The Preceptorship Resource Pack
The Preceptorship Resource Pack:

It is intended that this Resource Pack will act as a tool to guide both the preceptor and preceptee through the period of preceptorship. The expectation is that this resource pack will evolve as the organisation develops.

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Section 1
Preceptorship
What is preceptorship?

Preceptorship is a process in which qualified and accountable practitioners (preceptee’s) are supported by a qualified, accountable and experienced colleague (preceptor) to continue their professional development, build their confidence and further develop competence to practice (Department of Health 2009, NHS Northwest 2009).

Who is the preceptee?

The Preceptee – is an individual who is a newly qualified nurse, allied health professional, midwife, psychological therapist, health care scientist. A newly qualified assistant practitioner, new into a role, returning to the workforce following a career break of 5 years or more and those practitioners entering a new part of the register.

From the moment of registration/qualification all practitioners remain accountable for their actions.

Preceptorship is not:

An extension of training or intended to replace induction, mandatory or statutory training or performance management processes. The preceptee and preceptor should be clear about the boundaries of preceptorship as set out in the Preceptorship Contract within the Portfolio.

How long does the period of preceptorship last?

Preceptorship lasts from 6 to 12 months; the length of time will vary according to the individual development needs of the preceptee. If additional support is required it should be addressed as soon as possible and brought to the attention of the preceptee’s manager/team leader.

There will be a review meeting at 6 months and again at 12 months which will be conducted by the manager/team leader, in collaboration with the Preceptor. The review meeting is an opportunity for the preceptee to gain feedback from their manager/team leader regarding the progress made. The implementation of a preceptorship programme is not only useful for the preceptee but also has benefits for the preceptor, the organisation and ultimately service users.
Benefits for the Preceptee (DOH 2010)

- Consolidation of clinical skills and competencies.
- Development of clinical decision making skills.
- Increased confidence.
- Feel supported and able to adapt to their new role.
- Enhanced job satisfaction.
- Portfolio development.

Benefits for the Preceptor (DOH 2010)

- Continued Professional Development
- Development of critical thinking skills
- Portfolio enhancement
- Enhanced job satisfaction
- Demonstration of responsibility and leadership

Benefits for the Organisation (NHS North West)

- Improved outcomes for patients
- Reduction in complaints
- Reduction in clinical incidents
- Appropriate reporting of clinical incidents
- Increased staff satisfaction
- Reduction in sickness and absence
- Increased recruitment and retention of clinicians
- Increased organisational loyalty

Benefits for the Service Users (DOH 2010)

- Care delivered by competent, confident practitioners
- Delivery of safe and effective care
**Induction:**

Across the organisation all new starters, including preceptee’s attend corporate welcome followed by a period of local induction. This equips them to carry out their duties safely and effectively. During the period of induction the preceptee should complete the preceptorship training to gain an understanding of the process. The preceptee will also attend all the statutory, mandatory and role specific training:

- **Statutory Training:**
  
  Training that the organisation is legally required to provide as defined in law or where a statutory body has instructed organisations to provide training on the basis of legislation. For example Fire Safety required by statute of the Management of Health and Safety at Work Regulations 1997 amended 1999.

- **Mandatory Training:**
  
  A training requirement determined by the organisation. Mandatory training is concerned with minimising risk, providing assurance against policies and ensuring that the organisation meets external standards.

**Mentorship**

In general terms it is the role of the mentor to guide the individual and share knowledge and skills with the individual, therefore enhancing life-long learning and development. Essentially, a mentor will support an individual embarking on further education within their established role for example Specialist Practitioner candidates. Mentorship can be a long term on-going relationship.

