DIFFICULT CONVERSATIONS AND PRECEPTING; COMMON THEMES AND BACKGROUND MEANINGS

By

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DIFFICULT CONVERSATIONS AND PRECEPTING; COMMON THEMES AND
BACKGROUND MEANINGS

Abstract

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The preceptor’s ability to give constructive feedback to the graduate nurse is an important factor in the successful transition from new graduate to staff nurse. The preceptor must be able to effectively communicate and give constructive feedback that motivates and promotes confidence in the new graduate nurse. The inability to effectively communicate around difficult topics, situations, or behaviors can lead to miscommunication, unspoken expectations, and a negative precepted experience.

This qualitative hermeneutic pilot study explores the categories of conversations that are difficult for preceptors to have with their new graduate and student nurses. Focus groups were conducted to identify what topics or situations were difficult for preceptors to address with their preceptee. The barriers and challenges encountered while trying to have a difficult conversation with the new graduate nurse and student nurse were also explored. The themes uncovered in this study indicate there are certain topics, behaviors and conversations that preceptors do not feel comfortable addressing with their new graduate or student nurse. The outcomes of not having these conversations were stressful precepted experiences, adverse patient outcomes and preceptees failing to complete the orientation or clinical rotation. Implications, limitations and recommendations for future research related to preceptors and difficult conversations are addressed.
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CHAPTER ONE

Introduction

There is an alarming rate of attrition today among new nurses which is affecting the ability of the healthcare system to care for patients. Literature suggests 35 to 69% of new graduate nurses leave nursing within their first year of employment (Hayes & Scott, 2007). Many reasons are cited for this attrition, but of interest is the idea that poor role transition from new graduate to staff nurse plays an important role in the dissatisfaction and consequent decision to leave the nursing profession. In a recent study looking at graduate nurse perceptions of the work experience, Halfer and Graf (2006) noted that the preceptor plays an important role in this process.

Key in assisting the new graduate nurse in transitioning to staff nurse and the student nurse to graduate nurse is the preceptor’s ability to effectively communicate and give constructive feedback that motivates and promotes critical thinking (Swansburg, 1996). Lack of feedback or feedback that is negative and ambiguous leaves the new graduate or student with a sense of confusion about what is expected and can erode self confidence. The new graduate or student’s success depends in part on receiving feedback from the preceptor that is specific, goal oriented, and presented in a non-threatening way. Giving effective feedback in this way allows the new graduate or student nurse to assimilate their mistakes as learning opportunities, increase their self confidence and their ability to act in a staff role (Byrd, Hood, Youtsey, 1997).

The quality of the precepted experience relies heavily on the preceptor’s ability to engage the new graduate nurse in activities that promote critical thinking, confidence, and allows for constructive feedback. Preceptors who lack the communication skills necessary to give...
constructive feedback can de-motivate and destroy the confidence of new graduate or student nurses (Swansburg, 1996).

There has been a significant amount of research done on why nurses are leaving the profession and some of it points to the quality of the precepted experience. The literature also notes there are certain topics or conversations in the medical field that are difficult, yet essential to have for positive patient outcomes. A nationwide study conducted by Vital Smarts, (Maxfield, Grenny, Mcmillan, Patterson, & Switzler, 2005) and the American Association of Critical Care Nurses (2005), identified conversational themes known as the seven crucial conversations in healthcare that are not only difficult to have, but are considered critical for healthcare providers to master. These conversations center on broken rules, mistakes, lack of support, incompetence, poor teamwork, disrespect, and micromanagement. Not having these conversations results in poor outcomes related to “medical errors, patient safety, quality of care, staff commitment, employee satisfaction, discretionary effort, and turnover” (Maxfield, Grenny, Mcmillan, Patterson, & Switzler, 2005, p. 3). Preceptors are likely to have their own “crucial conversations” (2005) that are difficult, yet essential to ensure positive outcomes for themselves, their patients, their peers, and their preceptee.

For those new graduate or student nurses who have a positive precepted experience, the transition to staff and graduate nurse may be more successful with less job related stress leading to better job satisfaction and retention. For the new graduate or student nurse that has a poor precepted experience, the transition to staff or graduate nurse may be a turbulent time resulting in the preceptee feeling unprepared to meet the challenges presented in their role as a staff nurse (Cangelosi, Markham, & Bounds, 1998).
Purpose

The purpose of this pilot study was to explore the common themes and background meanings of the difficult conversations preceptors have with their preceptees and to examine what outcomes may result from either having or not having these conversations. Preceptors reflected on their experiences and the outcomes of conversations that were difficult to hold with new graduate and student nurses.

Literature Review

A literature review using CINAHL, OVID, and Medline data bases was performed using the following key terms: nurse preceptor, new graduate nurse, student nurse, communication barriers, precepting, issues in precepting, communication challenges, new graduate nurse retention, conflict, conflict resolution, lateral violence, crucial conversations, and new graduate nurse role transition. The literature suggests there is a high correlation between a preceptor’s ability to effectively communicate and constructively give feedback and a new graduate nurse’s perception of a positive role transition and job satisfaction. Grif Alspach (2006) alludes to this correlation in her explanation of how the Synergy model applies to the new graduate nurse and preceptor. She suggests new graduate nurse outcomes may be improved when new graduate needs and preceptor characteristics match. This can also be applied to the student nurse.

Hardin and Kaplow (2004) define synergy as an emerging factor that stems from the interaction between a patient’s needs and a nurse’s characteristics. Synergy then is the defining characteristic that leads to better patient outcomes (Hardin & Kaplow). In adapting the Synergy model for use with the preceptor and new graduate nurse’s relationship, the graduate or student nurse is substituted for the patient and the preceptor for the nurse.
A new graduate or student nurse’s ability to progress in attaining practice goals partly depends on the consistent evaluation of the novice nurse’s practice. Communication of the new graduate or student’s strengths and need for improvement in specific areas is also crucial (Singer, 2008). When a new graduate or student nurse does not perform well, the nurse preceptor needs to provide specific and honest feedback to guide the preceptee in identifying more effective ways to practice (Singer, 2008). Hsieh and Knowles (1990) found communication skills to be a key element in the ability of the preceptor to develop a positive relationship with the new graduate or student nurse. When a positive relationship existed; feedback was more likely to be received by the preceptee in a positive way. However, communication skills have been cited in the literature as one of the areas where preceptors felt they needed more education. Marshall and Robson (2005) note that healthcare providers did not feel comfortable addressing conflict and often avoided discussions that may have led to conflict. This fear of conflict led to communication failures whose outcomes ran the continuum from lateral violence to patient errors. Nurses are included in the group of healthcare professionals who acknowledged that conflict was not only difficult to address, but their training did not provide the necessary skills to effectively deal with difficult conversations that may lead to conflict.

