Relationship-Based Precepting

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Competence

Compassion

Collaboration

Socialization

Supervision

Professional Practice
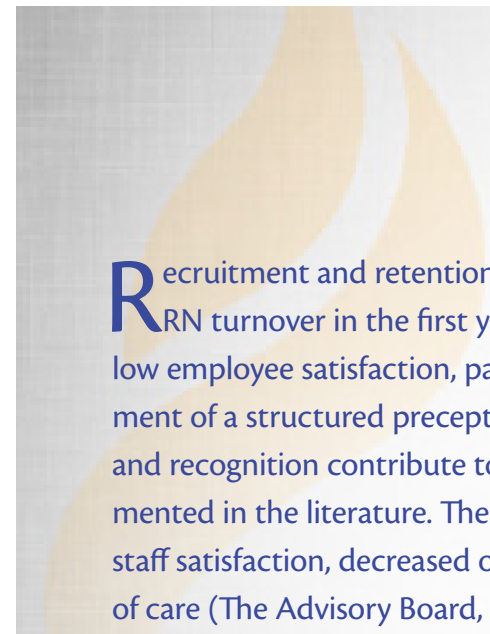
Resiliency

Relationship-Based Precepting and Preceptor Program Development

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Recruitment and retention of new nurses continues to be problematic for the health care industry. RN turnover in the first year of hire can be a significant financial cost to organizations and links to low employee satisfaction, patient safety, and quality of care (The Studor Group, 2009). The establishment of a structured preceptor program where preceptor selection, preparation, and ongoing reward and recognition contribute to improved orientation and onboarding outcomes has been well documented in the literature. These outcomes range from increased preceptor and orientee satisfaction, staff satisfaction, decreased orientation time, increased new graduate readiness to practice, and quality of care (The Advisory Board, 2008).

"There are many variables that influence turnover for newly licensed nurses." Pellico and co-authors discuss several qualitative and quantitative studies that examined this transition phase of the new nurse. Lack of social support is positively linked with turnover intentions, whereas work group cohesion is negatively linked with turnover intentions. The preceptor plays an integral role in both of these aspects of onboarding new nurses (Pellico et al., 2010).

Relationship-Based Precepting (RBP) is a conceptual framework that guides the day-to-day practice of precepting and the development and implementation of a comprehensive structured preceptor program. The RBP framework integrates four core elements that must be addressed in the day-to-day application of precepting. These elements are: supervision, socialization, professional practice, and resiliency.

Partnered with the four core elements of precepting are the four foundational relationships necessary to have a successful transition to practice during the onboarding process. These are relationship with self, colleague, learner, and organization.

The Relationship-Based Precepting framework is most successful when implemented in conjunction with a comprehensive program that contains the infrastructures and processes necessary to support the work of the preceptor, learner, and other stakeholders involved in the orientation process.

Expected outcomes from implementing the RBP framework in conjunction with a comprehensive preceptor program are:

- Improved preceptor satisfaction
- Improved preceptee satisfaction
- Improved readiness to practice of orientee/preceptee
- Decreased orientation time
- Improved staff engagement
- Improved staff satisfaction

The RBP framework centers on four core relationships that are partnered with four core elements to achieve best practice in precepting.

Relationship with Self

Preceptors must consistently cultivate a relationship that enhances their well-being. Without this attention to self, they put themselves at risk for developing compassion fatigue and worse: burnout. It is imperative that preceptors not only model healthy self-care behaviors, but that they instill this as a necessary practice (just as necessary as safe patient practices) in those they are precepting.

"The concept of well-being comprises two main elements: feeling good and functioning well. Feelings of happiness, contentment, enjoyment, curiosity and engagement are characteristic of someone who has a positive experience of their life. Equally important for well-being is our functioning in the world. Experiencing positive relationships, having some control over one's life and having a sense of purpose are all important attributes of well-being." (The New Economics Foundation, 2010)

Developing a sense of well-being is influenced by many factors. One of these factors relates to consistently practicing behaviors that in the day-to-day practice of nursing includes self-care. Self-care in the context of nursing includes taking scheduled breaks and lunches as well as utilizing resources (asking for help) when assignments are overwhelming and/or acuity has changed and the pace of the day does not allow for adequate teaching.