**Preceptorship**

Preceptorship involves providing support and guidance to those in transition from student to autonomous practitioner, returning to practice after a career break and anyone entering a different part of the professional register. Preceptorship is a time limited experience in order to support transition.
<table>
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<tr>
<th></th>
<th>Induction</th>
<th>Mentorship</th>
<th>Preceptorship</th>
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</thead>
<tbody>
<tr>
<td><strong>Staff groups</strong></td>
<td>All staff across the organisation</td>
<td>Individual or any staff group needing mentorship for a specific reason</td>
<td>Newly qualified staff, staff new into post, staff returning to practice after 5 years or more and staff entering a different part of the register Time limited relationship to support transition</td>
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<tr>
<td></td>
<td></td>
<td>In nursing all students will receive mentorship</td>
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<td></td>
<td></td>
<td>Can be long term ongoing relationship</td>
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<tr>
<td><strong>Who delivers?</strong></td>
<td>Organisation and individual service</td>
<td>Mentors/Educators recognised by their individual profession. Staff who may have received additional training to become a mentor or taken on the Clinical Educators role</td>
<td>Staff who have demonstrated appropriate attributes and have 12 months or more experience post qualification in same field as the preceptee</td>
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<td><strong>When does it happen?</strong></td>
<td>When staff commence work with an organisation</td>
<td>As required during an individual's career pathway.</td>
<td>At the start of a new post/role When returning to practice/entering a new part of the register</td>
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<tr>
<td><strong>Statutory requirement</strong></td>
<td>All staff across the organisation</td>
<td>Depends on professional body</td>
<td>Organisational and Health Education England requirement.</td>
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The Role of the Preceptor

The role of the preceptor is integral to the on-going development and growth of community / patient services. The role is one of the most important resources available within clinical settings. Preceptorship ensures confident and competent practitioners who will provide quality care to healthcare users. It has proved to be a highly useful strategy for clinical education. Preceptorship programmes benefit preceptors, preceptee's and Healthcare Institutions (Lockwood-Rayermann 2003).

Who can be a Preceptor?

A qualified allied health professional, health care scientist, nurse, psychological therapist or midwife who has been identified by the manager/team leader:
Working in the same area of practice as the preceptee.
With a minimum of 12 months post registration experience within the same area of practice or associated field.
Please note exceptions may occur in specialist roles, in these cases some negotiation and agreement will need to be sought.

What does the role involve?

A preceptor is a person, who advises, inspires, serves as a role model and supports the growth and development of an individual with the specific purpose of socialising them into a new role.

An effective preceptor is committed to:

Understanding, helping, advising, facilitating, supporting and guiding.
Sharing knowledge and skills and personal experiences.
Advising about new or unfamiliar situations.
Contributing to a high quality learning environment.
Developing an effective working relationship based on mutual respect.
Ensuring new colleagues are provided with opportunities to enable them to develop and advance.
Reflecting on their preceptor skills and acting on feedback to improve these. The expert preceptor is constantly doing the invisible planning, thinking ahead about things that will be helpful to the preceptee's progress (Skeff, Bowen and Irby, 1997).
Section 2

The Preceptorship Process
What is the Organisational Preceptorship Process?

- Practitioner is appointed and is identified as eligible for preceptorship.
- Manager/team leader allocates a preceptor to the preceptee.
- Preceptee meets with preceptor within the first week of employment ideally, no later than 2 weeks.
- A preceptorship contract is developed which identifies learning needs and actions for achieving the outcomes which will be signed by preceptee and preceptor.
- At 1 month, the preceptee is invited to complete a survey monkey regarding the first month Organisational requirement to provide induction and a named preceptor. If the answer to any question is No, the manager/team leader will action the missing component of the preceptorship process immediately.
- Meetings continue at agreed time intervals (at least monthly) until the process is complete. (Between 6-12 months)
- Collaborative working (which could be clinical care) will occur on a monthly basis between the preceptor and preceptee. The minimum collective time for meetings and collaborative working is 5 hours per month with at least 1 hour per month devoted to the meetings.
- It should be made clear that the preceptee will work collaboratively with other members of the multi-disciplinary team as well as the preceptor in order to gain the best possible experience from the preceptorship period.
- Evidence of achievement of outcomes to be brought to the meetings for discussion and reflection and should be documented in the portfolio.
- Review meeting to take place at 6 months facilitated by the manager/team leader in collaboration with the preceptor. If there are outstanding outcomes and learning needs, a remedial action plans with clear expectations and time frame to be in place.
- Final review meeting to take place at 12 months facilitated by the manager/team leader in collaboration with the preceptor. If there are outstanding outcomes at this point, final remedial actions plan to be devised. If after the agreed time frame the preceptee fails to meet the standards required, the manager should follow Trust performance management guidelines.
- On completion of the preceptorship programme, preceptee must complete the evaluation form at the back of the portfolio.
- Completed and signed portfolio to be sent to Clinical/Service Lead to be kept in the individual’s personal file.
- Preceptee to retain a copy of the portfolio as evidence to take forward to their first PDP.
- Trust compliance officer to be informed and OL&D to inform Health Education North West.
Preceptorship Contract

