LA PLANIFICATION DU PRÉCEPTORAT EST ESSENTIELLE À LA RÉTENTION DU PERSONNEL INFIRMIER PÉRIOPÉRATOIRE :

ASSOCIER LES STYLES D'ENSEIGNEMENT ET D'APPRENTISSAGE.

Auteure : *Tara Willemsen-McBride IA, B.Sc.Inf, CNOR, est diplômée du programme de sciences infirmières de l'université McMaster. Elle est enseignante périopératoire à l'hôpital St. Mary's General à Kitchener, en Ontario. Tara prépare actuellement sa maîtrise en enseignement à l'université Brock de Saint-Catherines, en Ontario.*

RÉSUMÉ :

Les carences actuelles en personnel infirmier en plus de l'échec des programmes d'orientation en soins infirmiers ont été des préoccupations majeures au cours de la dernière décennie puisqu'ils ont causé un faible taux de rétention du personnel, des soins de moins bonne qualité auprès des patients, une satisfaction professionnelle en déclin et un coût financier élevé pour l'organisation. Les spécialités comme la salle d'opération (SO) sont encore plus vulnérables à cause du milieu de travail stressant et l'ensemble des compétences en soins intensifs nécessaires. Nous estimons qu'environ 35 % à 65 % des nouveaux diplômés quitteront leur milieu de travail au cours de leur première année d'emploi, ce qui veut dire un taux de roulement du personnel de 55 %. Le coût d'orientation d'une nouvelle infirmière ou d'un nouvel infirmier dans un rôle périopératoire est d'environ 50 000 $ à 59 000 $ US. Il est donc impératif d'améliorer le programme d'orientation pour les nouvelles recrues ainsi que le personnel infirmier plus ancien. L'association du style d'enseignement du précepteur et du style d'apprentissage des infirmiers à sa charge est une façon de rehausser le niveau de satisfaction. Cet article revoit la documentation sur le préceptorat et offre des suggestions sur comment améliorer les programmes d'orientation existants.

Les normes de l'AIISOC relatives à cet article figurent dans la publication *Normes, lignes directrices et énoncés de positions pour la pratique de soins infirmiers périopératoires autorisés* (9e édition) de l'Association des infirmiers et infirmières de salle d'opération du Canada (AISSOC) de juin 2009, section 3, p.218, Normes 3.3.1.

PRECEPTORSHIP PLANNING IS ESSENTIAL TO PERIOPERATIVE NURSING RETENTION:

MATCHING TEACHING AND LEARNING STYLES

Author: *Tara Willemsen-McBride RN, BScN, CNOR, is a graduate of the McMaster University nursing degree program and a member of ORNAO. She is the perioperative educator at St. Mary's General Hospital in Kitchener, ON. Tara is currently working on her Masters in Education at Brock University, St. Catherine's, ON.*

ABSTRACT:

Current nursing shortages along with unsuccessful nursing orientation programs have been a major concern for the past decade because they result in poor retention, reduced quality of patient care, decreased job satisfaction and high financial costs to the organization. Specialty areas, such as the Operating Room (OR), are even more vulnerable due to the stressful working environment and critical care skill set. It has been estimated that approximately 35-65% of new graduates will leave their work place within the first year of employment, lending to the 55% nursing turnover rate. The cost of orientating a new nurse to the perioperative role is estimated to cost between $50,000 and $59,000 US. Thus, it is imperative to improve the orientation experience for both new and senior perioperative nurses. Matching preceptor/preceptee learning styles is one way to

Continued on Page 10

enhance job satisfaction levels. This paper revisits the literature on preceptorship and provides suggestions on how to enhance existing orientation programs.

