Preceptorship programs are widely used in undergraduate and postgraduate nursing programs in North America and the United Kingdom as an available, alternative teaching–learning method to the traditional approach to clinical teaching (Ellerton, 2003; Hardyman & Hickey, 2001; Myrick & Yonge, 2001). The purpose of most senior nursing students’ practicum experience is to facilitate smooth transition from student to graduate role (Hardyman & Hickey, 2001; Rush, Peel, & McCracken, 2004).

Although preceptored students are near completion of their program and are expected to have advanced knowledge and skills, their level of expertise can vary greatly. Some students require closer supervision than others if high standards of patient care are to be maintained (Yonge, Krahm, Trojan, Reid, & Haase, 2002a). When a student barely passes a clinical assignment and may be unsafe, precepting becomes a tedious and challenging process of remedial skill development rather than the provision of exciting learning opportunities (Rittman & Osburn, 1995). Preceptors recognize the competing demands of encouraging student independence and the professional obligation to ensure safe and competent practice. This leads to the dilemma of facilitating the entry of an unsafe student into the profession upon graduation (Duffy, 2004; Hrobsky & Kersbergen, 2002; Rittman & Osburn, 1995). To identify unsafe practice, it is important that preceptors recognize the “red flags” or hallmarks of unsafe clinical performance.

Most literature on preceptorship confirms the rewarding experience of precepting students because of an experienced increase in personal and professional growth (Glass & Walter, 2000), enhanced self-esteem and confidence (Green & Puetzer, 2002), and career advancement (Allen, 2002). However, the conflict between fostering learner independence and commitment to the profession, the extra time required for teaching and the greater-than-average workload associated with student evaluations because of the necessary documentation, and the need for confrontation can create a great deal of preceptor stress. Some excellent preceptors have “burned out” and refused to precept after a difficult encounter with a student (Langlois & Thach, 2000a; Yonge et al., 2002a).

In the nursing and other health professional education literature, the term “unsafe student” is used to describe students whose level of clinical practice is questionable with regard to competence, whose knowledge and psychomotor skills are lacking, or whose motivation or interpersonal skills are less than adequate (Hrobsky & Kersbergen, 2002; Rittman & Osburn, 1995; Scanlan,
The assumption that all students in their final semester just prior to graduation are ready for a preceptorship experience may not be valid. Many cases of reluctance to award a failing grade and of “giving the benefit of the doubt” to marginal students are well documented in nursing literature (Boley & Whitney, 2003; Duffy, 2004; Scanlan et al., 2001). The reasons cited for the reluctance to fail students when their performance was not up to the standard include (a) lack of experience and confidence (Duffy, 2004; Scanlan et al., 2001); (b) inability to identify or deal with the students’ problems early enough during the clinical placement; (c) the threat of appeals (Duffy, 2004; Dudek, Marks, & Regehr, 2005); (d) reluctance to fail students early in the program with a hope that students would pick up the necessary skills in future placements (Duffy, 2004; Scanlan et al., 2001); (e) reluctance to jeopardize the students’ future just prior to graduation (Duffy, 2004; Hawe, 2003); and (f) personal consequences such as anxiety, guilt, fear, or a feeling of personal failure (Duffy, 2004; Hawe, 2003). Such a decision has serious implications for the entry of unsafe students into practice upon their graduation.

There is inadequate literature to guide preceptors in difficult situations when students are failing or displaying unsafe practice (Hrobsky & Kresbergen, 2002; Scanlan et al., 2001). To identify unsafe practice, it is important that preceptors recognize red flags or hallmarks of unsafe practice.

THE STUDY

Design/Methodology

Grounded theory was used to explore how nursing preceptors manage or deal with students whose level of performance is borderline or unsafe (Glaser & Strauss, 1967; Strauss & Corbin, 1998). The aim of the grounded theory approach is to develop substantive theory about common social patterns.

The foundations of grounded theory emanate from symbolic interactionism in which the processes of interaction between people’s social roles and behaviors are explored (McCann & Clark, 2003). Meanings are created by experience, and although these experiences are unique to each individual, it is acknowledged that individuals sharing common circumstances, such as preceptors, experience common perceptions and thoughts and display common behaviors—the essence of grounded theory (McCann & Clark, 2003).

Sample/Participants

Twenty-two nurse preceptors associated with a final-year clinical practicum provided the sample for the study. Most participants were women and two were men. The participants’ age ranged from 26.5 to 62 years,
although three quarters of the preceptors ranged between the ages 40 and 60 years. Almost two thirds of the preceptors who participated in this study had a diploma level of preparation, and slightly more than one third was prepared at the baccalaureate level. About half of the preceptors in this study worked on surgery units, less than one third on psychiatric and medical units, and one on a burn unit. The main criteria for inclusion were previous knowledge and experiences in dealing with students engaging in unsafe practices.

