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# PRECEPTORS

are the essential link between what nurses are taught and what they do, and between what they know and what they *need* to know.

**Nurse preceptors** have the power and opportunity to inspire nurses to achieve greatness. Effective precepting programs depend on two critical groups: nurses who organize and manage the programs and nurses who support, teach, and coach. Beth Ulrich—nationally recognized for her research in work environments and transitional experiences of new graduate nurses—provides the knowledge, tools, skills, and wisdom both groups need for success.

Written for staff nurses, their managers, and educators, this second edition of *Mastering Precepting: A Nurse's Handbook for Success* teaches preceptors both the science and art of precepting and empowers them to seek the support they need to be effective. For managers, it emphasizes the importance of providing nurse preceptors with positive and supportive experiences. For educators, it provides the information and knowledge required to develop and improve preceptor programs. This fully revised new edition covers:

- **NEW:** Strategies and techniques for developing preceptors
- **NEW:** Information on developing, implementing, and evaluating preceptor programs
- **NEW:** Precepting advanced practice registered nurse students and new graduates
- Roles, planning, goals, and motivation
- Specific learner populations
- Self-care and burnout precautions

**Beth Ulrich, EdD, RN, FACHE, FAAN**, is a Professor at the Cizik School of Nursing at The University of Texas Health Science Center at Houston, teaching in the DNP Program, and Editor of *Nephrology Nursing Journal*, the professional journal of the American Nephrology Nurses Association.

*"In Mastering Precepting, Beth Ulrich and colleagues have provided an excellent resource for nurses who are learning to become preceptors and for educators who are responsible for preceptor development."*

—**Marlene Kramer, PhD, RN, FAAN**  
President,  
Health Science Research Associates

*"Preceptors are central knowledge workers in today's complex, fast-paced healthcare systems. 'On the spot' precepting calls attention to critical changes in patients across time, while also teaching a vast amount of local knowledge about how a community of practice learns, collaborates, and communicates. This book is an invaluable guide—a must-read for all preceptors and nurse managers."*

—**Patricia Benner, PhD, RN, FAAN**  
Executive Director,  
EducatingNurses.com  
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# MASTERING PRECEPTING

A Nurse's Handbook for Success

**SECOND EDITION**



**BETH  
ULRICH**

## Praise for the Second Edition of *Mastering Precepting: A Nurse's Handbook for Success*

*“Mastering Precepting is a must-have handbook for teaching and learning clinical science and a practical overview of how and when that science is relevant. Preceptors are central knowledge workers in today’s complex, fast-paced healthcare systems. ‘On the spot’ precepting calls attention to critical changes in patients across time, while also teaching a vast amount of local knowledge about how a community of practice learns, collaborates, and communicates. This book is an invaluable guide—a must-read for all preceptors and nurse managers.”*

–Patricia Benner, PhD, RN, FAAN  
Executive Director, EducatingNurses.com  
Professor Emerita, School of Nursing, Department of Social and Behavioral Sciences,  
University of California, San Francisco

*“Since the concept of reality shock was identified in the early 1970s, we have known that how nurses are socialized into the profession influences the success of their practice and their entire careers. Subsequent research has found that preceptors and a precepted experience are instrumental in helping new graduate registered nurses make the transition to professional nurses. In Mastering Precepting, Beth Ulrich and colleagues provide an excellent resource for nurses who are learning to become preceptors and for educators who are responsible for preceptor development.”*

–Marlene Kramer, PhD, RN, FAAN  
President, Health Science Research Associates

*“This book is the most significant contribution to the literature in the last two decades on the art and science of preceptorship in the nursing profession. Beth Ulrich and her fellow authors provide theories, practical applications, and ultimately the path forward for transforming organizations and individuals in a complex, modern world that requires disruptive thinking and intentional action to create a better tomorrow for our patients, our colleagues, and our profession.”*

–Cole Edmonson, DNP, RN, FACHE, NEA-BC, FAAN  
Robert Wood Johnson Foundation Executive Nurse Fellow Alumna 2012-2015 Cohort  
Chief Nursing Officer, Texas Health Dallas  
NLN Foundation Chair

*“This book is a brilliant and comprehensive resource for all nurses who participate in the critically important preceptor role. Beth Ulrich and her team have created an exceptionally practical and well-evidenced tool for preceptors and managers that is a must-read for all involved in this process! This book elevates the preceptor role firmly into a formal position that recognizes the essential responsibility preceptors hold.”*

–Judith G. Berg, MS, RN, FACHE  
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*“Preceptors are the linchpins in the smooth transition of nurses and students into new roles. Mastering Precepting: A Nurse’s Handbook for Success is a terrific guide to how to be successful in the preceptor role.”*

–Rose O. Sherman, EdD, RN, NEA-BC, FAAN  
Editor in Chief, *Nurse Leader*  
Professor and Program Director, Nursing Administration and Financial Leadership,  
Florida Atlantic University

*“I have had the privilege of being mentored by Beth Ulrich. I say ‘privilege’ because she takes mentorship to heart and, as such, would never take on a mentee if she was unable to give the person her all. This is but one of the essential qualities of mentorship I learned from her. I have met no one who is more skilled at helping mentees navigate difficult situations or reminding them to celebrate their successes. I celebrate you, Beth. Thank you for sharing your wisdom with me and the nursing community.”*

–Kenneth W. Dion, PhD, MSN, MBA, RN  
Assistant Dean for Business Development and Strategic Relationships  
Johns Hopkins School of Nursing

*“The second edition of Mastering Precepting: A Nurse’s Handbook for Success improves on the already excellent, evidence-based original. The new chapter on precepting advanced practice nurses adds essential content, and the final chapter, ‘Preceptor Development,’ gives the reader a template for applying every chapter in the book to a preceptor development program. This is a must-read for anyone developing or improving a preceptor program for new graduates transitioning from academic education to practice, for experienced nurses changing specialties or roles, or for nurses changing practice settings. In addition to facilitating the transition of nurses by ensuring adequate knowledge and competency, preceptors transmit the culture of quality and safety. This book keeps its promise—it truly is a handbook for creating successful transitions.”*

–Patsy Maloney, EdD, MSN, MA, RN-BC, NEA-BC, CEN  
Senior Lecturer, Nursing and Healthcare Leadership  
University of Washington Tacoma

*“Beth Ulrich has produced a wonderful book full of thoughtful resources to assist nurses in mastering the art of precepting new leaders. The contributions are masterful and useful for educators, clinicians, and nurse executives!”*

–Linda Burnes Bolton, DrPH, RN, FAAN  
Senior Vice President and Chief Nursing Executive  
Cedars-Sinai Medical Center

*“The role of preceptor is indispensable in the complex, dynamic environments in which nurses at all levels practice today. This second edition of Mastering Precepting provides a compendium of resources for anyone interested in becoming a preceptor, becoming a better preceptor, or improving an organization’s preceptor program. This edition contains practical tips and tools that can be tailored to unique situations and implemented immediately. It is also a ready reference for all nurses on coaching, communicating, selecting preceptors, and providing feedback.”*

