Achieving Excellence

in Professional Practice

A GUIDE TO

PRECEPTORSHIP AND MENTORING

CANADIAN NURSES ASSOCIATION
ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA

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October 2004

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October 2004

ISBN 1-55119-932-7

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Acknowledgements

We would like to acknowledge the following nurses who participated in the working groups that developed the initial drafts of the competencies for preceptorship and mentoring:

The Preceptorship Working Group:

Karen Carruthers RN BScN, Frances Fothergill-Bourbonnais RN PhD, Vonnie McIntosh RN, Nancy Watters, RN BScN MScN IBCLC

The Mentoring Working Group:

Marta Crawford RN MN, Linda Ferguson RN MN PhD(c), Francis Loos RN MN CNCC (C), Carol Mitchell RN MSN, Janet Murphy Goodridge RN MN IBCLC, Sandra MacDonald Rencz RN MEd, Katherine Stansfield RN MN

In addition, we thank the many nurses, nursing students and preceptors from across the country who refined the competencies through their thoughtful and timely participation in the validation process. CNA's member associations, as well as associate and affiliate groups, provided invaluable assistance in the distribution of the validation tools. Competency development and validation was made possible by funding from the Canadian Nursing Advisory Council (CNAC), and we thank them for this support.

Suzanne Massie of Assessment Strategies Inc. provided expert advice on competency development. Florence Myrick, Associate Professor, University of Alberta School of Nursing, provided expert advice on Canadian approaches to mentoring and preceptoring.

We also acknowledge the valuable work of our project coordinator, Nancy E. Watters, in collaboration with the project leader, Joni Boyd, Senior Nursing Policy Consultant at the Canadian Nurses Association.

October, 2004

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Part I:

Introduction

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Introduction

Dear Colleagues,

The Canadian Nurses Association (CNA) is committed to enhancing the profession of nursing in the interest of the public. One of our current priorities in support of this mission is to promote the quality of practice environments to help nurses achieve excellence in their professional practice.

The *Guide to Preceptorship and Mentoring* is an important tool for improving performance and job satisfaction through role modelling programs for nurses. Role modelling programs can help create a sense of achievement for both the role model (preceptor or mentor) and the learner (preceptee or mentee). By building on our existing human health resources – experienced, competent nurses – employers in the profession can foster healthier work environments and promote the successful transition and growth of new or developing nurses.

This guide is one step in CNA's Preceptorship and Mentoring Project, which also focused on the development of competencies for preceptors and mentors in nursing. The results of this unique and exciting work, including the final competency lists, are presented in Part V of the guide.

This work has been received enthusiastically by all involved. We have discovered that while much of the nursing community is in agreement on what preceptorship means to them, there is a varied approach to the process of mentoring, which is emerging in a variety of models across Canada in education, direct care, administrative and research work environments. Both preceptorship and mentoring hold much promise for making important differences in the quality of work life and practice quality for nurses.

The *Guide to Preceptorship and Mentoring* is also part of the series *Achieving Excellence in Professional Practice*, as is the 2002 CNA document *A Guide to Developing and Revising Standards.* These publications will be made available through the CNA website, at **www.cna-aiic.ca**, and will serve as the foundation for further work in this area. I am certain that the theoretical overview and the competencies developed through this important project will continue to evolve within the dynamic world of nursing.

Yours sincerely,

Lucille Auffrey, RN, MN
Executive Director
Canadian Nurses Association

Part II:

Overview

PHOTO: ITSTOCK

Overview

Purpose

The purpose of this guide is to assist nurses and other health professionals to develop and revise programs that use preceptors and mentors to enhance the quality of nurses' work environments and the quality of nursing practice.

This guide was written by the Canadian Nurses Association (CNA), whose mission is to advance the quality of nursing in the interest of the public. In advancing the quality of nursing, CNA is fully committed to shaping quality professional practice environments for nurses, so that they continue to provide safe, ethical and competent care for Canadians. Having programs that support teaching and learning through role modelling is a key part of a quality practice environment (CNA, 2001).

This guide is intended for individual nurses, health and educational institutions and professional groups. It can be a useful tool to achieve high quality programs that support learning through preceptorship and mentoring, for example, in the following situations:

- health care institutions wanting to:
  - improve the quality of practice environments
  - support novices in their direct practice at the unit or program levels
  - assist new professionals with socialization
  - provide resources nurses can use to further develop their competencies with respect to any of the domains of practice (direct care, administration, education and research)
- provincial or territorial registering bodies wanting to encourage continuing competence
- nurse educators, educational institutions and students interested in teaching and learning through role models
- administrators wishing to learn about role modelling programs for nurses
- employers or educational facilities wishing to develop or improve a program
- nurses and students in all settings wishing to develop a common understanding of the concepts related to preceptorship and mentoring

Contents

This guide provides an overview of role modelling programs in nursing with a particular focus on preceptorship and mentoring. It outlines considerations for setting up role modelling programs, including costs, benefits, roles and responsibilities. In addition, Part V of this guide presents competencies[1] for the roles of preceptor and mentor, which have recently been developed through CNA's Preceptorship and Mentoring Project and could form the basis of new programs. Some specific tools, guidelines, definitions and an extensive list of additional references with relevant website contacts are also included.

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[1] Knowledge, skills and personal attributes required by preceptors and mentors.

Role Models and Professional Practice

Health professionals learn throughout their careers. They learn from written materials, clients, educators, and they learn from each other.

When experienced nurses – the cornerstone of the profession – act as role models, we know that they benefit as well as the novices they assist. Novices acquire and perfect the competencies they require to practice safely and effectively in the settings in which they work and become socialized into nursing (Wright, 2002). The experienced nurses gain confidence, develop relationships, perfect teaching and communication skills and, in some cases, prevent or reverse burnout (McGregor, 1999).

Nurses have a professional obligation to support their peers in developing and refining competencies required for safe, ethical and effective practice. Nurses also have the responsibility to support the development and socialization of colleagues who are new to the profession, domain of practice,[2] specialty or setting. These responsibilities are identified in CNA documents that are foundational to nursing practice such as the *Code of Ethics for Registered Nurses* (CNA, 2002) and the *Blueprint for the Canadian Registered Nurse Examination: June 2005-May 2009* (CNA, 2004).

During the last 50 years in Canada, professional education has moved from apprenticeship, where learning occurred primarily within the workplace, to a learning model where student competencies are primarily developed within the educational institutions and combined with selective experiences in external practice settings (CNA, 1995). As a result, health care institutions and nurses may have less experience and investment in the education of students and other nurses than they did in the past.

In the past, health care institutions had education departments that were responsible for continuing education for their professional staff. Now, responsibility for staff programs is often decentralized to nursing units. Individuals, without previous experience in developing and providing programs such as preceptorship and mentoring, now have the opportunity to do so and require the tools to help them.

In the wake of the current health human resource crisis and financial strains, many health care staff members are experiencing excessive workloads and find it difficult to provide useful learning experiences for students and novice staff (Hynes-Gay & Swirsky, 2001). Nurses sometimes feel that they have inadequate time to respond to their client needs, let alone role model their practice to others. Yet, lack of role models and programs can lead to increased stress and dissatisfaction among nurses who need them, translating to higher rates of turnover in the health care setting (Messmer et al., 1995).

Nurses need to keep up with new technologies to maintain competence. Information technology has also allowed for rapid dissemination of breakthroughs in health care and treatment, increasing the pace of required learning. Immediate access to vast libraries of information has led an educated public to become more active participants in treatment and care. In turn, this has raised the standards of what is expected by the public.

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[2] For the purpose of this document, domains of nursing practice are direct care, education, administration and research.

Role models have been used for a long time in professional education to enhance learning. To be most effective, they must be part of an overall organizational strategy to create an environment that is directed toward continuous learning. Continuous learning environments enhance the quality of work life for health professionals, and they also improve outcomes for clients.

Nurses can support nursing students, new graduates and nurses who are new to a particular role by becoming role models. As role models, practising nurses become preceptors and/or mentors to prepare nurses for new roles that may range from planning population-based programs to acting as program managers, educators or researchers; or to providing direct care.

Who Is Involved in Role Modelling Programs?