Exploring the themes related to difficult conversations preceptors are reluctant to address with their new graduate or student nurses, will direct future research into the preparation necessary for preceptors to develop communication skills necessary for the success of their new graduate or student nurses.

**Research Question**

What are the common themes among preceptors related to difficult conversations and the impact of having or not having these conversations?
Definition of Terms

Preceptor. According to the online Free Dictionary (2008), a preceptor is defined as “a teacher or an instructor.” The operational definition of preceptor for the purpose of this study is a nurse who is employed by an institution and is supervising, instructing and evaluating the performance of a new graduate nurse or nursing student.

New Graduate Nurse. The operational definition of new graduate nurse is a nurse who has recently graduated from nursing school and has been hired into a precepted internship in an acute care hospital.

Student Nurse. The operational definition of a student nurse is a nurse who is enrolled in a nursing program, currently completing clinical hours at an acute care institution under the supervision of a nurse preceptor who is employed by that institution.

Significance to Nursing

Past studies have indicated that more than 60% of medication errors are caused by mistakes in interpersonal communication. “The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) suggests that communication is a top contributor to sentinel events” (Maxfield, Grenny, Patterson, & Switzler, 2005, p. 3). The authors of the Silence Kills study suggest that there are categories of conversations that are difficult for healthcare workers to have, yet, essential to have if patient safety is to be maintained. The premise that being skilled at communication prevents medical errors translates to preceptors when you consider one of the main functions of a preceptor is to evaluate and coach the new graduate nurse by providing feedback on their performance. The inability to give constructive feedback in a way that promotes confidence in the new graduate or student nurse has been suggested to lead to poor role transition from new grad to staff nurse and student to graduate nurse (Halfer & Graf, 2006).
Despite the acknowledgement that being a skilled communicator is a necessary skill for nurses, the literature also suggests that nurses do not feel skilled in communication around certain difficult topics that may lead to conflict.
CHAPTER TWO

Method of Study

Study Design

In seeking to understand the difficult conversations between nurse preceptors and the new graduate or student nurse, an interpretive hermeneutic approach was used guided by the philosophy of VanManen. A non traditional phenomenological method for data collection using focus groups was chosen as it provided a time efficient way to gain knowledge from a purposive sampling and provided the researcher a way to observe interactions between participants which yielded data that interviews would not have provided.

There is much debate over how phenomenological studies should be implemented (Crotty, 1996; Mackey, 2005; McNamara, 2005). Husserl ascribed to the position that phenomenology is descriptive in nature and requires that the researcher suspend all bias (Van Manen, 1990). Heidegger and other philosophers such as VanManen veered from Husserl’s position viewing phenomenology as interpretive. Heidegger subscribed to a phenomenological approach which used the personal interview as the favored means to data collection. VanManen ascribes to the philosophy that phenomenology is interpretive, however his approach to gathering data is less prescriptive, and although he does not specifically describe focus groups as a way to collect data one can infer from his writings that this is an acceptable approach. “This is a methodology that tries to ward off any tendency toward constructing a predetermined set of fixed procedures, techniques and concepts that would rule-govern the research project” (VanManen, p. 29). VanManen surmises there are certain methods that are recognized as fitting well within the tenets of phenomenology but holds to the idea that just as the phenomena must be uncovered
or invented, the methods should also be discovered in response to the questions being asked

VanManen (1990) was concerned with gaining an in depth understanding of the world
around him or of a particular phenomenon before any reflection or interpretation occurred.
“Phenomenology differs from almost every other science in that it attempts to gain insightful
descriptions of the way we experience the world pre-reflectively, without taxonomizing,
classifying, or abstracting it” (p.9). Van Manen described this approach to human science as the
“study of lived or existential meanings; it attempts to describe and interpret these meanings to a
certain degree of depth and richness” (p.11).

Moustakas (1994) described the concept of noesis and noema refering to meaning. When
the researcher looks at something, a concept, idea, or behavior, what is percieved intuitively,
constitutes the meaning of the particular phenomena. Husserl described the process by which a
person percieves something and then attaches meaning or judgement as an unconsious process.
As the researcher looks at a phenomena, and then relooks at it, the reality of it’s existence is
synthesized in such a way that concealed meanings and perceptions form a comprehensive
meaning. Similarly, VanManen described noesis and noema as a part of the lived meaning.
“Noema denotes that to which we orient ourselves; it is the object referent of noesis. Noesis is
the interpretive act directed to an intentional object” (VanManen, 1990, p. 183).

The hermeneutic researcher gains information from exploring the meanings of
phenomena as they are experienced by an individual (Polit & Beck, 2004).The researcher is to be
a facilitator and acts as a guide to help the participants describe their experience. The researcher
then attempts to gain understanding from the participant’s meaning of the lived experience (Polit
& Beck).
Hermeneutics is a philosophy, but also a theory of the interpretation of meaning (Bleicher, 1980). Hermeneutics, as defined by Van Manen (1990), is the theory and practice of interpretation perceived as a necessary element when the possibility of misinterpretation exists. Hermeneutics is both descriptive and interpretive as Van Manen purports there is nothing in existence that is uninterpreted. Therefore, a hermeneutics approach lends itself to the understanding that phenomena can only be understood within the context from which it arises and only from those with direct experience.

To understand the context from which a phenomena arises, Van Manen uses themes as a way to describe and interpret a lived experience. “In order to come to grips with the structure of meaning of the text it is helpful to think of the phenomenon described in the text as approachable in terms of meaning units, structures of meaning, or themes” (Van Manen, 1990, p. 78). He described a theme as being more than a characterization of a concept that occurs frequently, but rather, a concept that identifies the structures of experience. The researcher, when exploring themes, is to ask the question, “How do themes come about?” The researcher then reconciles how the theme correlates with the phenomenon.