The preceptorship contract is a written agreement between the preceptee and preceptor which is used as a plan to define the objectives of the preceptorship period. The contract will be written at the first meeting which ideally should be within the first week of employment. However it should be no longer than 2 weeks into commencement of employment. The contract can be found within the preceptorship portfolio.

The contract should:

- Be used flexibly according to preceptee needs.
- Be filled out at the beginning of the preceptorship period and added to at each meeting.
- Make expectations explicit and realistic.
- Be mutually agreed.
- Confidential.
- Be jointly owned between the preceptee and preceptor.
- Be linked to the Trust Strategic Objectives
- Be linked to the Trust values CARE.

Trust Strategic Objectives

- Put local people and communities first
- Strive for excellence
- Use resources wisely
- Be the partner of choice
- Be a great place to work

Trust Values CARE

1. COMPASSIONATE: We will deliver our services with warmth and understanding, going the extra mile to support patients, their families and carers, and those we work with.

2. ACCOUNTABLE: We will all take responsibility for our actions, embracing an open and honest culture and ensuring lessons are learned if things go wrong.
3. **RESPONSIVE**: Our care will be patient-centred addressing the needs of individuals in our communities and listening to service users, their families and carers, and our colleagues

4. **EFFECTIVE**: Our services will be delivered by skilled staff that strive for continuous improvement and aim for excellence.

5. **SAFE**: We will do everything we can to ensure our services are safe and of high quality so that patients receive the very best care.
Preceptorship Process

Practitioner is appointed and identified at point of recruitment as eligible for preceptorship.

Preceptee attends corporate welcome and local induction. All preceptee’s must attend preceptorship training to gain an understanding of the process within the first 2 weeks of employment.

All preceptors must attend the preceptorship training. Preceptee must attend alternate month peer group support meetings which will be held locally.

The initial meeting between the preceptee and preceptor must take place within the first 2 weeks of employment. The preceptee will access the portfolio and resource pack via the Trust intranet. A contract will be agreed and signed which outlines learning needs, goals/outcomes and the resources required.

Monthly hour long review meetings between preceptee and preceptor as agreed plus collaborative working (could be clinical care) for no less than 4 hours per month. End of first month, survey monkey to be sent to all preceptees. If preceptee’s answer NO to any question, manager to ensure this is addressed immediately.

6 and 12 month review meetings (with preceptee, manager/team leader and preceptor). If unmet outcomes/ additional learning needs, a remedial action plan required with clear expectations and time scale. If unsuccessful after final remedial plan at 12 months, manager to follow process for performance and capability.

A copy of completed preceptorship programme/portfolio with completed evaluation to be kept in preceptee’s personal file. Copy to be sent to OL&D.
Section 3
Useful Tools
And Resources
Useful tools and resources

Reflective Practice

Reflective practice is integral to preceptorship but should also be embedded in day to day working practice in order to provide quality and holistic patient/client care. The idea of learning from experience is not new. The use of reflecting on experience as a means of enhancing professional practice stems from the work of Schön (1983) who highlighted the weaknesses of using theory alone. Benner (1984) pointed out that not all knowledge embedded in expertise can be captured in theoretical propositions. Reflective practice should be used to identify the knowledge embedded in practice that will enable practitioners to access their professional development and, by providing understanding of actions, be used to guide less experienced practitioners. Lucas (1991) described reflective practice as a systematic enquiry into one’s own practice and deepens one’s understanding of it.

