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Strategies for Precepting the Unsafe Student

Florence Luhanga, PhD, RN
Olive Yonge, PhD, RN
Florence Myrick, PhD, RN

Precepting a student who is unsafe is distressing both for the preceptor and the student. This article derives from a grounded theory study that describes the careful thought reflected in strategies used by preceptors to teach students who are unsafe. Both preceptors of undergraduates and new employees may find these strategies useful, with the ultimate goal being patient safety. The findings have implications not only for preceptor preparation in the area of evaluation but also for faculty support and the need for evaluation guidelines.

Although most students are at a point in their education where the preceptorship experience merely facilitates their entry into the profession, some students require closer supervision, owing to skills deficit (Yonge, Krahn, Trojan, Reid, & Haase, 2002). Although preceptorship has become increasingly popular, little is known about precepting students who demonstrate an unsafe level of practice, and even less is known about the best way for preceptors to respond to these students (Scanlan, Care, & Gessler, 2001). It is important, however, for preceptors to be able to recognize and manage students' unsafe practice early in the experience for the sake of patient safety. The identification and management of unsafe students apply not only to preceptors of undergraduate students as they function as ''gatekeepers'' for the profession but equally to preceptors of new orientees because the ultimate goal is to ensure patient safety. A number of preceptors who have precepted an unsafe student were interviewed, and their recommendations for managing such students are presented in this article.

Florence Luhanga, PhD, RN, is Assistant Professor, Laurentian University, Sudbury, Ontario, Canada.

Olive Yonge, PhD, RN, is Professor and Vice Provost of Academics, University of Alberta, Edmonton, Alberta, Canada.

Florence Myrick, PhD, RN, is Associate Professor, University of Alberta, Edmonton, Alberta, Canada.

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REVIEW OF THE LITERATURE

In the nursing professional literature, the term *unsafe student* is used to refer to students whose level of clinical practice is questionable in the areas of safety or to students with marked deficits in knowledge and psychomotor skills, motivation, or interpersonal skills (Hrobsky & Kersbergen, 2002; Scanlan et al., 2001; Yonge et al., 2002). Scanlan and colleagues (2001) described unsafe clinical practice as ''an occurrence or a pattern of behaviour involving unacceptable risk'' (p. 25).

Clear policies and procedures are essential in guiding the preceptor, student, and faculty member when a student is engaging in unsafe practice. Scanlan and colleagues (2001), however, found no clear policies or guidelines that existed regarding clinical evaluation. More specifically, they found unclear criteria for student success, deficient or vague definitions

of unsuitability for nursing practice, and lack of specific policies and guidelines for dealing with unsafe students. A few studies across health professions, however, have attempted to provide preceptors with guidelines for managing students with unsafe practice.

In the nursing literature, Teeter (2005) suggested the use of an acronym, SUCCESS (*S*ee it early; *U*nderstand the student's perspective; *C*larify the situation with the student; *C*ontract with the student for success; *E*valuate the student's progress regularly; *S*ummarize the student's performance; and *S*ign the summary and look to the future), that can be used when dealing with the student failing in the clinical setting. Preceptors are encouraged to explore the student's perception of the situation. If the student does not improve, however, it is incumbent on the preceptor to assist the student to realize any deficits in performance and then counsel the student on the available options. The preceptor must help the student complete this process with another formula for success, allowing the student to save face and find a dignified way to exit (Teeter, 2005). Langlois and Thach (2000a) suggested that just like in medicine, approaches to teaching can be divided into *primary* (timely and constructive feedback), *secondary* (identification of red flags), and *tertiary* (assistance from faculty or other resources) prevention. Langlois and Thach (2000b) provided further information and suggested tips on managing difficult learning situations. They suggested the use of the ''SOAP'' (Subjective, Objective, Assessment, and Plan) format as a strategy for diagnosing and managing a difficult learning situation. In dentistry education, Hendricson and Kleffner (2002) developed a model with an acronym—''P-E-T'' (Prime, Partition and Praise, Empathy, Teach)—as a reminder for teachers, or preceptors in this case, of strategies particularly useful for the challenging or struggling student. The authors contend that teachers or preceptors in this case should focus more on helping students learn, rather than evaluating performance. Preceptors are advised to assist students in identifying skills that need to be improved and skills that students want to pursue and then create the appropriate opportunities for students to work on these skills and interests. Shapiro, Ogletree, and Brotherton (2002) identified four types of intervention strategies for dealing with borderline students in audiology and speech pathology. These included additional or modified practicum experiences, additional or modified supervision (supervisor/supervisee experiences), academic/remedial intervention, and noninstructional intervention.