If role modelling programs through preceptorship and mentoring enhance job satisfaction, quality of care, recruitment and retention of staff, then they create a win-win situation for all involved. Implementing and maintaining these programs successfully depends on collaboration at many levels – between individuals, institutions, organizations and governments. Some of their responsibilities are outlined below:

Individual Nurses

The *Code of Ethics for Registered Nurses* (CNA, 2002) states that nurses share their nursing knowledge with other members of the health team for the benefit of clients. To the best of their abilities, nurses should provide mentorship and guidance for the professional development of students of nursing and other nurses (p. 16).

Individual nurses are also responsible for acquiring the competencies they require to become good preceptors and mentors. There may be some competencies that are best learned from non-nurse professionals. In these cases, a nurse might invite a non-nurse to fulfill the preceptor or mentor role. Where programs do not exist, nurses may need to advocate for the resources necessary to develop and implement these programs.

Work Units and Departments

An organization's work units and departments are responsible for providing resources to ensure that preceptorship and mentoring programs are available and offered to the nurses who work in their setting. They are responsible for carrying out these programs and identifying the competencies nurses require in a particular setting.

Organizations Who Hire Nurses

Organizations are responsible for developing or offering programs for preceptorship and mentoring of nurses who work within their institution.

Professional Associations

Professional associations are responsible for advocating for funding adequate for the development and ongoing maintenance of preceptorship and mentoring of nurses. They are also responsible for setting and enforcing competencies for the profession.

Provincial, Territorial and Federal Governments

Governments are responsible for providing adequate funding to support preceptorship and mentoring programs.

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Part III:

Preceptorship and Mentoring

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Preceptorship and Mentoring

What They Are and What Nurses Need to Know About Them

Preceptorship and mentoring are two ways of using role modelling to support the learning and professional growth of nurses and to promote the overall quality of practice environments. While the international community sometimes equates mentoring and preceptorship (Hynes-Gay & Swirsky, 2001; Watson, 2003), there is a growing consensus in Canada about the differences between these approaches.

Many aspects of preceptorship and mentoring are similar. Both approaches depend upon effective role modelling in one-to-one relationships, self-directed learning, providing a safe environment for critical reflection and practice, the acts of advising, counselling, guiding, advocating, recognizing strengths and providing constructive feedback (BC Academic Health Council, 2002). However, preceptorships tend to focus on a formal process for assisting the novice practitioner to acquire beginning practice competencies through direct supervision over a limited period of time. Mentoring, which can be either informal or formal in structure, usually focuses on broader learnings, career development and personal and professional growth through a consultative approach over a longer term.

Competencies for preceptors and mentors which further describe these roles have been developed through CNA's Preceptorship and Mentoring Project and are presented in Part V of this guide. This chapter provides a more detailed review of preceptorship and mentoring illustrated by examples of these types of programs and references for further follow-up and information.

Preceptorship

Definition & Characteristics

The *Webster's New World College Dictionary* defines a precept as a "commandment, or direction meant as a rule of action or conduct," and a preceptor as a "teacher" (Neufeldt & Guralnik, 1998, p.1060).

While international definitions vary, Canadian nurses tend to refer to preceptorship as a "frequently employed teaching and learning method using nurses as clinical role models. It is a **formal, one-to-one** relationship **of pre-determined length**, between an experienced nurse (preceptor) and a novice (preceptee) designed to assist the novice in successfully adjusting to and performing a new role" (CNA, 1995, p. 3). Preceptorship usually involves acquiring a basic level of knowledge, skills and personal attributes as well as being socialized into the profession or domain of practice.

The novice may be a student or a practising nurse moving into a new role, domain or setting (CNA, 1995). As such, she or he is acquiring new competencies required for safe, ethical and effective practice based on commonly accepted standards. The new competencies may be developed in relation to the new setting or domain of practice. For example, competencies could relate to an emergency room, community health, university teaching or research setting; an administrative role; or providing direct care to particular types of clients, such as patients with burns or hepatitis C.

Preceptorship experiences tend to be short term (1-2 months). The length is often predefined by the educational institution or employer, who knows the characteristics of the typical participant, the requirements of the client group and the typical setting in which the work takes place.

A preceptor must be a capable instructor who has achieved at least the novice-level competencies required by the participant. Some of the competencies a preceptor requires will be dictated by the setting they work in and others by the nature of the preceptor role.[3] For example, it would be hard to imagine that a preceptor could be effective if they did not demonstrate enthusiasm for the role.

Preceptees participate in both formative (ongoing) and summative (final) assessment and evaluation. Formal evaluation occurring in preceptorship programs can serve institutions by ensuring that the novice has acquired the competencies required for safe, ethical and competent practice.

Most schools of nursing have programs that include preceptorship to help students gain clinical competence and prepare them for the transition to employment settings, especially in the final stages of the program (e.g., consolidation or senior practicum experiences). Educational programs for nurses who wish to acquire a degree in nursing, such as specialty and post-RN programs, also use preceptorship to help students adjust to new roles. As well, it has become common for staff developers in health service facilities and agencies to use preceptorship to orient new employees or nurses who transfer to different units or areas of specialty.

Benefits

As organizations begin to compete for diminishing resources, they must explore and implement practices known to increase job satisfaction for nurses (Ryten, 1997). Specifically, preceptorship programs have been found to benefit preceptees, preceptors, health care institutions and the profession of nursing (Lockwood-Rayermann, 2003; Mahayosnand & Stigler, 1999; Neumann, et al., 2004; Wright, 2002).

For the participant, preceptorship has been found to facilitate successful entry into the nursing profession, help in developing judgment and skills and reduce the time taken to function independently.

Preceptors benefit by having the satisfaction of seeing novices become more confident (Neumann, et al., 2004; Wright, 2002). They also tend to be less susceptible to burnout (McGregor, 1999). King and Bernick (2002) note that preceptors benefit from improved self-esteem and increased self-awareness by being a role model.

For the institutions, preceptorship increases the quality of the professional practice environment (CNA, 2001) and saves more money than that expended for a traditional orientation (Beeman, Jernigan & Hensley, 1999). A review of the literature by King and Bernick (2002) found that for the institutions, preceptorship resulted in fewer resignations, decreased staff turnover, increased staff satisfaction, enhanced knowledge and improved patient care.

The profession benefits by retaining practitioners with enhanced critical thinking (Myrick & Yonge, 2002).

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[3] See Part V: Competencies for Preceptors and Mentors – a list of competencies developed by CNA through the Preceptorship and Mentoring Project.

Some of the positive outcomes of preceptorship programs are summarized below:

Preceptee

- enhanced job satisfaction
- decreased stress
- significant personal growth
- increased confidence
- attainment of new attitudes, knowledge and skills (competencies)

Institution

- decreased cost of care
- increased recruitment of new nurses
- increased retention of those already in the workforce
- improved outcomes for patients
- increasing institutional loyalty
- increased productivity

Profession

- improved support for new graduates
- competencies required for safe practice
- programs to assist nurses to maintain competence and to acquire new competencies
- increased number of nurses with leadership and teaching skills
- improved retention of nurses
- reduced need to recruit and educate nurses

Costs

There is a dearth of information in the literature about the costs of carrying out preceptorship programs. The cost of preceptorship programs must take into consideration the following factors (CNA, 1995):

- time taken to plan, develop, carry out and evaluate the program
- time and effort to develop policies and to prepare necessary administrative documents
- time and resources required to publish written documents
- support, consultation and orientation for role models and participants
- preceptor recognition or remuneration
- program coordination, evaluation and modification
- possible travel costs for program coordinators

When undertaking a cost-benefit analysis of programs, it is necessary to weigh the projected cost of the program in relation to its goals. Increased direct costs may be acceptable if there are signification positive outcomes (Neumann et al., 2004).

Considerations for Successful Preceptorship Programs

Many factors must be considered in developing preceptorship programs, including stress on the preceptee, the preceptor's workload, conflict and partnership.

Preceptorship experiences can cause significant stress for preceptees (Yonge, Myrick, & Haase, 2002) and can lead to disillusionment about the nursing profession. It is important to maintain open sharing of information between the preceptee and preceptor, as well as the program coordinator and/or faculty advisor. Preceptors need to know how to recognize stress in the preceptee, how to assist them in managing the stress or where to seek further help such as counselling, when necessary.

