'm not going to build you up if you don't know my style, and I don't know your style…I think it's a two-way street".

Skillful application of theoretical knowledge about learning styles was reported as a necessary competency of an efficacious preceptor. Although information was covered as part of the didactic preceptor workshop, application to the learning environment was largely learned through practice on the job and took time. Donna felt her initial preceptor preparation class had included too much talking and not enough active learning on the subject of learning styles. She stated, "It's important to know their particular learning style, but then, how to apply that? I think it's the application that needs to be discussed more". During the Focus Group, Donna offered, "I am a very abstract random, so how do I deal with someone who is concrete?" Another proficient preceptor, Billie, said, "The first time I precepted I wasn't sure how to teach the person, and everyone learns differently". About the matter of time, Jane stated, "They all have different learning styles and different needs, but the more you do it, the more comfortable you are doing it".

When differences in learning styles between preceptor and preceptee might get in the way, developing an understanding of each perspective and providing effective feedback was identified as a means to mitigate threats to preceptor self-efficacy. Billie drew on insights from her personal learning style when working with preceptees, and most of the time this worked. She said, "I used my own sense of learning, how I learn best", and would suggest to preceptees, "Take notes…and the next time you will start to recall instead of waiting for me to tell you".

Although Billie described most orientees as being satisfied with her approach, she did encounter a preceptee who told her these strategies were not effective. "She basically said that the way I was teaching her, she wasn't getting it…I was teaching her like she wasn't smart". Billie sought help from her manager and other preceptors to find an alternative approach that would work. Another proficient preceptor, Ingrid, stated that because of the different learning styles of each preceptee, "You have to figure out how you are going to adapt to that and get comfortable changing the way you do things and the way you teach".

The idea of "pairing up people that learn very similarly", as a means of ensuring compatibility between the preceptor and preceptee, was suggested by Georgia. On a small scale, Carol's unit had employed what they referred to as "team precepting" among colleagues, to capitalize on the strengths of different preceptors and to enhance the learning experiences of preceptees. During the Focus Group, she said, "We try not to have the preceptee be with one person on our unit…people handle things just a little different." She continued, "What works for the preceptee is that they're exposed to different ways, different styles and different personalities in different people. We sometimes…switch orientees, because we both have different styles of doing things". Carol suggested that this method of preceptor assignment might increase preceptee satisfaction and preceptor efficacy within the learning environment.

Preceptor self-efficacy was predicated upon preceptor knowledge of learning styles. This included self-knowledge of the preceptor's preferences as well as ability to assess that of the preceptee's. Application of knowledge about learning styles within the preceptor-preceptee relationship was critical to ensure positive learning outcomes and learner satisfaction.

Finding 1.6 Nine out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on an ability to *build the learning for preceptee success*

Effectiveness in the preceptor role required a comfort and skill in guiding preceptees through a myriad of complex competencies within a designated orientation time period. The preceptor must be able to translate the learning into simpler sub-skills that could be readily mastered by the preceptee. Appropriate chunking of the learning by preceptors would allow progression of preceptees towards higher-level skills and competencies within the designated orientation period.

To effectively build the learning for preceptees, proficient preceptors recalled personal experiences of being a new nurse to guide their navigation through the requisite learning activities. Both Billie and Ingrid recalled feeling overwhelmed as novice practitioners, and they felt it was important, from the outset, to focus their preceptees' experiences on basic skills that would be easily mastered. Ingrid credited her knowledge of the need to distribute the learning into smaller chunks from her own reflections about being precepted. Ingrid recommended:

> If someone is brand new, give them [*sic*] a tour of the unit and have them observe, and then go from there. Maybe the next day, add a piece of taking one patient and doing one task for that patient, and build on that.

Billie recollected, "Those little things that preceptors did with me that worked or didn't work" as instrumental to how she taught her preceptees. Billie's advice was:

> Start with the easy stuff so it's not so overwhelming, so you can build from there…I think it's important to start on those little things so that you can feel out the person and find out how they learn the best.

Another preceptor prescribed a similar recipe for learner success during the Focus Group. Eduardo related, "I usually go with the most basic things. First, simple tasks that are easily doable, gives them a bit of confidence." He continued, "Before I go into more complex activities like doing a wound vac [*sic*], I would go with a simple dressing". Donna's comments echoed these recommendations, "Build a very basic patient that doesn't have a lot of complex things. And then move on to someone who might need some more complex care". Henrietta, Ingrid and Donna all stated that they carried in the back of their mind these words, "Start small, add on". Donna's advice was, "Work our way up, things I know they can handle, and we just build off that".

Advancing from simple to complex competencies was explained more fully by Georgia and Donna. Georgia reported that she assigned her preceptees manageable tasks based on their prior experiences and gradually added more involved patients as they were to achieve success. "Assign them patients that you feel are within their realm of caring for efficiently and effectively, giving them a task they can handle, then building on that". Georgia added:

> If they've had three patients, I'm not going to give them seven. Monitoring the type of patients that you give them initially for confidence builds that 'I can do this'. I wouldn't start them off with all I.V. push medications, it would be too overwhelming.

Donna said that she advanced preceptees based on their comfort level and the time frame of the orientation period. "You have to think about the end of the week, can they carry that whole assignment or do they need more time?"

Carol preferred to break the learner competencies into manageable segments, because preceptees often could only attend to one thing at a time. She explained, "You're thinking three things at once, and they're thinking of one thing at once." Henrietta found when teaching a new

concept or task, she would "pull it apart, break it down into steps" to facilitate preceptee comprehension. Because of her ability to simply explain each step of the process, Billie said she was seen as the go-to person for preceptees on her unit who were struggling with comprehension of content for a requisite exam for their work unit. Billie recommended using simple explanations and language that was readily understood. She said, "I don't use big words…for me that doesn't work, and for many people it doesn't work", and advised preceptees to "take notes, I give you every single step you have to go through". Being able to break complex skills and competencies into manageable chunks to build preceptee success was a skill that increased the self-efficacy of preceptors.

In subdividing the learning segments, preceptors with high self-efficacy reported being able to set reasonable expectations for preceptee attainment. Eduardo shared the example of asking his orientee what she would like to learn for the day, and she replied, "Everything". He responded, using humor, "That's impossible in the next eight hours, but maybe we can tackle the care of a patient with____ [patient diagnosis]". Eduardo used this example to illustrate the preceptor's role in helping the preceptee identify an attainable goal, based on the competencies to be achieved, and within the allotted time period. The preceptor focused the learning expectations by establishing what would be feasible.

To develop efficacy in their role, proficient preceptors needed to know how to advance the complexity of the learning for their preceptees. Carol related that as a novice nurse, her preceptor had escalated her responsibilities over time. Her preceptor allowed her to "handle more of the assignment and make more decisions", gradually increasing her independence to the point where she viewed her preceptor as a sounding board or resource. Reflecting once again on her personal experience, Carol related how, as an experienced nurse, she had changed jobs and

rather than having her review things she already knew, the preceptor tailored her learning to build on previous knowledge. "She focused on the things that I needed to learn and not so much on the things I already knew". Donna remembered her best preceptor, as "good at helping you grow, she explained things…developing you based on your skills at the time". Increasing independence incrementally was practiced by Jane, who said, "I give them more independence as we go through, when I can see what they are capable of, and what they need to know."

Eduardo, Billie and Carol described balancing the pace with which the segments of learning were delivered and the need to move forward. Eduardo commented that he could not "simply keep going, teaching for every minute of every hour because they will not absorb it. Give them some time to absorb, give them a break". Billie precepted an orientee who became emotional when she flooded her with information, "Maybe it was too much in one day she was being taught?" Carol spoke of a need to a structure the orientation time, "but not pushing them through", allowing some leeway for the preceptor to adjust time based on the learner needs.

Advancing the learner to the next level of complexity within the confines of the orientation period was an essential component of preceptor self-efficacy. Being able to clearly define this expectation provided validation to the preceptor and preceptee as to whether progress was occurring, and if the preceptee could move ahead. Billie felt it was important to clearly articulate this with her preceptee, and she would say, "Let's move up," and "What are we looking to do this week?" Billie identified this as an area that she needed to work on, and she stated that she had found past support in a weekly meeting with clinical educators to assist in establishing objectives to move the orientee forward.

Three proficient preceptors offered suggestions for improving preceptor self-efficacy related to structuring learning to build preceptee success; Donna, Eduardo and Frances felt that

preceptors could benefit from increased structure related to the competencies to be learned and how these should be accomplished. Donna verbalized that there was ambiguity in the current systems: "I know we have checklists, but it doesn't specifically give you any indication what you should start with." She suggested providing more instruction to preceptors related to moving orientees along, "a separate class, explain the basics, start here and then work up". Eduardo proposed improving checklists used by preceptors to decrease ambiguity: "What are the things we should be teaching them…and what are we trying to achieve in that task?" He felt that clearer directions about the expectations to meet a competency would help; "It would be nice if it were broken down, so that will guide us". Frances agreed that "a better checklist" listing relevant clinical experiences would be useful to preceptors in making decisions about potential learning activities. Eduardo and Frances recommended this as a project that preceptors might assume as part of their ongoing professional development.

Proficient preceptors reported that comfort with breaking complex competencies into simpler, achievable skills and establishing expectations for completion within the orientation period were essential ingredients for preceptor self-efficacy. Appropriate pacing permitted preceptors to build on prior skills and advance their preceptees to higher levels of competence. *Finding 1.7* Nine out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on an ability to *enable critical thinking in preceptees.*

Proficient preceptors reported that success in promoting critical thinking of preceptees was an essential competency of their role that promoted preceptors' sense of self-efficacy. Because nurses worked in a high-stakes patient environment, cultivation of appropriate problem solving and thinking skills in preceptees was identified as vital to ensure patient safety. They

described critical thinking acumen as gained through an accumulation of life and salient clinical experiences. Proficient preceptors used multiple teaching strategies as a means to develop critical thinking in their preceptees inclusive of questioning, consideration of alternatives, verbalization of thought processes aloud while engaged in practice, situated learning during salient events, performance observations with cueing, presentation of problems to solve, use of scenarios, "puzzling it out", and simulation.

Before they were able to teach critical thinking, proficient preceptors maintained that they had to develop a sense of their own efficacy related to critical thinking. Four proficient preceptors discussed their personal journeys towards becoming critical thinkers and competent preceptors. Georgia identified formative clinical "experiences" that were contributory to her critical thinking development. She noted that novice nurses tended to be "task oriented", but she felt that "within the year after, we start to see more critical thinking [*sic*]". Carol described learning to think critically as a new nurse employed in an ICU setting. She recalled, "There's a lot more crashing going on there…a lot more of that adrenalin learning", where the new nurses had to pull it all together quickly in order to survive in the work environment. In the ICU setting, critical situations occurred frequently, and Carol "learned through repetition" and many "different experiences". She watched, "how people responded to situations and learned from that."

Eduardo described critical thinking as meaning, "being smart, logical and knowledgeable." He explained that sometimes the preceptees "can be book smart, but don't have this so-called common sense", and that "critical thinking is developed as you go along with your career". Although Eduardo identified much acquisition of knowledge through schooling, he maintained that, "You have to see the clinical signs in real life and apply what you learned", and

that nurses "needed to *see* [emphasis added] those subtle signs" in their patients. Eduardo's critical thinking efficacy improved through multiple clinical experiences, "It's like building up, those experiences [*sic*]". Eduardo developed critical thinking through trial and error, noticing what had not been effective for the next time.

Ingrid stated she was able to teach others to think critically after she had gained "clinical expertise in my area and the experience of having gone through scenarios". In reflecting about contributors to her personal critical thinking capabilities, she mused, "School, orientation, learning on the job, it all plays in". Ingrid continued, relevant to her experiences, "When I felt comfortable making critical thinking decisions, then you are able to demonstrate and to talk about how you teach someone to do it. So it all developed over time."

Besides clinical experiences as foundational to the development of critical thinking self-efficacy, four proficient preceptors also reported that significant life events contributed to their capabilities. Jane and Billie noted that personal maturation had improved their critical thinking self-efficacy. Billie said raising children had taught her how to teach critical thinking, such as, "trying to get them to think before they acted, what would the outcome be if they did certain things." Jane acknowledged that she had been younger than most of her colleagues when she graduated from an associate's degree nursing program, and had limited life experiences. Since experiencing marriage and childrearing, she identified that "life experience in general has helped me" to think critically. Henrietta believed life experience had been a "huge component" in her critical thinking efficacy. She stated, "You can't teach that, you have to live it". Frances noted a difference in preceptees who had experienced more responsibilities and life events, and felt that many had better problem solving and critical thinking skills as compared to those with lesser experience.

Five proficient preceptors used questioning as a means to elicit critical thinking in their preceptees. Donna said, "I would ask them questions" about what they planned to do, while Ingrid would pose the following, "What do you think, what would you do?" Continually asking questions of preceptees to provoke thought, rather than giving the answers, was reported as beneficial by Billie. A typical example of this type of questioning included, "Okay, X, Y, Z, [*sic*] why are we doing this, what do you think is going to happen? What am I going to do if this happens, what does it mean if this happens?" When physician wrote medical orders, she would ask, "Why did he do that, what's going on? What are the labs showing you?" Billie also encouraged preceptees to question physicians about their rationale. She said, "Sometimes you catch them doing something and say, 'Do you really want to do that', because they're on *this* [emphasis added]". Adele encouraged preceptee thought by saying, "How are we going to move from A to B, if you don't do A [*sic*]?" She promoted consideration of alternatives when prioritizing by asking, "What's more important? What's the first thing that needs to be done? What are the priorities of this admission and figuring out what's next to be done?"

Georgia learned to pose questions as a stimulus for critical thinking from her preceptor role models. Her head nurse would query her each day about the plan for her patients, her actions, and Georgia said, "I find myself doing the same things." She heard herself saying, not unlike her former preceptor, "What did you do, what could you have done differently, and what did you do to inquire further?" Georgia felt it was important to empower preceptees to independently investigate potential causes of a patient's problem. Adele also felt it was crucial to encourage ownership of critical thinking. She would say, "Tell me what you would do," recommending, "Let them formulate the plan, so they feel they are in control." Adele offered suggestions as needed, helping the preceptee to reframe the plan.

Proficient preceptors described critical thinking in terms of "puzzling". Georgia said, "There's people that always want to know the 'why' or 'how come'; they are the deeper thinkers." She continued, "It is like putting pieces of a puzzle together, that's the critical thinking." Eduardo also used the term "puzzle" to characterize this type of critical thinking activity. Similarly, Carol related using a puzzling activity to stimulate preceptee thinking about the functioning of a piece of equipment. After providing pieces of equipment, she would ask them to try to figure out aspects of its use before explaining the procedure. Carol found this type of activity increased learner engagement and stimulated thought.

Jane tried to assist preceptees with seeing the bigger picture about their patients' conditions. She said, "If they have one lab value, vital sign", then she would "walk them through it". Jane refrained from immediately giving the answer, but would encourage processing of the information to allow the preceptee to come up with a solution: "Explain this to me, what could it be, what else do you need to assess? What are you looking for, what could be wrong?" She prompted preceptees to use their assessment skills, ensuring that they did not miss anything.

Both Eduardo and Frances detailed the process of involving a preceptee in the assessment, identification and prioritization of issues for the patient. Eduardo described the preceptee who might accompany him on rounds: "Sometimes when they go to the bedside, they are at a loss, what am I doing here? There should be a purpose why you went into that room." He would explain to the preceptee, "You don't simply go in there to chit-chat with your patient; there should be a goal". Eduardo next would process out loud each step of his assessment, including the patient's response to questions, vital signs, breath sounds, fluid balance, and explaining how each finding might be interpreted relevant to the patient's condition. Eduardo

continued this dialogue throughout the entire encounter and more in-depth outside the room, demonstrating use of a list that guided his assessment. He commented that although he had only intended to perform a routine check of lung sounds, his quick assessment had revealed other problems. For example, his patient had unexpectedly complained of pain, which was not the original reason for examining this patient. Eduardo said, "Now my priority becomes different. I have to medicate my patient to alleviate the pain." Eduardo modeled this reprioritization and transition to another priority for his preceptee to observe.

Another preceptor, Frances employed a similar strategy to teach critical thinking while providing patient care. Frances recounted performing a routine assessment of her patient while accompanied by a preceptee. By herself, she said it would have been "just a quick look, but for them it is probably a longer process when they first go into the room. I can multi-task all of that in a second." She encouraged preceptees to question by telling them, "There is never a stupid question, always ask". Frances detailed the performance of a head to toe patient assessment as conducted with a preceptee: "You have to explain all of that as you walk into the room". In addition, she would also seek input from the nursing assistant also assigned to the patient, and afterwards discussed her findings with the preceptee, critically examining what was occurring.

Donna used stories to illustrate a case in point and stimulate critical thinking. She stated she would "talk them through it, prompting them to think about the situation". Along the way, Donna would stop to check their comprehension and ask, "Does this make sense?" Ingrid used observation of preceptees as they worked, as a means to evaluate critical thinking skills. Because of her expertise with the patient population, Ingrid could tell "if they get it or if they don't". She continued, "and if they're not, you make pointers, 'You could do this, another way is this'" and would "provide them with more information" as needed.

Frances capitalized on significant events that occurred in the course of the workday as an opportunities to teach thinking skills. Frances said:

> Sometimes you are lucky that something critical does happen to your patient while you are orienting, because then you can see it all through. They can either have a chance to react on their own or watch you react to put it all together.

Frances provided an exemplar of being asked by another health professional to provide a pain medication for one of her patients, and she described working through this unfolding situation with the preceptee, explaining each step of her thought process. Upon examination, Frances and her preceptee deduced that the patient had experienced an episode of autonomic dysreflexia, as a result of sediment blocking his urinary catheter. Once they remedied this problem, the patient's condition improved, he became more comfortable, and returned to his baseline level of comfort, without pain medication. Frances said, "You try to teach them to look just a little bit deeper for them to recollect it for later on". She concluded, "If you live through it, you are going to remember it a whole lot better".

While reflecting on ways that she felt effective in promoting critical thinking, Frances offered the idea of using simulated clinical experiences. Since her hospital had recently invested in a high-tech simulation manikin, Frances suggested having preceptors develop typical scenarios to enable preceptees to practice interventions without compromising patient safety. She stated, "Unless they have experienced it, they aren't going to know what to look for, what to do properly". Since specific clinical events may not present during the orientation period, Frances suggested simulation as an option for teaching critical thinking relevant to predictable scenarios.

Proficient preceptors reported an essential component in the development of their self-efficacy was an ability to successfully promote critical thinking skills in their preceptees. Before

they could teach others how to think critically, nurse preceptors first recounted the need to develop confidence in their own critical thinking, and this was enabled through their lived and clinical experiences. Mechanisms that were described by proficient preceptors to teach critical thinking included questioning, considering alternatives, puzzling, problem solving, verbalizing thought processes aloud while engaged in practice, situated learning during critical events; performance observation with cueing, scenarios, and simulation. Because nurses work in a high-stakes healthcare environment, being able to cultivate appropriate problem solving and thinking skills in preceptees is vital to ensuring positive outcomes for patients.

Findings 1.8 Ten out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on an ability to *engage in ongoing learning.*

Proficient preceptors within a hospital setting reported that the ongoing pursuit and acquisition of clinical and pedagogical know-how was necessary to become a highly efficacious preceptor and to maintain high self-efficacy. Nurses related how the process of becoming a proficient preceptor took time and experiences. While didactic preceptor classes and formal advancement of nursing education were beneficial, proficient preceptors felt that active experiential learning while being precepted and in performing the role had been strong contributors to their development. Preceptors felt they were continually learning from preceptor colleagues, preceptees, physicians, other staff and patients, and required a culture of learning to flourish. Preceptors desired ongoing formal and informal learning opportunities to develop and maintain self-efficacy in the role.

To acquire the essential skills of the preceptor role, nine out of ten proficient preceptors that were interviewed recalled attending some variation of a formal preceptor class. Ingrid

remembered learning "communication and different strategies on how to organize your time and the basics". Adele and Frances recalled their didactic classes as being held over several days in the afternoon, which they found difficult to attend to during that time frame. However, Adele referred to a book that she had been provided on the subject of precepting and which she had shared with colleagues. Donna's remembrance of her class related to its primary focus on learning styles, which she suggested, might have been structured more effectively using active learning strategies. Donna felt conducting a "streamlined class" that focused on "how to apply" could be beneficial. Billie described herself as a "hands-on" learner, and did not recall the lecture content. Although all reported the initial didactic activities as contributing to preceptor self-efficacy, they felt that a stronger contributor had been their on-the-job learning.

Three out of the ten preceptors had been thrust in to the role before attending a didactic preceptor class and were able to gain preceptor self-efficacy through experimentation with what they had witnessed throughout their own experience of being precepted. Henrietta said she learned "on-the-job" and recalled her positive experience of being precepted by two strong nurses on her unit, to whom she attributed her knowledge of precepting. She said, "I learned from them, modeled after them, their behaviors and their styles, and then I developed my own style as a preceptor". Her charge nurse had told Adele, unexpectedly, that she was going to precept; she said, "I do not know how I was chosen, it was not even official". Eduardo also began precepting unofficially, learning on-the-job, but received formal training at a later date. He said, "We didn't call it 'preceptor' but we were encouraged to teach them and develop those newly grad [*sic*] nurses".

Once engaged in the preceptor role, preceptors reported it took time for them to learn the role and feel efficacious. Billie stated, "It takes me about six months to feel like I am doing

'good' at something, at a new job or any new responsibilities". Other preceptors, Jane and Henrietta, reported a longer time period to feel accomplished in the role. Jane reported that it had taken her about "a year or two to be confident," and Henrietta said, "It took a good two to three years to get comfortable in the role as a preceptor". She summed it up by saying, "I feel like it is just time. It's not something you learn overnight. Time and being in that environment gives us those skills." One preceptor, Ingrid, described the process of learning her role as "little by little until I felt comfortable", and another preceptor, Donna, said, "The more you do it, the easier it is".

Two proficient preceptors articulated that once they had attained a level of comfort and self-efficacy as a competent nurse and preceptor, there was more to learn. Adele stated, "Learning does not stop". She was continuing her nursing education and would soon be completing her graduate degree and transitioning to a new role. Adele said:

> The evidence has shown out there that learning is ongoing. And things are always changing. So don't let's be the status quo. You have got to move to the next. Change is good, we just have to learn to embrace it.

Along a similar theme, Frances noted, "We don't know everything. I learn something new all the time".

All of the proficient preceptors reported that self-efficacy in the role had been enhanced through sources outside of the clinical arena. These included advancement of their nursing education from unlicensed assistive personnel to a baccalaureate and graduate degree nurse, and through experiencing maturational life events. Henrietta and Jane commented specifically on the influence of life experiences. Henrietta felt they had shaped her to be a better preceptor: "I think life experience is a huge component." She related marriage, children, moving, and completing

an academic degree as contributing to her learning, "I brought all of that with me on board, and that, life experiences, you can't teach that, you have to live that [*sic*]". Jane stated about herself that she had "matured as an individual, and I have gotten better as a nurse".

Adele and Jane reported that the charge nurses or managers that championed their learning had promoted their preceptor self-efficacy. Adele felt she had been offered many opportunities for growth in her current position, but she had to be open to learning. Adele said, "The management or leadership here is strong empowerment, if you will take them", and an aspect of the organization that she especially appreciated was the "continual education". Jane related that a charge nurse who had encouraged her growth "took me under her wing and would teach me things". She also cited her manager's admonitions as propelling her to continually learn and grow. She quoted her manager said, "You have to keep improving yourself and raising your standards. Always improve, you want to grow, you want to get better, you don't want to be stagnant". Her manager reminded her that, "It's about the patients that you take care of, and this is their life".

Eduardo also had a charge nurse who was instrumental to his learning as a new preceptor. Eduardo said, "She was my mentor. She knew the do's and don'ts that you should be doing". He continued, "The charge nurse was trying to guide me my first few months of preceptorship". Eduardo also described learning from a clinical educator, who had met with him weekly regarding his preceptees' progress, "We go back and forth…we usually have this meeting. And they would say, 'Is the person getting [*sic*]', they will try to assess the status of the orientee".

Three proficient preceptors, Ingrid, Eduardo and Frances, related significant lessons that shaped them into efficacious preceptors. Ingrid shared how, at first, she had needed to "develop communication… some people aren't comfortable teaching, so that was a skill I developed over

time". Also based on the learner's needs, she learned how "to get comfortable with changing the way…that you teach". Initially, Ingrid said, "It was difficult being comfortable and knowing that I was teaching the right things, the right way." Eduardo described how he had learned to manage the stress of the preceptor role, saying, "I always admire people who can work under pressure. So I try to copy them". Conversely, Frances had identified the behaviors she did not want to emulate from observing the ineffective preceptor performances of colleagues. She said, "Some people will just sit and do other work while their poor person is out there [*sic*]…I don't want to learn the bad habits of others."

Although each participant of this study was regarded as an efficacious preceptor, six verbalized that preceptors needed to continually update and maintain their knowledge and skills. Relevant to precepting, Adele stated, "Every situation may be different. Learning is ongoing. So I am always yearning for more, so I don't know if I ever thought I am getting good at this [*sic*]". Eduardo reported, "I try to be a better preceptor the next time with my orientees. There is no end of learning and teaching", and he added, "I feel like it would be boring to do the same things over and over again". Speaking about precepting experiences, Georgia said, "I think it has been a learning experience from the first time". Despite years of precepting experience, she maintained, "I still think it is challenging". Jane stated that was important for preceptors to be "up to date on their skills". Carol said that "as a preceptor you may not know the answer" to questions that might arise while precepting and frequently would ask questions of physicians and other health providers. With the advances of computer technology currently available to preceptors, she added, "What's so great now is that the Internet is so much more available than it used to be." Eduardo stated, "Practices have been changing through the years, so I try to read as much as I can…nursing magazines, journals. Try to get in touch with the newer nursing, to keep

current". In discussing the need for ongoing education of preceptors, Billie asserted that, "older preceptors, if they haven't had a class or gone to a class in a long time, you forget too, you get stuck in a rut or your routine and you [need to] break out of it".

Billie reported that changing work units had forced her to learn new skills and develop competence with a different patient population. Billie described it as serving to, "raise my precepting up to another level". Billie also shared another developmental experience, being faced with the performance of a difficult procedure and use of a new piece of equipment at the same time while precepting. Billie was able to guide the preceptee through the procedure, and allowed her to do the hands-on. She said:

> Just her and me working together, she was really nervous, and I was nervous, but I didn't let her know I was nervous. Talking her through it…and having her succeed at this really difficult procedure that even I was nervous doing.

She learned together with her preceptee. When they were done, Billie said, "I can get this, I can teach another person to do that, even when I am nervous about how it is going to come out".

Henrietta, Georgia and Jane reported learning from their preceptees. Georgia recounted an experience of learning a new way of interacting with an anxious patient by watching her preceptee. She walked into the room to demonstrate how to start an intravenous (I.V.), and the patient was very anxious about dying. Where she would have delved into starting the I.V., the preceptee first alleviated the patient's fears of dying by taking her hand and providing reassurance. The patient was put at ease, and Georgia was able demonstrate starting an I.V., without interruption. "So just in hearing what a new grad, a new nurse to the floor, said to a patient, I learned from him". Henrietta also stated that she had learned from her preceptees, "Teaching is a mutual thing, it's not one-sided". Jane reported, "I felt like I learned from my

orientees. You learn as you work with them". During the Focus Group, the preceptors commented how their preceptees were "learning the latest and greatest", and might be ahead of their preceptors, especially as related to computers. Carol said, "We've had preceptees that have never seen paper charts, they've only done an electronic medical record". The preceptors indicated they could learn about computer technology from their preceptees.

Preceptors reported that other people had contributed to their self-efficacy, including the physicians and clinical nurse educators who they worked with. Georgia stated that she had learned through observing "how the docs [*sic*] have answered patients, addressed situations, and you learn from all that. That definitely impacts how you want to practice. So it all builds for the greater of the whole." Henrietta said, "You learn through your relationships with the physicians, your peers, with the nurses' aides…it's being here, immersed in the environment, that's how you learn". Ingrid had accessed the hospital educators to help manage difficult situations as a preceptor: "Clinical Resources [the clinical education department]…gave me things to try, it was still frustrating, and I worried about safety and things. How far do you go with that, how do I say this isn't safe, this isn't working?" Jane reported it had been helpful when clinical educators were "touching base with them [preceptors and preceptees]…to see if they [preceptees] are ready to come off [orientation]".

Three proficient preceptors reported they learned from other preceptors' ways of teaching. Carol observed, "We've noticed we have different teaching styles. The other preceptor teaches by giving quizzes, having them Google things on the Internet, just a different way….Every once in a while I try to do the quizzes and the different questions." When faced with a new situation, Donna would reflect about her own experiences and how her preceptor mentors would have handled the situation: "What would ___ [named a preceptor] do?"

Henrietta had learned from two role model preceptors, saying, "I relied on these two nurses for help when I was learning a new role as a nurse at HSC [*sic*]". She said of one of the role models, "If she doesn't know something, she knew where to find the information, and I always thought that was a good thing, because instead of guessing, she would find out that information and get back to me". Ingrid said she "observed other people in training, talked to other preceptors". She suggested new preceptors attend a Preceptor Forum, or "talk to other preceptors and see what they do". She felt that "the Forum was a place to make people feel comfortable that there's people to go to, discuss things, scenarios that come up, supporting them."

In addition to a basic preceptor preparation, six preceptors felt that ongoing professional development was helpful and necessary to maintain preceptor self-efficacy. Billie had attended courses periodically throughout the years, however, she lamented, "The only drawback is you just don't have the time to go. I wish there was a mandatory thing where you had to go so you wouldn't miss out". Eduardo, Henrietta and Carol said that they wished to participate in the hospital's monthly Preceptor Forum, but have found it difficult to attend due to patient care needs and lack of relief to get off the unit. Carol reported, "We often can't leave the floor". Henrietta suggested having preceptor meetings "on the unit…even for 20 minutes", or "at lunch" while on her break, and "off her assignment", to allow her to attend.

Despite the difficulty in getting coverage to attend a monthly preceptor meeting, several preceptors commented on the educational benefit of such a group as a means of increasing self-efficacy. During a Preceptor Forum meeting, Billie suggested preceptors "bring up an article, something that worked" for discussion. She proposed conducting a preceptor self-assessment to determine how their self-efficacy could be increased. However, Billie remarked that, "Preceptors may not know what [they] don't know". Carol advised "bringing the preceptors

together as a group to talk about new policies, trends in documentation, pain data, QI", so that preceptors would be up-to-date when teaching new staff and would be able to identify "resources that they could call on". Eduardo thought attending a forum was helpful to discuss "what are the things that we should be teaching them; what are we trying to achieve in that task." He suggested a review of high-risk skills and "another half day" of formal preceptor instruction. Donna advocated for continuing education that emphasized "how to help a nurse learn these tasks…how to apply that. I think it's the application that needs to be discussed more".

Carol recommended establishing a "culture that you can ask questions and share experiences" as important to promote the continued growth of staff and preceptors. Ingrid advised having nursing leadership take "more control over who is precepting", and to "keep developing their [preceptors'] skills." She stated, "We want people who still continue to be dedicated to it…and make sure they are still in it for the right reasons". In addition, she suggested, "giving them something new to work with, new ways, new ideas" to increase their preceptor self-efficacy.

Proficient preceptors reported that ongoing learning was a necessary component to developing and maintaining self-efficacy related to the role. Precepting acumen was developed over time through didactic, clinical, developmental and experiential sources of learning. Preceptors felt that a strong source of their own self-efficacy emanated from active learning while being precepted or precepting others. In addition, preceptors increased self-efficacy when practicing within a culture of learning, through preceptor colleagues, preceptees, medical staff and patients. Preceptors desired ongoing formal and informal venues to advance and maintain their preceptor self-efficacy in the role.

Finding 1.9 Eight out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on an ability to *serve as a role model*.

Proficient preceptors reported that they became efficacious role models for their preceptees through the example and tutelage of respected charge nurses, preceptors and colleagues. These individuals modeled the values that proficient preceptors aspired to, and instilled confidence, competence, professionalism and caring. Proficient preceptors observed the example of these nurses, who had demonstrated a willingness to serve, and this had shaped how they were to practice in their role with subsequent preceptees.

Six proficient preceptors, Georgia, Frances, Adele, Ingrid, Henrietta, and Eduardo, described a leadership or charge person who had influenced their self-efficacy as a role model to new hires. Georgia remarked that her head nurse had "modeled professionalism and caring for her staff" and as a result, she had "modeled her precepting after the way her role models had precepted". She believed that her head nurse's "love of nursing and positive attitude" had shaped her into the preceptor that she was today. Frances named several preceptors who had been instrumental to her clinical competence, and one that came to mind was an admired charge nurse. She stated that this nurse had "worked here for years and years" and was the "person you just went to". This charge nurse was "willing to help you out with whatever you had to do". Adele identified an influential charge nurse, who "had expectations, what had to be done by each nurse who was there during the week". Ingrid, as well, described role models who were "clinically expert" on her shift, and said, "I looked to see how they do [*sic*] things".

Eduardo said his role model was an expert nurse who "tried to teach me everything that he knew", and "he was good at the bedside, clinical-wise, knowledgeable." This role modeling

influenced Eduardo, who stated, "I tried to emulate what he had done [*sic*]….He demonstrated the knowledge, skills and attitude at the bedside" that would be desirable in a new nurse. Eduardo said that he would like his "students to see their preceptor as their role model".

Four proficient preceptors, Henrietta, Donna, Jane and Ingrid, described attributes of a role model that were valued as important. Henrietta's significant role model was "quiet, sure of herself and knew where to find the information". Donna felt that a role model should be a "good employee", defined as being "responsible for her actions and always being honest and truthful". Jane described model preceptors as "positive", and who "loved and cared about the hospital" that they worked at. Jane described a highly efficacious preceptor, who would teach his/her orientees that,

> It is about the patients that you took care of…did I do the best that I could for them; did I make them comfortable and put a smile on their face? That's what I want to teach people that I preceptor or mentor, that you do the best you can for them.

Ingrid stated, "The people that I used as role models fit my way of doing things. The role models that I looked up to worked in the same manner that I do…the way I organize was the way they organized and just similarities [*sic*]".

Proficient preceptors developed into highly efficacious role models through the example and guidance of charge nurses, preceptors and clinical experts within their unit of work. These admired people shaped their professional values, competence and confidence through their willingness to share. Preceptors reported that they would carry on this tradition by serving as efficacious role models and demonstrating caring behaviors with their own preceptees.

Finding 1.10 Five out of ten proficient nurse preceptors reported that the development of their

self-efficacy related to enactive mastery experiences was based on the ability to *elicit return demonstrations of modeled skills from preceptees*.

Preceptees who were able to perform desired competencies following an observation of the preceptor's modeled skills served to reinforce the self-efficacy beliefs of their preceptors. Since nursing was a practice discipline, dealing with human beings, they reported that effective precepting should evoke accurate and safe performances of return demonstrations from the learner.

Proficient preceptors used the instructional technique of return demonstration with preceptees as a means of teaching clinical skills. Billie related, "The first time I might run whatever through [*sic*]. The second time they are doing it, I am right there, but I want them to do it. It cements it in their heads". Billie drew from her own personal experience of how she learned to inform her use of return demonstration with preceptees: "I have them actually do it. If you talk to me, I will process a little bit of it, but I actually have to do it. So that is how I teach everybody."