Current nursing shortages and unsuccessful nursing orientation programs have been major concerns for the past decade because they result in poor retention, reduced quality of patient care, decreased job satisfaction and high financial costs to healthcare organizations.[1,2] It has been estimated that approximately 35-65% of new graduates will leave their work place within the first year of employment, a key factor in the current 55% turnover rate in nursing.[3] Specialty areas, such as the Operating Room (OR), are even more vulnerable due to the stressful working environment and required critical care skill set. With the average cost of orientating a new nurse to the perioperative role ranging between US$50,000 and US$59,000 perioperative nursing leaders need to continue investigating the causes of resignation and implementing strategies for retention.[4]

Orientation is a critical period for newly hired nurses to either accept or reject their recent change in career path. Orientation programs, accordingly, need to provide a positive, supportive, and welcoming learning environment. Preceptoring nurses, however, experience heavy workloads and have an inadequate amount of time available to provide useful learning experiences to the students, new graduates, or novice nurses they are orientating.[7] Schools of Nursing and health care institutions are not, unfortunately, providing formal preparation to assist nurses in acquiring the knowledge along with mastering the skills required to act in a preceptoring role.[6] Despite these challenges the Canadian Nurses Association (CNA) states that it is a nurse's professional obligation to support (preceptor) their peers in building and maintaining competencies required for safe, ethical, and effective nursing practice.

Schools and nursing associations, together with health care institutions, are working diligently to resolve this issue, and create solutions, by developing a variety of preceptorship handbooks, guides and workshops that review adult learning principles, facilitation strategies, and evaluation techniques. These resources, however, fail to include information about learning styles and, as a result, nurses continue to have negative preceptorship experiences.

The term preceptor is one used throughout the nursing profession around the world. Within Canada it refers to a highly qualified, competent nurse who acts as a mentor and a resource, providing a safe experiential learning opportunity for students in the form of preceptorship.[7] Preceptorship is defined 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."[5]

A preceptee may be a nursing student, new graduate, or an experienced nurse hired as a new employee. The concept of preceptorship is deeply rooted in the foundations of experiential learning. Therefore the purpose of preceptorship is to provide the preceptee with a clinical learning environment in order to facilitate understanding by means of applying academic knowledge to a real patient situation.

The purpose of this article is four-fold:

1. to review the evolution of nursing education;

2. to highlight issues with preceptor preparation;

3. to share information about Kolb's Learning Style Inventory (LSI); and

4. to make recommendations for improving the preceptorship experience.

The information provided refers specifically to the perioperative environment although it may also be applied to nursing practice in general.

Nursing Education in Retrospect

Historically, student nurses gained competency through a hospital sponsored apprenticeship program whereby all learning occurred within the clinical setting at the patients' bedside. This traditional 'hands-on' approach to nursing was taught by a "head" nurse.[5] Early nursing programs covered the general fundamentals of nursing care and were completed in under a year.

A transition began in the 1970s when Schools of Nursing became more formalized and learning started to occur in the college classroom as well as in the hospital setting with a nursing instructor.[8] College programs were extended in length to two years and later to three years. Nursing students would consolidate their didactic education on hospital wards such as surgery, maternity, and psychiatry, while accompanied by their nursing instructor.

Today the majority of learning for nursing students occurs within a university lecture hall or online, via the internet, as taught by a nursing professor. The nursing program has expanded to an average of four years, in order to accomodate the advances in medicine, science and technology. The curriculum ranges from basic anatomy and physiology to pharmacology and nursing research. There are a multitude of additional clinical areas such as cardiology, neurology, respirology, urology, obstetrics, gynaecology, paediatrics, oncology, etc. Undergraduate didactic clinical education is now a selective experience, gained through preceptorship with a staff nurse, in a variety of external health care settings.

Today's nursing students, as a result, graduate as generalists meeting entry-to-practice standards set by the CNA. Due to the advances in the health care environment, areas of expertise (such as the OR) have been removed from the earlier hospital-based curriculum.[9] This decline in exposure has led to a lack of awareness about career opportunities and the relevance of specialty technical training. The advanced knowledge required for the perioperative area is gained through additional continuing education (CE) courses. These advanced educational opportunities are offered through hospitals, colleges, and universities and vary from six weeks to one year in length. All perioperative programs combine classroom theory with clinical practice. Novice perioperative nurses, preceptored by OR nurses, perform their newly acquired surgical skills within the theater. Perioperative courses may be taken prior to, during, or after a nurse begins employment in the OR.