Similarly, work overload can result in job dissatisfaction for some preceptors (Lockwood-Rayermann, 2004; Neumann et al., 2004). Overload may come from having too many patients to care for while performing preceptor responsibilities, having too many preceptees, or possibly, from not being given a choice in taking on these added responsibilities. These are ethical issues which should be considered when undertaking preceptorship programs in the nursing workplace.

It is important to recognize that conflict may arise between the preceptor and preceptee (Mamchur & Myrick, 2003). Orientation programs should provide both the preceptor and preceptee with some insight and approaches to how to recognize and resolve conflict. The program coordinator and/or faculty advisor can facilitate this, when necessary. For a brief outline of approaches to recognizing and resolving conflict, see Appendix C.

Ideally, preceptorship is a partnership between the preceptor, who is responsible for teaching, evaluating and providing feedback, the preceptee and the program coordinator and/or faculty advisor. In successful preceptor programs, the latter are prepared to provide course orientation, evaluative support and information for and about the preceptors and preceptees.

Rewards

Many institutions find that although there is much intrinsic motivation for preceptors it is very important to also provide formal recognition and some reward (Greenberg et al., 2001; Neumann et al., 2004; Stone & Rowles, 2002). The following examples illustrate how organizations can reward preceptors.

Remuneration:

Role models can be compensated in a variety of tangible ways:

- an education day with pay
- a pay increase
- vouchers for continuing education programs

- a subscription to a nursing journal
- celebratory events or meetings that include a meal
- gift certificates for books
- a decreased workload during the period of role modelling

Recognition:

Role models can be recognized in a number of ways:

- names published in newsletters
- a name pin identifying the nurse as a role model
- recognition at celebratory events
- a preferential scheduling following role modelling experience
- certificates
- a personal thank-you by letter and/or in person from a key nursing administrator
- letters of recognition for their personnel file

It is important to include the role models themselves in the discussion of types of recognition, because what constitutes a reward or recognition can vary with individual preferences.

Examples of Preceptorship Programs

In the subtitle of their publication on the subject, King and Bernick (2002) describe the preceptor program offered by the Baycrest Centre for Geriatric Care as an "innovative program in which everyone wins!" The program was created following a unit-based orientation, in which a needs assessment indicated new employees had difficulty managing their workloads. Preceptors for the program must have:

- at least two years experience in the clinical area;
- leadership skills;
- a desire for professional growth;
- the personal attributes of sincerity, warmth, caring and flexibility;
- an understanding of the principles of adult learning; and
- highly developed communication skills.

Selected preceptors attend an orientation workshop and, given the one-to-one nature of the program, establish a learning plan with their preceptees. Other components of the program include orientation checklists, bi-weekly reflective meetings, access to resources, preceptor recognition and formative and summative evaluations.

Neumann et al. (2004) provide a detailed description of an agency-wide preceptor development program which includes levelled orientation sessions, cost considerations, approaches to providing recognition and ongoing preceptor-support ideas such as an intranet "preceptor forum" with multiple resources.

In British Columbia, there are a number of province-wide initiatives related to preceptorship. These include an information website, workshops on program development and a continuing education course entitled "From Practitioner to Practice". (See the BC Academic Health Council website: **www.bcahc.ca** for practical resources and ideas).

Other preceptorship materials such as learning style guides, tracking sheets, evaluation forms and preceptor performance tools are available from established programs. For examples, refer to the Peterborough Regional Health Centre's *Guided Learning Programs: Preceptor's Handbook* (Hill, 2003) or Internet resources such as the Maricopa Community College District Nursing Program's *Preceptor Packet* (2002) or the BC Academic Health Council's *Preceptor & Mentor Initiative for Health Sciences in BC* (2002).

Mentoring

Definition & Characteristics

The word *mentor* originates from Greek mythology, but in modern English, it refers to "one who is experienced and wise in one's profession," endowed with characteristics that cultivate learning for the novice in a similar professional role (Hynes-Gay & Swirsky, 2001, p. 12). The generally accepted view is that the mentor is older, more senior and experienced than the more junior mentee, sometimes called a protégé.[4] The relationship is long-term, with the goal of fostering the learning, growth and advancement of the mentee (Andrews & Wallis, 1999; Donner,Wheeler & Waddell, 1997).

The concept of mentoring, while traditionally associated with business or law, has become more prevalent in nursing since the 1980s, especially in response to growing job dissatisfaction and challenges to recruitment and retention. However, the definition of mentoring is not precise (Andrews & Wallis, 1999; Hynes-Gay & Swirsky, 2001; Kilcher & Sketris, 2003).

According to the CNA definition, mentoring involves a voluntary, mutually beneficial and usually long-term professional relationship. In this relationship, one person is an experienced and knowledgeable leader (mentor) who supports the maturation of a less-experienced person with leadership potential (mentee) (CNA, 1995). Mentoring provides a supportive environment and positively influences professional outcomes. It can lead to an ongoing relationship and can occur in all domains of nursing practice (administration, education, research or direct care).

The mentee often wishes to become more effective in a role, setting, clinical focus or domain of practice. Examples of mentees include: a new manager who wishes to develop knowledge and skills to manage effectively in a complex health care environment, a new educator working in a university setting or a new researcher who wishes to learn how to apply for funding and carry out research projects. The mentee is often motivated by a personal requirement for mastery within a complex environment.

Mentors may be experts and leaders within their field; however, an expert is not synonymous with a mentor. Federwisch (1997) distinguishes between the expert and the mentor suggesting, "an expert gives a definitive solution to a problem while a mentor guides people along"

[4] Both the terms *protégé* and *mentee* are commonly used to identify the person in a relationship with the *mentor*. This guide employs the term *mentee*, except where specific reference is made to programs or texts using *protégé*.

(p. 3). Others report that participants in mentoring programs prefer a newer practitioner as a mentor, one who can remember their own student experiences easily (Andrews & Wallis, 1999). It is a learning partnership positively influenced and better defined by the specific personal characteristics and professional qualities of the mentor.

The time period for mentoring is usually longer and often less precisely defined than for preceptorship (Andrews & Wallis, 1997; Hynes-Gay & Swirsky, 2001). People may be engaged in several mentoring experiences over their lives or even at one time. The length of the relationship can range from months to years and is usually determined by the time required for the mentee to achieve their objectives, but in some cases, by changes to the relationship between the mentor and mentee. The relationship differs from preceptorship as it is less instructional, focuses less on supervision and assessment of performance and more on positively influencing through role modelling and guidance.

Informal mentoring relationships are based on mutual identification or attraction, are unstructured and focus on the protégé or mentee achieving long-term career goals. In contrast, formal mentoring relationships are more structured in purpose and duration and usually involve organizational support (Kilcher & Sketris, 2003). Typically, this would be a situation where a nurse is socialized and develops competencies in a new setting by being matched with a more experienced colleague for support. Alternative approaches to mentoring include peer mentoring, mentoring groups or multiple mentors (Kilcher & Sketris, 2003; RNAO, 2003).

Benefits

CNA considers mentoring an essential component within a quality professional practice environment (CNA, 2001). A range of benefits for the mentor, mentee and institution have been identified as follows (Greene & Puetzer, 2002; Kilcher & Sketris, 2003):

Mentor

- enhanced self-fulfillment
- increased job satisfaction and feeling of value
- increased learning, personal growth and leadership skills
- motivation for new ideas
- potential for career advancement

Mentee

- increased competence
- increased confidence and sense of security
- decreased stress
- increased job satisfaction
- expanded networks
- leadership development
- insight in times of uncertainty

Institution

- improved quality of care
- increased ability to recruit
- decreased attrition
- increased commitment to the organization
- development of partnerships and leaders

Costs

Little information exists about the costs of mentoring programs; however, standard costs vary from little to no cost for informal mentoring, to the costs of funding provided in fellowship award programs, the cost of orientation education programs and staff time for monitoring or ongoing support. There may also be staff time costs where nurses take time away from the work setting to pursue their goals.

Considerations for Successful Mentoring Programs

An appropriate, nurturing environment for mentoring largely depends upon the personal characteristics of the mentor such as approachability and effective interpersonal and teaching skills (Andrews & Wallis, 1999). Brown (1999) suggests that an appropriate environment can be maintained by taking time for regular meetings to anticipate and propose solutions for potential problems. Both parties are encouraged to take risks, to discover the potential in each other, to avoid over-dependence and to recognize when to end the mentoring (Greene & Puetzer, 2002).