–David Marshall, JD, DNP, RN, CENP, NEA-BC, FAAN  
System Chief Nursing and Patient Care Services Executive  
The University of Texas Medical Branch

*“Learning facilitators are known by many names, and one of those is ‘preceptor.’ Preceptors abound because nursing relies on them to develop talent in specific situations. With the first edition of Mastering Precepting, Dr. Ulrich and her colleagues gave all who precept a ready reference to understand the role and specific skills to be successful. This second edition doesn’t disappoint. Being a preceptor is a complex challenge, a combination of expert practitioner and clinical educator. Because these roles are typically more focused on practitioner than educator, the book’s resources—tables that summarize key information, forms that invite readers to respond to questions—are especially useful. This second edition concludes with a chapter that supports the preceptor by offering a suggested outline of chapter-by-chapter learning. Mastering Precepting is a one-stop place to learn about what it means to precept, what preceptors do, and what a curriculum focused toward development of preceptors would include. With the emergence of the Certified Nurse Educator–Clinical credential from the National League for Nursing, this book becomes an even more valuable resource.”*

–Patricia S. Yoder-Wise, EdD, RN, NEA-BC, ANEF, FAAN  
Professor and Dean Emerita, Texas Tech University Health Sciences Center  
President, The Wise Group

*“Nurses are expected to lead and serve others toward a better health. Dr. Ulrich said it best: ‘Preceptors are leaders and influencers.’ This book is a must-have for all preceptors to ensure a successful professional journey. I was amazed to see the depth of knowledge found in this book. Furthermore, the content offers an opportunity for the reader to develop a professional plan. This is an excellent resource for all preceptors seeking and pursuing a lifelong journey of professional development.”*

–Sylvain “Syl” Trepanier, DNP, RN, CENP, FAAN  
Chief Clinical Executive Officer, Providence St. Joseph Health  
Southern California Region, Irvine, California

*“Mastering Precepting: A Nurse’s Handbook for Success, Second Edition, provides strategies for use by nurses at all levels of practice. The role of precepting has increased importance and newfound trials in today’s complex healthcare environment. Dr. Ulrich explores opportunities, challenges, and best practices in this book. Her contemporary view of precepting examines generational differences, specific learner populations, instructional technologies, and self-care strategies. This important book fills gaps in knowledge that nurses may not have known existed.”*

–Tamara Kear, PhD, RN, CNS, CNN  
Associate Professor of Nursing  
M. Louise Fitzpatrick College of Nursing, Villanova University  
Nursing Research Consultant, Main Line Health



# **Mastering Precepting**

## A Nurse's Handbook for Success

**Second Edition**

**Beth Tamplet Ulrich, EdD, RN, FACHE, FAAN**



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# Foreword

by Kathleen Sanford

I wish this wonderful book had been available when I graduated with my newly minted BSN. If it had been, perhaps my “preceptor,” a very competent nurse, wouldn’t have considered me ready to take on a full patient load after only a week of orientation. This book would have been very handy when, after a few months of practice, I was assigned to precept another novice. Having been through recent trial-and-error learnings myself, I thought I had improved on the process by adding patient care experiences to the two weeks my “preceptee” spent with me. I made sure she knew how to insert a Foley catheter, put in an IV, place an NG tube, and change a tracheostomy dressing. These were all procedures I had been sadly inept at doing at the time my preceptor said I was ready to take my place on the RN schedule.

Precepting was a fairly new concept in those years. It was just being defined in the literature, and nurses used the term loosely, as my early experiences illustrate. The cursory introductions many of us received to new roles and new jobs could scarcely be described as true initiations to the work and workplace, much less preceptorships. Some of us confused precepting with processes as different as orienting and mentoring for decades. Now, we have a more sophisticated understanding of these terms, and today’s preceptors are much better prepared, largely thanks to the first edition of this book, which received two *American Journal of Nursing* Book of the Year Awards in 2012.

In this second edition, Beth Ulrich and her contributing colleagues have compiled a comprehensive compendium about the science and art of precepting. They cover the various roles of a preceptor in depth while also addressing the needs of preceptees, managers, and organizations. They address crucial topics such as resilience, compassion fatigue, mindfulness, just culture, and critical thinking. The new edition includes information on using new instructional technologies and a chapter about precepting advanced practice registered nurses. I can’t think of anything they’ve left out about how to help nurses bridge the gap between theoretical knowledge and the realities of practice.

The success of these changes is vitally important. The year I started my nursing career, Marlene Kramer’s book *Reality Shock: Why Nurses Leave Nursing* was published. Among other things, she spelled out the merit of preceptorships to mitigate the reality shock that new nurses experience. Forty-four years later, preceptorships are needed more than ever. Working with hospital patients is becoming more complex at a time when an unprecedented number of expert nurses are retiring. As a result, we have a less experienced healthcare workforce, including a greater percentage of novice nurses, with a critical need for precepting.

That's why I'm grateful for this book. Nurses need help to successfully navigate change, whether they are moving from a student to a nurse role or from a nurse to a new specialty position. Patients need competent, caring, and confident nurses. To meet these needs, preceptors must be proficient in a variety of teaching, coaching, role-modeling, and leadership skills. This complete guide ensures that they will be.

–Kathleen Sanford, DBA, RN, FACHE, FAAN  
Chief Nursing Officer, Catholic Health Initiatives  
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# Foreword

by Gwen Sherwood

The work of nursing is physically and emotionally intense, made more challenging during periods of transition. We all have times when we benefit from an experienced preceptor—whether as a new graduate entering practice, an experienced staff nurse changing clinical areas, or a clinician transitioning to academia. Transitions involve a careful balance of role models, relationships, and reflection—three R's that are at the core of this signature second edition of *Mastering Precepting: A Nurse's Handbook for Success*.

Preceptors have a major role in nursing education. The special skills required have often been overlooked; not all great clinicians are effective preceptors. Teaching involves craft, and effective precepting involves both art and science. Like good teaching or good nursing care, good precepting is a carefully developed expertise that develops over time. This updated, expanded second edition is a comprehensive guide to the apprenticeship learning model that can apply to nurse educators, managers, and staff nurses.

A preceptor can ease transitions anytime roles and performance expectations change. Adjusting to a new role or clinical area presents challenges in demonstrating new competencies, learning the social milieu, and finding one's place in the new group. Having an experienced role model, the first key of an effective preceptor, helps smooth the adaptation process. Preceptors support the pillars of education by guiding the preceptee in learning to do, know, be, and work/live as a productive team member. This critical book recognizes the art and science of excellent precepting to help learners bridge the worlds of nursing education and practice.

The preceptor role is similar to that of a mentor; however, selection of preceptors is based on their accomplishment of competencies. Often overlooked is the imperative to provide preceptors for novice faculty transitioning from clinical areas to academia. The demands of understanding the politics of the academic environment, comprehending academic promotion and tenure, and establishing an area of scholarship—while demonstrating excellence in teaching—contribute to high turnover and faculty shortages. One strength of this book is its broad spectrum in applying the art of precepting. It provides a double model for schools of nursing by both helping faculty adapt and developing preceptors for their students.