Van Manen’s assumptions pertaining to themes arising from experiencing the phenomena were central to the methods used in this study. Van Manen’s (1990) assumptions are as follows: (a) themes are the meaning or point of what is experienced; (b) theme formulation is at best a simplification; (c) themes are intransitive and do not exist as an object, moment or thing; (d) themes are a form used to capture the phenomenon one seeks to understand. Using Van Manen’s principles, themes were used to gain a richer understanding of the preceptor’s lived experiences related to difficult conversations.
The aim of this study was to explore: (a) common themes and background meanings of difficult conversations between preceptors and new graduate or student nurses, (b) the context within which difficult conversations exist, and (c) the implications for the preceptor and new graduate or student relationship.

Population and Sample

Preceptors attending two different sessions of an Oregon Consortium Nursing Education (OCNE) state wide training session were invited to stay after the training to participate in a focus group examining the conversations that were difficult to have with preceptees. Participants were Registered Nurses (RNs) and had been preceptors for at least two years.

Data Collection Procedures

Prior to beginning each focus group, participants were informed of the purpose of the study, their rights and role as participants, and were given an opportunity to ask questions. Written consent was obtained prior to data collection. Focus groups containing 4-6 nurse preceptors, one nurse researcher, and one transcriber were conducted. The sessions were tape recorded. The first focus group met for approximately one hour. The second focus group lasted an hour and a half. The first focus group met at local hotel and the second group met at a hospital institution.

Participants in the focus groups were asked to tell their stories in response to the questions posed by the researcher. Narrative methods were used to help the participant focus on their story as the object of inquiry, to allow the researcher to glean the layers of meaning from each participant’s lived experience. Narrative research involves the process used by individuals to make sense of the everyday events in their lives. “What distinguishes narrative analysis from other types of qualitative research designs is its focus on the broad contours of a narrative” (Polit...
& Beck, 2008, p. 236). As the participants described their experience, the researcher clarified their meanings by rephrasing, and/or verifying the concept, or theme that was being made known.

The focus group participants were asked the following major questions: (a) Has there been a situation or a time when you had to talk with a new graduate or student nurse that was difficult for you or you felt intimidated to have a conversation about something that was not going well? Can you tell me about that? (b) What kinds of topics are difficult for you as a preceptor to talk about with your new graduate or Student? The focus group participants were then asked the following sub questions: (a) Can you describe what happens when you have these conversations and they don’t go well? What are the outcomes for your unit, for the new graduate or student, and for you? (b) Do you feel supported in the training you get to assist you in having these conversations?

The focus group sessions were tape recorded and a transcriber wrote the participant’s answers to the questions on flip charts during the sessions. Before moving on to another question, the researcher confirmed with the participant that what was written was the meaning or intent of the participant.

Data Analysis

The audio recordings and the data recorded on the flip charts were transcribed verbatim by the researcher. Transcripts of the data were reviewed by the researcher and an analysis team consisting of two nursing professors, and one graduate student. A preliminary theme reduction was performed by reading through the transcripts and taking notes on the elements or ideas that presented frequently among the participants. A thematic analysis was then performed by the analysis team who discussed the interpretations of each team member to form a richer
understanding of the phenomena being studied. The researcher and analysis team then reread the text several times until consensus about the common themes was achieved.

Credibility

Sandelowski (1986) noted that qualitative research is often criticized by those who perceive qualitative methods as being less rigorous than quantitative studies and points out that qualitative methods are often seen as inadequate when evaluated using the scientific rules for achieving reliability, validity, and objectivity.

The aim of phenomenological research is to understand a phenomenon as it is experienced by those living it. The methods to achieve this understanding to do so are as diverse within phenomenology as to make one set of criteria for rigor inadequate for application to all methods of inquiry (Sandelowski).

Truth value in quantitative research deals with how well threats to internal validity are managed. When there is confidence that the findings of a study are consistent with what is being studied and not the research procedure itself, then it is accepted that there is internal validity or truth value (Sandelowski). Truth value of a qualitative design is found in the discovery or exploration of the human experience as it is lived and perceived by the individual; the data is subjective in nature. Guba and Lincoln (1989) suggest using credibility instead of validity as the measure by which a qualitative study demonstrates truth value. Credibility is said to be expressed when the descriptions or interpretations of a study are recognized by others not involved in the study as being familiar or pertinent in the context of their own experience with the phenomena. Nurse preceptors not involved in the study read the data and interpretations and recognized similar themes in the context of their experience. Threats to credibility include the closeness of the investigator-subject relationship, making it necessary for the researcher to address their own
biases, behaviors, and experiences in relation to the subjects (Sandelowski, 1986). For over 15 years, I have worked with new graduate nurses and preceptors and found it difficult to keep with the original premise of the questions identified at the beginning of the study. For example, I had difficulty staying with the question as it was first proposed to the group when the answers I was expecting did not surface. For instance, as I asked, “What conversations as a preceptor do you find difficult to have with your new graduate or student?” some of the answers were superficial and were directed towards tasks. It was difficult for me not to probe with leading questions as I wanted them to answer in a way that validated my own experiences as a preceptor. Being aware of this bias, I had to really pay attention to the questions I was asking and allow the participants story to unfold. My bias was similar to that of the preceptors suppositions that it was often difficult and sometimes felt “not worth it” to have certain conversations for all the reasons that were identified in the data.

External validity is commonly addressed in quantitative studies to ensure representativeness and generalizability of findings. To do this quantitative researchers often use random sample selection and random assignment to experimental and control groups. This method does not fit well within the context of qualitative research as it is necessary to choose subjects who have experience with the phenomena being studied, therefore samples in qualitative studies may not be representative (Sandelowski, 1986). To this end, Guba and Lincoln (1981) suggest fittingness as the criteria for judging the applicability. “A study meets the criterion of fittingness when its findings can ‘fit’ into contexts outside the study situation and when it’s audience views it’s finding as meaningful and applicable in terms of their own experiences” (p. 242). To address fittingness, the researcher used two groups consisting of three preceptors, each from a local hospital institution to review the data and interpretations. They were then asked if
the themes and situations described were consistent with the preceptors own experiences of difficult conversations. All participants from both groups expressed familiarity with the themes in their own experience as a preceptor in working with new graduate nurses and students in addressing difficult conversations.