Roles and Responsibilities of Mentors[5]

Greene and Puetzer (2002) describe three mentor roles: (1) *role model* who assists by example, (2) *socializer* who helps to integrate the mentee in the social culture, and (3) *educator* who assesses learning needs and plans experiences for the mentee. Mentors in the CNA's 2002 hepatitis C mentoring program found they had the following responsibilities:

- act as professional role model and colleague
- confidently model competent practices
- collaborate with and advocate for the mentee
- commit to self-learning and learning of others
- be sympathetic, supportive and respectful
- have a consistent approach and clear expectations
- facilitate the mentee's introduction into the organization

[5] See Part V: Competencies for Preceptors and Mentors – a list of competencies developed by CNA through the Preceptorship and Mentoring Project.

- collaborate in the assessment of learning needs and review learning goals for feasibility
- communicate with the coordinator to clarify expectations where necessary
- provide encouragement and guidance to the mentee

In the same CNA project, mentees described their responsibilities as follows:

- participate actively in the program (become an active learner and colleague)
- co-assess specific learning needs and co-determine learning goals
- adhere to the institution's policies and mission
- adhere to provincial or territorial standards of practice and the *Code of Ethics for Registered Nurses* (CNA, 2002)

Rewards

The rewards for the mentor are intrinsic to the partnership and in the satisfaction of seeing the mentee progress. More formal mentoring programs often involve recognition at the institutional level. As is the case for preceptors, recognition can be in the form of educational days, time off or lighter workloads during the mentoring period. Some mentors are recognized with extra pay or with other rewards to show appreciation (See discussion of rewards and recognition for preceptorship pp. 16-17).

Examples of Mentoring Programs

The following examples illustrate the wide range of mentoring programs emerging for nurses in Canada:

A mentoring program focused specifically on advanced research skills is offered by the Canadian Health Services Research Foundation Career Reorientation Award (2002). Successful candidates, who may be nurses, work with an experienced research mentor over a 12-month period to develop a successful health research proposal.

The Advanced Clinical/Practice Fellowships program of the RNAO (2003) uses a structured 12-week mentoring experience to foster advanced clinical practice in specialty areas or leadership development, as directed by the applicant. Both primary and other mentors assist the "fellow" to develop a proposal and learning plan. The mentor maintains support throughout, and even beyond, the funded period. For example, nursing "fellows" have focused on acquiring expertise in using telehealth technology for rural or remote health care settings, developing an evidence-based diabetes education program, facilitating community re-entry following geriatric rehabilitation or enhancing community support for families with preterm infants.

A mentoring program designed specifically for new graduates in a staff nurse role was initiated in Saskatchewan in 2003 (Regina Qu'Appelle Health Region, 2004). Protégés are matched with experienced RN mentors from another work setting to work on professional growth within an area of clinical expertise, to work towards specialty achievement or to grow into a non-clinical role. The overall aim of this mentoring initiative is to improve the recruitment, support and retention of clinical nursing staff. Both mentors and protégés participate in an orientation workshop and receive ongoing support over a 12-month period.

The Calgary Health Region Mentorship Program (2002) focuses on career development for professional staff through voluntary, reciprocal mentoring relationships. The program offers mentor/mentee matching, formal orientation and ongoing support. Mentors provide support, challenge and vision in assisting protégés to advance their expertise and leadership skills, as well as improve work life satisfaction for both parties.

Coaching and Other Models for Integrating Work and Learning

Coaching

Coaching as a term has developed several meanings in the nursing profession. It most often describes an approach or strategy to develop skills and knowledge through positive, timely feedback. Coaching is an activity carried out as a part of the larger roles of educator, manager, preceptor or mentor (Fuimano, 2004; Kelly, 2002; Kilcher & Sketris, 2003; Lachman, 2000). Recently, "coaching" or "coach" is also being used to describe as a unique role designated to individuals hired to support the development and growth of employees on either a one-to-one or a group basis (Hope-Smeltzer, 2002; Nelson et al., 2004; Nigro, 2003).

Coaching as a role

The concept of coaching as a discrete role or job, while common in the business sector to enhance profitability, is being adapted for health care organizations (American Academy of Ambulatory Care Nursing, 2001; Donner & Wheeler, 2002). Coaching can refer to the promotion of skills development within either superior-subordinate (Hope-Smeltzer, 2002) or peer relationships (Broscious, 2001; Nelson et al., 2004).

Coaching can be accomplished in a group setting or one-to-one. The duration of coaching is usually until the desired competency is mastered or until the contract between the coach and participant is terminated. Coaches may or may not be in the same profession as the participant.

Coaching is used to assist participants to enhance a wide variety of professional and personal performance issues. Executive coaches promote leadership performance and productivity (American Academy of Ambulatory Care Nursing, 2001; Hope-Smeltzer, 2003). Personal lifestyle coaches may help their clients achieve work life balance or spiritual development. Career coaches focus on career planning to promote "career resilience" and job satisfaction (Donner & Wheeler, 2002). In direct care settings, the role of clinical practice or unit coach has recently been described to enhance quality of care and work satisfaction (Nelson et al., 2004).

In much of this literature, the role of coach is hard to distinguish from that of mentor (Grandinetti, 2000; Nigro, 2003). In this context, coaching is usually a formal paid job, structured around performance and "the bottom line", while mentoring is based on a more informal open-ended relationship. Although this is not always the case, coaching bears a strong commercial connotation. There is wide range of services, such as "cognitive coaching", advertised for sale, especially by entrepreneurs in the United States. Not all aspects of this business model for the "coaching role" are applicable to the not-for-profit health care service sector.

Donner & Wheeler define coaching as "a powerful, collaborative relationship between a coach and a willing individual, which can enable, through a process of discovery, goal setting and strategic actions, the realization of extraordinary results" (Personal communication March 26, 2004).

In one setting, the role of "unit coach" was to recognize the potential and target the growth of individuals, through careful attention to actual performance […] by prompting nursing staff to reflect upon their actions (Nelson et al., 2004). This pilot role was eventually incorporated into the role of the unit preceptor in this setting. The activities listed by these authors for the "unit coach" appear to be very similar to those performed by clinical instructors working with groups of nursing students during clinical practicum courses.

In another example, at St. Joseph's Health Care London, an experienced staff member, called a clinical practice coach, works in a formal one-to-one relationship within the work setting, to advance the learner's (student, new staff or peer) quality of the practice (St. Joseph's Health Care London, 2002).

No doubt, coaching as a role is an exciting new avenue for professional growth and development in the nursing workplace. However, as yet, this role is not well defined or clearly distinguished from other overlapping roles such as manager, teacher, preceptor or mentor.

Coaching as a Strategy

This resource uses the more traditional definition of "coaching" to describe an approach, strategy or activity carried out within a broader role to enhance learning (e.g., teacher, manager, preceptor, mentor). Coaching involves timely feedback on performance, to enhance skills and qualities for success (Fuimano, 2004; Kilcher & Sketris, 2003; Nelson et al., 2004). For example, a preceptor may use coaching while a preceptee is undertaking a new technical skill, reinforcing what the preceptee is doing well and providing tips along the way; a mentor might coach a mentee in developing a new skill such as chairing a meeting; nurses themselves use coaching when helping clients learn new skills such as bathing a newborn or self-administering insulin.

Other Models

Both preceptorship and mentoring focus on learning and growth within the work or practice setting. Other types of programs that integrate practical work experience and academic education are becoming more prevalent within nursing, although mostly outside of Canada. They can be found under many titles including learnership, externship, internship, apprenticeship and cooperative programs. Kerka (1999) reports that programs integrating work and learning were offered in the United States as early as 1906.

Internship

The word "intern" is built on the root "inter" that means between, among or together (Neufeldt & Guralnik, 1998) and confers a more neutral and preferable connotation than the term "orientation". A formal program for new graduates, internships help the transition to paid work and to specific positions within the health care setting.