Issues with Perioperative Preceptorship

The changes in affiliation between hospitals and nursing education have affected the level of hospital investment in nursing students. The didactic requirements have evolved and fewer clinical placements are in hospitals than was the case in the past.[5] Hospitals are now expected to provide "practical" experiences for nursing students who come from a variety of undergraduate or CE programs. Expert senior nurses are now required to preceptor students – a role that was formerly filled by the nursing instructor. Most staff nurses have had little or no formal training on how to precept, nor do they have an understanding of current program curricula, program structures, and what is expected of them as preceptors. Academic programs and hospitals also often neglect to reward or acknowledge the preceptor for their dedication to the preceptee, organization and profession.

Students begin their clinical placement in the perioperative environment with one of many levels of clinical competence and learning needs that vary depending on their program's curriculum requirements. Since these novice nurses are learning within the clinical environment, while providing patient care, it is important that assignments are within their scope of practice and can gradually increase in complexity in accordance with their learning objectives. This is problematic as each preceptee has a different starting point of knowledge and needs and the OR surgical list can vary greatly, with a combination of short and straightforward or long and complex cases, throughout the day and from one day to the next.

Continued on Page 16

Preceptorship (cont.)

At present the majority of ORs choose to randomly pair a senior, experienced, nurse with a novice nurse. This assignment may be based on:

(a) scheduling convenience for the charge nurse, educator, or manager as determined by employee availability;

(b) a personal request by the staff nurse; or

(c) the level of experience of nursing staff.[8,10]

Once a preceptor is chosen various scheduling challenges, such as sick-days or shift work, result in novice nurses often being re-assigned to one or more preceptors during their preceptorship experience. Another dilemma arises when some nurses are not trained to work in all the surgical services. As there are many sub-specialties within the OR there are often designated teams available to perform specialty services such as cardiac, paediatric, or robotic surgery. Novice nurses are often paired with different service-specific nurses. Neither the preceptor's teaching and learning styles (as adults usually teach using the style that suits their own learning preferences) nor the preceptee's learning style are taken in to consideration when pairing nurses for preceptorship. Literature regarding learning styles suggests that the preceptor's teaching and preceptee's learning experiences may, as a result, be unsatisfactory.[11]

When selecting a nurse to precept, scholars of andragogy (learning strategies focused on adults) suggest that consideration be given to pairing the teaching/learning style of the preceptor with the learning style of the preceptee. Research studies have reported a positive correlation between matched teaching/learning styles and successful preceptorship experiences.[8,12] Increased comfort and decreased anxiety lead to improved confidence in the preceptee when his/her learning style is well matched with their preceptor's teaching style. Dorothy MacKeracher, a professor of adult education, writes about learning style mismatch resulting in a mutually unsatisfactory experience for both the teacher and the learner. Adults are adept at knowing intuitively when teachers and learning situations are not congruent with how they learn. They tend, therefore, to choose teachers and environments that are compatible with their preferred learning style.[11] An in-depth understanding of learning styles is required in order for it to be of benefit to the nursing profession.

Each adult has his/her own preferred way or style of learning.[13] An adult will acquire knowledge through a variety of means and will generally favour some methods over others. Within the field of andragogy, Kolb's *Learning Style Inventory* (LSI) is a tool often used to define an individual's learning styles.

Kolb's Learning Style Inventory

In 1984 David A. Kolb, an adult educational theorist, developed a cycle, inventory, and model related to learning styles. Kolb's work was influenced by theorists of psychology including Carl Jung and Jean Piaget.[14] While scholars of education might find Kolb's explanation of learning styles to be straightforward, many health care professionals may, however, find the terminology to be unfamiliar and confusing. Thus, layperson terminology and descriptions have been provided here in order to better help the nursing profession understand and incorporate Kolb's work into preceptorship practice.

