AN EVALUATION OF THE PRECEPTOR METHOD OF INSTRUCTION IN AN OBSTETRICAL NURSING SPECIALTY

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ABSTRACT

Nursing has become increasingly specialized over time. Post-graduate education is now widely required for employment in most acute areas of nursing, including obstetrics. With the potential for the integration of an autonomous profession of midwives, courses preparing obstetrical nurses may be deleted or greatly changed in the future. It becomes of some interest to examine how such nurses are presently functioning.

Currently, in British Columbia, the British Columbia Institute of Technology offers the Obstetrical Nursing Specialty which would be modified or deleted if midwifery were to become common. The purpose of this study is to examine the role of the preceptor as a vehicle for instruction in the clinical portion of this program. Data are obtained from a case study group of four preceptors working in various locations in British Columbia.

Research questions for this study include: Are preceptors adequately qualified or prepared? What is the balance between the preceptors' responsibility to the hospital and their attention to the student? Do preceptors exhibit the various roles attributed to them in the literature i.e. facilitating appropriate learning experiences, role modelling, question-asking, supervising, and providing feedback? Do preceptors feel the preceptorship prepares students to assume employment following it? The research questions are addressed through observing the program in action, interviewing preceptors about their experience and gathering related data in the form of preceptor and clinical course evaluations by students and student evaluations by preceptors.

Research findings indicated that preceptors have difficulty with some of the role expectations related to teaching, in particular the role of evaluator. Preceptors received no formal preparation and were largely unclear in their ability to provide a clear definition of their role and understanding of their responsibilities. No formal process was identified for either selection of preceptors or preceptor performance evaluation by the British Columbia Institute of Technology other than through optional preceptee feedback.

The reliance on preceptors in the Obstetrical Nursing Specialty raises concerns around accountability for student supervision and evaluation. Results of this study confirm that clinical expertise does not translate automatically into preceptor expertise, and therefore, the British Columbia Institute of Technology program developers should re-examine their use of preceptors as the vehicle for instruction.

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CHAPTER 1: INTRODUCTION

Context of the Study

Obstetrical training and/or education is a contentious issue in today's society. Difficulties arise with the question of whether there is a role within the Canadian health care system for an autonomous profession of midwives, or whether the role should remain as a specialty of nursing. Appropriate educational preparation is very different depending upon which role is endorsed. I begin with a discussion of midwifery to provide a historical context for the study as Obstetrics as a specialty of Nursing cannot be separated from the evolution of the midwifery profession.

Deliberate midwifery practice goes back as far as biblical times. Before the age of literacy, knowledge was passed down orally from one generation to another. Until the end of the 16th century, midwifery was practised entirely by women, and men were punished - as drastically as burning at the stake - for witnessing childbirth (Donahue, 1985).

In the 17th century, males began to take up midwifery. The Chamberlens were a family of male midwives, famous for the invention of obstetric forceps. They repeatedly proposed to James I, unsuccessfully, that some order be laid down by the state for the instruction and civil government of midwives. It was not until 1902 that the first English Midwives Act was passed and State Registration of Midwives became compulsory by law (Sweet, 1984).

Prior to the Act of 1902, as a direct result of Louis XIV employing a surgeon from Paris to attend one of his mistresses, in preference to midwives, the French School of Midwifery was established which attracted doctors from all over Europe. Thus, by the 18th century, the number of male midwives had increased, maternity hospitals were founded and, by 1833, the subject of midwifery became compulsory for medical students.

The 19th century began the crusade to set up schools of midwifery with the awarding of certificates to successful candidates. From 1902 - 1916 the training period was three months. This has expanded to a three year direct entry program (for non-nurse applicants) or the current eighteen month program for registered nurses (Sweet, 1984).

The goal of midwifery education is to produce a licensed practitioner of normal obstetrics, according to the World Health Organization definition of a midwife. The specific goals are located in Article 4 of the European Economic Community Midwives Directives. In paraphrase, a midwife's education prepares her to give the necessary supervision, care and advice to woman during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility, and to care for the newborn and mother. Her training also prepares her to meet the need of parents for teaching, counselling and personalized preventive care. Midwifery students receive the clinical and theoretical training necessary to promote health in normal childbirth, and to assess abnormal or potentially abnormal conditions for which consultation with, or referral to, other health professionals is appropriate.

Until very recently, Canada was one of only nine industrialized countries which have no provision for midwifery in their health care system. The other countries are: Venezuela, Panama, New Hebrides, El Salvador, Dominican Republic, Columbia, Honduras and Burundi. Physicians in Canada are licensed to practice medicine and midwifery and they perform the bulk of normal obstetrical services with nurses performing a support role. Many would contend that nurses' role is much more than one of support.

The support role of nursing has expanded to include a midwifery component for Canadian outpost stations where doctors are in short supply. The universities of Memorial University in Newfoundland, Dalhousie University in Nova Scotia, University of Toronto - Masters program specializing in Maternal-Child Health (not midwifery) in Ontario and University of Alberta in Alberta offer programs of study that include some midwifery education.

In 1980, the Midwives Association of British Columbia was started, and the Midwifery Task Force formed, to introduce the midwife into the health care system. Other associations throughout Canada have formed with similar goals, Ontario having announced the intent to legalize in January of 1986 and Alberta expecting to soon proclaim the Midwifery Act as law. Alberta's Midwifery Regulations Advisory Committee appointed in early 1993 is presently developing policies and regulations for midwifery practice. Proclamation of the Midwifery Act in Ontario is anticipated towards the end of 1993. In May, 1993, Elizabeth Cull, the Health Minister of British Columbia,

announced her intention to legalize midwifery in this province as well.

However, despite recurrent coroner's jury recommendations to legalize midwifery as an autonomous profession[1], with its full integration into the health care system, the Canadian Nurses Association still sees the nurse-midwife as a specialist in the provision of primary care in maternal-infant nursing. The distinction here is differing views as to whether or not a general nursing diploma is required prior to becoming a midwife, assuming the notion of midwifery is accepted.

At present though, obstetrical education continues to be a component of the basic Registered Nurse Program, although student nurses generally have an observational role only during labour and delivery clinical experiences. They therefore graduate ill-equipped in knowledge, skill and experience to enter a job market which requires specialized skills and abilities.

Post-graduate education (or specialization) is now widely required for positions in most acute areas of nursing including obstetrics (i.e. paediatrics, critical care, coronary care, operating room, and obstetrics). There are many others, but the list is too long to complete here and new areas of specialization are added almost every day. To address this need, post-graduate obstetrical nursing specialty courses are offered whose goal is to provide comprehensive nursing care to child-bearing families during hospitalization.

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[1] Despite the current alegal status of midwives in Canada, many "midwives" practise in the community. Fatalities of mother or fetus result in a coroner's inquest.

This goal is very different to the goal of midwifery, previously identified.

With the trend of compartmentalizing nursing into specialties, however, the future in obstetrical nursing could very likely be further subdivided into specialists in antepartum, intrapartum and postpartum in the next few years, and evolving into even smaller areas down the road. This fragmentation of the whole is one of the more debated issues in Allied Health. A move toward generalist training is considered more cost-efficient, providing a more versatile source of labour, particularly for small facilities and rural areas (Gibson, 1987). The generalist versus specialist debate in nursing can be loosely parallelled with the midwife versus obstetrical nurse. It is not a direct parallel though, as the midwife could be seen as a generalist of a specialty.

At present, most obstetrical units in Canada are heavily staffed with Registered Nurses who have obtained midwifery certificates in other countries. Since these certificates are considered equivalent to any post-graduate nursing specialty course, most obstetric units prefer, and often require, midwifery training as a prerequisite to job application. But is it appropriate to expect an individual trained as an independent practitioner to function in the role of a nurse? Midwives are overqualified for that role and the frustration level of midwives working in Canada's health care system is high. Also, whereas several years ago immigration of qualified midwives was plentiful and hospitals were easily able to hire midwives into their obstetrical units, this is no longer the case. It is becoming more difficult to hire qualified staff with specialized knowledge, skills and abilities.

As the issue of integrating midwifery into our present health care system is an ongoing battle between stakeholders, nursing educators and curriculum developers have a difficult problem. Trained specialist nurses are required to care for child-bearing women if the system remains unchanged and possibly may still be required, at least temporarily, once midwifery receives legal sanction.

Statement of the Problem

Who will care for child-bearing women and how they will be educated is a complex problem. Midwives currently working in the Canadian health care system are over-prepared and under-utilized. At the same time, great controversy exists as to the future. In the meantime, the British Columbia Institute of Technology (B.C.I.T.) offers the Obstetrical Nursing Specialty. The problematic nature of this training provides the focus for this study.

The Obstetrical Nursing Specialty is one of the advanced diploma specialty programs for Registered Nurse graduates and the only program of its type in British Columbia. Therefore, this program will train the obstetrical nurses of the future. The three semester program consists of three theory and three clinical courses. The three theory courses, twelve weeks in length, are delivered by guided independent study using self-learning modules and weekly telephone tutorial support. By definition, correspondence education is a "two-way distant communication between teacher and learner by means of stores

information" (Baath, 1979). Benefits of the course allow the student to remain in his/her home setting and to maintain present employment.

Pure correspondence education, according to Baath (1979) seems to be well adapted to teaching that is directed toward cognitive goals of the verbal information or intellectual skills type. Learning of attitudes and motor skills appear, however, to require a higher degree of face to face contact. Therefore, the clinical portion of the program is done in a hospital setting.

The clinical courses are full time experiences of three, six and four weeks, respectively. The first clinical course contains three weeks of intrapartum experience, the second, four weeks of intrapartum and two weeks of postpartum, and the third, three weeks of intrapartum and one week of antepartum experience. The first two courses are in community hospitals, using a preceptor from the individual clinical setting for clinical instruction, and the third is based in a tertiary care unit with both a designated clinical instructor and a preceptor.

Students in the Obstetrical Nursing Specialty are supernumerary to ward staff. In the community hospital, only one student at a time is involved in the clinical area. Supernumerary status theoretically allows students to concentrate on obtaining course objectives, rather than cutting down staff workload - a task which often results in time consuming, mundane activities. Allotted time in the clinical setting is directly

proportional to the importance of supernumerary status and as time is at a premium in the Obstetrical Nursing Specialty, supernumerary status is important.

However, difficulties arise with the use of the preceptor model. Although the student is supernumerary, the preceptor is not, and situations often arise which require primary attention to workload, rather than student objectives.

Secondly, B.C.I.T. has no formal input or control over the choice of preceptor. Some institutions choose preceptors on the basis of ability and experience according to the subjective opinion of the Head Nurse. Volunteers suffice in other institutions.

Thirdly, preceptors receive no remuneration and their first responsibility is to the employing agency.

Finally, as hospital nurses, preceptors may see their primary function as practise role models, but may have limited background in teaching methodology. There may be a tendency to teach the student to simply "do the job". The difficulty arises between the ideal and the acceptable, in that if a student functions adequately in the workplace, then possibly goals are met.

Because of these potential difficulties with the preceptorship model, the quality of the program may be compromised. Quality assurance is, or should be, an integral part of

program monitoring. According to Dearden (1975) the standard when referring to programs of learning is that all students should receive quality instruction in order to meet goals set out. The quality of preceptor instruction in the Obstetrical Nursing Specialty impacts directly on the student product, and therefore ultimately on the quality of nursing care provided to childbearing women.

It is for these reasons that the role of the preceptor is the focus of this study.

Purpose of this Study

The purpose of this study is to examine the role of the preceptor within the clinical program.

Research questions for this study include:

1) Are preceptors adequately qualified or prepared?

2) What is the balance between the preceptors responsibility to the hospital and their attention to the student?

3) Do preceptors exhibit the various roles attributed to them in the literature[2], i.e. facilitating appropriate learning experiences, role modelling, question-asking, supervising, providing feedback and evaluating?

4) Do preceptors feel the preceptorship prepares students to assume employment following it?

[2]Preceptor roles in the literature identified in Chapter Two.

The research questions will be addressed through observing the program in action, interviewing preceptors about their experience and gathering related data in the form of preceptor and clinical course evaluations by students and student evaluations by preceptors.

Measurement of student outcomes is not a direct focus of this study. Too many variables impact on the validity of the results and would therefore be invalid in terms of something that can be objectively assessed. Preceptor opinions on potential or actual student outcomes, on the other hand, are included.

Results of this study will provide more information on the reality of the clinical experience using preceptors as the source of instruction and thereby assist program developers in improving the program.

Organization/Description of the Thesis

This study examines the role of the preceptor as it is used as a model of clinical instruction in the Obstetrical Nursing Specialty at B.C.I.T. It intends to discover the model's strengths and weaknesses as observed by the researcher and experienced by the preceptors, as well as how it impacts on the program as a whole. Chapter Two reviews the related literature to ascertain what has been already learned by others using preceptors as a vehicle for instruction. Chapter Three describes the methodology used, including a discussion of the rationale for the choice of syntax. An interview questionnaire

administered to the sample preceptors is also included. Chapter Four analyzes the results through the data matrix described in Chapter Three. Conclusions of the research and recommendations for change are included in Chapter Five as well as recommendations for further research.

CHAPTER 2: REVIEW OF THE LITERATURE

In order to critically examine the Obstetrical Nursing Specialty's use of the preceptorship concept in the clinical program, it is important to determine if and how the concept has been applied in other nursing programs. Consequently, the pages that follow describe what was learned through a thorough search of the nursing literature.

Emergence of Preceptorship

Historically, nursing students were part of hospital staff. Teaching was incidental as patient care needs took priority. For example, classes were often held at the end of a working shift and tired nursing students tried to absorb the information that was being taught. Also, duties on the ward often included mundane activities such as polishing bedpans which made little contribution to student education.

As a result, the debate of the student as part of the work force versus the educational needs of the student, created a struggle amongst nursing leaders. Eventually the educational needs won out and nursing education was transferred out of the hospitals and into the general education system (Mussallem, 1965). Students were now taught by nursing faculty-theory in the classroom of a nursing school and clinical skills in the hospital setting. As a result, hospital based training virtually disappeared.

No sooner had this transition been made, than problems began to surface. New graduates were voicing feelings of inadequacy regarding their ability to function in the service setting (Crancer, Fournier and Maury-Hess, 1975; McGrath and Koewing, 1978; Willis, 1981). Employers complained that the new graduates were unable to assume a full patient load.

This dissatisfaction with the new training by students and employers resulted in nursing service personnel and nursing educators each blaming the other for having created what became known as "reality shock" (Kramer, 1974). The term was coined to describe the uncomfortable feelings of new graduates upon entering the work force. In order to facilitate the role transition from student to graduate nurse, the preceptorship model emerged (Shamian and Inhaber, 1984; Myrick, 1988).

Having the general connotation of tutor or instructor, the nursing profession has adapted and modified the term preceptor to describe a unit based nurse who carries out one-to-one teaching of new employees or nursing students, in addition to her regular unit duties (Shamian and Inhaber, 1985)[3]. For example, the new graduate nurse would be assigned to an experienced Registered Nurse who works on the unit the new graduate has been hired onto. The experienced nurse acts as preceptor by assisting the new graduate to both consolidate her nursing skills and socialize her into the new environment. This role is

[3]I recognize the term "her" may be seen as sexist but historically, nursing was determined to be womens' work. Midwifery in particular continues to be within the domain of women and therefore I chose the female article to refer to individual nurses or midwives.

undertaken over and above regular job duties. The use of preceptors has become increasingly widespread since the 1970's when it first appeared as a classification in the International Nursing Index of 1975.

Application of the Model in the Literature

Over time, the role of the preceptor has not only become more widespread but has evolved in rather interesting ways. Preceptors now appear to have become the answer for any program or institution requiring clinical expertise. The underlying assumption is that the use of preceptors in a one-to-one situation provides a most effective mechanism for learning (Shamian and Inhaber, 1984) who conducted a review of the preceptorship literature of the 1970's and early 1980's. They note that "the preceptor role has been utilized in a variety of ways involving differences of purpose, role definition, selection of preceptors and preparation of preceptors" (Shamian and Inhaber, 1984, p. 80). They describe the use of preceptors in orientation of new employees or in internship programs for senior nursing students.

A review of the more current literature continues to describe the use of preceptors in orientation and internship programs (Allanach, 1988; Young, Theriault and Collins, 1989; Modic and Bowman, 1989; Cantwell et al, 1989; Griepp et al, 1989; Borland et al, 1991; Jairath et al, 1991; Andersen, 1991; Giles and Moran, 1989; Mooney, Diver and Schnackel, 1988), but the literature also includes descriptions that further expand the role.

Application of the preceptorship model has recently been described in recruitment or orientation to a nursing specialty (Hill and Lowenstein, 1992; Miller and Brosovich, 1991; Shaffer and Ward, 1990; Ferraro, 1989; Bizek and Oermann, 1990; Hafer and Sutton, 1990; Hartshorn, 1992; Trobaugh, 1989) as an answer to the nursing shortage through nurse recruitment and retention (Hitchings, 1989; Radziewicz, Houck and Moore, 1992), as an assist to foreign nurses (Williams, 1992; Angelucci and Todaro, 1991), in an attempt to bridge the theory to practise gap in baccalaureate trained nurses (Dobbs, 1988; Hovey, Vanderhorst and Yurkovich, 1990; Kirkpatrick, Byrne, Martin and Roth, 1990; Scheetz, 1989; Myrick, 1988) and even as a model for non-clinical specialties of administration (Garrett, 1990), graduate level education (Shah and Polifroni, 1992; Hill, 1989; Kimmel, 1989) and research (Viar, Booth and Patterson, 1988).

Despite the abundance of literature describing these various applications of the preceptorship model, there are comparatively few examples which dare to examine its potential drawbacks or identify what I perceive to be over-application of a potentially useful approach. Why has the nursing profession adopted such widespread use of this method? Surely there are limits to preceptorship suitability as they relate to both individual preceptors and programs.

Further examination of preceptor evaluation, role, characteristics, selection and preparation which follows may shed some light on the issue.

Preceptor Characteristics and Selection

Much of the nursing preceptorship literature does not address preceptor characteristics and selection. Articles focus on descriptions of the program and either leave out or make a cursory attempt only to describe choosing preceptors. However, helpful information is contained in the literature reviews by Shamian and Inhaber (1984) and deBlois (1991). Shamian and Inhaber reviewed twenty-three articles from 1973 - 1982, and deBlois reviewed thirteen articles from 1981 - 1987. Of these, only eight articles in each review addressed preceptor characteristics and/or selection. My own review of the later literature, 1988 - 1992, coupled with the findings of the previous literature, has shown that the emphasis on certain characteristics that influence preceptor selection has changed over time. The result of these three reviews is seen in Table 1, and further described in the following text.

