Preceptors for the Canterbury & West Coast Regions and NetP programmes will be Registered Nurses who have successfully undertaken preceptorship training or clinical teaching as per the accepted national framework for preceptorship. Access to the preceptee/graduate nurse throughout clinical practice placements especially during the period of clinical load sharing (NetP) must be consistent and regular for the duration of the preceptorship experience. Preceptorship is a clinical educational strategy where both the preceptor and preceptee work together for a specified period of time. The process of preceptorship involves teaching, learning and orientation to the clinical area. New staff will be provided with preceptorship which includes but is not limited to NetP graduates.

Team Approach to Socialisation

Preceptorship can be provided by a team which includes the Charge Nurse/Team Leader/Nurse Manager, Nurse Educator and other staff within the work environment. The Dedicated Education Unit (DEU) model supports a team approach utilising a clinical liaison nurse (CLN) as the primary contact. A primary preceptor or CLN is to be identified and supported to ensure accountability for negotiating and evaluating learning outcomes and coordination of formal feedback to the preceptee over the term of the programme/preceptorship experience.
Primary Preceptor Role

The primary preceptor or CLN is responsible for their ongoing development of knowledge related to the role of preceptorship. A preceptorship programme is designed to enhance knowledge and understanding of the role.

All preceptors should attend the DEU workshop or Canterbury Region’s preceptorship training provided by the Professional Development Unit (PDU), or provide evidence of equivalent learning to PDU. NetP Preceptors will be provided with 16 hours of initial training and then relevant continuing education. Nurse Manager/Team Leader/Charge Nurse will ensure that appropriate support and peer review are available to all clinical preceptors. The preceptorship role will primarily be reviewed through the annual performance appraisal process within the clinical areas.

Preceptor Contract

Preceptors will be put forward to enter relevant training by their Nurse Managers/Team Leaders/Nurses Managers. The preceptor will enter into an agreement to agree to preceptors roles and responsibilities. Preceptor Contract for Canterbury Region, West Coast and NetP Preceptors Form.

Preceptor Contract Process:

Nurse Manager/Team Leader discusses the preceptor contract with the potential preceptor and completes the preceptor contract form. This includes discussion around role and responsibility of preceptorship. Nominee agrees with nomination, completes their portion of the preceptor contract form and agrees to having annual review of role through performance review process within the clinical area.

The Nurse Manager/Team Leader arranges training through PDU or CPIT. The nomination form is kept by Nurse Manager/Team Leader.
The Canterbury and West Coast Region Directors of Nursing have agreed on the following preceptor eligibility criteria:

- Have a current practicing certificate in a Registered Nurse scope of practice
- Be registered with the Nursing Council of New Zealand ‘in good standing’ (i.e. with no restrictions on that registration that would negatively impact on their ability to perform as a clinical preceptor)
- Successfully completed a preceptor training programme
- Have knowledge of the NetP programme Learning Framework (NetP), toolkits and PDRP requirements
- Appropriate experience within the clinical service area where they are providing preceptorship
Roles and Responsibilities of Preceptors

**Role modelling**

Demonstrates a willingness to be a preceptor, accept responsibility of the role and has an understanding of Benner’s novice to expert theory within nursing.

Demonstrates competent professional nursing practice and encourages the preceptee to integrate theoretical, clinical and professional practice.

Demonstrates and guides a high standard of documentation within clinical notes, care plans, pathways, medication charts and referrals.

Demonstrates effective communication skills and interpersonal skills with the patient, whanau and team.

Provides safe environment for dialogue and acts on concerns, taking action where appropriate.

Demonstrates a broad knowledge of the patient profile and their clinical requirements for their area of practice and ensures appropriate clinical skills are maintained.

Demonstrates patient centered care.

Demonstrates adult focused teaching skills such as setting SMART goals (e.g. specific, measurable, achievable, realistic and time bound)

Participates and encourages preceptee participation in evaluation and assessment of role, NetP programme (where appropriate) and ongoing professional development.

**Skill Building**

Develops a learning contract or similar document that incorporates the preceptee’s goals for skill acquisition to function at the expected level of the work area.