Kolb's model of learning styles, based on experiential learning, continues to be one of the most commonly used approaches when working with adult learners.[13,15] Kolb divided the learning process into four phases of an experiential learning cycle (See Figure 1 on pg 20). The learning cycle can be initiated at any point in the circle depending on the learner's preferences. Starting at the top of the cycle, the phases are:

1. **Concrete Experience** (feeling):
   Learning from specific experiences, being sensitive to feelings and people;

2. **Reflective Observation** (watching):
   Observing before making judgments, viewing issues from different perspectives, looking for the meaning of things;

Continued on Page 18

3. **Abstract Conceptualization** (thinking):
   Logically analyzing ideas, planning systematically, acting on an intellectual basis; and

4. **Experimentation** (action):
   Learning through hands on' activities, dealing with people and events through action.[11,13,14,15]

Kolb discovered that people do not participate equally in all phases of the learning cycle. He noted that learners are influenced by their heredity, culture, past experiences, employment, and real life situations.[14] When studying adults, Kolb observed consistent characteristics demonstrated by learners, when processing information, which he later divided into four learning styles. Each of the four styles corresponds to specific phases in the learning cycle. Kolb divided the cycle into two dimensions, on opposing axes, pairing Concrete Experience with Abstract Conceptualization (abstract-concrete dimensions) and Active Experimentation with Reflective Observation (active-reflective dimensions) (See Figure 2 on pg 20). When completing the LSI, an individual can self-assess which style of learning they inherently prefer.

Since its creation, in 1984, Kolb's LSI has gone through many revisions, based on new data gathered from larger sample sizes. The latest version of the LSI uses a description ranking scale designed to determine adult learning style preferences. After completing the LSI the calculated sum of the ranks is placed into a matrix, between the axes to provide a learning style profile. The LSI is useful because it can help nurses explore their preferred teaching style and compare it to the learning style of their preceptees.[13]

Learning Style Preferences:

A **diverger** *(creator)* is a learner whose LSI results lie between Concrete Experience and Reflective Observation. Adults of this learning style are creative and imaginative. They are excellent "brainstormers", interact well with people, and look at an experience from many perspectives. One weakness of divergent learners is that they have difficulty selecting and staying focused on one task.[11,13,14,15]

A **converger** *(decision maker)* is a learner whose score is between Abstract Conceptualization and Active Experimentation. They have practical ideas, are problem solvers and decision makers. They prefer to work with things rather than with people and have a tendency to make decisions quickly.

An **assimilator** *(planner)* is an individual whose LSI results lie between Reflective Observation and Abstract Conceptualization. Assimilators, although not always practical, can create models and theories derived from their concrete experiences. Assimilators prefer to participate in learning through reading, listening, observing and reflection.

An **accommodator** *("do-er")* is a learner whose score is between Concrete Experiences and Active Experimentation. They pursue opportunities that involve action and taking risks. They enjoy a trial and error, experiential, approach to learning.

When explaining how the model applies to learning, Kolb indicates that people are not equally skilled at employing each of the four styles of learning. None of the styles is more valued than another and none are directly associated with higher intelligence or performance. Identifying individual learning styles simply helps adults recognize their personal learning strengths and weakness. A diverger (creator), for example, may excel at creativity but may need to improve his or her decision-making skills. Individual learning style preferences are susceptible to change and learning strengths and weaknesses will require reassessment over time.[11] Kolb's work in the learning style inventory, the experiential learning cycle, and the model of learning styles is usually described using "high level concepts" that require training in the field of education. Nursing leaders need to adapt this information in order to help their colleagues understand the relevance of learning styles. This knowledge may then be used, by nurse preceptors, to choose a precise facilitation strategy or evaluation tool that is suited to the learning style of their preceptee.