Table 1

Most Desirable Preceptor Characteristics

1973 - 1982 *Shamian and Inhaber (1984)*	**1981 - 1987** *deBlois (1991)*	**1988 - 1992**
1. Years of experience	1. Clinical competence	1. Clinical competence
2. Leadership skills	2. Communication skills	2. Desire to participate
3. Communication skills	3. Behavioural characteristics (i.e. Leadership)	3. Experience
4. Decision-making ability	4. Desire to participate	4. Interest/ability in teaching
5. Interest in professional growth	5. Job experience	5. Communication skills

As outlined in Table 1, earlier reports suggested the most important criteria included years of experience (Ferguson and Hauf, 1974; Ferris, 1980; Knauss, 1980; Taylor and Zabawski, 1982), leadership skills (Friesen and Conahan, 1980; Moyer and Mann, 1979; Murphy and Hammerstad, 1981), communication skills (Friesen and Conahan, 1980; Moyer and Mann, 1979; Murphy and Hammerstad, 1981; Plasse and Lederer, 1981), decision making ability (Friesen and Conahan, 1980; Moyer and Mann, 1979; Murphy and Hammerstad, 1981) and interest in professional growth (Friesen and Conahan, 1980; Murphy and Hammerstad, 1981).

Subsequently, clinical competence and performance took on a higher profile and was the most frequently cited criterion in deBlois' review (Hoaks, 1987; McLean, 1987; Shogan, Prior and Kolski, 1985; Flood and Rizzo, 1984; Bachman and Ridley, 1984; Harrison and Price, 1987; Begle and Willis, 1984 and Bastien, Glennon and Stein, 1986).

Most recently, the desire to participate in preceptorship programs has become as important as clinical competence (Andersen, 1991; Radiewicz, Houck and Moore, 1992; Trobaugh, 1989; Hill and Lowenstein, 1992; Young, Theriault and Collins, 1989; Bizek and Oermann, 1990; Ephron and Andrea, 1989; Cox, 1988). Also, near the top of the list recently is an interest/ability in teaching (Cox, 1988; Jairath, Costello, Wallace and Rudy, 1991; Hill and Lowenstein, 1992; Shaffer and Ward, 1990; Modic and Bowman, 1989; Bizek and Oermann, 1990).

We seem to have gone full circle by including an interest/ability in teaching to desirable preceptor characteristics. Historically, as previously described, hospital staff functioned as clinical teachers prior to the change to separate and distinct nursing schools and faculty. It is interesting that clinical teaching having been hard-fought to be a function of nursing schools and faculty is seemingly now evolving as an important function of hospital staff nurses acting as preceptors. I believe we need to consider that "while staff nurse preceptors are often chosen because of their success in the work role, it cannot be assumed that they will automatically be successful in transmitting that role to students" (Limon, Bargagliotti and Spencer, 1982, p. 18). Cox (1988) goes so far as to say preceptors need to be "able to convey instructions in an organized manner" and must be "able to recognize the keystones that influence learning" (p. 23). She acknowledges that this is the function of a teacher. Students in the Obstetrical Nursing Specialty at B.C.I.T. receive no other clinical instruction other than from their preceptor.

Success in the work role usually evolves over time. Early reports in the literature indicate required years of experience varying from one to ten years (Shamian and Inhaber, 1985) whereas the most recent literature indicates a much shorter requirement of nine months to two years (Anderson, 1991; Hill and Lowenstein, 1992; Young, Theriault and Collins, 1989; Modic and Bowman, 1989). B.C.I.T. requires a minimum of one year continuous employment in the hospital in which preceptors are currently working and prefers two years of labour/delivery experience. These are the only qualifications outlined by B.C.I.T., other than registration with the Registered Nurses' Association of British

Columbia (RNABC).

Other characteristics that are currently seen as important in the 1988-1992 literature include leadership skills (Jairath et al, 1991; Shaffer and Ward, 1990; Trobaugh, 1989; Bizek and Oermann, 1990), professional behaviour (Sams, Baxter and Palmer-Smith, 1990; Radziewicz, Houck and Moore, 1992; Young, Theriault and Collins, 1989; Dobbs, 1988), caring attitudes and behaviours (Jairath et al, 1991; Trobaugh, 1989; Hill and Lowenstein, 1992), problem-solving ability (Trobaugh, 1989; Modic and Bowman, 1989; Mooney, Diver and Schnackel, 1988), ability to use the Nursing Process (Cox, 1988; Young, Theriault and Collins, 1989; Trobaugh, 1989), ability to set goals and establish priorities (Cox, 1988; Mooney, Diver and Schnackel, 1988) and decision-making ability (Trobaugh, 1989).

Selection of qualified preceptors is carried out by nursing management of the hospital, by educators from the teaching settings, or jointly (Shamian and Inhaber, 1985). The majority of articles that describe a selection process for preceptors indicate the choice is made on the recommendation of the nurse manager (Davis and Barham, 1989; Young, Theriault and Collins, 1989; Jairath et al, 1991; Andersen, 1991). In situations where preceptors are utilized to teach nursing school students, the school may request that the hospital appoint preceptors (Ferris, 1980; Knauss, 1980) as is the case at B.C.I.T.

More recently, more elaborate mechanisms of preceptor selection are described in the literature. For example, Modic and Bowman (1989), in their preceptor program for orientation of new nurses, require a pre-test on their Foundation's policies and nursing policies, completion of an evaluation form by the candidate and the Head Nurse that appraises clinical proficiency, teaching skills and problem-solving capabilities, completion of their preceptor course, as well as attendance at five educational offerings per year. In this program, the unit based clinical instructor is responsible for the selection process. According to Modic and Bowman (1989), they developed their program from scratch as there was little guidance available in the literature. The contrast between B.C.I.T.'s preceptor selection and that described by Modic and Bowman highlights the problem.

Role of the Preceptor

As with preceptor characteristics little consistency exists in the literature regarding role responsibilities. This lack of consistency is demonstrated by the following statements: "Whereas all preceptors function as teachers and role models, only a few are responsible for program planning and evaluation of students or new employees" (Knauss, 1980, p. 45). In contrast, deBlois' (1991) literature review states "Most often, the preceptor was responsible for evaluation of learners...Less frequently mentioned responsibilities were learning assessments and teaching leadership roles" (deBlois, 1991, p. 80).

Table 2

Preceptor Role/Responsibilities

1973 - 1982	1981 - 1987	1988 - 1992
1. Orientation	1. Performance feedback and evaluation	1. Facilitator/guide/planner
2. Socialization	2. Orientation	2. Teacher/clinical instructor
3. Teaching, observation, evaluation	3. Skill demonstration	3. Role model
4. Establishment of objectives and priorities.	4. Objectives/goal setting	4. Evaluator
5. Communication to superiors re: progress	5. Clinical assignments	5. Resource/support

As one can see in Table 2, the role of the preceptor in the 1970's focused most often on orientation and socialization (Shamian and Inhaber, 1984). This is not surprising; as was previously discussed, the concept of preceptorship emerged due to the feelings of inadequacy experienced by new graduates regarding their ability to function in the service setting and the reality shock they felt. As time progresses though, the role of socialization diminishes and that of evaluation becomes prominent (deBlois, 1991).

Most recently, nursing has embraced the term "facilitator" and the current literature either uses it or describes it when discussing preceptor role responsibilities. Incorporating within its definition as a guide, planner and organizer, the facilitator has become the most frequently cited function of a preceptor (Shah and Polifroni, 1992; Stolte, Goss and Lim, 1988; Griepp, Whitson, Gehring and McGinley, 1989; Viar et al, 1988; Mooney, Diver and Schnackel, 1988; Modic and Bowman, 1989; Hill, 1989; Jairath, Costello, Wallace

and Rudy, 1991; Anderson, 1991; Hill and Lowenstein, 1992); however, the role of teacher/clinical instructor follows closely on its heels (Shah and Polifroni, 1992; Purnell, 1991; Stolte, Goss and Lim, 1988; Griepp, Whitson, Gehring and McGinley, 1989; Mooney, Diver, Schnackel, 1988; Morrow, 1984; Davis and Barham, 1989; Ephron and Andrea, 1989; Hill, 1989; Jairath, Costello, Wallace and Rudy, 1991; Anderson, 1991; Trobaugh, 1989). The above literature places the role of role model and evaluator next highest in priority.

As we can see in Table 3, the functions of the role of preceptor as described by B.C.I.T. are consistent with the most frequently mentioned role/responsibilities in the literature of 1988-1992.

Table 3

B.C.I.T. OBSTETRICAL NURSING SPECIALTY PRECEPTOR FUNCTIONS

1. Chooses experiences appropriate to the student's level.	→ Facilitator
2. Supervises the student in the clinical area.	→ Teacher
3. Makes suggestions to enhance the student's performance.	→ Teacher
4. Gives positive performance and constructive feedback.	→ Teacher/Evaluator
5. Facilitates student learning by role-modelling, providing problem solving opportunities, asking questions and giving support and encouragement.	→ Facilitator/teacher Role model/ Resource/support
6. Reviews daily self-evaluation forms.	→ Role Model Teacher/Evaluator
7. Completes Skill Assessment Tools	→ Evaluator
8. Completes "Summary" on Clinical Evaluation	→ Evaluator

It appears that the role responsibilities of the preceptor in nursing, and in particular at B.C.I.T., have moved away from the original intent of assisting orientation and socialization to one more closely resembling the role of an educator. The evolution is similar to that of the clinical instructor (Danbert, 1989) but the preceptor is not prepared as a teacher.

The education literature describes a mentoring process for beginning teachers that is similar in concept to the early preceptorship role in nursing. Anderson and Shannon (1988) identify mentoring functions such as providing a role model, focusing on professional and personal development, supporting, affirming, challenging, problem-solving and maintaining a caring relationship. The key difference between the mentoring process for beginning teachers and what has evolved as the current preceptor role in nursing is twofold. Mentor teachers are directed to be facilitative and non-evaluative (Cole and McNay, 1988; Clemson, 1987; Wagner, 1985) and they do not take on the role of instructor. Consequently, the parallel that used to exist between nursing and education can no longer be drawn. What seems important is that the change in the preceptor role in nursing was not planned, but has evolved as individual program needs surfaced.

Preceptor Preparation

A statewide survey done in North Carolina in 1983 found that although nurses spent less than 25% of their time teaching, most taught others either in a preceptor role, conducted classes or both. The majority had had no formalized preparation for assuming the

functions of teaching other professionals (Ferris, 1988). Being clinically competent does not make a nurse a competent teacher. The preceptor model builds on the teaching component already inherent in nursing practice but preceptors still require additional preparation for their role (Bizek and Oermann, 1990, p. 440).

As many authors recognize the need for additional preparation for the preceptorship role, many of the more recent programs described in the literature describe some form of preparation ranging from a short orientation or interview to a one or two day workshop (Radziewicz, Houck and Moore, 1992; Shaffer and Ward, 1990; Young, Theriault and Collins, 1989; Payette and Porter, 1989; Viar et al, 1988; Roberson, 1992; Nederveld, 1990; Allanach and Jennings, 1990; Borland et al, 1991; Hitchings, 1989; Garrett, 1990; Angelucci and Todaro, 1991; Hill and Lowenstein, 1992; Jairath et al, 1991; Ephron and Andrea, 1989; Modic and Bowman, 1989; Mooney, Diver and Schnackel, 1988; Limon, Bargagliotti and Spencer, 1982).

Content of the described workshops is broad and varies enormously program to program. However, there is a thread of continuity in the areas of emphasis described in the literature of the 1980's and early 1990's. Content areas and how often they are mentioned are outlined in Table 4. As the frequency of the content areas indicate, the literature appears to have adopted the expanded role of the preceptor described in the 1988 - 1992 column of Table 2.

Table 4

	PRECEPTOR COURSE CONTENT (27 REPORTS)	FREQUENCY
1.	Adult education theory	22
2.	Role/Expectations	20
3.	Evaluation	18
4.	Development/writing goals and objectives	12
5.	Communication skills/counselling	12
6.	Reality shock/socialization	12
7.	Teaching techniques/learning	11
8.	Constructive feedback	6
9.	Course content/Description of Preceptorship	5

The majority of programs incorporate five to six topics in an eight hour or less time frame. For example, Mooney, Diver and Schnackel (1988) describe an eight hour workshop which covers preceptor roles and responsibilities, reality shock, counselling and feedback, adult learning theories and teaching strategies. The preparation plan is the norm rather than the exception. In contrast, Shaffer and Ward (1990) manage to condense teaching of learning styles, characteristics of adult learners, evaluation, and teaching techniques into a four hour course.

At the least, it is recognized that preceptors need a clear definition of their role and an understanding of their responsibilities (deBlois, 1991). Appropriate preparation should be based on what exactly constitutes the role of the preceptor. It would seem reasonable that the preceptor functioning as clinical instructor with teaching and evaluating responsibilities requires far more in-depth preparation than the preceptor functioning as orientator or

facilitator.

Preceptors at B.C.I.T., despite having teaching and evaluating responsibilities, assume their role having had no formal preparation. The program coordinator arranges to meet with the student and preceptor early in the rotation for a short orientation, usually about one half hour. During that time, the preceptor role is clarified and any questions are answered. B.C.I.T. has fairly recently made available one day preceptor workshops but preceptors are not required to take them.

Despite the acknowledgement in the literature that preceptor preparation workshops are important, diversity in selection criteria and function of preceptors makes course content for preceptor preparation lack consistency. Planning an appropriate time frame for the workshop is also hampered.

Preceptor Evaluation

Assessing preceptor performance is a critical factor in judging program success. The responsibilities, as outlined previously in Table 2, are daunting and despite a thorough search through the literature, very little was found describing preceptor evaluation.

It is interesting that programs identify elaborate means to assess learner achievement (Hill and Lowenstein, 1992; Shaffer and Ward, 1990) but assume preceptors are functioning optimally. There are occasional attempts at beginning to address the issue such as a

"consultative process by a monitor" (Allanach, 1988), a "preceptor committee" that meets frequently to monitor progress of orientees and preceptors (Hill and Lowenstein, 1992) and a Clinical Nurse Specialist advisor that meets as needed during the rotation (Ephron and Andrea, 1989), but these attempts do not go far enough.

As Shah and Polifroni (1992) have pointed out, educators cannot assume that clinical expertise and preceptor expertise are identical. In her evaluation of a critical care nursing internship program, Hartshorn (1992) described the use of a Basic Knowledge Assessment Tool given to preceptors and preceptees. Her results showed that the preceptors did poorer than the interns although they were expected to serve as role models. These results have not been replicated elsewhere as yet. As a result, the study recommends further research to specifically assess preceptors in respect to both knowledge base and ability to evaluate. I would suspect that even poorer results would be obtained if preceptor expertise (teaching, evaluating, objective setting) rather than clinical expertise were assessed.

Although preceptor performance appraisals by supervisory personnel were alluded to in a couple of reports (deBlois, 1991; Shamian and Inhaber, 1989; Modic and Bowman, 1989; Davis and Barham, 1989), more frequently evaluation tools are described which rate preceptor characteristics to assist in preceptor selection (Russell-Babin, 1989; Modic and Bowman, 1989) or which leave preceptor evaluation to the preceptee (Russell-Babin, 1989) as is the case in the Obstetrical Nursing Specialty. Evaluation of preceptorship

programs is consistently described in the literature (Davis and Barham, 1989; Stolte, Goss and Lim, 1988; Ephron and Andrea, 1989; Ferris, 1988; Modic and Bowman, 1989; Hartshorn, 1992) but almost as consistently leave off the key element of appraising the one who will have the greatest effect on program success or failure. Preceptors themselves have concerns about their ability (Shaffer and Ward, 1990) and need to receive a fair appraisal which addresses areas in need of improvement (deBlois, 1991).

Preceptor Reward

The early preceptorship literature indicates that in general, preceptors found the experience very valuable (Shamian and Inhaber, 1975). The major perceived values are added job satisfaction (Chickerella and Lutz, 1981; Dell and Griffith, 1977; Friesen and Conahan, 1980; Limon et al, 1982; Murphy and Hammerstad, 1981; Turnbull, 1983) and opportunity for professional growth (Chickerella and Lutz, 1981; Friesen and Conahan, 1980; Knauss, 1980; Limon et al, 1982; Taylor and Zabawski, 1982).

The later literature endorses those same benefits (Young, Theriault and Collins, 1989; Davis and Barham, 1989) but more frequently includes reports of preceptor dissatisfaction when they are expected to fulfil a broader role solely for its intrinsic value (Mooney et al, 1988; Cantwell, Kahn, Lacey and McLaughlin, 1988; Hill and Lowenstein, 1992; Lewis, 1990; Yonge, Profetto-McGrath, 1990; Greipp, 1989; Shah and Polifroni, 1992; Roberson, 1992). Preceptors are identified to be at high risk of burnout from overuse, abuse and devaluation of the role (Modic and Bowman, 1989; Lewis, 1990; Turnbull,

1983; Greipp, 1989; Young, Theriault and Collins, 1989; Roberson, 1992). Of particular concern is preceptors' frustration and guilt at not being able to fulfil patient care and preceptor responsibilities due to inadequate time (Young, Theriault and Collins, 1989; Borland et al, 1991), and the unsupportive attitude/behaviour of nursing colleagues (Stolte, Goss and Lim, 1988; Young, Theriault and Collins, 1989).

In a survey of the *Critical Care Nurse* journal readership conducted by Alspach (1989), preceptors responded to a series of questions about themselves and their role. Sixty-two percent of respondents indicated they received no incentives, rewards or recognition for functioning as a preceptor. Forty-eight percent indicated they wished to receive tangible recognition, the majority (sixty-seven percent) of the forty-eight percent preferring a pay differential.

Recently, reward systems are often advocated in the literature but not described (Lewis, 1990; Modic and Bowman, 1989; Friesen and Conahan, 1980). Table 5 lists those suggestions that have been defined. Recognition luncheons appear to be the most popular reward mechanism (Greipp, 1980; Taylor and Zabawski, 1982; Hitchings, 1989; Borland et al, 1991; Young, Theriault and Collins, 1989; Roberson, 1992) although preceptors have indicated a preference for monetary recognition (Alspach, 1989) and stipulated that luncheons are not enough (Young, Theriault and Collins, 1989).

Table 5

	PRECEPTOR REWARDS
1)	Advancement on the clinical ladder
2)	Continuing education credits/tuition vouchers
3)	Joint appointment with educational facilities
4)	Write-ups in institutional newspapers
5)	Money/pay differential
6)	Honourary titles or some "formal" recognition
7)	Scheduling considerations
8)	Recognition luncheons
9)	Certificate of commendation/appreciation for personnel file
10)	Special name tag
11)	Library privileges
12)	Day off
13)	Formal planning day with orientee
14)	Adjustments
15)	Computer access
16)	Time and staff to relieve preceptors of routine work.

The Obstetrical Nursing Specialty at B.C.I.T., until very recently, has had a minimal reward mechanism in place. Preceptees often presented a gift to their preceptor at the conclusion of the rotation and the school sent a letter of thanks. As preceptors were often being requested to accept more than one student during the year, B.C.I.T. was placing their preceptors in a position of becoming "burnt out", as described in the literature. In the past year, the addition of preceptor pins, fruit baskets and a one-day preceptor course credit note has done much to improve B.C.I.T.'s recognition of preceptors in the Obstetrical Nursing Specialty.

Despite general agreement in the literature that material reward has an obvious place, practice has relied on preceptors receiving enough intrinsic value to continue fulfilling the role. It is that practise that needs to be examined considering the message it delivers and perpetuates. As Clark (1981, p. 318) says, "the amount of recognition given teaching assistants (or preceptors) directly reflects the value educational and health care institutions place on nursing and on excellence in clinical practise and clinical teaching".