Internship programs usually require a time investment of several months to a year, depending on the setting in which interns work and the level of the participant. Interns are usually paid employees. In some institutions, continued employment is contingent upon successful completion of the internship experience, which might include classroom or one-to-one teaching, support groups, individualized clinical experience, preceptorship or mentoring (Blanzola, Lindeman & King, 2004).

Internship programs are common in the United States (See Part VII: Further Reading). Many have written materials which can be accessed. Internship programs are not common in Canada, but have emerged in some settings, for example at St. Michael's Hospital in Toronto (2003).

Learnerships

Learnerships are common outside of Canada and are considered by some to be an exciting trend. The development of learnership is motivated, in part, by the nursing shortage.

Learnerships tend to be work-based education and skills development programs in which learners find out why and how things should be done (Geyer, 2002). In typical learnerships, educational and health care institutions work together. Educational institutions provide classroom-based education and practice occurs under normal working conditions. This is similar to education that occurred in Canada in hospital-based programs, the last of which closed in 1998.

Cooperative Program

The term "cooperative program" can have many meanings. For the purpose of this document, it refers to an education program offering students alternating periods of work and study.

While cooperative programs have existed in North America since the early 1990s, they have recently been developed for nurses. Most cooperative programs alternate paid work and study and are designed to enhance the development of the professional. They involve three main stakeholders: the employer, the student and the educational institution (Simon & Houze, 1999).

Students apply for these credit programs, and if they meet the specified criteria, the employer interviews them. Once accepted into the programs, students are expected to fulfill requirements of employment, and they usually receive employment benefits such as a salary, vacation, sick leave, retirement plans and life insurance.

The employer has the advantage of assessing students' potential as long-term employees. The students have real-life experiences in their chosen profession with potential employers. Upon graduation, many return to work for the employer. The educational institution benefits by being able to offer students this experience in a realistic setting to enhance their learning (Simon & Houze, 1999).

The University of Alabama and Regional Medical Center (2002) has a cooperative program for nurses. In this program, senior students work full time at the hospital during their summers and spring terms. Their earned wage increases as they gain experience. At first, students work as nursing assistants, and later they work with nurse preceptors. Students are credited for both the work as well as the class sessions. Placements are organized according to the best fit for the employer as well as the participant.

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Part IV:

Developing Programs for Preceptorship and Mentoring

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Developing Programs for Preceptorship and Mentoring

Steps for Developing a Successful Program

Role modelling as preceptor, mentor or other programs involving role models are most effective when they are part of an overall institutional strategy to create a learning environment.

More than one organization, or part of an organization, may contribute to the development and delivery of a program. Although research has not conclusively identified key ingredients, experienced institutions have identified the major activities that contribute to the quality of the program (CNA, 1995). Here we have adapted these activities into six steps for developing a successful program:

1. Assess needs
2. Identify the philosophy
3. Create the plan
4. Organize
5. Implement
6. Evaluate

General issues applicable to all participating organizations or departments are identified in the following sections.

Step 1: Assess Needs

The educational organization(s) or department performs a needs assessment before developing the program. The assessment does the following:

1. Demonstrates consultation with pertinent groups and individuals (including administrators, regulatory bodies and practicing nurses)
2. Demonstrates that the sponsoring organization and department has resources (human, physical, clinical and technological) to ensure successful completion and evaluation of the program
3. Provides an explicit statement of purpose identifying areas of competency acquisition, the level of practitioner for whom the program is planned and the roles for which participants are being prepared
4. Identifies competencies[6] required to practise within the specific domain[7] of nursing and practice setting

[6] Competencies are the specific knowledge, skills, judgment and personal attributes required for a person to practise safely and ethically in a designated role and setting (CNA, 2002a).

[7] For the purpose of this document, domains of nursing practice include direct care, education, administration and research.

5. Describes the characteristics of the participants that will affect their learning needs and styles (e.g., age, culture, societal roles, position)
6. Describes competencies required by the role models (see Part V)
7. Identifies participant and instructional staff competencies in using intended technology

Step 2: Identify the Philosophy

The program philosophy provides the necessary base for developing and implementing the program. Organizations must identify the philosophy in writing to reduce the possibility of misunderstandings that may arise from lack of clarity about the program or its participants. The organizations must ensure the following:

1. The philosophy identifies the relevant criteria and the relationships among the criteria including beliefs about the client, the nurse (adult learner), health, the setting and education.
2. The philosophy is clearly written and explained to participants, faculty and personnel in all organization involved with the program.
3. The philosophy being developed is congruent with the philosophy of the sponsoring organization(s), *Code of Ethics for Registered Nurses* (CNA, 2002b), provincial/territorial governments and relevant specialty standards of practice.
4. The philosophy is shared with and supported by senior administrators in all participating organizations.

Step 3: Create the Plan

The organizations or departments involved in the program provide a plan based on the needs assessment and philosophy and that meets these requirements:

1. Describes the roles and responsibilities of central participants (see Table 1)
2. Contains clearly written measurable program goals that are congruent with the philosophy and identified needs
3. Describes what will be accomplished, by when and with what resources (material, human and physical), as well as how it will be accomplished

Step 4: Organize the Program

The sponsoring organization shall provide an administrative structure and the resources for effective development. The sponsoring organization must perform the following tasks:

1. Provide for administrative structure to support the program.
2. Describe the relationships between the participating organization or departments and the lines of authority and responsibility within the organization.
3. Specify policies for selection, admission, progression, appeal and successful completion of the program.

4. Validate and prioritize competencies required and that will be gained by participants for each setting or domain of practice in which the program will be operating.
5. Address the issues of role model and participant liabilities.
6. Ensure adequate selection of and preparation of role models[8] (see Appendix B for suggested orientation topics).
7. Ensure adequate remuneration or reward for role models.

Step 5: Implement the Program

The sponsoring organization shall implement and maintain the following components of the program:

1. Ensure adequate staffing levels and work load for role models.
2. Maintain retrievable, complete and secure records according to acceptable standards; allow access to records for those who are authorized to view them; protect records against loss or unauthorized use and ensure resources and space for their storage.
3. Provide human, physical, clinical, research and technical resources needed to achieve the program goals.
4. Establish written contracts with organizations used for any clinical experiences.
5. Ensure careful allocation of role models to participants.
6. Provide for sufficient guidance, supervision and direction.
7. Ensure feedback is used to enhance the program.
8. Provide online technical support services for programs delivered by distance methods.

Step 6: Evaluate the Program

The sponsoring agency shall provide a plan for and carry out regular evaluation of the program. The plan shall include these details:

1. The methods by which the performance of participants will be assessed, during and at the end of the program in terms of stated learning outcomes or competencies
2. The criteria and methods by which mentors and preceptors will be evaluated
3. Logical strategy and criteria for formative and summative evaluation of the program related to the goals, which should include feedback from all stakeholders
4. The methods and schedule for using evaluation data in the ongoing development and revision of the program

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[8] While expertise may be important in certain situations, an expert nurse may not always make the best mentor. An expert nurse may make decisions rapidly, without going through the steps of problem solving in a way that can be followed by the novice. An experienced, competent nurse, not yet an expert, may be more helpful to the novice because that nurse will remember and/or use all the steps required for decision-making by a beginning nurse (Benner, 1984). It is important to consider the qualities of the individual nurse in selecting mentors, as well as the specific competency requirements of participants.

Table 1. Potential Roles and Responsibilities of Role Model and Participant

	Role Model	Participant
Relationships	Develops a partnership with the participant	Develops a partnership with the role model
Competency assessment	Assists the participant to identify the gap between acquired and desired competencies	Identifies the gap between acquired and desired competencies
Goal setting	Assists participant to set goals that are specific, measurable, achievable, realistic and time-sensitive with respect to competency acquisition	Sets goals for competency acquisition
Experiences	Works with participants to craft experiences leading to effective goal achievement	Works with role model to craft experiences leading to effective goal achievement Actively participates in experiences that enable goals to be achieved
Client care	Assists the participant to determine which client care responsibilities can be carried out safely in relation to competencies already held by the participant Provides support when competencies cannot be carried out safely	Achieves goals through client care, in consultation with role model Identifies and communicates where expectations exceed acquired competencies
Feedback	Provides effective formative (ongoing) and summative (final) feedback as required regarding progress towards goals Works with participants to adjust goals based on feedback	Provides effective feedback to role model on all aspects of the program Works with role model to adjust goals based on feedback
Motivation	Effectively motivates participant to continue to acquire competencies at an increasing skill level	Evaluates personal and organization factors that influence motivation levels and enhances the positive factors where possible
Program evaluation	Provides regular and effective feedback to ensure continuous improvement to role modelling program	Provides regular feedback to ensure continuous improvement to role modelling program
Socialization	Provides experiences to assist participant to be socialized into the profession	Participates fully in experiences aimed at socialization in the profession

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Part V:

Competencies for Preceptors and Mentors

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Competencies for Preceptors and Mentors

Overview

This guide is one component of CNA's Preceptorship and Mentoring Project. Overall, the project's aim is to support the development of role modelling programs with a focus on preceptorship and mentoring, to enhance the quality of workplaces for nurses in all domains of practice. The other key step for this project was developing and validating sets of competencies for preceptors and mentors. This chapter presents the results of this work, including the lists of competencies.