The relationship between preceptor and learner (preceptee) is the second key to an effective precepting experience. Learning by “doing,” or experiential learning, is a valued pedagogy for service professions. Learning by doing is a systematic, supervised process based on evidence-based standards of excellence in which learners demonstrate their applicable knowledge, skills, and attitudes. To learn by doing involves careful coaching, facilitation, mentoring, guidance, and supervision from a skilled practitioner;

thus, it is relationship-dependent. Preceptors must master the art of observation, assessment, and feedback while building a relationship of support and encouragement. Communication of the learner's development must be clearly delineated in the initial learning contract—whether it is with the nurse manager for a new employee or graduate or with a faculty member for student learners.

Good preceptors not only guide skill acquisition based on the science of nursing—they also practice the art of nursing by helping learners reflect on their experiences. Reflection, the third key to effective precepting, is the process of examining the meaning and objectively looking at varying perspectives to make sense of an event within the context of empirical knowledge. Reflecting to learn from one's experience is the basis of Patricia Benner's book *From Novice to Expert* (1984) that is used in many professional practice models. Preceptors are frontline guides who observe learners' developing competencies and thus have a key role in evaluation and assessment. Reflecting on their experiences helps preceptees identify areas of improvement and establishes the practice of lifelong learning.

Reflection also contributes to satisfaction through self-recognition of progress. Developing relationships and learning new roles amid the demands of caregiving is challenging; through systematic reflection, preceptees learn to balance ideal responses with reality and continually improve their work. An expert preceptor engages the learner in critical dialogue to explore outcomes and serves as coach, guide, and mentor in recognizing alternative perspectives and ways of performing.

These three R's—role models, relationships, and reflection—illustrate the competencies for mastering precepting. Authored by an experienced educator, scholar, and clinician who has lived the model for effective precepting, this book describes preceptor orientation, qualifications, and skills and details the assessment and evaluation process. *Mastering Precepting* will benefit all nursing education programs—transition to practice, new employee orientation in clinical settings, academic programs for learners in capstone courses, and advanced practice clinical experiences.

–Gwen Sherwood, PhD, RN, FAAN, ANEF  
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# Introduction

*“Live as if you were going to die tomorrow.  
Learn as if you were going to live forever.”*

*–Mahatma Gandhi*

Preceptors live at the intersections of education and practice and of the present and the future. They practice at the point where theoretical learning meets reality and where the gap between current and needed knowledge and expertise gets filled. Preceptors are the essential link between what nurses are taught and what they do, and between what nurses know and what they need to know. Having competent preceptors is critical to educating nursing students, transitioning new graduate nurses to the professional nursing role, and transitioning experienced nurses to new roles and specialties.

Preceptors teach at the point of practice. They create experiences in which the preceptee can engage and learn. Benner, Sutphen, Leonard, and Day (2010, p. 42) note that “only experiential learning can yield the complex, open-ended, skilled knowledge required for learning to recognize the nature of the particular resources and constraints in equally open-ended and undetermined clinical situations,” and that “experiential learning depends on an environment where feedback in performance is rich and the opportunities for articulating and reflecting on the experiences are deliberately planned” (p. 43). Teaching/precepting is a two-way street—it requires a constant back-and-forth communication between the preceptor and the preceptee. Precepting uses listening and observation skills as much or more than talking and doing skills.

## Myths

Several myths about preceptors and precepting need to be dispelled. The first is that because you are a good clinical nurse, you will be a good preceptor. While preceptors do indeed need to be competent in the area of nursing they will be precepting, becoming a preceptor is like learning a new clinical specialty. Although some previously learned knowledge and skills are useful, there are many more to be learned before you become a competent preceptor. The next myth is that you have to be an expert clinician to be a preceptor. In many cases, being much more expert than the person you are precepting can be a hindrance and is frustrating to the preceptor and the preceptee. Yet another myth is that precepting must work around whatever patient assignment is made and whatever is happening on the unit. Such activity is not precepting. It is ineffective at its best and, at its worst, disheartening and anxiety-provoking for the preceptor and the preceptee. Every nurse deserves a competent preceptor and a safe, structured environment in which to learn. That is not to say that every precepting activity will go as planned. It will not. There is much unpredictability in the nursing work environment, but precepting activities must start with a plan based on the needs of the preceptee and the outcomes that must be obtained. Part of the competence of preceptors is making the plan, adjusting when the need arises, and recognizing and using teachable moments.

## The Second Edition

When we wrote the first edition of *Mastering Precepting*, there was not a lot of information available on precepting, and most of the information that was available was largely focused on precepting nursing students in the clinical setting. The good news is that since the first edition, there has been an increased awareness of the importance of the use of preceptors and the need to educate and support RNs who transition into the preceptor role.

In preparation for developing the second edition, we asked for input and suggestions for improvement from people who had used the first edition of the book—preceptors and those who developed and implemented preceptor programs. In this second edition, all of the chapters have been updated with the most recent evidence. In addition, a chapter has been added on precepting advanced practice registered nurse (APRN) students and APRN new graduates (Chapter 10), and another chapter provides strategies and information on developing preceptors and on developing, implementing, and evaluating preceptor programs (Chapter 15).

## Who Should Read This Book

This book is a handbook for individual preceptors and a resource for those who are developing or improving preceptor programs. The book is both evidence-based and pragmatic. It provides information on the why and the how and is written in a style that can be easily read by busy registered nurses who are moving into the preceptor role and by current preceptors who want to improve their practice.

## Book Content

The chapters in the book build on each other and are designed to be read in order.

- Chapter 1 is an introduction to precepting and discusses all the aspects of the preceptor role.
- Chapter 2 provides an overview of learning theories, learning stages, learning styles, and learning preferences.
- Chapter 3 offers an overview of precepting strategies, beginning with the preceptor and manager setting role expectations and responsibilities.
- Chapter 4 is on core precepting concepts, including developing competence and confidence; critical thinking, clinical reasoning, and clinical judgment skills; and situational awareness, expert reasoning, and intuition.
- Chapter 5 is about planning experiences for preceptees and developing and using goals, objectives, and outcomes.
- Chapter 6 discusses communication skills, preceptee handoffs, and managing difficult communication.

- Chapter 7 provides information on establishing, conducting, and ending a coaching relationship.
- Chapter 8 presents an overview of instructional technologies—from web-based strategies to human patient simulation—and details on when and how to use the technologies effectively.
- Chapter 9 offers information and strategies on specific learner populations—prelicensure nursing students, NGRNs, post-baccalaureate graduate students, experienced nurses learning new specialties or roles, internationally educated nurses, and nurses from different generations.
- Chapter 10, a brand-new chapter, has details on precepting advanced practice registered nurses in student and graduate roles.
- Chapter 11 discusses assessing, addressing, and influencing preceptee behaviors and motivation and providing preceptees with action-oriented feedback as well as using just culture as a problem-solving framework.
- Chapter 12 offers pragmatic information on the day-to-day performance of the precepting role including organization and time management, delegation, problem-solving preceptor-preceptee relationships, and addressing challenging behaviors.
- Chapter 13 discusses the need for preceptors to practice self-care behaviors and provides suggestions to prevent burnout and create optimal healing environments.
- Chapter 14 is designed for managers and discusses how to select, support, and sustain preceptors.
- Chapter 15, another new chapter, includes information on developing preceptors and on developing, implementing, and evaluating preceptor programs.
- The appendix contains resources on precepting.