Alternatives to the Preceptorship Model

As identified at the beginning of Chapter Two, the preceptorship model has expanded far beyond its original intent. It seems relevant, therefore, to examine the literature for alternatives that may be described. As expected, there are relatively few reports that take a critical stance on the generally accepted use of preceptors and offer alternatives. It is not the intention here to promote or negate the validity of these alternatives but to suggest that it is important to encourage a closer examination of the preceptorship model.

As Griepp (1989) points out, it is daunting to expect a staff nurse to fulfil all the responsibilities of a preceptor in addition to performing regular patient care and staff responsibilities. "The role expectation is unrealistic for anyone with less than several years clinical experience and no advanced educational preparation" (Griepp, 1989, p. 184). Furthermore, Myrick (1988) indicates that there is limited empirical evidence to substantiate preceptors' effectiveness for student learning. This may be due in part to the "warm body syndrome" which frequently prevails, in that any nurse who wishes to be a

preceptor is acceptable regardless of educational background, experience or teaching ability (Myrick, 1988, p. 137).

The reliance on preceptors alone raises concerns around accountability for student supervision and evaluation (Zerbe and Lachat, 1991). Myrick (1988) and Bizek and Oermann (1990) indicate if preceptors are used at all, they need to be well qualified and well prepared to assume the added responsibilities of teaching and evaluating. As a result of these concerns, alternatives to the basic preceptorship model are suggested in the literature and are outlined in Table 6.

Table 6

	ALTERNATIVES (N=12) TO THE PRECEPTORSHIP MODEL	FREQUENCY
1.	Collaborative Nursing Service/Nursing Education	4
2.	Traditional Centralized Teaching/Clinical Teacher	3
3.	Unit-based Clinical Instructor/Educator	2
4.	Faculty Facilitator/Support System	2
5.	Expanded Preceptor Role	1

The authors that describe a collaborative approach (Hovey et al, 1990; Kirkpatrick et al, 1991; Zerbe and Lachat, 1991; Angelucci and Todaro, 1991) address the concerns of teaching and evaluating by preceptors by identifying a more appropriate or better qualified person to perform these responsibilities. For example, in Zerbe and Lachat's (1991) description of a three-tiered model, responsibility for student learning is shared between preceptors, clinical instructors and the course coordinator. The Masters prepared clinical

instructor has advanced preparation in the specialty area and clinical teaching expertise. She is responsible for supervising and supporting the preceptor-student dyad, assisting with bedside teaching, and performing the student evaluation. The Doctorally prepared course coordinator is responsible for course content and course instruction. This model makes student supervision and evaluation more manageable according to the authors and preceptors express satisfaction with it.

Other reports have identified two extremes in belief around preceptorship issues, those that feel that the battle to give nursing to the educators was hard fought and argue the case for traditional centralized teaching (Bizek and Oermann, 1990; Myrick, 1988) and one that expands the role of preceptor into management (Cox, 1988).

Traditional teaching proponents support their stance by arguing that preceptors have not been shown to be superior to clinical teachers (Huber, 1981; Marchette, 1984; Olson et al, 1984; Myrick, 1988). However, Cox (1988) believes that expanding the preceptor role to make them answerable for execution, completion and outcome and involving them in problem-solving functions of the training department, incorporates them into the management process and thereby assists in budget control by reducing early turnover.

Modic and Bowman (1989) and Griepp (1989) describe the use of unit-based clinical instructors for use in orientation. Their role is to develop a unit orientation program and maintain responsibility for the orientees with assistance from other staff, be they in the

role of preceptor or not. Griepp (1989) indicates that the one-on-one preceptor relationship is not required as orientees need to develop a confidence and independence and work with all staff. However, Modic and Bowman (1989) advocates the use of preceptors but under the direct supervision of the clinical instructor who supports them on a daily basis and enhances their accountability.

Finally, less structured alternatives of facilitator (Hseih and Knowles, 1990) and empowerer (Carlson-Catalano, 1992) are described. These reports support the preceptor-student relationship but indicate it is part of a bigger picture and suggest the relationship could be assisted by the use of mentors or facilitators.

Summary

In an effort to examine issues surrounding the use of the preceptorship model, I examined the nursing literature. As a background to this study in which I examined the role of preceptor, I observed preceptors in one post-basic obstetrical nursing program and examined its effectiveness as a vehicle for instruction in the clinical portion of this program.

One of the main points extracted from the literature is what appears to me to be an overapplication of the preceptorship model. Preceptor characteristics and role/responsibilities have expanded over time to include those qualifications and functions now traditionally seen as the nursing instructor role.

Despite the small amount of literature that addresses preceptor characteristics and selection, the literature identifies that preceptors are often chosen by the nurse manager for success in the work role. The concern is around the assumption that clinical expertise can be translated into preceptor expertise. This study looks at the qualifications and role/responsibilities of preceptors in the Obstetrical Nursing Specialty.

Difficulties regarding the overall lack of preceptor evaluation is highlighted in the literature, as well as issues surrounding the inconsistency of preceptor role preparation. Preceptors are described as neither trained as educators nor prepared for the education role in a consistent manner. This study looks at the preparation for the preceptor role at B.C.I.T.

I researched the literature for a critical stance on the preceptorship model and its application, but little was found. Some interesting alternatives were described as a result of some authors' less than complete acceptance of the model, and is possibly worth another look following this study. I will return to the key issues identified in the literature with my findings in the Obstetrical Nursing Speciality in the final chapter.

CHAPTER 3: METHODOLOGY

Introduction

To gather information about the clinical experience and the effectiveness of the role of preceptor, I selected four preceptors who supervised students in either the first (low risk) or second (moderate risk) clinical course. This supervision occurred over a selected two month period.

As identified in Chapter One, I intended to obtain information on the qualifications and/or preparation for the preceptorship role; the balance between the preceptor's responsibility to the hospital and their attention to the student; preceptor's ability to exhibit the various roles attributed to them in the literature; and preceptors opinions on whether the preceptorship prepares students to assume employment following it.

Selecting the Sample

Because the first and second clinical courses in the Obstetrical Nursing Specialty are entirely preceptor supervised, they were used as the target population. The third course has some instructor involvement, and was therefore not used in the study.

Two consecutive months were chosen at the convenience of the investigator and a list of the total number of preceptors who would be having students in the first course or in the intrapartum portion of the second course at the selected time was provided by the B.C.I.T.

course coordinator.

A letter of introduction which briefly outlined the study and a request for participation was sent to the full sample of fifteen preceptors throughout British Columbia. A covering letter indicating B.C.I.T.'s support of the project was included. For reasons of confidentiality, preceptors' home addresses and phone numbers were unknown to B.C.I.T. and therefore the letters were sent to the employing agency with a request to contact the investigator if willing to participate.

The element of time became a frustrating factor in affecting the sample. The clinical courses are short (Level I - 10 shifts, Level II - 13 shifts) and preceptors and students arrange their time to suit themselves. As a result, students had sometimes started their clinical course earlier than anticipated and delayed response by preceptors to the request for participation in the study resulted in students finishing or about to finish their scheduled shifts prior to the investigator being able to arrange observation time. This factor resulted in the loss of four potential sample preceptors.

As a result of the introductory letter, two preceptors immediately agreed to participate in the study and one refused. Four others agreed to participate as a result of a follow-up phone call and were included in the study. Inability to effect communication with two other preceptors resulted in their loss to the sample. Other attrition resulted from conflict of interest due to the investigator being in a position of authority over one of the

preceptors, discomfort of one preceptor with the observation portion of the study, and withdrawal of one student from the clinical program due to accident. It is worthy of note that the preceptor who was uncomfortable with the observation portion of the study was a casual employee who was undertaking precepting for the first time.

The remaining sample size of five was further reduced by one due to a hospital administrator's refusal to allow research to take place prior to the meeting of the Clinical Investigations Committee. This committee was not scheduled to meet for over a month and would therefore be too late to accommodate this study.

The Case Study Group

Despite significant attrition, four representative preceptors agreed to participate and were subsequently identified as a case study group for the purposes of this project. The case study group are employed in hospitals in different geographic locations within British Columbia. The hospitals range from community level to tertiary care and deliver a range of 600 - 3500 babies per year.

Three of the preceptors are working with students in the low risk (ADNS 645) course and the other is with a student taking moderate risk (ADNS 647). The case study group varies in preceptoring experience from never having been a preceptor for B.C.I.T. before, to having been a preceptor for one student only before the current one, to having been a preceptor for several students.

Although the sample size is small, the case study group reflects the ratio of first and second course students (see Table 7).

Table 7

Comparison of Total Sample to Case Study Group

Total Sample	Case Study
ADNS 645 = 50 students	ADNS 645 = 3 students
ADNS 647 = 16 students	ADNS 647 = 1 student

There were an additional 11 students in a different core program but they are not included as they do not impact on the program being evaluated.

Research Design:

Rationale for Method Choice: No sharp boundary divides research and evaluation. Historically, research was a quest for laws and evaluation largely descriptive of some phenomena set against a standard. At present, both fields have expanded allowing a cross-over to exist. Research has expanded methodologically as evidenced by the bulk of qualitative research now published, and more methodology has been integrated into the field of evaluation.

With this background, I have chosen Stake's (1973) Model of Responsive Evaluation as the syntax for this qualitative research study. My assumption is that an evaluation based

on qualitative analysis will yield the most beneficial results in answering the research questions.

As Stake says, no one model is "the right way" to evaluate. Therefore, as a preparatory step, I examined other models of evaluation, concentrating on those that accentuated different aspects of the Obstetrical Nursing Specialty. These included Tyler's (1949) "Behavioural Objectives" model which focuses on the curriculum and student outcomes, Eisner's (1976) "Connoisseurship" model which highlights the preceptor and Stake's (1973) "Responsive Evaluation" which accentuates the practicum.

The fundamental problem with Tyler's model is the assumption that we either know, or can readily identify, the educational objectives for which we strive, and thereafter the educational outcomes. It is difficult to resist the assumption that those we can measure are the elements we consider most important. The cumulative side effects of any objective are at least as important as the main effect, thus the objective itself is an oversimplification.

The use of behavioural objectives implies a poverty-stricken model of teacher-student interaction. The methodology for the acquisition of each clinical skill is excessively described (i.e. wash hands, introduce self, etc.). Thus, as a role model and teacher, the preceptor would be sadly lacking without the aid of the optimum approach set out in behavioural objectives. The weakness, of course, is the reliance on objectives.

Finally, related to student outcomes, achieving certain outward and visible signs is all too frequently consistent with failing to achieve the state of mind desired. In evaluating, so many "correct behaviours" can mask misunderstanding. As Holt (1981) states, "Values are implicit in every educational act, and there is no 'objective' or 'systematic' way in which the quality of an act can be separated from the way it is performed".

In contrast to behavioural objectives, the Connoisseurship model is present rather than future orientated. The emphasis is on the education process whose features may differ from individual to individual and context to context.

Teaching is seen as an activity that requires artistry, thereby enhancing the quality of an educational experience. The main advantage of the model is that it exploits the particular expertise and finely developed insights of those persons who have devoted much time and effort to the study of a precise area.

The preceptor's qualifications, as outlined by B.C.I.T. consist of one year continuous employment in the hospital where they are presently working, and current employment in the Labour/Delivery unit - although they do stipulate that two years of experience is preferred. Hence, the preceptor as connoisseur would be the strength of Eisner's model, but the major weakness when applied to the Obstetrical Nursing Specialty.

According to Stake (1973), an evaluation is responsive if it orients more directly to program activities than program intents. Consequently, Stake rejects the focusing of the curriculum on prespecified objectives that enable judgements to be made on future behaviour, as does Eisner.

The preceptor, as an integral part of the dynamic learning environment would be an important link in evaluating according to Stake's model. Part of the advocacy of the responsive approach is the reliance on natural communication to assimilate information, rather than formal communication.

Another strength in the model is the non-assumption of instructor qualifications. The efficacy of different preceptors would become apparent with the use of observation based descriptions of program activities. Thus, the difficulty of the Connoisseurship model would be overcome with this approach. The program activities, and thus the practica of the Obstetrical Nursing Specialty is the area of emphasis in Responsive Evaluation.

The strength of this model is the holistic approach in attributing importance to all components of the program. As Stake (1973) says, the important matter for the evaluator is to get his information in sufficient amount from numerous independent and credible sources so that it effectively represents the perceived status of the program, however complex. This action-research approach in which people implementing programs are helped to conduct their own evaluation, advocates its use.

The main weakness, according to Stufflebeam and Webster (1980) is the lack of external credibility and the susceptibility to bias on the part of the people in the local setting. Stake would counter that subjectivity can be reduced by replication and operational definition of ambiguous terms, even while relying heavily on the insights of personal observation.

It is important to note that in contrast to a formative evaluation, a responsive evaluation contains judgements based on the observations. Stake advocates that evaluation reports should reveal the "multiple reality" of an educational experience. Tests and other data gathering should not be seen as essential but neither should they be ruled out. The choice of instruments in responsive evaluation should be made as a result of observing the program in action and of discovering the purposes important to the various groups having an interest in the program.

Role of the Investigator: My personal experience in relation to the Obstetrical Nursing Specialty includes the role of staff nurse, preceptor of both low and moderate risk clinical courses, and Head Nurse, lending familiarity with the program from different perspectives.

Methods of investigation are to be chosen to fit the issues, according to Stake (1973). Problems are best solved directly by local people close at hand. My experience as a preceptor contributes to a researcher bias but Stake's methodology does not preclude me as evaluator. The educator will often be his/her own evaluator or a member of the

evaluation team (Stake, 1967).

The advantage of Stake's model, as applied to the Obstetrical Nursing Specialty, is that I as preceptor and program evaluator, can make use of both direct and vicarious experience as outlined by Stake. This would lend credence to any results. It could also be a combination of the formative and summative approaches, as a report to the program developer judging the outcomes of the existing program could work towards improving the program.

Data Collection: According to Stake, the educational program must be fully described and fully judged.

In the matter of selection of variables for evaluation, the evaluator must make a subjective decision. The variables ruled out will be those he/she assumes will not contribute to an understanding of the educational activity. Stake reiterates that the rationale for the research will impact on the evaluator's choice of characteristics to be observed. I believe that my choice of assessment criteria will elucidate the role of the preceptor in the Obstetrical Nursing Specialty.

To be true to Stake's model, as already outlined, the data gathering must be obtained from multiple credible sources, and in sufficient amount that it effectively represents the perceived status of the program. Sample loss has resulted in the reduction of anticipated

sources and therefore may be a potential drawback to the use of Stake's model. However, the case study group is reflective of the whole and data is obtained through other tools such as written clinical course evaluations and preceptor evaluations by students of the case study group.

Observing the program, according to Stake, should absorb approximately thirty percent of evaluation resources, twice as much as any other area of focus. For this study, the evaluator spent one twelve hour shift with each of the case study group preceptors and their student. The evaluator role was maintained as an observer only. Every attempt was made to be as inconspicuous as possible so as not to interrupt the natural preceptor-student communication. Patients and physicians were apprised of my study and my role and gave permission for my attendance in their birthing experience prior to my involvement. I took notes throughout the day but did not interrupt to ask questions.

Following the observation period, I had a private interview in a quiet environment with each preceptor. Each preceptor was asked the same questions as per the questionnaire in Appendix A. The questions were chosen as they were thought to provide clear, focused information in addressing the research questions and at the same time allowing preceptors to expand if they wished on issues important to them. Also, many of the questions had previously provided enlightening information in a Critical Care Nurse (1989) readership preceptor survey and had been shown to be issues of importance to preceptors. The interview also provided the opportunity to address questions that arose from the

observation period.

Data Reduction (Display)

According to Miles and Huberman (1984) data reduction is a form of analysis that sharpens, sorts, focuses, discards and organizes data in such a way that "final" conclusions can be drawn and verified. They also state that the ideal model for data collection and analysis is one that interweaves them from the beginning, and to that end they outline a system of coding to assist in developing patterns or themes.

Stake's data matrix "codes" the data into intents, observations, standards and judgements (see Appendix B). It performs the same functions as outlined by Miles and Huberman, the difference being that all data is focused to allow evaluation. Stake (1973) believes that it is helpful to distinguish between antecedent, transaction, and outcome data.

Briefly, an antecedent is any condition existing prior to teaching and learning which may relate to outcomes. Transactions are the countless succession of engagements which comprise the process of education, and outcomes are the consequences of education - immediate and long-range, cognitive and conative, personal and community-wide. Transactions are dynamic whereas antecedents and outcomes are relatively static. The boundaries, though, need not be distinct (Stake, 1967).

The data from each research question is reduced and applied to Stake's model as a method

of data analysis.

Judgements: Responsive evaluation contains judgements based on the observations.

In the Obstetrical Nursing Specialty, there are certain technical skills that should be measured, and other skills which would be better evaluated by description using portrayals, narratives and the like. Stake acknowledges a potential weakness in the sacrifice of some precision in measurement to hopefully increase the usefulness of the findings to persons in and around the program.

Miles and Huberman (1984) appear to quantify their conclusions with extensive efforts to replicate and verify their findings. Meanings emerging from the data have to be tested to ensure their validity. Responsive evaluation makes a judgement based on the observations and measures against a standard. The results, therefore, would have a utility that would be missed if they were not reported due to the inability to verify their validity.

Judgement is a subjective act, but can be minimized as indicated in the rationale for this choice of method. One can obtain an overall or composite rating of merit that is helpful in making educational decisions.

Limitations of the Model

Stake's (1973) Model of Responsive Evaluation was selected as the syntax for examining the preceptorship method of instruction in the Obstetrical Nursing Speciality. It seems possible that the case study group shares much in common with other preceptors who have volunteered to teach for B.C.I.T., but we do not know they are representative of this population in general. To be true to Stake's model, data should be gathered from multiple credible sources and in a sufficient amount that it effectively represents the perceived status of the program. The restriction of subjects to preceptors and their students poses a limitation in the use of the model, as does the small sample size.

CHAPTER 4: FINDINGS

Overview of the Data:

The data presented were collected from an interview (Appendix A) and observation of a twelve hour shift with each subject preceptor; clinical evaluations (Appendix C and D) and skill inventory assessments (Appendix E) completed by the case study group and clinical course evaluations (Appendix F), and preceptor feedback forms completed by their students (Appendix G).

For each of the subject preceptors, relevant data from these sources were compiled into Stake's data matrix for each research question; I also prepared case studies for each subject. Stake's data matrix provides a summary tool to facilitate data analysis and allow for judgements to be made. More detailed description and analysis comes through the text of the case studies. In order to illustrate the process of data analysis and forming of judgements, I have included the matrices for each research question for one of the cases.

To reiterate, research questions included the following: Are preceptors adequately qualified or prepared?; What is the balance between the preceptor's responsibilities to the hospital and their attention to the student?; Do preceptors exhibit the various roles attributed to them in the literature i.e. facilitating appropriate learning experiences, role modelling, question-asking, supervising, providing feedback and evaluating?; Do preceptors feel the preceptorship prepares students to assume employment following it?

I examined the case study data for trends and typical occurrences related to each research question in an attempt to represent the experience of preceptors in the Obstetrical Nursing Specialty. Results are outlined in four summary matrices which follow the individual case studies. Any trends that were noted unrelated to the research questions are also described.

Case Studies

Alex. Alex was born and grew up in the community in which she now works. Nursing has always been her career since she graduated from her training hospital twenty years ago, although she did take a significant break to raise her four children. Alex has done a variety of roles in nursing including two years as a surgical nurse, a year as an office nurse and four years as a day-surgery assistant. She has also had a few years of experience working in the obstetrical field, although never in labour and delivery.