Why Reflect

- Understand the complexity of your work.
- Value your experience.
- Develop an ownership of your continued Professional development.
- Confront and think through incidents.
- Create an agenda for discussion.
- Analyse your experience and view it more critically.

There are a number of reflective models available to act as a framework they can be used in isolation or collectively. The selection of the model used is up to the individual using it.

Using reflection is valuable when related to your practice it will benefit your clinical work where you feel you have learnt something that is of value to your practice and future career. It may be a positive experience where something went well or a negative one where you need to think about what has happened. From each piece of reflection you must identify what you have learned from the experience and how this relates to the theory that you have been taught or researched. To help you with this reflection there are several models that might be useful to help guide your reflection. You can choose any that you feel will help you. Examples of useful models of reflection are:
Gibbs' model of reflection (1988)

Gibbs Framework for Reflection

Stage 1:

Description of the event
Describe in detail the event you are reflecting on. Include e.g. where were you; who else was there; why were you there; what were you doing; what were other people doing; what was the context of the event; what happened; what was your part in this; what parts did the other people play; what was the result.

Stage 2:

Feelings and Thoughts (Self-awareness)
At this stage, try to recall and explore those things that were going on inside your head. Include

- How you were feeling when the event started?
- What you were thinking about at the time?
- How did it make you feel?
- How did other people make you feel?
- How did you feel about the outcome of the event?
- What do you think about it now?

Stage 3:

Evaluation
- Try to evaluate or make a judgment about what has happened. Consider what was good about the experience and what was bad about the experience or what did or didn’t go so well

Stage 4:

Analysis
Break the event down into its component parts so they can be explored separately. You may need to ask more detailed questions about the answers to the last stage. Include:

- What went well?
- What did you do well?
- What did others do well?
- What went wrong or did not turn out how it should have done?
- In what way did you or others contribute to this?
Stage 5:

**Conclusion (Syntheses)**
This differs from the evaluation stage in that now you have explored the issue from different angles and have a lot of information to base your judgment. It is here that you are likely to develop insight into your own and other people’s behaviour in terms of how they contributed to the outcome of the event. Remember the purpose of reflection is to learn from an experience. Without detailed analysis and honest exploration that occurs during all the previous stages, it is unlikely that all aspects of the event will be taken into account and therefore valuable opportunities for learning can be missed. During this stage you should ask yourself what you could have done differently.

Stage 6:

**Action Plan**
*During this stage you should think yourself* forward into encountering the event again and to plan what you would do – would you act differently or would you be likely to do the same? Here the cycle is tentatively completed and suggests that should the event occur again it will be the focus of another reflective cycle. Gibbs model incorporates all the core skills of reflection. Arguably it is focused on reflection on action, but with practice it could be used to focus on reflection in and before action.
Johns’ Model of Reflection (1994)

The following cues are offered to help practitioners to access, make sense of, and learn through experience.

Description
What are the key issues within this description that I need to pay attention to?

Reflection
What was I trying to achieve?
Why did I act as I did?
What are the consequences of my actions?
  - For the patient
  - For myself
  - For people I work with

How did I feel about this experience when it was happening?
How did the patient feel about it?
How do I know how the patient felt about it?

Influencing factors
What internal factors influenced my decision-making and actions?
What external factors influenced my decision-making and actions?
What sources of knowledge did or should have influenced my decision making and actions?

Alternative strategies
Could I have dealt better with the situation?
What other choices did I have?
What would be the consequences of these other choices?

Learning
How can I make sense of this experience in light of past experience and future practice?
How do I NOW feel about this experience? Have I taken effective action to support myself and others as a result of this experience?
How has this experience changed my way of knowing in practice?
Kolb’s Learning Cycle (1984)

Experiencing
First of all, we have an experience. Most experiences are not worth further movement on the cycle as we are already familiar with them and they need no further interpretation and hence no need for learning.