The first 13 chapters end with a Preceptor Development Plan, a manager plan concludes Chapter 14, and a plan to do an initial assessment in preparation for developing a preceptor program wraps up Chapter 15. The Preceptor Development Plans are templates for preceptors to use to create their own development plans. The templates are available from [www.SigmaNursing.org/MasteringPrecepting2](http://www.SigmaNursing.org/MasteringPrecepting2) as modifiable Microsoft Word documents and can be used by individuals or by organizations. By putting your own plan in writing, you will be making a commitment to implement the plan. For organizations, the plans can be used to set goals and measure progress for participants in preceptor programs.

### More Information Online

Follow our @RNPreceptor Twitter handle to engage with us and other preceptors. For tools and other resources, go to [www.RNPreceptor.com](http://www.RNPreceptor.com).



## Final Thoughts

Precepting is a complex endeavor that requires competence and commitment. By becoming a preceptor, you have accepted the professional responsibility of sharing your knowledge and expertise with others. There is no greater contribution to nursing and to patient care than to ensure the competence of the next generation of nurses.

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Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation*. San Francisco, CA: Jossey-Bass.



*“The most important practical lesson that can be given to nurses is to teach them what to observe, how to observe, what symptoms indicate improvement, what the reverse, which are of importance, which are of none, which are evidence of neglect and of what kind of neglect.”*

*–Florence Nightingale*

# Core Precepting Concepts

–Beth Tamplet Ulrich, EdD, RN, FACHE, FAAN

# 4

At the heart of any precepting experience is the development of competence; the development of ability and expertise to effectively utilize that competence; and the confidence to take action when needed. Combined with other core precepting concepts, these form the foundation of effective, safe nursing practice.

## Competence

Professional competence is required of all registered nurses (RNs). Although we mostly talk about clinical competence for nurses, all nursing roles and positions require competence. The purposes of ensuring the competence of nurses are to protect the public (the primary purpose), advance the profession, and ensure the integrity of the profession.

Competence is included in *Nursing: Scope and Standards of Practice*: “The registered nurse seeks knowledge and competence that reflects current nursing practice and promotes futuristic thinking” (American Nurses Association [ANA], 2015b, p. 5) and in the *Code of Ethics*: “The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth” (ANA, 2015a, p. 73). In addition, the ANA Position Statement on Professional Role Competence (ANA, 2014) defines competence and competency and identifies principles for addressing competence in the nursing profession (see sidebar).

## OBJECTIVES

- Understand development of competence
- Understand critical thinking, clinical reasoning, and clinical judgment and how to help preceptees develop each skill
- Understand the development of preceptee confidence
- Understand core concepts of nursing practice

## ANA Position Statement on Professional Role Competence

The public has a right to expect registered nurses to demonstrate professional competence throughout their careers. ANA believes the registered nurse is individually responsible and accountable for maintaining professional competence. The ANA further believes that it is the nursing profession's responsibility to shape and guide any process for assuring nurse competence. Regulatory agencies define minimal standards for regulation of practice to protect the public. The employer is responsible and accountable to provide an environment conducive to competent practice. Assurance of competence is the shared responsibility of the profession, individual nurses, professional organizations, credentialing and certification entities, regulatory agencies, employers, and other stakeholders.

Source: ANA, 2014, p. 1

The ANA (2014) defines a *competency* as “an expected level of performance that integrates knowledge, skills, abilities, and judgment” (p. 3). Knowledge, skills, ability, and judgment are defined as follows (ANA, 2014, p. 4):

- *Knowledge* encompasses thinking; understanding of science and humanities; professional standards of practice; and insights gained from context, practical experiences, personal capabilities, and leadership performance.
- *Skills* include psychomotor, communication, interpersonal, and diagnostic skills.
- *Ability* is the capacity to act effectively. It requires listening, integrity, knowledge of one's strengths and weaknesses, positive self-regard, emotional intelligence, and openness to feedback.
- *Judgment* includes critical thinking, problem-solving, ethical reasoning, and decision-making.

Requirements for competence and competency assessment have been established by national nursing and nursing specialty organizations, state boards of nursing credentialing boards, and statutory and regulatory agencies. The presence (or absence) of competency can also be a legal issue.

The ANA Position Statement on Professional Role Competence states, “Competence in nursing practice must be evaluated by the individual nurse (self-assessment), nurse peers, and nurses in the roles of supervisor, coach, mentor, or preceptor. In addition, other aspects of nursing performance may be evaluated by professional colleagues and patients/clients” (ANA, 2014, p. 5). Competence is not about checking items off a list. In fact, the frequent use of terms such as “competency checklist” and “checking off preceptees” devalues the work required to develop and maintain competence and makes the process of validating competence sound as if it requires little thought—that it is merely an inconsequential nuisance and a documentation chore to be completed as quickly as possible. Nothing could be further from the truth. The validation of competence is one of the most critical elements to ensure safe, high-quality patient care and competent role performance.

## ANA Principles for Competence in the Nursing Profession

- Registered nurses are individually responsible and accountable for maintaining competence.
- The public has a right to expect nurses to demonstrate competence throughout their careers.
- Competence is definable, measurable, and can be evaluated.
- Context determines what competencies are necessary.
- Competence is dynamic, and both an outcome and an ongoing process.
- The nursing profession and professional organizations must shape and guide any process assuring nurse competence.
- The competencies contained in ANA's various scope and standards of practice documents are the competence statements for each standard of nursing practice and of professional performance.
- Regulatory bodies define minimal standards for regulation of practice to protect the public.
- Employers are responsible and accountable to provide an environment conducive to competent practice.
- Assurance of competence is the shared responsibility of the profession, individual nurses, regulatory bodies, employers, and other key stakeholders.

*Source: ANA, 2014, pp. 6–7*

### Competence Development

Seeking to better understand the development of competency, the National Council of State Boards of Nursing (NCSBN) completed a qualitative longitudinal (5-year) study of a national sample of nurses from 2002–2008 (Kearney & Kenward, 2010). By the end of the fifth year, nurses had identified and demonstrated five characteristics of competence:

1. Juggling complex patients and assignments efficiently
2. Intervening for subtle shifts in patients' conditions or families' responses
3. Having interpersonal skills of calm, compassion, generosity, and authority
4. Seeing the big picture and knowing how to work the system
5. Possessing an attitude of dedicated curiosity and commitment to lifelong learning

Participants described how competence developed and changed over time. Also of interest was how the development of competency affected their career plans and job satisfaction. Kearny and Kenward (2010) note:

Those who continued to feel insecure in their ability to efficiently identify and respond to important downturns in patients' conditions in a high-acuity environment, who continually felt beaten down in their attempts to get resources and help for patients from fellow nurses, and/or who believed physicians did not listen to them or respect them appeared most likely to change jobs to less complex or less acute settings or to leave nursing. (p. 13)

This study clearly has implications for preceptors. Nurses' career decisions and job satisfaction are both affected by how well they develop competence, especially for less experienced nurses.