Why Develop Competencies?

Competencies are the knowledge, skills, judgment and personal attributes required for a person to practise safely and ethically in a designated role and setting. Competencies in nursing are developed at the entry level, at the specialty level and at the advanced practice level (CNA, 2002, p.15).

The relationship between competencies, standards of practice and clinical guidelines are described in CNA's *Achieving Excellence in Professional Practice: A Guide to Developing and Revising Standards* (2002). Standards are based on the mission and values of the organization or professional group. Competencies are derived from standards to describe the practice in a specific role or setting. Clinical guidelines are systematically developed statements, based on a review of evidence from research, that assist the practitioner to make appropriate decisions about care (p. 18).

There were a number of reasons for developing competencies for preceptorship and mentoring:

- to enhance recognition for the importance of the mentoring role within the profession
- to promote professional development for individual nurses by enhancing leadership
- to provide a mechanism for identifying potential nurse mentors
- to provide a mechanism for promoting continuing competency among nurses
- to enhance role satisfaction for preceptors, preceptees, mentors and mentees
- to enhance the quality of work environments for nurses and ultimately, the quality of care

The Process

The competencies for preceptorship and mentoring were developed over several months with the input of expert working groups for each area. The process for developing these competencies was similar to that used for the Canadian Registered Nurse Examination and national nursing specialty exams. In this process, a group meets, agrees upon the definition for the concept of "competency" and quality criteria. Once statements are produced, the group refines and critiques them. To validate the competencies, CNA sent surveys to professional associations, national nursing groups and members of the nursing community who expressed an interest in participating in the validation process for preceptor competencies and/or the development and validation of mentor competencies. Survey participants were

required to be registered nurses with experience in a preceptorship or mentoring program, depending on the survey they responded to. Nurses from across the country and across domains of practice took part in the process, which yielded the following results:

Preceptor Competencies

The final list of competencies for preceptors is divided into five major categories:

- *Collaboration*
- *Personal Attributes*
- *Facilitation of Learning*
- *Professional Practice*
- *Knowledge of the Setting*

Mentor Competencies

The final list of competencies for mentors is divided into four major categories:

- *Personal Attributes*
- *Modelling Excellence in Professional Practice*
- *Fostering an Effective Mentor/Mentee Relationship*
- *Fostering Growth*

Although there are some similarities between the frameworks for mentor and preceptor competencies (for example, the inclusion of categories for personal attributes and professional practice), the individual competencies and other categories differ significantly.

The process of developing these competencies revealed the extent to which nurses value the role of preceptorship and mentoring programs in advancing the profession and supporting nurses in providing quality care. Committed to producing quality work, members of the expert working groups who drafted the initial competency lists continued to provide consultation on the project.

Both validation tools were received with enthusiasm. Nurses responded from across the country and from all domains of practice – education, administration, research and direct care. Many respondents provided additional insights and expressed appreciation for the quality and importance of this work.

The data collected indicated that the mentoring role for nurses is not as well understood as that of preceptor – a conclusion supported by the literature used in this study. While preceptorships have long been used in nursing, mentoring is more recently being adapted for nursing from the corporate setting. In particular, the concepts of risk-taking, creativity and innovation – core aspects of the mentoring process – are not as familiar within nursing.

The following final lists of competencies for preceptors and mentors were developed by CNA through the Preceptorship and Mentoring Project. For a comparison of preceptor and mentor competencies see Table 2.

Preceptor Competencies[9]

A. Collaboration

1. Collaborates with the preceptee at all stages of preceptorship
2. Establishes and maintains collaborative partnership with faculty advisor/manager and other partners, as appropriate (e.g., peers, colleagues, other health care professionals, clients)
3. Networks with other preceptors to share best practices, when possible
4. Assists preceptee to interpret the preceptee's role to individuals, families, communities and populations, as appropriate to the setting

B. Personal Attributes

1. Demonstrates enthusiasm and interest in preceptoring
2. Displays a genuine interest in the preceptee's learning needs and growth
3. Fosters a positive learning environment
4. Adapts to change
5. Demonstrates effective communication skills with clients and colleagues
6. Demonstrates effective conflict-resolution skills
7. Demonstrates readiness and openness to learning along with the preceptee
8. Displays respect for the diversity of the preceptee (e.g., educational background, race, culture)
9. Integrates the preceptee into the social culture of the agency
10. Possesses self-confidence and patience
11. Recognizes personal limitations and consults with others, as appropriate

C. Facilitation of Learning[10]

1. Assesses the preceptee's clinical learning needs in collaboration with preceptee and with faculty advisor/program coordinator, when applicable:
   a. Reviews the core competencies according to the domain (i.e., practice, education, administration), standards of practice, setting (e.g., hospital unit, clinical specialty, community, educational setting), course or program objectives and level of practice
   b. Discusses the expected learning outcomes based on the identified core competencies

[9] CNA proposes this set of preceptor competencies as an ideal to be worked towards and as a guide for preceptor selection and orientation. It is recognized that many excellent nurse preceptors may not demonstrate 100 per cent of these competencies.

[10] This core component of the preceptor role is distinct as an addition to the professional working role of the nurse. Education in how to effectively facilitate learning using the principles of adult learning would be a key focus of a preceptor orientation program.

c. Reviews past experience of the preceptee with respect to knowledge and skills to obtain an understanding of strengths, areas for growth and specific learning needs in the practice setting

d. Identifies the potential learning opportunities/assignments available in the practice setting that will match the identified areas for growth and learning needs

e. Assists the preceptee to develop individualized learning outcomes, for the practice role, according to available guidelines:

i. specific

ii. measurable and observable

iii. achievable within the time and resources available during preceptorship

iv. relevant and individualized to the preceptee and the setting

v. timelines are clearly identified (e.g., daily, weekly, other).

2. Plans clinical learning activities in collaboration with preceptee and with faculty advisor/program coordinator, when applicable:

a. Assists preceptee to seek out a range of learning activities to address each learning outcome and to make optimal use of preceptee's time (e.g., clinical practice assignments, structured educational activities, reading, written or computer exercises, committee attendance, selected observational experiences, simulated skills practice, nursing rounds)

b. When possible, chooses the clinical assignments/learning activities based on identified learning outcomes and preceptee learning style

c. When possible, sequences clinical assignments/learning activities during the preceptorship from simple to complex levels of challenge to promote increasing independence, for example:

i. physical condition (stable to unstable)

ii. single and multiple therapies

iii. psychosocial factors (e.g., family dynamics, language, culture, gender, financial status)

iv. workload

3. Implements clinical learning activities in the practice setting in collaboration with preceptee and with faculty advisor/program coordinator, when applicable:

a. Arranges appropriate clinical learning opportunities and strategies

b. Assists preceptee to obtain available resources in preparation for the learning activity

c. When possible, reviews the activities the preceptee intends to carry out and addresses any areas for improvement or adjustment prior to actually carrying out the practice activity

d. Discusses with the preceptee potential complications or unexpected events and possible appropriate responses (e.g., troubleshooting), as relevant

e. Clarifies the role of the preceptor and preceptee for the planned activity

f. Provides ongoing constructive feedback (e.g., coaching, encouragement, support, reinforcement)

g. Intervenes immediately to prevent unsafe and unethical actions

h. Adjusts level of supervision to foster autonomous functioning

4. Evaluates the clinical learning outcomes in collaboration with preceptee and faculty advisor/program coordinator:

   a. Provides ongoing constructive feedback using structured evaluation tools, when available (e.g., formative evaluation usually occurs daily and weekly)

      i. Asks probing questions to gain an understanding of what the preceptee has learnt from the activity (e.g., How do you think you did? What went well? What could you have done differently?)