Proficient preceptors reported how they would first model a competency, and then have their orientees performing. Eduardo said that he would "let them do the return demonstrations", and Adele stated, "I demonstrated it", and subsequently her orientee would "return the demonstration". Ingrid and Frances viewed successful observation of their preceptees' return demonstrations as indicative of learning. Ingrid recounted teaching them something and "then saw them doing it on their own". Frances would model or identify where to locate resources, and then had them demonstrate their comprehension independently. She explained, "I am going to tell you where, but you are going to get it. If I get it for you, you aren't going to remember".

Adele also interpreted preceptees' return demonstration of modeled skills as indicative of comprehension and learning. Adele said:

> What I had demonstrated, he was able to do on the second time. By his responses and the way he was repeating what I had said, he had understood the rationale. I would consider that effective demonstration of what I had taught him.

Proficient preceptors used return demonstration of modeled skills by preceptees as indicative of learning. Such demonstrations served to reinforce the self-efficacy beliefs of preceptors in their ability to elicit desired competencies from their preceptees using this method.

Finding 1.11 Eight out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on an ability to *evaluate preceptee achievement of goals.*

Proficient preceptors reported that being able to evaluate the performance of preceptees relevant to established orientation goals was necessary to be efficacious as a preceptor. Preceptors perceived themselves as entrusted by managers with the evaluation of their preceptees' performance. This involved daily and ongoing assessment of progress, identification of problem areas or need for developing a remediation plan. Preceptors were relied upon to inform the manager when the preceptee had satisfactorily met the basic competencies of the job.

In evaluating preceptee performance, preceptors spoke of a "trust" that they had been given relevant to evaluation of the preceptee. Donna reported that her manager had "trusted me to evaluate their [the preceptees'] performance". Frances reflected about her responsibility as a preceptor: "Are you going to be able to make a nurse that you want to work with?" She observed that it could be problematic if the preceptee "gets off orientation and has not met some basic competencies during the orientation period". Frances reported that her manager had

"respected her opinion" regarding a preceptee performance's and terminated the employment when the person did not meet expectations.

Since staff nurses were not accustomed to evaluating the performance of peers as part of their daily activities, proficient preceptors reported that assessment of preceptee performance had to be learned, and was necessary to developing self-efficacy in their role. Eduardo and Frances identified the need for preceptors to effectively evaluate preceptee performance. During the Focus Group, relevant to assessing preceptees, Eduardo spoke of the need "to gauge them [preceptees], how they're progressing every day". Frances indicated that preceptors who possessed less efficacy with this competency might, "need a push", to enable them to work effectively with preceptees and assess their performance.

Being able to identify preceptees' achievement of goals and rapidly invoke steps to remedy problem situations were cited by preceptors as important indicators of their effectiveness. Carol learned this practice through her own experience of being precepted and reflected, "My preceptor noted if I can do this", and "after how many times I did it". When Henrietta identified an emerging problem, she would engage her preceptee in finding solutions. She said, "I would have the preceptee involved too. Is there something that they need? Maybe more time, more situations?"

To initiate corrective actions, Ingrid maintained that, early on, preceptors needed to ascertain when a problem was developing. She stated that in some cases, the preceptor might determine that "it's not going to work out." She reflected, "At some point, you've got to figure if it's not going to be a good match, and let them know about it". Four proficient preceptors, reported how evaluating and addressing struggling preceptee performance required extra attention, energy, and supports. Henrietta described one preceptee who "was setting herself up

for failure" and eventually made a mistake. She said, "It took more time and energy from me." In this situation, Henrietta sought help from a clinical educator. She related how they "all sat together and discussed what happened and set up a detailed plan". Henrietta said that eventually this preceptee "succeeded, and I was glad". Jane experienced working with a preceptee who was not "receptive to what I had to teach him". In this case, she obtained "assistance from the manager, and we just kind of worked through it, and I tried to stay positive and teach him what was right". Adele and Billie also reported difficult evaluations of preceptee performances that had necessitated additional support. Adele consulted with her manager about an underperforming orientee, which eventually resulted in the person's employment being terminated. Before this occurred, she and the manager "discussed what the behavior was, and they [*sic*] suggested talking to the person first". Billie also checked with the other preceptors on the unit, in addition to her unit manager, as validation of her assessment about the problem orientee. Next, Billie discussed the unfavorable evaluation with the preceptee and after this, concluded, "You needed a support system" to feel efficacious when delivering a negative assessment of performance.

In addition to identifying problems, proficient preceptors indicated that they had to be able to determine when a preceptee had satisfactorily completed orientation. Georgia's preceptor "knew when it was time for me to fly", and she saw that as the hallmark of an efficacious preceptor.

Proficient preceptors reported that an ability to evaluate the performance of preceptees on an ongoing basis was an essential component of preceptor self-efficacy. Hospital managers entrusted proficient preceptors with assessment of preceptee readiness to function as a full team member. When faced with underperforming orientees, preceptors expended extra energy and

required manager or educator support to feel efficacious in their assessment and evaluation of the employee.

Finding 1.12 Five out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on an ability to *engage in guided practice with their preceptees.*

Proficient nurse preceptors reported that being able to engage their preceptees in learning through use of guided practice enhanced their sense of preceptor self-efficacy. Preceptors walked the preceptees through various skills before and during the patient encounter. This strategy was used as a mechanism to protect patients and to facilitate preceptee success in skill attainment.

Two proficient preceptors, described having preceptees practice skills outside of the patient room in a simulated setting before endeavoring a live performance with a patient. Carol said that she "reviewed the procedure with the equipment just prior to doing it." For example, before attempting an intravenous insertion, Carol had the preceptee:

> Take the catheter out of the sheath in the Med [*sic*] Room, and show [*using her arm*] this is a good vein, this is where I'd like you the place the needle [*in the patient*]. And then work with the equipment in the Med Room.

Next, she would have the preceptee attempt the insertion with the patient so he/she could "learn from hands-on, active participation, rather than just me talking". Adele described a similar process, "I drew on a paper what it would look like, and I had a sponge so she would feel what it felt like. And we went in, and she did a good job".

A valuable skill of preceptors with high self-efficacy was being able to safely guide preceptees through new procedures with patients. Adele and Ingrid termed this act "coaching".

Adele said that she "coached" her preceptee, and observed that this person was able to translate what she had demonstrated previously with the patient. Ingrid invited her preceptee to "step in and be coached" while participating in a medical emergency. Frances explained her actions as, to "cue them along the way", while the preceptee engaged in a new skill. Billie said she "talked her [preceptee] through it and had her do the hands on". She described her role as helping the preceptee to "succeed at this really difficult procedure".

Carol and Frances believed using guided practice provided other benefits, to protect the confidence of the preceptee while preventing unnecessary angst to the patient. Carol said that her rehearsal with the preceptee blocked patient awareness of their inexperience: "The patient doesn't even know it's their first time". Frances said that she would prevent the patient from knowing by "talking to them outside the room and telling them this is what you are going to do or would do". Then she would go into the room with the preceptee to do the procedure.

Proficient preceptors reported successful use of guided practice in teaching preceptees new skills during both simulated and live patient experiences. Preceptors reported that engaging learners in guided practice enhanced preceptee and patient perception of competence in relation to performance of the skill, and contributed to preceptors' sense of self-efficacy.

Finding 1.13 Three out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on an ability to *use repetition as a vehicle to learning with preceptees.*

Preceptors reported using repetition as a teaching strategy enhanced the recall and reproduction of the desired behavior. Repetition was helpful to preceptors as learners, as well as with their preceptees. With increased repetition, the skills became part of the repertoire of the preceptee or new preceptor and served to increase the self-efficacy of both groups.

Carol articulated the value of "repetition" as a vehicle to her own learning as a new nurse. She had first been employed in an environment where she was repeatedly thrust into critical patient situations, which increased her confidence and competence as a nurse. Eduardo also identified repetition as instrumental to his own development. He said, "If you were way behind on a doing a task, the next admission would be on your assignment again…until you developed your own pace and mastery". During the Focus Group, Donna shared how, as a new preceptor, she had learned to function effectively in the role through repeated precepting experiences. She stated, "The more you do it, the easier it is" to precept.

Since repetition was viewed as helpful to their own development as a nurse and preceptor, proficient preceptors also used repetition with their preceptees. Georgia and Francis listed repetition as an essential teaching strategy of preceptors. Georgia explained, "When you are in orientation, you get information so quickly. And then, if you do it again, it gets digested. And it begins to solidify the experience, and you can move forward". When Frances had an orientee who had a misstep, she would take space for a minute, then "go back" and ask the preceptee to re-do the skill.

Repetition was reported by proficient preceptors as a helpful teaching strategy for their own learning, as well as for preceptees, and enhanced the recall and reproduction of desired behaviors. Proficient preceptors reported that repetition served to increase the self-efficacy of both preceptor and preceptee groups.

Finding 1.14 Six out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on their *use of varied teaching strategies to enhance preceptee learning.*

Proficient preceptors reported that having a repertoire of teaching strategies was essential to their sense of preceptor self-efficacy. Examples mentioned included note taking, sharing worksheets and tools, posing quiz questions, role-playing, presenting scenarios, thinking out loud, and experiential learning. Having a variety of strategies to meet a myriad of active learning situations was necessary for preceptors to develop self-efficacy.

Two proficient preceptors identified writing or written information as effective strategies for promoting orientee retention of information. While explaining how to use a piece of equipment, Billie said that she "encourages preceptees I am teaching to write it down" as a means of increasing recall. She believed this method increased "autonomy and independence" in the learner. Carol reported giving preceptees a sample worksheet or other tools as visual models of documentation and work organization. Another strategy mentioned by Carol and learned from another preceptor was the use of informal written or verbal "quizzes" to test the knowledge of preceptees.

Three proficient preceptors referred to the use of scenarios and role-playing as a means to teach nursing and preceptor skills. During the Focus Group, Donna suggested that "role-playing would be helpful" to teach nurses new to the preceptor role. Ingrid and Frances recommended the "use of scenarios", whereby they could pose hypothetical situations that might confront preceptees to stimulate thought and discussion.

Eduardo used the teaching strategy of thinking out loud in conducting an assessment of a patient with his preceptee. He said he would "explain to the preceptee the purpose and what he is looking for when he goes into a patient room." Frances also used a similar method to explain to her preceptee what was happening with a patient when they encountered a problem.

One proficient preceptor talked of having to learn about teaching strategies through trial and error. Eduardo stated:

> It was hard [precepting] for the first few months. Here I am trying to teach them to be a good nurse…and I don't have the proper knowledge or training [to do it]. I am just teaching from my own experiences".

Eduardo's self-efficacy as a preceptor developed through on-the-job and repeated experiences of precepting and trying different approaches.

Proficient preceptors reported that possession of a variety of teaching strategies contributed to their perception of self-efficacy in the role. Instructional strategies that were employed included note taking, sharing models of documentation and work organizers, quizzes, role-playing, use of scenarios to promote discussion, and thinking aloud while performing care. Knowing how to use diverse teaching strategies to meet learning needs was invaluable to preceptor self-efficacy development.

Finding 1.15 Six out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on an ability to *use situated learning as opportunities for growth.*

Proficient preceptors reported that opportunities for learning presented throughout the workday on a patient care unit, and use of such occurrences as valuable teaching lessons was learned experientially by proficient preceptors as novice nurses and new preceptors. Proficient preceptors subsequently adopted this practice as a teaching strategy with their own preceptees. Salient events that emerged in the course of providing care to patients were regarded as teachable moments and created lasting impressions on the learner. Being able to effectively use situated learning as opportunities for growth was identified as contributing to preceptor self-efficacy.

Proficient preceptors identified impromptu learning opportunities that emerged while engaged in practice as a powerful growth stimulant. Donna recalled that as a new nurse her preceptor had been "good at finding new experiences and things I had never done before", and these events had helped her to grow. Ingrid viewed unexpected medical emergencies as opportunities to have the preceptee gain experience as first the "observer, then a recorder, then doing hands-on" in the crisis. Frances explained, "Critical things happen during the day while you are orienting, and the preceptor can see it through with the orientee. The [orientees] have the opportunity to react on their own or watch you react".

Often, significant learning occurred when missteps happened, and preceptors were often able to turn potentially traumatic events into learning experiences. Two proficient preceptors vividly recalled committing errors that they had never forgotten and shared with their preceptees. Adele related how she had made a medication error, and her preceptor had completed an incident report about the event. Adele said:

> I was just so upset that an incident report was done. It taught me, and as of this day, to be sure when you are giving an I.V. that everything goes in. I took it thereafter as a learning experience. That's what they are.

She continued to use her example when debriefing with preceptees about their medication errors. Another preceptor, Carol, stated, "I remember my first mistakes…they don't teach you this". When Carol's preceptees made mistakes, she shared her mishaps with them: "I let them know that we're all nurses, errors and oversights can happen", and would use the occurrence as an opportunity for learning.

Jane used a near mistake as an opportunity for learning with her preceptee. She described an experienced nurse preceptee who was resistant to her oversight. The preceptee told her, "You

don't need to stand over me. I've been doing medications." Jane allowed the preceptee to prepare the medications independently, but asked to check them before administration. Jane said, "When I checked, there were missing medications", which potentially could have led to an error of omission. She seized on this finding as an opportunity to teach medication safety to the preceptee, saying, "You have to check, you have to double check".

Proficient preceptors reported that learning occurred for preceptees, as well as themselves, through situations that arose while providing nursing care to patients. Preceptors reported powerful learning as a result of their personal missteps as nurses, which they shared with preceptees in similar situations. Self-efficacy in the role was increased when preceptors were able to use significant events of the day to teach and reinforce learning with preceptees.

Finding 1.16 Four out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on an ability to *manage stressors while engaged in precepting.*

Proficient preceptors reported that assuming the preceptor role increased responsibilities and stressors. Stressors were attributed to internal and external sources, including challenging patient assignments added to preceptor responsibilities, limited time for planning and teaching, managing multiple responsibilities, and potential for burn-out. Proficient preceptors indicated that being able to anticipate and manage potential stressors contributed to preceptor self-efficacy.

Proficient Preceptors identified additional stressors associated with serving as a preceptor. Frances believed that current staffing numbers on her unit made it challenging to precept and was a contributor to stress. She noted changes in staffing patterns and patient composition had occurred at her hospital since the 1990's, when she started precepting. She explained, "Orientation was done differently in the 90's. You did not count in the numbers of

staffing" while precepting. She recalled that the number of patients assigned to her while precepting was dependent on how far along the orientee was with their orientation. She said, "Because if you had somebody who didn't move along, you didn't have to get all this other stuff done, too."

Ingrid and Henrietta stated that additional time was needed to perform their preceptor duties. Ingrid reported, "It takes time to precept. The assignment needs to be realistic for precepting." She recommended taking into consideration where the orientee was in the orientation progression when making out the daily work assignment. She suggested that the preceptor needed "more time in the beginning and less time later on as the preceptee becomes increasingly independent". Henrietta lamented the fact of sometimes being faced with, "not enough staff to enable time to precept". At times, she was juggling multiple responsibilities in addition to precepting", and had to deal with the "stress of multiple priorities". Ingrid concurred, saying, "Being assigned as a resource nurse [charge nurse], and having staff interrupt for help, pulls the preceptor away from their preceptee." Ingrid felt that some preceptors could be vulnerable to "burn-out", the fatigue associated with constant and unrelenting exposure to stressors in the workplace.

Three proficient preceptors had suggestions to promote preceptor self-efficacy in managing daily stressors. Both Henrietta and Ingrid advised that "knowing in advance that they would be precepting" might be helpful, as it would permit them to mentally plan out their day. Ingrid also proposed a rotation for preceptors, rather than relying on the same people repeatedly, and breaking up the precepting responsibilities. She would also allow preceptors who were not invested in precepting to "deselect" themselves. Eduardo tried to modify his own behaviors to help him deal with stress. He said, "I always admire people who can work under pressure. I try

to copy them." He also stated, "I came to realize that whatever I do, there is always something that will be left for the other shift to do". He recounted that he strives, instead, to "focus on the tasks at hand" rather than everything all at once, as a means of avoiding mistakes and to assist with de-stressing at work.

Preceptors reported that assuming the preceptor role increased their responsibilities and potential stressors. Stressors emanated from internal and external sources related to the workload, multiple responsibilities, and lack of time for planning and teaching. Proficient preceptors suggested that being able to anticipate and plan in advance, as well as having reasonable expectations of the role could increase their perceptions of self-efficacy.

Research Question 2.0 What do proficient nurse preceptors report about the development of their self-efficacy related to vicarious experiences?

Finding 2.1 Seven out of ten proficient nurse preceptors reported that the development of their self-efficacy related to vicarious experiences was related to their ability to *learn from observations of competent preceptor models.*

Proficient preceptors reported that they developed self-efficacy as nurses and preceptors through observations of competent nurse preceptor models throughout their careers. These models demonstrated professionalism, competence and willingness to share their knowledge and serve as a preceptor. Proficient preceptors tried to model themselves after the examples that they had witnessed, often early in their careers.

Preceptors described how, on their journey towards becoming highly efficacious preceptors, they attended to the actions of significant nurses and preceptors. These encounters profoundly influenced their trajectory in a positive direction. As a new nurse on a pediatric critical care unit, Carol described shadowing an experienced nurse, which she found beneficial.

Carol labeled this nurse, the "Mother Hen" of the unit. She said, "We saw how she handled parents and things like that. So you would watch her from afar and see how she handled things." Carol also noted how other seasoned staff handled situations, "Learning from watching: through observation, seeing how people ran things and how they responded to the situation, and learning from that". Adele recalled two nurses that had positively influenced her development, but one especially stood out. She said, "That's where I learned, how she did things. She was very instrumental in those things I learned. I saw what she did and didn't do, how she demonstrated as a preceptor". Ingrid and Eduardo both described observation as a means of their learning. Ingrid stated she learned through "observation in general", and Eduardo commented that his preceptor "showed him how to do those bedside things".

Two proficient preceptors, Henrietta and Ingrid, shared that they had learned to function in an emergency by observing how competent models enacted their roles during a well-run event. Henrietta said:

> In a code situation, I observed how other nurses performed their duties, and when you transcribe the code, you are observing their role. I felt like I learned from how they interacted with a physician and how they interacted in the code.

Ingrid stated, "When I learned about codes, I went in as an observer". She also described learning to handle another emergency situation by watching the charge nurse manage a patient who had fallen. Ingrid explained, "I was watching the charge nurse go through this situation step-by-step. I watched what they were doing and knew how to handle situations better the next time."

The positive attributes of models that contributed to preceptor perceptions of self-efficacy were calmness, confidence, and willingness to share knowledge. Carol noted that the nurses who

showed her how to be a nurse were "open and accepting. They never gave me the feeling that you were interfering with their day". Donna remarked about her model's characteristics, "She was very calm, explained things, and had a good way". Donna admired another attribute of her model, "She was confident in everything she did, so it truly made me more confident, because I realized, why this isn't such a big deal, I can do this!" Frances appreciated that her preceptor had been "willing to show you how to do something", because, as she explained, "I am one of those people, if you show me how to do it, I am better off than reading. I need to see it done to be able to do it".

Henrietta reported that she had learned to be a preceptor by witnessing preceptors in action on her work unit. She remarked that, "I learned on-the-job through my peers, my other preceptors who were on the unit." After observing their behaviors, she said "I modeled after them, their behaviors and their styles, and then I developed my own style as a preceptor". Henrietta disclosed that she had been particularly impressed by Ingrid's example. She said, "Ingrid's way up there as far as I'm concerned. To obtain that level of expertise, you really raise the bar, you model her behavior", as an exemplar of excellence.

Proficient preceptors described vicarious learning through observation of excellent models, in their process of development as a nurse and preceptor. These models demonstrated attributes of professionalism, competence and willingness to serve as a preceptor. Preceptors stated that emulating these behaviors served to increase their perceptions of self-efficacy in the role.

Finding 2.2 Eight out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by their ability to *facilitate observations of competent models for their preceptees.*

Proficient preceptors reported that being able to facilitate opportunities for vicarious learning through observations of competent models was an effective teaching strategy. Evidence of preceptee comprehension through this method also contributed to the development of preceptor self-efficacy. Proficient preceptors would demonstrate skills or could employ knowledge of available resources to locate competent models within the clinical setting. Being able to identify learning opportunities and to strategically place preceptees, enabling observation, was a necessary component of efficacious precepting.

Two proficient preceptors described a process whereby the orientee would spend the first day on the unit watching how they performed. Jane stated, "If it is someone's first day, I will have them shadow me so they can get an idea [*sic*]", and Frances said, "Usually the first day, I have the orientee just watch me".

Because of their knowledge of the work unit, proficient preceptors could readily identify learning opportunities for the preceptee to observe. Prior to having the new staff member tackle a new procedure, preceptors reported that they would model the skill in front of the preceptee. Adele explained that if she learned of a procedure that her preceptee might benefit from, she would call them over, saying, "Let's do this, this needs to be done". She then would "demonstrate it", so that they could see how it was performed.

Carol recounted the steps she followed when teaching a peripheral I.V. start. "I see if they've got veins that we can use, and I've literally taken the catheter out of the sheath in the Med Room and said, 'This is where I'd like you to place the needle'." She continued, "They want to watch me before they attempt the procedure."

During the Focus Group, Donna commented that she had precepted new nursing instructors from affiliating colleges whose students were on the unit, and she would be called

upon to demonstrate procedures and skills that they were unfamiliar with. She stated, "A new professor came, and she observed my assignment. For the first couple weeks the instructor asked to have her students watch", while the Donna performed the skill. The fact that a nursing instructor had sent her students to observe Donna's competent modeling had elevated her self-efficacy as a preceptor.

Similar to the manner in which they had been precepted, Henrietta and Ingrid capitalized on situations or unexpected emergencies as opportunities to have preceptees observe competent models in action before asking them to actively perform. Henrietta maintained:

> It's good to observe in the beginning, because you have to see the roles of everyone in that situation. It's a lot of stress, you are under a time constraint, and you see a lot of people interacting together. When they all interact well, you can see how things play out from beginning to end.

Likewise, Ingrid commented, "If something were to happen, I would have them there trying to take it in to see what I did". She also would show them "how to trouble shoot, find people to help, look up the policy or where their resources are, so they can help themselves" for future situations.

Eduardo addressed the subject of modeling professionalism with his preceptees, which he defined as having the proper "knowledge, skills and attitude" as a nurse. He continued, "Since application is done at the bedside, I try to show that to them. If they see these things in me, they might actually copy what I am showing".

Proficient preceptors reported they were able to seek out observational experiences for preceptees that facilitated opportunities for vicarious learning. These observational experiences could be modeled by the preceptor or by other competent individuals within the environment.

Proficient preceptors suggested that an ability to identify and provide these observational experiences contributed to the development of preceptor self-efficacy.

Finding 2.3 Two out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by an ability to *learn from observations of family outside the work environment.*

Proficient preceptors reported that they learned vicariously through observations of people and family peripheral to the work environment. Although emanating from sources outside of the workplace, they believed their observations had helped them to become highly efficacious preceptors.

Both Billie and Adele identified that their birth order and lessons learned from observing family members had contributed to their growth as a preceptor. Within her family, Adele observed some members that did "not make the wisest of decisions", which influenced her personal and professional choices. Since she was the first in her family to attend college, she stated that her siblings now, "look to me for some decision making". Billie described herself as the youngest child in a large family, and she watched her older siblings grow, seeing "the choices they made and the outcomes." She said, "You pay attention to that for the next time", and those observations helped her to think critically and enabled her to share the lessons she learned with others as a preceptor.

Proficient preceptors learned vicariously through observations of family members outside of the work environment. Through the experience of watching siblings, preceptors maintained that they had learned lessons that contributed to and promoted preceptor self-efficacy.

Finding 2.4 Three out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by an ability to *learn from observations of leadership models.*

Proficient preceptor described the observation of leaders within the healthcare environment as contributing to their self-efficacy as a preceptor. Preceptors mentioned observing and learning from interactions with physicians and from nurses who they saw as leaders within their own units.

Adele reported that she had learned from the observations of nurse leaders that she encountered. She stated, "It depends on which leader you are being led by. You need the right leadership to steer the followers". She described one charge nurse who had been instrumental in the development of her preceptor self-efficacy. She said, "She laid the foundation, she empowered us". Henrietta identified preceptors who had demonstrated leadership qualities, "I observed strong leadership in both those nurses" and noted that these individuals had contributed to her sense of effectiveness as a preceptor.

Another influencer of self-efficacy was the modeling exhibited by physician colleagues. Georgia stated that she had learned from observing, "How the docs [*sic*] have answered patients, addressed situations" and "you learn from that". Henrietta also attributed self-efficacy growth to interactions with physician colleagues, "You learn through your relationship with physicians", and she related how she had benefited through their collaborations.

Proficient preceptors noted that they learned how to be a more efficacious preceptor through the example of physicians and nurses they identified as leaders. Through their example, the preceptors were able to learn skills that contributed to success in their role.

Finding 2.5 Five out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by an ability to *learn from observations of modeling failures.*

Proficient preceptors reported that observing preceptor modeling failures and noting that as an example of what not to be had reinforced their sense of preceptor self-efficacy. In addition, experiencing preceptor failures personally had made a lasting impression that spurred them to higher levels of efficacy in the role.

Proficient preceptors noted that they had seen, first-hand, ineffective preceptor behaviors and viewed these as models of what they did not want to be. Carol had been the recipient of ineffective modeling, and its unpleasant recollection had spurred her development in the opposite direction as a preceptor. Carol disclosed, "My first preceptor here was *not* [emphasis added] a good experience. She had me in tears….The preceptor basically ignored me". She continued, "It showed me the things not to do with your orientee". Frances stated, "I learned from some bad ones I observed." She had witnessed some underperforming preceptors, who she said, "Just sit and do other work while their orientee is out there [*sic*]". Frances noted this to have a detrimental effect on orientee learning; "The preceptee doesn't want to ask them anything because that will show that 'I don't know what I am doing'." Her comment about another ineffective preceptor model was, "I don't know why that person is precepting….When they go check up on them, instead of constructive criticism, they're [*sic*] just criticism". She learned vicariously from this observation, "You observe habits that you are just not going to do".

Two proficient preceptors echoed the theme of inefficacious precepting as lessons to avoid. Adele stated, "It hurts me when people are precepting, and they are not doing a proper job because…it is not fair to the person". Eduardo noted that preceptors within his hospital were

rewarded with an extra premium to precept, and observations of ineffective preceptor models had prompted his question, "What if you are being paid to be a preceptor, and you are not doing your job?" He commented, "A few of them just come to get that check every two weeks." He maintained that a preceptor with high self-efficacy would model differently, "My approach is different…you should do the job first, then you get paid, that is the sequence". Jane expressed the sentiment that underperforming preceptors should not be allowed to precept: "The last person you would want precepting is someone who is saying, 'I hate this place and I really need a new job'…not someone who just wants the preceptor money."

Proficient preceptors reported that they had learned vicariously how to be a more efficacious preceptor through experiences or observations of preceptor modeling failures. First-hand experience of being precepted by a poor model, as well as observations of ineffective precepting by peers had spurred their resolve to develop efficacy in a positive direction.

Finding 2.6 Six out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by an ability to *recall effective preceptor modeling for subsequent use in the role.*

After observing the performance of effective preceptor models, proficient preceptors reported that being able to subsequently recall salient preceptor behaviors was also an important step in developing preceptor self-efficacy. Proficient preceptors remembered the behaviors demonstrated by preceptor models that they wanted to emulate, and they believed that their protégés, who might one day become preceptors themselves, would subsequently recall their effective behaviors in the role.

Five proficient preceptors recounted recollections of effective modeling that had influenced their development into competent nurses and, later, preceptors with high self-efficacy.

When she was a new nurse, Carol had observed and retained her preceptor's strategy for providing oversight. Carol said, "She was good at the beginning to show me what I needed to do, then would slowly step away". Eduardo recalled his preceptor's actions, "I tried to simulate what he had done [*sic*] with me". Adele shared remembrances of positive behaviors that she had observed in her preceptor, "These are the little things that she had done [*sic*] that were stuck in my brain and that I admired. And I took those elements to build for myself". This tradition of recalling for future use what they learned from their preceptor was borne out by a preceptee of Adele, who said, "I will never forget some things you taught me".

When reflecting about their acquisition of precepting skills, Billie, Ingrid and Donna recited recollections of the behaviors of efficacious preceptors that had influenced their development. Ingrid stated, "I remembered when I was precepted and saw other people on my unit", who were precepting. Donna who been precepted by and admired Ingrid, reported that she would ask herself, "What would Ingrid do? I would just think about Ingrid…and situations that she told me about." Billie mused, "I might have seen what worked, some things they did, and put it in how I teach". When discerning how to perform her role, Billie stated that, "I remembered certain things that preceptors did that worked or didn't work with me". During the Focus Group, members brokered the recall of competent preceptor behaviors as instrumental to learning. Donna summarized by saying of her preceptees, "They start by observing you or me as a preceptor, and then they pick up on that. So next time, when it's their turn to precept, they can think back to, 'What did Donna do with that orientee'?"

Proficient preceptors reported that an ability to recall observations of effective preceptor modeling was significant to developing self-efficacy in the role. Preceptors applied this recall of excellence to their own practice with preceptees. Preceptors believed that their demonstration of

efficacious modeling would likewise subsequently be recalled by their protégés for future application.

Finding 2.7 Nine out of ten proficient nurse preceptors reported that the development of their self-efficacy through vicarious experiences was related to an ability to *share with other preceptors.*

Proficient preceptors reported that being able to share with other preceptors contributed to their self-efficacy. They found opportunities to share through formal venues such as the monthly Preceptor Forum and with peers on their work unit, and honest interchange between preceptors that would enable frank sharing, required trust. Vicarious learning occurred when preceptors shared information and experiences, discussed precepting conundrums, and supported each other within a safe learning environment. Proficient preceptors with access to vicarious sharing among peers reported that they were able to discover a wide spectrum of possible learning options and resources that were influential in promoting their self-efficacy.

Eight of the ten proficient preceptors identified participation in the hospital's monthly Preceptor Forum as beneficial to their role development as preceptors. Several had participated in the hospital's group that had been established the previous year. Both Ingrid and Georgia desired a safe place for preceptors to share and grow. Ingrid valued the monthly Preceptor Forum and said that, "making people feel comfortable that there's people to go to, discuss things, scenarios that come up and supporting them" was important. In reference to the Preceptor Forum, Ingrid stated, "just knowing they have support is huge". Georgia maintained that "feeling secure enough to ask other preceptors" was important. She had attended a helpful support group at another hospital, "where preceptors could meet and talk about their experiences" and felt the Preceptor Forum could serve a similar purpose.

Some ideas of ways the Preceptor Forum could support vicarious learning were shared. Billie suggested a monthly meeting, "where preceptors could share, bringing an article or some things that worked" would benefit other preceptors. Frances wanted to use the Preceptor Forum for "sharing stories" to promote learning. In reference to the range of situations that might confront a preceptor, she added, "You can never even think that it is going to happen". Besides providing a safe haven for discussion, Ingrid viewed the Preceptor Forum as a mechanism to increase the efficacy of preceptors. She said, "Get that core group, work with them on their skills and see if they have any issues, and if so, how could you help them." During the Forum, preceptors might raise issues related to the role with other preceptors and educators. She said, "I have probably asked other preceptors, 'How do you feel about this person?' Talking with educators, other people, to see if we are all on the same page". Another idea that Ingrid proposed was to use the Preceptor Forum to develop the self-efficacy of newer preceptors. She said, "Have new preceptors…talk to other preceptors…see what they do". She recommended teaching modalities including "use of videos or on-line resources for preceptors".

One challenge mentioned by several proficient preceptors was their inability to get off the work unit to participate in a formal Preceptor Forum. While Jane, Carol, Eduardo and Henrietta reported that they liked the idea the group, it had been difficult for them to attend. Jane said, "Preceptor Forum, unfortunately, I haven't been able to make it, but I think it's great." Henrietta suggested "having meetings on the unit, during lunch break" for shorter amounts of time to allow preceptors on the unit to share.

Informal sharing on the unit was identified as a way that proficient preceptors had vicariously learned from other preceptors. Carol worked on such a unit that had, what she termed, "a culture of asking questions or sharing experiences". She explained, "Even if we're

not orienting, we're sharing experiences with each other". When her unit had expanded to provide care for a new patient population, she said, "The preceptors were teaching each other, sharing information…because parts were new to all of us". Henrietta reported that preceptors on her unit worked "side by side" with each other. She verbalized that if a preceptor "needed assistance with something, I'm sure they'd come to you and say, can you show me how to handle this situation", and then a discussion would ensue. During the Focus Group, proficient preceptors related how they had learned vicariously from each other over the years. Eduardo stated, "I learned that from Frances and also them", motioning towards two other group members.

Proficient preceptors in both Focus Groups disclosed how telling and hearing the stories of other preceptors within the informal setting of their work units helped develop self-efficacy in their role. Donna and Henrietta discussed how they had shared precepting experiences with peers. Donna said, "I personally am a story teller," and she appreciated the opportunity to "talk about what happened during the day, the day before" with other preceptors. She explained,

> That would be helpful because my co-workers are hearing what I had to deal with, and they can say, "That was a good way to do that", or "maybe that wasn't the best way, maybe I would have done it this way".

Henrietta agreed, saying, "It's almost like debriefing. You're talking about your experience, and you're getting assurance from other co-workers, like, 'I could have done that', so it's actually good to talk about your situation".

Sharing experiences of difficult precepting situations with other preceptors was raised during the Focus Group. Proficient preceptors discussed how they learned vicariously from each other. Carol had experienced a preceptee who was struggling, and she shared the situation with

peers to get their perception and input. "Amongst ourselves, trying to brainstorm…because there was nothing you could put your finger on and say this". She added, "Everybody just had a feeling, and she didn't last either". Ingrid said, "We had the same situation. We went through all of that with different preceptors. Everyone agreed that the person was abrupt and not following safety checks, blowing things up everywhere".

To help other preceptors to develop self-efficacy in dealing with difficult precepting situations, Billie would offer her stories of challenge as a preceptor. Billie explained:

> There's one instance I tell other preceptors on my unit…so they can prepare themselves, because, you never know….I share an experience that didn't go well and how I handled it, and it seems to be valuable feedback to them. They will say, if this happens, "I can go to Billie and say, how should I handle this?" It makes them feel better to have someone to talk to.

Billie believed that having the opportunity to share precepting struggles, so others could learn vicariously, was beneficial and supportive.

Proficient preceptors valued sharing among preceptors as a means to develop self-efficacy in the role. Sharing occurred in formal venues such as a monthly Preceptor Forum and informally among preceptors on the work unit. Essential ingredients of preceptor sharing that were identified included trust and honesty. Preceptors could share experiences relevant to the role, using each other as sounding boards and mutual support. Proficient preceptors felt that access to a variety of both formal and informal sources of vicarious learning were instrumental to the development of preceptor self-efficacy.

Finding 2.8 Seven out of ten proficient nurse preceptors reported the development of their self-efficacy through vicarious experiences was related to an ability to *share stories with preceptees*.

Along the road to becoming an efficacious preceptor, proficient preceptors reported that wisdom was gained through missteps and challenging experiences. Use of past experiences as a tool to advise or console preceptees was felt to be helpful. Sharing these experiences with preceptees increased preceptor perceptions of self-efficacy in the role.