Ensures the preceptee becomes familiar with the core competencies of the work area and allow the preceptee to focus on the steps of a skill with minimal distraction.

Is actively studying and updating own skill base and knowledge.
Creates learning opportunities, which allow for practice, repetition and self correction while adjusting their teaching technique to match the learning styles of the preceptee.

Works with Team Leader/Nurse Manager to arrange extra clinical time out of the work area as applicable, e.g. for experience and ongoing education within clinics, theatres, and/or clinical procedures.

**Critical thinking**

Identifies previous knowledge and skill and uses this as base for setting SMART goals while empowering the preceptee to think or trouble shoot through problems.

Creates an environment which facilitates an understanding of risks, allowing preceptee to learn while encouraging them to ask questions.

Offers regular, specific and constructive feedback to preceptee.

Has the ability to articulate the rationales for their own clinical practice and decision making.

**Socialisation**

Works with the team to welcome the new member to the institution and the work area to promote an environment of trust.

Ensures understanding of the social aspects of the ward, “unspoken rules”, unit functioning, chain of command, resources etc.

Orientates the preceptee to the place of work through introduction, community of practice (the group of people who share the profession i.e. multi disciplinary team), team culture, and rosters etc.

---

Encourage critical reflection, promote self directed learning, foster creativity and research based practice
The preceptor is required to:

Be accountable for their own practice.

Practice in accordance with the vision and values of the employer.

Be familiar with the roles and responsibilities of the preceptor, preceptee and the rest of the preceptoring team.

Be familiar with new tools and policies in the area.

Be aware of the familiarisation processes of the area.

Have input into the performance evaluations of the preceptees, providing constructive feedback on the preceptee’s strengths and areas for improvement as required.

Take responsibility to obtain the skills and knowledge necessary to guide a preceptee.

Be familiar with assessment and feedback skills and processes.

Preceptor Training

All Preceptors will attend initial Preceptor Training run through the Professional development Unit (PDU).

Currently there will be two more days provided for varying levels of preceptorship through the PDU.

Other courses include CPIT’s introduction to clinical teaching and DEU workshops.

Preceptorship will be appraised in the preceptor’s annual performance appraisal.

For further information visit:
PDU: http://www.cdhb.govt.nz/Hospitals-Services/HealthProfessionals/Education-and-Development/Study-Days-and-Workshops/Pages/Preceptor-Programme.aspx
or
NETP: http://www.cdhb.govt.nz/Hospitals-Services/Health-Professionals/netp/Pages/Preceptorship.aspx
NetP Preceptors

As a NetP preceptor it is a requirement as set out in the National Health Workforce New Zealand (HWNZ) specifications that you undertake training and participate in continuing education for this role. If you act as a preceptor for a new graduate nurse you will be provided with 16 hours of initial training and then relevant continuing education.²

The CDHB currently provides three levels of preceptor training (for novices to experienced). Ideally, we would like you to attend the 3 levels of preceptorship training before taking on this role and responsibility. However, it is understood that this is not always possible.

Following on from these courses other relevant education and training may also add value to your role as a preceptor. Your Nurse Educator can help guide you on other types of training/education.

Some examples could include but are not limited to: an ECG course to aide with teaching preceptees; Wound care course to enable demonstration of correct techniques to preceptee.

The NetP programme receives partial funding from HWNZ to help contribute to supernumerary time, study days and preceptor development. The NetP office passes on these finances to the cost centers as designated by the Director of Nursing (DON) for each division or area.

It is recommended that preceptors review and repeat training approximately every two to three years to help keep abreast of any changes to education and training needs.

Currently preceptorship training is being reviewed to ensure we meeting the needs of all preceptors across the Canterbury Health Region.
Overview of the CDHB Preceptor Education

There are currently three levels of Preceptor study days (these are under review at present). These study days have been designed to provide concepts of preceptoring, education and socialisation for all staff involved in the preceptorship relationship and/or role.

Day One is an introduction to the preceptor role and is suitable for nurses who have not participated in any formal training in preceptoring or clinical teaching.