Vaughn, Baker, and DeWitt (1998) explained that preceptors from different disciplines may differ in their perceptions of how difficult it is to manage different problem-learner types. Thus, solutions for managing students with unsafe practices cannot be generally prescribed but instead should be unique to the individual school, hospital, discipline, and environment (Vaughn et al., 1998).

METHOD

Grounded theory was used as the framework for this study because there is very little information in the literature on how preceptors teach or manage nursing students with unsafe practices (Glaser & Strauss, 1967). Data were collected mainly through semistructured interviews (lasting between 20 and 50 minutes) with individual preceptors. Relevant documents such as guidelines for preceptorship and the preceptorship-based course outline were also reviewed to augment the data. The interviews were guided by questions that had been influenced by the literature and that had evolved in content emanating from the participants' responses. Data were analyzed using constant comparative analysis (Glaser & Strauss, 1967), with the goal being to discover a core variable. Data analysis was achieved through coding at three levels: open, theoretical, and selective coding.

Permission to conduct the study was sought in writing from the associate dean of the undergraduate nursing program at the university, and ethical approval was requested and granted from the ethics review committee.

SAMPLE

Twenty-two preceptors in selected acute care practice settings who had worked with students in the final clinical practicum of a 4-year program at a large university in Western Canada were the sample for the study. Twenty were women; two were men. The participants' age ranged from 26.5 to 62 years, although about three quarters were over the age of 40 years. Most (two thirds) of the preceptors had been prepared at the diploma level. The main criteria for inclusion in the study were previous knowledge and experiences in precepting students engaging in unsafe practices.

FINDINGS

Preceptors were asked the following questions: How do you think students with unsafe practices should be dealt with? Having experienced precepting such a student, what recommendations would you make to other preceptors? The subsequent strategies they recommended can be classified under three

subcategories: (1) strategies for prevention of unsafe practice, (2) early identification of unsafe practices, and (3) dealing with unsafe practice.

Strategies for Prevention of Unsafe Practice Before It Occurs

Almost all preceptors indicated that they try as much as possible to prevent unsafe practice from occurring. Some preceptors indicated that they familiarized themselves with the course expectations prior to the clinical rotation. This gave them an idea of what the school expected from them as preceptors and helped determine the student's level of competency.

Some preceptors indicated that they set clear expectations that they shared with students at the beginning of the rotation. As one preceptor commented,

> I try to nip it in the bud pretty quickly so as to prevent it. Upfront, I tell students what I expect. Like, I expect you to know every med you give. I expect if you don't know something to ask me, we'll look it up. I don't expect you to know everything, so don't feel pressured.

Some preceptors also indicated that it was important for them to review the student's own expectations because these assisted preceptors in creating successful learning experiences for students and prevented conflict that may have resulted from unrealistic goals. One preceptor emphasized the need for faculty instructors to ensure that the clinical setting to which students are assigned will offer the experiences and appropriate learning opportunities necessary for students to meet their objectives.

Early Identification of Unsafe Practices or Problems

Students' unsafe practices are identified through direct observation, close monitoring of the student, feedback from colleagues, and in some cases, additional information about the student from faculty instructors. Most of the preceptors reported having identified indicators of unsafe practices very early in the rotation. Once unsafe practice was recognized, preceptors became more vigilant about the student performance to make sure that patient safety was not compromised. They checked with colleagues and faculty instructors to acquire additional information regarding the student to verify the level of competence and to determine if this was a single incident or a pattern of behavior. Although preceptors acknowledged the issues related to confidentiality, they still believed that this information was important in selecting appropriate interventions for dealing with such students. Other preceptors explained that once they confirmed that a pattern of behavior existed, it was important for them to document their findings.

Strategies for Dealing With Unsafe Practice

Preceptors acknowledged that despite efforts to prevent unsafe practices, incidents that require careful management and involvement of the faculty instructor or other resources may still occur. The following are some of the strategies that preceptors recommended for dealing with unsafe practice.

Communicate the problem to the learner

Most preceptors indicated that once they recognized unsafe practice, they communicated their concerns directly to the student. At this point, they try to ascertain whether the student was aware of the problem and if they could identify the source or contributing factors of the unsafe behavior. One preceptor acknowledged that students who were able to identify their weakness are easier to deal with. Thereafter, the student is given the chance to respond and, if possible, indicate how the student could improve his or her performance.