Recommendations for Improvement

While one learning style is no better than another, each nurse will demonstrate strengths

and weaknesses based on her/his preferred method of learning. Having an awareness of one's own preferred learning style could help a nurse preceptor recognize if her preceptee has a similar learning style or if there will be different preferences in learning methods. This knowledge could improve the expert nurse preceptor's ability to meet the learning needs of the preceptee by allowing for the use of favoured teaching strategies and evaluation assessments. Matched learning styles can optimize the time, resources and capabilities of both the preceptor and preceptee and create a more enjoyable and productive experience for both parties.

To implement this strategy, the educator or manager would distribute the LSI instrument to nurses interested in preceptoring as well as to student or novice nurses being preceptored. The nurses would then answer the questions on the instrument to determine their style of learning. The educator or manager would then pair preceptors and preceptees based on learning & teaching styles. The concept of matching preceptor/preceptee learning styles is not an unknown concept as it has been attempted in the past by other nursing leaders and the research results have been encouraging.

In 1998, Anderson used the Myer-Briggs Type Indicator (a tool used to determine personality type)[17] to investigate the relationship between students and nurses, some of whom had been matched based on learning styles, and to measure their perceived satisfaction with the orientation process. The study reported a significantly higher level of satisfaction among preceptees and preceptors whose learning styles were matched when compared with those who were not matched.[18]

Brunt and Kopp attempted to validate these findings by repeating a similar pilot study in 2003. They expanded the assessment process by including two additional instruments, Kolb's Learning Style Inventory (LSI) and Dunn and Dunn's Productivity Environmental Preference Survey (PEPS)[18]. They concluded that there was a positive correlation between matched learning styles and satisfaction, although the findings were not significant. They accredited the inconclusive findings to a small sample size and the challenge of matching preceptor/preceptee learning styles with three assessment instruments.[12]

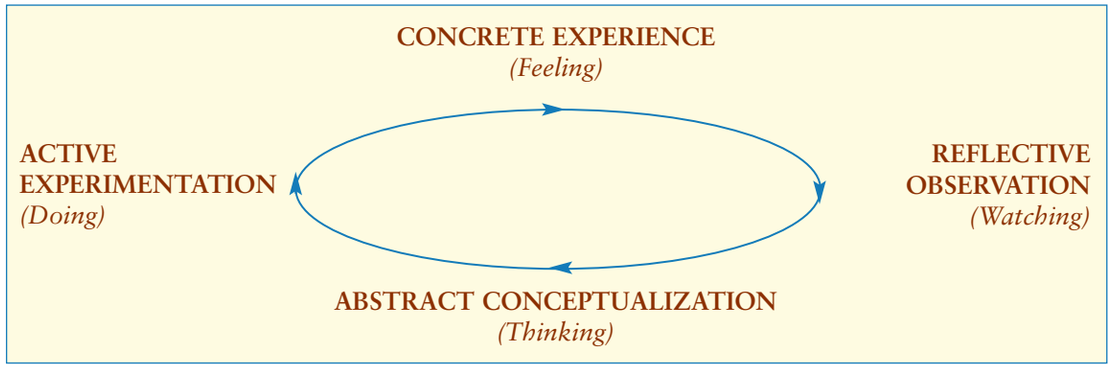
Although the model of matching learning styles of preceptors and preceptees could result in many positive outcomes for perioperative preceptorship, implementing such a program is, however, not always easy. Identifying the expert nurse preceptors' teaching/learning style and matching it with the novice preceptee's learning style requires education, time, and resources (there is a monetary fee involved in the distribution and use of Kolb's LSI). It can also be problematic when a facility is not able to accommodate a preceptor/preceptee match due to lack of available preceptor candidates. Some writers also argue against pairing the same learning styles and instead encourage a mismatch, believing it will challenge nurses to teach and learn in different ways.[11]

CONCLUSION:

Orientation experiences can leave a permanent impression on nurses and affect their perception of the profession. The author would like the following scenario to be considered when justifying the importance of choosing preceptor/preceptee teams.