Four proficient preceptors described relating stories of personal nursing mishaps to show support and empathy with their preceptees. Donna shared a personal anecdote: "I like to tell them about the time I made someone throw up…I gave a patient too much tube feeding." After telling the preceptee about her experience, she concluded with, "Don't ever do that, I've learned from my mistakes". Later, when Donna and her preceptee went into the room to feed a small child, the preceptee stated, with very little prompting, "I am only going to put a little bit of water so I don't overfeed this baby". Donna viewed this as evidence of preceptee learning that was enhanced by her story and was an effective method of getting her point across.

Adele related an experience of committing a medication error, and when her preceptee made a similar error, she shared her own error story. Although Adele had been upset at the time of her own error, she said she had since come to view it as a "learning experience" that she never forgot, and that she could share with preceptees. She stated, "I used what was taught me about twenty years ago" to help her orientee learn from the incident. Another preceptor, Jane, said, "If they are beating themselves up, I say, 'Listen, when I first did this,' and I'll share a story of something that happened to me, or how I learned something, so that they get more comfortable".

When Billie had an orientee who was highly anxious, she would use her own misadventure stories as a means to calm her preceptee. Billie stated:

> I've seen a lot of things, and when I can tell they are nervous, because they have never done it before, I will sit them down and say, "Back when I was new and we were doing"...and I will tell them some crazy story, and it will calm them down.

Henrietta, Carol and Ingrid told their own stories as a way to prevent preceptees from experiencing mishaps. Henrietta would share stories "to kind of brace them, prepare them for experiences". She continued, "I like to tell, share my experiences and what I have learned from situations, how to deal with things". When discussing medication administration, Carol would "tell them to double check this, because it's happened to me. And when it happens, then you remember." Ingrid said that talking about "scenarios" was a way to help orientees prepare for typical situations that would confront them.

Proficient preceptors reported that they were able to share their significant developmental experiences with preceptees for the purpose of learning. They felt this type of sharing allowed them to demonstrate support, enhanced vicarious learning for preceptees and helped preceptors to feel efficacious in their role.

Finding 2.9 Four out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by an ability to *share preceptor responsibilities with another preceptor.*

Four proficient preceptors reported that they found co-precepting with a compatible team member to be a helpful teaching strategy that allowed them to experience a higher sense of self-efficacy in the role. Sharing preceptor responsibilities allowed the preceptee to benefit from the strengths of more than one preceptor, and was especially effective when the preceptors were able to communicate regularly.

During the Focus Group, Ingrid stated that preceptees could "learn from multiple preceptors". She explained, "You pull something from everybody, and you find your own way after that". Eduardo commented, "Using multiple preceptors is like collecting your skills [motioned to two proficient preceptors in the Focus Group]. Carol is good at something, Billie is good at something. I try to learn all those things and bind them together." Eduardo indicated he would choose to share his preceptor responsibilities with a nurse who had different strengths.

Donna and Henrietta also discussed shared preceptor responsibilities. To feel efficacious as a co-preceptor, they believed that it was important for preceptors to have time to share information among themselves and to compare notes about preceptee progress regarding what experiences might prove beneficial. Donna recommended discussions such as, "The orientee did this yesterday, she did great", or "I had to redirect her, provide feedback, so if this response, watch for this particular issue". She continued, "I think that would be really helpful". Henrietta stated that having time to talk among preceptors was particularly important, especially "near the beginning and end of the orientation periods".

Proficient preceptors reported that being able to share preceptor responsibilities with a compatible co-preceptor was a teaching strategy that enabled a greater sense of self-efficacy in the preceptor. Sharing responsibilities allowed the preceptee to benefit from the strengths of each preceptor. To co-precept effectively, time for preceptor sharing regarding orientee plans and progress was necessary.

Finding 2.10 Eight out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by an ability to *judge their capabilities relevant to the attainments of others.*

Proficient preceptors made inferences about their self-efficacy based on observations of performance attainments of preceptees. In addition, comments of preceptees about the efficacy of their preceptors or satisfaction with one preceptor relevant to another impacted self-efficacy beliefs. Nurse preceptors also made judgments about their performance by observing other preceptors within the work unit, and compared their own performances to these vicarious sources of information.

Preceptors commented how their observations of preceptee performances were taken as an indicator of their efficacy as a preceptor. Frances commented that when she observed former preceptees, she would think, "I'm proud I oriented that person, but this other person isn't looking so good here. I guess that is my own self-check". Georgia had oriented many of the nurses on her unit, and she said of her preceptees, "I see them now, and it's me, I am almost like the 'Mom', and I am looking out over [*sic*]. I see all my new people coming in." She continued on about former orientees that had performed well, "They are looking at how to divide the assignment, without oversight, and trying to figure it out together, the two of them. They get it, and they can start it….They are self-driven to do more".

Proficient preceptors interpreted preceptee forward progress as indicative of their self-efficacy in the role. Ingrid inferred that she had done her job effectively when she saw "people that I oriented being independent". Jane said, "If I've done a good job, and they've learned and had a good day and are moving forward, that's rewarding for me and rewarding for them". At one of his former work sites, Eduardo reported that there had been a productivity expectation of new nurses. Eduardo stated:

> One nurse should be able to take care of six patients on the unit I worked, so if the new grad is taking care of less than six patients within the next four weeks, there might be

something wrong. So they're trying to check me [as a preceptor] as well. Am I doing all right, am I still comfortable?

When preceptees failed to make desired progress or were perceived as negative or disinterested, preceptors questioned their efficacy. Carol related the story of working with a challenging preceptee and comparing notes with other preceptors: "We had one nurse and… nobody was sure why…but she left." She continued, "We wanted her to progress, but we couldn't understand why the preceptee wasn't bringing everything together." Adele said of her experience with a problem preceptee, "I was hindered by her behavior and her lack of positive responses." Billie stated, "If you have a negative kind of person, precepting that kind of person can be rather difficult".

Preceptors also made positive inferences about their precepting skills from comments of former preceptees. Carol recounted of a person she had precepted several years before, that she "had remembered how I explained something to her", and a former preceptee "was complementary of how I taught her in hospital orientation". Ingrid and Jane's preceptees had compared them favorably to other preceptors. Jane's preceptee told her, "The best day I had was with you", and Ingrid's preceptee stated, "So and so isn't showing me as much as you are", and this made them feel efficacious in their preceptor role.

Besides to noting their preceptees' performance and comments as evidence of their own performance, proficient preceptors also made inferences about their self-efficacy through observations of other preceptors' performances. Carol had seen good and bad precepting throughout her career. She said, "My first preceptor was calm and supportive." Conversely, she noted that some of her peers had been the victims of bad preceptors who "ate their young". When Carol changed jobs, she also experienced ineffective precepting, which led her to

conclude, “This is ridiculous. I shouldn’t be chasing my preceptor, because I wasn’t treated that way at my first job”. Jane had overheard a similar report from newer nurses, “Some of the other nurses on my unit will say that they feel like they are learning on their own. And I don’t let that happen if they are with me”. Proficient preceptors were cognizant of preceptors who were not effective and expressed dismay at this observation.

Upholding standards was important to Carol and Adele when precepting and observing under-functioning peers reinforced their sense of self-efficacy as a preceptor. Carol stated, “It is hard, you are trying to teach the preceptee the process of doing something, but they’ll see that other nurse, another shift, didn’t do the exact thing that you are trying to teach them to do”. Adele asserted, “You aren’t going to make one bad apple spoil the whole bunch of us here”, and expressed her commitment to strive for excellence as a preceptor. Despite these few negative observations of under-functioning peers, Georgia, who had worked as a preceptor in other settings, compared preceptors favorably at her hospital to a previous job in acute care and stated that overall, “Preceptors do an amazing job teaching those subtleties of change about our patients” to preceptees.

Proficient preceptors made vicarious inferences about their performance based on observations of preceptees’ performance and verbalized satisfaction. Other indicators reinforcing preceptor self-efficacy were comparisons with other preceptors on their unit or with other preceptors with whom they had had experience throughout their careers. These vicarious sources provided confirmation and elevation of self-efficacy.

Finding 2.11 Four out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by an ability to *self-reflect about their enactment of the preceptor role.*

When performing the preceptor role, four proficient preceptors reported that taking time to self-reflect was an important component of self-efficacy development. Self-knowledge and willingness to reflect about professional behavior and growth opportunities was seen as a key to enabling effective preceptee/preceptor relationships. Self-reflection was also reported as necessary for identifying better preceptee learning strategies and successful outcomes.

During a Focus Group discussion, Henrietta stated that to be an effective preceptor, "You have to have a good understanding of yourself, how you feel about yourself". Billie believed it was important for preceptors to assess their knowledge of the preceptor role and responsibilities. In completing the Preceptor Self-Efficacy Evaluation Form as part of this study, she discovered aspects of precepting that she felt she needed to develop: "There were a couple things I scored myself lower on, because I'm like [*sic*], 'I don't even think about that'. You want to have all that, but you don't know what you don't know".

Although he has been a preceptor for many years, Eduardo reported that learning is ongoing. "There are times I am still confused, I still didn't get it, and those are the times I was self-doubting myself. Am I doing the right thing here, or am I the right preceptor for this orientee?" Eduardo said he would try to put himself in his preceptee's shoes, thinking, "What would I like to learn today?" Henrietta reflected about decisions she had made: "You end up delegating something that you feel like, is it the right call, delegating this task to them [the preceptee]? You are thinking in the back of your mind, do they feel comfortable in that role?"

In the event that preceptee discomfort or problems were to arise, Georgia and Billie identified the importance of self-reflecting. Billie experienced a preceptee who perceived her as condescending. Billie stated, "I could see where some people would say that. I think you can't walk away from a situation and not think about what you did, too. She was very sensitive and

we're kind of sarcastic". Billie used this self-reflection to change her approach and the preceptee was able to succeed in completing orientation. Georgia tried to "remember what it was like to be a newer nurse" and learning to do something for the first time. She remembered, "I am feeling nervous, and they are asking me [*sic*]." She concluded that "self-reflecting was important" in developing self-efficacy as a preceptor.

Proficient preceptors reported that self-reflection about their competence in enacting the role was important. Taking pause to consider how their actions could be perceived by preceptees, as well as considering alternative teaching strategies or goals, was felt to be necessary to ensure positive learner outcomes and preceptor development of self-efficacy.

Finding 2.12 Three out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by an ability to *listen to the experiences of others.*

Proficient nurse preceptors reported that listening to the experiences of others contributed to their development as efficacious preceptors. They were able to learn from listening to other preceptors, their preceptees and other staff with whom they worked.

Proficient preceptors learned vicariously through listening to the experiences of other nurses and staff. Regarding the benefits of listening, Frances stated:

> Listen to other preceptors on the unit, especially if they have had a little bit of different nursing experience than you. If they have worked in critical care, they might see, we all see, the same patients, but we all see them in a different way.

Also, she learned by attending to other nurses' personal accounts of caring for ill family members, "Along the way, they had some relative that they took care of. Some sort of personal experience they might have shared". She continued, "You listen, and you learn from other

people how they went about it". Henrietta said, "You learn through your relationships with your peers, with the nurses' aides. You learn from their experiences and pull from that".

Besides learning from fellow staff members, proficient preceptors spoke of listening and learning from their preceptees. Frances endorsed "listening to orientees" as helpful, and Henrietta said, "I learned through their experiences how they would handle a situation". Georgia maintained that preceptors should listen and "be receptive to where the orientee's coming from". She noted that more of her preceptees were mature, had "worked elsewhere, and they have different ideas and can share their knowledge with us as well".

Proficient preceptors learned vicariously by listening to other nurses, preceptors, and staff who shared different experiences of handling situations throughout their career. Being attentive to the thoughts and experiences of preceptees was also reported as instructive for preceptors. Self-efficacy development and vicarious learning was enhanced through the preceptor's use of listening skills.

Finding 2.13 Seven out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by an ability to *know their learners.*

Proficient preceptors identified getting to know their learners as people was critical to their success in working with preceptees and for developing preceptor self-efficacy. Preceptee sharing about significant maturational experiences with their preceptors helped in designing relevant learning experiences. When preceptors were able to ascertain what pertinent job-related skills the preceptees brought to the workplace, they were able to build on prior learning.

Proficient preceptors reported that knowing their learners and the significant milestones or life events that had shaped them was important to selecting learning approaches, and to advancing their professional relationship. Jane wanted to know, "How long have you been a

nurse?" and Frances would ask, "Where have you worked before, do you have kids, are you married?" Frances explained that it was helpful in planning for orientation to know something of her preceptees' backgrounds and recounted examples of newer staff that she had recently oriented. "Some people, like Bob, had been graduated for a while before he started here…while Marilou literally graduated school and started here". Frances related that during the interim period between school and employment as a registered nurse (RN), "Bob had worked as a private duty nurse's aide". Because he had not found employment as an RN immediately following graduation, there was gap in time since he had performed RN skills. Conversely, Marilou had performed RN skills as part of her nursing program, contiguous with her hire as a graduate nurse. Frances also believed knowing something of her preceptee's personal life "made a big difference" and was helpful in teaching. She said, "I notice that the people who are not necessarily older, but have different responsibilities in their life…think differently." During the Focus Group discussion, Adele described an unfortunate experience with a preceptee who had been unwilling to share, and was secretive and dishonest as to how she had presented herself. Adele wondered if the preceptee "had something to hide", found this person "extremely challenging to teach", and the preceptee resigned shortly after orientation was completed.

During a separate Focus Group, two proficient preceptors, Donna and Henrietta, expressed similar thoughts about wanting to know about the person's background and life experiences. For this purpose, Donna would ask, "Where did you go to school, where are you at in your life today?" Henrietta also related that knowing about her preceptees' "life experience, educational experience…helped me teach them". Donna expressed her belief that "people that have more life experience, educational experience, are actually easier to precept". She explained, "They're not as focused on the tasks, but more on the general assignment, what they

have to do for the day". Henrietta commented how knowing the preceptee's maturity and emotional intelligence was important in "tailoring it [the orientation] for each orientee, because everybody is different".

Besides knowing the preceptee as a person, Georgia believed it was also important to determine the "orientee's perception of what the preceptor is to do for them". She stated that sometimes there might be incongruous expectations between preceptor and preceptee, so dialogue to clarify expectations might be helpful.

Proficient preceptors reported that knowing their preceptee was a necessary component of developing effective learning strategies and a professional relationship between preceptor and preceptee. Preceptee sharing of significant life and work experiences that might impact learning could enhance preceptee success, and may also increase preceptor perceptions of efficacy relevant to their role.

Finding 2.14 Five out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences advance by an ability to *demonstrate respect for the learner.*

Proficient preceptors reported that being able to demonstrate respect for their learners contributed to their self-efficacy as a preceptor. Offering choices, options, and being open and receptive to the learner could serve this purpose. Proficient preceptors tried to accomplish this by acknowledging preceptee opinions and feelings and demonstrating an attitude of respect.

Eduardo stated that he would begin his interaction with a preceptee by asking him/her, "What would you like to learn today?" He would invite dialogue and jointly negotiate a workable plan. Georgia said, "I want to be open and receptive to them", and "A lot of the new ones that we currently have are middle-aged and have had a life before they got here". Because

preceptees were adult learners, Adele reported it was important to "acknowledge and respect their opinions". Jane asserted, "If you treat them like they don't know anything that can be offensive".

Proficient preceptors expected that preceptees might be anxious and respectfully tried to encourage their participation. Carol has had success with getting preceptees to attempt feared tasks. She stated, "Give options, offer choices rather than telling them what to do". She said, "After we've talked it through", most were willing to perform the skill, and "Then they get it in [an I.V.], and they feel really good."

When proficient preceptors' use of choices and options resulted in positive outcomes for the learner, they reported that their self-efficacy was elevated. Acknowledgement and respect for the learner as a partner in the learning was noted to be a mutually beneficial learning strategy for both preceptee and preceptor.

Finding 2.15 Four out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by an ability to *promote the social integration of the preceptee.*

Proficient preceptors reported that an essential function of efficacious preceptors was promoting the socialization of their preceptees into the culture of the hospital and the specific unit on which they worked. This involved introducing them to other members of the team, helping them to feel welcomed and an integral part of the team. Preceptors also provided protection from difficult team members or helped them to navigate the tacit rules of the unit.

Carol's experience with an ineffective preceptor led her to be highly sensitive to the feelings of a new person. She stated,

My preceptor literally left the floor and went off to lunch. I didn't know where the preceptor went. So I went to the cafeteria, and she's sitting there with the other nurses. Never said, "Oh, I'm going to lunch, do you want to come along with me?"

Frances had observed a new person who came to her unit, and was waiting at the desk to be acknowledged for several minutes. She said, "The poor person's just standing there waiting to be acknowledged". Frances intervened and offered to help.

Because hospitals were comprised of multidisciplinary teams, proficient preceptors indicated that their preceptees needed to learn the roles and be introduced to the various disciplines. Towards this aim, Billie observed, "I orient them to our unit's social environment…all those other disciplines, it multidisciplinary". She continued, "You're going to be part of a team", so she would introduce the person to the group as a new member and not just as "the new person". In addition, she would "encourage their interaction with staff", so that if the preceptee needed help and she was unavailable, fellow staff "might feel comfortable" in offering corrective strategies to aid the preceptee.

In socializing a preceptee to their units, Frances and Georgia identified a need for the preceptor to serve as a protector as well. Frances remarked, "You don't just throw them to the wolves", and Georgia stated, "You don't have a sense of the politics when you are so new". As a new nurse, she had appreciated that her preceptor assisted with that aspect of socialization, so that she could focus on learning the new competencies. She said, "You have the preceptor interface all of that."

Proficient preceptors reported that being able to promote successful preceptee socialization towards acceptance as an integral part of the healthcare team was an essential component of becoming a preceptor with high self-efficacy. Preceptors said that they

introduced, provided explanations of the culture, and served as a protector of the preceptee as they learned to navigate the specific unit and hospital culture.

Finding 2.16 Six out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by an ability to *work side by side with their preceptee to promote competence.*

Proficient preceptors reported that working side by side with preceptees was an effective way to promote vicarious learning. The preceptee was able to closely observe the skilled performances of the preceptor. One theme that was echoed by proficient preceptors, which contributed to their self-efficacy, was the need to work together with preceptees to provide modeling, guidance and support as the new person was learning.

Three proficient preceptors verbalized the need to work closely with preceptees to perform their role effectively. Adele said, "You break together, you do things together", and Carol reinforced this, saying that preceptors and preceptees should "work side by side". Jane expressed similar sentiments, "I always stay right with the preceptee. I am teaching them as we go throughout the day. I need to be with them to see what they are doing, know they are doing it right".

Billie worked alongside the preceptee as a means to encourage her orientee. She would tell the preceptee, "Let's work together, and you will get there". Carol used a similar strategy, telling her preceptees, "Let's go into the patient's room and we're going to do this together." She said that she "did the assignment with them", rather than expecting them to do it alone.

Ingrid noted one potential barrier to working alongside preceptees that could be problematic to preceptor self-efficacy. She mentioned that other nursing responsibilities, such as

serving as the "resource" nurse to others on the unit, or charge nurse, might interfere with precepting duties. She said,

> If I am on an assignment, and I am precepting, but yet the other staff is still coming to me, in addition, for stuff, and you don't want to leave your person. You can take them with you, but then they have their stuff to do.

She suggested "having someone else as a resource, so you can stick with your preceptee".

To develop preceptor self-efficacy, proficient preceptors reported that they needed to be able to work side by side with their preceptees. When working alongside their preceptee, they were able to demonstrate, teach and provide guidance and oversight to the new person to enable preceptee success.

Research Question 3.0 What do proficient nurse preceptors report about the development of their self-efficacy related to verbal persuasion?

Finding 3.1 Four out of ten proficient nurse preceptors reported the development of their self-efficacy related to verbal persuasion was advanced by *being selected for the special role of preceptor.*

Staff nurses were selected by their manager or charge nurse to become a preceptor after they had demonstrated clinical competence on their work unit. Designation as a preceptor meant that the manager believed the employee possessed the capabilities requisite of the role. This verbal encouragement and expression of faith in the nurse's ability was important to the development of preceptor self-efficacy.

Four proficient preceptors reported that their identification as a preceptor was not an expectation of all nurses, and specially selected nurses were offered this extended role on their unit. Eduardo described being "selected" by nursing leadership for the role at his current

workplace and at two previous hospitals, saying, “I didn’t even volunteer”. Donna said that only “selected” nurses became preceptors at on her unit and at two previous jobs she had held. Jane also indicated that she had been “chosen” to become a preceptor.

Two proficient preceptors described charge nurses who pushed them to assume their role by engaging them in teaching and instructing new students and staff before they had received the official “selection” designation. Eduardo stated that a “charge nurse…selected me” as a candidate for this position. Adele had a charge nurse who expressed faith in her capabilities to be a preceptor and “was very instrumental in those skills that I attained”. Adele advised that nursing leaders should select nurses with the ability to perform the role and express confidence in those selected to encourage self-efficacy in this group. She said, “I would recommend you identify nurses, from talking to the leaders on the unit, who are willing to share, willing to precept and teach new nurses, who have the skills to do this”.

Charge nurses and unit managers nominated competent bedside nurses to become preceptors by “selecting” these individuals, providing verbal persuasion that they possessed the abilities to take on the preceptor role. Preceptors reported that since this role was not an expectation of every nurse on their unit, the verbal and written expression of confidence by respected persons encouraged their development towards becoming a preceptor with high self-efficacy.

Finding 3.2 Four out of ten proficient nurse preceptors reported the development of their self-efficacy related to verbal persuasion was advanced by an ability to *receive feedback from credible sources about their capabilities.*

Proficient preceptors wanted to hear from stakeholders how their performance of preceptor responsibilities was perceived. A credible source of information for preceptors was the

verbal affirmations from their preceptees. Also important was positive verbal feedback that they received from co-workers, managers or nursing leaders and patients. Verbal encouragement about their capabilities was most credible and effective in elevating preceptor self-efficacy when it was received from their preceptees.

Six proficient preceptors reported that hearing positive feedback from the recipients of their services, the preceptees, was most indicative to them of their efficacy in the role. Billie summarized these sentiments by saying, "I would feel best if it wasn't an authority figure saying that I was good, it was when the person I was precepting said to me that I was doing a good job". She stated, "That was *most* [emphasis added] important to me". Jane said, "I get good feedback from the people I precept, which makes it easier for me". She felt affirmed when one of her orientees had said to her, "No one else has explained things this way to me; no one else has shown anything to me, this is the best day I've had in orientation".

Preceptee recommendations about proficient preceptors were perceived as credible evidence, validating their self-efficacy. Because Jane's preceptee had experienced a good day while working with her, Jane later learned that "she shared that with other nurses I have precepted". Eduardo overheard his former preceptees telling new staff, "You go see him, because he was my preceptor before. I learned from him". Ingrid had a similar story, "People I have precepted and co-workers say that 'I am a resource', that 'I am doing this, I am doing good, and people are getting a good experience out of it.' So when I got the external feedback, that really said it for me [*sic*]".

Donna had overheard the conversation of two preceptees that made her feel affirmed as a preceptor. She said, "I had two orientees who were arguing. It was a friendly argument about which was going to have me as their preceptor. So, that made me feel pretty good [*sic*]".

Henrietta also reported that hearing what preceptees thought of her performance was important to her self-efficacy, and sometimes this was missing when a preceptee moved on to another unit. She suggested, "Share the feedback if the preceptee moves on to another unit. That would be helpful".

Hearing positive verbal comments of managers, co-workers, patients and clinical educators was also identified as supportive of preceptor self-efficacy. Frances shared that people would tell her, "You should be an instructor because you have a lot of patience; you don't get mad, and don't show you are impatient". She had also received compliments from one manager who said, "That was a good pick-up", and a clinical educator told her that she was "good at precepting". These comments served to reinforce her sense of higher self-efficacy. Georgia cited the "teammates that she works with" as providing verbal feedback about her performance as a preceptor.

Georgia also mentioned receiving "praise from patients themselves", and she saw that as a credible source of information about how she modeled as a preceptor. She related the story of a patient's wife who provided validation for her, "She was waiting for me at the elevator, and said 'Thank you so much', and just that reinforcement for me that I was doing the right thing."

Verbal persuasion about their capabilities as a preceptor was most effective in increasing the self-efficacy of proficient preceptors when it came from credible sources. This included relevant verbal feedback from preceptees, managers, co-workers, other nursing leaders and patients. The most significant source of verbal persuasion was from the preceptees with whom the preceptors had worked.

Finding 3.3 Nine out of ten proficient nurse preceptors reported the development of their self-efficacy related to verbal persuasion was advanced by an ability to *provide encouragement to preceptees to enable success.*

Provision of verbal encouragement to preceptees to enable successful completion of orientation was an important skill of a preceptor with high self-efficacy. Proficient preceptors reported that they learned to be encouraging from the modeling of their own preceptors, and they used these same skills with their preceptees. To counteract preceptee frustration, preceptors provided encouragement by sharing their own stories. Preceptees needed encouragement to attempt new skills, recall past successes, increase confidence, and continually improve.

Four proficient preceptors learned the importance of verbal encouragement of preceptees through their own experience of being precepted. Eduardo stated he had received "constant verbal encouragement" from his preceptor. Frances said that her daytime charge nurse provided encouragement, telling her, "You could do that". Adele recalled her preceptor had said to her, "You got it; go ahead and do this or that". To encourage her to attempt something new, Donna recalled that her preceptor had "encouraged me to make me feel comfortable, and she always made me feel confident".

Because preceptees might often lack confidence to attempt new skills, proficient preceptors reported that they would provide encouragement to nudge their preceptee along. Henrietta explained, "You want to encourage a preceptee…some are fresh out of school and lack confidence. To build that, you have to encourage them". When preceptees were faced with new experiences, Carol has often heard, "I don't think I could do that", so she has responded, "I think you could do it, give it a try". To encourage her preceptees, Adele has said, "Let's see what's

going to happen", and "Let's team up and get whatever it is to be done [*sic*]", to reduce preceptee anxiety.

Sometimes preceptees would become distressed and needed a reminder of their capabilities. Highly efficacious preceptors would provide this validation, sharing personal stories of adversity and success as a novice nurses with their preceptees to alleviate their angst. Jane, Eduardo and Billie related stories of preceptees who needed such encouragement. Jane said, "If they're beating themselves up, 'I'm never going to get this right', I'll share a story". For preceptees who were anxious, Eduardo would remind them, "You've done this one before; you should be able to do it again". Sharing his own stories was a helpful strategy employed by Eduardo. He stated, "I always use myself when I am encouraging them. I keep telling them that I expect them to be better than me". Billie worked with a preceptee who had become despondent about her progress, and Billie used her personal experience to encourage. When her preceptee said, "I'll never get this, I'll never understand it", she replied, "I'm not anything special. I was *you* [emphasis added] five years ago. I didn't know what I was doing".

At times, preceptees who had been doing well initially experienced periods of distress when confronted with new situations. Efficacious preceptors anticipated this, responding with encouragement to promote preceptee success. Billie said, "I think a big thing is encouragement. New people, new grads coming on the job really beat themselves up because they think they should be higher than they are at, and I don't think they have realistic expectations." Billie continued, "You build them back up…you encourage them and show them, that 'you do know things', so that the seeds of self-efficacy start building them back up in a different image than when they came to the hospital". Henrietta had precepted a struggling new nurse, and she

explained, “I had to keep encouraging. I kept saying, you’re doing fine…but it took a little time because she didn’t have confidence, and she was a new grad. Eventually she came on board”.

Once preceptees had achieved a level of competence and confidence, proficient preceptors continued encouraging their protégés to learn. Adele stated, “There are simple things that I see nurses need to work on…I always encourage the nurses to do it”. Ingrid provided helpful suggestions, saying, “You can do it quicker or easier” this way. Jane encouraged preceptees in the manner used by a former manager, “Always improve, you want to grow and get better”. Jane explained, “They want to feel good about what they are doing, so they need to be doing the right things”.

Provision of verbal encouragement was a necessary skill reported by proficient preceptors towards the goal of enabling successful preceptee outcomes. Proficient preceptors learned verbal encouragement skills through observing their own preceptor models and replicating these behaviors with preceptees. Preceptors provided verbal encouragement to try new skills, remind about past successes, promote ongoing learning, and shared their stories to help alleviate preceptee stress.

Finding 3.4 Six out of ten proficient nurse preceptors reported that the development of their self-efficacy related to verbal persuasion was advanced by *receiving positive verbal feedback about their performance in the role.*

Proficient preceptors mentioned positive verbal feedback as an important means of gauging their role effectiveness and in developing their self-efficacy. Preceptors especially wanted to hear from their preceptees, although they also valued positive comments from educators and staff. Receipt of such feedback conveyed the message that they were viewed as effective in their role, and positive verbal feedback was especially rewarding.

Preceptors were verbally persuaded that they been efficacious in enacting their precepting duties when they received positive affirmation from preceptees, and they reported that it provided incentive to persevere in their precepting efforts. Billie and Jane verbalized how their self-efficacy was elevated when their preceptee gave positive feedback. Jane stated, "It makes you feel good when someone tells you, 'You did a good job'. It makes you want to keep doing it." When Billie's preceptees told her, "You are such a good teacher", she said, "That makes me feel good". Eduardo also reported that positive verbal comments, "Makes me feel better", and he thought, "I must be doing something right. So I just keep doing what I could do".

Henrietta stated that she appreciated hearing how preceptees viewed her as a preceptor, and it provided an indication of her effectiveness. Receiving verbal feedback increased Henrietta's self-efficacy and reassured her that the preceptees were "receiving what they needed to learn. It validated what I was doing was correct. It took me a few years to know I was getting good at being a preceptor, and the feedback helped me".

Besides helping preceptors to know how they were performing, preceptors felt rewarded when they received positive verbal comments from preceptees. Jane said:

> They thought I did a good job, and that's rewarding for me. It feels like the next time it is easier, it comes easier, so I don't mind it. So, it makes me feel good about that so I enjoy doing it.

Carol described a time when she had oriented a number of nurses, and "afterwards that group gave me a lot of feedback as far as, 'It was great working with you'."

Sometimes the verbal comments that preceptors heard were at a later date or received secondhand through other staff and three proficient preceptors described this experience. Ingrid said, "I do remember other staff saying, 'You're a good preceptor', and she heard staff saying to

the preceptees, “Ask for Ingrid, she’s a good preceptor, you’ll learn a lot”. In addition, preceptees stopped her to ask, “Can I go with you tomorrow…because you can show me more?” Carol worked with some of her former preceptees, and years later a person said to her, “Carol, I remember the day that…” and she recounted what Carol had taught her years earlier. Eduardo overheard remarks coming from former orientees to his co-staff and preceptees such as, “He is a good one”, which served to elevate his self-efficacy as a preceptor.

Positive verbal feedback provided preceptors with information from which they were able gauge their self-efficacy in their role. Verbal feedback from preceptees was viewed as particularly meaningful, and they also heard comments from co-workers and former preceptees. The preceptors reported that positive comments served to increase their self-efficacy perceptions and to persevere in the role.

Finding 3.5 Eight out of ten proficient nurse preceptors reported the development of their self-efficacy related to verbal persuasion was advanced by an ability to *establish a learning environment that provided for open exchange.*

Proficient preceptors reported that being able to provide a learning environment that allowed for open exchange of ideas was a necessary ingredient in the development of self-efficacy in the role. To make this happen, preceptors listed qualities such as openness, approachability, reassurance, supportive and calmness when communicating with preceptees. Proficient preceptors endeavored to promote a positive learning environment that was non-punitive, caring, and engaged the trust of preceptees, to allow the advancement of meaningful learning.

To set the stage for learning, proficient preceptors wanted to be perceived as accessible and open in their communications. Donna stated that preceptors “need to be approachable, so if

the preceptees are having an issue, they feel comfortable going to you" and would say, "I need help with this" or "How do I deal with this?" Georgia and Carol learned from the example of their own preceptors in regards to openness and caring. Georgia gave the following description of her preceptor: "She was, first off, very approachable, and that was huge. If I felt, and your orientee feels, that they can come to you with anything [*sic*]", and "She always had a great sense of humor. I would come to her scared to death, and she would make me laugh". Carol remembered her preceptor as being "open and accepting…it was a good experience". To develop a rapport with her preceptees, Billie shared stories that "created freedom of expression, where they can come to you and have conversations and not feel bad about asking questions of you".

Another characteristic of effective precepting was the support and reassurance communicated to preceptees. When Georgia doubted her own abilities as new nurse, her preceptor would say, "Okay you can do this, you're going to do this, and I'll be here". Georgia would say, "Are you sure?", and her preceptor would reassure her, "Yes, you'll be fine". Donna and Carol both had preceptors who emanated calmness. Donna stated that because "she was calm, it made me calm even when I was nervous doing something for the first time", and Carol said, "My first preceptor was calm and supportive".

One of the key elements of an efficacy-enabling learning environment was the establishment of a non-punitive approach to learning. Adele used the words, "safe culture" to describe her work environment. When Billie had a preceptee who was struggling, she chose language that avoided blame. She would say to her preceptee, "Clean slate, we're good. I am not going to hold this against you". Billie explained, "That's important, to keep that negative energy out. You've got to let go". Another preceptor, Henrietta, had a similar experience, and

she commented, “You want to be on the same side. It’s a learning experience. Stay focused on the goal of orienting the preceptor or orientee”.

Trust was a key component of a learning environment that Eduardo felt contributed to preceptor and preceptee self-efficacy. “They are opening up because they trust you”. He continued, “I try to be honest with them. I think it’s about trust; it all begins with trust. If they trust you, they will listen to you and it comes with attitude as well”. He explained that trust was a mutual thing, “I keep telling them to be patient with me as well.” Henrietta believed that, “You have to be vulnerable as a preceptor” to engage the trust of the learner.

An aspect of verbal persuasion relevant to establishing a supportive learning environment was the communication of caring about the learner. Eduardo tried to do this by adopting a brotherly or fatherly attitude towards his preceptees, “You have to talk to them like your little brother or sister or you kid”. The effectiveness of his approach was borne out when a former preceptee, who was then working on another unit, stopped by to share news with Eduardo of her success in assuming the charge nurse role. Georgia recalled her preceptors as being “very warm” and described the interest they took in her wellbeing as creating a “bond”. She said, “It was a more personal experience for me”. Jane recounted:

> Sometimes people go home at the end of the day in tears because they had a bad day. I don’t want them to have that bad day with me, and I want to do what I can to stop it.

To feel effective as a preceptor, she said, “I like people to feel good about what they are doing”.

Proficient preceptors reported a need to establish a learning environment that supported open exchange of ideas with preceptees, and this element was an essential component of preceptor self-efficacy. Proficient preceptors fostered this culture by being open, approachable, reassuring, supportive and calm in their communications with preceptees. Establishment of a

non-punitive and caring relationship that invoked trust was identified as necessary for meaningful learning to occur.

Finding 3.6 Five out of ten proficient nurse preceptors reported the development of their self-efficacy related to verbal persuasion was advanced by an ability to *frame feedback to be positive.*

Proficient preceptors reported that learning to frame feedback to preceptees in a way that was positive was a necessary skill that contributed to self-efficacy as a preceptor. They identified that being able to communicate in a way that could be perceived as non-threatening would promote learning. Proficient preceptors maintained that an emphasis on the positive helped preceptees to persevere.