### **Conscious Competence Learning**

The concept of *conscious competence learning* is a description of how individuals learn new competencies. The concept serves to remind us that learning a competence happens in stages. The stages of the conscious competence as described by Howell (1982) and expanded on by Cannon, Feinstein, and Friesen (2010) include unconscious competence, conscious incompetence, conscious competence, and unconscious competence.

- **Unconscious incompetence**—The individual seeks to solve problems intuitively with little or no insight into the principles driving the solutions. This stage is especially dangerous with novices. When NGRNs first begin professional practice or experienced nurses move into a new role, they often don't know what they don't know. Preceptors have to be especially vigilant with a preceptee at this level.
- **Conscious incompetence**—The individual seeks to solve problems logically, recognizing problems with their intuitive analysis, but not yet knowing how to fix them. This awareness—of knowing what you don't know—can affect confidence. Preceptors can help preceptees in this level understand what they are expected to know at this point vs. what they will learn in the future.
- **Conscious competence**—As skills are acquired, individuals become more confident but need to realize that the skills have not yet become automatic. They are not yet ready to spontaneously transfer the concepts of the skill to new situations. Preceptors need to help preceptees see how the concepts transfer from one situation to another.
- **Unconscious competence**—At this level, skills become second nature and are performed without conscious effort. Skills can be adapted creatively and spontaneously to new situations. You know it so well, you don't think about it. The challenge in this level is to not become complacent and be closed to new ways of doing things.

A fifth level of conscious competence learning—reflective competence—has been suggested (Attri, 2017). It involves an awareness that you’ve reached unconscious competence; analyzing and being able to articulate how you got there well enough to teach someone else to reach that level and opening yourself to the need for continuous self-observation and improvement.

This concept supports adult learning theory concerning learner readiness in the assertion that individuals develop competence only after they recognize the relevance of their own incompetence. It also blends easily with the levels in Benner’s Novice to Expert model.

### Competency Outcomes and Performance Assessment (COPA) Model

Lenburg (1999) developed the Competency Outcomes and Performance Assessment (COPA) model. She describes it as “a holistic but focused model that requires the integration of practice-based outcomes, interactive learning methods, and performance assessment of competencies” (Lenburg, 1999, para. 2).

The basic framework of the model consists of four guiding questions (Lenburg, 1999):

1. What are the essential competencies and outcomes for contemporary practice? Identify the required competencies and word them as practice-based competency outcomes.
2. What are the indicators that define those competencies? Only identify the behaviors, actions, and responses mandatory for the practice of each competency.
3. What are the most effective ways to learn those competencies?
4. What are the most effective ways to document that learners and/or practitioners have achieved the required competencies? Develop a systematic and comprehensive plan for outcomes assessment.

Eight core practice competency categories define practice in the COPA model (Lenburg, 1999):

1. Assessment and intervention skills
2. Communication skills
3. Critical thinking skills
4. Human caring and relationship skills
5. Management skills
6. Leadership skills

7. Teaching skills
8. Knowledge integration skills

In the COPA model, learner performance is assessed against a predetermined standard after the learning and practice have occurred. Lenburg (1999) notes how important it is to separate these activities—assessing versus learning/practicing—to keep the focus of each clear. The learner is then better able to concentrate on learning, and the preceptor can concentrate on teaching and coaching during the learning and practice periods, rather than both trying to split their attention and their purposes between learning and assessing and, perhaps, one not always knowing the focus of the other.

Lenburg (1999) has found that assessments are most effective when they are designed and implemented based on 10 basic concepts: examination, dimensions of practice, critical elements, objectivity, sampling, acceptability, comparability, consistency, flexibility, and systematized conditions.

### **Wright Competency Model**

The Wright Competency Assessment Model is an outcome-focused, accountability-based approach that is used in many healthcare organizations. The following principles form the foundation of the model (Wright, 2015, p. 5):

- Select competencies that matter to both the people involved and to the organization.
  - Competencies should reflect the current realities of practice, be connected to quality improvement data, be dynamic, and be collaboratively selected.
  - Competency selection itself involves critical thinking.
- Select the right verification methods for each competency identified.
- Clarify the roles and accountability of the manager, educator, and employee in the competency process.
- Employee-centered competency verification creates a culture of engagement and commitment.

The model is grounded in three concepts—ownership, empowerment, and accountability (Wright, 2005):

- In **ownership**, competencies are collaboratively identified and are reflective of the dynamic nature of the work.
- **Empowerment** is achieved through employee-centered verification in which verification method choices are identified and appropriately match the competency categories.

- In **accountability**, leaders create a culture of success with a dual focus—focus on the organizational mission and focus on supporting positive employee behavior.

## Critical Thinking

Critical thinking is an essential competency for nurses to provide safe and effective care (Berkow, Virkstis, Stewart, Aronson, & Donohue, 2011). Alfaro-LeFevre (2017) says that *critical thinking* is “deliberate, informed thought” (p. 2) and that the difference between thinking and critical thinking is control and purpose. “Thinking refers to any mental activity. It can be ‘mindless,’ like when you’re daydreaming or doing routine tasks like brushing your teeth. Critical thinking is controlled and purposeful, using well-reasoned strategies to get the results you need” (p. 5).

Jackson (2006, p. 4) notes that three themes are found within all definitions of critical thinking: “the importance of a good foundation of knowledge, including formal and informal logic; the willingness to ask questions; and the ability to recognize new answers, even when they are not the norm and not in agreement with pre-existing attitudes.” Chan (2013), in a systematic review of critical thinking in nursing education, found that despite there being varying definitions of clinical thinking, there were some consistent components: gathering and seeking information: questioning and investigating; analysis, evaluation, and inference; and problem-solving and the application of theory. The principles of skepticism and objectivity underlie critical thinking (Chatfield, 2018). *Objectivity* includes recognizing and dealing with both conscious and unconscious bias.

### Critical Thinking—A Philosophical Perspective

In 1990, the American Philosophical Association conducted a Delphi study of an expert panel to define critical thinking and to identify and describe the core skills and dispositions of critical thinking. The expert panel, led by Peter Facione (1990), defined *critical thinking* to be a pervasive and deliberate human phenomenon that is the “purposeful, self-regulatory judgment which results in interpretation, analysis, evaluation, and inference, as well as explanation of the evidential, conceptual, methodological, criteriological, or contextual considerations upon which that judgment is based” (p. 2). The core skills and sub-skills identified by the expert panel are shown in Table 4.1.