Several years of being a full time mother meant Alex was required to take some form of upgrading before she could re-enter the workforce in nursing. She chose to specialize in obstetrical nursing and enroled in the B.C.I.T. Obstetrical Nursing Specialty, where she completed the low risk course and the theory portion of the moderate risk course.

Alex has been working for her current employer, in Labour and Delivery, since she completed the low risk clinical preceptorship just over two years ago. Alex has always enjoyed teaching people, so when she was approached by her Head Nurse and asked if

she would like to take on a student, she thought "why not?". She is now acting as a preceptor for her second low risk student in her hospital which delivers about 2,000 babies per year.

As we can see in Figure 1, the key data obtained from Alex regarding the first research question, "Are preceptors adequately qualified or prepared" is displayed through Stake's (1973) responsive evaluation data matrix. The qualifications standards are as outlined in the Preceptor Manual (B.C.I.T., 1989) (Appendix H). I deliberately chose to address the standards through data from B.C.I.T.

Occasionally in my analysis I make some judgements regarding those standards. I do not accept them as non-problematic, however, my intent is to show where a deficit occurs which causes concerns when measuring preceptors against them. I am aware I am making judgements at two levels, however, I believe it helps elucidate the problem.

Other than the antecedent standards identified, there are no other qualification standards specified by B.C.I.T. However, there are several intents, which are described by B.C.I.T. as "benefits" for the preceptor and agency. Most of these intents are listed under the matrix heading of the same name as I saw them fitting into the divisions of antecedent, transaction and outcome descriptors.

Figure 1

Are Preceptors adequately qualified or prepared?

"Alex"

INTENTS	OBSERVATIONS		STANDARDS	JUDGEMENTS
Preceptors meet standard set by B.C.I.T. Preceptor has at least one year and preferably two years labour and delivery experience Preceptors who volunteer will be of "good quality".	Alex is licensed by RNABC Alex has worked in Labour and Delivery for two years and four months B.C.I.T. moderate risk theory is highest level of educational preparation Alex attained.	ANTECEDENTS	Current licensure by RNABC Minimum of one year continuous employment in current hospital Current employment in Labour and Delivery	Alex meets standard as outlined by B.C.I.T.
Agency will have an opportunity to give recognition to and recommend good clinical nurse practitioners as preceptors	Head Nurse asked Alex if she wanted and felt comfortable to take on a student No preceptor training program offered or taken Alex likes to teach-she enjoyed working with basic nursing students	TRANSACTIONS	No B.C.I.T. standards identified for clinical and/or teaching expertise No B.C.I.T. involvement in preceptor selection	Lack of criteria for assessment and selection, therefore questionable qualifications and preparation
Preceptor may be stimulated to further professional growth Preceptor feels a sense of recognition for her nursing competence	Alex feels supported by her colleagues Alex feels "drained" at end of 10 shifts and does not feel rewarded by B.C.I.T. Positive preceptee feedback.	OUTCOMES	No B.C.I.T. standard for evaluation of preceptors. No B.C.I.T. follow-up to assess preceptor satisfaction.	Lack of criteria for performance evaluation and/or level of satisfaction, therefore, inadequate quality assurance.

Although the intention of B.C.I.T. is reasonable, if not ideal, the standards fall far short of ensuring quality preceptors for the program. Alex meets the standards as set by B.C.I.T. but, as supported by the observations, we do not know enough about Alex to confirm the appropriateness of her selection as a preceptor. B.C.I.T.'s lack of criteria for assessment, selection and performance evaluation results in an inability to ensure program quality.

B.C.I.T. is not alone in their inability to ensure program quality, however, as their lack of criteria for assessment, selection and evaluation is consistent with the findings in the literature. Also consistent with the literature, as previously identified in Chapter 2, is the reduction of years of experience from the early reports requiring up to ten years to the recent reports requiring only nine months to two years. Interestingly, though, Alex indicates an enjoyment of teaching, one of the top five preceptor characteristics identified in the recent literature, although it is not required by B.C.I.T.

In summary, therefore, Alex is qualified for the preceptor role when measured against the few standards outlined by B.C.I.T. but the standards themselves are insufficient to ensure appropriate selection and therefore quality of program instruction.

In Figure 2, we can see the data from Alex related to the balance between the preceptor responsibility to the hospital and their attention to the student. B.C.I.T.'s Preceptor Manual clearly outlines the allocation of accountability and responsibility and are used

Figure 2

What is the balance between the preceptor's responsibility to the hospital and their attention to the student?

"Alex"

INTENTS	OBSERVATIONS		STANDARDS	JUDGEMENTS
Preceptor supervises the student in the clinical area	Alex has only one student assigned to her There are no other post-basic students on the ward	ANTECEDENTS	The preceptor is responsible for one obstetrical nursing student in the clinical area at any one time	Clinical Assignment meets standard
Preceptor facilitates student learning by role modelling, providing problem solving opportunities, by asking the student questions, by making suggestions to enhance the student's performance and by giving support and encouragement	Alex takes equal share of the workload "Sometimes the teaching has to be put aside...." "...Basically we went all night and it wasn't until the next shift that I actually got to say, okay, let's go over what we did last night..."	TRANSACTIONS	The preceptor's primary responsibility and accountability is to the employment agency and not to B.C.I.T.	Ability to fulfill preceptor functions is workload dependent, therefore preceptor time dedicated to student is inconsistent
Preceptors have assisted in the completion of clinical course objectives	"Maybe I should be dropping back more...but ultimately I'm responsible for that patient, you know!..." Clinical course objectives nearing completion	OUTCOMES	The preceptor reports to the B.C.I.T. coordinator of the Obstetrical Nursing Program in relation to his or her student should any concerns or problems arise	Responsibility to both a student and employer causes strain and results in completion of course objectives being more greatly weighted than the educational experience.

as the standards in Figure 2. I have selected from the preceptor functions (Appendix H) those statements that I feel are related to the research question for the intents column of the matrix.

Alex's own statements in the interview, key examples of which are located under observations in Figure 2, are the best examples of her struggle with her responsibility to both her employer and her student. The day I spent with Alex on the ward, workload was not overwhelming and Alex was able to concentrate her efforts on her student. Even if not workload related, Alex struggles with both her desire to give direct care to her patients and her wish to facilitate student experience. For example, one of the women who had recently given birth was to be transferred to the postpartum ward. This is generally a good opportunity for the nurse caring for her to ensure physical and emotional recovery is proceeding as it should prior to transfer. It is often a more relaxed time than care during labour and promotes the feeling of "a job well done" for the woman and her nurse. Alex started to involve herself with direct care, then said to me, "Maybe I should let her do it - I find it hard to pull back".

The above example was non-workload related but in my experience as a preceptor and head nurse, when excess workload becomes a factor, the preceptor resumes the role of staff nurse and, depending on the abilities of the student, the student either shadows the preceptor and observes or provides independent care as needed without direct supervision of the preceptor.

Alex is clear in her accountability to the employer. She said:

> "It's the type of area where you can't not carry your one third of the load when there are three of you on. You have to be part of that team and sometimes the teaching has to be put aside to either a break or the next shift...which is exactly what we had to do on one night shift. We had eight or nine admissions and seven deliveries...basically went all night and it wasn't until the next shift that I got to say to her, okay, let's go over what we did last night...I really don't think I let them (the staff) down and I know I won't let them down."

It's clear from this quotation that accountability to the employer results in student objectives becoming secondary. However, preceptors recognize the need for attaining student objectives by the end of the preceptorship. Alex spent time with her student going over what was "done" and what skills were still "to do". As an example, Alex sent her student to another area so she could "finish up her skills" as two of the specified skills were not routine practice in labour. In doing so, Alex delegated the educational process of attaining the skill i.e. teaching, role modelling, practising and evaluating it, but the objective was assessed as completed or "done". Therefore, the completion of the objectives appears to carry more weight than the educational experience.

Figure 3 outlines the data from Alex related to how preceptors exhibit the various roles attributed to them in the literature. The standards in the matrix were gleaned from my review of the literature and the matrix intents from the B.C.I.T. list of functions of the preceptor (Appendix H). As previously identified in Chapter 2, the functions of the role of preceptor as identified by B.C.I.T. are consistent with the most frequently mentioned role/responsibilities in the literature (see Table 3).

Figure 3

Do preceptors exhibit the various roles attributed to them in the literature?

"Alex"

INTENTS	OBSERVATIONS	ANTECEDENTS TRANSACTIONS OUTCOMES	STANDARDS	JUDGEMENTS
In consultation with the student, the preceptor chooses experiences appropriate to the student's level	After report, Alex asks student which patient she would choose. They jointly decide on a primip at 7-8 cm Alex suggests student teach patient to breastfeed Alex arranges for student to transfer patient to postpartum		The facilitator, incorporating within its definition a guide, planner and organizer, is the most frequently cited function of a preceptor	Learning experiences appropriately facilitated
Facilitates student learning by role-modelling, providing problem-solving opportunities, by asking the student questions and by giving support and encouragement Makes suggestions to enhance performance Gives positive and constructive feedback	Alex asked student if she identified any risk factors Alex demonstrated checking of resuscitation equipment Alex suggested student put baby to breast rather than clean up the room "...it's more of a priority" Student asked if patient needed "the hands and knees", Alex said, "no"		Next to facilitator, the roles of teacher/clinical instructor, role model, evaluator and resource/support are the most frequently cited in the recent literature	Alex role-modelled and asked questions well but was largely directive in feedback Student not always encouraged to problem solve
Completes skill assessment tools for designated clinical skills Completes "summary" on clinical evaluation tool	•"I don't really see it (evaluator) as my role...". •Terminal objectives initialled as "met" •No examples identified. •Skill inventory "checked" for all skills. •Summary indicates positive feedback - areas for improvement identified as related to lack of time.		From 1981 onwards, the role of evaluator becomes prominent when discussing preceptor role responsibilities	Alex unskilled and unprepared for role of evaluator

As can be seen in the matrix, Alex does well at facilitating appropriate learning experiences, role modelling and asking questions. However, I observed Alex often being directive in her instructions and feedback. For example, in preparing her student to transfer a mother to postpartum she said: "I want you to get her up to shower, get clean pads and ice, do one more set of vital signs then give report to postpartum staff."
As Alex's student was on her eighth of ten shifts, I expected this knowledge base to be elicited from the student, rather than through Alex.

During her interview, Alex indicated her frustration with what she perceived as her student's lack of initiative. During the initial shifts of the preceptorship, Alex indicated that she had already "gone over" the skills and expectations several times with her student where I, as observer, had noticed direction still being given. I observed little attempt at encouraging the student to do the problem solving. Alex may have attempted to do this earlier in the preceptorship but her frustration by this stage resulted in a directive feedback approach.

Alex had difficulty with translating her concerns into evaluation. As can be seen in the matrix, Alex did not see the role of evaluator as integral to her role of preceptor and also identified it as the least comfortable aspect of the role in her interview. She said:

> "I don't really see it (evaluator) as my role as strongly as the teacher because basically I think people are going to pass their preceptorship in the fact that they have done the ten shifts. I don't think that it is in my capacity just as a staff nurse to be able to say you shouldn't be in obstetrics or you should be, like you're cut out for this field or you're not. I don't really see it as a strong part of it."

In the formal evaluation tool (Appendix C) Alex has simply initialled all skills and objectives as completed. There are no descriptors documented. Although there is designated space allocated in the tool, B.C.I.T. indicates that completion of the "summary" section of the clinical evaluation only is required to be completed by preceptors. This makes appropriate student evaluation impossible, as preceptors are the only clinical supervisors and therefore need to be performing complete assessments. Even in the summary, Alex's concerns have not been clearly addressed. She identified one area for improvement but indicated this to be as a result of insufficient time.

In summary, Alex exemplifies the deficiency in the evaluator role and process in particular, in examination of the various preceptor roles identified in the literature.

Figure 4 displays Alex's data in relation to the last research question, "Do preceptors feel the preceptorship prepares students for employment following it?" Intents are taken from the Purposes of the Preceptorship (Appendix I) outlined in the Preceptor Manual. Standards are taken from the description of student evaluation (Appendix J) in the Preceptor Manual.

As can be seen in the matrix, Alex strongly believes that students are not prepared to assume employment after the low risk course. Observations statements were taken from her interview. Alex bases some of her opinions on her own personal experience as a graduate of the B.C.I.T. program. For example, Alex said: "... using my own

Figure 4

Do preceptors feel the preceptorship prepares students for employment following it?

"Alex"

INTENTS	OBSERVATIONS	ANTECEDENTS TRANSACTIONS OUTCOMES	STANDARDS	JUDGEMENTS
Purpose is to develop independence in the role of an obstetrical nurse	Alex's student is on her 8th shift of 10 in the low risk course "...I don't really think the low risk modules prepare you for how quickly things can go wrong...."		Students must complete an ongoing daily self-evaluation tool	Alex feels students are ill-prepared to enter the preceptorship Students are unaware of what knowledge they are lacking
Students will have opportunities to perform selected obstetrical nursing skills Students will apply the nursing process in the obstetrical nursing setting	..."Some of the skills are so basic...it doesn't address half of what you take on when you take on a laboring patient..." ..."Like right now all they have to do is observe things. I would want more of getting them actually to do it..." B.C.I.T. wants to see the piece of paper that you've completed the skills		Students must complete the required clinical experiences specific to their level Preceptors complete the Skill Assessment Tool	Alex interprets clinical experience at this level as largely observational which is not entirely consistent with B.C.I.T.'s expectations
Purpose of preceptorship is to prepare students to assume employment within the obstetrical nursing specialty	"...I think you need both level (low and mod) before being hired into an area..." "...She's not prepared to be a staff nurse whatsoever" "...it's going to differ so much from person to person as far as who gets what out of their preceptorship"		Minimal acceptable performance is the pass requirement for all clinical course objectives as identified in the clinical evaluation tool	Alex believes students are not prepared to assume employment following the low risk course

experience, ... I did not have any confidence whatsoever in my own abilities and I think I should have taken at least the moderate, and go back and do more preceptorship. I did not feel that you were adequately prepared."

Alex feels that not only is the low risk preceptorship insufficient as preparation for employment, the low risk theory modules are insufficient preparation for the preceptorship itself.

> "Where it really came together for myself was when I took the moderate to high risk, the next level up. Then I really focused on what exactly I was doing, what I should be looking for, what was important and what wasn't important. Because you can get into an emergency situation so quickly and a good case can turn into a bad case so fast I don't really think the material you cover in the low risk modules prepares you for how quickly things can go wrong or exactly what can go wrong." (Alex)

According to Alex, the low risk preceptorship is largely observational, as can be seen in the matrix. Although there are many clinical experiences that require observation only, B.C.I.T. does outline experiences that require direct patient care. (Appendix K) This inconsistency and expectation is problematic regarding Alex's perception of her role as preceptor and may also have a bearing on her belief regarding preparation for employment.

> "... like right now all they have to do is observe a delivery and observe things. I would want more of getting them actually to do it with you (preceptor) as an observer, as a helper role... I think that if you are going to get hired just on what you studied and preceptored as a low risk student, you haven't got enough tools". (Alex)

Alex acknowledges however, that all students are different and that sometimes, like with her first preceptorship student, they are already working in Labour and Delivery and taking the course to learn or update theory knowledge and application of that knowledge to practice.

> "the one (student) I had in January was already working in Labour and Delivery. I felt good about letting her go back home again because she was going to do a good job - she really had a good grasp. She had everything figured out and had done everything before." (Alex)

On the whole though, Alex feels that the low risk preceptorship is insufficient as preparation for employment and would change the program as follows:

> "I think you need both levels before being hired into an area. I think the information that they are offering is okay but I think ... probably what I would do is make the preceptorship longer in the low risk and make it a little bit more involved. ... A combination of low and moderate risk would be more helpful."

The case study of Alex included tables based on Stake's data matrix as well as data from the observations, interviews and supporting documents. The remaining case studies draw on the same matrix but the tables are not included to avoid repetition. However, the intents and standards remain the same across the case studies. The observations and judgments of each of the remaining case study preceptors are described in the text which follows.

Bobbi

Bobbi has a varied background and has obtained an extensive amount of experience since her graduation from nursing 30 years ago - not all of it nursing. Bobbi has done, and still does, volunteer work. She has also run a business and a home. As mom to her only daughter, Bobbi took several years off from nursing to concentrate her efforts on raising her daughter. Bobbi has lived coast to coast in Canada and the United States, and worked in large and small hospitals alike.

Bobbi's nursing experience includes intensive care, paediatrics, specialty medicine, obstetrics and geriatrics. Her recent experience on a large medical ward was harried and non-rewarding. She missed having the time to spend with her patients just talking and comforting them. As a result, Bobbi considered leaving nursing.

Obstetrics was a specialty that Bobbi had always considered fun, and not really nursing, so she decided to enrol in the B.C.I.T. Obstetrical Nursing Specialty program. Bobbi completed the low risk course and was then hired by the hospital where she currently works. The hospital is a tertiary care centre and performs about 3500 deliveries a year[4]. She carried on to complete the moderate risk theory course while continuing to work in labour/delivery, a job she has now held for six years.

[4]Tertiary care hospitals generally handle the higher risk patient. It is a referral centre and a teaching hospital.

Bobbi's Head Nurse generally solicits preceptor volunteers through the ward communication book. Although the Head Nurse had approached Bobbi before about taking on a student, Bobbi had not felt ready to volunteer. Recently, Bobbi was ready to "do something different" and offered to take on the student for whom she now acts as a preceptor. Bobbi's student is taking the low risk course and was on her eighth of ten shifts when I observed them.

In addressing the first research question, "Are preceptors adequately qualified or prepared?", Bobbi meets standards set out by B.C.I.T. previously outlined in Figure 1. With six years of experience, she surpasses the intent of two years preferable length of experience in labour/delivery. Like Alex, Bobbi has not taken or been offered a preceptor training program, or any other formal preparation for the preceptor role. Although she had a brief meeting with the program coordinator about what she was supposed to be doing, Bobbi said she felt "kind of left to the wolves in a way". Bobbi's concern regarding becoming a preceptor is also shown by her statement, "I enjoy teaching but I also am really fussy about doing things my way when it's my patient and I didn't know how I would cope with somebody there sort of doing things a different way". With no B.C.I.T. standards identified for clinical and/or teaching expertise, nor any B.C.I.T. involvement in preceptor selection, preceptors like Bobbi are left to wonder about their suitability for the preceptor role. Bobbi says she does not feel supported or rewarded for being a preceptor. She has some concern regarding how accepting her colleagues are of her having a student. She says:

> "I think that sometimes it's a hardship for the staff to accommodate this because I'm always needing a low risk patient and usually we just go down the list (of nurses) and you get whatever patient. So they have to sort of organize things a little differently when we're doing the preceptorship and they have to put a little thought and consideration into it...".

Despite the fact that Bobbi says she doesn't feel rewarded, she says she is enjoying being a preceptor and has agreed to accept another student later in the year. The request for Bobbi to take on another student prior to the completion of her first preceptoring experience, is testimony to the problematic situation regarding evaluation of preceptors. B.C.I.T. has recontracted for Bobbi to teach another student without any formal mechanism to assess her current preceptor performance still in progress.