Reliability in quantitative studies refers to “the consistency, stability, and dependability of a test or testing procedure (Sandelowski, 1986). Reliability also refers to the concept of repeatability of study results which adds to credibility of research findings, thereby enhancing generalizability of the study. Reliability in quantitative studies relies on the assumptions that the researcher can replicate testing procedures without affecting the variables being studied. Qualitative research aims to seek out variations in the very experiences or phenomena being studied, which often make replication unrealistic. Auditability is proposed by Guba and Lincoln (1981) as better criteria to evaluate reliability. Auditability is present when another researcher can clearly see the path or “decision trail” used by the investigator to carry out the research. Step by step articulation of how the study was conducted, with progression of events that leads to conclusions and findings, were kept in the notes of transcripts and subsequently help to exhibit auditability.

Human Subjects Considerations

The study was reviewed by the Institutional Review Board at Washington State University and certified as exempt prior to data collection.
CHAPTER THREE
Findings and Discussion

Sample Characteristics

A total of eleven nurses from around the Portland Metropolitan area in Oregon participated in two focus group sessions. All participants were female, nurse preceptors, and had been a registered nurse for at least two years.

Analysis of transcript interviews revealed five common themes related to what made conversations difficult: (a) avoiding being a bad guy, (b) feeling powerless, (c) it’s me, (d) managing difficult attitudes, and (e) feeling unprepared. These themes, their meanings, and the outcomes associated with not having the difficult conversations that were identified as being difficult are presented here. Dialog from each preceptor is labeled by P with a number, x indicating focus group one, and y indicating focus group two.

Research Questions One and Two

What are the common themes among preceptors related to difficult conversations and the impact of having or not having these conversations?

Avoiding being the bad guy

Preceptors in both focus groups identified being perceived as the “bad guy” as a barrier to speaking up and having conversations with their new graduate nurse or student. Conversations that might hurt the preceptee’s feelings or have the potential to result in the preceptee perceiving the preceptor as unkind were often avoided. P1x experienced this as she was working with a student who was teaching a patient. The preceptor noticed that the student missed some key points that needed to be explained to the patient and attempted to add the key points to the discussion. The student became frustrated and defensive saying things like “I was going to say
that.” When asked what specifically made that conversation difficult for the preceptor and why the preceptor did not address the defensive behavior with the student, P1x responded:

I didn’t want to hurt her feelings. I had seen how she reacted in the room when I corrected her, although I wasn’t really correcting her, I was just adding to what she was telling the patient in a way I felt was non-threatening, so I was unsure how she was going to react outside the room.

P2y echoed P1x’s feelings, stating:

I do ICU internship programs, and what you find is we all want to be friends with our interns. And sometimes evaluating and confronting them on some of these issues is really a problem because you want them to like you, and they want you to like them.

Another participant noted that “Everybody wants everybody to love them.” (P3y)

I tried to get to the heart of this concept by asking, “So am I hearing that another theme may be that it’s not worth having some of these difficult conversations if nothing is going to come from it?”

P4x stated, “Oh absolutely.”

P2x added, “You know it’s not going to go anywhere, you might as well not deal with the pain and anguish of having it.”

P4x, “Yea, why be the bad guy?”

Other focus group members indicated agreement with these comments by saying “yep,” “uh huh,” or by nonverbal cues such as head nodding.

Being perceived as the bad guy was a deterrent to having difficult conversations around sensitive topics. The desire to be liked by the preceptee and to have a good relationship often overrode the desire to initiate difficult conversations.
Feeling Powerless

Powerlessness was expressed when preceptors did not feel supported by leadership. This was demonstrated when a preceptor recommended extending or terminating a preceptee’s learning experience. When leaders did not follow through with decisions congruent with the recommendations given by the preceptor, a feeling of “why bother?” followed.

P6x stated:

I had a situation with a night nurse that had multiple safety issues with the patient. I went to my charge nurse and my charge said I had to go to my manager. The manager said to write it down. Well, I wrote it down and about a year later it came back to me that the manager had let it out that I was the one who had said something. Now this nurse won’t even talk to me. So, it’s easier just to let some things go rather than hold them accountable because some things will come back to bite you.

This statement also demonstrated a violation of trust. When trust is violated, especially by those in leadership positions, a feeling of powerlessness can result.

P5x gave the following example of the consequences of feeling powerless: “It’s easier to just brush it under the rug. Especially, if they [management] are aware of the issues and there is someone there to plug the staffing hole.” Powerlessness was expressed when the preceptors efforts were not supported. Management may have put their own needs, in this case staffing needs, as a priority over the preceptor’s concerns. The risk of having a conversation that placed the preceptor in the position of being the bad guy, when not supported by leadership led to a sense of powerlessness. Preceptors not only felt powerless to influence management decisions but they also felt powerless to influence the preceptee’s performance. P6y expressed a sense of
powerlessness when describing her experience in giving feedback to a preceptee about inappropriate body language.

So when you try to give them feedback about their attitude, their behavior, or their comments, their rolling of the eyes, it doesn’t seem like they really even care that you are trying to say that this is unacceptable. And then it ends up being, “well, I guess there is nothing I can do.” In addition to feeling powerlessness over influencing management decisions and individual preceptee behaviors, preceptors noted that when unit staff did not support their precepting efforts they also felt powerless and alone.

P3x, “I think they support you, but maybe they (referring to the other staff on the unit), are not willing to put the same time and effort into it when there is a problem, because it is easier to ignore it, and then I do feel alone.”

When the preceptors discussed why they felt their colleagues did not support them, they talked about their colleagues sharing the feeling, that it was not worth it, was too much trouble, and was often easier to just ignore poor performance and do their job. This led me to think that powerlessness was not just an issue for the preceptor, but an issue for the culture of the entire unit, which affects the preceptors’ ability to initiate difficult conversations.

I asked, “So, what would make it so that you would feel empowered to have those conversations directly with the individual you have an issue with? What would the unit culture or circumstances look like for you? P1x discussed having a unit culture where it was the expectation rather than the exception that everyone had these conversations as issues arose: Sometimes, what I think would make having these conversations easier are if everyone on the unit would have these conversations. Like me when I am following someone and
their charting is not done, and I tell them, “your charting is not done” instead of everybody groaning after she is gone.

Feeling powerless was a deterrent to preceptors having difficult conversations with their preceptee. Those preceptors who felt powerless to influence management decisions, individual preceptee behaviors or peers felt unmotivated to step up to difficult conversations.