**Table 4.1 Core Critical Thinking Skills and Sub-Skills**

**INTERPRETATION:** To comprehend and express the meaning or significance of a wide variety of experiences, situations, data, events, judgments, conventions, beliefs, rules, procedures, or criteria

*Sub-skills:* Categorization, decoding significance, clarifying meaning

**ANALYSIS:** To identify the intended and actual inferential relationships among statements, questions, concepts, descriptions, or other forms of representation intended to express beliefs, judgments, experiences, reasons, information, or opinions

*Sub-skills:* Examining ideas, detecting arguments, analyzing arguments

*continues*



**Table 4.1 Core Critical Thinking Skills and Sub-Skills (cont.)**

**EVALUATION:** To assess the credibility of statements or other representations that are accounts or descriptions of a person's perception, experience, situation, judgment, belief, or opinion; and to assess the logical strength of the actual or intended inferential relationships among statements, descriptions, questions, or other forms of representation

*Sub-skills:* Assessing claims, assessing arguments

**INFERENCE:** To identify and secure elements needed to draw reasonable conclusions; to form conjectures and hypotheses; to consider relevant information and to deduce the consequences flowing from data, statements, principles, evidence, judgments, beliefs, opinions, concepts, descriptions, questions, or other forms of representation

*Sub-skills:* Querying evidence, conjecturing alternatives, drawing conclusions

**EXPLANATION:** To state the results of one's reasoning; to justify that reasoning in terms of the evidential, conceptual, methodological, criteriological, and contextual considerations upon which one's results were based; and to present one's reasoning in the form of cogent arguments

*Sub-skills:* Stating results, justifying procedures, presenting arguments

**SELF-REGULATION:** Self-consciously to monitor one's cognitive activities, the elements used in those activities, and the results deduced, particularly by applying skills in analysis and evaluation to one's own inferential judgments with a view toward questioning, confirming, validating, or correcting either one's reasoning or one's results

*Sub-skills:* Self-examination, self-correction

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*Source: American Philosophical Association, 1990*

According to the American Philosophical Association Delphi Study, the affective dispositions of critical thinking (approaches to life and living) include (Facione, 2011):

- Inquisitiveness with regard to a wide range of issues
- Concern to become and remain generally well informed
- Alertness to opportunities to use critical thinking
- Trust in the processes of reasoned inquiry
- Self-confidence in one's own ability to reason
- Open-mindedness regarding divergent world views
- Flexibility in considering alternatives and opinions
- Understanding of the opinions of other people
- Fair-mindedness in appraising reasoning

- Honesty in facing one's own biases, prejudices, stereotypes, and egocentric or sociocentric tendencies
- Prudence in suspending, making, or altering judgments
- Willingness to reconsider and revise views where honest reflection suggests that change is warranted

The dispositions to specific issues, questions, or problems include (Facione, 2011):

- Clarity in stating the question or concern
- Orderliness in working with complexity
- Diligence in seeking relevant information
- Reasonableness in selecting and applying criteria
- Care in focusing attention on the concern at hand
- Persistence though difficulties are encountered
- Precision to the degree permitted by the subject and the circumstance

### Critical Thinking in Nursing

Facione and Facione (1996) suggest that to observe and evaluate critical thinking in nursing knowledge development or clinical decision-making, you need to have the thinking process externalized by being spoken, written, or demonstrated. For preceptors, this means having preceptees externalize their thinking processes. Preceptors must also be able to externalize their own critical thinking to role model critical thinking for preceptees.

Paul, the founder of the Foundation for Critical Thinking, and Heaslip note, "Critical thinking presupposes a certain basic level of intellectual humility (i.e., the willingness to acknowledge the extent of one's own ignorance) and a commitment to think clearly, precisely, and accurately and, in so far as is possible, to act on the basis of genuine knowledge. Genuine knowledge is attained through intellectual effort in figuring out and reasoning about problems one finds in practice" (Paul & Heaslip, 1995, p. 41). Expert nurses, say Paul and Heaslip, "can think through a situation to determine where intuition and ignorance interface with each other" (p. 43).

Building on the work of Facione and the American Philosophical Association Delphi study, Scheffer and Rubinfeld (2000) conducted a Delphi study of international nursing experts (from 27 U.S. states and eight countries) to develop a consensus statement of critical thinking in nursing. The result of the study

was a consensus statement and identification of 10 affective components (habits of the mind) and seven cognitive components (skills) of critical thinking in nursing.

Critical thinking in nursing is an essential component of professional accountability and quality nursing care. Critical thinkers in nursing exhibit these habits of the mind: confidence, contextual perspective, creativity, flexibility, inquisitiveness, intellectual integrity, intuition, open-mindedness, perseverance, and reflection. Critical thinkers in nursing practice the cognitive skills of analyzing, applying standards, discriminating, information seeking, logical reasoning, predicting and transforming knowledge (Scheffer & Rubenfeld, 2000, p. 357).

### **Precepting Critical Thinking**

Berkow and colleagues (2011) note that identifying and providing feedback on specific strengths and weaknesses is the first step to help nurses meaningfully improve their critical thinking skills. They interviewed more than 100 nurse leaders from academia, service settings, and professional associations and developed a list of core critical-thinking competencies in five broad categories: problem recognition, clinical decision-making, prioritization, clinical implementation, and reflection. Each of the categories has detailed competencies.

Alfaro-LeFevre (1999) developed a list of critical-thinking key questions that can be used by a preceptor to help preceptees learn how to think critically:

- What major outcomes (observable results) do I/we hope to achieve?
- What problems or issues must be addressed to achieve the major outcomes?
- What are the circumstances (what is the context)?
- What knowledge is required?
- How much room is there for error?
- How much time do I/we have?
- What resources can help?
- Whose perspectives must be considered?
- What's influencing my thinking?

In addition, Alfaro-LeFevre (1999) offers suggestions on thinking critically about how to teach others:

- Be clear about the desired outcome.
- Decide what exactly the person must learn to achieve the desired outcome and decide the best way for the person to learn it.
- Reduce anxiety by offering support.
- Minimize distractions and teach at appropriate times.
- Use pictures, diagrams, and illustrations.
- Create mental images by using analogies and metaphors.
- Encourage people to remember by whatever words best trigger their mind.
- Keep it simple.
- Tune into your learners' responses; change the pace, techniques, or content if needed.
- Summarize key points.

Preceptors can also use role-playing, case studies, reflection, and high-fidelity patient simulation to teach clinical thinking.

## Clinical Reasoning

Tanner (2006) defines *clinical reasoning* as “the processes by which nurses and other clinicians make their judgments, and includes both the deliberate process of generating alternatives, weighing them against the evidence, and choosing the most appropriate, and those patterns that might be characterized as engaged, practical reasoning (e.g., recognition of a pattern, an intuitive clinical grasp, a response without evident forethought)” (pp. 204–205).

Tanner (2006), in reviewing research on nurses and reasoning, found three interrelated patterns of reasoning that experienced nurses use in decision-making:

- **Analytic processes**—Breaking a situation down into its elements; generating and systematically and rationally weighing alternatives against the data and potential outcomes.
- **Intuition**—Immediately apprehending a situation (often using pattern recognition) as a result of experience with similar situations.
- **Narrative thinking**—Thinking through telling and interpreting stories.