As the data emerged, however, a select number of preceptors with no direct experience of such students were also asked to participate. This process enabled the researcher to search for “negative cases.” Theoretical sampling continued until theoretical saturation was achieved. Saturation in grounded theory occurs “when no new data emerges relevant to particular categories and subcategories, categories have conceptual density, and all variations in categories can be explained” (McCann & Clark, 2003, p. 11).

Data Collection

Data were collected mainly through one-to-one semi-structured interviews with individual preceptors that lasted between 20 and 50 minutes. The study was conducted in selected acute care practice settings. Interviews with participants, initially accessed through the respective hospitals, were conducted at a mutually agreed upon place and time. A review of official documents such as guidelines for preceptorship was also conducted to supplement data whenever necessary. It was assumed that the mixed approach to data collection would provide richer data than a single approach would. The interviews evolved, in content, based on responses from participants. The questions in the interview guide were obtained and compiled from the literature.

Validity and Reliability

The researcher had the participants validate the findings of the study through member checks and member validation as proposed by Sandelowski (1986) to ensure credibility. Credibility was achieved by the researcher engaging with participants over time and by developing rapport, establishing trust, and working collaboratively with them. Fittingness was enhanced by collection of data from different acute care settings. The researcher ensured that there was a comprehensive audit trail for future use by others to ensure confirmability.

Ethical Considerations

A letter of permission and ethical approval from the ethics review committee were obtained. To ensure confidentiality, names of the participants were not used on the audiotape recordings, written transcripts, or field notes.

Data Analysis

Data were analyzed by the researcher using constant comparative analysis as described by Glaser (1978). The main goal of data analysis in a grounded theory approach is to discover a core variable that illuminates and explicates the main theme of the preceptor’s experience (Glaser, 1978; Streubert & Carpenter, 1999). Data analysis began simultaneously with data collection and was achieved through the process of coding. Coding occurred at three levels: open coding, theoretical coding, and selective coding. Open coding is the process of “fracturing” or breaking down the data into discrete parts to identify and name relevant categories (McCann & Clark, 2003). Theoretical coding is a process in which the ordering of the data and the inter-relation of the substantive categories occur. During selective coding, the researcher moved from data analysis to concept and theory development. This was accomplished through the process of data reduction, by filtering information relevant to the topic, discarding extraneous information, and applying selective sampling. During this stage, the core category that ties together all other categories in the theory was identified and related to other categories (Glaser, 1978). The data analysis revealed a multifaceted process, which was labeled “promoting student learning and preserving patient safety” as the core variable or main process involved in precepting a student with unsafe practice. Five major categories were revealed: (1) hallmarks of unsafe practices, (2) factors contributing to unsafe practice, (3) preceptors’ perceptions and feelings, (4) grading issues, and (5) strategies for managing unsafe practice. This article will focus on the category “hallmarks of unsafe practice.”

FINDINGS

The preceptors described several behaviors that prompted them to consider the possibility of unsafe practice. These were categorized into four subcategories: (1) inability to demonstrate knowledge and skills, (2) attitude problems, (3) unprofessional behavior, and (4) poor communication skills. Although signs of unsafe practice could occur at any stage in the preceptorship experience, most preceptors in this study indicated that these occurred early in the preceptorship experience. Once they identified unsafe practices, some preceptors indicated that they gave students usually a week or two to become familiar and comfortable with the routines on the units before addressing the problem or asking for external assistance.
Inability to Demonstrate Basic Knowledge and Skills

The most common behavior prompting preceptors to intervene in this subcategory related mainly to the students’ lack of knowledge and poor skill performance. Other common behaviors were sloppiness or lack of organizational skills; students’ inability to ask questions; ineptness to follow instruction, resulting in frequent repetitive mistakes; and lastly, failure to practice basic safety measures (such as aseptic technique).