When communicating with preceptees, three proficient preceptors spoke of a need to accentuate the positive. Carol said, "Preceptees want to hear positive feedback first". Eduardo felt that his preceptees performed better when he emphasized what they had done right. He said, "People actually perform better if they hear positive feedback". Along this theme, Donna remarked, "I think it's all in the approach." She continued, "If you remain positive, it's definitely better."

Frances employed a similar approach, and would say to her preceptee, "Oh, you did that really well, instead of 'you should have done that differently". Donna said, "If someone is just immediately confronted with negative things, then there is no motivation. They just get angry". Frances indicated that when she needed to communicate corrective feedback, she would say, "You did a good job, and this is a way to not feel like you are overwhelmed". She said she tried to "make them feel a little bit good [*sic*] about themselves." Adele would frame communication about a misstep in a positive manner. She said that if a mistake were made, "It should not be

something to be punitive about." She would advise the preceptee, "Take it as a learning experience", and encourage the preceptee to grow from the occurrence.

The ability to frame feedback in a way that was positive was reported by proficient preceptors to be a necessary skill to attain high self-efficacy in the preceptor role. They believed that the learner would perceive a negative emphasis in communication as de-motivating, whereas feedback communicated in a positive manner was viewed as helpful and encouraging.

Finding 3.7 Six out of ten proficient nurse preceptors reported the development of their self-efficacy related to verbal persuasion was advanced by an ability to *mentor others.*

Proficient preceptors reported that identification of a mentor for themselves, as well as being able to mentor others, had helped to develop preceptor self-efficacy. A mentor was described as an informal, ongoing resource beyond the designated orientation period for a preceptee and also for a new preceptor. Proficient preceptors had informally established a mentoring relationship with their protégés by maintaining communication with them beyond the orientation period.

Proficient preceptors described mentoring as an informal relationship that extended beyond the orientation period that advanced the self-efficacy of the protégé, as well as their preceptor. Three proficient preceptors described having a mentor when they were new to their roles. Jane stated, "I had kind of a mentor" that helped her to grow as a nurse and preceptor. She said, "We developed a relationship, and she took me under her wing". She explained, "You tend to follow a mentor that you respect or if you like their style". Eduardo described two mentors who had impacted his development. One was a seasoned nurse on his work unit, of whom he said, "My mentor, she was there [as a nurse on that unit] for 20 years." He also recalled another mentor who had been instrumental in encouraging his growth. Eduardo said,

"You could see the dedication in him. He treated me like his own kid, like this father figure, big brother figure, at the same time". Frances recollected of three nurses who had encouraged her development: "Always go to Barbara. She was your mentor. If she wasn't there, it was call Bob or Susan. It was those three people".

Similar to the manner in which they had been mentored, proficient preceptors also served as a mentor for their preceptees or newer preceptors. Adele stated, "I am willing to foster whatever or whoever needs that mentoring". She maintained, "The preceptorship is over, but mentorship will always be there…I see myself as a mentor". Eduardo described how former preceptees now looked up to him as a mentor, "They acknowledge your presence, not simply being a worker, but their mentor, someone they can look upon if there's any problem". He continued, "I treat them like my kids sometimes". Georgia remarked that preceptees still come to her with problems and questions, long after the orientation period had ended. She stated, "There is still mentoring, even a year later".

To continue encouraging her preceptees after the orientation had concluded, Jane reported that she would check in on them. When she did see them, she made a point to inquire about their progress. She said, "I try to check in, 'How was your night, how are you doing?'" Jane had continued as a helpful mentor for one particular nurse. She reported, "She'll seek me out, so I try to be a resource for her".

One recommendation of proficient preceptors towards enhancing the self-efficacy of newer preceptors was to mentor newer preceptors. Carol advised that sharing of "our own experiences as a preceptor with the novice preceptor" would be beneficial, and might be accomplished during a venue such as the monthly Preceptor Forum.

Identifying a mentor for preceptors who was able to encourage their growth was felt by proficient preceptors to be an important source of self-efficacy enhancement. Proficient preceptors recounted the impact of a mentor on their own professional nursing practice, and in turn, they have continued this tradition of informally mentoring others after the orientation has concluded. Mentoring was suggested as beneficial for developing novice preceptor self-efficacy.

Research Question 4.0 What do proficient nurse preceptors recommend regarding best practices for ongoing preceptor professional development?

Finding 4.1 Seven out of ten proficient nurse preceptors recommended that a best practice for ongoing preceptor professional development included *effective communication between preceptors regarding preceptee progress*.

Proficient preceptors recommended that ongoing preceptor professional development included communication between preceptors relevant to preceptee progress. Preceptors felt this was particularly important in that preceptees were often assigned to more than one preceptor, might transition from day to an off-shift, and as in the case of float staff, needed to orient to multiple units. Since preceptors may work part time, weekends and off-shifts, strategies to facilitate communication and sharing among the preceptors were felt to be valuable.

Both preceptor focus group members identified communication between preceptors as a necessary component of effective precepting. One of the proficient preceptors, Ingrid, remarked that if there were multiple preceptors, she would "ask the preceptee where they are at, rather than start from scratch". However, Frances noted, "The preceptee's interpretation of where they're at is probably very different than the preceptor's interpretation of where they are at [*sic*]", and the focus group members affirmed, "All the time", to this statement. To alleviate this type of preceptor/preceptee discrepancy, Billie stated, "Three of us on our unit will sometimes sit down

to talk about a new person….how things are going, what we have to work on". Billie felt it was beneficial "to have all the preceptors talk and that helps the preceptors air out any concerns". Along this line Eduardo explained:

> There may be something that might be helpful to talk with another preceptor about the person that you are orienting. If I am the preceptor, and I'm sharing this orientee with another preceptor, we could sit down and share our experiences with the new orientee.

In the other proficient preceptor focus group, Henrietta also mentioned communication between co-preceptors as an important topic for preceptor professional development. She explained that she would share with the co-preceptor "the plan for the next day, what you are going to do…especially if there's a different preceptor, like if you are going to be off".

Frances identified challenges that should be addressed, especially how to communicate with a co-preceptor that may work a different schedule. She explained:

> Sometimes you may not see the other preceptor. If you're here 32 hours a week, that means you have two days off during the week, and if the orientee is here 40 hours, two of those days they're going to be with somebody else. You may never see that person…to give feedback about the orientee.

Frances reported that there had been recent discussions during the Preceptor Forum about ways to communicate preceptee progress, such as "where to put the orientation checklist on the unit, so you could just go into the folder" and see what the orientee had accomplished.

Another challenge to preceptor communication, identified by Donna, was the transition of the orientee from the day to evening or night shift. When this occurred, she also said, "Preceptors may not have had the opportunity to talk to that other preceptor about where the

person is in their orientation." Donna suggested, "A brief verbal report or exchange would be helpful. Especially about someone you are co-precepting, I feel it would be really helpful".

Two proficient preceptors suggested a mechanism to enhance communication among preceptees of float staff. This involved use of a form by preceptors, that Billie and Frances called the "Ticket to Ride", and that provided documentation that the preceptee was ready to progress to the next orientation unit. Using this form, preceptors were supposed to list competencies achieved by the preceptee. This form was to be carried by the preceptee to the next unit and enabled preceptors to focus on areas requiring attention. Billie said, "It's important if someone's going from one unit to another". Adele supported this statement, saying, "It's a good thing, that "Ticket to Ride".

Proficient preceptors recommended that a best practice for ongoing preceptor professional development would address communication between preceptors relevant to preceptee progress. They maintained that since preceptees were often oriented by more than one preceptor and on more than one shift and unit, sharing about mechanisms to enhance communication among preceptors was important.

Finding 4.2 Three out of ten proficient nurse preceptors recommended that a best practice for ongoing preceptor professional development included *opportunities for exchanges among preceptors*.

Proficient preceptors identified that being able to discuss matters relevant to precepting with other preceptors was essential to development in their role. They related that they enjoyed learning from each other in a group setting, receiving a preceptor newsletter, and networking with other preceptors to keep up-to-date on changes within the institution. They maintained that these exchanges served to increase their sense of self-efficacy as a preceptor.

Three out of ten proficient preceptors identified that they felt having opportunities for preceptor exchanges was a best practice for preceptor development. Billie remarked, "We've all precepted, and just a little discussion about how things are going and what we have to work on" would be important. Carol described the Preceptor Forum and newsletter as specific examples of preceptor exchanges for best practice. She said that "the Preceptor Forum, the preceptor group, and the little thing [newsletter] that comes out afterwards [*sic*]" were helpful.

A concern expressed by proficient preceptors within the focus group was the feeling that they were not, at times, as current in their knowledge about changes in policies that were occurring within the institution as their preceptees. Carol stated:

> Sometimes new things come out and the preceptor is the last one to know. The orientee comes in from orientation classes and tell us, 'Well, I learned in I.V. Class that there was a new policy', and [the preceptor's] like [*sic*], 'Really? Nobody told me!'"

Frances added to Carol's comment, saying that her orientee might think, "Look at my dumbbell [*sic*] preceptor". Carol felt that Preceptor Forum could be a place for the "discussion of new things that have come out or are coming out so that we're not the last to know".

Proficient preceptors indicated that having opportunities for exchanges of information relevant to precepting was a best practice for ongoing professional development. Preceptors reported that the Preceptor Forum and newsletter were forms of exchange that were valuable, and sharing of information helped them to stay abreast of changes and maintain preceptor self-efficacy.

Finding 4.3 Four out of ten proficient nurse preceptors recommended that a best practice for ongoing preceptor professional development included *engaging peer support for the preceptor role*.

Proficient preceptors reported that a best practice for ongoing preceptor development was to engage the interdisciplinary team and coworkers in supporting their role. This theme was addressed by proficient preceptors in both focus groups as an aspect necessary for success.

Billie and Frances used the colloquial expression, "It takes a village" when describing the support required by preceptors to carry out the responsibilities of their job. Frances said, "It does take a village to develop a nurse that you [would] want to work with", and her focus group members agreed. Henrietta and Donna also identified "peer support" as a best practice for preceptor and preceptee development. Henrietta said, "Peer support, it's not just a vacuum out there. Your whole experience, the preceptee's experience, is the whole unit itself, the interaction with the physicians, the therapies, the talking together with colleagues". Donna added, "Especially the physicians." She indicated that helping preceptees to work together with these other team members was necessary.

Proficient preceptors reported that a best practice for ongoing preceptor development included the engagement of support from peers and the interdisciplinary team. They maintained that the preceptor needed the support of the group to be efficacious in the role.

Finding 4.4 Seven out of ten proficient nurse preceptors recommended a best practice for ongoing preceptor professional development include *mentoring of new preceptors*.

Proficient preceptors indicated a best practice for ongoing professional development of preceptors involved mentoring by a seasoned preceptor, who would provide role modeling and anticipatory guidance to the new preceptors. They maintained that mentoring was enhanced through the sharing of scenarios to encourage reflection about typical preceptor-preceptee situations. Such scenarios would enable assessment of learning and provide opportunity for the provision of corrective feedback.

Donna and Henrietta felt that designating a "role model or resource" for a novice preceptor to "emulate" was a best practice for preceptor ongoing development. Billie stated, "I think that's a good idea, that if the other preceptor on the floor is a newer preceptor and they talked to an older preceptor…talk back and forth". Frances identified what she viewed as a learning deficit of newer preceptors, "how to organize, teach them to precept as well as the orientee." She quoted a fellow preceptor, Eduardo, who earlier had described advising new preceptors: "By this time of day, we usually try to have this done." Ingrid also recommended using the older preceptors "as a resource" to the new preceptors.

Proficient preceptors advised mentors to share typical precepting scenarios as an effective way to serve as a resource and enhance learning. Henrietta stated, "Give them a situation and say, how do you [handle it]", rather than having them learn independently through trial and error. Donna recommended the use of "role playing of the more sticky things that come up". She suggested, "Present a situation, and ask the new preceptors how they would handle it. Ask and provide feedback about the best way to handle the situation". Ingrid and Carol proposed using the monthly Preceptor Forum as a place where proficient preceptors could share knowledge using scenarios.

Proficient preceptors felt that having a seasoned preceptor serve as a mentor and role model was a best practice for ongoing preceptor development. They reported that a competent preceptor could be a resource and guide to the newer preceptor. They recommended sharing of typical precepting scenarios as an effective means to encourage reflection, permit assessment of learning and provide opportunity for corrective feedback.

Finding 4.5 Two out of ten proficient nurse preceptors recommended that a best practice for ongoing preceptor professional development included *access to learning resources about precepting.*

Proficient preceptors reported a best practice for ongoing preceptor development involved access to learning resources to improve in the role. They specifically mentioned access to media and computer resources.

During the focus group, Frances described a media learning activity that she had engaged in during a Preceptor Forum. This involved viewing "videos" about precepting, followed by discussion. The videos had depicted "the not-so-good way to teach someone and the better way to teach someone." Frances explained one of the scenarios to the group, "The preceptor was fixated on something else, and the poor orientee was like [*sic*], and then they showed the better way to do it".

One issue that was raised by Carol regarding off-unit educational activities was that many preceptors would be unable to attend. She stated, "If you have a video and it's down here, we can't [get of the unit to] do that, but if it's short", then she could view it on her unit. She stated, "If they could be put on the Intranet, that would help", so the education could be accessible to all preceptors on the hospital's computers.

Proficient preceptors recommended a best practice of having readily available resources to continue learning about preceptor responsibilities. Since preceptors may not be able to leave patient care responsibilities to attend off-unit offerings, a suggested solution included having media resources accessible via the hospital's Intranet.

Finding 4.6 Seven out of ten proficient nurse preceptors recommended that best practice for ongoing preceptor professional development involved *inculcating professional preceptor attributes*.

Proficient preceptors identified professional inculcation into the preceptor role as essential for preceptors who would be shaping the behaviors of their preceptees. They asserted that that new preceptors must demonstrate professional comportment that included willing acceptance of the added responsibilities inherent in the role and modeling compassion for patients as befitted a nursing professional. A best practice for ongoing preceptor development was instillation of these values as part of the precepting culture.

Cultivation of an attitude of willingness to perform the responsibilities inherent in the preceptor role was described as a best practice by four proficient preceptors. Georgia and Ingrid indicated that preceptors had to want to precept. Ingrid maintained, "You've got to be in it for the right reasons". When accepting the commitment to preceptee a new employee, Carol said that it was not just "being assigned for the day". Frances explained, "You've got to have a mindset" when precepting a new employee. "You have got to get up in the morning and know that you are doing that." Because of his preceptor designation, Eduardo viewed himself as an available resource to any new employee, whether or not he was the assigned preceptor for the day. He stated, "We always present ourselves as available, it doesn't mean that because I am not your preceptor you cannot ask me".

Besides cultivating an attitude of willingness, both Ingrid and Jane maintained that precepting also required additional efforts above the usual nursing duties. Ingrid stated that a preceptor had to "be willing to put in that extra time with the preceptee". Conversely, Frances observed that when preceptors did not demonstrate willingness or effort, it impacted "what the

new person sees", forming an unfavorable impression. She said, "The poor person is standing there probably thinking, 'Oh great' [*sic*]."

In addition to modeling a positive attitude towards their job responsibilities, proficient preceptors reported that professional knowledge, skills and compassion were essential role attributes. Eduardo summed this up by saying;

> You should be able to balance these three criteria: knowledge, skills and attitude. What good is it if you have a good attitude and you don't have any knowledge or skills? And you might have the best knowledge in the whole world, but you lack attitude or skills. So I think it is balancing those three criteria.

Frances said:

> I think sometimes we forget here, we teach them medications and how to do treatments, but sometimes I think we lose sight that there's actually a person we are treating. To recognize that the person in the bed is a person who has a family.

She explained that a preceptor must help the preceptee "to look at the person". Georgia concurred, and Ingrid stated that the preceptor must also "teach compassion" to their preceptee.

Because preceptors shape the behavior of new hires, proficient preceptors reported that professional inculcation to the preceptor role was a best practice for preceptor development. They maintained that preceptors must demonstrate an attitude of willingness to serve in this capacity and to assume the added responsibilities of the role. Preceptors also needed to model competence and to cultivate compassion in preceptees. They recommended that ongoing preceptor professional development would instill these values within the precepting culture of its members.

Finding 4.7 Six out of ten proficient nurse preceptors and both focus groups recommended that best practice for ongoing preceptor professional development included *establishment of a learning environment that encouraged open exchanges between preceptor and preceptee.*

Proficient preceptors reported that a best practice for preceptor development included establishing a learning environment where the preceptor was seen as open, approachable, and respectful of the learner. Preceptors maintained that learners should feel comfortable to ask questions. Use of humor to lighten stressful learning situations was mentioned as a valuable tool of the preceptor.

Three proficient preceptors mentioned that a best practice for ongoing preceptor development required the preceptor to establish an environment conducive to learning. Adele stated that "openness" was important in precepting. Donna and Henrietta said they felt the preceptor needed to "be approachable" to the preceptee. Focus group members identified that part of creating an open and approachable learning environment was giving the preceptee permission to ask questions. Jane said she would tell her preceptees, "Don't hesitate to ask questions; no question is a stupid question", to encourage the preceptee to seek help.

Because preceptees may be anxious while orienting to a new position, two proficient preceptors, Henrietta and Georgia, described humor as an important tool of the preceptor. Henrietta said, "Humor is a good thing. You want to keep things light. You don't want to seem so serious." Georgia recalled that in learning a new job, humor had been helpful in promoting her learning; "A sense of humor, I think it is huge." Georgia recounted her preceptor's use of a humorous code phrase during her orientation experience, "Boots and pants". She said, "The humor stuck, and it made my experience" by facilitating relaxation and helping her to focus on the learning.

Another aspect of a learning environment that would foster open exchanges was demonstration of respect for the learner and two proficient preceptors identified this practice as important to encouraging openness. Henrietta observed, "You can learn from the orientee. They can teach you something. Not necessarily the task, but how to deal with the situation that might be different from what you expect." Because preceptors often did things repeatedly or had not been exposed to other ways of doing things, an outside person could bring new ideas to the workplace. Henrietta remarked, "Sometimes you get so stuck on things, your mindset is stuck in one way, and they can give you new ideas…Sometimes you do have tunnel vision". Donna agreed, saying, "If you do the same thing, the same way, over and over, and then there's someone new to enlighten you". Both recalled a former preceptee, who had worked on their unit while going to medical school. Henrietta explained that when changing an infant's tracheostomy ties, "the normal way to do them was to reach over. She actually placed her sideways in the bed and sat there and did the trach [*sic*] ties from the side. What an idea, because you were actually observing the trach [*sic*]." Donna reflected that this technique was probably something the preceptee had learned in medical school, and Henrietta continued, "I had not done it that way, but that's a good idea, a different point of view, a different reference". Although both Donna and Henrietta were experts in caring for their patient population, their openness and respect for the learner allowed them to discover a new approach from the preceptee.

Establishing a learning environment that allowed for open exchanges between preceptor and preceptee was identified as a best practice for ongoing preceptor professional development. Towards this aim, preceptors must be perceived as open, approachable and respectful of the learner. Encouraging questions and using humor were identified as helpful to the learning process and to establish open preceptor and preceptee exchanges.

Finding 4.8 Five out of ten proficient nurse preceptors and focus groups recommended that best practice for ongoing preceptor professional development included *using knowledge of the learner to promote learning.*

Proficient preceptors indicated that knowledge of the learner was a best practice that enabled them to be more effective with preceptees. This included discerning what life and work experiences the preceptee brought to the learning environment for the purpose of tailoring the learning to his or her needs. In addition, knowledge of the person's learning style preferences was recognized as helpful in planning the learning and allowed the preceptor to adjust his or her own style to the learner's.

Proficient preceptors reported that getting to know their preceptee was a best practice, vested in individualized preceptee development, and that this should be included in ongoing preceptor development. Georgia believed that "knowing where the person is from and knowing what their baseline is" was important in planning their learning. Henrietta agreed, saying that "learning about the orientee" was important.

Three proficient preceptors also recommended matching relevant learning strategies to preceptee preferences for instruction. Donna expressed the belief that "learning styles are [*sic*] important to know," but that "application of them in real life as a nursing preceptor" was what was necessary. Georgia suggested that "personality matching" might be tried. She said:

> Have them write down what they feel like they need from you, how to best mesh all of that. Find out, 'How do you learn best? Verbal? Demonstration? Read the policy? Do hands-on first?' We've all had a variety of people and all learn differently.

Preceptors felt that knowledge of their preceptees' learning styles would provide beneficial information that could aid in their instruction.

A best practice recommended by proficient preceptors for ongoing preceptor development included getting to know their preceptees in a myriad of ways. Having knowledge of the life and past work experiences of preceptees, as well as their preferred learning styles and preferences, could contribute to enhanced preceptor self-efficacy and instruction.

Finding 4.9 Three out of ten proficient nurse preceptors recommended that best practice for ongoing preceptor professional development included *socializing the preceptee into the culture of the work unit.*

Proficient preceptors reported that a best practice for ongoing preceptor development included the socialization of the new person as a full member of the team. Aspects of socialization included welcoming, acknowledging, and introducing the new person to the team. Billie recounted her own experience of being new and the awkwardness of being unfamiliar: "It happened to me, the time I went to one of the respiratory units, just standing there for about ten minutes. I was like, 'Hello, there's a person here'." Frances related an incident where a preceptee was not being welcomed on the unit, and noticing the person's discomfort, she intervened. She explained:

> Sometimes they are just standing there waiting to be acknowledged, and everyone's just doing their thing, and that person's just standing there. I remember when Sarah [a preceptee] came over to our unit, she was just standing there, and I said, "Can I help you?"

To alleviate first day discomfort, Carol suggested a best practice for preceptors: "I know they have brought the orientees up [to the patient care unit]. She continued, "Have the preceptees come up to the unit to meet" their preceptors during this time. She believed this might help preceptees to feel less anxious about their first days on the unit.

To decrease the stress associated with meeting co-workers and a new job, proficient preceptors identified a best practice for preceptor development was socializing the preceptee within the team. Providing an opportunity for the preceptee to meet their preceptors during the general hospital orientation days and acknowledging the person when they arrive on the unit were suggested as ways to welcome the new employee.

Finding 4.10 Three out of ten proficient nurse preceptors recommended that best practice for ongoing preceptor professional development included *utilizing effective structures to guide their precepting.*

Proficient preceptors reported that utilizing effective structures as a guide to precepting was a best practice for ongoing preceptor development. Preceptors indicated that competency lists with targets for completion provided them with benchmarks from which preceptee progress might be judged. However, preceptors wanted a structure that was flexible enough to permit individualization of the learning within the allotted time constraints. To facilitate preceptee success within this established framework, preceptors maintained they had to be organized in their approach to the learning.

Henrietta identified a need for "a general framework to start" when precepting. Donna appreciated structure that provided benchmarks, such as, "By the end of this week, your orientee should be at this point. You know they should be able to manage two patients". Frances mentioned the use of an orientation checklist, or "Professional Education Plan". She said their current tool required revision to reflect current practice and suggested enlisting her preceptor colleagues to update it, saying, "We need everyone's input. The old tool had things we don't do anymore".

Although a standard checklist was viewed as necessary, preceptors also wanted the ability to modify as necessary based on preceptee needs. Donna said, "I think it should be individualized for each person, because you need flexibility and everyone does not learn in the same way or at the same pace. Donna wanted to "tailor" learning for the learner. Ingrid mentioned "individualizing" the learning for the preceptee.

While the proficient preceptor members of the focus group agreed that they liked being able to individualize learning, Frances also stated that organization in their approach was needed to enable accomplishment of the requisite competencies. While precepting, Frances stated:

> You have to be organized, even if none of our days here is ever the same…You teach them that each day isn't a carbon copy of the last day. But they have a general routine, and as long as they stick to the general routine, they can roll with the punches.

Frances maintained it was important to "organize, to teach them to precept, as well as the orientee".

Proficient preceptors reported that a best practice for ongoing preceptor professional development included using effective structures to guide their precepting. An example of an effective structure included competency lists with timeframes for achievement of competencies. Preceptors valued structures that were flexible enough to allow for individualization, but at the same time, enabled them to be organized in their approach.

Finding 4.11 Four out of ten proficient nurse preceptors recommended that best practice for ongoing preceptor professional development included *planning the learning.*

Planning the learning was identified by proficient preceptors as a best practice for ongoing preceptor development. Planning was viewed as beneficial to preceptor and preceptee, facilitating effective management of both nursing and precepting responsibilities. Preceptors

believed that planning focused the instruction on specific preceptee goals and learning needs, and alleviated anxiety by providing some predictability within the learning environment.

Proficient preceptors wanted advance warning that they would be orienting a new person so that they would be able to plan out their day. Donna stated, "It is helpful to know in advance. You can think about it and form a plan". She continued, "So you can think, this is what's going on, on the unit right now." Donna explained that when she knew in advance that she had been assigned to precept on a given day, she would "think about what would be a good thing to start with today, what assignments, what patients would be good for today", based on the needs of the preceptee.

Henrietta expressed similar preferences about advance notice of precepting assignments. She said:

> You have to build that into your evening or day, whatever you are working. Because you plan your day according to what you are given, and if you walk in and you've got a student and an orientee, and codes [medical emergencies],

she would describe such a day, as stressful. Donna concurred, saying, "It's mentally exhausting sometimes, by the end of the day. It is nice to know going into it, that this is what's in store for me today". To facilitate advance communication about preceptor assignments, Henrietta suggested, "An e-mail or something, just to give a 'heads up' so we are prepared. Sometimes the paper [preceptee schedule] is in my mailbox, but sometimes it's not".

Planning was also helpful for co-preceptors, who often worked opposite schedules from the primary preceptor, and had little chance for face-to-face communication with their counterparts about the preceptee goals and plan for meeting these. Henrietta said that she would "give the plan for the next day, what you are going to do, especially if there's a different

preceptor, like if you are going to be off". She also recommended writing it down and "making lists, as you can't remember everything".

Besides providing direction and predictability for preceptors, planning to establish goals was considered helpful to alleviate preceptee anxiety. Ingrid stated, "It's nice to give them a plan, so they will know what [to expect] for the next day; they will feel more relaxed". Frances said she would ask her preceptee, "What would you like to do tomorrow?" Then, she would "develop goals each day, small goals and build each day". She explained, "Sometimes it's better for them to know the night before that you're taking these six, and add this on", to reduce the preceptee's angst about the unknown. Donna also identified "setting goals" as important to the planning process, and added that a review of "how to set goals" when planning might benefit newer preceptors.

Proficient preceptors identified planning the learning as a best practice for preceptor ongoing professional development. They reported planning was beneficial to both preceptor and preceptee, as it provided goals and direction for the learning activities, increased perceptions of control over the learning environment, and decreased preceptee anxiety. Because co-preceptors often worked opposite schedules, having a plan was important to ensure continuity of the learning experience.

Finding 4.12 Three out of ten proficient nurse preceptors recommended that best practice for ongoing preceptor professional development included *provision of effective feedback to preceptees.*

Proficient preceptors reported that being able to provide effective feedback to preceptees about their performance was a necessary skill, and should be a considered best practice for ongoing preceptor professional development. Effective feedback was described as ongoing,

encouraging, and might be corrective. However, preceptors expressed discomfort with giving negative feedback, and a need for support and education relevant to constructive feedback was identified.

Supplying feedback to preceptees on an ongoing basis was reported as a necessary component of the preceptor role. Frances found it helpful to dialogue and reflect with her preceptee at the end of each day. Frances suggested:

> At the end of the day, you could ask, "How did you think today went?" If they didn't like things, [ask] "How do you think we could have done it better?" or "Do you think maybe I could have taught you differently?"

Frances also tried to provide positive feedback: "You're like [*sic*], 'you can do it'…Giving them that little boost of confidence". She also recommended reviewing the preceptee activities of the day, "Going over, what did we do, did we sign off the flow sheets, did we do our charting?" Ingrid would end the clinical day by clarifying expectations of the preceptee for the next day. She said, "It's nice to give them a plan, know what [*sic*] for the next day, they will feel more relaxed".

Although preceptees generally responded well to positive feedback, proficient preceptors often found negative or constructive feedback to be difficult. Two proficient preceptors recommended education and support to help preceptors effectively communicate with a struggling preceptee. Georgia feared that constructive feedback given by preceptors could easily be "misconstrued", to which, Billie commented, "Perception is 99% of the truth". Billie suggested:

> I think another developmental tool is how to have hard conversations. I think many preceptors struggle with that because you don't want to have those conversations, but

they need to happen. And I think there needs to be a lot of support with that. Some people don't know how to have a hard conversation. They simply don't have the tools, either they feel bad or come off too harsh.

To enact the preceptor role efficaciously, proficient preceptors reported that provision of effective feedback was a vital function and should be considered a best practice for ongoing preceptor professional development. They described feedback as ongoing, positive, corrective and constructive. Because provision of corrective feedback was perceived by many preceptors as especially difficult, proficient preceptors identified the need for education and support in sharing constructive feedback.

Finding 4.13 One out of ten proficient nurse preceptors recommended that a best practice for ongoing preceptor professional development would include *mechanisms for obtaining feedback from preceptees.*

One proficient preceptor recommended evaluation feedback relevant to preceptor performance as a necessary component of ongoing preceptor professional development and a best practice. Feedback could be obtained from various sources, and since preceptee evaluations were collected at the end of the orientation period, Ingrid suggested, "Go through their [preceptees] evaluations. Make sure the feedback [gets to the preceptor] if you see trends". This feedback would assist the preceptor in identifying opportunities for growth and development of self-efficacy in the role.

Summary of Key Findings

This study investigated proficient preceptors reports of the development of preceptor self-efficacy based on aspects of the conceptual framework of Bandura (1997). Individual interviews and focus groups of proficient nurse preceptors within one hospital setting were conducted.

From the reports of participants within this action research group, best practices were compiled to recommend ongoing professional development for nurse preceptors within their hospital setting. Study findings were reported according to the three research questions based on Bandura's (1997) sources of self-efficacy theory, and a fourth research question asked for recommendations of best practices for ongoing preceptor development.

Sixteen findings were elicited from the study participants pertinent to the first research question: "What do proficient preceptors report about the development of their self-efficacy related to enactive mastery experiences?" All ten of the proficient preceptors reported that being able to model the clinical competencies of the job was an essential requirement for preceptor self-efficacy attainment. Eight out of ten study participants identified themselves as role models that others would be emulating, hence their need to skillfully represent excellence in nursing practice. Because of their special designation as a role model to other staff, all ten proficient preceptors reported a desire to continue learning on an ongoing basis to keep pace with the rapid changes occurring in the workplace related to technological and clinical advancements in care. In addition, precepting was noted to present extra responsibilities layered on their usual nursing duties, and four out of ten proficient preceptors thought that being able to manage the stressors of the job while precepting contributed to their self-efficacy.

Proficient preceptors reported that effective use of instruction to promote enactive mastery experiences was important to the development of preceptor self-efficacy. Eight out of ten proficient preceptors recognized the necessity of being able to assess the learning styles of preceptees. In order to promote preceptee success in achieving desired competencies, nine out of ten proficient preceptors articulated a need to be able to break complex skills into manageable sub-skills. Since new nurses practice in a high stakes environment where preceptee decisions

may impact patient outcomes, nine out of ten proficient preceptors reported that being able to develop critical thinking skills in their protégés was indicative of their preceptor self-efficacy.

Other instructional strategies that were named by proficient preceptors included return demonstration, engaging in guided practice, use of repetition, situated learning and varied teaching strategies. Five out of ten proficient preceptors listed use of return demonstration as a mechanism for learning. Six out of ten reported engaging in guided practice, which involved rehearsing a complex skill with the preceptee prior to performing on a live patient, and coaching through the steps associated with performing the skill on the patient. Four out of ten reported that they would have the preceptee repeat a skill more than once to embed the learning. Six out of ten reported varied teaching techniques as a vehicle to learning, and six out of ten also would use situational learning. Situated learning involved using patient events or crisis occurrences as opportunities for teaching and learning.

A final component of instruction cited by proficient preceptors was the ability to evaluate preceptee achievement of goals. Eight out of ten proficient preceptors suggested that this aspect of instruction was necessary for the development of preceptor self-efficacy related to enactive mastery experiences.

Sixteen findings were elicited from study participants relevant to research question number two, "What do proficient preceptors report about the development of preceptor self-efficacy related to vicarious experiences?" Nine out of ten proficient preceptors felt that it was important to be able to share with other preceptors as a mechanism to develop self-efficacy in the role. They provided examples of sharing in a formal venue, such as their monthly Preceptor Forum, and informally on their work units with other preceptors that they could learn from and use as a sounding board. Four out of ten proficient preceptors reported that being able to share

precepting responsibilities with another preceptor who complimented their strengths and weaknesses was beneficial towards enhancing preceptor self-efficacy.

Seven out of ten preceptors reported vicarious learning through the observation of competent preceptor models; three out of ten preceptors learned vicariously from observing leadership models; and two out of ten reported vicarious learning through family or people outside of the precepting environment. Conversely, five out of ten proficient preceptors gleaned from observations of modeling failures what they would not do as preceptors. Recalling behaviors of effective models was viewed as significant, by six out of ten proficient preceptors, in enabling efficacious preceptor behaviors.

Proficient preceptors reported increased perceptions of their self-efficacy when they were able to further vicarious learning for preceptees. Six out of ten proficient preceptors asserted that knowing their preceptees was essential to planning salient learning experiences. Four out of ten proficient preceptors indicated that successful social integration of the preceptee into the team and unit culture was an important competency of the preceptor role. Five out of ten proficient preceptors stated that demonstration of respect for their adult learners, who each contributed skills upon which to build, was essential. Besides demonstrating respect, three out of ten preceptors felt good listening skills, to hear what the preceptee was communicating, were requisite. Six out of ten proficient preceptors reported that working side by side with preceptees at the bedside allowed them to share vicarious learning experiences. Eight out of ten proficient preceptors felt that having the ability to facilitate observations of competent models in the workplace, as a means to promote meaningful learning, was important to preceptors' perception of self-efficacy. Eight out of ten proficient preceptors advocated sharing of personal anecdotes as a means to reduce anxiety and illustrate teaching points.

Four out of ten proficient preceptors maintained that being able to reflect on their actions as a preceptor helped them to develop professionally in the role. Eight out of ten proficient preceptors would judge their capabilities as preceptors in relation to the attainments of others.

Seven findings were elicited from research question number three, "What do proficient preceptors report about the development of preceptor self-efficacy related to verbal persuasion? Four out of ten proficient preceptors indicated that they had been specially "selected" for the position of preceptor by a respected mentor or leader. Eight out of ten proficient preceptors related that receiving information about their capabilities from credible sources helped to bolster their sense of efficacy. Six out of ten proficient preceptors stated that the experience of serving as a mentor to others was important to build a personal sense of self-efficacy.

Nine out of ten proficient preceptors reported that the use of encouragement as an instructional strategy had beneficial effects on both the learner and preceptor. Six out of ten proficient preceptors stated that receiving positive feedback regarding their precepting ministrations served to elevate their own self-efficacy. Five out of ten proficient preceptors stated that learning to frame feedback in a positive manner helped learners constructively hear their feedback and improved their teaching effectiveness. Eight out of ten proficient preceptors agreed that establishing a trusting learning environment that allowed for open exchanges would improve preceptee learning and support preceptor self-efficacy development.