Day Two looks in-depth at assessment, feedback, and having the difficult conversation as well as an introduction to documentation and linkage to competency.

Day Three currently consists of two modules. These modules are primarily for participants who have previously attended preceptor or clinical teaching training and are seeking a refresher or further education in these areas.

We have developed a three level programme that contains the requirements of the National Framework for Nursing on Preceptoring and the NetP Learning Framework.

Contact and Enquiries re Preceptor Training

Contact the PDU Administration Assistant on 03 364 0646 for all booking enquiries regarding dates and available spaces, participant confirmation on nominated date, access to training database regarding participant’s previous preceptor training. For all other enquiries contact the Facilitator, Jacqui Gapes at Jacqui.Gapes@cdhb.govt.nz or phone 033640640, extension 81681
Malcolm Knowles developed a theory he called andragogy derived from the Greek aner, meaning man. He has defined andragogy as the art and science of helping adults learn.

- As we get older we get more self-directed in our learning
- You accumulate a growing reservoir of experiences that become an increasing resource for learning
- Your readiness to learn increases as your level of responsibility increases i.e. as you become a father or mother and breadwinner etc.

Knowles\(^6,7\)

Skinner\(^8\)

Behaviour is shaped

Responses that are reinforced are learnt

Responses that are punished are suppressed and an organism avoids or escapes from punishment
Thus Skinner suggests that a technology of teaching is an arrangement of reinforcements to encourage learning. For this to happen you require a series of well structured and organised learning experiences for the student.

**Rogers**

Rogers suggests the following about adult learners

- Human beings have a natural potentiality for learning
- You can trust the student
- Significant learning takes place when the student perceives it to be relevant
- Significant learning takes place in a safe environment
- Learning is facilitated when the student participates in the learning process
- Much significant learning is required through doing
- Self initiated learning that involves the whole person of the learner – feelings as well as intellect – is the most lasting and pervasive

**VARK**

VARK is a system of understanding how we learn. As we indicated above, people all learn differently and it is important we identify our own style as well as our learner’s style of learning

- V – Visual – learnt through seeing
- A – Auditory – learnt through listening
- R – Read/write – learnt through reading and writing (general school system)
- K – Kinesthetic – learnt through doing, touching

You can be one or a combination of these. Generally you favour one more than the other.
Self awareness is essential to the process of reflection and can be defined as “...the gradual and continual process of noticing and exploring aspects of the self, whether behavioural, psychological or physical with the intention of developing personal and interpersonal understanding. To become more aware of and to have a deeper understanding of ourselves is to have a sharper and clearer picture of what is happening to others”.

Reflective practice should be part of your every day practice in order to provide quality and holistic patient care.

Engaging in reflection is a complex process and the level of self-awareness that is required often means the process can be uncomfortable at times. Having someone you can trust to support and challenge you is important. Here are two methods to aide in your reflective process:

**Brookfield**

- Adults learn throughout their lives, the transitional stages of the life-span are the immediate causes and motives for much of the learning.
- Adults exhibit diverse learning styles – strategies for coding information, cognitive procedures, mental sets – and learn at different ways, at different times, for different purposes.
- Learning activities should be problem-centered, meaningful to their life situation, and adults want their learning to have immediacy of application.
- The past experiences of adults affect their current learning, sometimes serving as an enhancement, sometimes a hindrance.
- Effective learning is linked to the adult’s subscription to a self concept of his or her own self as a learner.

**Reflective Practice**

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Reflective practice is important as it enables us to learn from our experiences. Developing reflective practice means developing ways of reviewing our own teaching so that it becomes a routine and a process by which we might continuously develop.

Kolb developed a theory of experiential learning that can give us a useful model by which to develop our practice. This is called The Kolb Cycle, The Learning Cycle or The Experiential Learning Cycle. The cycle comprises of four different stages of learning from experience and can be entered at any point but all stages must be followed in sequence for successful learning to take place. The Learning Cycle suggests that it is not sufficient to have an experience in order to learn. It is necessary to reflect on the experience to make generalisations and formulate concepts which can then be applied to new situations. This learning must then be tested out in new situations. The learner must make the link between the theory and action by planning, acting out, reflecting and relating it back to the theory.