The literature that supports well-being as a focus for learning also includes having a sense of purpose (The New Economics Foundation, 2010). Preceptors must be whole heartedly connected to their personal values (mission) related to nursing and to precepting. This is why we do what we do or why we went into nursing in the first place. Without a solid understanding of our personal value system as a nurse and preceptor, we can lose sight of what is important and get lost in the minutia of day-to-day obstacles. Keeping our values at the forefront of our work allows us to navigate the complexity that can, from time to time, creep up and cause havoc in our work environment. Keeping our glass "full" rather than "half empty" provides us with the capacity to deal with the ups and downs that come with being a health care provider. When we have a full tank of capacity, we are better positioned to handle whatever comes our way. Barbara Fredrickson describes this capacity in her Broaden and Build theory. She ascertains that positivity allows us to broaden the way we think about things and the way we interact with others. When we cultivate positivity, we are more likely to reach out to others and connect in a healthy way. When we allow ourselves to engage in negative thinking, we dampen our ability to engage with others and we think in ways that keep us stuck in old ways of being (Fredrickson, 2004). Positivity is a useful concept when we apply it to the learning/precepting environment. It is a necessary component to our ability to develop resiliency, one of the core elements of the Relationship-Based Precepting framework.

When implementing the RBP framework, it is important to include the concepts of well-being and the research that links stress to poor health and poor critical thinking and learning outcomes.

Basic preceptor education should include:

- Identification of personal mission and vision related to nursing and precepting.
- Identification of practical strategies for self-care in the day-to-day work environment.
- Engaging in behaviors that support personal and professional well-being.

Relationship with Colleagues

We cannot enter the sacred space of the patient or the learner if we have unhealthy relationships with our team or there is an underlying lack of trust between teams or individuals. Many teams think they can keep dysfunctional behaviors and attitudes away from the eyes and ears of the patient; however, this is not usually the case. More often than not, patients will overhear or see how we as a team treat each other. If we do not genuinely care for each other, then the message we send to the patient is incongruent with the promise we make to provide excellent and safe patient care. This mismatch in messages, even if it is unconscious, leads to the patient feeling uneasy about us as caregivers and creates a lack of trust. Without trust, patients will experience anxiety, stress, and fear as part of their experience in our care, and preceptees will have a similar experience. Anxiety, stress, and fear have the capacity to shut down learning and delay the development of needed critical thinking skills.

When addressing colleague relationships in the precepting process, consideration should be given to the following:

- Unit specific actions that support and build teamwork should be a consistent theme when unit based preceptor councils are developing strategies to improve the unit learning environment.
- Participation and collaboration with the manager and educator related to their role in supporting precepting strategies will be necessary to sustain the practice of any initiatives the preceptors develop.

An example of this might be how staff is formally involved in the precepting process. A unit-based council from a small community hospital in Oregon decided they wanted to involve staff in the orientation process of new people. At their monthly unit-based preceptor meeting they discussed how they could leverage the strengths and skills of clinically expert staff who were not preceptors in a way the orientee would benefit from and the staff nurse would enjoy. With input from staff and other preceptors, they developed "the mentoring hour." Once a week, the charge nurse and the primary preceptor would cover a staff's assignment for an hour to free up the "mentor" to teach a specific area of expertise. Unit staff were invited to participate and those who were interested in the opportunity volunteered. Mentors volunteered to share their knowledge for one hour and had to be willing, with help from the educator, to develop specific objectives related to their area of expertise. The preceptors then debriefed the experience with the preceptee and provided verbal feedback to the mentor. The outcome of this piloted strategy was increased staff engagement and increased mentor ownership of the staff orientation process. Mentor's reported an increased level of satisfaction with their job due to the relationships forged with both learner and preceptor. Preceptees reported satisfaction with the variety and level of knowledge and experience they were exposed to during the mentoring hour that they may not have gotten with their primary preceptor due to variability in preceptor clinical skill.