A junior nurse, Ava, nervously stands among her classmates as the educator reviews the list of eligible preceptors. As the educator reads aloud the name of each student the preceptor, Ava, realizes she has been assigned to the senior nurse who she fears most, Helga. Helga was the "master of her domain", an expert in every surgical service, could perform both the scrub and circulatory role, had decades of experience, and was assertive with the surgeons. From a manager's, educator's, and charge nurse's perspective Helga was the ultimate preceptor. But as her preceptee, Ava was terrified of her! A lot was learned over the next few weeks but there was often too much apprehension involved in asking questions and worry about making a mistake. This left an anxious, and often nauseous, preceptee. Then, to make an uncomfortable situation worse, Helga was

Figure 1. Kolb's Experiential Learning Cycle

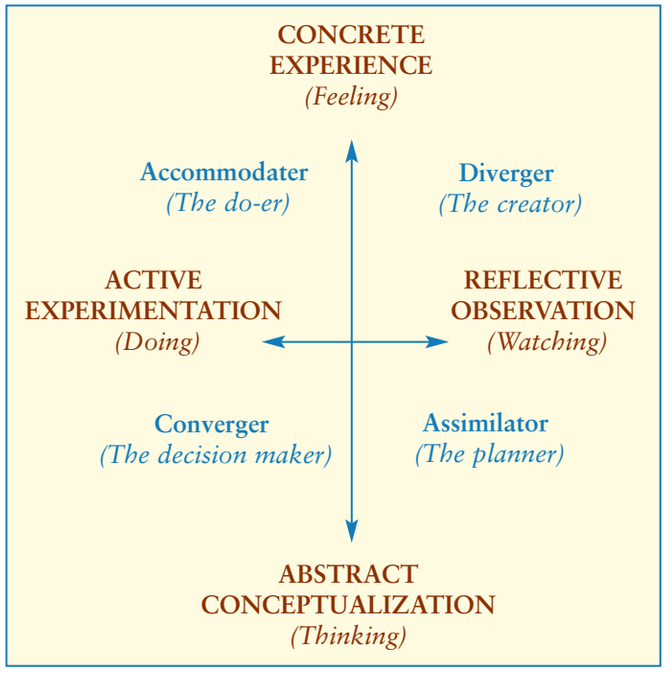


(HayGroup, 2009; MacKeracher, 2004, p. 57)

unavailable one morning and another preceptor was assigned to the task. The new preceptor ignored Ava and provided no support while she was scrubbed. An error was made, which the surgeon abruptly corrected. Ava, feeling disgraced by the situation, left the OR in tears, went to the change room and emptied out her locker. The educator learned of the incident and convinced Ava not to leave. It was extremely difficult for Ava to face the staff the following day knowing that they were aware of the incident from the day before and to make matters worse she was then reprimanded by Helga for being too sensitive!

Many novice nurses who are put in this position might not return. With a surplus of nursing employment opportunities why would they? Reflecting upon this experience, the author would speculate that the preceptor was a converger (decision maker) and the preceptee to be an accommodator (do-er). The negative orientation incident could have been avoided if the preceptee was consistently paired with a preceptor who she did not find intimidating, who she felt comfortable learning from, and who understood how she learned.

Figure 2. Kolb's Learning Styles



(HayGroup, 2009; MacKeracher, 2004, p. 84)

The purpose of preceptorship is to enhance the quality of learning in the clinical environment, which in return helps novice nurses achieve excellence and confidence in their professional practice. In addition, the mentoring relationship between the preceptor and the preceptee assists with socialization into the profession.[16] A positive preceptorship experience also improves performance, job satisfaction, and retention levels of both the preceptor and the preceptee.[5,6,16] In order for this to successfully occur. the selection, development, and training of each nurse, who serves as either preceptee or preceptor, is vital.[1] Choosing a preceptor for a preceptee needs to be a collaborative process between the educator, senior staff and novice nurse. Matching the learning styles of the preceptor with the preceptee is one suggestion for improving this experience. Expert nurses are our greatest resource and we need to utilize them as preceptors accordingly – and novice nurses are our future and as such require the right teaching and support.