In summary, Bobbi meets the few qualifications set out by B.C.I.T. but she has neither been formally prepared or evaluated. B.C.I.T.'s lack of specified standards related to clinical and/or teaching expertise results in an inability to assure Bobbi's suitability for being a preceptor.

The next research question addressed with Bobbi concerns the balance between the preceptor's responsibility to the hospital and their attention to the student. In her interview, Bobbi identified this as being the most frustrating aspect of doing the preceptorship. She said:

> "I still have in the back of my mind that I'm responsible for a patient and yet I'm wanting (the student) to do her learning and to gather the skills she needs without me hanging over her shoulder. So for me, there's always that inner fight - being

> a patient's advocate and wanting to make sure the patient gets the proper care and wanting to address (the student's) needs too. For me, the patient always come first as well. You know, sometimes a struggle like this morning, the patient came first in my mind. That patient's needs outweighed those of (the student). When it was appropriate I tried to show (the student) a few little things, but in general we didn't go into great detail. To me, that was not appropriate for the patient to be hearing all that chatting in the background when she was so exhausted and having such a hard time. I was wanting for (the student) to know why I was doing what I was doing and to involve her in some of the care but there wasn't time to do it and it wasn't appropriate".

Part of the difficulty I observed was related to the choice of patient, which will be discussed under the next research question but Bobbi is not alone in her struggle with the dual accountability. Their assigned patient who Bobbi refers to in the quotation, had risk factors which changes her status to moderate risk and involved skills her student was not familiar with performing. The woman unfortunately delivered an abnormal baby which required immediate intensive care and would require further follow-up. The parents were understandably very upset and were spending much time talking to the neonatologist. It was at this point that I removed myself from further involvement in order to allow the parents their privacy. Bobbi's student was also clearly upset and wasn't sure whether she should continue caring for this couple or not. Bobbi said to her, "You can decide whatever you wish and I won't judge either way". The student chose to remove herself which resulted in no further experience for her for the remainder of the shift. When I asked Bobbi about these events in her interview she said:

> "It was going through my mind - yes - (the student) is upset but this is life and this is life in labour/delivery. We started off with this patient and we should continue as a pair but I wanted to ask the patient what she wanted because still to me that is the most important thing. So had (the student) showed more signs of

wanting to be in there I would have gone into the patient and talked with her or her husband to see how that would be for them".

As the preceptor's primary responsibility and accountability is to the employment agency and not to B.C.I.T., situations such as the one described exemplifies how student objectives become secondary resulting in inconsistency of preceptor time dedicated to the student and reduction or lack of student experience. Although this is a single example, it involved one tenth of the clinical experience and the frustration with the balance of responsibility was weighted by Bobby as being the most frustrating aspect of the whole preceptorship.

The next research question addresses whether Bobbi exhibits the various roles attributed to her in the literature. As previously described in Alex's case study, the standards are taken from the literature and the intents from B.C.I.T., as can be reviewed in Figure 3.

Facilitating appropriate learning experiences begins with the patient assignment. As alluded to in the previous research question regarding accountability to the employer and student, the choice of a patient with risk factors effectively removed the student from active participation in her care. The particular unit where Bobbi works designates the charge nurse to allocate patient assignment, consequently, Bobbi did not choose or have input into the patient assignment. When I asked her about this in her interview, Bobbi indicated that although she had had no input, the charge nurse had discussed it with her student and they had jointly decided. I asked Bobbi if it had been left up to her, would

the choice have been the same. She said:

> "Well, there were three other multips pushing and we had no way of knowing ours was going to end up the way it did. We just happened to get the one that wasn't going to deliver vaginally. There's no way of knowing that. She'd been pushing just an hour but they hadn't seen any progress at all so maybe the writing was on the wall at that point....I guess I was disappointed for (the student) and I was feeling rather frustrated for me because (the student) hasn't done any Pit,[5] except maybe break relief and with epidurals - same thing...So she moved back into the observer role and I moved into showing her".

Often in a labour/delivery unit there is no "perfect" choice of patient, as there is not always a clearly low risk patient to select. Bobbi was not clear as to whether she would have chosen the same patient but indicated that the charge nurse often does elicit her input as well - as Bobbi says, "I guess there wasn't much of a choice this morning".

The concern here is that by not choosing the learning experience, Bobbi did not take on the role intended by B.C.I.T. or the literature and resulted in the facilitation of further experience being hampered, at least on the day I observed. Bobbi summarizes well in saying, "We're at the point now where (the student) is taking more responsibility in things that she feels comfortable with. You know, I'm stepping back and letting her actually perform the tests. You probably didn't see much of that this morning because of the case we had - She didn't do very much really".

Despite the difficulties with the patient assignment, Bobbi did exhibit the roles of role

[5]Pit is a shortened term for pitocin or oxytocin, a drug used to induce or augment labour.

model, instructor, and facilitator in so far as was possible. For example, patients who have an epidural in place cannot feel their contractions and Bobbi directed her student to palpate contractions as it was something she could do and with which she needed practise. Bobbi also indicated silently to her student, by pointing to the monitor strip, things she should be taking note of, and correcting. As well, she explained how to adjust the patient's legs in stirrups and why. Bobbi was very good at providing constructive feedback when her student did not do something she expected her to. For example, when a pregnant woman is on her back, the head of the bed should be raised and the student did not elevate the bed when this occurred. Bobbi reiterated to her student that the head of the bed should be raised and told her to correct it when the physician was finished examining the woman. In her interview, Bobbi said:

> "We have talked about the bed. I've stressed to her several times that pregnant women shouldn't be flat on their back. So I left it for a while to see if she noticed it...I try to leave her a little room to make an adjustment if it's not a real life threatening situation and if she doesn't pick up on it then I'll say something"

Although Bobbi appears to be demonstrating the roles identified by B.C.I.T. and the literature, she was unable to clearly describe its components. Bobbi's description of the role of preceptor specific to this course and how she would see herself performing it is as follows:

> "Probably it's walking somebody through the theory that they know, coupling that with experience...sort of an interfacer between the theory and the practicum and that where I see my role is - helping the person join those two together. I would see myself doing that I guess - well - just step by step. When somebody comes

> in to be admitted, you know, why do we do this before that, so on and so forth. I try to bring some theory along with it so that it makes sense".

In her interview, I tried to elicit from Bobbi what she felt was the most comfortable aspect of the role for her. Twice I obtained the response that Bobbi "doesn't feel comfortable with the role". When I prompted with choices i.e. role modelling, teaching, facilitating, and evaluating, her response was "Probably role modelling is the easiest because I'm in control". She indicated that she thought she was going to find evaluating difficult.

> "I think I'm going to find that very difficult for me because I don't have a clear idea where she should be at this stage. I want to be nice and supportive and encouraging, and yet I want to be realistic and give her honest feedback too. So I think it's going to be a real struggle for me to stay honest. I'm going to ask myself if I'm being too hard on her. Where are the guidelines there? I don't know, I just don't know".

Having never been a preceptor before, Bobbi's concerns were future oriented. As with Alex, though, the objectives on the Clinical Evaluation and the Skill Inventory were simply ticked off as being met and satisfactory, although two skills were identified as requiring more practise. The only comment Bobbi made in the goals for development section of the summary statement was, "More practise fine tuning skills - ten shifts not enough". Bobbi was correct in her self-assessment that she is unprepared and unskilled to assume the role of evaluator.

In regards to the last research question, "Do preceptors feel the preceptorship prepares students for employment following it?", Bobbi believes that Level I (Low Risk) is insufficient preparation for a staff nurse in labour/delivery as students simply haven't had enough experience. Bobbi says:

> "Ten shifts really isn't...that could be just ten patients, you know. If I had a patient everyday who required 12 hours of my help before they delivered, that's one patient a day, that's only ten patients. That's not very much. Maybe if it was twice that, or even fifteen shifts, a few more anyway, then she could start building on something she had done before. I don't think she'd be very happy with the responsibility involved (of a staff nurse). She's still not getting her vaginal exams right at all and having problems with monitoring - problems with lots of different things. She doing well...everyday she builds on it but she's not ready yet to assume full responsibility".

Bobbi does believe, though, that the preceptorship is an ideal learning experience for students, although she is not clear about how it should be actualized. Bobbi says:

> "It's really important for them to learn on the unit. So however that's accomplished, whether they're learning with an instructor or with a nurse, I don't think it matters, but I think it's important to have that ward experience. It's just (the student) is learning my way of doing things which isn't necessarily the best way, so I think the best preceptorship would be a shared thing where the student would work with a different person everyday, so she would learn different ways of doing things. It's important for a person who wants to work in this area to see it all. Now, it would probably be hard on the student...".

Bobbi describes a buddy system which decreases continuity of learning and which is hard on students, as she correctly points out. She also acknowledges what I believe is a key

point, in that with a preceptor the student is learning to "do the job" the way her preceptor does, not necessarily the ideal way. This would be further complicated with several preceptors, as consistency of information would suffer and make evaluation even more problematic.

Chris:

Chris was born and grew up in a small rural community. She has done a fair bit of travelling, both for enjoyment and to attend various schools. Upon graduation from high school, Chris travelled to the city to attend university in a program totally unrelated to nursing. After a year, she decided to try nursing but was unable to obtain a space until a year later. She completed her diploma nursing program and moved to a small town where she worked as a surgical nurse for a short time. Never one to stay in any one place for long, Chris then went world-travelling. When money ran out, she went back to work again for two years in surgery and paediatrics before heading for England to do midwifery. Once qualified as a midwife, Chris worked in England for six months then returned to her small town in Canada where she has remained with her husband and two children ever since. Chris has been working in the labour/delivery unit of her hospital for about eight years. The hospital perform about 600 deliveries a year and regularly accepts post-basic obstetrical nursing students. Chris has precepted "at least three" students and was, at the time, acting as preceptor for a low risk student who was on her sixth of ten shifts when I met then.

The first research question examines whether preceptors are adequately qualified or prepared. Chris' educational preparation includes a midwifery certificate and credit for the B.C.I.T. advanced obstetrical program which is being applied to her Bachelor's degree in progress. Chris has also tutored the moderate risk theory course and has been asked to be a guest tutor for a course later in the year. Although no preceptor preparation course was offered prior to her first student, the program coordinator at B.C.I.T. called a year ago and offered Chris a reduced price if she was interested in taking the new B.C.I.T. clinical teaching course, which she did. This course is three months of distance learning with one full day workshop at the end. Chris completed the course and found it helpful. She said:

> "It reaffirmed some of the things I already knew and gave me a little bit of a better basis for setting things up in my mind as far as teaching goes. Like setting up levels and how much to expect from her (the student). It reaffirms that adults learn by hands on more importantly than reading - but that people have different levels of learning. You have to take into consideration the education they already have and that they have personal experiences they can bring in...".

Chris far exceeds the standard qualifications outlined by B.C.I.T. in years of experience. She also possesses educational preparation in both the clinical specialty and teaching methodology although neither is a standard requirement of B.C.I.T. Chris indicated that she became involved as a preceptor because the B.C.I.T. program coordinator asked her to. This is quite different from the usual process of placing requests through the Head Nurses and the hospital soliciting volunteers. Although the Head Nurse was involved, there was direct contact between B.C.I.T. and their preceptor. This reflects that B.C.I.T.

has made some judgement or evaluation regarding Chris's suitability for the preceptor role, a standard that is not formally in place at B.C.I.T.

Chris feels very supported by B.C.I.T., and supported by her colleagues most of the time. She thinks the B.C.I.T. program coordinators are "fabulous" and finds them "usually accessible by phone when you want them". She finds being a preceptor altruistically rewarding. She does not wish "to stagnate like some other ward nurses" and gets a great deal of pleasure out of positive feedback from her students. Chris thinks being a preceptor is a really good way to maintain professional currency and stimulate personal growth.

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In summary, Chris exceeds the qualifications set out by B.C.I.T. and, although B.C.I.T. has no standards to judge by, appears to be well qualified and prepared for the role.

The second research question addresses the balance between the preceptor's responsibility to the hospital and their attention to the student. In her interview, Chris voiced similar concerns to Alex and Bobbi regarding the difficulty in trying to meet student needs when your first responsibility is to the employing agency. Chris said:

> "...On a day like that you can't be a teacher until later and its a good experience for her to see the actual scenario but it's not a good experience because she's learning nothing except "Wow, we should put roller skates on". It's really difficult sometimes because the agency and the patient, client or whatever you want to call it, comes first and the student comes second. I actually had to send the student home one day because it was just too bizarre. Another day the student just

> worked because she had worked before as a Nursery nurse. It's too bad because the experience that she really needed was the experience that I was dealing with (in labour/delivery) but I had no time for her. It was uncomfortable for me because I really wanted her to learn and I didn't have the time and it wasn't the level she was at either".

Chris' experience shows in her statement and comprehensively covers the antecedent, transaction and outcome observation data related to describing what the balance is between hospital and student. The day I observed Chris with her student, there was only one patient for induction of labour in labour and delivery. Although the level of patient was moderate risk, Chris had plenty of time to dedicate to her student. Chris' data supports the judgement previously made that responsibility to both a student and an employer causes strain and the ability to fulfil preceptor functions is workload dependent, and therefore inconsistent.

The next research question addressed with Chris is "Do preceptors exhibit the various roles attributed to them in the literature?". The literature identifies the role of facilitator as the most frequently cited function of a preceptor, and B.C.I.T. intends that the preceptor, in consultation with the student, choose experiences appropriate to the student's level. As identified in the discussion of the previous research question, Chris had no option but to care for a moderate risk patient as she was the only patient in labour/delivery. However, Chris ensured her student performed the applicable low risk skills for that patient such as abdominal palpation, admission assessment and monitoring

of the fetal heart.

When asked in her interview how she saw the role of preceptor specific to this course, Chris answered "a facilitator for learning. You're there to facilitate hands-on learning experience....they already supposedly have the theory base. You're not there to grade them, you're there to help them". Chris also assisted her student in obtaining her objectives by arranging for her to see a prenatal ultrasound and scheduling her to perform a booked non-stress test.

Next to the facilitator, the roles of teacher/clinical instructor, role model, evaluator and resource/support are the most frequently cited in the literature. Chris believes that teaching is important but it should be done slowly, that it is not the absolute first thing you would do. She says:

> "She's already got a lot of theory that's new to her and you don't want to bombard her with a whole scenario of clinical things immediately. You want to be able to guide her along and teach her slowly. You're giving her a chance to absorb what she's already done and what she has already learned. I don't want to be like an instructor who stands there and lectures...".

Chris appears to attach a certain meaning to the word "teaching" that conjures up classrooms and lectures. She identifies more with the term facilitator although my observation indicated she both facilitated learning experiences and taught clinical skills.

For example, Chris facilitated the experience of abdominal palpation and when the student was having difficulty, she demonstrated the palpation, explaining what she was doing, then corrected her student's technique by indicating "press harder", asked the student what she was feeling, then compared the student's findings with her own and explained how the palpation would be described and charted. This example incorporates the transaction intents outlined by B.C.I.T. which can be reviewed in Figure 3. Other examples include asking the student to describe her palpation findings on the woman having a non-stress test, correcting the student's placement of the uterine tocometer and showing her the difference in pick-up of contractions with the corrected placement, and assisting the student in starting an intravenous and saying "good girl" when she was successful. Chris also indicated in her interview that she and her student discuss potential scenarios regarding what you would do if the patient presented with certain signs and symptoms. This exercise reinforces student learning and assists the preceptor in assessing student progress.

Although Chris was unable to identify the role of the evaluator as being part of the preceptor role until prompted, she did acknowledge that she was evaluating all the time. She said, "You're evaluating how she's learning, what stage she's at in her learning, and whether she's actually learned what you have taught". Chris did not appear to have difficulty with the role of evaluator and seemed equally comfortable with the prospect of giving a negative evaluation as a positive one. She did indicate, though, that she would approach the student long before a negative evaluation would be given to discuss the

situation.

Chris' comfort level with evaluation is supported by her completion of the Clinical Evaluation tool. Not only are objectives ticked as "met" or "unmet" but concise, descriptive examples are notated for every clinical objective. As the reader of the evaluation, I received a clear picture of her student's abilities, experiences, and needs. The Summative Skill Inventory was initialled for all low risk skills and a couple of higher level skills. This would indicate to B.C.I.T. that the student had received experience in those areas, even though the skill is not required at the lower level.

In summary, Chris demonstrates skill in evaluative measures and does not identify it as an area of discomfort. She exhibits all the roles identified both in the literature and at B.C.I.T.

For the final research question, Chris believes, as did Alex and Bobbi, that students are not prepared for employment following the low risk preceptorship. She believes even the good students need to have more experience and recommends they get a good general obstetrical overview by working in all areas for at least six months immediately after Level 1. She qualifies experience in labour/delivery as a float or third person only. Chris believes that the moderate risk preceptorship is the minimum requirement for staffing in labour/delivery.

Although Chris feels the low risk preceptorship is not sufficient for preparing students for employment, she thinks it is a better learning experience than having a clinical teacher with a group of students as it is more of a one-to-one basis. Like Bobbi, Chris thinks that others can fill the teaching role as well as the preceptor. She explains:

> "You know, you can delegate certain things and still have a learning situation even though she's my responsibility. Like (the student) can go with the nursery nurse to learn about baby bathing and go with someone else to do an admission of a newborn. And because we're a small ward, the student gets to know more people...and they're all willing to teach and willing to help".

It is possible that the situation in small hospitals is such that staff are more teaching oriented than in larger hospitals, but I believe that unless the experience is outwith the knowledge base of the preceptor i.e. ultrasound, then the preceptor should maintain the consistency of information and quality of instruction by teaching her own student as much as possible. In my opinion, transfer of the vehicle for instruction should require the original preceptor to evaluate qualifications and abilities of the surrogate preceptor and should not be simply related to area of work.

If Chris were the program developer at B.C.I.T., she would make the preceptorship longer than ten shifts. She thinks it should be a minimum of twelve to fifteen shifts especially for smaller units in order to have a greater chance at achieving a more rounded experience. "In ten shifts we've never entirely met the criteria with the people I've preceptored". Chris also believes that experiencing "five normal deliveries is not enough and never has been enough. I'm a firm believer in the fact that they need ten - the first

five are a blur". Despite her concern with the program length, Chris believes the Obstetrical Nursing Specialty is a good course.

Sam:

Sam has spent her whole life in the same city. She managed to graduate from high school, although she acknowledges she didn't attend class much, and then went to work in a clothing shop. Some of her friends were taking a First Aid course so she went with them and found herself very interested in it. She says that's what prompted her to go into nursing. Sam was lucky to find a nursing school that would accept her borderline marks and began what became her career. Sam had found her niche and really enjoyed both nursing and going to school. Upon graduation with her diploma in Nursing, Sam worked on a medical floor for two years. She decided she wanted to get out of medicine and applied for labour/delivery because she knew some people who worked there. She was hired and has worked there ever since - a total of eighteen years.

A couple of years after starting in labour/delivery, Sam married and has given birth on five occasions over the last fourteen years. She has never left her work in labour/delivery but has worked varying degrees of full time and part time hours since her first child was born. She is anxious to go back to school to get her degree and would also like to take midwifery once her youngest child reaches a sufficient age to permit it.