Inadequate knowledge and inability to perform skills

While in the preceptorship experience, students are expected to practice with increasing independence under the supervision of the preceptors. The main concern among preceptors was that students were ill prepared for the preceptorship experience as many still lacked basic clinical skills. Preceptors felt frustrated when some students exhibited minimal clinical skills, leaving the preceptor to spend time teaching the basic skills instead of providing the “finishing touches” prior to graduation. As this preceptor commented:

when we get a student that’s [sic] not up to par because by the time they [sic] are ready to graduate, there shouldn’t be a lot of stuff that I have…to teach them [sic]. I should serve as just kind of smooth the edges, so to speak…

Other preceptors believed that students were unsafe because they lacked the knowledge base to carry out the required skills. One of the most striking findings was the prevalence of medication errors among students. Three quarters of the preceptors who were interviewed reported this occurrence. One of the critical skills for nursing students is the ability to calculate drug doses accurately. Most preceptors in this study, however, indicated that some students were deficient in this skill. As one preceptor explained:

There was a medication incident, specifically I believe it was Zofran and I think the order was 4 mg…It comes in a 4 mg dose and she was going to give 2 [tablets] so the patient would have had 8 [mgs]…there were other cases where she didn’t compute properly…but quite often she got things wrong.

In addition, preceptors indicated that they became concerned if a student did not seem alert to the possibility of making mistakes.

Sloppiness or lack of organizational skills

Many students were unable to organize basic patient care activities or also demonstrated careless behavior. Although preceptors expect students in their final practicum to be well organized, with strong time management skills, this was not always the case. One preceptor described a student who was displaying careless behavior on the unit:

There was…an incident where one of my students accidentally knocked over some pills. The patient brought them in…She would leave stuff lying around, leaving the med room open…not signing up for medications. I had to constantly be on her back all the time.

Not asking questions

Preceptors also indicated that they preferred students who asked questions to those who did not and then made mistakes. Preceptors also indicated that they tended to trust students who asked questions because they could then ascertain their level of competence and assist them accordingly.

Inability to follow instructions and safety measures

Other behavior of great concern and frustration for preceptors was related to the students’ inability to follow instructions. One preceptor expressed her frustration:

You tell her to go into a patient’s room to discontinue this IV, then they [sic] always go to the wrong patient…every time you give them [sic] instruction it seems like they [sic] will do it wrong. Those I think were the hardest.

Although preceptors acknowledged that “we all make mistakes,” they still believed that, when students do not follow instructions and make repetitive errors, they are unsafe and should not be trusted with patient safety. A final subcategory of behavior identified by a few preceptors was related to students who did not practice basic safety measures or principles of surgical asepsis.

Attitude Problems

Most of the preceptors who were interviewed indicated that students with attitude problems were the most difficult to work with. Under this subcategory, the common behaviors alerting preceptors to unsafe practice related to overconfidence or a “know-it-all” attitude, defensiveness or an un receptive attitude to feedback, and an indifferent, “I don’t care” kind of attitude.

Overconfidence

Three quarters of the preceptors indicated that most of the fourth year students tended to be overconfident or “cocky.” Preceptors believe that overconfidence can be unsafe because, in most cases, students think they know what they are doing when, actually, they do not. These overconfident students often interpret supervision
as a lack of trust on the preceptor’s part, which can be frustrating for both parties.

**Unmotivated to learn or work**

Nearly half of the preceptors acknowledged that it was difficult and frustrating to work with students who did not seem to be interested in learning, were not interested in nursing, or were lazy. One preceptor confirmed:

She would do as little as she could because as a preceptor I would still be there to help her out with certain things...I still found she preferred to do the minimum but I still had to really push her.

Preceptors expressed concern about students who tended to dismiss certain learning opportunities once they had accomplished a task by saying “done that before” or “I don’t want to repeat it.” Other preceptors made reference to the fact that the present generation did not work as hard as they did as students:

I think some of the students are so relaxed; you know, they don’t work as hard as when we were students.

**Defensiveness or unreceptive attitude toward feedback**

Preceptors believed that students who were unreceptive toward feedback were the most difficult to teach and manage. Not only was it difficult to trust such students, but also, preceptors were especially concerned if a student did not seem alert to the possibility of making mistakes.

**Unprofessional Behavior**

Preceptors also described a number of behaviors and actions that were identified as unprofessional. These behaviors and actions were related primarily to a poor work ethic, dishonesty, lack of confidence or extreme nervousness, and intentional unsafe behavior.

**Poor work ethic**

More than half of the preceptors identified behaviors related to a poor work ethic, most of which reflected behavior that demonstrated an inability to meet the demands and expectations of a work environment, such as negligence, laziness, gossiping, crying, eating, or using cell phones while on duty. Another preceptor described a student whom she believed was lazy and disrespectful to the staff on the unit. She explained:

She spent a lot of time visiting and laughing, and just having a good time...She comes in to the report, puts her feet on the table, and she eats her breakfast in the report. She didn’t seem to have respect...or if it’s just the generation thing, where people are more relaxed and think that’s okay.