This strategy is just one example of how using the RBP framework can guide the thinking of those doing the day-to-day work of precepting and lead to innovative and creative precepting processes and strategies. This particular strategy fits within the best practices of socialization and professional practice while addressing the relationship to colleagues.

Empowering individuals who do the work of precepting to participate in the development of relationship-based strategies engages the internal motivation of preceptors and has the potential to elevate their level of practice and credibility with their team.

Relationship with the Learner

As a nurse, our primary responsibility is to the patient and family. As a preceptor, we are also responsible for the learning experience of our preceptee. This means that we must be proficient in our ability to inspire confidence and the feeling that we have our learner's back, even if things go wrong. This type of attitude can be challenging to master when we also have the responsibility of evaluating the competency of that individual. Making sure we honor our commitment to the learning experience of our preceptee means that we make their learning a priority. It means we put thought into the assignments we will take based on the preceptee's needs. It means we will collaborate with our team (manager, charge nurse, and other staff), to determine how best to meet their needs. For example, if the preceptee needs a patient assignment that is higher in acuity, and that means that another staff member has to give up one of their patients to provide that to the preceptee, ideally the preceptor has communicated to all those involved and the team participates in that process together. It means that the preceptor collaborates with the manager and charge nurse to find time to debrief and complete necessary evaluations whether formal or informal on a consistent basis. It means the preceptor prepares for their preceptee by reviewing the preceptee's learning goals and revising the goals with the preceptee as necessary. In essence, it means the preceptor takes a Primary Nurse role and applies it in the learning context during the precepted experience. The primary preceptor ensures that the learning plan (similar to a patient care plan) gets carried out throughout the precepted experience. As the primary preceptor, it also means the preceptor is coordinating and communicating with other preceptors who may have the preceptee when the primary preceptor is not available or the preceptee has moved to another shift (i.e., from days to nights).

Relationship with the Organization

When a preceptor agrees to work for an organization, the preceptor enters into a relationship with that organization. This relationship implies the preceptor will carry out the mission, vision, and values of the institution for which they accepted employment. It implies they will practice to certain professional standards and be proactive in maintaining the competencies necessary for them to sustain and support those professional standards. It also implies they will be accountable for the outcomes associated with their care in the various roles they are expected to practice in, including precepting.

- The roles and responsibilities of the preceptor should be clearly articulated and defined in a standardized organizational policy.
- Specific Preceptor competencies should be identified, and completion of these competencies should be included in their performance evaluation.

Relationship-Based Precepting centers on supervision, socialization, professional practice, and resiliency.

Supervision

In the precepting context, supervision is defined in the literature as a necessary component to protect the safety of the patient and to safeguard the well-being and safe learning environment of the novice nurse (Boyer, 2008). Supervision provides the ability to not only correct potential errors, but to also notice and provide positive feedback to the nurse who does something correctly. This is not limited to technical tasks, but can be applied to interpersonal interactions between the preceptee and others as well.   When thinking about how to apply the concept of supervision to the precepting process, the following must be considered.

- Any method of precepting must include a high level of supervision. Supervision in the RBP framework is defined as the observation of preceptee interactions with patients, families, and clinical support staff; this includes direct observation of hands-on skills, as well as indirect observation (listening) to interpersonal interactions.
- When inadequate supervision exists, there are missed opportunities for the preceptor to provide valuable feedback (both positive and constructive) and add to the existing knowledge base of the preceptee. Without consistent feedback, the preceptee does not have the necessary information to critically reflect on his or her practice in a way that effectively builds critical thinking and clinical decision making skills.
- Patient assignments should be made in a way that provides the most supervision possible. Precepting methodologies that use high levels of supervision should be used instead of less formal methods of precepting where a divide and conquer strategy can be defaulted to.
- Staffing matrices should not include preceptees.
- Preceptors and/or preceptees must never be considered "extra hands" due to the fact there are two people taking a patient assignment.

Socialization

Research suggests that a sense of belonging is a critical component of the learning environment. Levett-Jones and Lathlean describe a sense of belonging as a key priority in developing clinical competence in their conceptual framework, The Ascent to Competence (Levett-Jones & Lathlean, 2009). Peplau's theory of interpersonal relations also supports the assumption that developing healthy relationships is fundamental to an individual's ability to function and that early socialization of nurses is an important element during the orientation phase (Peplau, 1997).