Reflecting
Having experienced something which does not fit well into our current system of understanding, we then have to stop and think harder about what it really means. This reflection is typically a series of attempts to fit the experience to memories and our internal models (or schemata). Reflecting on new experiences is first a process of explaining as we try to use our existing models to make sense of our experience. When we cannot fully explain what happened, reflecting also includes confusion when they do not fit in with existing models. If we can explain what happened, then the cycle stops here as there is nothing to learn. Much of life is like this. Many of us also avoid going past this stage as we fake and fix our experiences so we do not have to go through the pain of learning.

Theorizing
When we find that we cannot fit what we have experienced into any of our memories or internal models, then we have to build new models. This theorizing gives us a possible answer to our puzzling experiences. For some people, this is a wonderful stage as they consider all kinds of possibilities. For others, it is a struggle as they try to make sense of the senseless.

Experimenting
After building a theoretical model, the next step is to prove it in practice, either in 'real time' or by deliberate experimentation in some safe arena. Again, this can be enjoyable or worrisome, depending on the individual personality and perspective. If the model does not work, then we go through the reflection loop again, figuring out what happened and either adjusting the model or building a new one.
Evidence for Preceptorship Portfolio

Be aware of confidentiality when gathering the evidence. Any evidence that you collect should be anonymous in order to maintain confidentiality. All evidence should link to the Trust Strategic Objectives and the Trust Values CARE

1. Reflective evidence may relate to communication:
   - Dealing with a difficult situation.
   - Liaising with other staff.
   - Scenarios with patients/service users, families and carers
   - Developing learning contracts.
   - Meetings with preceptor.

Examples of evidence
   - Records/record keeping – demonstrates communication consistent with legislation, policies and procedures.
   - Reflection - when communication went well. -when communication was ineffective and what happened.
   - Copies of emails relating to communication.
   - Copies of learning contracts.
   - Copies of meetings with preceptor.

2. Reflective evidence may relate to personal/service development:
   - Preceptorship
   - Being actively involved in own development e.g. Continuing Professional Development
   - Development of competencies
   - Development of services

Examples of evidence
   - Training records and reflection of how training has made a difference and what you have done about it.
   - Copies/or reflection on formal or informal presentations.
   - Copies of learning contracts.

3. Reflective evidence may relate to Health and Safety:
   - Support in applying policy to practice i.e. child protection
   - Learning safer and more secure ways of working

Examples of evidence
   - Records – demonstrating safeguarding/advice
• Evidence of safe practice
• Reflection on a best interest or safe-guarding meeting.

4. Reflective evidence may relate to Service Improvement:

• Involvement in team meetings.
• Involvement in audit

Examples of evidence
• Reflection on team meetings.
• Minutes of team meetings showing active participation.

5. Reflective evidence may relate to Quality:

• Involvement in development and implementation of any guidance relating to quality.
• Awareness and knowledge of policies or guidance and implications

Examples of evidence
• Reflection.
• Copy of guidance, policies and procedures.
• Feedback from colleagues, service users, managers

6. Reflective evidence may relate to Equality & Diversity:

Consider that it is the responsibility of every person to act in ways that supports equality and diversity. Equality and diversity is related to actions and responsibilities of everyone-users of services including patients, clients and carers, work colleagues, employees, people in other organisations and the general public.

• Care of patient/service user whom have different needs e.g. mental health, children.
• Raising knowledge regarding legislation, policy and procedure.
• Awareness of complaints procedure/PALs.

Examples of evidence
• Reflection on specific patients'/service user needs and how they were managed.
• Explaining how health care can reach hard to reach groups -how you address this.
• Reflection on how professionals can manage to achieve equal access for all clients.
• Reflection on diversity training.
Evidence comes from a variety of sources

Flying start is a useful resource for any person embarking on the Preceptorship Programme. The website is: www.Flyingstartscot.nhs.uk

The diagram below demonstrates a variety of resources where evidence for your portfolio may be gained.
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