Develop a plan of action

Some preceptors suggested that the next step would be to jointly set up and document a detailed action plan that would provide specific learning opportunities to enable the student to learn and improve. This plan, however, would depend on the nature and severity of the problem. For instance, preceptors attempted to resolve minor straightforward problems with limited impact on the patients with the student before seeking external help. Some preceptors also suggested that the approach would also partly depend on how receptive students were to constructive feedback.

Communicate the problem to the faculty instructor

Most preceptors suggested that they would inform the faculty instructor only if the problem happened for the second time or if something major occurred. Otherwise, students would be given time to improve. However, if there was no apparent improvement in the behavior after a specified time, the faculty instructor would be consulted. Some preceptors acknowledged that it was important to contact the instructor, even for what appeared to be a relatively minor concern, so they could receive advice, guidance, and support. As one preceptor affirmed,

> I learned from experience that, if you have any questions at all, things aren't quite coming together

right away, let the instructor know so that way they [sic] can help out the student, assess the student too, and then from that, go on.

If a major mistake occurs, interrupt and explain the correct approach

Several preceptors suggested that if they recognized a major incident of unsafe practice that may jeopardize patients' or others' safety, they would immediately stop the student and take over whatever the student was doing. Most preceptors indicated that they initially demonstrated new skills then gave students the opportunity to provide a return demonstration.

Constant observation and allowance for gradual clinical independence

Most of the preceptors confirmed that once unsafe behavior had been identified, they initially closely monitored the student then gradually allowed them clinical independence. One preceptor who had an experience with unsafe students explained,

> And for a period of time when they start, if they seem to be unsafe to me, I'm constantly there. I have to closely watch what they are doing until they have proven they have gotten better and they have changed their ways. Then, I can let them be more independent again.

Encourage students to practice skills

Some preceptors also stressed the need to encourage students to continue practicing the skills once they have correctly performed a task. It is important for students to master skills because there are certain students who, having successfully performed a task, display a ''been there done that'' attitude.

Question and give reading assignments

A few preceptors described how they challenged students through questioning and reading assignments. As one explained,

> I question them on their knowledge and theory everyday, and I ask them for research and make them look for stuff even though they think okay they know the stuff. . .I keep on questioning.

Create an environment conducive to learning

Preceptors created a supportive or conducive learning environment for students. One preceptor recognized that the relationship she has with her colleagues influences how the other staff will respond to the student. Preceptors were encouraged to have a good rapport with students, so students could feel comfortable approaching them with their concerns. Although preceptors acknowledged that working with students with unsafe practice could be stressful, they were still encouraged to be patient and supportive with such students.

Give timely, specific, honest, ongoing, and constructive feedback in private

Most preceptors stressed the importance of giving timely, specific, honest, ongoing, and constructive feedback in private. Some preceptors stressed the importance of giving feedback to both students and instructors. Preceptors noted that feedback is more effective if it is specific and given as close in time as possible to the occurrence of the event. Most preceptors also stressed the importance of acquiring input from their colleagues as a second opinion on the student's performance.

Importance of self-evaluation

The importance of self-evaluation was also indicated. As one preceptor commented,

> You need to look at yourself. . . [And] say, am I seeing it right or is it me you know. . .So you have to look at your own practice and see whether or not you are not imposing some sort of philosophy that you have on the student and take it that they [sic] are unsafe.

Some preceptors encouraged their colleagues to be receptive to other ways of doing things as long as students are able to explain the principles underlying their actions. Allowance should be made for individual differences and without justifying actions with ''this is the way we do things here.''

Maintain a high standard of practice

One preceptor reflected on the importance of maintaining a high standard of practice even while precepting students with unsafe practices. Although this preceptor acknowledged intergenerational issues and that students may be undertaking a course of educational preparation different from that of their preceptors, this preceptor believed that colleagues must maintain their professional practice standards.

Seek external help

Some preceptors also suggested that if nurses are relatively new to the preceptor role, they must seek guidance from a more experienced preceptor or colleague. Preceptors are advised to solicit help from colleagues or faculty instructors as early as possible when they realize that they cannot contend with the

situation or when they require more information about the student to confirm a pattern of behavior.

Remedial interventions and decision to fail

The following interventions were recommended in cases where the above strategies did not lead to successful resolution: change of environment or preceptor, reduction of the student's patient load, review of areas of practice with instructor, additional/repeat practicum, and counseling of the student to discontinue the program. Several preceptors suggested the option of reducing the student's patient assignment, as illustrated in the following statement,

> I felt [sic] if she was on a unit where the patients were far more stable, with less number of demands on the nurse's attention, she would do better . . .