Sam has taken the occasional university course but, as used to happen many years ago, has basically come into labour/delivery without any formal preparation in the specialty. She has been preceptor many times and has had four students in the past year. She became involved as a preceptor by volunteering when the hospital was asking for interested people to come forward. Sam likes to do more at work than just her job. She says she always tries to take on something extra as it keeps her work challenging and prevents her from getting bored. She also enjoys teaching so being a preceptor appealed to her.

When I met her, Sam was precepting a moderate risk student who was on her ninth of thirteen shifts. The student has completed three of those shifts in the antenatal and diabetic assessment units, and was on her sixth shift in labour/delivery. The hospital where the preceptorship was taking place is a tertiary care centre which performs about 3,000 deliveries a year.

The first research question applied to Sam concerns whether preceptors are adequately qualified or prepared. Although Sam has no formal educational preparation for the clinical specialty, she meets and exceeds B.C.I.T.'s standard as she has so many years of experience. Sam has never taken a preceptor training program or any other formal preparation for the preceptor role. As she says, "I've had small bits from B.C.I.T. and when open learning came over, I spent half a day...just little chats with B.C.I.T.". As previously stated, Sam enjoys teaching and volunteered for the role. Similar to the other

case studies, B.C.I.T.'s lack of criteria for assessment and selection of preceptors results in questionable qualifications and preparation.

Sam, in her interview, acknowledges the deficit in preparatory support and lack of standards for preceptors. She said:

> "I think it would be nice to have some support at the beginning when you're just starting, to help you feel comfortable with your role and what you have to do. Experience really is what helps the most, but it does help to have a little bit of extra information to use and have some extra tools...I do think it (being a preceptor) is a lot of responsibility and I think also that if the agency was willing to put some pay on it they would be willing to set some standards for what they were doing".

Sam thinks preceptors should be experienced at teaching and have an understanding of the learning process before doing the job. She thinks she does a much better job now than she did with her first three students. She also has some concerns regarding evaluation of preceptors and the quality of the clinical preceptorship. Sam says:

> "I guess I wonder how comfortable B.C.I.T. can feel with the kind of experience everybody's getting because people (students) are going to different places everywhere. The people running the program having only met the preceptor briefly so I guess they take the word of the Head Nurse on the unit that you are capable. I don't feel that there is any guarantee of having a good instructor or knowing the process is being followed through well unless they have contact with us (preceptor). I don't think they (B.C.I.T.) can really evaluate the preceptor. There isn't any guarantee that I'm doing a good job of teaching...that would be my concern.".

Sam thinks that preceptors work much harder when doing a preceptorship because they

are always busy, but does not feel rewarded for doing so. She says she does the preceptorship for herself - for intrinsic rewards. Sam's own previous statements identify well the problematic nature of obtaining adequate preceptor qualifications and preparation for the preceptor role at B.C.I.T.

Sam had very little to say in regards to the second research question which addresses the balance between the preceptor's responsibility to the hospital and their attention to the student. She acknowledged, though, the same concerns as the other case study group preceptors regarding stretching yourself between what the agency requires and the student's needs. She said, "I think when you (preceptor and student) work on the unit it's difficult because people tend to look at you as two people and if it gets busy, you're used more that way. You (preceptor) have to set limits with people yourself and that's a hard thing to do when the unit is busy".

The day I observed Sam with her student, there were only two patients in labour/delivery, only one of which was in labour, therefore there was ample time to dedicate her efforts to her student. As previously identified, therefore, the ability to fulfil preceptor functions is workload dependent and time dedicated to the student is inconsistent.

The intent of B.C.I.T. is that preceptors assist in the completion of clinical course objectives but Sam finds it hard to "stand back and let people (student) do things in their own way rather than just doing things yourself, and also allowing them the space to

learn". Also, patient needs take priority over student needs and can impact on available time for teaching and discussion. For example, Sam's student was having difficulty with interpretation of fetal monitor strips and was asking questions. The patient was well advanced in labour and required coaching. Although the student had much experience coaching and little experience with fetal monitoring, the patient's needs were more important. Sam said, "If we get a chance later, we can go over the monitor strip -you can be thinking about what you think could be causing the decelerations". In her interview, Sam said that although there was plenty of educational material on fetal monitoring around the unit, they haven't had as much time to spend on it as she would have liked. Summarizing, the preceptor's responsibility to the employing agency as well as joint responsibility to the patient can impact on achieving completion of some clinical course objectives.

The third research question asks does Sam exhibit the various roles attributed to the preceptor in the literature? The literature indicates that the facilitator is the most frequently cited function of a preceptor. B.C.I.T. intends that the preceptor, in consultation with the student chooses experiences appropriate to the student's level. As Sam's student is taking the moderate risk course, clinical experiences should be at a higher level than with the other case studies. The day I observed, there were only two patients in labour/delivery and the charge nurse asked Sam what she wished her student to do. Sam and her student appropriately chose the only patient that was in labour.

Much of what I observed during that shift involved Sam facilitating various experiences for her student and encouraging her to assume more responsibility for the patient's care. For example, Sam left her student unsupervised to go and assess her patient, she encouraged her to check the resuscitation equipment even though the student asked her to go over it with her, she told the student she would leave her to assist with an epidural and reminded her to keep up her charting. There was very little direct feedback or checking the findings of her student. When I asked Sam about this in her interview, she said:

> "I know she knows how to do those and I don't need to be there. I want her to go in and do it and I wanted her to come out and tell me what she'd done. I didn't want to be in the room with her because I want her to do it of her own initiative and decide what she has to do herself. What's been happening is that she's been stepping back. I've told her that if she steps back I'll have to step in and give the patient care because the patient needs to get care. I don't think she realizes how much I've been filling in".

Sam was pleased that the type of patient available was one that provided the kind of follow-through experience that her student needed. In her words, "She's done all of those things in bits and pieces. It was nice today because we had a very clear follow-through so it was a perfect day for us. We got the right patient at the right time and we got a chance to formulate our thoughts and work through and develop them".

Next to the facilitator, the roles of teacher/clinical instructor, role model, evaluator and resource support are the most frequently cited in the literature. B.C.I.T. intends the

preceptor to facilitate learning by role-modelling, providing problem-solving opportunities, by asking the student questions and by giving support and encouragement. In her interview, Sam identifies the role as being very broad, incorporating the functions of a role model, a liaison between the student and the agency, a teacher who helps students tie in their past experience with what they're learning, and a support to help them feel confident and recognize their strengths. With the exception of not identifying the role of the evaluator, which will be discussed later, Sam is very close to the literature in her interpretation of the role of preceptor.

When I observed Sam with her student, she did very little role-modelling and teaching was generally limited to question-asking, summarizing situations and organizing care. For example, Sam asked her student how she felt about the progress her patient was making. When her student identified that she didn't think she was doing too much, Sam agreed and summarized the concerns by saying, "She was 3-4 cm this morning at report and she only progressed 0.5 cm before the rupture of membranes and now she doesn't look like she progressing". She then organized subsequent care by suggesting to her student that she needed to assess the contractile pattern and quality of contractions and do a fetal monitor strip, as it was important that the patient now make progress in labour. Sam made a conscious choice to be more directive in the teaching role that shift based on student need. She said:

> "She (the student) admits she has trouble being organized. I decided that today I would give her a very direct day and tell her how to be organized. Show her

how it works when you're organized so she can see what the system is like, how to get through it. I've been trying to give her space to organize herself before now but she hasn't been picking up enough on what I'm doing and taking over. Tomorrow, I'll talk to her about that and see how she felt about today before we get started on our next day".

Sam identified in her interview that teaching was probably the most comfortable aspect of the preceptor role for her but indicated that no one part of the role is significantly more comfortable than another for her. It is hard to assess Sam's clinical skill teaching as the student independently performed and reported her findings with little or no feedback from Sam, as Sam was comfortable that the student could perform the skills accurately and independently. Rather than just role modelling, Sam asked plenty of pertinent questions which made her student think, such as "What would you like to say about that?" (the monitor strip), "What other thing can you check on that?" (the resuscitation equipment), "Think about what you would anticipate to see when she delivers in relation to her progress in labour, decelerations, etc. Play a game with yourself and check out your assumptions". The only example of role modelling I saw was treating fetal distress. The student had not noticed the decrease in the fetal heart so Sam acted to protect patient safety.

Sam was very encouraging and supportive with her student. When the student was worried about assisting with an epidural, Sam said, "Don't worry, you'll be fine" and stayed close by. Sam gave her student a look to indicate she should respond to the anaesthetist's questions, but filled in when the student got stuck.

Although Sam did not initially generate the role of evaluator as a component of being a preceptor, she believes that it is and tries to make time every day to evaluate what's gone on in the day. She tries to get the student to participate in that and set goals for the next day. Sam believes that goal-setting is involved in the evaluation process. Although Sam feels comfortable with evaluation now, she said that it was the least comfortable part of the role to start. She said:

> "I think at first I felt more uncomfortable with it than now. I had to make myself do it because it's always hard...it can be hard to say something (negative) to somebody. Usually now, if it's bad, I can get them to say it themselves. I feel that it's really important to be honest and positive during an evaluation and try to use it as a building tool. It's no big deal to write it up because we've already talked about the stuff that's in it".

Sam's desire to encourage independent care by her student made for what I observed to be missed opportunities for constructive feedback. For example, the student did an abdominal palpation then gave an unsure and incomplete report on her findings. Sam did not follow-up by repeating the palpation herself or giving feedback regarding the incomplete response. Also, vaginal exams were neither checked or discussed, even when the student indicated "it might be posterior, it's not a good fit".

Despite Sam's indication that she was comfortable with evaluating, the Clinical Evaluation tool was simply initialled for all objective groupings, and the Summary Skill Inventory dated for the relevant skills. There were no examples or comments written on the evaluation except in the summary section, which contained a reasonable overview of her

her student's capabilities. Areas for improvement contained comments related to the available experience and not the student i.e. exposure to more complicated patients. The way Sam completed the evaluation tools is reflective of her opinion that "it's no big deal to write up because we've already spoken of the stuff that's in it and there's nothing new, so that (the tool) is just an accessory". Ongoing or formative evaluation is important but summative evaluation is also important, especially as a reference for B.C.I.T. since the preceptor is the only clinical evaluator. Sam appears to have the skill she needs for evaluating both at the bedside and on paper, but could improve her practice. In summary, Sam exhibits all the roles attributed to preceptors in the literature to a greater or lesser extent.

The final research question addresses whether or not preceptors feel the preceptorship prepares students for employment following it. Sam believes that students who have completed all three levels are fairly well prepared. As she says, "It's sure a lot better than what we used to have before when you got an R.N. fresh off the street, like when I started working in the Case Room". Sam has seen many nurses start in labour/delivery after Level II (moderate risk) and succeed, but feels they would do better if their preceptorship was longer. She, like the other case study preceptors, is decisive that Level 1 is not adequate as preparation for employment due to insufficient time in the preceptorship.

Sam believes that experience in the clinical area is critical and likes that component of

the preceptorship. However, she is undecided about whether the current use of preceptors is the ideal way to provide that clinical experience. She says:

> "The only way you can learn and have a good understanding of what a labour/delivery unit is, is to be there with a woman in labour and follow her through, and get a feel for what's happening. You have to have really good observation and assessment skills to work as a labour/delivery nurse - it's something you can only get through doing. I think it's important to have one person staying with them (the student) as much as possible because you (preceptor) understand where the student is at and can help them develop. I'm not sure if it might be better to have one person doing a bigger volume (of students) and just doing that. I'm quite happy with the way it goes actually. It's the consistency of one person that I like".

If Sam were the program developer at B.C.I.T., she would make two major changes in the program. Firstly, she would like to be able to evaluate the preceptor and the student more effectively. She doesn't feel that B.C.I.T. has any mechanism for ensuring quality instruction or student evaluation. She says, "I can write anything on the evaluation, even if somebody (student) isn't ready, if I'm not comfortable writing that on the evaluation then I can just say anything and there isn't really a guarantee that that person is going to be a good nurse or that I'm doing a good job teaching". The second change she would make is to add more time to each of the preceptorships. Sam feels that the current time frame gets the student through the main objectives but allows no buffer zone for improving weaker skills or obtaining any extra experiences.

Summary

Throughout this chapter, judgements have been made based on the intents, observations and standards identified for each of the four research questions as they relate to each of the case study group preceptors. In order to summarize the data and facilitate recognition of trends, I have produced a summary matrix for each research question, (Figure 5 - 8) which incorporates the data from the case study group as a whole.

Regarding qualifications and preparation, we can see in Figure 5 that preceptors vary enormously in both length of clinical experience and formal clinical preparation. Preceptors support the findings in the recent literature in that they volunteer for their role, and receive intrinsic benefit for doing it despite not feeling rewarded by B.C.I.T. As previously identified in the individual case studies, the lack of criteria for assessment, selection and evaluation is problematic and results in inadequate quality assurance of instruction.

Figure 6 addresses the concern of preceptors regarding their ability to meet the student's needs and fulfil their responsibility to the employer. Although clinical course objectives were met, preceptors consistently identified several instances where workload demands resulted in lack of attention to student objectives.

Figure 5

Are Preceptors adequately qualified or prepared?

"Summary"

INTENTS	OBSERVATIONS		STANDARDS	JUDGEMENTS
Preceptors meet standard set by B.C.I.T. Preceptor has at least one year and preferably two years labour and delivery experience Preceptors who volunteer will be of "good quality".	All preceptors meet outlined standards. Preceptors vary in length of experience from 2 - 18 years. Preceptors vary in educational preparation from no preparation to advanced clinical with some teaching methodology.	ANTECEDENTS	Current licensure by RNABC Minimum of one year continuous employment in current hospital Current employment in Labour and Delivery	All preceptors meet standard set by B.C.I.T. but vary greatly in educational preparation and experience.
Agency will have an opportunity to give recognition to and recommend good clinical nurse practitioners as preceptors	Three out of four preceptors volunteered for role through their Head Nurse. All preceptors had no preceptor training program prior to becoming a preceptor - one now has. All preceptors like to teach.	TRANSACTIONS	No B.C.I.T. standards identified for clinical and/or teaching expertise No B.C.I.T. involvement in preceptor selection	Lack of criteria for assessment and selection therefore questionable qualifications and preparation.
•Preceptor may be stimulated to further professional growth •Preceptor feels a sense of recognition for her nursing competence	•Preceptors take on preceptorship for intrinsic reasons - do not feel rewarded by B.C.I.T. •All preceptors receive positive preceptee feedback.	OUTCOMES	•No B.C.I.T. standard for evaluation of preceptors. •No B.C.I.T. follow-up to assess preceptor satisfaction.	•Lack of criteria and formal process for preceptor performance evaluation by B.C.I.T. •Preceptee feedback insufficient •Lack of process for assessing level of preceptor satisfaction. •Overall, inadequate quality assurance

Figure 6

What is the balance between the preceptor's responsibility to the hospital and their attention to the student?

"Summary"

INTENTS	OBSERVATIONS	ANTECEDENTS TRANSACTIONS OUTCOMES	STANDARDS	JUDGEMENTS
Preceptor supervises the student in the clinical area	All preceptors have one student only assigned to them.		The preceptor is responsible for one obstetrical nursing student in the clinical area at any one time	Clinical assignment meets standard.
Preceptor facilitates student learning by role modelling, providing problem solving opportunities, by asking the student questions, by making suggestions to enhance the student's performance and by giving support and encouragement	All preceptors identify that teaching is secondary to patient/workload demands and have several examples where student objectives could not be met.		The preceptor's primary responsibility and accountability is to the employment agency and not to B.C.I.T.	Ability to fulfil preceptor functions is workload dependent, therefore preceptor time dedicated to student is inconsistent.
Preceptors have assisted in the completion of clinical course objectives	All preceptors had clinical course objectives completed by end of preceptorship despite incidences where educational experience was removed or diminished.		The preceptor reports to the B.C.I.T. coordinator of the Obstetrical Nursing Program in relation to his or her student should any concerns or problems arise	Responsibility to both a student and employer causes preceptor frustration and discomfort and may result in minimal attainment of course objectives.

As we can see in Figure 7, preceptors varied in their enactment of the various role components identified in the literature. Preceptors demonstrated different strengths and tended to be more comfortable with role modelling than some of the other components. The majority of the case study group were unskilled and unprepared for the role of evaluator and acknowledged their discomfort with this aspect of the preceptor role.

Finally, Figure 8 identifies that preceptors have concern regarding the readiness of students to accept the responsibility of Labour/Delivery staff nurses upon completion of the preceptorship. They believe the courses are too short and therefore the students' lack of experience would be problematic.

This summary describes trends in the results and although they cannot be generalized to the entire preceptor population, they can assist in better understanding the issues inherent in the program.

Figure 7

Do preceptors exhibit the various roles attributed to them in the literature?

"Summary"

INTENTS	OBSERVATIONS		STANDARDS	JUDGEMENTS
In consultation with the student, the preceptor chooses experiences appropriate to the student's level	Where there was a choice, three out of four preceptors chose patient assignments and learning experiences appropriate to the student's level.	ANTECEDENTS	The facilitator, incorporating within its definition a guide, planner and organizer, is the most frequently cited function of a preceptor	The majority of learning experiences appropriately facilitated Poor choice of learning experience severely inhibits student participation.
Facilitates student learning by role-modelling, providing problem-solving opportunities, by asking the student questions and by giving support and encouragement Makes suggestions to enhance performance Gives positive and constructive feedback	Three out of four preceptors role modelled often. Two preceptors asked questions well but promoted little problem solving opportunities. Very little role modelling/instruction with moderate risk student. All preceptors supportive of their students.	TRANSACTIONS	Next to facilitator, the roles of teacher/clinical instructor, role model, evaluator and resource/support are the most frequently cited in the recent literature	Preceptors vary greatly in clinical management and demonstration of the various preceptor roles. Preceptor role could be affected by level of student.
•Completes skill assessment tools for designated clinical skills •Completes "summary" on clinical evaluation tool	•Three out of four preceptors saw evaluation as the least comfortable aspect of their role. •One preceptor did not see evaluation as part of her role. •Three out of four preceptors insufficiently completed Clinical Evaluation tool.	OUTCOMES	•From 1981 onwards, the role of evaluator becomes prominent when discussing preceptor role responsibilities	•Majority of preceptors unskilled and unprepared for role of evaluator.

Figure 8

Do preceptors feel the preceptorship prepares students for employment following it?
"Summary"

INTENTS	OBSERVATIONS		STANDARDS	JUDGEMENTS
Purpose is to develop independence in the role of an obstetrical nurse	All students between 60-80% through preceptorship and none are functioning independently - regardless of course level.	ANTECEDENTS	Students must complete an ongoing daily self-evaluation tool	Expectation of independence too high.
Students will have opportunities to perform selected obstetrical nursing skills Students will apply the nursing process in the obstetrical nursing setting	"Right now all they have to do is observe". "I've never entirely met the criteria with the people I've preceptored". "10 shifts could mean just ten patients - that's not very much". "Experience in the clinical area is critical".	TRANSACTIONS	Students must complete the required clinical experiences specific to their level Preceptors complete the Skill Assessment Tool	All preceptors have concern that the low risk preceptorship is too short to complete and practise required skills.
Purpose of preceptorship is to prepare students to assume employment within the obstetrical nursing specialty	"Qualified to be 3rd person or float only after Level 1". "She's not prepared to be a staff nurse whatsoever". "Problems with clinical skills improving but she's not ready to assume employment".	OUTCOMES	Minimal acceptable performance is the pass requirement for all clinical course objectives as identified in the clinical evaluation tool	Preceptors believe that graduates of Level 1 are too inexperienced to take on the level of responsibility required of a Labour/Delivery nurse. All preceptors believe completion of moderate risk should be minimum requirement for employment.