“It’s Me”

Preceptors in both focus groups often second guessed their own perceptions and observations when a new graduate or student was not succeeding. They attributed preceptee behaviors such as not retaining information, or displaying disruptive attitudes to their own inadequacies as preceptors. Because some preceptors lacked confidence in their abilities and believed that any failure on the part of the new graduate or student was their fault, they often gave the new graduate or student multiple chances to improve without having direct discussions about what the problems were or how to improve their performance. P2y, when describing a difficult preceptee that was eventually terminated due to not being able to follow instructions expressed a feeling of the behavior as being somehow her fault. “I thought, ‘Oh, it’s me; I’m just not the right person with this intern.’”

Others expressed similar sentiments. P3y described feeling that when the problem is not related to specific tasks but relates to personal qualities or behaviors, giving feedback gets too personal.

But when it comes to actual personality issues, for me is a lot harder to address, then it gets really personal. I think for me that is where I kind of shut down, maybe it’s me, my own insecurity.
Preceptors who felt they were the reason their preceptees were not succeeding often sought other preceptors to take over for them. They described feeling that perhaps someone with “better skills” or “more experience” might do better. P2x described feeling that her lack of skill as a preceptor might be the reason her preceptee was not “getting it:”

It was a basic issue of the preceptee not being able to recall something that had just happened. Maybe I wasn’t asking the right questions, or maybe I wasn’t guiding her the right way. Maybe I’m just not doing it right, so that if someone else does it, she will just need more time.

Preceptors torn by their own insecurities about guiding the new employee also struggled with determining whether an issue was a “personality clash” or a professional practice concern. In addition some wondered if their actions might have long term repercussions. P5x described feeling a sense of overwhelming responsibility for the preceptee’s success; wondering if “Am I going to ruin this person for life?”

Managing Difficult Attitudes.

Preceptors in both focus groups expressed angst when having to deal with preceptees who had “attitudes” perceived as difficult. These attitudes ranged from not listening, behaving as if they knew it all, and body language conveying disrespect, to inappropriate or unprofessional behaviors. Many of the behaviors associated with difficult attitudes described by the focus group participants such as eye rolling, defensive tone of voice, closed body language, and interrupting were noted as barriers to having difficult conversations.

P1y expressed concern over a preceptee with what she felt was a “know it all” attitude.
I had this one preceptee who came to our floor feeling like he knew everything. Every time I would confront him and say, “Maybe we should do it this way” or ask him to repeat a skill, he had this attitude of “I’m better and I already know it.”

As I probed to understand why this was difficult for this particular preceptor, she continued to tell her story, “It was the way he presented himself to me, and his attitude was, ‘well, it didn’t get done, so I guess it doesn’t have to get done.’ He just made it seem like it’s not a big deal.” When asked if this particular preceptor had a conversation around the preceptee’s attitude, she said, “no” and said that she continued to talk to him about the task. The attitude never got addressed.

P2x described a similar situation; although her experience included feeling intimidated when the feedback led to confrontational behavior:

I can’t even remember if we sat down and had a conversation about it, she was very confrontational. She did not take feedback well at all, and so it’s hard to give feedback to someone even if you’re trying to be positive, like how do you put a positive spin on this one, I’ve got someone who already has their hackles up. I think that was more of a deterrent than “how can I say this,” but rather, “how can I say this without being jumped on.”

It was clear in talking with the preceptors from both groups, that it was much easier for them to center their discussions around task performance and not behaviors that were perceived as disruptive or confrontational. P5y told the group about a preceptee who she thought acted unprofessionally. She described the preceptee as engaging in conversations containing inappropriate sexual content with both patients and colleagues.

How do you say, “Stop acting like an 8th grader? This is not professional.” This was not comfortable to talk about. People around her would say things like: “Where is the bar? I
don’t see one” because they felt she was saying things that would only have been said in a bar.

Several of the other preceptors in the group commented and this led to a discussion about unit cultures that they felt contributed to a reluctance to speak up. Participants saw “where is the bar” as a passive aggressive statement that was not confronted resulting in the entire staff enabling the behavior and colluding in not addressing the issue directly. Ultimately, no one on the unit felt safe having a direct conversation around behaviors or attitudes that were described as unprofessional.

Another preceptor gave the example of a student who wanted to do the technical aspects of her work such as starting IVs or medication administration but didn’t want to do the hands on work such as bathing or toileting of the patients. When the preceptor tried to address this the student became defensive in her body language, “she rolled her eyes, turned her head, twitched, and kind of looked like she was ignoring me” (P5y). I tried to clarify what the problem was by asking, “So help me understand, once it gets to behavior, stepping up to the conversation around the behavior is difficult?”

P6y shared that talking about tasks was much easier than talking about the preceptee’s behavior and that often if you addressed the preceptee behavior it did not necessarily mean things would get better.

It is easier to say, you took that blood pressure wrong and this is how you do it versus you have a bad attitude and you need to fix it. So when you try to give them feedback about their attitude, their behavior, or their comments, their rolling of the eyes, it doesn’t seem like they really even care that you are trying to say that this is unacceptable. It ends up being “well, I guess there is nothing I can do.” This example demonstrates the
preceptors’ frustration with feeling it is not worth being the bad guy if nothing is going to change in the end.

Preceptors in both groups described situations where they explained in detail a certain concept or procedure to the preceptee and then found themselves a short time later re-explaining the same concept again as the preceptee did not retain the information. Some preceptors felt this was related to an uncooperative attitude. Some expressed concern that it was related to an attitude of “I don’t have to listen, or I don’t care what you have to say.” P2x expressed it as the “etch a sketch syndrome:”

I had a student; I was actually her 2nd or 3rd preceptor, where by the time she got to me I had heard things in the background. She didn’t seem to understand what these other preceptors were saying. She had nailed everything when she was with me, and then the next day, she would come back and it was like starting all over again. It was like a new slate, I called it the etch a sketch syndrome cause she would come back and it was all gone.

When behaviors were puzzling or seemed to result from attitudes rather than knowledge or skill, preceptors found holding crucial conversations more difficult. Adding to their reluctance was a sense that the preceptors had not been provided with the training necessary to do the job.

Feeling Unprepared.