      ii. Describes the preceptor's assessment of the activity

      iii. Discusses any discrepancies between the assessment of the preceptor and the preceptee

   b. Participates with the preceptee in completing structured evaluation tools emphasizing the importance of self-evaluation for the preceptee, to identify progress towards learning outcomes and potential next steps (e.g., summative evaluation occurs at mid-point and end of preceptorship)

   c. Provides reinforcement and a supportive learning environment by focusing on the preceptee's strengths, achievements and progress toward meeting objectives throughout the evaluation process

   d. Provides concrete feedback about areas for improvement or failure to meet agency, professional or personal objectives

   e. Takes appropriate action if progress towards the learning outcomes is not satisfactory (e.g., consults the faculty advisor/program coordinator, following established protocol)

   f. Asks open questions to preceptee to gain an understanding of the effectiveness of the preceptor's interventions to facilitate clinical learning

D. Professional Practice

1. Practices autonomously and consistently in accordance with the relevant nursing standards established by the appropriate provincial or territorial regulatory body and the *Code of Ethics for Registered Nurses*

2. Works towards meeting the current national/international standards of the nursing specialties and best practices

3. Assists the preceptee to acquire the knowledge, skills and judgment to practice in accordance with the relevant provincial or territorial nursing standards and the *Code of Ethics for Registered Nurses*

4. Clarifies the roles, rights and responsibilities related to preceptorship with the appropriate authority (e.g., agency, educational institution)

E. Knowledge of the Setting

1. Is knowledgeable of the basic content of the agency's:
   a. mission and philosophy
   b. systems of care (e.g., family-centered, team nursing, primary nursing, buddy systems)
   c. policies and procedures
   d. physical environment
   e. interdisciplinary roles and functions
   f. forms, documentation and reporting mechanisms
   g. learning resources
2. Demonstrates the role of the nurse within the multidisciplinary team (e.g., pharmacist, social worker, psychologist, occupational therapist, unregulated health workers, physician)
3. Reviews the guidelines of the educational institution for preceptee and preceptor (e.g., expectations of the preceptorship, what the preceptee can do prior to and during preceptorship)

Mentor Competencies[11]

A. Personal Attributes

1. Demonstrates effective communication skills
2. Displays respect, patience and good listening skills
3. Demonstrates trustworthiness in working relationships
4. Demonstrates a positive attitude, enthusiasm, optimism and energy about the work environment, nursing and mentoring
5. Expresses belief in the value and potential of others
6. Is open and accepting of the diversity of others
7. Demonstrates confidence
8. Reflects on own attitudes, values and beliefs
9. Displays visionary qualities (e.g., forward thinking and creative problem-solving)
10. Displays willingness to take risks (i.e., to develop and/or apply innovative ideas).

B. Modelling Excellence in Professional Practice

1. Displays commitment to nurses and to the nursing profession
2. Displays commitment to the goals of the organization or the team

[11] CNA proposes this set of mentor competencies as an ideal to be worked towards and as a guide for mentor selection and orientation. It is recognized that there is a variety of informal and formal arrangements emerging for mentoring in nursing. The applicability of these competencies for mentoring will vary according to the program and the setting.

3. Demonstrates strong knowledge, judgment, skill and caring in their domain of practice
4. Is credible and respected by colleagues, the organization and the community
5. Demonstrates critical thinking by challenging ideas, knowledge and practice, as appropriate
6. Actively expands knowledge base using research evidence and remains current with latest thinking and best practices in area of expertise
7. Uses an ethical framework to guide professional practice and interpersonal relationships
8. Uses socio-political knowledge of the organization to work effectively within or beyond the system
9. Conveys ability to see the "big picture" (historical, political or systems context)
10. Uses a strong and diverse network to collaborate with others in the work setting and the broader system (i.e., health care system and wider community, where relevant)
11. Demonstrates effective negotiation and conflict-resolution skills

C. Fostering an Effective Mentor/Mentee Relationship

1. Establishes trust and maintains confidentiality
2. Makes time for the mentoring relationship and is approachable and welcoming
3. Demonstrates respect for the mentee as an individual and belief in the mentee's potential
4. Demonstrates caring for the well-being of the mentee
5. Nurtures the mentee by providing support, encouragement and a safe relationship
6. Provides honest feedback and gentle confrontation; becomes a "critical friend"
7. Engages mutually in the mentoring relationship (i.e., is willing to share of self and is open to personal change)
8. Reflects on own interactions to challenge, stimulate and support the mentee
9. Collaborates and negotiates in setting the purpose, goals, process, boundaries and evaluation of the mentoring relationship
10. Plans for appropriate closure or transition of the relationship
11. Celebrates achievements and successes with the mentee
12. Respects mentee's right to make decisions, but recognizes when it is ethically necessary to intervene to prevent harm
13. Demonstrates an understanding and respect for the power differential between the mentor and mentee

D. Fostering Growth[12]

1. Coaches the mentee towards goal achievement

   a. Encourages the mentee to identify own strengths, gaps and growth potential

   b. Supports the mentee in the selection of appropriate and realistic goals

   c. Guides the mentee to identify options/activities to meet goals

   d. Encourages the mentee to identify realistic timelines for goal achievement reflecting work and life balance

   e. Guides the mentee to select an optimum level of challenge within their role, setting or domain of practice (e.g., range of goals, incremental levels of difficulty or complexity)

   f. Guides the mentee to identify, clarify, define and manage barriers, problems and issues

2. Facilitates the mentee's access to a wide variety of resources and opportunities to meet goals (e.g., journals, space, activities, people, literature, agencies, interest groups, committees, funding)

3. Encourages independence and autonomy

   a. Encourages the mentee to reflect on own growth or achievements and future actions

   b. Questions, probes and guides the mentee to explore new perspectives and insights

   c. Knows when to provide direction and when to challenge the mentee

   d. Encourages learning from mistakes and/or disappointments

   e. Guides the mentee to avoid pitfalls and manage crises

   f. Guides the mentee to develop own leadership in practice

   g. Chooses an appropriate balance when contributing own experiences (i.e., good story-telling and metaphors), as relevant

   h. Guides the mentee to develop effective negotiation and conflict-resolution skills

4. Encourages the mentee in a process of visioning through free thinking, creativity and innovation, as relevant to the setting

   a. Challenges the mentee by offering new ideas, knowledge and practices

   b. Assists the mentee to enhance the quality of the professional practice environment and to initiate change, where relevant and possible

   c. Assists mentee to identify an alternate view of the future that may not be seen by mentee (i.e., looking at the "big picture", seeing beyond the details)

   d. Assists the mentee to identify patterns, themes and trends and to acquire new perspectives

   e. Encourages and supports the mentee in risk taking (i.e., in developing new knowledge, skills and innovations for the workplace)

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[12] This core component of the mentoring process is distinct, as an addition to the usual professional working role of the nurse. A development program for mentors that focuses on how to foster growth would be a helpful adjunct to this emerging role in nursing.