Some preceptors recommended that once unsafe practice has been recognized, arrangements should be made for the student to review with the instructor the specific areas that the student needs to practice to become safe in the clinical setting. Then, the student needs to be tested prior to being allowed back to the setting. Most preceptors, however, suggested that the students must be given a chance to repeat the practicum or be granted an extension of the practicum if they are struggling. Most of the preceptors, however, recommended that if the problem of unsafe practice cannot be resolved, for the sake of patient safety, the student should be failed.

DISCUSSION

The study findings suggested several strategies for dealing with a student who demonstrates unsafe practices. Almost all the preceptors indicated that they try as hard as possible to prevent unsafe practice from occurring. This was accomplished by familiarizing themselves with course expectations, orienting students to the unit, and sharing expectations with the students or setting clear expectations and goals with them (Langlois & Thach, 2000a). For example, sharing expectations with students is important because a clear understanding of the preceptor's expectations and goals may assist students to adapt more readily to the new environment and avoid significant problems (Langlois & Thach, 2000a).

Most of the preceptors in this study identified hallmarks of unsafe practice very early in the rotation. Once the preceptors identified unsafe practice, they verified with colleagues their observations of the student's clinical performance or behavior. Similarly, many preceptors in Duffy's (2004) study emphasized the importance of accumulating input from their colleagues to acquire a second opinion on the student's performance. Some preceptors indicated that they had to contact the instructors to acquire additional information about the student. Thus, preceptors are encouraged to, whenever possible, try to gather data from all possible sources to be able to decide on an appropriate plan of intervention for students.

Strategies recommended by the preceptors in this study for managing an unsafe student included documentation as an essential step in the process of addressing unsafe practice situations. The preceptors also recommended having the student perform a self-assessment to establish his or her perspective on the situation. This process is particularly important because some students may lack awareness of their incompetence, thus requiring more specific feedback.

Some preceptors in this study suggested jointly setting up and documenting a detailed action plan to provide the student with the learning opportunities to enable the student to improve. Many authors also recommend the development of a joint learning contract or plan (Myrick & Yonge, 2005; Shapiro et al., 2002; Teeter, 2005) when dealing with borderline students. Regardless of the severity of the problem, preceptors are encouraged to contact the faculty instructor so they can receive advice, guidance, and support (Duffy, 2004; Myrick & Yonge, 2005).

In the clinical setting, unsafe practice must be resolved immediately, often with the preceptor taking over the task. Hendricson and Kleffner (2002) suggested that preceptors must take a more proactive coaching role by guiding students in patient care activities using demonstrations, cues, prompting questions, and constructive feedback. Several authors (Hendricson & Kleffner, 2002; Langlois & Thach, 2000a; Teeter, 2005) suggested that preceptors should give immediate corrective feedback during and after performance or when errors occur.

This study also highlighted the importance of a good learning environment, largely influenced by the student–preceptor relationship and the relationship between the student and the greater healthcare team. Studies suggest that the staff is a key figure in establishing and maintaining an atmosphere conducive to learning in the clinical setting (Myrick & Yonge, 2001). One preceptor encouraged colleagues to reflect on their own practice to ensure that they are practicing within the acceptable standard of practice before concluding that the student is unsafe. This is crucial because some preceptors may think that their own way of performing procedures is the only right way.

Although preceptors acknowledged that working with students with unsafe practice could be stressful, especially with students continually following and asking them questions, they were still willing to be

patient and supportive with such students. It is necessary for preceptors to be empathetic, remembering what it was like to be a student (Hendricson & Kleffner, 2002; Teeter, 2005). They need to let the student know that they will try to work through the problem together and that they will work with the instructor to provide support for learning to take place.

CONCLUSION

Although the number of students with unsafe practices in preceptorship programs may be low, they still require a considerable amount of instructional time and resources. In this era of increasing demands and dwindling resources, the investment of working with students who demonstrate unsafe practices needs to be addressed. In conclusion, the results of this study may provide data for university faculty and administration to consider when exploring issues that may require adjustments in curriculum. Given the impact that the aforementioned challenges have on the students, preceptors, and the educational programs, working effectively with students with unsafe practices deserves significant consideration. The area of evaluation is critical. Preceptors need preparation in evaluation methods, including adequate guidelines and unwavering faculty support.

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ADDRESS FOR CORRESPONDENCE: Olive Yonge, PhD, RN, 3rd Floor, Clinical Science Building, University of Alberta, Edmonton, Alberta, Canada T6G 2G3 (e-mail: olive.yonge@ualberta.ca).