Thirteen finding were elicited during the two focus groups related to research question number four, "What do proficient nurse preceptor recommend regarding best practices for ongoing preceptor professional development?" Seven of ten proficient preceptors felt that inculcating professional dispositions among preceptors was a foundational best practice that should be embedded within the preceptor culture and curriculum. Seven of ten proficient

preceptors recommended a best practice of mentoring of newer preceptors by excellent preceptors, as well as provision of opportunities for preceptor exchanges, such as in the Preceptor Forum or newsletter. Two of ten proficient preceptors felt that a best practice would be to provide preceptors with ready access to resources relevant to precepting. Four of ten proficient preceptors felt that engaging peer support for their role within the workplace was a best practice.

In addition, proficient preceptors recommended best practices for preceptor professional development that included socialization of new hires and instructional approaches to the orientation. Four of ten proficient preceptors identified facilitation of successful preceptee integration into the team as a best practice for preceptor professional development.

Several instructional approaches were included as best practices. Seven of ten proficient preceptors believed that communication between preceptors about preceptees was a best practice for preceptor development, and six of ten proficient preceptors identified being able to create learning environments that would encourage open exchanges was important. Five of ten proficient preceptors identified knowing their learners to optimize learning experiences and also, utilizing effective structures to guide the learning as best practices. Four of six proficient preceptors described planning the learning. Three of six proficient preceptors would include provision of effective feedback as a best practice for preceptor ongoing professional development. Lastly, one of ten proficient preceptors recommended a need to obtain evaluative feedback related their own performance as a preceptor as a best practice.

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction to the Chapter

Chapter Five presents conclusions derived from the findings identified in Chapter Four. A brief summary of the study will be provided, followed by a restatement of the research questions and recap of the research methods. Each conclusion will be discussed, followed by recommendations for practice and for research. The chapter ends with implications for practice and the researcher's reflections on the study.

Summary of the Study

This study invited proficient nurse preceptors within one hospital setting to explore the development of their self-efficacy in the preceptor role and to recommend best practices for ongoing preceptor professional development. Nurse preceptors within healthcare settings are entrusted with guiding new staff through the vulnerable first weeks to months of employment (Ulrich, 2011). To effectively perform as a preceptor, the nurse must acquire pedagogical competencies that are not typically emphasized in undergraduate nursing curriculums (Boyer, 2008). Accepting this expanded role translates into additional responsibilities above their usual nursing duties, which can contribute to job stress, dissatisfaction and burnout (Griffin et al., 2002; Hautala et al., 2007). Therefore, finding ways to cultivate the preceptor group and mitigate the effects of job-related stress associated with the role would be important. Since experienced, proficient preceptors have been able to thrive despite the rigors of the job and are significant contributors to a healthy workforce, learning what influenced their growth as a preceptor and what they relay as essential for professional development would be instructive.

Self-efficacy is a social construct that refers to beliefs that people hold about their capabilities to perform in given situations and their ability to effect desired outcomes (Bandura,

1997). The literature has reported that individuals with higher self-efficacy were more likely to persevere when confronted with job stressors (Bandura, 1997; Grau et al., 2001; Jex et al., 2001), teach students who demonstrated higher achievement (Schwarzer & Hallum, 2008), and create better social networks (Caprara et al., 2006). Because highly efficacious people are more likely take on new job responsibilities, rate their job satisfaction and commitment higher, and enjoy better health states (Bandura, 1997; Grau et al., 2001; Jex et al., 2001), it would be advantageous for hospital preceptors to possess this attribute, and the research questions asked in this study use self-efficacy as a lens through which to explore proficient preceptors' responses.

Proficient preceptors practice within the context of a value-driven and resource-deficient healthcare system. Because of changes in reimbursement from Medicaid and Medicare services, hospitals must reduce costs while at the same time demonstrate quality patient outcomes to survive (CMS, 2013; Conway, 2009; Craig et al., 2011). Having a competent workforce to provide effective care is integral to achieving high quality outcomes. Hospitals can ill afford to lose experienced preceptors due to burnout or lose new staff due to ineffective precepting (Jones, 2008). Listening to the preceptor study participants has provided valuable data that hospital administrators may need to justify resources allocated in support of ongoing professional development as a vehicle to elevate preceptor self-efficacy. The purpose of this action research study was to engage proficient nurse preceptors in exploring the development of preceptor self-efficacy and to recommend best practices for ongoing professional development.

Research Questions

The following research question guided this action research study of proficient nurse preceptors within a long-term acute care hospital setting. These questions were designed to

explore the proficient preceptor's perceptions of the development of their preceptor self-efficacy and to recommend best practices for ongoing professional development.

Research Question 1.0

What do proficient nurse preceptors report about the development of their preceptor self-efficacy for the purpose of recommending ongoing professional development and best practices within a hospital setting?

1.1 What do proficient nurse preceptors report about the development of their self-efficacy related to enactive mastery experiences?

1.2 What do proficient nurse preceptors report about the development of their self-efficacy related to vicarious experiences?

1.3 What do proficient nurse preceptors report about the development of their self-efficacy related to verbal persuasion?

1.4 What do proficient nurse preceptors recommend regarding best practices for on-going preceptor professional development?

Conceptual Framework

The conceptual framework that guided this study drew on the work of Bandura's (1997) social cognitive theory of self-efficacy. Self-efficacy refers to the beliefs that people have about their capabilities to perform in given situations and their ability to achieve desired outcomes. Studies within the literature have demonstrated a positive relationship between levels of individual self-efficacy and job productivity, wellness states, satisfaction, and organizational commitment (Grau et al., 2001; Jex et al., 2001; Caprara et al., 2006; Schwarzer & Hallum, 2008). In addition, workers with high self-efficacy may be more likely to continue their education, request additional responsibilities and expend greater effort on the job (Schwarzer &

Hallum, 2008). One study reported that teachers who were highly self-efficacious had higher achieving students and better interpersonal co-worker networks (Caprara et al., 2006). The association between higher self-efficacy and desired positive worker characteristics may be a significant reason for healthcare employers to engage proficient nurse preceptors in exploring the development of their self-efficacy as a preceptor for the purpose of recommending best practices for ongoing professional development within a hospital setting.

Bandura (1997) hypothesized that self-efficacy is shaped by four sources of information throughout a person's life: enactive mastery experiences, vicarious experiences, verbal persuasion, and emotional or physiologic states. Social, personal and situational factors influence how people interpret and integrate perceptions of self-efficacy. People judge their self-efficacy based on these factors and a combination of "rules or heuristics that people use to weight and integrate efficacy information from different sources in constructing beliefs about their personal efficacy" (Bandura, p. 79). In this study, three of Bandura's (1997) sources of self-efficacy were used as the lens through which the developmental experiences of proficient nurse preceptors were viewed and guided the collaborative recommendations for ongoing preceptor development and best practices.

Design of the Study

This study employed an action research design, grounded in a qualitative research paradigm. Stringer defined action research as "a collaborative approach to inquiry or investigation that provides people with the means to take systematic action to resolve specific problems" (p. 8) and to "gain greater clarity and understanding of a question, problem or issue" (p. 19). In addition, action research seeks to empower the participants to take meaningful action based on the findings of the research.

The design of the study included individual interviews and a focus group. Following University of Hartford and the hospital IRB approval, a purposive sample of ten proficient preceptors were identified using the Preceptor Expertise Evaluation instrument from the Vermont Nurse Internship Project (VNIP, 2007), and the Preceptor Self-Efficacy Evaluation, adapted by the researcher from the VNIP (2007) for the preceptor to conduct a self-rating.

The interviews and focus groups were conducted following the Preceptor Individual Interview Protocol and the Focus Group Protocol, which were developed by the researcher. Both individual interviews and focus groups were voice recorded and transcribed verbatim. An axial coding strategy was employed, findings were categorized, and themes emerged from the data.

Prior to participating in the interview or focus group, human subjects were protected through completion of informed consent. To maintain confidentiality, the research participants were cautioned to refrain from disclosing information shared within the confines of the interview or focus group. However, since the study design involved a group, confidentiality was maximized, but could not be guaranteed. To protect anonymity, participants were assigned pseudonyms, which appear in this and any other report, and their work unit was disguised. Transcripts and tapes are secured and will be destroyed by the researcher seven years after completion of the study.

Credibility of the study was established through use of triangulation, member checking and participant debriefing. Multiple sources of information were used to verify the interpretation of the data. Also, participants were allowed to review the data and reports derived from the research data to confirm the trustworthiness of the study. Due to the nature of this action research study, and as it was conducted at one hospital site, the results are generalizable only to this setting. However, rich, thick description was used to allow the reader a better understanding

of the participant's meaning and context, and such detail may permit a determination of trustworthiness and applicability of the findings to other healthcare environments. In addition, bracketing was used to identify the researcher's bias, and her advisor, who is outside the healthcare arena, provided valuable feedback relevant to potential bias.

The findings of this study will be shared with the Research Committee and the various stakeholders within the hospital. One of the goals of an action research study is to empower the participants to take action and suggest changes based on meaningful data. By sharing their knowledge and lived experiences, proficient preceptors, in collaboration with the researcher, will recommend best practices for ongoing professional development within the study hospital and embark on solutions that are supported by the findings.

Summary of the Findings

Research Question 1.0 What do proficient nurse preceptors report about the development of their preceptor self-efficacy for the purpose of recommending ongoing professional development and best practices within a hospital setting?

Finding 1.1 Ten out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on an ability to model the occupational skills/clinical competencies of their unit of work.

Finding 1.2 Eight out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on their ability to provide effective feedback in ways that enhanced preceptee performance.

Finding 1.3 Six out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on their ability to provide constructive feedback to preceptees.

Finding 1.4 Seven out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on the ability to utilize feedback as a mechanism for growth relevant to precepting.

Finding 1.5 Eight out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on an ability to use knowledge of learning styles to engage learners.

Finding 1.6 Nine out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was related to an ability to build the learning for preceptee success.

Finding 1.7 Nine out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on an ability to enable critical thinking in preceptees.

Findings 1.8 Ten out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on their engagement in ongoing learning.

Finding 1.9 Eight out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on an ability to serve as a role model.

Finding 1.10 Five out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on the ability to elicit return demonstrations of modeled skills from preceptees.

Finding 1.11 Eight out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on an ability to evaluate preceptee achievement of goals.

Finding 1.12 Five out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on an ability to engage in guided practice with their preceptees.

Finding 1.13 Three out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on an ability to use repetition as a vehicle to learning with their preceptees.

Finding 1.14 Six out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on their use of teaching strategies to enhance preceptee learning.

Finding 1.15 Six out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on an ability to use situated learning as opportunities for growth.

Finding 1.16 Four out of ten proficient nurse preceptors reported that the development of their self-efficacy related to enactive mastery experiences was based on an ability to manage stressors while engaged in precepting.

Research Question 2.0 What do proficient nurse preceptors report about the development of their self-efficacy related to vicarious experiences?

Finding 2.1 Seven out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was related to their ability to learn from observations of competent preceptor models.

Finding 2.2 Eight out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by their ability to facilitate observations of competent modeling for their preceptees.

Finding 2.3 Two out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by an ability to learn from observations of family outside the work environment.

Finding 2.4 Three out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by an ability to learn from observations of leadership models.

Finding 2.5 Five out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by an ability to learn from observations of modeling failures.

Finding 2.6 Six out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by an ability to recall effective preceptor modeling for subsequent use in the role.

Finding 2.7 Nine out of ten proficient nurse preceptors reported the development of their self-efficacy through vicarious experiences was related to an ability to share with other preceptors.

Finding 2.8 Seven out of ten proficient nurse preceptors reported the development of their self-efficacy through vicarious experiences was related to an ability to share stories with preceptees.

Finding 2.9 Four out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by an ability to share precepting responsibilities with another preceptor.

Finding 2.10 Eight out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by judgment of their capabilities relevant to the attainments of others.

Finding 2.11 Four out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by the ability to self-reflect about their enactment of the preceptor role.

Finding 2.12 Three out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by an ability to listen to the experiences of others.

Finding 2.13 Seven out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by an ability to know their learners.

Finding 2.14 Five out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences advance by an ability to demonstrate respect for the learner.

Finding 2.15 Four out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by an ability to promote the social integration of the preceptee.

Finding 2.16 Six out of ten proficient nurse preceptors reported the development of their self-efficacy related to vicarious experiences was advanced by an ability to work side by side with their preceptee to promote competence.

Research Question 3.0 What do proficient nurse preceptors report about the development of their self-efficacy related to verbal persuasion?

Finding 3.1 Four out of ten proficient nurse preceptors reported the development of their self-efficacy related to verbal persuasion was advanced by being selected for the special role of preceptor.

Finding 3.2 Four out of ten proficient nurse preceptors reported the development of their self-efficacy related to verbal persuasion was advanced by an ability to receive feedback from credible sources about their capabilities.

Finding 3.3 Nine out of ten proficient nurse preceptors reported the development of their self-efficacy related to verbal persuasion was advanced by an ability to provide encouragement to preceptees to enable success.

Finding 3.4 Six out of ten proficient nurse preceptors reported the development of their self-efficacy related to verbal persuasion was advanced by receiving positive verbal feedback about their performance in the role.

Finding 3.5 Eight out of ten proficient nurse preceptors reported the development of their self-efficacy related to verbal persuasion was advanced by an ability to establish a learning environment that provided for open exchange.

Finding 3.6 Five out of ten proficient nurse preceptors reported the development of their self-efficacy related to verbal persuasion was advanced by an ability to frame feedback to be positive.

Finding 3.7 Six out of ten proficient nurse preceptors reported the development of their self-efficacy related to verbal persuasion was advanced by an ability to mentor others.

Research Question 4.0 What do proficient nurse preceptors recommend regarding best practices for ongoing preceptor professional development?

Finding 4.1 Seven out of ten proficient nurse preceptors and preceptor forum members recommended that best practice for ongoing preceptor professional development included ensuring effective communication between preceptors regarding preceptees' progress.

Finding 4.2 Three out of ten proficient nurse preceptors recommended that best practice for ongoing preceptor professional development included opportunities for exchanges among preceptors.

Finding 4.3 Four out of ten proficient nurse preceptors recommended that a best practice for ongoing preceptor professional development included engaging peer support for the preceptor role.

Finding 4.4 Seven out of ten proficient nurse preceptors and preceptors in focus groups recommended a best practice for ongoing preceptor professional development that included mentoring of new preceptors.

Finding 4.5 Two out of ten proficient nurse preceptors recommended that a best practice for ongoing preceptor professional development included access to learning resources about precepting.

Finding 4.6 Seven out of ten proficient nurse preceptors recommended that best practice for ongoing preceptor professional development involved inculcating professional preceptor dispositions.

Finding 4.7 Six out of ten proficient nurse preceptors and both focus groups recommended that best practice for ongoing preceptor professional development included establishment of a learning environment that encouraged open exchanges between preceptor and preceptee.

Finding 4.8 Five out of ten proficient nurse preceptors and focus groups recommended that best practice for ongoing preceptor professional development included using knowledge of the learner to promote learning.

Finding 4.9 Three out of ten proficient nurse preceptors recommended that best practice for ongoing preceptor professional development include facilitating social acceptance of the preceptee to the work unit.

Finding 4.10 Three out of ten proficient nurse preceptors recommended that best practice for ongoing preceptor professional development included utilizing effective structures to guide their precepting.

Finding 4.11 Four out of ten proficient nurse preceptors recommended that best practice for ongoing preceptor professional development included planning the learning.

Finding 4.12 Three out of ten proficient nurse preceptors recommended that best practice for ongoing preceptor professional development included provision of effective feedback to preceptees.

Finding 4.13 One out of ten proficient nurse preceptors recommended that best practice for ongoing preceptor professional development included mechanisms for obtaining feedback from preceptees.

Conclusion and Recommendations

Conclusion I

Proficient nurse preceptors reported the development of their self-efficacy was related to their growth as an instructional leader within the organization.

Conclusion I is derived from study findings 1.1, 1.2, 1.3, 1.5, 1.6, 1.7, 1.10, 1.11, 1.12, 1.13, 1.14, 1.15, 2.1, 2.2, 2.3, 2.5, 2.6, 2.8, 2.12, 2.13, 2.14, 2.16, 3.3, 3.5, 3.6.

Given that a principal role ascribed to preceptors is teacher/educator (Swihart & Figueroa, 2014; Ulrich, 2012), it is not surprising that proficient nurse preceptors reported that their self-efficacy development was related to instructional competence. This conclusion resonated with findings of researchers (Cangelosi, 2009; Foy, et al, 2013; Kaviani & Stillwell, 2000; Nelson et al., 2012; Spiva et al., 2013) who identified competence in pedagogy as vitally important to the enactment of preceptor responsibilities. Proficient preceptors in this study described varied aspects of instruction as contributing to preceptor self-efficacy. Topics within the category of instruction included modeling, the learning environment, teaching strategies, communication and feedback, and use of evaluation.

Modeling.

Since nursing is a practice discipline, preceptors must first be able to model the competencies of their work unit to serve as an effective preceptor. Boyer (2008) stated that preceptors must be able to "lead by example" and "adhere to standards of practice" of the work unit. In an earlier study of graduate nurse preceptors, Myrick and Yonge (2004) related how the clinical and teaching expertise of preceptors profoundly impacted the experience of the preceptees, "the expertise of the preceptor played a prominent, if not most significant, role in the graduate student experience" (p. 375). Proficient preceptors Eduardo and Georgia identified expertise with their patient population and an ability to model the skills effectively as important to preceptor self-efficacy. Eduardo explained, "You should have knowledge, otherwise you will not be able to impart properly, which is right, which is not." Georgia observed that preceptees, "Look to see how you perform, how you carry through, how you make your assessment, and then they internalize what you are doing and will perform in the same way". Carol expressed concern that having a preceptor who lacked self-efficacy could negatively impact patient

safety. She recounted a personal example having a preceptor who had little experience, "There were some nights none of us knew what was going on". Conversely, three proficient preceptors related opposite experiences of learning from a preceptor who was “knowledgeable". Henrietta described her preceptor as "confident and basically knew A-Z how to get the job done". Frances said of her preceptor, "she was your resource", and Georgia stated that her preceptor, "reinforced…why you do things, when you do things…all the interventions and the rationales why".

Becoming a master of the clinical skills that were necessary for modeling was reported as taking time and field experiences. Ingrid said she felt ready to be a preceptor when she “knew enough of the time management, the organization to share it with other people,” and that her “self-efficacy developed over time; learning on the unit and being there so long, I knew who my resources were”. To achieve a level of competence, Billie stated, "It takes me about six months to feel like I am doing a good job at something, at a new job or any new responsibilities".

New nurse preceptors and researchers described how watching excellent preceptors in action contributed to their instructional competence in the role (Benner et al., 2010; Cangelosi et al., 2009; Spiva et al., 2013). Bandura (1997) wrote, “People actively seek proficient models who possess the competencies to which they aspire. By their behavior and expressed ways of thinking, competent models transmit knowledge and teach observers effective skills and strategies for managing environmental demands” (p. 88). In this study, seven out of ten proficient preceptors experienced competent modeling that influenced their development and enactment of the preceptor role. As a newly licensed nurse, Carol observed the behaviors of an expert nurse on her unit, nicknamed, the “Mother Hen”, who served as a preceptor and resource to the novice nurses. Henrietta gained instructional competence as a preceptor through enactive

learning, saying, “I learned on the job through my peers, the other preceptors on the unit”. Henrietta developed as a preceptor through their example, saying that she, “modeled after them, their behaviors and their styles, and then I developed my own as a preceptor”. She said, “You would watch her from afar and see how she handled things”. Ingrid, Adele and Eduardo also observed competent nurse preceptors in action. Ingrid described “observation in general” as a means of her learning, while Adele identified a competent role model who was “instrumental,” to her learning. Eduardo’s peer role model “showed…how to do those bedside things [*sic*]”.

Proficient preceptors described observations of competent preceptor models as especially beneficial to teaching and learning emergency skills. Henrietta and Ingrid related their experiences as new nurses when they were watching their preceptors in action before being expected to practice skills within the high stress environment of a medical emergency. Ingrid stated that initially, “When I learned about codes, I went in as an observer”. As a preceptee, Henrietta also had been invited to first watch her preceptor in an emergency situation, to view team members and “how they interacted in the code”. Both proficient preceptors reported that these observations better equipped them to participate when later confronted with medical emergencies, and they continued to use this strategy with their own preceptees.

Positive attributes modeled by effective preceptors included nurturing behaviors (Haggerty et al., 2012; Horton et al., 2012; Spiva et al., 2013), confidence (Ulrich, 2011) and willingness to teach (Baltimore, 2004; Hautala et al., 2012; Spiva et al., 2013). Proficient preceptors mentioned similar descriptors when discussing effective preceptor characteristics. Carol recalled preceptors who she had perceived as “open and accepting”, who “never gave me the feeling that you were interfering with their day”. These attributes were contributory to Carol’s development. Donna verbalized that when her preceptor had exuded self-confidence, “It

truly made me more confident, because I realized, why this isn't such a big deal, I can do this!" Frances appreciated her former preceptor's "willingness" to share knowledge and skills, and noted this as a helpful instructional attitude for preceptors.

Adult learners (Knowles, Holton & Swanson, 2012) bring prior life experiences and knowledge to the workplace and the learning environment, and this knowledge can influence the acquisition of future competencies. Ulrich (2011) stated that these prior experiences provided adult learners with a broader base on which to relate new learning. This is in keeping with the observational capacities of proficient preceptors related to how they had learned instructional competencies. Two proficient preceptors identified that learning from their observations of people outside of the healthcare environment had contributed to their preceptor self-efficacy with critical thinking. As the youngest in a large family, Billie had learned from observations of siblings. She explained, "You pay attention to the choices made and the outcomes". Adele shared that as the first person in her family to achieve higher education, her siblings "look to me for some decision making". In addition, developmental life experiences, such as raising children, were mentioned as contributing to teaching critical thinking and problem solving with newly licensed nurses.

The reports of preceptors and preceptees within the literature indicated that these individuals were often fully cognizant, and could later recount, observations of ineffective precepting behaviors that had hindered their development as a new practitioner (Chandler, 2012; Myrick & Yonge, 2004; Richards & Bowles, 2012; Sandau & Halm, 2011; Spiva et al., 2013). Such examples included ineffective communication (Myrick & Yonge, 2004; Spiva et al., 2013), unwillingness to precept (Henderson et al., 2006; Spiva et al., 2013), and lack of oversight (Chandler, 2012; Spiva et al., 2013). Proficient preceptors related similar ineffective precepting

behaviors that served as exemplars of what not to do, including reluctance to precept, lack of preceptor oversight, and critical and discouraging communication. Carol shared the experience of being assigned to a preceptor who "basically ignored me" and "did not want to precept". She asserted, "It showed me the things *not* [emphasis added] to do with your orientee". Frances also had witnessed substandard preceptor performance, "I learned from some bad ones I observed". She noted that ineffective preceptors would "just sit and do other work while their orientee is out there [on the patient care unit]". Three proficient preceptors had encountered deleterious preceptor behaviors during their career that they eschewed. Adele verbalized distress about these observations, maintaining, "It is not fair to the person". Eduardo commented negatively about preceptors who did not appear interested performing their role, but rather in the pay premium they would be awarded while precepting. He stated, "My approach is different…you should do the job [precepting], then you get paid. That is the sequence". Jane expressed a similar sentiment, "The last person you would want precepting is someone who is saying, 'I hate this place and I really need a new job'…someone who just wants the preceptor money." Proficient preceptors believed preceptors should demonstrate willingness and expend necessary effort to help preceptees.

Frances noted that the ineffective preceptor whom she had observed sitting in the unit's conference room was not providing adequate oversight to the preceptee, and that could have had a detrimental effect on learning. She said, "The preceptee doesn't want to ask them anything because that will show, 'I don't know what I am doing'." Also, she noted that when this preceptor did check in with the preceptee, "instead of constructive criticism, there's just criticism". Frances learned vicariously from this observation what not to do: "You observe habits that you are just not going to do" while precepting.

Proficient nurse preceptors reported that being able to recall earlier precepting experiences for future application to preceptor responsibilities was another means of obtaining instructional competence. Bandura (1997) described observational learning as governed by four sub-functions, one of which included retention processes and recall. Bandura wrote that "recall involves a process of reconstruction rather than simply retrieval of registered events", and that observers could "create new variants of actions that fit the structure but go beyond what was seen or heard" (p. 90). In choosing instructional strategies, proficient preceptors modeled after preceptors' behaviors they had perceived as helpful and wanted to emulate. Ingrid drew from her own experiences, "I remembered when I was precepted and saw other people on my unit" who were being precepted. Eduardo spoke highly of his preceptor and that he had "tried to simulate [*sic*] what he had done with me". Adele shared remembrances of positive behaviors that she had retained from her preceptor, "There are the little things that she had done [*sic*] that were stuck in my brain and that I admired". Adele reported a similar reaction from one of her recent preceptees, who said to her, "I will never forget some things you taught me". Billie recalled the "things that didn't work with me" when deciding what instructional methods to select for her preceptees. When Donna was faced with difficult teaching situations, she remembered the example of her former preceptor. She would ask herself, "What would Ingrid do?" Donna summarized how preceptors might vicariously learn instructional skills, "They start by observing you or me as a preceptor, and then they pick up on that. So next time, when it's their turn to precept, they can think back, 'what would [preceptor name] do with that orientee'?"

Since modeling is an important aspect of learning (Bandura, 1997), proficient preceptors tried to model professionalism through adherence to professional standards and in the choice of models permitted to work with their preceptees. Baggot et al. (2006) identified preceptors as key

personnel within hospitals in maintaining patient safety through their instruction. "When asked who has had the most significant impact on their job satisfaction and success, the new hires tell us most frequently that it is their preceptor" (Baggot et al., 2006, p. 142). Eduardo tried to instill through his modeling of the requisite "knowledge, skills and attitude" of a nurse. He said, "Since application is done at the bedside, I try to show that to them. If they see these things in me, they might actually copy what I am showing".

Working side by side with the preceptee, to model appropriate care and ensure patient safety while learning, is an important component of effective precepting (Chandler, 2012). Using this approach, proficient preceptors in this study were able to directly observe and model care, while supporting inclusion and socialization of the new person. Jane stated, "I always stay right with the preceptee; I am teaching them as we go throughout the day." Working side by side assisted Jane in the assessment of performance and permitted just-in-time remediation during a teachable moment. Carol reported that she "did the assignment along with them", rather than expecting her orientees to go it alone. In addition to working side by side with her preceptees, Adele added, "You break together, you do things together". Billie employed the teaching strategy of togetherness for the purpose of encouraging preceptees as they tackled complex problems. "Let's work together and you will get there".

One proficient preceptor mentioned a potential self-efficacy deflator and barrier to the use of working side by side as an instructional strategy. Ingrid described competing demands on the preceptor's time to teach, such as serving as charge or "resource" nurse on the unit. She reported feeling conflicted about taking time away from precepting when this occurred:

> If I am on an assignment, and I am precepting, but yet the other staff is coming to me in addition for stuff, and you don't want to leave your person. You can take them with you, but then they have their stuff to do.

Ingrid recommended assigning another staff person to perform the role of charge or "resource" nurse rather than the preceptor. Unfortunately, this phenomenon, termed "complexity compression", has increasingly confronted experienced nurses in the value driven healthcare environment of the United States (Krichbaum et al., 2007; Schmalenberg et al., 2008). Experienced nurses may be called upon to care for the sickest patients, participate in a myriad of professional activities, as well as perform leadership functions of preceptor and charge on a unit. This can result in feelings of stress and lack of efficacy in performing their role responsibilities (Bratt, 2009; Henderson et al., 2006; Hyrkäs & Shoemaker, 2007; Krichbaum, et al., 2007).

One aspect of modeling, important to instructional competence, is the ability to facilitate observations of competent performance for learners. With their unique knowledge of the work environment and culture, unit-based preceptors could readily identify and select appropriate learning opportunities to meet preceptee needs (Chandler, 2012; Swihart, 2014; Ulrich, 2011). An instructional strategy, called "thinking out loud", was described in the literature, whereby a competent preceptor explained his/her thought processes aloud while engaged in care. This helped the learner to better understand the priorities and multitasking activities of the nurse (Schmalenberg et al., 2008). Proficient preceptors described using this strategy with preceptees. Eduardo said he would "explain to the preceptee the purpose, and what he [was] looking for" as he conducted an assessment of his patient.

Proficient preceptors used variations on this modeling strategy to encourage comprehension. Initially they related having the preceptee observe care and routines. Jane

stated, “If it is someone’s first day, I will have them shadow me so they can get an idea”. After the first day, proficient preceptors would select an assignment based on preceptee learning needs. If Adele identified an activity that would benefit preceptees, she would invite their participation by saying, “Let’s do this, this needs to be done” and would “demonstrate it” so they could observe it performed. Carol recounted the initial steps she would initiate when teaching a technical skill, such as a peripheral I.V. insertion. She would walk the preceptee through the steps in a private place with the equipment, before proceeding to the patient room. Carol said, “They want to watch me before they attempt the procedure themselves”.

Demonstration or modeling by a competent nurse, followed by return demonstration from the learner is frequently used in clinical teaching settings (O’Connor, 2006; Spiva et al., 2012). Proficient preceptors spoke of having their preceptees do a return demonstration following observation of care. Skillful return demonstration by preceptees served to reinforce preceptor self-efficacy beliefs related to instructional competence. Billie said, “The first time I might run…through. The second time they are doing it, I am right there, but I want them to do it. It cements it in their heads”. She applied self-knowledge about learning to the situation, “If you talk to me, I will process a little bit of it, but I actually have to do it. So that is how I teach everybody”. Adele interpreted preceptees’ return demonstration of modeled skills as indicative of comprehension and learning. Adele said:

> What I had demonstrated, he was able to do on the second time. By his responses and the way he was repeating what I had said, he had understood the rationale. I would consider that effective demonstration of what I had taught him.

Such modeling is a requirement of efficacious clinical instruction, as is the establishment of an environment that is conducive to learning. Modeling has been identified as an essential

component of a successful preceptor program (Casey et al., 2004; Chandler, 2012; Myrick & Yonge, 2004; Spiva et al., 2013). Another aspect relevant to the learning environment with implications for learning included respect between learner and preceptor (Casey et al., 2004; Chandler, 2012; Myrick & Yonge, 2004). Sharing of experiences between preceptors, preceptees and other members of the team (Baggot et al., 2005; Bratt, 2009; Hautala et al., 2007; Horton et al., 2012; Hyrkäs & Shoemaker, 2007; Schmalenberg et al., 2008), and listening to the learner help promote learning at all levels (Myrick & Yonge, 2004) were also important elements that impacted learning. Using knowledge of the learner (Foy et al., 2013; Hickey, 2009; Knowles et al., 2012) and learning styles to promote learner success (Foy, Carlson & White, 2013; Hautala et al., 2007; Nelson et al., 2013; Sandau et al., 2011) were critically important to a supportive learning environment.

The learning environment.

Proficient preceptors identified establishment of a safe learning environment that would allow open exchanges between teacher and learner as vital to preceptor self-efficacy as instructional leaders on their units. For this to occur, preceptors needed to adopt attitudes that would engender trust, such as being approachable, open and accepting (Nelson, et al., 2012; Myrick & Yonge, 2004). Proficient preceptors also articulated these attitudes as contributing to their learners' success. Donna believed it was important to establish that if preceptees had "an issue, they feel comfortable going to you" and could say, "I need help with this", or "How do I deal with this?" Georgia learned from a preceptor who she described as "very approachable, and that was huge". She stated that her preceptees should "feel that they could come to you with anything". Carol used the words, "open and accepting" to describe her preceptor, and that created for her "a good experience".

Because new hires and novice nurses have reported increased perceptions of stress during the orientation period (Benner, 1984; Bratt, 2009; Duchscher, 2008; Nelson et al., 2012), preceptor attitudes of reassurance and support were identified as necessary instructional approaches (Casey et al., 2004; Nelson et al., 2012). It has been observed that students who experienced high levels of anxiety demonstrated decreased comprehension and retention in the clinical setting (Moscaritolo, 2009; O'Connor, 2006). Proficient preceptors recalled working with effective preceptors who had created a supportive learning environment for them as new nurses through their positive approach and demeanor that reduced stress. When Georgia had doubted her abilities as a new nurse, her preceptor had provided reassurance, "You can do this, and I'll be here," and "You will be fine". This same preceptor also used humor to alleviate preceptee tension; Georgia related, "I would come to her scared to death, and she would make me laugh". Likewise, Donna described the effect of her preceptor's calmness on her performance: "It made me calm, even when I was nervous doing something for the first time".

Another aspect of instructional competence that impacted the learning environment was the establishment of trust between the preceptor and preceptee (Nelson, et al., 2012; Myrick & Yonge, 2004). Eduardo reported that his preceptees were "opening up, because they trust [me]". He stated, "I try to be honest with them, I think it's all about trust; it all begins with trust. If they trust you, they will listen to you and it comes with attitude as well". Eduardo believed that trust should be mutual: "I keep telling them to be patient with me as well". Henrietta, advised, "You have to be vulnerable as a preceptor as well" to engage the trust of the learner.

Hinged upon trust was the concept of demonstrating a genuine attitude of concern and caring towards the learner (Horton et al., 2012; Nelson et al., 2012; Richards & Bowles, 2012). Georgia recalled working with preceptors that she had perceived as "warm", took an interest in

her well-being and created a "bond". As a result, she said, "It was a more personal experience for me". Eduardo adopted a brotherly or fatherly attitude towards his new graduate preceptees, "You have to talk to them like your little brother or sister or your kid". He related how former preceptees returned to share their success stories after they have moved on to another unit or role.

One aspect that contributed to a safe learning environment was adopting a non-punitive culture for the learner (Spiva et al., 2013), and there were days when preceptor facilitation could make a difference. Jane recounted, "Sometimes people go home in tears because they had a bad day. I don't want them to have that bad day with me, so I do what I can to stop it". She continued, "I like people to feel good about what they are doing". Billie also had experienced a struggling preceptee, and she intervened by consciously choosing language that did not assign blame. She explained, "That's important, to keep that negative energy out. You've got to let go." Henrietta expressed similar thoughts: "It's a learning experience. Stay focused on the goal of orienting the preceptor or orientee".

Demonstration of respect for the learner has been identified as an important aspect of instruction (Casey et al., 2004; Chandler, 2012; Myrick & Yonge, 2004). The demographics of nurses and nurse preceptees have been changing within the past decade as the workforce becomes increasingly diverse and intergenerational (NLN, 2011). Proficient preceptors noted that they now worked with many second career preceptees. Georgia said, "A lot of the new ones [preceptees] that we currently have are middle-aged and have had a life before they got here". Jane stated, "If you treat them like they don't know anything, that can be offensive". An instructional strategy employed by Adele with preceptees was to "acknowledge and respect their opinions".

Approaches for demonstrating respect and acknowledging the preceptee as a partner in the learning included providing choices and options rather than dictating what the preceptee would do. Eduardo would ask his preceptee, "What would you like to learn today?" He invited dialogue and negotiated a workable plan for the day. When Carol wanted her preceptee to tackle a more challenging assignment, she had success by giving "options, offering choices, rather than telling them what to do". She enlisted their support after talking it through and had them attempt the activity.