CHAPTER 5: SUMMARY AND DISCUSSION

Summary of the Study

This study examined the instructional role of the preceptor in the Obstetrical Nursing Specialty at B.C.I.T. Obstetrical education is currently a specialty of Nursing but care of childbearing women is very likely to change in the near future with the integration of an autonomous profession of midwives and therefore educational preparation may not remain within the jurisdiction of nursing. In the meantime, however, concern with the preceptorship model of nursing education in the Obstetrical Nursing Specialty prompted four research questions, which were addressed in this study. They were:

1) Are preceptors adequately qualified or prepared?

2) What is the balance between the preceptor's responsibility to the hospital and their attention to the student?

3) Do preceptors exhibit the various roles attributed to them in the literature i.e. facilitating appropriate learning experiences, role modelling, question-asking, supervising, providing feedback and evaluating?

4) Do preceptors feel the preceptorship prepares students to assume employment following it?

The discussion and conclusions that follow should be seen in the light of the limitations of this study discussed in Chapter 3.

Contributing to the concern with the preceptorship model is the facility with which those in nursing education are embracing the preceptorship concept when there is such limited

evidence available in the literature regarding its effectiveness (Myrick, 1988). Despite the long term struggle of nursing educators to assume complete jurisdiction over the didactic and clinical teaching of nursing students, there are a plethora of articles in the literature, as we have seen in Chapter 2, describing programs using preceptors as clinical instructors, once again placing the responsibility of clinical teaching in the hands of staff nurses. Shamian and Inhaber (1984) called for an evaluation of the assumption that the preceptorship model provides a win-win situation. They felt an evaluation was warranted in order to prove the value of preceptors and to select those methods for training preceptors that are most effective.

This study accepted the challenge of Shamian and Inhaber and examined the preceptorship model as it is actualized in the Obstetrical Nursing Specialty. A case study group of four preceptors were observed and interviewed. Other supporting documents, such as clinical evaluations and feedback forms were also accessed to assist in the evaluation of the model. The major findings and how they compare to the findings of the literature follows.

Conclusions

The results of this study indicated that all preceptors possessed the minimum length of employment standard set by B.C.I.T., but they varied greatly in educational preparation, for which B.C.I.T. has no standard in place. Furthermore, B.C.I.T. has no involvement in preceptor selection nor any process for performance evaluation. Observation of the

case study preceptors revealed that they varied greatly in how they enacted their roles. Most preceptors required prompting to identify specific role components, in particular that of evaluator.

B.C.I.T. is consistent with a shortcoming in the literature in that the literature identifies the importance of well qualified preceptors (Radziewicz, Houck and Moore, 1992; Myrick, 1988; Bizek and Oerman, 1990) but, as described in Chapter 2, little attempt has been made to address selection of preceptors or assessment of their abilities. This is a particularly problematic omission in my opinion as quality assurance of program instruction cannot be assured. Also problematic, preceptors at B.C.I.T., despite having teaching and evaluating responsibilities, assume their role having had no formal preparation. One preceptor did not see evaluation as part of her role at all. The literature recommends that appropriate preparation should be based on what exactly constitutes the role (deBlois, 1991; Myrick, 1988). The results of this study indicate that preceptors received minimal preparation for their role and confirms that they are neither clear in their understanding of preceptor role expectations, nor confident in their ability to carry them out.

This study also identified that responsibility to the employing agency and to the student caused both frustration in preceptors and lack of consistency in time dedicated to achievement of student objectives. This concern was also reflected in the literature (Hill and Lowenstein, 1992; Ephron and Andrea, 1989; Griepp, 1989). The ability to provide

optimal student education must be questioned when the priority of those responsible for teaching the program is both identified by B.C.I.T. and acknowledged by preceptors to be to the employing agency and not to the student.

In answering the final research question, the case study group preceptors were strong in their opinions regarding readiness for employment following the preceptorship. All preceptors felt the clinical courses were far too short to ensure achievement and consolidation of course objectives and would not be comfortable relying on graduates as co-workers particularly following completion of the Level I preceptorship. Preceptors felt the moderate risk level was a minimum requirement. The exception to this, according to Alex and in my experience, are graduates who worked in a Labour/Delivery unit prior to enrolment and who choose to take the Level I program to supplement their knowledge base. The apparent success of this particular group of students supports the preceptors' opinion that the time factor for clinical experience is relevant and important. Many preceptorship programs described in the literature do not identify timelines but those that do generally outline a much longer time frame than that offered by B.C.I.T. (Hill and Lowenstein, 1992; Radziewicz, Houck and Moore, 1992).

As well as the time frame, preceptors had difficulty with the "minimal acceptable performance" being the pass requirement for clinical course objectives. As previously identified, most preceptors were unskilled and unprepared in the role of evaluator, consequently clinical course objectives were not assessed for quality of performance but

measured in terms of being "done". The combination of the unskilled evaluator coupled with the very short time frame for achievement of objectives results in an unknown student performance level. I would venture to suggest that minimal acceptability would not instill confidence in the heart of employers or pregnant women! Furthermore, what minimal acceptability actually means is open to interpretation.

B.C.I.T. has recently deleted their intent to prepare students for employment from the Purposes of the Preceptorship identified in the Preceptor Manual of 1989, and changed the minimum acceptability requirement to achievement at a level of acceptability with which both preceptor and student are comfortable. For this change to be an improvement, evaluative ability of preceptors needs to improve.

Although the case study group preceptors indicate a deficit in the clinical course, the clinical course evaluations (Appendix F) completed by their students rated all questions related to actual clinical experience as good or excellent. There were a couple of isolated marginal or poor assessments in relation to accuracy of information prior to enrolment and how well the course manual helped meet objectives. Of particular interest, though, were students' responses related to length/timing of clinical shifts which they rated as good or excellent. There was only one comment that clinical time was not long enough. However, one other student indicated that she experienced an insufficient number of low risk patients and another misinterpreted the question and commented only on the variety of patient experiences with no comment at all on the time factor. Consequently, I am

unsure that the student response regarding time frame is indicative of their satisfaction. It would have been interesting to ask students if they felt comfortable to assume employment following their preceptorship.

In conclusion, my research supports those few studies in the literature that dare to challenge the general acceptance of widespread use of preceptors for nursing education. (Shah and Polifroni, 1992; Myrick, 1988). Nurse educators and hospital management cannot assume that clinical expertise and preceptor expertise are identical. I agree with Myrick (1988) when she says:

> "Preceptorship, if carefully designed, can be useful but only if well developed criteria are provided that guide preceptor selection and education...and, it is only following a carefully planned and directed program of orientation provided by faculty which includes principles of adult learning, clinical teaching strategies and, most importantly, methods of evaluation, that a staff nurse can be considered for the role of preceptor or be expected to assume the added responsibility of teaching and evaluating a nursing student".

Recommendations

B.C.I.T. chose the preceptor model in order to facilitate clinical experience in or near to the student's home setting. As the course is the only such program available throughout British Columbia, retention of this goal may be important and would make a centralized instructed clinical course difficult to consider. However, the issue of personnel qualified to teach the program is of paramount importance.

Throughout this research, I have been in close communication with the coordinators of the Obstetrical Nursing Specialty and have shared my concerns with them. My feedback was openly received and much work is underway with the goal of improving the program. A six week course which combines low and moderate risk clinical experience for a small group of students at one time is now offered. This course is initially instructor supervised and uses preceptors for the last two weeks. The instructor is hired by B.C.I.T. This new program requires evaluation regarding instruction and preceptor selection, student outcomes, hospital acceptance and preceptor and student satisfaction but appears to be on a better track than the courses my research were based on.

The Compressed Time Frame just described appears similar to the three-tiered model described by Zerbe and Lachat (1991) which is outlined in Chapter 2. In this model, responsibility for student learning is shared between preceptors, clinical instructors and the course coordinator. The Masters-prepared instructor takes on the responsibility for supervising the preceptor-student dyad, assisting with bedside teaching and performing the student evaluation. This role description would address the concerns identified in this study regarding preceptor expertise and would also assist in the dual accountability concerns raised, as instructors would relieve preceptors of time spent evaluating and could address student goals during busy workload shifts when preceptors' priority is to their employer.

The debate between traditional educators and the advantages of traditional centralized teaching versus the preceptorship model of teaching with its advantages of one-to-one learning, is a difficult issue to resolve. In my opinion, capitalizing on the strengths of both models would enhance student outcomes and improve clinical teaching. I would therefore recommend to B.C.I.T. that a carefully selected instructor whose priority is to B.C.I.T. be integrated into the program for the purposes as previously outlined by Zerbe and Lachat (1991). This instructor would be particularly important in the teaching of new skills in order to encourage the ideal rather than the acceptable. I am hopeful that this recommendation comprises the intent of B.C.I.T. with the Compressed Time Frame, as the integration of an instructor refocuses the priority of the educator onto student objectives which is an improvement over the current program.

As the Compressed Time Frame is new, it has the potential for difficulties to surface. At the least, I expect there to be issues around increased cost due to instructor salary and difficulty with student placement. Should these and other difficulties prove overwhelming and the current use of the preceptorship method of instruction be revisited, there are several recommendations I would suggest based on my study and my experience that would meet the more immediate needs of the program with the goal of improving it. Some of the following suggestions could also be incorporated into the Compressed Time Frame in so far as the suggestions relate to preceptors. The recommendations are:

1) Preceptors should apply to, and be selected by, B.C.I.T., using an appropriate

selection process that addresses clinical and teaching qualifications.

2) Preceptors should be required to attend a preparatory full day workshop, paid by B.C.I.T., that addresses content areas that are specific to the role expectations.

3) Preceptors should receive a fair appraisal of their performance from a qualified evaluator at B.C.I.T.

4) Preceptors should receive either remuneration for their services or other reward seen as valuable by preceptors.

5) B.C.I.T. should facilitate closer collaboration with preceptors during the preceptorship through possible liaison visits or close telephone support.

6) B.C.I.T. needs to markedly increase the length of the clinical practicum, particularly in the first level.

Recommendations for Further Research

As described in Chapter 3, more research is needed to gather data from both a larger sample of preceptors as well as other sources impacted by the program such as labour/delivery staff nurses and past students.

A particularly logical area for further research that arose out of this study involves the assessment of student outcomes using preceptors as the clinical educators. Although the literature is replete with descriptions concerning the advantages of preceptorship, there is limited empirical evidence to substantiate its effectiveness for student learning (Myrick, 1988).

Another recommendation for research is a comparative study of the current clinical program courses which use preceptors as the vehicle for instruction and the new Compressed Time Frame, which is instructor taught and combines the low and moderate risk clinical courses.

Also, of interest would be research evaluating the role of behavioural objectives in the Obstetrical Nursing Speciality, particularly with differing methods of instruction.

In conclusion, the intent of this study was to describe the clinical preceptorship with the goal of assisting program developers in improving the program. The study helped us to understand the experience of preceptors and their opinions on the clinical program. It also elucidated difficulties in the program with the selection and preparation of preceptors and how their role was enacted. As described, improvements are underway at B.C.I.T. which should assist future preceptors but, in the meantime, present preceptors are to be commended for their dedication to student learning and their resourcefulness in the face of minimal B.C.I.T. guidance.

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APPENDIX A

INTERVIEW QUESTIONNAIRE

Pre-interview information:

a) Level of hospital
b) Annual number of deliveries
c) ADNS 645 or 647

1. How many years has it been since graduation from your basic nursing program?

2. Have you taken any post-basic education. If so, what is the highest level you completed?

3. How many years have you worked as a staff nurse in Labour/Delivery?

4. Is this your first preceptor experience? If no, how often have you acted as a preceptor?

5. How did you get involved as a preceptor for B.C.I.T.?

6. Have you ever taken a preceptor training program or were you offered any formal preparation for your preceptor role? If so, what?

7. How do you see the role of preceptor specific to this course? (ie. role model, facilitator, teacher, evaluator).

8. What is the most comfortable aspect of the preceptor role for you?

9. What is the least comfortable aspect of the preceptor role for you?

10. Do you feel supported and/or rewarded for being a preceptor? If so, how? If not, what would help?

11. Do you feel the preceptorship is an ideal learning experience for students? If yes, why? If no, why not?

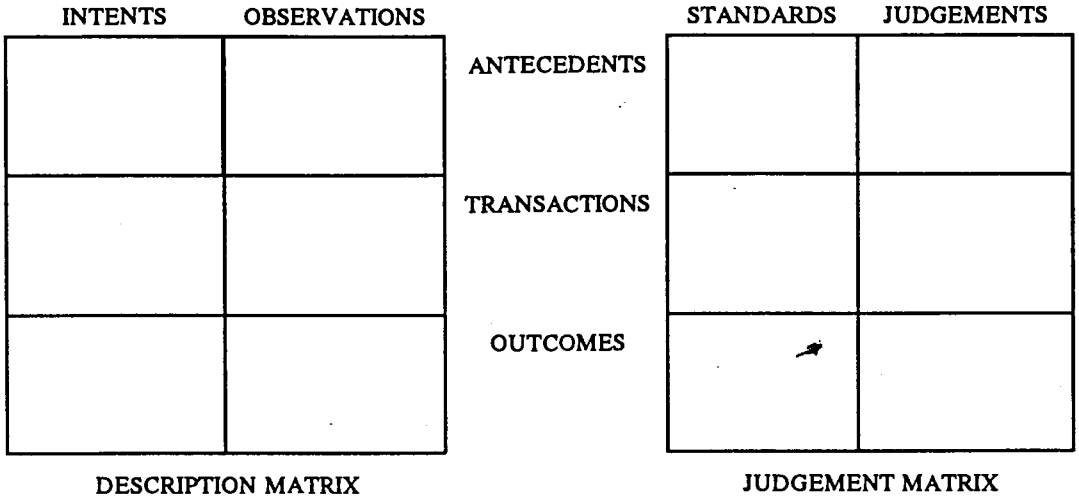
12. Do you feel students are prepared to assume employment in obstetrical nursing after the preceptorship?

13. If you were the program developer at B.C.I.T., what changes would you make in the clinical courses, if any? (ie. time frame, method of instruction).

Questionnaire adapted from Alspach (1989), Preceptor Survey, Critical Care Nurse, 9 (5), 2-14 and 2-16.

APPENDIX B

STAKE'S RESPONSIVE EVALUATION DATA MATRIX



STAKE'S RESPONSIVE EVALUATION

APPENDIX C

CLINICAL EVALUATION - ADNS 645

BRITISH COLUMBIA INSTITUTE OF TECHNOLOGY

ADVANCED NURSING SPECIALTIES

CLINICAL EVALUATION

Student Name: _____
Surname First Name

Hospital/Agency: _____ Dates: _____

Planned Hours of Experience			Hours Absent
Clinical	Lab	Total	
113		113	

Evaluation Completed By: _____

Position: _____ Date: _____

Preceptor's Recommendation: Pass ☐ Fail ☐

Faculty's Recommendation: Pass ☐ Fail ☐

Signature : _____ Date: _____
Preceptor

Signature: _____ Date: _____
Faculty

Signature: _____ Date: _____
Student

Objective	Met	Unmet	N/A	Examples/Comments
Terminal Objective #1 Uses the nursing process with direction from a conceptual model for nursing, to integrate knowledge, skills and attitudes from nursing and other science disciplines in order to provide care for the low risk childbearing family. **1.1 Collects data relevant to individual clients.** 1.1.1 Performs an interview with client. 1.1.2 Reviews client records. 1.1.3 Performs a complete physical assessment. 1.1.4 Collects data from relevant family members/significant others. **1.2 Identifies Problems** 1.2.1 Analyzes data collected. 1.2.2 Recognizes abnormal findings by comparing with normative data. 1.2.3 Identifies actual and potential patient problems and provide rationale. 1.2.4 Develops nursing diagnoses.				

Objective	Met	Unmet	N/A	Examples/Comments
1.3 Plans individualized nursing care				
1.3.1 Lists problems in order of priority				
1.3.2 Establishes goal statements				
1.3.3 Identifies appropriate nursing interventions and provide rationale				
1.3.4 Applies theory to data collected to develop a plan of nursing care				
1.3.5 Uses knowledge of the family and culture in plan of care				
1.4 Implements Plan of Care				
1.4.1 Implements plan of care with skill.				
1.4.2 Documents nursing interventions and outcomes.				
1.4.3 Identifies changes in the data base.				
1.5 Evaluates Plan of Care				
1.5.1 Identifies normal and abnormal responses to therapeutic measures				
1.5.2 Reassesses patient on a routine basis				
1.5.3 Recognizes the need for reassessment based on changes in patient condition				
1.5.4 Documents findings				

Objective	Met	Unmet	N/A	Examples/Comments
1.6 Modifies Plan of Care				
Terminal Objective #2 Uses effective communication skills in the practice of nursing low risk childbearing families. 2.1 Uses skills of empathy, warmth and respect when communicating with patients and family. 2.2 Recognizes and respects beliefs, attitudes and values which can influence communication with patients and others. 2.3 Communicates effectively with patients, instructional staff, agency staff and colleagues. 2.4 Promotes patient/family interaction with the health care team. 2.5 Documents all nursing care and relevant data.				
Terminal Objective #3 Demonstrates organizational ability in the provision of nursing care to low risk childbearing families. 3.1 Organizes the care of assigned patients. 3.2 Completes assignments within a reasonable period of time. 3.3 Revises planned care as unanticipated events occur.				

Objective	Met	Unmet	N/A	Examples/Comments
Terminal Objective #4 Demonstrates ability to work independently, interdependently and collaboratively with the Health Care Team. 4.1 Works cooperatively with all members of the health care team. 4.2 Accepts direction from buddy nurse/preceptor/instructor/ other health care workers with discretion. 4.3 Participates in decisions regarding patient care management. 4.4 Provides assistance to and shares knowledge with other members of the health care team as appropriate. 4.5 Demonstrates sound judgement in recognizing and initiating independent, interdependent and collaborative nursing functions.				
Terminal Objective #5 Demonstrates Leadership in the Practice of Nursing 5.1 Uses a problem solving approach in making clinical decisions. 5.2 Initiates appropriate independent nursing interventions. 5.3 Demonstrates assertiveness in clinical practice.				

Objective	Met	Unmet	N/A	Examples/Comments
5.4 Acts as a patient advocate. 5.5 Recognizes legal and ethical dilemmas.				
Terminal Objective #6 Demonstrates responsibility and accountability for the recognized standards of nursing practice. 6.1 Recognizes limitations of own knowledge, skills and experiences and seeks guidance appropriately. 6.2 Identifies and communicates own learning needs. 6.3 Seeks out learning opportunities. 6.4 Uses appropriate resources to meet learning needs. 6.5 Evaluates own progress and reformulates learning needs. 6.6 Complies with policies and procedures established by: • BCIT. • the clinical setting. • professional practice standards.				