Facione and Facione (2008) discuss research in human reasoning that has found evidence of the function of two interconnected “systems” of reasoning. System 1 is “reactive, instinctive, quick, and holistic” and often “relies on highly expeditious heuristic maneuvers which can yield useful response to perceived problems without recourse to reflection” (Facione & Facione, 2008, p. 4). System 2, on the other hand, is described as “more deliberative, reflective, analytical, and procedural” and is “generally associated with reflective problem-solving and critical thinking” (p. 4). They note that the two systems never function completely independently and that, in some cases, the two systems actually offer somewhat of a corrective effect on each other. In fact, they say, “Effectively mixing System 1 and System 2 cognitive maneuvers to identify and resolve clinical problems is the normal form of mental processes involved in sound, expert critical thinking” (p. 5).

Simmons, Lanuza, Fonteyn, Hicks, and Holm (2003) investigated clinical reasoning of experienced (2–10 years) medical-surgical nurses. They found that the nurses used a number of thinking strategies (heuristics) that consolidated patient information and their knowledge and experience to speed their reasoning process. The most frequently used heuristics were (Simmons et al., 2003):

- Recognizing a pattern or an inconsistency in the expected pattern
- Judging the value of the information about which they were reasoning
- Providing explanations for why they had reasoned as they had
- Forming relationships between data
- Drawing conclusions

## Clinical Judgment

Critical thinking, clinical reasoning, and clinical judgment are interrelated concepts (Victor-Chmil, 2013). Critical thinking and clinical reasoning are processes that lead to the outcome of clinical judgment (Alfaro-LeFevre, 2017). Facione and Facione (2008) describe the relationship in this way: “critical thinking is the process we use to make a judgment about what to believe and what to do about the symptoms our patient is presenting for diagnosis and treatment” (p. 2).

Tanner (2006) defines *clinical judgment* to mean “an interpretation or conclusion about a patient’s needs, concerns, or health problems, and/or the decision to take action (or not), use or modify standard approaches, or improvise new ones as deemed appropriate by the patient’s response” (p. 204). Clinical judgment relies on knowing the patient in two ways—knowing the patient as a person and knowing the patient’s pattern of responses (Tanner, Benner, Chesla, & Gordon, 1993).

Tanner (2006) has proposed a model of clinical judgment, based on a synthesis of the clinical judgment literature, that can be used in complex, rapidly changing patient situations. The model includes:

- **Noticing**—“A perceptual grasp of the situation at hand” (p. 208). Noticing, Tanner says, is “a function of nurses’ expectations of the situation, whether they are explicit or not” and further that “these expectations stem from nurses’ knowledge of the particular patient and his or her patterns of responses; their clinical or practical knowledge of similar patients, drawn from experience; and their textbook knowledge” (p. 208).
- **Interpreting**—“Developing a sufficient understanding of the situation to respond” (p. 208). Noticing triggers reasoning patterns that help nurses interpret the data and decide on a course of action.
- **Responding**—“Deciding on a course of action deemed appropriate for the situation, which may include ‘no immediate action’” (p. 208).
- **Reflecting**—“Attending to the patients’ responses to the nursing action while in the process of acting” (reflection in action) and “reviewing the outcomes of the action, focusing on the appropriateness of all of the preceding aspects (i.e., what was noticed, how it was interpreted, and how the nurse responded)” (p. 208; reflection on action).

The use of this model can be helpful to preceptors as a structure for debriefing. It is a model of expert practice—what the new graduate aims for and what the experienced nurse needs to perfect. Based on Tanner’s model, Lasater (2007) developed a detailed rubric (Lasater Clinical Judgment Rubric [LCJR]) that could be used in simulation with dimensions for each of the phases of the model:

- **Noticing**—Focused observation, recognizing deviations from expected patterns, information seeking
- **Interpreting**—Prioritizing data, making sense of data
- **Responding**—Calm, confident manner; clear communication; well-planned intervention/ flexibility; being skillful
- **Reflecting**—Evaluation/self-analysis, commitment to improvement

While the LCJR has been primarily used in academic settings, Miraglia and Asselin (2015) suggest that it can be used as a framework to enhance clinical judgment skills of novice and experienced nurses.

New graduate registered nurses (NGRNs) have been shown to need major improvements in their clinical judgment skills. In reviewing 10 years of data using the Performance Based Development System (PBDS) for assessment, del Bueno (2005) found that only 35% of NGRNs met the entry requirements (safe level) for clinical judgment, regardless of their prelicensure educational preparation. They were unable to translate theory into practice. Accordingly, del Bueno posits that clinical practice with

preceptors who ask questions (as opposed to giving answers) is the most critical intervention needed to improve the clinical judgment skills of new graduates.

## Developing Situational Awareness, Expert Reasoning, and Intuition

Situational awareness, expert reasoning, and intuition are critical attributes to move from novice to expert nurse. If you've ever walked into a patient room and instantly become alert because you knew that something wasn't right—even if you didn't know what was wrong—you've used your situational awareness, expert reasoning, and intuition.

Situational awareness is the foundation of decision-making and performance. Put simply, *situational awareness* is being aware of what is happening around you, understanding what that information means now, and anticipating what it will mean in the future (Endsley & Jones, 2012). Begun in the aviation industry, the formal definition of situational awareness is “the perception of the elements in the environment in a volume of time and space, the comprehension of their meaning, and the projection of their status in the near future” (Endsley, 1995, p. 36). Endsley's model of situational awareness has three incremental levels: perception of the elements in the environment (gathering data); comprehension of the current situation (interpreting information); and projection of what can happen in the future (anticipation of future states) (Endsley, 1995; Orique & Despina, 2018; Stubbings, Chaboyer, & McMurray, 2012).

The first level includes becoming aware of overt and subtle important cues that can be perceived through any or all of the senses. A nurse's abilities, training, experience, and information-processing, as well as level of stress, workload, noise, and complexity, can all positively or negatively affect whether and how well the cues are perceived.

The next level is interpreting the significance of and discerning the relationships between the cues and synthesizing what may appear to less-skilled nurses as disjointed cues into the whole of the situation.

The last level in the model is predicting and anticipating what will happen next. Endsley and Jones (2012) note the importance of time in situational awareness—that is, anticipating how much time is available in which to act. Nurses with expert situational awareness can quickly identify that something is wrong, distill the important cues, put the pieces of information together, anticipate what will happen next and how quickly it will happen, and know what to do to intervene.

Malcolm Gladwell, in his book *Blink* (2005), discusses the *adaptive unconscious* of the mind, which he describes as “a kind of giant computer that quickly and quietly processes a lot of the data we need in order to keep functioning as human beings” (p. 11) and a “decision-making apparatus that's capable of

making very quick judgments based on very little information” (p. 12). The key themes of the research described in *Blink* are:

- Decisions made very quickly can be every bit as good as decisions made cautiously and deliberately.
- We have to learn when we should trust our instincts and when we should be wary of them.
- Our snap judgments and first impressions can be educated and controlled.