An aspect of instruction that that evoked learning in both preceptor and preceptee was the use of active listening skills. Proficient preceptors learned vicariously from listening to the experiences of fellow preceptors, team members, as well as from the preceptees. Active listening involved focusing attention on the person speaking without judging what is being said or dismissing the message based on the person's status within the frame of reference (Ulrich 2012). Listening in a non-judgmental manner allowed the person delivering the message to feel validated and the receiver to attend to the non-verbal message being delivered. In addition, listening could promote a learning environment that encouraged openness, exchange of ideas and creativity (Myrick & Yonge, 2004). Frances stated it was beneficial to:

> Listen to other preceptors on the unit, especially if they have had a little bit of different nursing experience than you. If they have worked in critical care, they might see, we all see, the same patients, but we all see them in a different way.

Proficient preceptors also spoke of listening and learning from their preceptees. Henrietta attended to what her preceptees had to share, and stated, "I learned through their experiences how they would handle a situation" differently. Georgia commented, "Preceptors should be receptive to where the orientee's coming from", and noted that more of her preceptees

were “mature, had worked elsewhere, and had different ideas and can share their knowledge with us”.

Getting to know their learners was an aspect of instruction that contributed to a learning environment that encouraged open exchanges between proficient preceptor and preceptee. Adult learners bring to the workplace a plethora of prior life experiences, which if shared with the preceptor, might be used as a platform to base further instruction upon (Knowles, 2011; Ulrich, 2012; Washington, 2013). Additionally, knowing their learner reframed the preceptor from the role of teacher to that of facilitator of learning experiences (Hickey, 2009).

Proficient preceptors reported that they wanted to know their preceptee as a person and what significant milestones or life events had shaped them. Jane stated she would ask, “How long have you been a nurse?” and Frances wanted to know, “Where have you worked before, do you have kids, are you married?” Both felt it was helpful in planning the orientation to know something of the learner’s background. Frances recounted examples of newer staff that she had recently oriented. “Some people, like Bob, had been graduated for a while before he started here…while Marilou literally graduated school and started here.” Frances explained that during the interim between school and employment as a registered nurse (RN), “Bob worked as a private duty nurses’ aide”. Conversely, Marilou had been practicing RN skills as part of her pre-licensure nursing education until very recently. Knowing this information, she would plan the orientation differently for each. Frances also noted that preceptees “who are not necessarily older, but had had different responsibilities in their life…think differently”, and another preceptor, Donna, believed that “they were actually easier to precept.” In getting to know her preceptee, Georgia also wanted to understand the “orientee’s perception of what the preceptor is to do for them” and that such a discussion could help prevent misconceptions. Proficient

preceptors viewed learners who were not willing to share or were secretive as "extremely challenging to teach".

Preceptors' use of knowledge about learning styles could have the ability to improve the instructional experience and learning environment during the orientation period (Foy et al., 2013; Hautala et al., 2007; Hickey 2009; Richards & Bowles, 2012). Learning styles has generally been an accepted component of the basic nurse preceptor class (Ulrich, 2012; Swihart & Figueroa, 2014). Proficient preceptors reported that application of knowledge about their own learning style as well as the preceptee enabled positive learning outcomes and promoted learner satisfaction. Georgia recalled her initial preceptor education as including content on learning styles, inclusive of self-analysis and exploration of the type of learner each person was. She remembered the question, "What learning style does best with what type of preceptor, making you look at yourself to see how you respond and would problem solve things". Billie was a self-described active, hands-on learner, who took copious notes, adding diagrams to aid recall. She said, "I had a little notebook on me to write everything down, because when people talk to me, it doesn't always stick". In addition to learning their own style, proficient preceptors felt that knowing their preceptees' styles was important, so they would select appropriate teaching methods. Georgia suggested a check-off list about preceptee learning preference, "How do you learn best, is it visual, auditory, lecture…how do they learn best?"

Self-knowledge by preceptees was also felt to be valuable, according to Georgia. She stated, "It is much more helpful when the new person says, 'I don't learn well like that. I need to see it.' I find that if they are a young person, maybe they don't have that knowledge about themselves." To determine how her protégés might learn best, Billie would give small tasks at

first. She said, "You learn how they learn…I'm not going to build you up if you don't know my style and I don't know your style. I think it's a two-way street".

Proficient preceptors reported that they sometimes needed help with the application of knowledge about learning styles. Donna stated, "It's important to know their particular style, but then how to apply that? I think it's the application that needs to be discussed more". Billie disclosed having a preceptee who felt her approach was not meeting her needs. "She said the way I was teaching her, she wasn't getting it…I was teaching her like she wasn't smart." Billie enlisted the help of her manager and other preceptors to find an alternative approach that worked for the preceptee. The idea of intentionally pairing the preceptor-preceptee dyad was suggested by Georgia, and has been mentioned in the healthcare literature as having some merit (Vaughn & Baker, 2008). Another suggestion was to assign more than one preceptor. Carol said, "What works for the preceptee is that they're exposed to different ways, different styles and different personalities in different people". Sandau et al. (2011) identified an optimal number of three to four preceptors per orientee as associated with the highest level of orientee satisfaction. By sharing the responsibility of precepting among a small number of preceptors with complimentary approaches, a learning environment supporting differences could be created that would contribute to preceptor self-efficacy.

Teaching strategies.

Facility with teaching methods to meet the needs of the learner within the clinical setting was identified as a necessary competency of preceptors (Benner et al., 2010; Foy et al., 2013; Sandau et al., 2011). Using Bandura's (1997) framework, proficient preceptors identified enactive, vicarious and persuasive teaching modalities that they felt had contributed to preceptee success and preceptor self-efficacy. These teaching approaches have been mentioned in the

nursing literature as well and include breaking the learning into manageable sub-skills (Baltimore, 2004; Bandura, 1997), using guided practice (Forneris & Peden-McAlpine, 2009) and repetition (Bandura, 1997; Chandler, 2012; O'Connor, 2006; Spiva et al., 2013) to ensure retention of information. Because nursing is a practice discipline, preceptors were also uniquely able to teach during emerging situations in the clinical setting (Benner et al., 2010). Proficient preceptors also mentioned various other teaching strategies to meet the needs of diverse learners. Vicarious learning was promoted through the sharing of personal experiences and stories to promote preceptee comprehension. This finding was consistent with the nursing literature (Bratt, 2009; Walker et al., 2013).

Effectiveness as a preceptor required instructional competence in guiding preceptees through a myriad of complex skills and competencies within a designated orientation time period (Sandau et al., 2011). Translation of skills into simpler sub-skills to enable mastery would provide a platform to move the learner on to higher levels of competence (Bandura, 1997; Swihart, 2014). An ability to build the learning to ensure preceptee success was identified by proficient preceptors as essential to the development of preceptor self-efficacy as an instructional leader.

Two proficient preceptors recalled feeling overwhelmed during their orientation period with the volume of information and skills they were expected to master during this short time. From hindsight, they gained instructional acumen so as not to overwhelm the preceptee. Billie advised, "Start on those little things so that you can feel the person out…find out how they learn best". Ingrid said, "If someone is brand new, give them a tour of the unit, have them observe, then go from there. Maybe the next day adding a piece…doing one task, and build on that".

Commencing instruction using basic, achievable goals to promote success was iterated by proficient preceptors. Eduardo advised, "I usually go with the most basic things. First, simple tasks that are easily do-able, give them a bit of confidence". Donna reported initially choosing "a very basic patient that doesn't have a lot of complex things. And then move on to someone who might need more complex care". Henrietta, Ingrid and Donna said they carried in the back of their minds the words, "Start small; add on".

As preceptees achieved goals, proficient preceptors related that they would select feasible goals based on the prior experiences of their adult learner preceptees and gradually build on this foundation. Georgia described this process: "Assign them patients that you feel are within their realm of caring for efficiently and effectively…building on that". She added, "If they've had three patients, I'm not going to give them seven. I wouldn't start them off with all I.V. push medications, it would be too overwhelming". Carol translated each step into manageable segments because preceptees might only be able to attend to one thing at a time. She explained, "You're thinking three things at once, and they're thinking of one thing at once". Billie recommended simple explanations in language that is readily understood. She said, "I don't use big words…for me that doesn't work and for many people it doesn't work". She broke skills into steps and advised her preceptees to take notes.

Eduardo cautioned that he often had to help his preceptees with reasonable expectations for building on the learning segments. When he asked what one wanted to learn for the day, his preceptee replied, "Everything". He humorously responded, "That's impossible in the next eight hours, but maybe we can tackle care of a patient with [listed a patient diagnosis]". In developing instructional competence related to building on prior learning, proficient preceptors reported they needed to know how to pace the learning to enable preceptee progression towards attainment of

goals. Carol learned from an excellent preceptor who "focused on the things that I needed to learn and not so much on the things I already knew". Donna described adding complexity and autonomy towards the goal of independence, "I give them more independence as we go through".

Teaching learners to enable completion of all the required competencies before the end of orientation was an instructional challenge faced by proficient preceptors. Given the current fiscal constraints on healthcare organizations, providing orientation of new hires in the most effective and cost-effective manner is important (Jones, 2008; Jones & Gates, 2007; Ulrich et al., 2010). While the proficient preceptor may have aimed towards speeding the progression of the preceptee, consideration of just how quickly the learner was able to absorb the information was important. As her preceptee achieved success, Billie would say, "Let's move up. What are we looking to do this week?" Eduardo advised that the learning had to be paced. He stated that the preceptor could not "simply keep going, teaching for every minute of every hour, because they will not absorb it. Give them some time to absorb, give them a break". Billie recalled a situation that illustrated this point. She had a challenging experience with a preceptee who became emotional when overloaded with information, which caused her later to reflect, "Maybe it was too much in one day she was being taught." Carol suggested better structuring of the orientation segments to guide progression, "but not pushing them through", and allowing leeway for individualization based on learner needs. Eduardo and Frances were in favor of involving preceptors in improving their current preceptor program structures. Eduardo proposed reviewing the orientation competency lists, to "break it down, so that will guide us". Frances suggested "a better checklist of what experiences would be good" that would enable development of the preceptor's teaching and instructional self-efficacy.

Proficient preceptors reported that being able to engage their preceptees in learning through the teaching strategies of rehearsal and guided practice increased preceptor self-efficacy related to instruction. Rehearsing the skills permitted preceptors to walk through various activities before and during the patient encounter with the preceptee (O'Connor, 2006). This type of strategy served to protect the patient and the preceptee, with the preceptor providing expert guidance as needed.

Carol used the insertion of an I.V. catheter as an example of a situation where rehearsal and guided practice was helpful. She recounted having her preceptee review "the procedure with the equipment, just prior to doing it", and "work with the equipment in the Medication Room" before going into the patient's room. Then Carol proceeded to the patient's room to have the preceptee perform the procedure to "learn from hands-on, active participation, rather than just me talking". Adele and Ingrid called this type of action, "coaching". Ingrid related having her preceptee "step in and be coached" by herself during a medical emergency. Billie "talked her [preceptee] through it and had her do the hands-on". She said this had helped the preceptee to "succeed at this really difficult procedure". One final benefit that proficient preceptors noted related to guided practice was that it protected and bolstered the often fragile confidence of the preceptee. Carol articulated about the I.V. insertion, "The patient doesn't even know it's their first time", and Frances said she would prevent the patient from knowing by "talking to them [preceptees] outside the room and telling them this is what you are going to do". Then she would step into the room with the preceptee.

Preceptors needed to have a variety of teaching strategies to ensure their own instructional competence and self-efficacy in the preceptor role. Strategies identified by proficient preceptors and in the literature included the use of repetition (O'Connor, 2006) to

solidify what was learned, as well as role-playing (Nelson, et al. 2012), scenarios (Nelson et al., 2012) and experiential learning activities (Boyer, 2008; O'Connor, 2006). As preceptors were most often teaching in the clinical environment and were confronted with diverse learners, they had to be flexible to meet the demands of the learner (Haggerty et al., 2012; Hyrkäs & Shoemaker, 2007; Sandau et al., 2011; Smedley, 2008).

Repetition was seen as necessary to solidify what had been taught within the learner's psyche. Eduardo recalled that when he was learning, "If you were [having difficulty] doing a task, the next admission would be on your assignment again…until you developed your own pace and mastery". Georgia said, "When you are in orientation, you get information so quick. And then if you do it again, it gets digested." When Frances had a preceptee who did not perform well, she would take space for a minute, then "go back", and ask the preceptee to repeat the skill.

Several teaching strategies that had been used successfully by proficient preceptors were note taking, use of visual models and worksheets, quizzing, scenarios and role-playing. Billie recommended note taking, and she encouraged preceptees to "write it down". She believed this technique increased the preceptee's autonomy and independence rather than relying on her expertise. Carol provided a sample of a completed worksheet and other visual models of documentation and organization to help the new hire. Another strategy that Carol sometimes used was informal verbal "quizzes" to determine if her preceptee understood her explanation. Ingrid and Frances used "scenarios", where they would pose hypothetical situations that might confront preceptees to stimulate discussion and thought.

Because Eduardo, like many nurses, had received little education relevant to teaching pedagogies during his prelicensure education, he reported learning to teach while on the job. Eduardo shared:

> It was hard [precepting] for the first few months. Here I am, trying to teach them to be a good nurse…and I don't have the proper knowledge or training to do it. I am just teaching them from my own experiences.

He eventually gleaned what would work through repeated experiences of precepting.

Proficient preceptors have been expected to demonstrate instructional competence in teaching novices or new hires amid an often-unpredictable environment of patient care (Benner et al., 2010). Unusual and unexpected events frequently emerge, presenting a goldmine of teachable moments that an efficacious preceptor might take advantage of (Nelson et al., 2012; Forneris & Peden-McAlpine, 2009). Learning while actually living the experience was described as a powerful growth stimulant by proficient preceptors. Ingrid used an unexpected medical emergency as an opportunity to have her preceptee learn through serving, first, as an "observer, then a recorder, then doing hands-on" in the crisis. Francis reported, "Critical things happen during the day while you are orienting, and the preceptor can see it through with the orientee. The [orientees] have the opportunity to react on their own or watch you react."

While medical errors made in the delivery of care may be traumatic, proficient preceptors observed that often they were able to turn these events into meaningful learning opportunities. Two proficient preceptors vividly recalled their own errors. Adele related, "I was just so upset that an incident report was done. It taught me…to be sure when you are giving an I.V. [medication] that everything goes in. I took it thereafter as a learning experience". Adele shared this story when debriefing with a preceptee who had committed a medication error. Carol said,

"I remember my first mistakes…they don't teach you this". She also shared these experiences with preceptees while working with them, warning, "Errors and oversights can happen," and used her mistakes as an opportunity for their learning.

Another preceptor, Jane, used her preceptee's 'near-miss' as a teachable moment. She was supervising an older preceptee who told her, "You don't need to stand over me, I've been doing meds [*sic*]." Jane allowed this preceptee to prepare the medications independently, but asked to verify them before administration to the patient. Jane reported, "And when I checked, there were missing meds," which potentially could have resulted in an error of omission. Her discovery illustrated the necessity of checking before administering medications, and Jane was able to do "just-in-time" education about an important patient safety concept. Preceptors reported that sharing their own stories of success and failure with preceptees were powerful instructional tools that enhanced learner comprehension. Along the road to gaining self-efficacy in the role, proficient preceptors had experienced mistakes and challenges as they evolved into competent practitioners, which they used to enhance preceptee learning.

Besides enhancing learner understanding, proficient preceptors used personal storytelling to demonstrate empathy and mitigate preceptee distress and this reflected what nurse researchers reported of preceptors as well (Bratt, 2009; Walker et al., 2013). When her preceptee would act nervous, Donna related that, "I like to tell them about the time I made someone throw up…I gave a patient too much tube feeding". After telling about the experience, she ended with, "Don't ever do that, I've learned from my mistakes". She recounted how subsequently, as the preceptee performed a similar procedure, he recalled her story as a reminder to himself not to overfeed his patient. Donna viewed this behavior as indicative of the effectiveness of her storytelling teaching method.

Jane stated she would share her experiences with a preceptee who was upset over a misstep. She remarked, "If they are beating themselves up, I say, 'Listen, when I first did this,' and I'll share a story of something that happened to me, or how I learned something, so that they get more comfortable." Billie also used stories of personal misadventures to reassure highly anxious preceptees. She explained,

> When I can tell they are nervous because they have never done it before, I will sit them down and say, "Back when I was new and we were doing"…and I will tell them some crazy story and it will calm them down.

Other proficient preceptors shared stories as a vehicle to prevent preceptees from committing mistakes. Henrietta told stories to "brace them, prepare them for experiences". Carol's stories provided advice related to topics such as medication administration: "Double check this, because it's happened to me. And when it happens, then you remember". Ingrid liked to use "scenarios" as a way to give information and help prepare for typical situations that they might be confronted with.

An ability to promote critical thinking was an aspect of instructional competence that proficient preceptors said was paramount to the development of preceptor self-efficacy. As healthcare has become increasingly complex and resource deficient, hospital preceptors are pressured to complete orientation with preceptees as quickly and efficiently as possible (Conway, 2009; Jones & Gates, 2007; Sandau & Halm, 2010; Ulrich, et al., 2010). Since novice nurses are frequently criticized for their lack of critical thinking skills which can compromise patient safety, preceptors play a vital role in facilitating this attribute among their protégés. However, they may have had little formal pedagogical training in how best to accomplish this goal (Casey et al., 2004; Forneris & Peden-McAlpine, 2009; Foy et al., 2013; Myrick & Yonge,

2004; Nelson et al., 2012; Sandau et al., 2011). Preceptors described their own acquisition of critical thinking skills through personal experience as formative to their choice of strategies. Teaching methods that proficient preceptors found helpful in promoting critical thought processes in others were similar to those found in the literature (Benner et al., 2010; Forneris & Peden-McAlpine, 2009; Nelson et al., 2012; Sandau et al., 2011). Proficient preceptors identified questioning, considering alternatives, verbalizing thought processes aloud while engaged in practice (Forneris & Peden-McAlpine, 2009; O'Connor, 2006), situated learning during a salient event (Benner et al., 2010), performance observation with cueing or coaching (O'Connor, 2006), presentation of a problems to solve & use of scenarios (Nelson et al., 2012), "puzzling it out" (Forneris & Peden-McAlpine, 2009), and simulation (Bratt, 2009; Richards & Bowles, 2012).

Before they could consider teaching others about critical thinking skills, preceptors felt they needed competence in critical thinking skills themselves. Proficient preceptors reported that maturational life events had helped them develop critical thinking, such as marriage and childrearing. Relevant to parenting, Billie shared, "Trying to get them [her children] to think before they acted, what would the outcome be if they did certain things" had helped her to teach critical thinking skills. Carol learned to think critically by observing "how people responded to situations", and Ingrid attributed her acquisition of critical thinking skills to "school, orientation, learning on the job, it all plays in". In addition, participation under the tutelage of their own excellent preceptor role models imbued them with critical thought processes over time, and as they gained competence and confidence, proficient preceptors sought to replicate these modeled teaching strategies with their own preceptees.

Teaching strategies that proficient preceptors recommended to evoke critical thinking in preceptees included questioning, considering alternatives, puzzling and presenting a problem to solve. Rather than quickly providing solutions, proficient preceptors maintained that posing questions about assumptions, assessments and findings, or permitting the learner to consider alternatives and "puzzle" out the answer, provided greater understanding and awareness of the issues at hand. Adele encouraged thinking by asking, "What's more important?" or "What's the first thing that needs to be done? What are the priorities of this admission?" Georgia described critical thinking as "putting pieces of a puzzle together", and Carol had the preceptee solve a thought problem about how a piece of equipment might work, before providing a detailed explanation.

Seeing the bigger picture was an aspect of critical thinking that was often difficult for new nurses who were more focused on "tasks". Jane observed performance and cued the preceptee to help elicit thought, saying, "What could this be; what else do you need to assess? What are you looking for and what could be wrong?"

Eduardo used a process whereby he verbalized thought processes aloud while engaging in critical thinking in practice. Describing a routine physical assessment to his preceptee, Eduardo stated, "There should be a purpose why you went into that [patient's] room, there should be a goal". He would process out loud each step of the assessment, the patient's response to questions, vital signs, breath sounds, and fluid balance. While in the room, the patient might complain of pain. Eduardo recounted, "Now my priority becomes different. I have to medicate my patient to alleviate the pain". Eduardo modeled this reprioritization and transitioning to another priority for his preceptee to observe.

Frances used significant events that occurred in the course of the day to teach critical thinking skills. She maintained, "Sometimes you are lucky that something critical does happen to your patient while you are orienting because then you can see it all through." The literature refers to this as situated learning (Benner et al., 2010) or contextual learning in practice (Forneris & Peden-McAlpine, 2009). Frances described such a situated learning event when she received a report that her patient needed pain medication. Upon further examination of the patient with her preceptee, she discovered that the problem was not pain, but autonomic dysreflexia, caused by a kinked urinary catheter. Frances and her preceptee quickly unclogged the catheter, and the patient's symptoms spontaneously resolved within a short period of time. As the event unfolded, she verbalized aloud her thought processes to the preceptee. She stated, "You try to teach them to look just a little bit deeper for them to recollect it for later on". She concluded, "If you live through it, you are going to remember it a whole lot better".

One modality that has become increasingly popular with advances in technology is the use of simulation (Richards & Bowles, 2012; Ulrich, 2011; Wilson, Acuna, Ast & Bodas, 2013). Frances suggested simulation as an option that preceptors could perhaps take advantage of in the future. In particular, she suggested engaging preceptors in identifying typical scenarios that might be encountered infrequently, but that could pose a risk to the patient if the nurse were not cognizant or competent in this aspect of care. She noted that if preceptees did not have actual patient opportunities during orientation, "they may not know what to look for, what to do properly", and that simulation might be an option for teaching critical thinking related to infrequent, but predicable experiences.

Communication.

Communication skills are foundational to instructional competence and a basic requisite of efficacious precepting. (Swihart & Figueroa, 2014). Because preceptors work closely with new hires and novice practitioners and are the employee's first introduction to the work environment, it is critically important that they master basic skills related to feedback (Foy et al., 2013; Sandau & Halm, 2011; Spiva et al., 2014). Proficient preceptors identified characteristics of effective feedback. Encouragement (Chandler, 2012) was a valued communication device that was appreciated by preceptees and preceptors alike. An aspect of instructional communication that preceptors found difficult, but which was especially helpful when preceptees needed redirection was constructive feedback (Foy et al., 2013; Nelson et al., 2012; Sandau et al., 2011). Being able to frame feedback to emphasize capabilities rather than deficiencies assisted preceptors in communicating their message to the learners (Sandau et al., 2011; Spiva et al., 2013).

A cornerstone of instruction for preceptors with high self-efficacy revolves around an ability to communicate through the use of effective feedback (Foy et al., 2013; Horton et al., 2012; Sandau et al., 2011; Spiva et al., 2012). Proficient preceptors identified the quality of their feedback as a crucial variable that impacted preceptee achievement of objectives. Swihart & Figueroa (2014) described effective feedback as timely, ongoing, specific, and relevant to the knowledge and skills being learned. In addition, offering feedback in a consistent and sensitive manner was important. Preceptors also felt effective feedback should emphasize the positive and be encouraging (Chandler, 2012).

As an instructional tool of proficient preceptors, feedback was used extensively to communicate information, goals and progress to preceptees throughout the workday. On

reflecting about his former preceptor's communications with himself, Eduardo commented, "There was constant [feedback] at the end of the day, what happened….There should be feedback [as to whether] they are learning something or not". Feedback that was timely would be delivered close to the event and involved seeking the perceptions of the learner. Adele provided an example of this, stating she would ask her preceptee, "How did your day go today?" After getting the preceptee perspective, she would say, "Let's look back on all the events we have done together", and address specific concerns right then, "How could we fix that, so it won't occur again?" Donna also commented on the timing of feedback to preceptees. She said, "They're more receptive to feedback if it's right on the spot." The preceptee would then have the opportunity to "ask questions" for clarification, if needed, and "If you have to correct something that's not done the right way…it's better to say something right away rather than waiting". Specific feedback that was effective would validate the person's comprehension of the message. Jane told preceptees that she "would not assume" what they knew, and would ask questions. After providing an explanation, Carol would ask preceptees, "Does this make sense?"

Realistic and encouraging feedback was noted to be necessary, particularly when precepting newly licensed nurses. Eduardo learned from his mentor as a novice preceptor, "There should be constant verbal encouragement". Billie believed that new nurses frequently had unrealistic expectations about their attainments. She noted that after a period of time, "They dipped down in their performance, feeling bad about themselves. That's where you build them back up". Her feedback consisted of correcting incorrect assumptions about their progress and providing encouragement: "I don't expect you to be as far along as you think." Later, as they began to feel more comfortable, she would point out their progress, "Look at how good you are doing". When her preceptee despaired, saying, "I'll never get this, I'll never understand it",

Billie would respond as a means of encouragement, "I'm not anything special. I was *you* [emphasis added] five years ago".

Providing feedback through humor (Ulloth, 2002) and helpful hints was reported as a beneficial strategy by highly efficacious preceptors. Frances employed humor to convey her message in a non-threatening way. She described using a mocking voice and exaggeration to get her point across, "Okay, I'm the mom now", and "You don't have to look at me for the check mark every single time". At times, Frances related that to avoid showing impatience, "you have to just walk out of the room". After collecting her composure, she would return with a clearer directive. In a situation where her preceptee was floundering, she might "clue them [*sic*] along the way" to assist with problem solving in the moment. Frances also offered her preceptees "helpful hints to give them a bit of their own chops [*sic*] to be able to say, 'I can't do this right now'" when addressing certain patients in demanding circumstances.

Consistent with the literature (Foy, et al., 2013; Haggerty et al., 2012; Luhanga, Yonge & Myrick, 2008), provision of corrective feedback in a constructive manner was perceived as difficult by preceptors, but was seen as a necessary instructional competency for achievement of self-efficacy in the role. Preceptors felt responsible for protecting patient safety while their preceptee was learning. Ingrid felt that "the hardest part is the negative feedback", especially, "if they don't take any of that feedback [well]". Of a particularly challenging employee, she continued, "How far do you go with that? How do you get through to someone that you feel knows everything? It was frustrating, and I worried about safety and things".

When confronted with delivering constructive feedback, proficient preceptors expressed a need for support and assistance of managers, other preceptors and educators. Regarding a difficult situation with an unreceptive preceptee, Jane stated, "I needed help", and "You can't

teach someone what's right if they don't want to listen". Billie related a stressful experience with a preceptee who responded emotionally when corrective feedback was provided. She said, "You never want to tell somebody, 'You're not doing good [*sic*].' It's a hard pill to swallow. So that's probably the biggest challenge." In this case, she chose to postpone giving additional feedback at that time, saying, "Let's take a break, this isn't productive; another day we will do it". Billie sought the help of her manager, and they were able to reconvene the next day with the preceptee, who was more receptive to the feedback.

Reflecting on why provision of negative feedback seemed so difficult, Donna identified that "she did not like confrontation", and stated that she perceived correcting unprofessional behaviors as more difficult than correcting skill performance. Frances ventured, "Nobody wants to hurt anybody's feelings". She explained this reluctance, as "sometimes we're just too nice, because we have to work with each other afterwards", and worried about how the feedback might impair their relationships.

Despite reticence in providing difficult feedback, proficient preceptors maintained that their facility in the delivery of such feedback was essential to preceptee learning. Ingrid said that when providing corrective feedback, she would "find specific examples and frame it in a way that was a constructive criticism, not a 'wrong', but 'you can do this quicker or easier' this way". In addition, emphasizing capabilities rather than deficits enabled the preceptee to hear and use the constructive feedback. Carol said, "Preceptees want to hear the positive first". Donna maintained, "If someone is immediately confronted with negative things, then there is no motivation. They just get angry." When offering correction, Frances recommended emphasizing positives first, "Oh, you did that really well, and this is a way to not feel like you are overwhelmed". She continued, "Try to make them feel a little bit good about themselves.

Relevant to how communication might be framed, Donna stated, "It's all in the approach…If you remain positive, it's definitely better". Sensitivity to the learner with regards to the location of delivering constructive feedback also could impact the learner (Swihart & Figueroa, 2014). Use of a "quiet area" to deliver corrective feedback was recommended by Carol and Billie and served to prevent embarrassment and humiliation in front of patients and other staff.

Evaluation.

A final component of instructional competence that proficient preceptors identified as necessary for the development of self-efficacy in the preceptor role was evaluation. The preceptor must be able to effectively evaluate preceptee performance relevant to achievement of orientation competencies (Luhanga et al., 2008; Paton & Binding, 2009; Spiva et al., 2013). Since bedside nurse preceptors may have had little exposure to evaluation as part of their basic nursing education, some have reported feeling uncomfortable evaluating the performance of peers (Myrick & Yonge, 2004; Swihart & Figueroa, 2014). Proficient preceptors found this particularly difficult when their evaluation had identified deficiencies that may have contributed to the termination of employment. This weighty responsibility gave proficient preceptors a sense of being "entrusted" by their managers, and necessitated their ongoing assessment of preceptee performance during the orientation period.

Proficient preceptor, Donna, spoke of the "trust" that her manager placed in her related to decisions about preceptee performance and achievement of orientation objectives. Frances reflected about her feelings of responsibility to ensure the competence of her protégé, "Are you going to be able to make a nurse that you want to work with?" She believed that it could be problematic for her team if the preceptee "gets [*sic*] off orientation and has not met some basic

competencies during the orientation period". She believed her manager "respected" her opinion as to whether a particular orientee was going to achieve success.

Assessing daily to discern how preceptees were performing was referenced as an important competency of efficacious preceptors (Patton & Binding, 2009; Yonge et al., 2012). Eduardo reported that preceptors needed to "gauge [preceptees], how they're progressing every day". Noting preceptees' achievement daily was helpful in making corrections or moving up to more complex goals. Carol extracted this practice from through her own precepting experience, observing, "My preceptor noted if I can do this, after how many times I did it". If a problem were noted, Henrietta would engage the preceptee in finding solutions. Henrietta said, "I would have the preceptee involved, too. Is there something that they need, more time, more situations?"

Dealing with preceptees who were not evaluated favorably was observed to require additional time and energy from their preceptors. Efficacious preceptors would seek help from the manager or educator for support in these situations. When Henrietta encountered a preceptee who was underperforming, she observed, "It took more time and energy from me", as well as extra meetings with the manager, educator and preceptee. Billie vividly described a challenging performance issue, which ultimately ended in preceptee success. However, she noted that, "It was really good, but you needed a support system" to feel efficacious in delivering a negative assessment of performance and developing a plan for remediation. Ingrid described a situation where her assessment of a preceptee's progress had ended with the conclusion, "It's not going to work out". She said, "At some point, you've got to figure if it's not going to be a good match and let them know about it".

A crucial evaluative decision made by proficient preceptors was whether the preceptee had finally met the basic competencies of orientation and was ready to perform independently. Knowing when "it was time for me to fly" was what Georgia described as the hallmark of her excellent preceptor's acumen. As gatekeepers entrusted with the initiation of new nurse hires on their units, proficient preceptors' instructional competence with evaluation was an essential competency.

Recommendations for Practice

Proficient preceptors reported six best practices for ongoing preceptor professional development relevant to instructional competence. These included the creation of a learning environment that would encourage open exchanges, employing knowledge of the learner to promote learning, utilizing effective structures to guide the learning, planning the learning, providing effective feedback and obtaining evaluative feedback for preceptors.

The first instructional best practice for preceptor ongoing professional development related to instruction required the preceptor to create a safe learning environment of openness and comfort. Preceptors needed to be seen as approachable and willing to entertain questions. Since preceptees could be expected to experience stress in a new work environment, using tools such as humor to allay preceptee anxiety may be helpful. Another aspect of this learning environment was mutual respect, cultivated by preceptor receptiveness to preceptee concerns or suggestions. Preceptees, as adult learners, bring a multitude of skills and perspectives to the workplace that could positively influence the learning and contribute to preceptor growth as well. As one proficient preceptor, Henrietta noted, "You can learn from the orientee. They can teach you…not necessarily the task, but how to deal with that situation that might be different from what you expect." Although proficient preceptors were skilled in caring for a specific patient

population, they recognized that knowing how to create an open environment that demonstrated mutual respect could prove beneficial to both preceptee and preceptor.

The second best practice for ongoing preceptor professional development related to instruction was for preceptors to get to know their learners. Knowledge of the learner included cognizance of the preceptee's life and work experiences, as well as their learning style preferences. The purpose of garnering such information was to enable individualized and effective preceptee instruction. To maximize learning, proficient preceptors suggested matching the styles of the preceptor and preceptee dyad. In addition, helping preceptors to apply theoretical knowledge about learning styles with instructional choices within the clinical environment would be beneficial.

A third best practice recommendation for ongoing preceptor professional development related to instruction included utilizing effective structures to guide precepting. To be effective in their role, preceptors desired a general framework and tools to guide the orientation process that was organized in approach, yet flexible enough to accommodate individual needs. Preceptors described effective structures, inclusive of competency and skills lists with time frames against which to benchmark orientee progress, as necessary components of effective precepting. Preceptors requested participation in the evaluation and revision of current structures and processes.

The fourth best practice recommendation for ongoing preceptor professional development related to instruction included planning the learning. Planning broadly included advance notification of all parties about the precepting assignment. Planning encompassed strategizing objectives with the preceptees and provided direction and predictability to facilitate preceptee learning and anxiety reduction.

Because precepting duties required an extra expenditure of energy and planning, proficient preceptors wanted advance notification of their precepting assignments to allow mental preparation and consideration of appropriate learning activities. Also, since preceptees frequently expressed anxiety about what might confront them during their formative first weeks on the job, a best practice recommendation for planning included provision of accurate schedules with preceptor names. In addition, the preceptor could engage the learner in planning the activities for the upcoming day or week, allowing the preceptee time to prepare.

The fifth best practice recommendation related to instruction was identified as provision of effective feedback to preceptees. Effective feedback was described as continual and ongoing, encouraging, and at times, corrective in nature. Although constructive or negative feedback was a necessary component of their role, proficient preceptors found this aspect of communication to be most difficult, and a best practice solution would target professional development specifically towards the provision of constructive criticism and feedback. Activities such as role-playing or simulation of typical scenarios with other preceptors and within a safe environment for learning were suggested as learning options. Since delivery of effective feedback by preceptors is such an essential competency of the role, ongoing professional development is necessary to achieve and maintain excellence.

The sixth best practice for ongoing preceptor professional development related to instruction included the need of preceptors to obtain feedback about their role performance from the learners. Preceptors indicated that they wanted information about how their performance measured up in the eyes of their stakeholders. Establishing consistent mechanisms to ensure preceptors received meaningful feedback about preceptee perceptions, as well as trends related to

the effectiveness of the preceptor program, was seen as a best practice for ongoing preceptor development.

Recommendations for Research

Recommendation for Research 1.1

A survey study could be conducted in an attempt to elicit the types of modeling that is formally and informally performed by preceptors.

Recommendation for Research 1.2

A survey could be conducted on the types of teaching strategies employed as well as the timing of these strategies when engaged in precepting.

Conclusion II

Proficient nurse preceptors reported the development of their self-efficacy was related to the availability of preceptor support systems.

Conclusion II is supported by findings 1.8, 2.7, 2.9, 3.1, 3.2, 3.4.