There was a consistent feeling among members of both focus groups that the training they received from their institutions was not sufficient to meet their needs as a preceptor. P4y stated, “As preceptors there is little or no training.” P5y added to this conversation, “I did take a four hour class, after I had precepted two or three people, and I was like “oh there is a class?” P1y agreed:
I got my first orientee as a new hire and they just said, “This person is coming, you are going to work with them this day and this day and there you go. I had no idea what to do, they gave me a little packet, and it just had a little half page blurb about what a preceptor is supposed to do, and a little thing I was supposed to fill out about the preceptee and turn in at the end and that was it.

Other comments from the group about training included, “stark,” “helpful, but not enough.” P5x stated that having training classes that centered on how to have these difficult conversations would be helpful. “I like the idea of more training on conflict resolution or how to have difficult conversations. It does feel like practice or role play would be helpful.”

Poor Outcomes

Preceptors in both focus groups identified poor outcomes associated with having a difficult conversation that did not go well, as well as poor outcomes associated with not having the difficult conversations at all. These outcomes included: deterioration of preceptee relationship, inability of the preceptee to progress, ineffective teaching/learning environment, lack of preceptor confidence for future precepting, and patient errors.

There were multiple factors that caused deterioration in the preceptor/preceptee relationship. The “etch a sketch” syndrome, as described previously, was an attitude that was perceived by the preceptor as an intentional way to dismiss or disregard what the preceptor was trying to tell the preceptee. This perception led to the preceptor feeling that they could not trust the preceptee and resulted in a damaged relationship where the learning environment was described as stressful. The focus group participants acknowledged that sometimes they wondered if this was due to preceptee stress, however, on some occasions, it seemed as if the preceptee just didn’t care enough to pay attention. The preceptor described knowing something was “amiss”
when the preceptee was not able to recall information the preceptor had just gone over, but the
preceptor couldn’t put her finger on it. P2x stated, “It’s like there was something wrong, but I
didn’t know what it was.”

All preceptors recognized that when they did not address behaviors or topics they
considered were difficult the result was a deterioration of the preceptor/preceptee relationship.
This was reflected in a deterioration of the teaching/learning environment, and could lead to the
preceptee not progressing. P3y stated, “It kind of puts a wedge in-between you, where you have
that elephant in the room kind of thing where it’s like, well, this conversation didn’t go well,
there was no resolution, and yet it’s still there.” This sentiment was common through both focus
groups. One preceptor said, “I don’t feel they succeed as much.”

When the discussion didn’t go well and there was no resolution; the preceptor felt this led
to the development of mistrust on the part of both the preceptor and the preceptee. Distrust in
turn made it difficult for the preceptee to freely ask questions and could lead to isolation. P3y
stated:

When they put themselves in that defensive mode when you are trying to address an
issue, and you say, “what can I do to help you” and they say, “nothing, I’ve got it” then
they kind of isolate themselves from others and their career is a lot rockier in the
beginning, they’re not willing to ask for help when they are drowning or overwhelmed.

When asked, “What are the outcomes when you try to have these conversations and they
don’t go well?” one preceptor commented that difficult conversations became more difficult for
her to address in the next preceptor/preceptee relationship. P6y explained:

You’re reluctant to have them [conversations] again, because it didn’t go well the first
time. The relationship deteriorates and if the behavior does not get resolved and just goes
on then no good comes of it. So then I take that bad experience into my next 
preceptor/preceptee relationship and this does not help me be a better preceptor. That 
experience makes it difficult to step up to a conversation the next time.

Patient errors were also described by preceptors as being a poor outcome resulting from 
not initiating difficult conversations. P2x illustrated how not having a difficult conversation led 
to a patient error:

I think that she went on to more preceptors after me, even thought I said that she was 
defensive. The poor outcome was that she did make a huge error, and all four preceptors 
had a hard time stepping up and saying this was a problem. We all recognized it was a 
problem, but weren’t sure how to approach it. Finally a nurse said, “This is an error” and 
we recognized that this was an error that was largely in part due to us not being able to 
step up and point these kinds of things out earlier.

Positive outcomes were noted when preceptors did hold difficult conversations, that went 
well, and where issues were resolved. Preceptors noted that they were able to move on and 
address learning needs more efficiently. Preceptees were more likely to succeed during the 
precepted experience, and some noted that the positive relationship they cultivated during the 
precepted time carried over into the peer relationship once the preceptee became a staff member.
Positive outcomes for students were associated with a better learning experience and a better 
preceptor/student relationship that led to a better chance of the student wanting to apply to the 
unit after graduation and to being hired as a staff once they had graduated.

The themes uncovered in this study indicate that there are certain topics, behaviors and 
conversations that preceptors did not feel comfortable addressing with their new graduates or 
student nurses. The outcomes of not having these conversations were stressful precepted
experiences, adverse patient outcomes, or preceptees failing to complete the orientation or clinical rotation. When the preceptors avoided important conversations, failed to provide clear feedback or the interaction was ineffective, some preceptors questioned their competency as a preceptor. Other barriers to addressing important issues with preceptees arose from preceptors feeling powerless to influence management decisions about new employees, lack of support from unit peers, and lack of preparation for the preceptor.
CHAPTER FOUR

Introduction

The purpose of this pilot study was to explore the common themes and background meanings of difficult conversations preceptors have with their preceptee. This study additionally examined outcomes associated with having a difficult conversation that did not go well, as well as poor outcomes associated with failing to hold the difficult conversation at all. In this chapter, implications, limitations and recommendations for future research are discussed.

Discussion

When exploring the themes behind difficult conversations preceptors had with their preceptees, this study uncovered five themes that contributed to making conversations difficult. The categories of difficult conversations included (a) avoiding being a bad guy, (b) feeling powerless, (c) it’s me, (d) managing difficult attitudes, and (e) feeling unprepared. Avoiding being the bad guy not only dealt with not wanting to hurt other’s feeling but also the perception that being perceived as the bad guy could lead to conflict that the preceptor was not comfortable addressing. The phenomenon of avoiding conflict as described in this study as being perceived as the bad guy is supported in the nursing literature as common not only to nurse preceptors but to healthcare workers in general. Communication skills are noted in the literature as essential to have as a healthcare provider. The American Association of Critical Care Nurses have indicated that being a skilled communicator is as essential to nursing practice as is being clinically competent (AACN, 2007). Yet, the results from the landmark study, *Silence Kills* indicates that less than 10% of those in the healthcare field confront behaviors in their peers that are likely to lead to conflict. Other studies (Sheldon, Barrett & Ellington, 2006) have indicated that nurses...
often use avoidance or what they term as “compartmentalization” as a coping strategy when dealing with negative emotions or difficult communication.