**Lack of confidence**

About half of the preceptors identified extreme nervousness as a warning sign of poor performance or unsafe practice. As expressed by one preceptor:

She was extremely nervous, even the patient commented that she was nervous.

Other preceptors also commented that when a student was hesitant and unsure, it was difficult for them to trust such a student with patient safety.

**Dishonesty**

One third of the preceptors identified behavior related to dishonesty as unprofessional. These included lying, hiding errors, and not admitting one’s own mistakes.

**Intentional unsafe practice**

Other behavior that would alert a preceptor to unsafe practice involved verbal or physical abuse of patients and acts of embellishment. There was, however, no direct evidence of a student who either verbally or physically abused a client. One preceptor described a student who used to embellish stories, which led the preceptor to mistrust the student.

**Poor Communication Skills**

Behavior related to poor communication or to interpersonal skills involved inappropriate interaction with the preceptor or instructor (being too argumentative and disrespectful); inappropriate interaction with patients; and inappropriate nonverbal communication such as eye rolling, sighing in front of patients, chewing gum, or yawning.

**Inappropriate interaction with preceptors or instructors**

This included personal behavior that interfered with the students’ ability to self-evaluate and perform their work responsibilities. For example, one preceptor recalled an incident where a student had an intense argument with the instructor, to the point where the preceptor believed that the student was being disrespectful. Another preceptor described an encounter she had with a student after giving the student final evaluation:

She cried and cried...basically told me it was my fault that she was going to fail. It wasn’t her fault, it was my fault.
because I was a poor preceptor and she had said that previously all of her other preceptorships and in all the other courses she was an honors student.

Inappropriate interaction with patients

Inappropriate interactions with patients included boundary crossings such as self-disclosure, which was indicated by one quarter of the preceptors, most of whom were working in psychiatric settings. For instance, one preceptor recalled an incident which she described as unprofessional and "kind of weird," in which she observed a student on her knees beside the bed talking to a patient. Other preceptors gave examples whereby students would share personal information that had nothing to do with the patient’s therapy.

Inappropriate nonverbal interaction with preceptors

Another behavior identified by preceptors as unprofessional related to inappropriate nonverbal interaction with preceptors, such as eye rolling, yawning, or sighing in front of patients. As one of the preceptors commented:

I will be in the room and trying to teach her to do a dressing and she will be rolling her eyes and sighing in front of the patient, which I thought is unprofessional…

DISCUSSION

The results of this study indicate that the first process in managing a student with unsafe practice is the actual identification of unsafe practices. To identify unsafe practice, the preceptors noted that they initially had to recognize the red flags or hallmarks of unsafe clinical performance which generally occurred early on in the preceptorship (Duffy, 2004; Hrobsky & Kersbergen, 2002). Behavior or attitudes that alerted preceptors to be more vigilant or watchful over the student were related to inability to demonstrate knowledge and skills, attitude problems, unprofessional behavior, and poor communication skills (Hendricson & Kleffner, 2002; Hrobsky & Kersbergen, 2002; Wolf-Burke, 2005).

While in a final practicum, students are expected to perform all role functions and to assume an increasingly larger patient assignment in a more proficient, organized, skillful, and independent manner (Hill, Wolf, Bossetti, & Saldam, 1999). As some students were still lacking in these skills, there exists the possibility, therefore, of some students becoming registered nurses without mastering some basic skills. In fact, this observation was affirmed by one preceptor who gave an example of a bachelor of science in nursing graduate who did not know how to give an injection. This concurred with findings in a study where students were concerned that they had not gained sufficient experience in a number of basic skills such as taking blood pressure or giving injections (Dolan, 2003).

Preceptors in this study believed that students were unsafe because they lacked the knowledge base to carry out required skills. Preceptors, however, need to be realistic about their expectations of students in relation to both clinical knowledge and practical skills. Students enter the preceptorship experience with varying levels of knowledge and skills and different types of clinical experiences (Langlois & Thach, 2000a, 2000b; Myrick & Yonge, 2005; Oermann & Garvin, 2002). Rather than viewing the student as incompetent, therefore, preceptors must instead plan patient assignments and learning activities that will enable students to develop the competencies that they are lacking (Bick, 2000; Oermann & Garvin, 2002). One preceptor in this study emphasized the need for faculty members to ensure that the clinical setting to which they assign students offers the experiences that will provide the learning opportunities necessary for students to meet their objectives.

One of the most striking findings in this study was the medication errors discovered to be common among students. One preceptor attributed this lack of knowledge and skill to the fact that nursing students are not taught basic courses such as pharmacology, which she believed were fundamental in drug administration and nursing (Bullock & Manias, 2002; King, 2004).