Nurses accept additional responsibilities when precepting new hires within the work unit, and these duties are assumed amid the rigors of complex patient care and multiple demands on the preceptors' time (Griffin et al., 2002; Hautala et al., 2007; Yonge et al., 2002). It was within this context that proficient preceptors identified preceptor support as important to developing self-efficacy in their role. Proficient preceptors reported a need for a variety of formal and informal supports to help them succeed with precepting new staff through the orientation transition (Biggs & Schriner, 2010; Hyrkäs & Shoemaker, 2007). First, being formally selected and recognized as a preceptor was perceived as supportive of the nurse's potential for this role (Biggs & Schriner, 2010). Opportunities to network with other preceptors were also valued (Baggot et al., 2005; Hautala et al., 2007; Hyrkäs & Shoemaker, 2007; Nelson et al., 2012;

Sandau et al., 2011). Being able to access and participate in ongoing learning experiences that could contribute to their professional growth were identified as necessary to attain and maintain competency. When enacting their role, having another preceptor to share the responsibilities of precepting was felt to be supportive (Beecroft, Hernandez & Reid, 2008). To continue growing, proficient preceptors appreciated evaluative managerial feedback about their precepting, including recognition of positive comments, and suggested institution of mechanisms to ensure a steady stream of relevant information regarding the role.

Selection and recognition.

Proficient preceptors reported that being singled out to become a preceptor by a respected mentor or nursing leader supported their beliefs about their capabilities related to the precepting role (Biggs & Schriner, 2010). Proficient preceptors described being "selected" by a charge nurse as a candidate for the role. Eduardo and Adele had been informally invited by their charge nurses to instruct students and new staff prior to receiving the official preceptor "selection" designation and preceptor training by their hospital. Adele reported that her charge nurse had expressed faith in her capabilities and "was very instrumental in those skills that I attained". Adele felt that this practice of distinguishing nurses with precepting talents and interest should be continued, saying, "I would recommend you identify nurses, from talking to the leaders on the unit, who are willing to precept and teach new nurses, who have the skills to do this". Recognition by nursing leadership of the special capabilities and skill potential of the chosen was viewed by proficient preceptors as supportive to preceptor self-efficacy development.

Preceptor to preceptor support.

After their initiation and initial training for the role, being able to access a variety of formal and informal preceptor-to-preceptor support mechanisms was viewed by proficient

preceptors as a helpful contributor to preceptor self-efficacy. Using a preceptor committee or forum for sharing among preceptors has been mentioned in the literature as a means of preceptor education and support (Nelson et al., 2012; Sandau, 2011). Proficient preceptors reported that vicarious learning through sharing with other preceptors had been invaluable to their development.

The majority of proficient preceptors had participated in the hospital's monthly Preceptor Forum and shared that they saw this venue as supportive of their development. Georgia viewed a preceptor forum as a place "where preceptors could meet and talk about their experiences". Ingrid had attended the hospital's monthly Preceptor Forum, and felt this type of formal support mechanism could make "people feel comfortable that there's people to go to, discuss things, scenarios that come up". Ingrid related about the hospital's Preceptor Forum, "Just knowing they have support is huge". Georgia also felt a preceptor forum could be a place where new preceptors might experience a sense of community and feel "secure enough to ask other preceptors" questions regarding instructional and clinical practice. Billie's idea for preceptor to preceptor support was a place "where preceptors could share, bringing an article or some things that worked", to benefit other preceptors. Vicarious learning through "sharing stories" was suggested by Frances. Ingrid maintained it was important to identify a core group of preceptors and to "work with them on their skills and see if they have any issues, and if so, how you could help them." Also, Ingrid believed that mentoring of newer preceptors could be promoted through the use of a preceptor forum, "have new preceptors talk to other preceptors…see what they do".

One difficulty observed by proficient preceptors was finding relief to attend the off-unit Preceptor Forum during their scheduled hours. This challenge has also been articulated by

researchers within the nursing literature (Henderson & Malko-Nyhan, 2006). Solutions proffered by proficient preceptors included scheduling "meetings on the unit" or "during lunch" breaks, or perhaps for shorter amounts of time to permit other preceptors on the units to participate. While the Preceptor Forum or lunch sessions would provide a formalized exchange, Carol suggested cultivating an informal sharing network among preceptors on every unit. Carol reported that her unit had tried to develop a "culture of asking questions or sharing experiences". She maintained, "Even if we're not orienting, we're sharing experiences with each other". On Henrietta's unit, preceptors worked "side by side", and when a preceptor needed assistance, he/she would seek out another preceptor, saying, "Can you show me how to handle this situation?" This trust was evident during this study's focus group, where proficient preceptors indicated that they had learned from each other over the years. One preceptor stated, "I learned from Frances, and also them", and pointed to two other members of the group.

Informal vicarious learning by proficient preceptors was enhanced through sharing of personal precepting anecdotes. Donna related that she preferred to "talk about what happened during the day, the day before" with other preceptors on her unit. She said they would give her feedback such as, "That was a good way to do that", or "Maybe that wasn't the best way", and suggested alternatives. Henrietta commented, "It's almost like debriefing", reviewing what happened and getting the perspective of her preceptor peers. This was particularly helpful in managing challenging precepting situations. Three proficient preceptors shared the challenges of working with preceptees who were struggling and the value of networking with other preceptors. Carol said, "Amongst ourselves, trying to brainstorm [about a problem]…because there was nothing you could put your finger on and say this" was the issue. Ingrid had experienced a difficult preceptee, and believing something was wrong, ran her hunches by other preceptors on

her unit for validation, “Everyone agreed that the person was abrupt and not following safety checks”. Billie felt it was helpful to share lessons learned through her difficult experiences with newer preceptors, saying, “It seems to be valuable feedback to them. They will say, if this happens to me, I can go to Billie and say, ‘How should I handle this?’ It makes them feel better to have someone to talk to.”

Ongoing learning.

While it is well established that preceptors should receive some form of basic preceptor workshop or education to prepare them for the role (DeWolfe et al., 2010), additional professional development has also been recommended (Horton et al., 2012). In order to develop high self-efficacy in the role, proficient preceptors reported a need for ongoing professional development support systems that were experiential and academic in nature. These included finding a mentor for themselves, advancing nursing credentials through further academic study, accessing educational resources within the hospital, seeking out knowledgeable colleagues, and learning from preceptees.

All but one of the proficient preceptors recalled attending a basic preceptor workshop in preparation for the preceptor role. While this provided a foundation of theoretical knowledge for instructing new hires in a clinical setting, preceptors reported that it took months to feel that they were efficacious as a preceptor. Billie stated that it required “about six months” to feel competent, while Henrietta said that it took her “a good two to three years to feel comfortable in the role as a preceptor”. She continued, “It’s just time, it’s not something you learn overnight…time and being in the environment”. Adele verbalized a recurring theme among the preceptors that “learning does not stop”. She continued, “Things are always changing.…change is good, we just have to learn to embrace it”.

To continue her professional growth, Jane found a mentor who "took me under her wing and would teach me things". Her manager also supported her, saying, "You have to keep improving yourself and raising your standards". Eduardo said that his mentor had "showed me the do's and don'ts", and with this person, he could discuss his preceptees' progress. Carol maintained that having a culture that encouraged "questions and sharing experiences" was important to the continued growth of preceptors and staff.

Because of the advances in technology and implications to patient care, Carol reported it was imperative to keep abreast of changes and discovered various supports within her workplace. Computer educational resources were much more accessible at her hospital and she said, "What's so great is the Internet is so much more available now". Billie discovered that she had to learn simultaneously with her preceptees at times, particularly as new equipment or patient populations were introduced. Three proficient preceptors mentioned learning new things from their preceptees who had different and innovative approaches and were, in some ways, ahead of their preceptors with regards to computer technology. Colleagues from other disciplines, who supported preceptor as well as preceptee learning, were also helpful. Henrietta said, "You learn through your relationships with the physicians, your peers". Ingrid sought out the support of the clinical educators when faced with a precepting conundrum, "Clinical Resources [the hospital's nursing education department] gave me things to try". Jane indicated that she felt supported by the nurse educators who, she noted, had touched base with herself and her preceptees to assist with determining their readiness to complete orientation.

Besides providing support for the initial educational preparation of preceptors, proficient preceptors identified support for ongoing professional development as essential to sustaining preceptor self-efficacy. Billie suggested conducting a preceptor self-assessment to help focus

education towards the needs. She remarked, however, that "preceptors may not know what [they] don't know". In addition to support for preceptors to enable attendance at the monthly Preceptor Forum, Eduardo suggested a review of high-risk clinical skills and "another half day" of formal preceptor instruction. Donna wanted formal classes to emphasize the "application" of pedagogical knowledge and to provide exemplars of how "to help a nurse learn". By supporting formalized professional development, Ingrid hoped to be "giving [preceptors] something new to work with, new ways, new ideas" to increase their self-efficacy in the role.

Shared precepting responsibilities.

A mechanism to support ongoing preceptor professional development was the concept of shared precepting between preceptors. This concept has been mentioned in the literature (Sandau et al., 2011; Ulrich et al., 2010), and when strategically planned out, might serve to mitigate preceptor stress and burnout. One study identified that three preceptors represented the optimal number assigned to an orientee during the orientation period (Sandau et al. 2011). Using more than three preceptors was associated with a decreased perception of satisfaction among preceptors and preceptees.

Proficient preceptors believed that having more than one preceptor to share the responsibility was beneficial for the preceptee and the preceptors. During the Focus Group, Eduardo described co-precepting as "collecting your skills." He motioned to fellow preceptors who were sitting near him, "Carol is good at something; Billie is good at something." When the preceptee was able to experience more than one preceptor who complimented each other's strengths, Ingrid said, "You pull something from everybody".

To effectively team or co-precept, proficient preceptors reported that they needed supports to enable communication between preceptors. When they communicated progress and

information among themselves about their preceptee, co-preceptors were able to feel efficacious in their role. Discussions such as those held by Donna, "The orientee did this yesterday; she did great" or "I had to redirect her, provide feedback, so if this response, watch for this particular issue" were helpful. Henrietta noted that communication was especially important at critical junctures in the orientation, "near the beginning and end of the orientation period".

Feedback about preceptor performance.

Another preceptor support system, identified by preceptors in the literature as contributing to ongoing professional development and self-efficacy in their role, was receiving performance feedback (Henderson et al., 2006; DeWolfe et al., 2009; Richards & Bowles, 2012). Preceptors wanted to know how they were performing from key stakeholders, and proficient preceptors found feedback from preceptees especially gratifying. Mechanisms for ensuring consistent collection and sharing of feedback would be beneficial and would support the growth of preceptors by reinforcing successful teaching strategies.

When preceptees provided positive feedback about their orientation experiences, preceptors interpreted this as indicative of their self-efficacy. The majority of proficient preceptors reported this as the most credible indicator. Billie emphasized, "When the person I was precepting said to me that I was doing a good job, that was *most* [emphasis added] important to me". She felt feedback from the manager was less significant to her than that of the person she had been instructing. Donna said, "I had two orientees who were arguing. It was friendly argument, which one was going to have me as their preceptor. So that made me feel pretty good". Receiving feedback supported Henrietta's self-efficacy and provided her with reassurance that her preceptees were "receiving what they needed to learn. It validated what I was doing was correct." When Eduardo heard positive verbal comments, it reinforced his

behavior. He said he thought, "I must be doing something right. So I just keep doing what I could do [*sic*]".

Feedback from patients and co-workers was also mentioned as supportive of preceptor self-efficacy. Georgia said she had received "praise from the patients themselves" relevant to her modeling. Oftentimes, feedback from these sources was secondhand, either the preceptor overheard someone talking or the information was relayed from another person. Ingrid recited the example of overhearing her co-workers and former preceptees saying, "Ask for Ingrid, she's a good preceptor", or "Can I work with you tomorrow…because you can show me more?"

Providing support structures to enable preceptors to receive feedback about their performance is important for ongoing preceptor self-efficacy development. Direct consumer feedback was believed to be most credible source of information.

Recommendations for Practice

Proficient preceptors reported four best practices for ongoing preceptor professional development relevant to preceptor support. These included mentoring of new preceptors by seasoned preceptors, engaging the assistance of the healthcare team to support the preceptor in performing their role, providing opportunities for preceptors to exchange information and learn from each other, and being able to access educational resources.

The first best practice would invoke mentoring support for new preceptors as they assimilated into a new role. This relationship was envisioned by proficient preceptors as an informal process, where seasoned preceptors could be identified as a "resource" and person to "emulate" while precepting. Another recommendation relevant to mentoring was to engage veteran preceptors to script and share typical precepting scenarios.

The second best practice related to ongoing preceptor professional development would enlist the support of the interdisciplinary team and coworkers to assist in sharing information and welcoming the preceptees. This is consistent with what is found in the nursing literature, where to effectively enact their role, preceptors reported needing the help of their peers (Richards & Bowles, 2012). Since the preceptee will be functioning within an interprofessional team whose focus is positive patient outcomes, learning from and appreciating the contributions of other disciplines is important. Supporting the preceptor, the coordinator of education for the preceptee relevant to patient care, is the responsibility of everyone on the healthcare team and fosters interprofessional collaboration.

The third best practice identified by proficient preceptors for ongoing preceptor professional development is providing support to preceptors that would enable sharing and exchange of information about the role and responsibilities. Specific examples identified by proficient preceptors included participation in a monthly preceptor forum, distribution of a preceptor newsletter, updates relevant to practice changes and sharing of evidence-based practice findings. Preceptors appreciated the opportunity of meeting with other preceptors as a support mechanism and for the sharing of information. It was suggested to reserve a segment of the hospital's monthly Preceptor Forum for "discussion of new things that have come out or are coming out" to support preceptor learning and promote self-efficacy.

The fourth best practice for ongoing preceptor professional development relevant to preceptor support identified a need for ready access to learning resources about the role. Since preceptors might be unable to obtain relief from patient care duties to attend an off-unit meeting or continuing education offering, proficient preceptors requested resources that were convenient to their work units. Suggestions included hosting educational content on the hospital's Intranet

[employee web-site available only within the hospital and by user password], as well as videos or computer modules. Being able to easily and efficiently view media on patient care units could provide valuable learning options that could be worked into the preceptor's work schedule.

Preceptor support was a theme that emerged as a best practice for ongoing professional development of preceptors. Preceptor support took various forms including mentoring of new preceptors to the role, interdisciplinary and peer support of the preceptor, provision of opportunities for preceptor exchanges and readily accessible learning resources for the preceptor.

Recommendations for Research

Recommendation for research 2.1

A qualitative longitudinal study examining the dyad of preceptor-to-preceptor support mechanisms over the course of a five year period could be conducted to determine if there was a developmental aspect of preceptor support between preceptors.

Recommendation for research 2.2

A comparative study using a self-efficacy tool for assessment could be conducted in order to ascertain whether the Preceptor Forum was building self-efficacy among the preceptors. A group of preceptors who were not in attendance would also complete the assessment and the responses compared.

Conclusion III

Proficient nurse preceptors reported the development of their self-efficacy was related to the acquisition of professional preceptor dispositions.

Conclusion III is supported by findings 1.4, 1.9, 1.16, 2.4, 2.8, 2.11, 2.15.

Proficient preceptors felt that the acquisition of professional preceptor dispositions was essential to promoting preceptor-self-efficacy and was a best practice for ongoing preceptor

professional development. Since preceptors are among the first teachers of new hires within the hospital setting, the attitudes and modeling they display may significantly affect the professional comportment and success of novice practitioners and new hires (Casey et al., 2004; Sandau & Halm, 2011). Besides competence, the professionalism transmitted by preceptors may impact patient outcomes at that facility, and healthcare institutions can ill-afford negative results on quality indicators in the current value-driven reimbursement system (Conway, 2009). A solution recommended by proficient preceptors was the inculcation of professionalism within preceptors' work environments, including professional growth mechanisms such as evaluation and self-reflection, role modeling and promotion of social integration, and healthy management of stressors while precepting.

Inculcation of professionalism.

Professionalism was inculcated through formal and informal feedback mechanisms, evaluation of preceptor performance, and through self-reflection by the preceptor. Feedback from preceptees was seen as a powerful indicator of preceptor performance of duties, and positive feedback was perceived as a reward. Jane stated, "They thought I did a good job. That's rewarding for me, and it feels like the next time…it comes easier." Ingrid also looked at preceptee achievement as a reflection on her teaching and professional capabilities. She said that because of her precepting, that "they would tell me…they were ready to fulfill their role". She felt validated when she noted preceptees were able to "demonstrate everything they needed to do or performed a skill independently because they had been taught it". Informal, second-hand comments about preceptor effectiveness also validated and reinforced professional behaviors in preceptors. Eduardo reported that he had overheard, "He's a good preceptor, you'll learn a lot".

This influenced his thinking that "I must be doing something right. So I just keep doing what I could do".

Proficient preceptors read observations of preceptee forward progress as reflective of high preceptor self-efficacy and professionalism. Jane stated, "If I've done a good job, and they've learned and had a good day and are moving forward, that's rewarding". Eduardo related that, "One nurse should be able to take care of six patients on the unit I worked, so if the new grad is taking care of less than six patients within the next four weeks, there might be something wrong. So they're trying to check me [the preceptor] as well." Eduardo viewed his preceptee's progress as indicative of his capabilities to enact his role.

To encourage professional growth, proficient preceptors requested evaluative information about their precepting skills. Georgia explained, "I'd like more feedback on what the orientee thought of you [*sic*] as a preceptor…constructive feedback for the nurses for him or herself to grow". Carol wanted especially to know about problems or "big things", saying these should be addressed immediately. Receipt of constructive feedback for the preceptor, according to Jane, should occur proximal to the event. She stated, "I would want to know then [emphasis added]", and would prefer having the person "tell you in private". Ingrid tried to facilitate this feedback by regularly asking her preceptee, face-to-face, "Are there any issues, is there anything at all?" Inquiring proactively about the preceptee's perceptions might circumvent misunderstandings and promote professionalism between preceptor and preceptee.

Formal feedback mechanisms that promoted professional accountability were mentioned as especially important for continued preceptor development. When Ingrid received formal written evaluations from her preceptee, she stated, "It made me feel better, more comfortable, and made me extend myself a little further". Ingrid and Henrietta identified that they would

appreciate management feedback addressing precepting activities during their annual performance evaluation process. Ingrid recommended "using evaluations" as a means to improve preceptor professionalism and competence. Henrietta stated that she wanted to feel good about her practice, and that "feedback is always the best" way to support preceptor growth.

When preceptees struggled or failed to progress, proficient preceptors questioned their professional acumen, and the supportive consultation and feedback of respected preceptor colleagues was valued. Carol related the story of such a case, "We had one nurse, and it was every nurse preceptor, not just somebody in particular, nobody was sure why…but she left." She continued, "We wanted her to progress [but]…the preceptee wasn't bringing everything together". The informal and supportive evaluative feedback consultation with preceptor peers helped to validate that preceptor's assessment of her preceptee.

Proficient preceptors felt that inculcation of professionalism among preceptors required being selective about who was allowed to precept. They were keenly aware of colleagues who were underperforming in their role, and found these few individuals distressing. Adele commented, "You aren't going to make one bad apple spoil the whole bunch", and expressed her commitment to excellence as a preceptor. When discussing preceptor colleagues who were dedicated to their role, Georgia commented that most "preceptors do an amazing job teaching those subtleties of change about our patients".

Proficient preceptors used self-reflection to identify gaps in knowledge, as well as behaviors and attitudes that could undermine professionalism and self-efficacy in the role. While engaged in precepting activities, Henrietta said, "You have to have a good understanding of yourself, how you feel about yourself." Billie used the Preceptor Self-Efficacy Evaluation Form as diagnostic of her own competence and discovered aspects of precepting that were

underdeveloped. She reported, “There were a couple things I scored myself lower on, because, I’m like, ‘I don’t even think about that’. You want to have all that, but you don’t know what you don’t know”.

Knowing when and how to use self-reflection was instructive to maintaining professionalism while dealing with a challenging preceptee. Billie shared her use of self-reflection as an adjunct to managing a precepting dilemma. She recounted, “I think you can’t walk away from a situation and not think about what you did.” Billie used the insights gained from the self-reflection process to change her approach, which restored her professional relationship and resulted in improved preceptee performance.

Role modeling and social integration of preceptees.

A professional disposition that is fundamental to preceptor self-efficacy is the ability to serve as a role model for preceptees, and also to continue as a resource or mentor to new hires after the orientation has ended (Myrick & Yonge, 2004). Since nursing is a practice discipline, preceptors must be able to clinically model nursing skills and attributes for the preceptee to observe while providing care to patients. Proficient preceptors related experiences of being strongly influenced through the excellent tutelage of one or more outstanding role models during their formative years. These role models helped proficient preceptors to feel welcomed and paved the way for the social acceptance of the preceptee as a contributing member of the interdisciplinary team. Since the attitudes and behaviors of their primary role models were still so strongly represented in proficient preceptors’ consciousness, providing ongoing preceptor professional development related to professionalism in role modeling is critical.

Proficient preceptors also learned professionalism through vicarious observation of the behaviors of nurse leaders, who Adele said, “laid the foundation…empowered us”. Three

proficient preceptors identified significant role models that had impacted their professional inculcation as a nurse and preceptor. Specific descriptors of exemplary characteristics were recalled, including "love of nursing", "positive attitude", "quiet and sure of herself", "willing to help", and "had expectations. Being "clinically expert" and "good at the bedside, clinical-wise, knowledgeable" were also professional characteristics that were mentioned by Eduardo and Ingrid as significant about their role models. Eduardo said that he continued to emulate "the knowledge, skills and attitude at the bedside" that were learned from his primary preceptor role model. Accountability was identified as an essential attribute by Donna, and her role model was described as a "good employee" who was "responsible for her actions and always…honest and truthful". Jane felt that a professional preceptor role model should "love and care about the hospital". This belief was shared when refocusing her preceptee that, "it is about the patients that you take care of…and that's what I want to teach people that I precept or mentor, that you do the best you can for them".

As role models, preceptors also demonstrated professionalism by helping preceptees to socialize and become an accepted member of the healthcare team (Baltimore, 2004; Casey et al., 2004; Chandler, 2012; Hickey, 2009; Spiva, 2013). Billie's described her responsibility as "orienting [preceptees] to the team" to facilitate acceptance. In addition, she said she "encourages their interaction with staff" and tried to involve other team members in meeting their learning needs. Professionalism by the preceptor was described by Frances as being a protector of the preceptee from the effects of horizontal violence. She said, "You don't just throw them to the wolves", and Georgia added, "You don't have a sense of the politics when you are so new…so you have the preceptor interface all of that".

Mentoring.

Mentoring as described in the nursing literature involved an ongoing professional relationship between a novice and a seasoned nurse for the purpose of grooming a person for a role or aiding professional development beyond the orientation period (Bratt, 2009; Gavlak, 2007; Spiva et al., 2009). An aspect of professionalism that proficient preceptor, Adele, identified about herself was readiness to serve as a resource and mentor to former preceptees. She said, "I am willing to foster whatever or whoever needs that mentoring". Although her assignment as preceptor may have completed, she stated, "Mentorship will always be there. I see myself as a mentor".

Managing stressors.

One of the challenges that confronted proficient preceptors was the risk of burnout or mental and physical exhaustion, which could impair interactions with preceptees. Employees such as preceptors, who work in a resource deficient healthcare environment and who experience the increased volume and complexity of their work assignment may especially be vulnerable (Grau et al., 2001; Jex et al., 2001; Hyrkäs & Shoemaker, 2007; Yonge et al., 2009). Proficient preceptors reported that being able to manage the stressors of the role professionally while engaged in precepting was a characteristic of the preceptor with high self-efficacy.

Ingrid reported that "it takes time to precept", and "the assignment needs to be realistic for precepting", and Henrietta lamented the fact of often being faced with "not enough staff to precept." Both proficient preceptors reported feeling conflicted about their professional obligation to the preceptee when they experienced the "stress of multiple priorities" and Ingrid worried that the preceptor could be vulnerable to "burnout" fatigue. Finding ways to mitigate job-related stressors to enable preceptors to continue enacting their role professionally was an

important component of preceptor self-efficacy. Suggestions offered by Henrietta and Ingrid included, "knowing in advance" of precepting assignments; rotating precepting assignments, and allowing preceptors who were not invested in precepting to "deselect" themselves. Another solution proposed by Eduardo involved the modification of his own professional behaviors to help in dealing with stress. He said, "I came to realize that whatever I do, there is always something that will be left for the other shift to do", so he tried to "focus on the tasks at hand" to avoid mistakes and de-stress while doing his job professionally.

Inculcation with professional preceptor dispositions was an essential component of preceptor self-efficacy development. Because preceptors can influence the attitudes and competence of new hires through their instruction, which may also impact patient outcomes, providing ongoing professional development relevant to the concepts of role modeling, mentoring, social integration of new hires and managing stressors while acting as preceptors would be important.

Recommendations for Practice

Proficient preceptors identified three best practices for ongoing professional development relevant to professionalism. These included inculcating professional preceptor dispositions among preceptors, expediting social acceptance of the preceptee into the work environment, and ensuring effective communication between preceptors about preceptee progress.

First, because preceptors are such key players in the acculturation process of new nursing staff (Axelrod, et al., 2002; Hensinger et al., 2004), a best practice recommendation for ongoing preceptor development was the inculcation of professional preceptor dispositions. Cultivation of a dedicated preceptor group, who would demonstrate not only competence, but also positive attitudes, was identified as crucial to the development of a vibrant workforce to carry out the

mission of the hospital and is consistent with recommendations found in the nursing literature (Sandau & Halm, 2010; Spiva et al., 2013).

Selection as a preceptor should consider suitability based on attitudes and attributes demonstrated by the candidate. Proficient preceptors verbalized that preceptors had to be willing and committed to assume the weighty responsibility of teaching preceptees for the period of weeks or months. Essential nursing attributes that proficient preceptors wanted to embody and instill in preceptees through professional modeling were a sense of compassion and empathy towards patients.

A second best practice recommendation for ongoing preceptor professional development related to professionalism involved promoting the social acceptance of the new person within the work unit. Welcoming the preceptee and providing introductions to the healthcare team was especially important during their impressionable first days at a new job (Baltimore, 2004; Casey et al., 2006; Spiva et al., 2013). Indeed, the literature has reported new hires as vulnerable to horizontal violence in some workplace settings (Wilson, Diedrich, Phelps & Choi, 2011), and the preceptor could help prevent this occurrence by modeling professional behaviors and responses in interpersonal interactions. Facilitation of introductions and welcoming the new person was especially important on a preceptee's first day (Ulrich, 2012).

A third best practice recommendation for ongoing preceptor professional development related to professionalism involved ensuring effective communication between preceptors about preceptee progress (Foy et al., 2013; Sandau et al., 2011). Since preceptees are frequently assigned to more than one preceptor, effective communication about orientation plans and progress among preceptors was essential for continuity and consistency with the learning plan. Because nurse preceptors work different shifts and schedules, face-to-face dialogue between

preceptors has oftentimes been impossible, hence, other communication mechanisms are necessary. Developing mechanisms to improve accountability of the preceptors related to hand-off communication could prevent redundancy and eliminate gaps in learning activities.

In summary, proficient preceptors identified three best practices related to professionalism to be included in their ongoing professional development activities. Inculcation of professional preceptor dispositions should be inherent to the role, promotion by preceptors of social acceptance of preceptees into the work environment is essential, and ensuring effective communication between preceptors about preceptee progress would improve continuity and consistency of the preceptee experience.

Recommendations for Research

Recommendation for research 3.1

An in-depth qualitative case study could examine professional dispositions and the reliability of these dispositions to their level of preceptor expertise.

Recommendation for research 3.2

A discourse analysis could be employed to investigate the dyadic conversations between preceptors and preceptees regarding feedback and communication patterns.

Recommendation for research 3.3

A case study of one patient care unit could be conducted to ascertain how preceptors integrate preceptees into the social fabric of the unit.

Implications of the Study

This action research study engaged proficient nurse preceptors in exploring the development of their preceptor self-efficacy using Bandura's (1997) social cognitive theory as lens to focus the research questions. Based on reports from study participants, the researcher

compiled a list of best practices for ongoing preceptor professional development within a long-term acute care hospital (LTAC) setting. The action research design and small sample size, ten proficient nurse preceptors at one hospital site, limited the generalizability of the study to all hospital settings (Coghlan & Brannick, 2010; Herr and Anderson, 2005; Stringer, 2007). However, this study uncovered important information about preceptor self-efficacy development and best practices for professional development that resonate with findings of nurse researchers in other settings relevant to instruction (Boyer, 2008; Hillman & Foster, 2011; Nelson, et al., 2012; Sandau et al., 2011; Swihart, 2007; Ulrich, 2011). Findings from this study will be used to focus preceptor professional development efforts within this hospital. The study has triggered ideas that beg further investigation and will serve as a springboard for additional research studies related to preceptors across disciplines and job classes. Such recommendation include evaluating the effectiveness of best practices and their applicability to preceptors from other disciplines.

Because preceptors are the first teachers and role models of new hires, the quality of their precepting directly impacts the competence and acculturation of new staff on their patient care unit (Axelrod et al., 2002). Ineffective precepting affects orientee satisfaction, staff turnover, and patient outcomes (Haggerty et al., 2012; Sandau et al., 2011; Twibell et al., 2012). Preceptors practice within value-based health systems, and their financiers are increasingly challenged to cut costs while producing high quality patient care outcomes or face cuts in reimbursement (Conway, 2009; HCHAPS, 2013; HHS, 2013). Healthcare administrators rely heavily on the contributions of proficient preceptors with high self-efficacy to successfully on-board new hires and perpetuate a culture of excellence (Hensinger et al., 2004). Despite this identification of preceptors as essential personnel, limited resources in this state have been

invested into formal professional development of preceptors beyond an initial workshop day (Thomas, 2013). In this environment of scare resources, it is crucial that nurse preceptors develop self-efficacy. It is also integral to the profession that their insights be used to guide best practices for preceptor development.

Self-efficacy is a construct that describes how people feel about their capabilities to perform in job-related situations (Bandura, 1997), and preceptors with high self-efficacy might be expected to manage stressors, as well as teach and persevere at a greater level of expertise than preceptors with lower self-efficacy. This study provided information from a largely untapped resource, proficient preceptor participants, regarding their own self-efficacy development.

Thirty-nine findings were elicited from participants related to preceptor self-efficacy development, which were further categorized. Three themes related to self-efficacy development emerged: Instruction, Preceptor Support and Professionalism. Twenty-five of the findings were clustered under Instruction, eight under Professionalism, and six under Preceptor Support. Because teaching and modeling is an integral part of the preceptor role, it stands to reason that proficient preceptors would describe pedagogies related to instruction as vital knowledge for developing preceptor self-efficacy. Instruction categories that were identified included modeling, the learning environment, teaching strategies, communication skills and evaluation. Nurses receive limited education related to clinical pedagogy as part of their undergraduate nursing curriculum (Bonnel & Starling, 2003; Luhanga et al., 2010; Yonge et al., 2008), and the need to provide additional professional development related to teaching competencies were validated through the findings elicited from study participants about their self-efficacy development.

Eight findings related to self-efficacy development fell under the theme of Professionalism, which was encouraged and perpetuated through competent role modeling and inculcation of a culture of excellence within the hospital's preceptor program. Proficient preceptors grew through observations of exemplary preceptor and leadership role models in action, who had welcomed and encouraged them as new nurses and preceptors, and served as the standard against which they judged their capabilities. This professionalism was likewise passed on to subsequent preceptees via the proficient preceptors' role modeling and mentoring. Proficient preceptors also communicated professionalism through their interactions with preceptees amid the complexities of patient care, and being able to successfully meet challenges elevated their sense of efficacy in the role.

In order for preceptors to attain a sense of self-efficacy in the role, six categories relevant to Preceptor Support were identified as necessary. Since nurse preceptors frequently work in emotionally charged environments and assume additional duties while precepting, they could be more vulnerable to stress effects (Griffin et al., 2002; Hautala et al., 2007; Krichbaum et al., 2007; Sandau et al., 2011, Yonge et al., 2008). Proficient preceptors described supportive structures that could be embedded within the preceptor program to support their role and mitigate the effects of job stressors. Preceptor supports that were identified as beneficial would create opportunities for preceptor discourse and encourage peer support as a means to further self-efficacy development. Preceptors carry weighty responsibilities in acculturating new hires. A selection process to identify appropriate candidates was seen as supportive and the majority of proficient preceptors had been "selected" by a respected nurse manager or leader. Rewards that supported preceptors included receiving encouragement and feedback about their contributions towards the development of new staff, and having mechanisms to provide consistent feedback.

Support for ongoing learning related to clinical and pedagogical knowledge were viewed as necessary to develop and sustain preceptor self-efficacy.

After reflecting about their personal self-efficacy attainment, proficient preceptors were asked to recommend best practices for ongoing preceptor professional development within an LTAC hospital setting. Having preceptors that are highly skilled and efficacious is a necessity to maintain a healthy workforce capable of caring for increasingly complex patient needs (Biggs & Schreiner, 2010). Engaging proficient preceptors in an action research study such as this has provided salient and innovative ideas for preceptor development that could be adopted by the study hospital, as well as other hospitals within the state. Proficient preceptors identified 13 best practices that were clustered under three categories: Instruction, Preceptor Support and Professionalism. Similar to the results reported about proficient preceptors' self-efficacy development, the largest number of best practice findings was categorized as Instruction. Six findings were categorized as Instruction, four as Preceptor Support, and three as Professionalism.

Nurses who become preceptors must learn a new skillset to instruct preceptees at the bedside. In order to effectively instruct preceptees, proficient preceptors identified a best practice to create a safe learning environment where open exchanges between teacher and learner were of primary importance. An awareness of their contributions to such a milieu would be developmental for new preceptors, and an environment of respectful learning would also enable preceptors and preceptees to learn from each other as adult learners.

Proficient preceptors suggested other best practices for instructional professional development of preceptors, including knowing their learners to promote preceptee success, utilizing effective structures to guide the learning, planning the learning, feedback, and evaluation. Preceptors reported that knowing their learners was related to using adult learning

principles to effectively assess the learner's needs and expectations. Discovering the talents, occupational skills and life experiences that the preceptee brought to the workplace could provide a springboard to higher levels of success. Preceptors also desired meaningful orientation structures within which they could practice and that would guide their enactment of their role. This included having a framework of competency tools and realistic time frames to benchmark preceptee progress against, and they recommended engaging proficient preceptors in developing and revising these structures. Preceptors indicated a best practice was to plan out the learning experiences. Planning provided predictability and a sense of control for the preceptee and preceptor, and served to reduce anxiety of the new hire.

Feedback and evaluation were described as essential ingredients of ongoing professional development of preceptors. An integral aspect of the preceptor role is the ability to provide effective feedback on a continual basis to preceptees. What proficient preceptors reported as difficult was providing constructive or negative feedback when the preceptee was not meeting expectations. This aspect of feedback aroused feelings of discomfort in preceptors as well as preceptees, and often required involvement of the manager and clinical educator. Professional development in the form of role-playing, simulations or vicarious sharing during Preceptor Forum was suggested as ways of practicing constructive to provide difficult feedback.

To provide feedback to preceptors about their role performance, a best practice for preceptor development would include consistent evaluation mechanisms. Proficient preceptors desired information from their consumers regarding their enactment of the role and wanted information about areas needing improvement. Preceptors felt rewarded when they received positive feedback from preceptees, and suggested a best practice solution of including manager feedback as part of the annual performance evaluation.