Reflective Practice Through Kolb’s Cycle of Experiential Learning

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Characteristics of experiential learning

Learning is a process rather than an outcome

“No two thoughts are ever the same as experience always intervenes”

Learning is continuous and grounded in experience

Experience involves action and reflection

Learning is holistic

Learning involves transactions between the person and the environment

Learning is a process of creating knowledge

Typology of Learners\textsuperscript{15, 16}

Activists (Do)

Immerse themselves fully in new experiences

Enjoy here and now

Open minded, enthusiastic, flexible

Act first, consider consequences later

Seek to centre activity around themselves

Reflectors (Review)

Stand back and observe

Cautious, take a back seat

Collect and analyze data about experience and events, slow to reach conclusions

Use information from past, present and immediate observations to maintain a big picture perspective.

Theorists (Conclude)

Think through problems in a logical manner, value rationality and objectively
The Honey & Mumford Learning Styles Questionnaire (LSQ) is a self-development tool and differs from Kolb’s Learning Style inventory by inviting people to complete a checklist of work-related behaviours without directly asking how they learn.

The LSQ (learning Style Questionnaire) is a questionnaire to determine your preferred learning style. Knowing your learning style can accelerate your learning as well as your preceptees through you undertaking activities that best fit your preferred style.

Knowing your learning style can also help you and your preceptee avoid repeating mistakes by undertaking activities that strengthen other styles. For example, if you tend to “jump in at the deep end”, consider spending time reflecting on experiences before taking action.

Pragmatists (Plan)

Keen to put ideas, theories and techniques into practice
Search new ideas and experiment
Act quickly and confidently on ideas, gets straight to the point
Are impatient with endless discussion

Learning Style Questionnaire

Assimilate disparate facts into coherent theories
Disciplined, aiming to fit things into rational order
Keen on basic assumptions, principles, theories, models and systems thinking
Act quickly and confidently on ideas, gets straight to the point
Are impatient with endless discussion

Check out http://rapidbi.com/learningstyles/ for some examples of questionnaires and further reading.
Borton’s framework for reflective practice was selected because of its structured, stepped approach. This framework guides the facilitator and/or the person relaying the experience through the analytical process of describing an experience, revisiting the theory and knowledge behind their actions and exploring future possibilities and changes. The contextual issues surrounding these changes are also discussed.

This framework is used in group reflection sessions within the NetP programme and we encourage this model or a similar type model to be used within individual reflection.

### Borton’s Reflective Practice Framework

**Descriptive level of reflection**

- **What**
- **What** was the problem/difficulty/reason for being stuck/reason for feeling bad/reason we don’t get on/et?
- **What** was my role in the situation?
- **What** was I trying to achieve?
- **What** actions did I take?
- **What** was the response from others?
- **What** were the consequences
  - For the patient?
  - For myself?
  - For others?
- **What** feelings did it evoke
  - In the patient?
  - In myself?
  - In others?
- **What** was good/bad about the experience?

**Theory and knowledge building level of reflection**

- **So what** does this tell me/teach me/imply/mean about me/my patient/others/our relationship/my patient’s care/the model of care I am using/my attitudes/my patient’s attitudes/etc., etc?
- **So what** was going through my mind as I acted?
- **So what** did I base my actions on?
- **So what** other knowledge I can bring to the situation?
  - Experiential
  - Personal
  - Scientific
- **So what** could/should I have done to make it better?
- **So what** is my new understanding of the situation?

**Action oriented (reflective) level of reflection**

- **Now what** do I need to do in order to make things better/stop being stuck/improve my patient’s care/resolve the situation/feel better/get on better/etc., etc?
- **Now what** broader issues need to be considered if this action is to be successful?
- **Now what** might be the consequences of this action?