Gladwell describes what he calls *thin-slicing*, “the ability of our unconscious to find patterns in situations and behavior based on very narrow slices of experience” (p. 23). In this case, the term “experience” is not being used, for example, to mean the long-term experience of caring for many patients of the same type, but rather “very narrow slices of experience” would refer to when you first walk into a patient’s room and within seconds know that something does not fit the pattern you expect to see.

Gary Klein (1998) has studied nurses and other people who make decisions under time pressure when the stakes are high (e.g., firefighters, Navy SEALs, battlefield platoon leaders). Based on his research, he has found that what is generally termed “intuition” comes from experience, that we recognize things without knowing how we do the recognizing, and that what actually occurs is that we are drawn to certain cues because of situational awareness. He also notes, however, that because we often don’t understand that we actually have experience behind “intuition,” intuition gets discounted as hunches or guesses. His research, indeed, shows just the opposite. His findings indicate that the part of intuition that involves pattern matching and recognition of familiar and typical cases can be trained by expanding people’s experience base.

Klein (1998) describes what he has termed the recognition-primed decision model, a model that brings together two processes: “the way decision makers size up the situation to recognize which course of action makes sense, and the way they evaluate the course of action by imagining it” (p. 24).

Decision makers recognize the situation as typical and familiar . . . and proceed to take action. They understand what types of goals make sense (so priorities make sense), which cues are important (so there is not an overload of information), what to expect next (so they can prepare themselves and notice surprises, and the typical way of responding in a given situation. By recognizing a situation as typical, they also recognize a course of action likely to succeed (Klein, 1998, p. 24).

This is compared to a rational choice strategy, a step-by-step process of considering and eliminating alternatives, which is similar to what we do in the nursing process. Though a rational choice strategy is often needed as a first step for novices or for initially working in teams to determine how everyone



views the options, it is less useful with experts, who usually look for the first workable option (based on their knowledge and experience) in the current situation, and for high-risk situations that require rapid response.

Klein (1998) notes many things that experts can see that are invisible to others (pp. 148–149):

- Patterns that novices do not notice
- Anomalies, events that did not happen, and other violations of expectancies
- The big picture (situation awareness)
- The way things work
- Opportunities and improvisations
- Events that either already happened (the past) or are going to happen (the future)
- Differences that are too small for novices to notice
- Their own limitations

In describing expert nursing, Dreyfus and Dreyfus (2009) note that experts use *deliberative rationality*—that is, when time permits, they think before they act, but normally, “they do not think about their rules for choosing goals or their reasons for choosing possible actions” (p. 16). Deliberative rationality (the kind of detached, meditative reflection exhibited by the expert when time permits thought), they say, “stands at the intersection of theory and practice. It is detached, reasoned observation of one’s intuitive, practice-based behavior with an eye to challenging, and perhaps improving, intuition without replacing it by the purely theory-based action of the novice, advanced beginner, or competent performer” (pp. 17–18).

Debriefing after an incident in which situational awareness, expert reason, and intuition are used is important to learning. The preceptor needs to walk through the whole process step-by-step with the preceptee—discussing observations, rationale for actions, etc., and answering whatever questions the preceptee has. This may take some practice and reflection for the preceptor in order to be able to break down what was done intuitively so the preceptee can understand the steps and the logic.

## Confidence

Self-efficacy (confidence) is the belief of individuals in their capability to exercise some measure of control over their own functioning and over environmental events (Bandura, 1997). According to Bandura, “A capability is only as good as its execution. The self-assurance with which people approach and manage difficult tasks determines whether they make good or poor use of their capabilities.

Insidious self-doubts can easily overrule the best of skills” (1997, p. 35) and “unless people believe they can produce desired results and forestall detrimental ones by their actions, they have little incentive to act or to persevere in the face of difficulties. Whatever other factors may operate as guides and motivators, they are rooted in the core belief that one has the power to produce effects by one’s actions” (Bandura, 2009, p. 179).

Kanter (2006) notes that confidence consists of positive expectations for favorable outcomes and influences an individual’s willingness to invest. “Confidence,” she says, “is a sweet spot between arrogance and despair. Arrogance involves the failure to see any flaws or weaknesses, despair the failure to acknowledge any strengths” (p. 8).

Manojlovich (2005), in a study of predictors of professional nursing practice behaviors in hospital settings, found a significant relationship between self-efficacy and professional behaviors. Ulrich et al. (2010) found that self-confidence improved in NGRNs across and beyond an 18-week immersion RN residency that used one-to-one preceptors.

Helping preceptees develop confidence in themselves requires the use of many of the preceptor roles described in Chapter 1 and requires the creation of a positive, enriching, and supportive learning environment. Competence and confidence are interrelated—each builds on, reinforces, and promotes the other.

## Conclusion

Competence, critical thinking, clinical reasoning, clinical judgment, and confidence are all necessary components of any preceptorship. Role competence can be attained only by the connection of theory and practice. Critical thinking, clinical reasoning, and clinical judgment are the keys to making that happen. Competence without confidence is opportunity wasted. Preceptors are charged with helping preceptees master critical thinking, clinical reasoning, and clinical judgment skills so preceptees can move from novice to expert competency.

Preceptor Development Plan: Core Precepting Concepts			
<p><i>Review the information on the core precepting concepts described in this chapter. What are your strengths? In which areas do you need to increase your knowledge and expertise? What is your plan for expanding your knowledge and expertise? What resources are available? Who can help you?</i></p>			
Name:			
Date:			
Competence Assessment			
Strengths	Needs	Plan	Resources
Competence Development			
Strengths	Needs	Plan	Resources
Critical Thinking			
Strengths	Needs	Plan	Resources

<b>Clinical Reasoning</b>			
<b>Strengths</b>	<b>Needs</b>	<b>Plan</b>	<b>Resources</b>
<b>Clinical Judgment</b>			
<b>Strengths</b>	<b>Needs</b>	<b>Plan</b>	<b>Resources</b>
<b>Situational Awareness, Expert Reasoning, and Intuition</b>			
<b>Strengths</b>	<b>Needs</b>	<b>Plan</b>	<b>Resources</b>
<b>Confidence</b>			
<b>Strengths</b>	<b>Needs</b>	<b>Plan</b>	<b>Resources</b>

Note: Available as a modifiable Microsoft Word document at [www.SigmaNursing.org/MasteringPrecepting2](http://www.SigmaNursing.org/MasteringPrecepting2)

Preceptor Development Plan: Preceptee Role Competencies				
<p><i>Review the competencies that are required for your preceptee. If written descriptions of these competencies are not available, work with other stakeholders to develop them. Assess your own knowledge and expertise on each of the competencies. What are your strengths? In which areas do you need to increase your knowledge and expertise? What is your plan for expanding your knowledge and expertise? What resources are available? Who can help you?</i></p>				
Preceptee Role:				
Competency	Preceptor Strengths	Preceptor Needs	Plan	Resources

Note: Available as a modifiable Microsoft Word document at [www.SigmaNursing.org/MasteringPrecepting2](http://www.SigmaNursing.org/MasteringPrecepting2)

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