Best practice recommendations that were categorized as Preceptor Support and Professionalism enabled the best practices for Instruction. With regards to Preceptor Support, proficient preceptors identified a need to network and discourse with other preceptors about their role as a means for professional growth and support. This is consistent with what was found in the nursing literature, where preceptors were able to participate in a group at exemplary hospitals and appreciated opportunities for networking. It was reported that these connections were associated with higher ratings on satisfaction surveys of preceptors who had participated (Baggot et al., 2005; Nelson et al., 2012; Henderson et al., 2006). In addition, new preceptors could learn vicariously how to be an effective preceptor through the support of a proficient preceptor mentor, who would encourage preceptor self-efficacy in performing role responsibilities. In addition to preceptor networking and mentoring, a best practice for preceptor learning would involve alternative learning options that would be readily available to the preceptor who might not be able to leave the patient care unit for education, such as computer and Intranet options.

Since embarking on this action research project, the researcher has collaborated with educators and preceptors within the hospital to convene a monthly preceptor forum, hosted on alternating days of the week and times to encourage attendance by different preceptors. The members have begun to incorporate this study's best practice findings when planning group activities. An example of this was the Preceptor Forum's initial meetings, during which the members examined and redefined the role and professional responsibilities of the preceptor within this hospital, inculcating these best practices into hospital standards. In addition, the hospital's Preceptor Forum has provided a haven for discussion and education on precepting topics such as encouraging socialization, selecting goals, assessing learning styles, providing feedback, and fostering critical thinking. Every two months, a short newsletter, summarizing an

educational topic, has been distributed via e-mail to hospital preceptors, and featured the contributions of an excellent preceptor. The study hospital's monthly Preceptor Forum members are currently engaged in planning a hospital-wide preceptor celebration to honor preceptors who have served the hospital over the past year.

The third theme, Professionalism, aligned with three best practices and supported the Instruction best practices by promoting excellence according to hospital and professional practice standards. Proficient preceptors identified a need to select candidates for the preceptor role who demonstrated willingness to serve and whose comportment aligned with the values of professionalism. Preceptors transmit the culture of the organization, inculcating professional dispositions among preceptors, facilitating socialization of new staff and fostering communications.

The sharing of practices and the translation of these practices into ongoing procedures represented the relevance and power of these best practice recommendations in the final step of this action research study. One of the objectives of an action research study is the empowerment of the participants and reinvigoration of the preceptor group. It is anticipated that additional follow-up research would build on these findings, and lead to a continued assessment of the ability of best practice recommendation to increase self-efficacy among preceptors and to empower the participants of this research to embark on meaningful changes. This study has contributed to a heightened awareness of the power of the preceptor to contribute to the health care arena and a healthy workplace. Preceptors represent an untapped capacity to inculcate significant change in the development and promotion of nurse professionalism.

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Appendix A

Survey of Connecticut Hospitals Related to Ongoing Preceptor Development

Data source: Nursing Educator (e-mail survey)
Researcher: Jeanne Thomas, MSN, RN-BC
May-June 2013

Question	Yes	No
1. Do you currently provide ongoing preceptor development at your hospital (post-initial class)?	5	15
2. Do you have a group for preceptors to share (e.g. preceptor forum, support group, council)?	2	18
3. Once initiated as a preceptor, is there an annual (or periodic) reappointment?	1	19
4. Do you hold interdisciplinary initial preceptor classes?	5	15
		[a]n=24

Appendix B

Preceptor Expertise Evaluation-Revised Instrument

Preceptor Expertise Evaluation-Revised

Preceptor: _____ Evaluator:_____ Date:_____

This form is used to evaluate the performance expertise of the Preceptor in working with new hires, novice nurses, or those new to a specialty area or unit. Rating should be conducted by the clinical educator or clinical manager who has observed the preceptor's performance. The scoring uses Benner's (1984) Novice to Expert language, aligned to a 1-5 rating:

Performance will be rated on a continuum as:

1=Novice/rarely to 5=Expert/consistently *(circle choice for each item)*

Preceptor Performance Competency	**Novice Rarely**				**Expert Consis-tently**
Core Competence: Assessment & Intervention					
1. Assesses preceptee's organization of care within specified time frame.	1	2	3	4	5
2. Evaluates preceptee's attitudes in the work environment.	1	2	3	4	5
3. Evaluates preceptee's capabilities in the work environment.	1	2	3	4	5
4. Identifies preceptee difficulties with role transition.	1	2	3	4	5
5. Assists preceptee's identification of learning needs.	1	2	3	4	5
6. Seeks out learning experiences to meet preceptee's needs.	1	2	3	4	5
7. Ensures a safe environment of care for patients.	1	2	3	4	5
8. Ascertains preceptee adherence to hospital and professional practice standards.	1	2	3	4	5
9. Protects preceptee from making errors that could have adverse outcomes.	1	2	3	4	5
Core Competence: Communication					
10. Listens attentively to preceptee.	1	2	3	4	5
11. Facilitates preceptee development of effective communication skills.	1	2	3	4	5
12. Feedback is timely.	1	2	3	4	5
13. Feedback is conducted in a private location.	1	2	3	4	5
14. Feedback is delivered in a respectful manner.	1	2	3	4	5
15. Feedback is objective and clear.	1	2	3	4	5
16. Difficult conversations are managed effectively.	1	2	3	4	5
Core Competence: Critical Thinking					
17. Assesses prioritization skills of preceptee.	1	2	3	4	5
18. Encourages reflective thinking in the preceptee.	1	2	3	4	5
19. Uses questioning to develop preceptee's critical thinking processes.	1	2	3	4	5
20. Explores alternative nursing actions/priorities to promote critical thinking.	1	2	3	4	5

Adapted from the Preceptor Expertise Evaluation (2007), by permission of the Susan Boyer, Vermont Nurses In Partnership (VNIP).

(Continued on Page 2)

Core Competence: Human Caring & Relationships					
21. Socializes preceptee into the work environment (e.g. introduces and links with others).	1	2	3	4	5
22. Advocates for preceptee on the work unit.	1	2	3	4	5
23. Supports the preceptee's successful transition into the culture of the unit.	1	2	3	4	5
24. Positively reinforces preceptee's achievement of goals.	1	2	3	4	5
25. Encourages a learning environment of openness, trust and inquiry.	1	2	3	4	5
Core Competence: Leadership					
26. Role models professional behavior that engenders peer respect.	1	2	3	4	5
27. Manages conflict resolution effectively.	1	2	3	4	5
28. Serves as a mentor to less experienced preceptors.	1	2	3	4	5
Core Competence: Management					
29. Establishes realistic goals in collaboration with preceptee.	1	2	3	4	5
30. Meets on a regular basis with preceptee to evaluate goals and outcomes.	1	2	3	4	5
31. Provides evidence of competent practice by the preceptee.	1	2	3	4	5
32. Provides resources to the orientee when appropriate.	1	2	3	4	5
33. Manages preceptor responsibilities effectively in addition to usual nursing duties.	1	2	3	4	5
Core Competence: Teaching					
34. Teaches from a foundation of clinical expertise.	1	2	3	4	5
35. Teaching plan considers preceptee's stage of professional development.	1	2	3	4	5
36. Teaching skills/techniques are effective for the preceptee's needs.	1	2	3	4	5
37. Coaches for clinical competence.	1	2	3	4	5
38. Breaks the learning into manageable chunks to enable mastery.	1	2	3	4	5
39. Continually updates the orientation plan based on orientee progress.					
Core Competence: Knowledge Integration					
40. Differentiates between practice variations and violation of principles.	1	2	3	4	5
41. Models use of evidence-based practice to support patient care.	1	2	3	4	5
42. Encourages the preceptee to apply ethical principles to care.	1	2	3	4	5
43. Demonstrates cultural awareness in working with diverse learners.	1	2	3	4	5

Adapted from the Preceptor Expertise Evaluation (2007), by permission of the Susan Boyer, Vermont Nurses In Partnership (VNIP).

Appendix C
Preceptor Self-Efficacy Evaluation Instrument

Preceptor Self-Efficacy Evaluation

Preceptor: _____ Date: _____

This form is a self-evaluation tool to be completed by the preceptor.
Please rate your confidence (on a scale of 1-5) that you ***can effectively perform*** the competencies below ***on a regular basis***:

Performance will be rated on a continuum as: 1=rarely to 5=consistently
(circle choice for each item)

While precepting, *I am confident that I can:*	**Rarely/ Novice**		**Some what**		**Almost always /Expert**
Core Competence: Assessment & Intervention					
44. Assess preceptee's organization of care within a specified time frame.	1	2	3	4	5
45. Evaluate preceptee's attitudes in the work environment.	1	2	3	4	5
46. Evaluate preceptee's capabilities in the work environment.	1	2	3	4	5
47. Identify preceptee difficulties with role transition.	1	2	3	4	5
48. Assist preceptee in identifying their learning needs.	1	2	3	4	5
49. Seek out learning experiences to meet preceptee's needs.	1	2	3	4	5
50. Ensure a safe environment of care for patients.	1	2	3	4	5
51. Ascertain that the preceptee adheres to hospital and professional practice standards.	1	2	3	4	5
52. Protect preceptee from making errors that could have adverse outcomes.	1	2	3	4	5
Core Competence: Communication					
53. Listen attentively to preceptee.	1	2	3	4	5
54. Help the preceptee to develop effective communication skills.	1	2	3	4	5
55. Give timely feedback.	1	2	3	4	5
56. Provide feedback in a private location.	1	2	3	4	5
57. Give feedback in a respectful manner.	1	2	3	4	5
58. Give feedback that is objective and clear.	1	2	3	4	5
59. Manage difficult conversations effectively.	1	2	3	4	5
Core Competence: Critical Thinking					
60. Assess the prioritization skills of the preceptee.	1	2	3	4	5
61. Encourage reflective thinking in the preceptee.	1	2	3	4	5
62. Use questioning to develop preceptee's critical thinking processes.	1	2	3	4	5
63. Explore alternative practitioner actions/priorities to promote critical thinking.	1	2	3	4	5

Adapted from the Preceptor Expertise Evaluation (2007), by permission of the Susan Boyer, Vermont Nurses In Partnership (VNIP).

(Survey continues on Page 2)

Core Competence: Human Caring & Relationships					
64. Socialize preceptee into the work environment (e.g. introduce and link with others).	1	2	3	4	5
65. Advocate for the preceptee on my work unit.	1	2	3	4	5
66. Support the preceptee's successful transition into the culture of my unit.	1	2	3	4	5
67. Positively reinforce preceptee's achievement of goals.	1	2	3	4	5
68. Encourage openness, trust and inquiry in the preceptor/preceptee relationship.	1	2	3	4	5
Core Competence: Leadership					
69. Role model professional behaviors that engender peer respect.	1	2	3	4	5
70. Manage conflicts effectively.	1	2	3	4	5
71. Serve as a mentor to less experienced preceptors.	1	2	3	4	5
Core Competence: Management					
72. Establish realistic goals in collaboration with the preceptee.	1	2	3	4	5
73. Meet on a regular basis with preceptee to evaluate accomplishment of goals and outcomes.	1	2	3	4	5
74. Provide evidence of competent practice by the preceptee.	1	2	3	4	5
75. Provide resources to the preceptee when appropriate.	1	2	3	4	5
76. Manage preceptor responsibilities effectively in addition to my usual patient care duties.	1	2	3	4	5
Core Competence: Teaching					
77. Teach from a foundation of clinical expertise.	1	2	3	4	5
78. Consider preceptee's stage of professional development in developing a teaching plan.	1	2	3	4	5
79. Use teaching skills or techniques that are effective for the preceptee's needs.	1	2	3	4	5
80. Use coaching skills to help preceptee gain insights and problem solve.	1	2	3	4	5
81. Break the learning into manageable chunks to enable the preceptee to gain mastery.	1	2	3	4	5
82. Adjust my teaching strategies for the specific learner populations (e.g. students, novice practitioners, experienced staff).					
Core Competence: Knowledge Integration					
83. Differentiate between practice variations and violation of principles.	1	2	3	4	5
84. Model the use of evidence-based practice to support patient care.	1	2	3	4	5
85. Encourage preceptee application of ethical principles.	1	2	3	4	5
86. Demonstrate cultural knowledge in working with diverse learners.	1	2	3	4	5

Adapted from the Preceptor Expertise Evaluation (2007), by permission of the Susan Boyer, Vermont Nurses In Partnership (VNIP).

Thanks for your participation in this survey.

Appendix D

Preceptor Individual Interview Protocol

Preceptor Individual Interview Protocol

Purpose of the interview:

Your manager or clinical educator has identified you as a proficient and highly skilled preceptor at this hospital. The purpose of this interview is to help us better understand how preceptors develop from a new, novice preceptor into a proficient preceptor. In learning about your experiences, we might gain insights related to preceptor development and strategies to help other preceptors grow. We would also like to engage your expertise as a proficient preceptor as we identify best practices for supporting preceptor development within this hospital.

Preceptors have been identified in the nursing literature as vital to the development of a healthy and competent workforce: Your efforts and influence shapes the next generation of nurses who will be working with you at this hospital. We would like newer or less effective preceptors to develop the preceptor competencies that you have learned and for them to become what social scientists would call a preceptor with high "self-efficacy".

This action research study will look at this subject using the theory of self-efficacy, which was described by a scientist named Albert Bandura. Self-efficacy is a psychological construct or term that describes how people feel about their capabilities and their ability to affect desired outcomes or goals. In this case we will be talking about self-efficacy related to precepting. For example, I would say that I have high self-efficacy when I feel that I possess the capabilities to perform well as a preceptor and can guide an orientee in my work environment to become a competent team member. Self-efficacy is formed throughout a person's lifetime and develops through four sources of information (we will talk about three of these):

Enactive Mastery Experiences: This is the strongest source of self-efficacy. It works best to increase a person's self-efficacy when a person is actively engaged in learning; when the learning activities consist of incrementally more difficult goals; when the person is able to achieve mastery of a goal, then moves on to more difficult goals; and when the person is able to self-correct along the way towards achievement of a goal.

Vicarious experiences: This is when another person similar to you (e.g. another preceptor), shares their experiences (e.g. how they handled a precepting situation). You might compare yourself with, and may identify with, that person, and maybe would conceive of a different way of doing something related to precepting. Another way to learn vicariously might involve watching a video or a role-play of a situation that could give a different perspective and repertoire of responses.

Verbal persuasion: This is when a person, particularly one in authority or that you respect, provides encouragement about your capabilities, tells you that you have ability, and that are capable of achieving a desired goal. They also might provide positive reinforcement to you as the learner of a new role, like the preceptor role.

Why do we care about self-efficacy?
Self-efficacy is important because people with higher self-efficacy have been shown to be better performer in the workplace, are more likely to continue their education, have better social networks, better health states (e.g. manage stressors better) and have students who perform better. Also, they may be less likely experience burnout on the job, less likely to become cynical, or to express an intention to leave their job. They have higher commitment to their job. So, this is a quality that we would like to cultivate in our preceptors, who are very important people in a hospital setting.

We would like to learn about your experience as a preceptor:

1. Please begin by telling me about your personal journey as a preceptor:
    a. How long have you been a nurse and where did you go to school?
    b. How long have you been at this hospital?
    c. How much experience had you had as a nurse before you became a preceptor?
    d. How much experience had you had on your work unit before you became a preceptor?
    e. How long have you been a preceptor?
    f. What type of setting (specialty, number of beds) have you been a preceptor on?
    g. How many other preceptors were on your unit? Was it a job expectation of all nurses or just selected nurses?
    h. How many orientees do you estimate that you have precepted?

2. How were you prepared for the preceptor role? (EME, VE)

3. Describe people who helped you to learn the role of preceptor (e.g. a role model or mentor). (EME, VE, VP)

    a. How did you see them develop self-efficacy or use self-efficacy? (VE)

4. How do you think you could develop self-efficacy in others? (EME, VE, VP)

5. What elements of the self-efficacy framework that I have described were influential to your own development as a preceptor? (EME, VE, VP)

6. Vicarious experiences are described as hearing about the experiences of others like you and how they behaved and thought in a given situation. Can you think of an example of how you learned through a vicarious experience that helped you to grow as a preceptor? (VE)

7. Have you ever shared your own clinical experiences *(vicarious experiences)* with your orientees to help them understand a different way of looking at or doing something? (Can you think of an example?) (VE)

8. What life experiences taught you or helped you to know how to teach critical thinking? – (EME, VE).

    a. How do get your orientee to develop his/her critical thinking, in a way that will lead to a different understanding of the problem? (EME, VE, VP)

9. Thinking back on your history as a preceptor, tell me the moment that you felt "I am finally getting good at this"? (EME)

    a. How long did it take for you to achieve this level of expertise in precepting? (EME)

    b. How many orientees did you have to precept before you felt you could precept well? (EME)

    c. Can you recall a time that you were working with a preceptee and you felt your decision with him/her was the right one…when you felt you had developed mastery in terms of instructing your preceptee? (EME)

10. Tell me a time that you felt you were verbally persuaded you were good at your job? Tell me about a time that you felt that you were hindered by the comments of others? (VP)

11. How did you think through a problem related to precepting? What was most difficult about being a preceptor and how did you think your way through it? (VE, VP)

12. What could we do to better develop new and older preceptors within this hospital and at other hospitals? (EME, VE, VP)

    a. What do we do well to develop new and older preceptors within this hospital and other hospitals? (EME, VE, VP)

Appendix E

Focus Group Protocol

Focus Group Protocol

Welcome to Participants*:*

I am conducting an action research study as part of a doctoral program of study, and I appreciate that you have agreed to join my study and participate in this Focus Group.

Introductions: Do you know each other? Please say your name, what unit you work on, and how long you have been a preceptor.

Purpose of the Focus Group*:*

Your manager or clinical educator has identified you as a proficient and highly skilled preceptor at this hospital. During this Focus Group, I am asking you to please share your preceptor reflections with this group of other preceptors so that we can learn more about preceptor development and identify strategies to help other preceptors grow. I also would like to engage your expertise as experienced and proficient preceptors in identifying best practices to support preceptor development within this hospital. I will be recording our Focus Group discussion to help me in transcribing accurately your thoughts related to preceptor development and self-efficacy. Following this group, I will contact you to provide an opportunity for you to review the transcript for accuracy. It is an expectation that information shared within this group is kept confidential.

The purpose of this Focus Group is to:

- Help us better understand how preceptors develop from a new, novice preceptor into a preceptor with high self-efficacy (like yourself).
- Reflect on preceptor development through the lens or perspective of self-efficacy (which I will explain).
- Recommend best practices to support the growth of other preceptors within this hospital.

Why is this focus group important?

Preceptors have been identified in the nursing literature as vital to the development of a healthy and competent workforce: Your influence and efforts will shape the next generation of nurses who will be working here at this hospital. We would like newer preceptors to develop the preceptor competencies that you have learned and for them to become what social scientists would call a preceptor with high "self-efficacy".

Theoretical Framework Guiding the Focus Group Questions:

This action research study will look at preceptor development using a framework of self-efficacy, which was described by a social scientist named Albert Bandura. Self-efficacy is a psychological construct or term that describes how people feel about their capabilities and their ability to affect desired outcomes or goals within a given context. In this case we will be talking about self-efficacy related to precepting new hires at this hospital. For example, I say that "I

have high preceptor self-efficacy" when I feel that I possess the capabilities to perform well as a preceptor and can effectively guide an orientee in this work setting to become a competent member of the team.

Self-efficacy is formed throughout a person's lifetime and develops through four sources of information (we will talk about three of these):

Enactive mastery experiences: This is the strongest source of self-efficacy. It works best to increase a person's self-efficacy:

- When a person is actively engaged in doing the learning;
- When the learning activities consist of incrementally more difficult goals;
- When the person is able to achieve mastery of a goal, then moves on to more difficult goals; and
- When the person is able to self-correct along the way towards achievement of a goal.

Vicarious experiences: This is when another person similar to you (e.g. another preceptor):

- Shares their experiences (e.g. how they handled a precepting situation).
- You compare yourself with, or identify with, that person,
- Visualize or conceive of a different way of doing something related to precepting.
- Might involve watching a video or a role-play of a situation to give a different perspective and repertoire of responses (modeled attainments).

Verbal persuasion: This is when another person, particularly one in authority or that you respect, provides encouragement about your capabilities, tells you that you have ability, and that are capable of achieving a desired goal. They also might provide positive reinforcement to you as the learner of a new role, like the preceptor role.

Why do we care about self-efficacy?
Self-efficacy is important because people with higher self-efficacy have been shown to be better performer in the workplace, are more likely to continue their education, have better social networks, better health states (e.g. manage stressors better) and have students who perform better. Also, they may be less likely experience burnout on the job, less likely to become cynical, or to express an intention to leave their job. They have higher commitment to their job. So, this is a quality that we would like to cultivate in our preceptors, who are very important people in a hospital setting.

Focus Group Questions:

13. How do you think you could develop self-efficacy in others? (EME, VE, VP) (Describe development broadly)

14. Enactive mastery experiences is described as when a person is actively engaged in doing the learning; and the learning activities consist of incrementally more difficult but achievable goals; and the person is able to self-correct along the way towards achievement of a goal. Can you think of an example of how you could develop self-

efficacy in a novice preceptor via enactive mastery experiences or active participation? (EME)

15. Vicarious experiences are described as hearing about the experiences of others like you and how they behaved and thought in a given situation. Can you think of an example of how you could develop self-efficacy in a novice preceptor using vicarious experiences? (VE)

16. Verbal persuasion is described as when another person, particularly one in authority or that you respect, provides encouragement about your capabilities, tells you that you have ability, and that are capable of achieving a desired goal. Can you think of an example of how you could develop self-efficacy in a novice preceptor using verbal persuasion? (VP)

17. What would professional development look like that would have as its goal the raising of self-efficacy for preceptors? What would be best practice for the development of self-efficacy for novice preceptors?

Appendix F
Informed Consent Form

Informed Consent Form

The purpose of this study is to engage proficient preceptors in an exploration of the development of your preceptor self-efficacy, to recommend ongoing professional development and best practices within a hospital setting.

Self-efficacy refers to the beliefs that people have about their capabilities to perform in given situations and their ability to achieve desired outcomes.

Proficient nurse preceptors have been identified as valuable employees within the hospital who teach, coach, support, role model, and evaluate the competencies of new hires. The researcher in this action research study will collaborate with participants to identify and recommend best practices to benefit all preceptors who, in turn, may impact orientee success and patient care outcomes.

1. Participation in the individual interview and focus group is **voluntary**.
2. Your time commitment will be two hours:
   - The individual interview will last ***one hour***.
   - The focus group will last ***two hours***.
3. You may stop the individual interview or focus group at any time.
4. You may withdraw from participation in the study at any time without adverse consequences to your relationship with Hospital for Special Care or the University of Hartford.
5. *Benefits of participation*: Your insights about the development of self-efficacy as a preceptor will be helpful for identifying and planning strategies to help grow other preceptors within your institution.
6. *Risks of participation in the individual interview and focus group*: It is not expected that you will experience discomfort and/or adverse effects (e.g. bad memories) as a result of participation. However, if this should occur, you may withdraw from the study at any time and would be encouraged to seek professional counseling through the hospital's Employee Assistance Program (EAP).
7. The principal investigator will maintain confidentiality of information shared, but cannot guarantee that the focus group participants will do so.
8. The individual interviews and focus groups will be recorded and transcribed verbatim.
9. The individual interview and focus groups will not be coded in any identifiable manner.

10. Your name will remain confidential and not be associated with your responses to individual and focus group questions.
11. Responses will be categorized with answers from other participants.
12. Aliases will be used when making reference to you in written notes.
13. Unit of employment will be disguised to prevent identification of the participant.
14. Your transcript from the individual interview and focus group interview may be reviewed to verify their accuracy. The researcher will contact you to share this with you following each session after transcription.
15. The principal investigator and research advisor are the only people who will review the raw data.
16. All digital recordings and transcriptions will be stored in a secure location by the principal investigator for seven years after completion of the study and then will be destroyed.
17. If you have questions about your rights as a research subject, please contact the University of Hartford Human Subjects Committee (HSC) at 860-768-4310. The HSC is a group of people that review research studies and protect the rights of people involved in research.

Thank you for participating in this action research study. If you have questions about this study, you may contact the following:

Principal Investigator
Jeanne B. Thomas, MSN, RN-BC, EdD(c)
Hospital for Special Care
2150 Corbin Avenue
New Britain, CT 05053
860-827-1958 (Office)
jthomas@hfsc.org

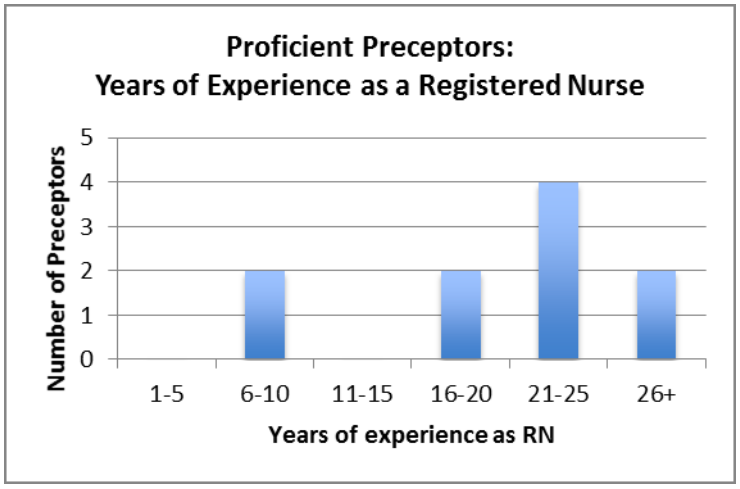
Research Advisor
Karen I. Case, PhD
University of Hartford
200 Bloomfield Avenue
West Hartford, CT 06117
860-768-4369 (Office)
kcase@hartford.edu

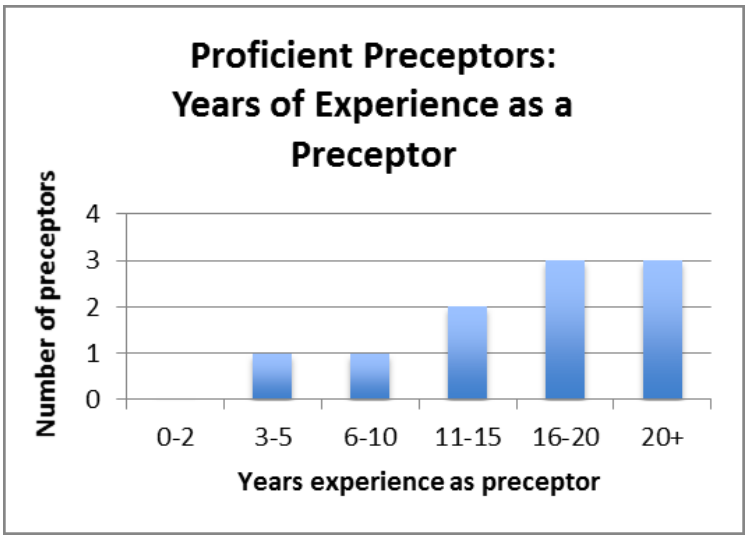
By signing below, you are indicating that you have read and understand this informed consent.

Signature of Participant Date

Signature of Principal Investigator Date

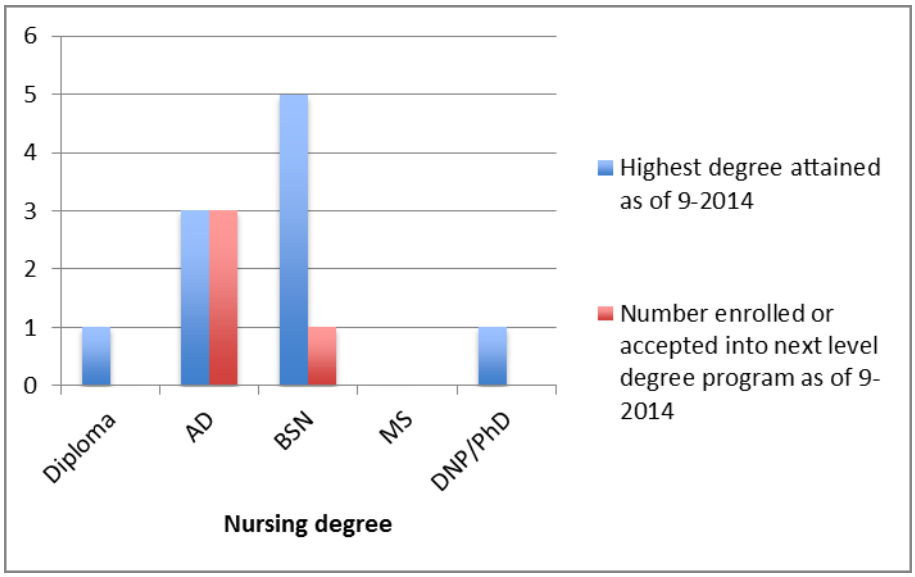
Appendix G
Demographics of Sample





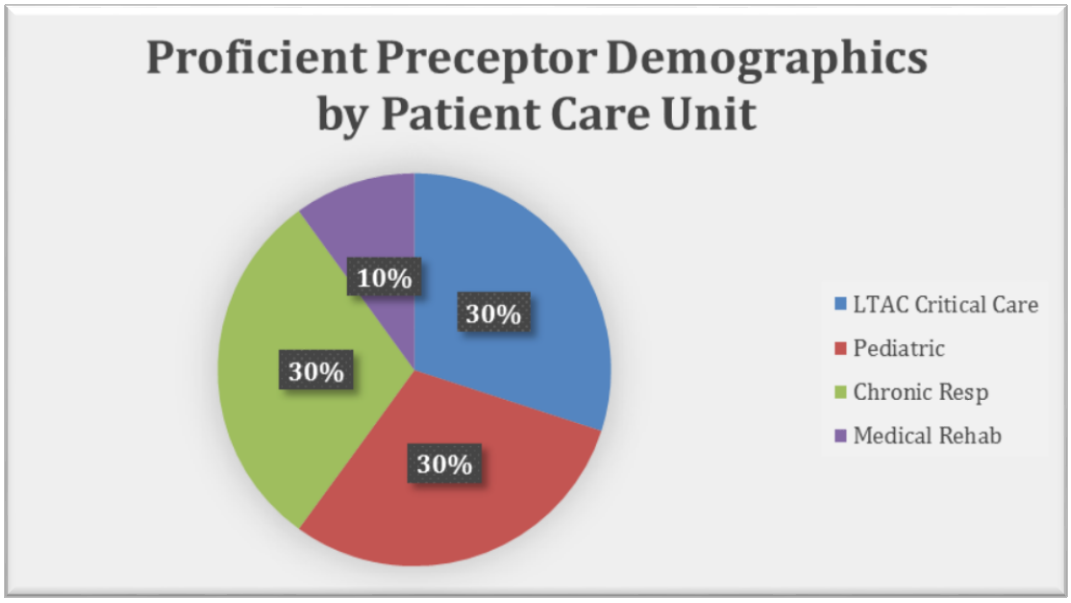
Appendix H

Highest Nursing Degree Attained by Proficient Nurse Preceptors



Appendix I

Sample Distribution by Patient Care Unit



Appendix J

Matrix related to Research Question 1.0

What do proficient nurse preceptors report about the development of their self-efficacy related to enactive mastery experiences?

Participant	Findings 1.1 Model clinical competencies	1.2 Give effective feedback	1.3 Give constructive feedback	1.4 Use feedback to grow	1.5 Assess learning styles	1.6 Build learning for preceptee success	1.7 Enable critical thinking	1.8 Engage in ongoing learning
Adele	X			X			X	X
Billie	X	X	X		X	X	X	X
Carol	X	X			X	X	X	X
Donna	X	X	X		X	X	X	X
Eduardo	X	X		X		X	X	X
Frances	X	X	X	X	X	X	X	X
Georgia	X	X	X	X	X	X	X	X
Henrietta	X			X	X	X		X
Ingrid	X	X	X	X	X	X	X	X
Jane	X	X	X	X	X	X	X	X
Participant	1.9 Serve as a role model	1.10 Use return demo	1.11 Evaluate goal achievement	1.12 Engage in guided practice	1.13 Use repetition	1.14 Use varied teaching strategies	1.15 Use situated learning	1.16 Manage stressors while precepting
Adele	X	X	X	X			X	
Billie		X	X	X		X		
Carol			X	X		X	X	
Donna	X		X		X	X	X	
Eduardo	X	X	X	X	X	X	X	X
Frances	X	X	X	X	X	X		X
Georgia	X				X			
Henrietta	X		X					X
Ingrid	X			X		X	X	X
Jane	X	X	X				X	

Appendix K

Matrix related to Research Question 2.0

What do proficient nurse preceptors report about the development of their self-efficacy related to vicarious experiences?

Participant	Findings							
	2.1 Observe competent preceptor modeling	2.2 Facilitate obser-vations of competent modeling	2.3 Learn from obser-vations of family	2.4 Learn from obser-vations of leadership models	2.5 Learn from obser-vations of modeling failures	2.6 Recall effective preceptor modeling	2.7 Sharing with other preceptors	2.8 Share stories with preceptees
Adele	X	X	X	X	X	X		X
Billie			X			X	X	X
Carol	X	X			X	X	X	X
Donna	X					X	X	X
Eduardo	X	X			X	X	X	
Frances	X	X			X		X	X
Georgia		X		X			X	
Henrietta	X	X		X			X	X
Ingrid	X	X				X	X	X
Jane		X			X		X	X
Participant	2.9 Share precepting responsibilities with another preceptor	2.10 Judging capabilities relevant to attainments of others	2.11 Self reflect for growth	2.12 Listening to others	2.13 Knowing the learner	2.14 Respect for the learner	2.15 Promote social integration of preceptee	2.16 Work side by side with preceptee
Adele		X			X	X		X
Billie		X	X				X	X
Carol		X				X	X	X
Donna	X				X			
Eduardo	X	X	X		X	X		
Frances		X		X	X		X	X
Georgia		X	X	X	X	X	X	
Henrietta	X		X	X	X			
Ingrid	X	X						X
Jane		X				X		X

Appendix L

Matrix related to Research Question 3.0

What do proficient nurse preceptors report about the development of their self-efficacy related to verbal persuasion?

	Findings						
Participant	3.1 Selected as a preceptor	3.2 Receiving information about capabilities from credible sources	3.3 Use encouragement	3.4 Receive positive feedback	3.5 Establish learning environment that provides open exchanges	3.6 Framing feedback	3.7 Mentoring others
Adele	X		X		X	X	X
Billie		X	X	X	X		
Carol			X	X	X	X	X
Donna	X	X	X		X	X	
Eduardo	X	X	X	X	X	X	X
Frances		X	X			X	X
Georgia		X			X		X
Henrietta		X	X	X	X		
Ingrid		X	X	X			
Jane	X	X	X	X	X		X

Appendix M

Matrix Research Question 4.0
What do proficient nurse preceptors recommend regarding best practices for ongoing professional development?

Instruction	**Preceptor Support**	**Professionalism**
4.7 Establishment of a learning environment that encouraged open exchanges.	4.2 Opportunities for exchanges among preceptors.	4.1 Effective communication between preceptors regarding preceptees' progress.
4.8 Using knowledge of the learner to promote learning.	4.3 Peer support of the preceptor role.	4.6 Inculcating professional preceptor dispositions.
4.10 Utilizing effective structures to guide the learning.	4.4 Mentoring of new preceptors.	4.9 Facilitating socialization of the preceptee to the work unit.
4.11 Planning the learning.	4.5 Access to learning resources about precepting.	
4.12 Providing effective feedback.		
4.13 Mechanisms for obtaining evaluative feedback for preceptors.		