Reflection looks at the positives and negatives of a situation. This enables discussion and resolution to some degree and a greater understanding.
Good Clinical Teaching

Plan to follow a process

Activate prior knowledge through questioning and briefing

Bridge new to pre-existing information; examples, analogies, comparison

Where possible, highlight key points of the experience before it happens

Debrief as soon after the event as possible

Promote discussion and reflection to check how much they understand

Break it down into ‘bite size’ chunks

Use broader context

Summarise periodically

Ask the preceptee to give you the take home points Model not being afraid to ask

Model using Evidence Based Practice (EBP)

NetP Reflection Guidelines

Preceptors facilitate critical and reflective practice within the workplace environment and through the two development days offered.

Reflection involves looking at a situation and critically reviewing events that took place. Reflection may involve identifying positive and negative aspects of an event.

NetP Nurse Educators may also facilitate reflection sessions for new graduate nurses to share and reflect on their experiences in the NetP programme. This is an opportunity to discuss programme requirements and clarify questions you may have about appraisals, assessments or completion criteria.
Socialisation—Reality Shock

According to the free dictionary\(^\text{20}\) socialisation is “the process individuals learn to [exist] in accordance with the expectations and standards of a [specific] group or society... [learning] its beliefs, habits, values and accepted modes of behaviour... [it is] the procedure by which society integrates the individual.”

Reality shock\(^5, 21, 22, 23\) is a phenomenon that occurs when new staff discover that their knowledge and skills do not necessarily match the values and ideals that they were anticipating, there can be the reality that the job isn’t what they were expecting.

The phrase “I am just a student nurse” is no longer valid. The reality of being a beginner practitioner becomes real. The graduate nurse lacks the security of having an expert to discuss or explain differences in practice or answers their questions.

There are four phases a new employee may transition through: the honeymoon, the shock/crisis, the recovery and the resolution. This paradigm is also described by Patricia Benner and her colleagues in the Novice to Expert model.

### Phases of Reality Shock \(^5, 21, 22, 23\)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Behaviours</th>
<th>How to Help</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Honeymoon</td>
<td>Perceives everything as being wonderful</td>
<td>Harness the preceptee’s enthusiasm for skills and routines</td>
</tr>
<tr>
<td></td>
<td>Fascinated by the newness of the experience</td>
<td>Be realistic but don’t stifle the enthusiasm</td>
</tr>
<tr>
<td></td>
<td>Focused on mastery of skills, routines and integration with the staff</td>
<td>Introduce the preceptee to the staff, be inclusive</td>
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**Phases of Reality Shock**

- **The Honeymoon**: Perceives everything as being wonderful.
  - Fascinated by the newness of the experience.
  - Focused on mastery of skills, routines and integration with the staff.
  - How to Help: Harness the preceptee’s enthusiasm for skills and routines.
  - Be realistic but don’t stifle the enthusiasm.
  - Introduce the preceptee to the staff, be inclusive.
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<tbody>
<tr>
<td>The Shock/Crisis</td>
<td>Sets in when needs and goals are not met</td>
<td>Be a good listener</td>
</tr>
<tr>
<td></td>
<td>Experiences outrage</td>
<td>Have the preceptee record their suggestions for improvement</td>
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<td></td>
<td>Rejects work values</td>
<td>Provide opportunities to vent</td>
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<tr>
<td></td>
<td>Preoccupied with the fast</td>
<td>Assist the preceptee to see more of the situation and view it more objectively</td>
</tr>
<tr>
<td></td>
<td>Globally negative</td>
<td></td>
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<tr>
<td>The Recovery</td>
<td>Sense of humor returns</td>
<td>Assist preceptee to see positives</td>
</tr>
<tr>
<td></td>
<td>Tension lessens</td>
<td>Talk about ways to improve the work environment</td>
</tr>
<tr>
<td></td>
<td>Discrimination between effective and ineffective behaviours</td>
<td>Verify and support critical thinking efforts</td>
</tr>
<tr>
<td>The Resolution</td>
<td>Conflicts in values resolve in either constructive or destructive ways (crisis doesn’t last forever)</td>
<td>Assist the student with constructive problem solving</td>
</tr>
<tr>
<td></td>
<td>Could see rejection of role/nursing or burnout, or new ways to cope positively</td>
<td>Help the student with new, more helpful coping mechanisms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acknowledge and manage conflicts that persist</td>
</tr>
</tbody>
</table>
Duchscher\textsuperscript{22} looks at socialisation and reality shock through the term Transition Shock. “Transition shock emerged according to Duchscher as the experience of moving from a known role of a student nurse to the relatively less familiar role of professionally practicing nurse.”\textsuperscript{17}