Organizational ability and priority setting are essential to professional practice (Myrick & Yonge, 2005). Preceptors expected students in the final practicum to be organized and have time management skills, but this was not always the case. However, these are skills that are difficult to teach in university but are better learned through experience in the clinical setting (Bick, 2000).

The kind of questions that students asked helped the preceptor to determine their level of competence, plan appropriate learning experiences, judge when and how to provide backup to safeguard patients’ well-being, and build a trusting relationship. It is important for preceptors, however, to realize that a student with a weak knowledge base may not feel comfortable asking or answering questions for fear of not knowing the correct answers.

Attitudinal problems that were particularly frustrating and challenging and that alerted preceptors to possibilities of unsafe practice included acute defensiveness, unenthusiastic attitude toward learning or work, and the cocky, know-it-all attitude (Duffy, 2004; Hendricson & Kleffner, 2002; Hrobsky & Kersbergen,
Preceptors in this study described students who were unreceptive to feedback as the most difficult to teach and manage. Some students may undermine the preceptor or project their failure onto the preceptor. It is important, therefore, that feedback be given cautiously and in an advisory rather than accusatory manner; otherwise, the student may become dissatisfied with the evaluation process and then lose trust in the value of self-assessment.

Preceptors expressed concerns about students who did not seem to be interested in learning (Hill et al., 1999). Students, however, must be assisted to practice what they are learning and be made aware that performing a task once is not enough to become proficient. Preceptors need to be aware that, sometimes, acute defensiveness, lack of motivation, and a know-it-all attitude may be behavioral manifestations of underlying learning deficiencies or medical problems (Hendricson & Kleffner, 2002).

Older nurses expect the younger nurses to be committed to work (Wieck & Landrum, 2006). They often complain that younger nurses are disloyal and spoiled and are more interested in technology and money instead of nurturing. Younger nurses, on the other hand, see their older colleagues as out of touch and stuck in a work model that disappeared years ago (Domrose, 2001). Preceptors in this study believed that these students did not work as hard as previous generations of students. These sentiments by preceptors may be a reflection of the differences in the values and work ethics between the multiple generations currently in nursing practice settings. Potential misunderstanding regarding generational values and work ethics can contribute to stress and conflict during the preceptorship experience. An awareness of the different needs of each learner will help create learning strategies and an environment suitable for varied generational needs to maximize the learning experience (Oblinger, 2003; Wieck & Landrum, 2006).

A student who lacks confidence in performing a skill will normally demonstrate extreme nervousness. Extreme nervousness or high levels of anxiety, however, can impair concentration and the ability to receive and process information; thus, it impedes a student’s clinical performance (Langlois & Thach, 2000b).

Preceptors described various behaviors that were identified as unprofessional. Dishonest behavior such as lying violates both legal and ethical standards of nursing practice (Canadian Nurses Association, 2002). Gaberson and Oermann (1999) further suggested that clinical dishonesty among students is usually a result of one or more of the following factors: competition for good grades in clinical courses, educational emphasis on perfection, poor role modeling, and impaired moral development. Because of its potentially devastating impact, prevention of clinical cheating or lying should be a priority for preceptors and nursing faculty. It is also suggested that nursing curricula must reflect the values of the profession and be structured to nurture the moral development of students (Gaberson & Oermann, 1999).

CONCLUSIONS

This study revealed that early identification and intervention of the student with unsafe practices are crucial when working with such students in the clinical setting. The study findings suggest that there is the perception that students may not always be receiving adequate practical skills or basic knowledge from the university program, such as drug administration. Nursing faculty must ensure that students possess the required knowledge, skills, and competencies to participate in the preceptorship program. This finding implies that students need to be adequately prepared and assessed for their readiness for the preceptorship experience. Selecting suitable students for preceptorship is important for client safety, student achievement of course objectives, and minimization of the level of burden on the preceptor.

It is recommended that unsafe students be identified early so they can be given the opportunity to improve. Descriptions of unsafe and unprofessional behaviors identified in this study could be used by preceptors to identify early warning signs of poor performance or unsafe practices. Ongoing support and workshops geared toward staff development in the area of preceptorship also need to be in place to improve preceptor confidence in identifying and assisting students with unsafe practice. Preceptors are responsible for identifying and fostering behavior that is consistent with professional expectations and for modeling that behavior themselves.

ACKNOWLEDGMENT

The authors would like to acknowledge Quinn Grundy, research assistant, for assistance with this article.

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