SUMMARY

PRECEPTOR'S COMMENTS

Areas of Strength:

Goals for Development:

STUDENT'S COMMENTS:

APPENDIX D

CLINICAL EVALUATION - ADNS 647

BRITISH COLUMBIA INSTITUTE OF TECHNOLOGY

ADVANCED NURSING SPECIALTIES

CLINICAL EVALUATION

Student Name: _____
Surname First Name

Hospital/Agency: _____ Dates: _____

Planned Hours of Experience			Hours Absent
Clinical	Lab	Total	
226		225	

Evaluation Completed By: _____

Position: _____ Date: _____

Preceptor's Recommendation: Pass ☐ Fail ☐

Faculty's Recommendation: Pass ☐ Fail ☐

Signature : _____ Date: _____
Preceptor

Signature: _____ Date: _____
Faculty

Signature: _____ Date: _____
Student

Objective	Met	Unmet	N/A	Examples/Comments
Terminal Objective #1 Uses the nursing process with direction from a conceptual model for nursing, to integrate knowledge, skills and attitudes from nursing and other science disciplines in order to provide care for the low risk childbearing family.				
1.1 Collects data relevant to individual clients.				
1.1.1 Performs an interview with client.				
1.1.2 Reviews client records.				
1.1.3 Performs a complete physical assessment.				
1.1.4 Collects data from relevant family members/significant others.				
1.2 Identifies Problems				
1.2.1 Analyzes data collected.				
1.2.2 Recognizes abnormal findings by comparing with normative data.				
1.2.3 Identifies actual and potential patient problems and provide rationale.				
1.2.4 Develops nursing diagnoses.				

Objective	Met	Unmet	N/A	Examples/Comments
1.3 Plans individualized nursing care				
1.3.1 Lists problems in order of priority				
1.3.2 Establishes goal statements				
1.3.3 Identifies appropriate nursing interventions and provides rationale				
1.3.4 Applies theory to data collected to develop a plan of nursing care				
1.3.5 Uses knowledge of the family and culture in plan of care				
1.4 Implements Plan of Care				
1.4.1 Implements plan of care with skill.				
1.4.2 Documents nursing interventions and outcomes.				
1.4.3 Identifies changes in the data base.				
1.5 Evaluates Plan of Care				
1.5.1 Identifies normal and abnormal responses to therapeutic measures				
1.5.2 Reassesses patient on a routine basis				
1.5.3 Recognizes the need for reassessment based on changes in patient condition				
1.5.4 Documents findings				

Objective	Met	Unmet	N/A	Examples/Comments
Terminal Objective #2 Uses effective communication skills in the practice of nursing low risk childbearing families. 2.1 Uses skills of empathy, warmth and respect when communicating with patients and family. 2.2 Recognizes and respects beliefs, attitudes and values which can influence communication with patients and others. 2.3 Communicates effectively with patients, instructional staff, agency staff and colleagues. 2.4 Promotes patient/family interaction with the health care team. 2.5 Documents all nursing care and relevant data.				
Terminal Objective #3 Demonstrates organizational ability in the provision of nursing care to low risk childbearing families. 3.1 Organizes the care of assigned patients. 3.2 Completes assignments within a reasonable period of time. 3.3 Revises planned care as unanticipated events occur.				

Objective	Met	Unmet	N/A	Examples/Comments
Terminal Objective #4 Demonstrates ability to work independently, interdependently and collaboratively with the Health Care Team. 4.1 Works cooperatively with all members of the health care team. 4.2 Accepts direction from buddy nurse/preceptor/instructor/ other health care workers with discretion. 4.3 Participates in decisions regarding patient care management. 4.4 Provides assistance to and shares knowledge with other members of the health care team as appropriate. 4.5 Demonstrates sound judgement in recognizing and initiating independent, interdependent and collaborative nursing functions.				
Terminal Objective #5 Demonstrates Leadership in the Practice of Nursing 5.1 Uses a problem solving approach in making clinical decisions. 5.2 Initiates appropriate independent nursing interventions. 5.3 Demonstrates assertiveness in clinical practice.				

Objective	Met	Unmet	N/A	Examples/Comments
5.4 Acts as a patient advocate. 5.5 Recognizes legal and ethical dilemmas.				
Terminal Objective #6 Demonstrates responsibility and accountability for the recognized standards of nursing practice. 6.1 Recognizes limitations of own knowledge, skills and experiences and seeks guidance appropriately. 6.2 Identifies and communicates own learning needs. 6.3 Seeks out learning opportunities. 6.4 Uses appropriate resources to meet learning needs. 6.5 Evaluates own progress and reformulates learning needs. 6.6 Complies with policies and procedures established by: • BCIT. • the clinical setting. • professional practice standards.				

SUMMARY

PRECEPTOR COMMENTS

Areas of Strength

Goals for Development

STUDENT COMMENTS

APPENDIX E

SUMMATIVE SKILL INVENTORY

BRITISH COLUMBIA INSTITUTE OF TECHNOLOGY

ADVANCED NURSING SPECIALTIES

SUMMATIVE SKILL INVENTORY

Nursing Specialty Obstetrical Nursing Specialty

Student's Name _____ S.I.N. # _____

The * star beside each skill indicates the course within which the skill is to be initiated.

When a skill is performed satisfactorily, initial and date the appropriate box.

Skill	Clinical		
	ADNS 645	ADNS 647	ADNS 649
Admission of Patient to Labor Area	*		
Abdominal Palpation (Technique only)	*		
Measurement of Fundal Height	*		
Auscultation of Fetal Heart	*		
Assessment of Uterine Contractions	*		
Assessment of Amniotic Liquor	*		
Performance of Vaginal Exam (Technique only)	*		
Performance of Antenatal Non-Stress Test	*		
Assessment/Interpretation of Fetal Heart Strips		*	

The * star beside each skill indicates the course within which the skill is to be initiated.	When a skill is performed satisfactorily, initial and date the appropriate box.		
	Clinical		
Skill	**ADNS 645**	**ADNS 647**	**ADNS 649**
Initiation and Management of Oxytocin Induction/Augmentation		*	
Initiation and Management of Magnesium Sulphate Therapy (S)			*
Initiation and Management of Tocolytic Therapy			*
Maintenance of Hydration During Labor	*		
Assistance With Surgical Induction/Artificial Rupture of Membranes	*		
Application of FECG (Assist nurse/physician only)	*		
Initiation and Maintenance of Intrauterine Pressure Catheter			*
Nursing Management of Ante/Intrapartum Hemorrhage			*
Preparation of Patient for Cesarean Delivery	*		
Intrapartum and Postpartum Catheterization	*		
Surgical Scrub, Gowning and Gloving (S)	*		
Management of Vaginal Birth Following Cesarean Section		*	
Administration of Entonox (S)	*		
Initiation and Management of Epidural Anesthesia (S)	*		

The * star beside each skill indicates the course within which the skill is to be initiated.	When a skill is performed satisfactorily, initial and date the appropriate box.		
	Clinical		
Skill	ADNS 645	ADNS 647	ADNS 649
Fetal Scalp Sampling (S)			*
Umbilical Cord Gases at Delivery			*
Care of Family with Ante/Intrapartum or Neonatal Death (S)			*
Postpartum Assessment of Fundus and Flow	*		
Postpartum Assessment of Perineum	*		
Examination of Placenta	*		
Administration of Oxytocin Infusion to Control Postpartum Flow		*	
Nursing Management of Postpartum Hemorrhage			*
Establishment of Breastfeeding in Delivery Room	*		
Administration of Oxytocin at Delivery	*		
Intramuscular Injection of Neonate		*	
Postpartum Breast Care		*	
Assistance with Breastfeeding	*		
Assistance with Bottle Feeding (S)	*		

The * star beside each skill indicates the course within which the skill is to be initiated.

When a skill is performed satisfactorily, initial and date the appropriate box.

Skill	Clinical		
	ADNS 645	ADNS 647	ADNS 649
Manual Expression of Breast Milk		*	
Reception of the Newborn at Delivery	*		
Neonatal Suctioning — Mouth and Anterior Pharynx	*		
Demonstration of Neonatal Resuscitation		*	
Clamping and Cutting of Umbilical Cord	*		
Assessment of Apgar Score	*		
Administration of Neonatal Eye Prophylaxis	*		
Infant Blood Sampling by Heel Stick (S)		*	
Care of the Newly Circumcised Infant		*	
Teaching Parents to Bathe Their Infant		*	
Initiation and Monitoring of Parenteral Fluid Administration in Newborns			*
Gavage Feed of Neonate		*	
Care of Infant of Diabetic Mother (S)		*	

APPENDIX F

CLINICAL COURSE EVALUATION

BRITISH COLUMBIA INSTITUTE OF TECHNOLOGY

ADVANCED NURSING SPECIALTIES

CLINICAL COURSE EVALUATION

STUDENT NAME (Optional) _____

COURSE _____

CLINICAL AGENCY _____

DATES _____

Your feedback on this course is very important for future revisions. Please complete this form and send it to BCIT faculty. If you prefer, the completed form may be sent to the Program Head in care of Health Part-Time Studies.

This is not an evaluation of your preceptor/instructor.

Please rate each area and comment as appropriate. We would expect and appreciate explanatory comments if a rating of marginal or poor is given.

Rate this clinical course by circling the appropriate number. Your explanatory comments are invited in the space provided.

	POOR	MARGINAL	GOOD	EXCELLENT
Overall, how smoothly did the course run for you?	1	2	3	4

COMMENTS:

_____

_____

_____

Course Access

Assess the accuracy of information available prior to enrollment.	1	2	3	4
Assess how well the information prepared you for the first day of the course.	1	2	3	4

COMMENTS:

_____

_____

_____

Learning Experiences

Assess the availability of appropriate clinical assignments.	1	2	3	4
Assess the degree to which the clinical assignments helped you to meet the course objectives.	1	2	3	4

How many of each of the following shifts did you work?

_____ x 12 hr; _____ x 8 hr;

_____ days; _____ evenings; _____ nights

	POOR	MARGINAL	GOOD	EXCELLENT
Asses how appropriate the clinical shifts (length/timing) were to your learning needs.	1	2	3	4

COMMENTS:

_____

_____

_____

Written Materials

Asses how clearly the objectives reflected the course expectations.	1	2	3	4
Assess how well the course manual helped you meet the course objectives.	1	2	3	4
Assess the quality/usefulness of the Skill Inventory Tools.	1	2	3	4
Assess the quality/usefulness of the Clinical Evaluation Tool.	1	2	3	4

COMMENTS:

_____

_____

_____

ANY OTHER COMMENTS?

_____

_____

_____

APPENDIX G

PRECEPTOR FEEDBACK

BRITISH COLUMBIA INSTITUTE OF TECHNOLOGY

ADVANCED NURSING SPECIALTIES

PRECEPTOR FEEDBACK

Specialty: _____

Preceptor's Name: _____ Date: _____

Clinical Agency: _____ Student Name: _____

When you complete the form, give it to your preceptor. If you do not feel comfortable sharing your feedback with the preceptor, submit it directly to the Obstetrical Faculty in care of Health Part-Time Studies.

Role	How was this role fulfilled?	Suggestions
1. Familiarized student with: • environment/health care team • policies • equipment		
2. In relation to course objectives initially assessed student's: • knowledge base • clinical skills • learning needs/goals		
3. Planned daily goals for clinical experience		
4. Collaboratively planned learning experienced to meet: • daily goals • course objectives		

Role	How was this role fulfilled?	Suggestions
5. Utilized agency resources to fulfill planned experiences and solve problems.		
6. Supervised patient care as required.		
7. Available when needed.		
8. Scheduled brief daily meetings to review progress and plan further clinical experiences		
9. Provided verbal and written feedback regarding performance.		
10. Acted as role model.		

Completed By: _____ Date: _____
Student

Reviewed By: _____ Date: _____
Preceptor

_____ Date: _____
Faculty

APPENDIX H

ROLE OF THE PRECEPTOR, QUALIFICATIONS

ACCOUNTABILITY & RESPONSIBILITY, GENERAL FUNCTIONS

C. ROLE OF THE PRECEPTOR

1. Qualifications

a. Current licensure with R.N.A.B.C.

b. Minimum of one year continuous employment in the hospital where they are presently working.

c. Current employment in the labour and delivery unit (2 years of experience is preferred).

2. Accountability and Responsibility

a. The preceptor reports to the B.C.I.T. Coordinator of the Obstetrical Nursing Program in relation to his/her student.

b. The preceptor is responsible for one obstetrical nursing student in the clinical area, at any one time.

c. The preceptor's primary responsibility and accountability is to the employment agency, and not to B.C.I.T.

3. General Functions

a. In consultation with the student, the preceptor chooses experiences appropriate to the student's level.

b. Supervises the student in the clinical area, as designated by the clinical course objectives.

c. Makes suggestions, as required, to enhance the student's performance.

d. Gives both positive and constructive (negative) feedback to the student.

e. Facilitates student learning by role-modelling, providing problem-solving opportunities, by asking the student questions, and by giving support and encouragement.

f. Reviews Daily Self-Evaluation Forms with the student on a weekly basis; or more often if necessary.

g. Completes Skill Assessment Tools for designated clinical skills.

h. Completes "Summary" on the Clinical Evaluation Tool.

i. Contacts Obstetrical Nursing Coordinator at B.C.I.T. should any concerns or problems arise.

APPENDIX I

PURPOSES OF THE PRECEPTORSHIP

INTRODUCTION

Welcome to the role of the preceptor with the B.C.I.T.' Advanced Obstetrical Nursing Program. The purpose of this manual is to give you information on the ADNS 647 - Obstetrical Clinical Preceptorship 2, and to outline your role as a preceptor within this course. B.C.I.T. has chosen the "preceptorship" approach to clinical learning for the Level I clinical courses, so that the student can achieve the clinical components of the Advanced Obstetrical Nursing Course in her community or regional hospital.

GENERAL INFORMATION

A. PURPOSES OF THE PRECEPTORSHIP

The purposes of the ADNS 647 - Obstetrical Clinical Preceptorship are to enable the student, through a four week clinical experience in labour and delivery; and two week experience in antepartum/postpartum:

1. to develop independence in the role of an obstetrical nurse
2. to have opportunities to perform selected obstetrical nursing skills
3. to enhance his/her organizational and planning skills in the obstetrical specialty
4. to be able to cope with the responsibilities inherent to the obstetrical nursing specialty
5. to apply the nursing process in the obstetrical nursing setting. This includes data collection and analysis, identification of patient problems, planning and implementing the nursing care plan, and ongoing evaluation.
6. to develop his/her abilities in a leadership role within the obstetrical nursing specialty
7. to be prepared to assume employment within the obstetrical nursing specialty.

APPENDIX J

STUDENT EVALUATION - ADNS 645

Student Evaluation - ADNS 645

The evaluation process for ADNS 645 includes three evaluation tools. Examples of each together with guidelines for use are found in Appendix I. Students will be graded on a pass/fail basis only. No mark will be assigned for this course. The final grade will be based on accomplishment of the objectives for the course.

1. Daily Self-Evaluation Tool

   This will be completed by the student on a daily basis for the first week and 2 to 3 times per week for the last two weeks. They will be reviewed by the preceptor.

2. Skill Assessment Tool

   This will be completed by the preceptor upon observation of your performance of required skills.

3. Clinical Evaluation Tool

   This form will be completed with your preceptor at the end of the clinical course. Student input will be obtained. Students will have the opportunity to enter written comments before signing the evaluation tool. The evaluation of the student will be kept on file.

Evaluation is based on achievement of the clinical course objectives which are listed in the clinical evaluation tool. All objectives are critical objectives which means that all must be achieved at a level of minimum acceptability in order to achieve a passing grade. The designated behaviours and the incremental behavioural steps to achieving them are listed in both the course objectives and the clinical evaluation tool.

Although minimal acceptable performance is the pass requirement, students are encouraged to progress beyond to the extent that their capabilities will permit.

Evaluative data will be collected from:

1. Student self-evaluations;

2. Preceptor observations of student performance in the clinical setting;

3. Nursing Process Assignment and Fetal Monitoring Exam.

Progress will be reviewed at least once per week at a meeting between the student and the preceptor. This may happen more frequently at the request of either party.

If a student is not achieving the course objectives, the student will be informed prior to the summative evaluation interview to allow sufficient opportunities to modify unsatisfactory behaviour.

The preceptor will notify the coordinator upon identification of any student that has the potential to be unsuccessful. Both students and the instructor are encouraged to consult the Obstetrical Specialty Coordinator for additional assistance if it is required by either the student or preceptor.

If there is a discrepancy between the preceptor and the student evaluation that cannot be resolved, the matter is to be referred to the Obstetrical Specialty Coordinator for resolution.

Insufficient clinical time because of illness or personal difficulties may constitute an incomplete or a failure. The decision to select incomplete or failure rests with the coordinator who will consider input from both the preceptor and the student.

The student is responsible for returning the Daily Self-Evaluation Forms, Summative Skills Inventory, and the Clinical Evaluation within 2 weeks of completing ADNS 645. Failure to do so will result in an incomplete.

APPENDIX K

REQUIRED CLINICAL EXPERIENCES - ADNS 645

Required Clinical Experiences *

Observation

1. Observe three low risk SVD's

2. Observe two neonatal resuscitations:
   - one for meconium stained fluid
   - one for asphyxia

3. Observe two ultrasound examinations:
   - one first trimester
   - one third trimester

4. Observe one cesarean delivery (scrubbed).

Direct Patient Care

Provides nursing care with assistance/under supervision/or in consultation with preceptor at the preceptor's discretion.

1. Cares for five low risk patients during labor, delivery and immediate postpartum.

2. Performs three admission assessments on patients in labor.

3. Participates in care of one patient prior to, during and following cesarean birth including recovery and transfer to postpartum.

4. Cares for three term neonates at delivery: (includes neonatal assessment)

   - one cesarean birth
   - two vaginal births

5. performs three antenatal non-stress tests

6. Completes attached fetal monitoring modules.

* If a required experience is not available during your preceptorship, don't panic — simply document and discuss with faculty.

Please call program faculty at BCIT half way through the clinical experience. If we are unavailable please leave your name and number and the best times to call you back.

APPENDIX L

REQUIRED CLINICAL EXPERIENCES - ADNS 647

Required Clinical Experiences

Observation

1. 1 amniocentesis
2. 1 chorionic villi sampling (if possible)

Direct Patient Care

Antepartum

1. 1 patient with PIH
2. gestational diabetes
3. stabilized antepartum hemorrhage
4. 1 patient selected from student's particular area of interest. e.g. substance abuse, hyperemesis

Intrapartum

1. Independently manages labor, delivery, immediate post partum care for 10 low risk families, including one low forceps or vacuum extraction.
2. With assistance, under supervision or in consultation with preceptor provides care for:
   - 1 forceps rotation/extraction
   - 1 post term labor/delivery/immediate postpartum (includes neonate at birth)
   - 1 patient with pregnancy induced hypertension
   - 1 patient with pre-term labor greater than 32 weeks gestation
   - 1 patient with malpresentation/malposition of fetus
   - 1 patient with gestational diabetes
   - 1 initiation of a planned induction
   - 2 other patients of student's choosing e.g. substance abuse, intrauterine death
3. Completes fetal monitoring modules.
4. Participates in 2 neonatal resuscitations:
   - 1 asphyxia
   - 1 meconium stained fluid