Of importance to the experience for the new nurse is the clear difference between relationships, roles, knowledge and performance expectations between the academic role and the practice role.

This is depicted in the above transition shock model and can be related to the phases of reality shock on the previous pages.

Understanding the initial stages of role transition will assist managers, educators and preceptors to appropriately support and facilitate this professional adjustment.
The below model identifies the stages newly qualified nurses transition through. Duchscher developed the model to understand the phases of transition in relation to practicing over a twelve month period.

Through her research she identified there were three definitive stages: doing, being and knowing. It was identified that the initial three months of newly graduated nurse’s transition is consumed with adjustment, coming to terms with responsibilities, acceptance of differences between theoretical orientation of their education and the practical focus of professional work, and integration into a environment that emphasizes teamwork as opposed to individually based care. Following from this it was noted that a significant change in the newly graduated nurse’s perception of their experience is noted at approximately five to seven months, propelling them to another stage of greater consolidation and meaning. See reference list for further reading on Duchscher’s work.

Permission to reproduce model received June 2012 from Duchscher.
Nursing aspects of Socialisation

The National Framework for Nursing Preceptorship Programmes in New Zealand outlines the roles and responsibilities of the preceptorship team which includes socialisation. The framework emphasises that preceptorship is a team approach with a nominated primary preceptor.

The preceptor in terms of socialisation has a responsibility to:

- Work with the team to welcome the new member to the institution and the work area.
- Ensure understanding of the social aspects of the ward, unspoken rules, unit functioning, chain of command, resources etc.
- Orientate the preceptee to the place of work e.g. introduction, community of practice (the group of people who share the profession i.e. MDT), team culture, rosters etc.
- Promotes an environment of trust
- Identify other resource people to assist with learning

As previously indicated if the effort is made to welcome and socialise new nurses at the initial stages and there is an understanding of the impact of reality shock/transition shock on new nurses, they are more likely to stay in nursing, feel part of the team and consolidate their skills earlier in their practice.
Communication is dialogue between two or more people that involves discussion, verbal interchange and thought. When communication is constructive it is serving to improve something, being helpful, positive, practical and productive.

**Principles of Effective Communication:**

- Show interest and acceptance
- Maintain eye contact and do not compare to others
- Be open – minded and avoid prejudging the speaker or the message
- Tune into words, meanings and feeling conveyed
- Focus on the central message or the message being sent
- Note the other person’s body language (and your own…)
- Avoid interrupting
- Listen first then respond
- Respond to what is communicated rather than how the message is sent
- Ask questions to verify your understanding of the message: ‘Do I understand you correctly that …’ ‘What I hear you saying…’.

Communication involves both the sending and receiving of a message

‘I’ messages (I think, I feel) are more effective than ‘you’ messages; they minimize defensiveness and resistance to further communication. ‘Should’ and ‘Ought’s’ hinder communication.

Communication is more effective when it involves talking with and to rather than at the listener.

- Think of and select solutions
- Decide on necessary actions and implement them
- Reassess, monitor, evaluate and replan as necessary
Feedback is FAST

“Who owns the problem, what is the problem...”

How to Problem Solve:21

Define and clarify the problem

Identify and understand the cause(s)

List a number of possible solutions for each cause: identify evidence

Think of and select solutions

Decide on necessary actions and implement them

Reassess, monitor, evaluate and replan as necessary

Questions to Ask

What is the problem and who owns the it

Whose behaviour causes the problem? Is this the person you intend to confront? (if not, are they good reasons for you confronting someone else?)

How important is the issue to me?