Preceptors described unit environments where nurses who took the risk of being the bad guy were not supported by leadership and colleagues. This culture resulted in nurse preceptors feeling that their efforts to provide evaluative feedback were “not worth” making. This in turn led to a sense of powerlessness. Geradi (2004) noted similar responses in that nurses do not address concerns with their peers due to an inability to confront another person and the belief that conversations of this type don’t do any good. Nurses or preceptors who feel powerless to effect change, are less likely to initiate a conversation they view as being difficult or that has the possibility of leading to conflict.

Another factor contributing to reluctance to hold difficult conversations was demonstrated by preceptors who did not trust their own judgments and were worried that their peers or leadership might not agree with their assessments of their new graduate or student nurse. Cleland, Knight, Rees, Tracey, & Bond, 2008) speak to this issue when they address the concept of failure to fail. The authors note that one of the barriers to failing a student when disruptive behaviors exist or when performance is poor has to do with the preceptors anticipation of the preceptees negative reaction to their feedback. Fear that their perceptions and consequent evaluation of a student will be scrutinized and negatively judged by peers and leadership were a deterrent to initiating conflict prone discussions.

Some of the categories identified in this study were similar to those found in the Silence Kills study (Maxfield, Grenny, McMillan, Patterson, & Switzler, 2005), Although the themes of difficult conversations for preceptors were different, two of the preceptor themes including feeling powerless, and managing difficult attitudes had similarities with the silence kills
categories of “Lack of Support” and “Disrespect.” Lack of support was described in the *Silence Kills* study as peers displaying behaviors that were inconsistent with supporting each other’s workload when they needed help or complaining when having to do so. Preceptors similarly described feeling powerless when peers and management acted in ways they felt did not support their precepting efforts. Disrespect was described in *Silence Kills*, as behavior that was condescending, insulting, or rude. (Maxfield, Grenny, McMillan, Patterson, & Switzler, 2005). Managing difficult attitudes which included these behaviors was identified by preceptors as a key barrier to having difficult conversations with new graduate or student nurses. Preceptor examples of the ways disrespect was conveyed by preceptors included voice intonation, body language such as rolling of eyes, or not listening. Preceptors when probed as to why having conversations that addressed disrespectful behavior was difficult noted fear as a barrier; fear of not being liked, fear of ruining the preceptee’s career, fear that their own incompetence as a preceptor was the real reason their new graduate nurse or student was having difficulty.

Marshall and Robson (2005), in an article that cites several different research studies related to conflict state that “a culture of fear is a culture of conflict” (p. 39). The authors note that unresolved conflict is a common problem in the healthcare industry which leads to anxiety, mistrust and eventually communication failures, lack of teamwork and poor patient outcomes (2005). The idea that fear leads to conflict supports the notion that preceptors who fear certain outcomes, conversations or situations are more likely to avoid conversations that could be confrontational. Avoiding important but difficult conversations allows problems to persist, and delays conflict, often making situations worse (2005). Many of the behaviors in this study associated with difficult attitudes described by the focus group participants such as eye rolling, defensive tone of voice, closed body language, and interrupting were also noted as barriers to
having difficult conversations. Pugh (2005) describes these same behaviors as lateral violence and states that these types of behaviors are common in the nursing profession (Pugh, 2005-6). Lateral violence is a term defined in the nursing literature as “physical, verbal or emotional abuse of an employee” (Center for American Nurses Statement of Position, 2008). Rowell (2007) described lateral violence as “any inappropriate behavior confrontation, or conflict- ranging from verbal abuse to physical and sexual harassment between coworkers” (Rowell, 2007). Other studies (Johnson, Rea, 2009) expand the definition of lateral violence to be a one time behavior and describe workplace bullying to be lateral violence that happens over a period of time. Behaviors that are included in the definition of lateral violence and workplace bullying are noted to be subtle and include such actions as (a) withholding information that affects a persons performance, (b) being ignored or excluded, (c) being shouted at or being the target of spontaneous anger, (d) spreading of gossip and rumors, (e) persistent criticism of your work and effort and (d) repeated reminders of your errors or mistakes. These behaviors not only affect preceptors, but the nursing profession in general. At one institution on the East coast it was estimated that before preventative measures were taken, sixty percent of nurses left the institution within six months of their hire date due to behaviors consistent with those described as difficult attitudes by this study’s focus group participants (Bartholomew, 2006). Consistent with the literature, preceptors are likely to experience burnout as a result of experiencing and not being able to resolve behaviors associated with difficult attitudes.

Preceptors in both focus groups described doubting their own judgments and their assessment of their preceptees. This self doubt was themed “It’s Me” and described the experience of preceptors who assessed their preceptee as not performing up to standards, but did not have faith in their own judgment and allowed the preceptee to pass the precepted internship
even though the preceptor felt there were issues with the preceptee’s performance that warranted termination or placement on a different unit. Lack of confidence is described in the literature as being common to educators and preceptors. Educators or preceptors may not feel comfortable addressing performance issues because they lack confidence giving negative feedback, feeling like they do not have the skill necessary to give negative feedback effectively, and the sense that it is the preceptor who is at the root of the underperformance (Cleland, Knight, Rees, Tracey, & Bond, 2008). Duffy (2005) in a study that examined factors that influence decisions regarding assessment of students’ competence to practice, noted that nursing professors often give students the benefit of the doubt despite their observations of the students’ poor performance; in doing so, they perpetuate their feelings of self doubt and their own judgments. Lack of the instructors faith in their ability to balance conflicting roles as supporting versus assessing were other factors that added to the sense that the student’s poor performance was a reflection of the instructors ability to teach (Cleland, Knight, Rees, Tracey, & Bond, 2008).

Perhaps the most concerning outcome from not initiating a difficult conversation was identified by preceptors in this study as patient errors. Preceptors recognized that not addressing certain preceptee behaviors had the potential to lead to poor patient outcomes or errors. This is not surprising and is consistent with the *Silence Kills* (Maxfield, Grenny, McMillan, et al. 2005) finding that sixty percent of all medication errors are a result of some type of communication failure.