5. Facilitates the mentee's integration within the organization and larger professional community, as relevant to the setting
    a. Shares professional networks with mentee
    b. Helps the mentee navigate the system
    c. Shares informal rules
    d. Promotes the mentee by communicating their successes within the organization and the profession
    e. Shares ideas about opportunities for advancement
    f. Encourages the mentee to engage in professional leadership activities such as presentations, partnerships, specialty associations
    g. Acts as a champion for the mentee
    h. Solicits corporate (i.e., organizational) support for the mentee

Table 2: Comparison of Preceptorship and Mentoring[13]

	Preceptorship	Mentoring
Definitions While definitions for these concepts vary internationally, the definitions presented here are commonly accepted by most nurses in Canada.	"A frequently employed teaching and learning method using nurses as clinical role models. It is a formal, one-to-one relationship of pre-determined length between an experienced nurse (preceptor) and a novice (preceptee) designed to assist the novice in successfully adjusting to a new role. The novice may be a student or an already practising nurse moving into a new role, domain or setting" (CNA, 1995, p. 15).	"A voluntary, mutually beneficial and long-term relationship where an experienced and knowledgeable leader (mentor) supports the maturation of a less-experienced nurse with leadership potential (mentee)" (CNA, 1995 p. 15). "A mentor is someone who guides another individual in the development and examination of their own ideas, learning & personal and professional development … an advisor, coach, counsellor" (BC Academic Health Council, 2002).
Purpose	• Acquire new competencies • Develop competencies in relation to a new setting, client or domain of practice • Fulfil a requirement of senior nursing education program or new employees	• Foster professional and personal growth and effectiveness • Acquire particular competencies for a new setting or new role • Become socialized into the profession • Develop network and career
Type of relationship	• 1:1, professional • Formal, structured • Direct instruction and supervision through a shared workload for learning • Based on requirements of education program or employer	• 1:1, but can also be in small group • Informal and unstructured; can be more formalized • Guiding, advising rather than supervising • Reciprocal relationship directed by needs of mentee
Time frame	• Short-term (weeks) • Pre-defined by educational institution or employment setting	• Medium to long-term (months-years) • Determined by the average amount of time required in relation to the objectives
Level of recognition for the role model	Usually recognized at the unit level; sometimes recognized at the institutional level	Recognition may be informal/personal or, in formal mentoring programs, this may occur at the institutional level
Characteristics of role model	• A preceptor has mastered at least novice-level (beginner) competencies required by the participant. • Preceptors and preceptees are sometimes peers from the same work setting.	• A mentor is often recognized as expert in the field, at least as highly proficient professionals. • Mentors are usually older and more senior than the mentee. • Mentors and mentees may or may not be from the same work setting.
Participant characteristics	Participant is novice to the profession (senior nursing student or new graduate) or to the domain of practice or setting.	Participant is not a novice to the profession but may be a novice in relation to a role or set of skills.
Assessment and evaluation	Formal assessment and evaluation	Informal; may be more formalized within structured mentoring programs

13 This table is a composite of ideas based on recent literature, current examples of preceptorship and mentoring programs in Canada and the CNA experience in developing competencies for preceptors and mentors.

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Part VI:

Conclusion

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Conclusion

Preceptorship and mentoring programs are exciting avenues for stimulating professional growth, career development, staff morale and quality of care within nursing workplaces. As health care organizations compete to attract and retain a high-caliber nursing workforce, they will need to focus on providing quality practice environments.

The goal of CNA's Preceptorship and Mentoring Project is to foster the development of carefully planned and well-supported programs for new and experienced staff nurses in all domains of practice. This guide includes an overview and description of preceptorship and mentoring and suggests approaches for creating and improving programs. The extensive reference lists and examples of existing programs in Canada should provide practical support for agencies and individual nurses to start or fine-tune their own programs. Through a step-by-step process involving expert working groups and validation surveys, CNA developed the lists of competencies for mentors and preceptors published in the guide, offering a unique contribution to the advancement of this work.

CNA encourages staff nurses, educators, managers and decision-makers at all levels to use this guide as a foundation for building preceptorship and mentoring programs to help nurses define and achieve their goals. The benefits of these programs – improved quality of care, a sense of accomplishment, job satisfaction – demonstrate the value of preceptorship and mentoring in helping nurses take that vital step from maintaining competence to achieving excellence.

Part VII:

Further Reading

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Further Reading

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Appendixes

PHOTO: COMSTOCK IMAGES / GETTY IMAGES

Appendix A: Definitions

Buddy System

An unprofessional term referring to a relationship between an experienced nurse and a novice, in which the senior buddy is a resource person the newcomer can go to for advice or information on an episodic basis. The term buddy is best relegated to other venues.

Coaching

"Coaching", an idea derived from the world of sports, is most often used to describe an approach or strategy to foster development (especially skills learning) through positive, timely feedback. Coaching is an activity frequently carried out as part of the larger roles of educator, manager, preceptor or mentor.

Competencies

Competencies include, but are not limited to, knowledge, skills attitudes, values and judgments, as well as applied values and judgments required to practise nursing within a particular context, setting or role.

Cooperative Education or Work Study Programs

An education program offering students periods of work and study. This is not one-to-one teaching/learning, and students are usually paid during the work periods.

Externship

A period of concentrated practice for students who generally receive pay at ancillary rates – not necessarily one-to-one teaching/learning. Also referred to as an internship.

Internship Program

A formal program for graduates of educational programs, usually with paid positions, to help in the transition to work. While not necessarily one-to-one teaching/learning, the programs provide familiarity for recent graduate or experienced nurses new to the area of specialization.

Mentoring

A voluntary, mutually beneficial and long-term relationship where an experienced and knowledgeable leader (mentor) supports the maturation of a less experienced nurse with leadership potential (mentee).

Online Mentoring

Use of Internet technology (chat, e-mail, etc.) to carry out aspects of mentoring. Advantages of online mentoring include efficiency of communication, open correspondence and access to more geographically isolated regions.

Preceptorship

A frequently employed teaching and learning method using nurses as clinical role models. It is a formal, one-to-one relationship of pre-determined length, between an experienced nurse (preceptor) and a novice (preceptee) designed to assist the novice in successfully adjusting to a new role. The novice may be a student or an already practising nurse moving into a new role, domain or setting.

Role Modelling

A teaching strategy used in many situations, not necessarily a one-to-one relationship, in which the novice observes the practice of the master. This is an essential element of preceptorship and mentoring.

Transition Program

An in-depth program to assist the experienced nurse to acquire the competencies she or he required for subspecialty practice.

Appendix B : Orientation Topics

Many organizations have programs that assist preceptors and mentors to work effectively with participants within the work setting. Gillan (2000) has identified the need for standardized preparation courses to ensure that both participants get off to a good start. Some institutions have formal ongoing programs and have included sessions on the following topics:

1. The organization and its culture
2. All about the preceptorship and mentoring program
3. Principles of adult learning
4. Competency assessment
5. Goal setting
6. Identifying and working with people of various learning styles
7. Identifying, choosing, and practicing teaching strategies and clinical situations in relation to learning styles
8. Providing effective feedback
9. Motivating the participant
10. Conflict resolution
11. Use of program tools including assessment, learning objectives and evaluation documents

Appendix C : Resolving Conflicts Productively

When people's lives, jobs, pride, self-concept, ego, personality and understanding of purpose are involved, conflict is inevitable.

Causes of Conflict

- Poor communication
- Dissatisfaction with management style
- Weak leadership
- Lack of openness or willingness to share

Positive Outcomes of Conflict

- Leads to clarification of important issues
- Results in solutions
- Involves those for whom the issues are important
- Releases anxiety and stress
- Builds cooperation
- Shares resolutions
- Leads to understanding

Win-Win Approaches to Conflict Resolution

- Address the problem, not the individual
- Express feelings in a non-blaming way
- Take ownership of role in the problem
- Listen to the other person and see the issue from their perspective
- Identify underlying need
- Do not solve other person's problem
- Encourage different view
- Have honest discussion
- Focus on what can be done

Appendix D: Competency Rating Scale

DESCRIPTION OF COMPETENCY	RATING			INITIALS		ADDITIONAL COMMENTS
	3	2	1	Role Model	Participant	
Knowledge or topic area 1						
Skills or topic area 2						
Attitudes or topic area 3						
Values or topic area 4						

Explanations

1. The description of competencies means describing the knowledge, skills or personal attributes required for practice in a specific setting, specialty or domain. For example, conduct a catheterization (skill), describe admission procedure (knowledge), demonstrate willingness to be sensitive to culture (value) and describe the importance of life-long learning (attitude).
2. A rating of 1 is expert, 2 is acceptable and 3 is beginning or safe.
3. The initials column can be used where other practitioners are involved in competency assessment or if used in a cooperative program, it can be assessment from a teacher and then a co-worker.

Appendix E: Questions for Evaluating a Role-Modelling Experience

1. Did the experience meet your personal learning objectives?
2. How did you meet your personal learning objectives?
3. How was the process helpful?
4. What have you learned?
5. What can you do better? Why?
6. What hindered your learning? How could you have overcome this factor?
7. Describe how you plan to use this newly learned information?
8. What have you learned that will benefit your practice, clients and/or community?

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