How important is the relationship to me? (the more important the relationship, the more important it is to be open and spontaneous about so-called minor grievances).

Decision Making

Determine situation that needs action

Analyse potential courses of action and potential side effects

Determine pros and cons, gather facts and opinions

Select the best course of action from available alternatives

Implement action

Monitor the effect

Reevaluate the decision in light of the effects

PRECEPTOR RESOURCE
Feedback

There is an art to feedback. It needs to be FAST.

Frequent
Accurate
Specific
Timely

Be realistic with the time needed and set this time aside

Ensure that both you and the preceptee are aware of the purpose of the meeting

Don’t attempt to take the other by surprise, organisation is essential

State your preference for the process to be used, e.g. you may want to start by stating your case succinctly, hear the preceptee’s response then have a general discussion around it.

Constructive Feedback

Giving constructive feedback in a non-threatening way is often difficult. It is well known that many new staff would like honest feedback so that they know where they stand. It is important to give feedback as soon as possible to avoid the snowball effect.

Remember:
Unsafe practice must always be acted on appropriately
Strengths and limitations identified should be supported by examples and evidence
It is important to ensure that the responses are candid and truthful
The preceptee is checked to make sure they understand what the feedback means by asking them to repeat it back to you in their own words.
Useful Feedback is:  

Given with Care—you need to feel concern for the person receiving the feedback

Given with attention—pay attention to what you are doing when giving feedback

Expressed directly—be specific, clear, use observable behaviour/specific clear incidents.

Expressed fully—state the facts with their implications, so that the effects of the actions can be understood

Checked out and clarified—where appropriate feedback given on performance should be checked out with others to determine its validity

Well timed

Easily acted on

Be precise in gaps of performance

Ensure that it is a safe environment for both parties, remember feedback is confidential

Honest Feedback:

Focus on the behaviour rather than the inferences. Example:

“You finished all parts of the admission except the blood pressure was not recorded”

Instead of

“Don’t you know enough to take a patient’s blood pressure?” or “You have been here long enough to know to take the patient’s blood pressure and record it on admission”
Use descriptive terms rather than judgment terms. Example:

“I notice that your hand was shaking when you gave that injection
Instead of
“You were a nervous wreck”.

Feedback Sandwich:

This is a good way to deliver negative feedback. Start with a positive comment, follow it with the area that requires improvement and finish it with a positive comment around how the area of concern can be improved.

“You gathered all the correct equipment for the dressing and prepared the patient well for the procedure. However, I notice that you mixed up your clean and dirty hands. With more practice, if you take more time to think the procedure through it will become easier for you”.

Effective Feedback:

Is given as soon as possible after the performance or action.

Is gathered from a number of credible, knowledgeable and well intentioned sources including the giver of the feedback

Contains concrete and accurate data

Contains models for appropriate behaviour

Is focused on behaviour rather than the person

Is sensitive to the receivers self esteem

Is given frequently but not excessively

Reduces uncertainty for the recipient and relates to goals that have been defined by the recipient.
Conflic Resolution

Conflict results from four main conditions: miscommunication, different values, different backgrounds/personalities, and different wants & needs.

If handled constructively, it can increase understanding of different positions and increase innovative thinking and creativity.

A conflict situation has a better chance of being resolved if the people involved: forget about winning, forget about being right, and concentrate on understanding what the other person is saying and why. Take responsibility for your own feelings, beliefs, actions, and when handling high emotions, name the source of the emotion.

When handling defensive behavior, name the problem and the problem behavior.

Step 1

Name the problem or your concerns clearly.

Example: ‘I am concerned about you doing Mr. Jones dressing on your own this morning because you have not seen it and it is a very complex wound’.

Step 2

Remember 3 things:

Place attention on the preceptee

Show empathy

Don’t interrupt their reply in response to your emotions

You respond to defensive behavior with your key feelings by using key words.

Example: ‘You seem anxious about doing the dressing’.

Actively listen as this technique does not work if the preceptee feels they have not been heard.
Step 3

Re assert your concerns by using 20 words or less.