Skillfully dealing with difficult conversations requires learning and practicing effective communication strategies. Many preceptors however, lack the training, skills and confidence, to engage in difficult conversations. Avoidance is one of the common ways nurses deal with conflict and can be the cause of stress between staff/preceptor and preceptee (Speers,
Strzyzewski, & Ziolkowski, 2004). Preceptors in both focus groups described feeling a lack of preparation to precept especially when precepting required them to engage in conversations that were perceived as difficult or likely to lead to conflict.

Limitations of Study

Purposive sampling was used to select participants for this study, and while this method has its strength in providing for a representative sample of the total population and informs the study by providing data from a sample that has specific knowledge of a particular phenomenon, this method could be viewed to lend itself to selection bias. The small sample taken from a single location is another limitation. Since this was a pilot study designed to obtain a description of the phenomena associated with difficult conversations among preceptors and preceptees further research to deepen and broaden understanding of the experience is needed. Research that looks at difficult conversations from the preceptee’s experience might also give a fuller picture of difficult conversations experienced in the preceptor and preceptee relationship.

Conclusion

This pilot study uncovered themes of difficult conversations preceptors have with their new graduate and student nurses and the meanings of those themes. Similar to other communication studies (Maxfield, Grenny, McMillan, et al., 2005; Sheldon, Barrett, & Ellington, 2006), communication or conversations that nurses believe may potentially lead to conflict are often avoided, thereby causing persistence or escalation of problems. The outcomes of preceptors avoiding these difficult conversations with their preceptees can result in deterioration of preceptee and preceptor relationship, inability of the preceptee to progress, ineffective teaching/learning environment, lack of preceptor confidence for future precepting, and patient errors.
The findings confirm many of the outcomes identified within nursing and healthcare literature that identify communication failures to be at the root of unhealthy work environments, medical and patient errors, and new graduate nurse burnout.

Nurses and nurse preceptors are being called to accept as their professional responsibility the need to not only be clinically competent, but also skilled communicators. For nurses to embrace this responsibility, it is important for nurses to recognize the path and the barriers to becoming a skilled communicator.

Recommendations arising from this study have particular implications for the planning and delivery of nurse preceptor curriculum, the supportive role of nurse managers for preceptors and the practice of nursing in general. Recommendations related to education, management, research and practice are included.

**Education**

Generally and traditionally, basic preceptor curriculums have focused on how to facilitate knowledge transfer, socializing the preceptee, role modeling professional behaviors, concepts related to adult learning theory, generational differences and how to give feedback. More complex communication strategies for giving feedback are not usually integrated into basic preceptor curriculums, but presented as part of advanced skill development programs. To improve nurse preceptor preparation, educators should ensure that communication training begins in the basic courses and continues to be developed as a competency throughout the preceptor curriculum. Further, an ongoing process for evaluating communication skills is needed to determine the level of skill mastery and determine additional communication education and support.

**Management**
Managers should complete the same training and be held to the same communication competencies as the nurse preceptors. Role modeling skilled communication for difficult conversations can help to create an environment where skilled communication is the standard and avoiding difficult conversations is not acceptable. Essential to reducing the sense of powerlessness expressed by many preceptors is collaboration between managers and preceptors to create an environment where preceptors feel their input and skill are valued.

Research

There is a need for further research into the perceptions and experiences of nurse preceptors related to the kinds of conversations that are difficult to have with their preceptees. Research should include a longitudinal study where specific communication courses or programs are evaluated to determine what types of curriculum are effective for providing preceptors the skills necessary to initiate difficult conversations. Finally, studies that focus on one or more of the themes identified in this study, with a larger sample from different parts of the country, would be helpful in providing in-depth insight into specific aspects of the communication needs and barriers presented to preceptors when they are faced with difficult conversations with their new graduate or student nurse.

Nurse preceptors are responsible for facilitating a positive learning environment for our new graduate and student nurses. A poor precepted experience can lead to poor role transition from new graduate to staff nurse and student nurse to graduate nurse. The new graduate or student’s success depends in part on receiving feedback from the preceptor that is presented in a non-threatening way and facilitates the growth and learning of the preceptee. Preceptors in this study have expressed several factors or themes that lead to ineffective communication strategies resulting in poor outcomes. Providing nurse preceptors with the tools to become skilled
communicators is a first step to ensuring future generation of nurses are successful in their transition from graduate to staff nurse and student to graduate nurse. Further, fostering skilled communication in nurses is also the first step in providing solutions to complex problems such as nurse burn out, medical and patient errors, sentinel events and lateral violence for which communication failure is a known contributor.
REFERENCES


MEMORANDUM

TO: CAROL ALLEN and Traci Hanlon,

FROM: Patrick Conner (for) Kris Miller, Chair, WSU Institutional Review Board (3005)

DATE: 5/16/2008

SUBJECT: Certification of Exemption, IRB Number 10413-001

Based on the Exemption Determination Application submitted for the study titled Difficult Conversations: The Nurse Preceptor's Perspective, and assigned IRB # 10413, the WSU Institutional Review Board has determined that the study satisfies the criteria for Exempt Research contained in 45CFR 46.

Exempt certification does not relieve the investigator from the responsibility of providing continuing attention to protection of human subjects participating in the study and adherence to ethical standards for research involving human participants.
This certification is valid only for the study protocol as it was submitted to the IRB. Studies certified as Exempt are not subject to annual review. If any changes are made to the study protocol, you must submit the changes to the IRB for determination that the study remains Exempt before implementing the changes. Request for Amendment forms are available online at http://www.irb.wsu.edu/forms.asp.

In accordance with federal regulations, this Certification of Exemption and a copy of the study protocol identified by this certification must be kept by the principal investigator for THREE years following completion of the project.

It is important to note that certification of exemption is NOT approval by the IRB. The study materials should not include the statement that the WSU IRB has reviewed and approved the study for human subject participation. Please remove all statements of IRB Approval and contact information from study materials that will be disseminated to participants.

Washington State University is covered under Human Subjects Assurance Number FWA00002946 which is on file with the Office for Human Research Protections.

If you have questions, please contact the Institutional Review Board at (509) 335-3668. Any revised materials can be mailed to the Office of Research Assurances (Campus Zip 3005), faxed to (509) 335-6410, or in some cases by electronic mail, to irb@mail.wsu.edu.
Review Type: New Protocol

Review Category: Exempt

Date Received: 5/16/2008

Exemption Category: 45 CFR 46.101 (b)(2)

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