ORNAC Standards pertaining to this article can be found in the Operating Room Nurses Association of Canada (ORNAC) (June 2009) *Recommended Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice (*9th edition), Section 3, p. 218, Standard 3.3.1.

REFERENCES:

1. Jane J. Baltimore. "The hospital clinical preceptor: Essential preparation for success". *Journal of Continuing Education in Nursing* 35.3 (2004) : 133-140.
2. M. VanOyen Force. "The relationship between effective nurse managers and nursing retention". *Journal of Nursing Administration* 35.7 (2005) : 336-341.
3. J.M.Hayes & A.S. Scott. "Mentoring partnerships as the wave of the future for new graduates". *National League of Nursing, Nursing Education Perspective* 28.1 (2007) : 27-29.
4. Lucy B. Trice, Catherine Brandvold & Elizabeth Bruno. "Practice and Education: Partnering to address the perioperative nursing shortage". *AORN Journal,* 86.2 (2007) : 259-264.
5. Canadian Nurses Association (2004). *Achieving excellence in professional practice: A guide to preceptorship and mentoring*. Ottawa: Canadian Nurses Association. Retrieved September 2008 http://www.canaiic.ca/bookstore/freepdfs/AchievingExcellence 2004_e.pdf
6. Margo Kertis. "The One-Minute Preceptor, A Five-Step Tool to Improve clinical Teaching Skills". *Journal for Nurses in Staff Development*. 23.5 (2007) : 238-242.
7. Kristiina Hyrkas & Martha Shoemaker. "Changes in the preceptor role: re-visiting preceptors' perceptions of benefits, rewards, support and commitment to the role". *Journal of Advanced Nursing* 60.5 (2007) : 513-524.
8. Judy Anderson. "Orientation with style, matching teaching/learning style." *Journal for Nurses in Staff Development* 14.4 (1998) : 192-197.
9. Karin Page-Cutrara. "Perioperative nursing education in Canada: Current and future perspectives." *Canadian Operating Room Nursing Journal.* 25.1 (2007) : 10-19.
10. Suzy Lockwood-Rayermann. "Preceptor leadership style and the nursing practicum." *Journal of Professional Nursing*. 19.1 (2003) : 32-37.
11. Dorothy MacKeracher. *Making sense of adult learning* (2nd ed.). (Toronto: University of Toronto Press 2004) 71-91.
12. Barbara A. Brunt & Denise J. Kopp. "Impact of preceptor and orientee learning styles on satisfaction, a pilot study." *Journal for Nurses in Staff Development*. 23.1(2007) : 36-44.
13. Patricia Cranton. Theoretical Foundations of Adult Education. In *Planning Instruction for Adult Learners 2nd Ed.* (Toronto: Wall & Emerson 2000) 6-24.
14. Anne Poonwassie. Facilitating Adult Education: A Practitioner's Perspective. In D.H. Poonwassie & A. Poonwassie (Eds.), *Fundamentals of Adult Education*. (Toronto: Thompson Educational Publishing 2001) 67-158.
15. HayGroup, Kolb's Learning Style Inventory, Author Unknown, Retrieved April 8, 2009, from: http://haygroup.com/tl/Downloads/Why_People_Learn.pdf
16. Amanda Henderson, Robyn Fox & Kristina Malko-Nyhan. "An Evaluation of Preceptors' Perceptions of Educational Preparation and Organizational support for Their Role." *The Journal of Continuing Education in Nursing*. 37.3 (2006) : 130-136.
17. The Myers Briggs Foundation. Retrieved October 2009 http://www.myersbriggs.org/
18. Rita Dunn, Shirley A. Griggs, Jeffery Olson, Mark Beasley & Bernard S. Gorman "A Meta-Analytic Validation of the Dunn and Dunn Model of Learning-Style Preferences." *The Journal of Educational Research*. 88.6 (1995) :353-362