Example: ‘I’m concerned about your lack of knowledge to do this dressing because it is complex wound’.

When difficult attitudes and repetitive inappropriate behaviours occur, clarify and organise your thoughts, ask the person involved to change the behaviour or actions by:

Stating a time and place if possible:

Example: ‘This morning during the medication round’

Describe the behaviour objectively, what you see and hear

Example: ‘I noticed you were abrupt in your response to me’.

Explain what impact this has on you and how you feel about it

Example: ‘I felt frustrated because you were abrupt with me’.

Specify how you would like this behaviour to change

Example: ‘If you were to tell me what was worrying you’.

Consequences – describe how the behaviour would affect you

Example: ‘I would be able to explain what I have been doing and perhaps we could understand each other a little better’.

If these behaviour patterns continue document instances and start a paper trail. Report concerns to the Unit Manager and the NetP Nurse Educator.
Speak up is the use of one’s voice to make known specific information or knowledge that might make a difference in ensuring a safe patient outcomes to a person with positional power or authority.

“Speaking up in the face of potential breach of patient safety is everyone’s business, rather than the responsibility of a few”.

As the nurse is frequently the advocate and voice for patients it is imperative that the nurse has the ability to speak up and in turn demonstrate effective communication.

We also must be aware that personal beliefs and values may pose as potential obstacles and may hinder registered nurses to speak up this in turn reflects the need for collaborative practice across the health care team.

Speak up has been implemented by Canterbury and West Coast regions as there is an understanding that NetP graduates are one of the vulnerable populations within the health sector. This is due to the natural power imbalances felt in relation to being a new/junior (novice) member of staff.

The Health Quality and Safety Commission has a campaign focused on patient safety. The speak up strategy fits with this remit and has been endorsed by the Directors of Nursing across the Canterbury and West Coast regions.

Speaking up if you see something or think you see something that is not right, is imperative. Speak up is integral to professional accountability and action (NCNZ competency 1.1 and Code of Conduct 8.4 & 8.5). It may be that all the information about the situation is not available but the perspective that is brought forward may be something that has been overlooked. Crucially, it is not about who is right, but what is right. Doing right by patients is the responsibility of all nurses.
It has been proven that health care workers who are confident in their ability to raise crucial concerns observe better patient outcomes, work harder, are more satisfied, and are more committed to staying on the work place.

Many complaint cases to the health and disability commissioner in New Zealand has shown that someone in the health care team knew something that could have prevented harm but did not share that information.\textsuperscript{28,30} This in its self highlights the need for such initiatives as speak up.

The Steps for Graduates to Enable The m to Speak Up Effectively:

Pause and consider:

“what’s going on here?”

- Can I deal with this myself? Should I let someone more senior know?
- What needs to happen now?
- Who can I talk to for advice at this moment? (CNM, NIC, Duty Manager, CTC, NE or NetP NE)
- Re-priorities—What else can I then be doing in the meantime?
- What do I need to document? (clinical notes, incident forms etc.)
- Who can I talk to reflect/revise what happened?

Thinking through the situation, discussing and looking at all the avenues to solve the issue is imperative to maintain patient safety.

"Speaking up is integral to professional accountability and action."

Relevant Documents to Speak Up:
- Health Practitioners Competency Assurance Act
- NCNZ Code of Conduct and Professional Boundaries
- Organistional Code of Conduct
- NZNO Documentation Guidelines
- NCNZ competencies for practice

Relevant Websites to Speak Up:
- NZNO
- NCNZ
- Health and Disability Commissioner
- Health Quality and Safety Commission
Related Documents

Service Specifications Nursing Entry to Practice Health Workforce New Zealand July 2014 2/B46
Preceptoring for Excellence National Framework for Nursing Preceptorship Programmes, July 2010
Endorsement for Canterbury Region, West Coast and NetP Preceptors Form.
Canterbury and West Coast Regions Preceptorship Policy
Nursing Entry to Practice Learning Framework

Websites

HWNZ - http://www.healthworkforce.govt.nz/
CDHB NETP - http://interweb-d/netp/default.htm
References