A fundamental and primary psychological human need is to feel a sense of belonging. Without this sense of belonging, individuals often have difficulty assimilating into new routines and environments without a significant amount of stress (Levett-Jones & Lathlean, 2008). High levels of stress can affect an individual's ability to process new information, and learning can be delayed or even stunted. Precepting methods or strategies must include a thoughtful and formal process of integrating and socializing new staff into their teams. Socialization in the Relationship-Based Precepting framework is defined as inviting individuals to participate in the formal and informal processes and or routines that create social networks, friendships, and attachments. Socialization is not just introducing individuals to staff and showing them where to put

their personal items and where the cafeteria is; although these activities may be part of the socialization process, socialization is a long-term commitment to individuals to look out for their best interests and in the process get to know them as a person.

Professional Practice
This is an essential element in the commitment to owning your practice as a preceptor. Similar to your obligation as a nurse to uphold and practice under a set of standards such as the ANA Standards of Professional Nursing Practice, preceptors have an additional obligation to be competent in assessing critical thinking, teaching using effective adult learning strategies, providing feedback using competent communication skills, and modeling healthy interactions between co-workers.

Preceptor Competencies:
Preceptors must be proactive in acquiring and developing their own skills in the domains of:

- Technical (clinical)
- Interpersonal (communication and emotional intelligence)
- Critical Thinking and Clinical Decision Making
- Leadership
- Teaching

Preceptee Competencies:
Preceptors are competent in evaluating preceptee's in the following domains at the appropriate skill level using Benner's novice to expert model.

- Technical

Advanced Beginner, Proficient, Competent, Expert:

- Interpersonal
- Peer-to-Peer Conversations

Speaking Up:

- Critical Thinking and Clinical Decision Making
- Leadership

Formal Leadership Role:
Preceptors are utilized in an expanded role outside of the orientation process. In this expanded role, preceptors are included as part of the unit leadership team. Preceptors receive the same leadership training as charge nurses and others who are considered part of the unit-based leadership team (unit-based co-leads, for example). Preceptors are socialized into this role by the unit manager in a way that allows staff to recognize them as part of the leadership team and expect them to function in that role

outside of the orientation process. Each organization will determine how preceptors will function in the expanded role and how that will fit within the current leadership team structure. An example of this is an organization in the Northwest which utilized the expanded leadership role of the preceptor to be the content experts for the practices of the therapeutic relationship as outlined in the book and workshop *See Me as a Person* (Koloroutis & Trout, 2012). Preceptors were responsible for modeling the practices in their day-to-day work, assessing and mentoring other staff as needed, being resources to staff when questions or barriers arose in applying the practices, and holding monthly reflective sessions to deepen the unit knowledge related to the therapeutic practices of attuning, wondering, following, and holding. As content experts and role models in a formal leadership role, preceptors were able to coach and mentor staff related to the use of the therapeutic practices and build the entire team's competency.

Preceptors Function in a Primary Preceptor Role:
In the Relationship-Based Precepting framework, primary preceptors are assigned to a preceptee. The primary preceptor has oversight for the entire learning experience of the new staff. This means they ensure that best practices in teaching, evaluating, validation, and facilitation of critical thinking are used. They coordinate the learning experience, engaging the talents of associate preceptors and expert clinical staff who engage in the learning process under the primary preceptors guidance and direction. The role of the primary preceptor parallels the role of the Primary Nurse when used in the learning context of the precepted experience.

Resiliency
Preceptors are responsible for building capacity in others. Resiliency in the RBP framework is defined as the ability to navigate stress by engaging attitudes, thoughts, communication strategies, and behaviors that build a healthy and emotionally safe working environment. When an individual's capacity to handle stress is fully developed, he or she is able to more fully engage in a therapeutic relationship that inspires trust and healing. A trusting relationship between preceptor and preceptee is necessary for a positive learning experience. This is supported by Barbara Fredrickson's Broaden and Build theory which states that those who engage in behaviors that facilitate trust, healing, and positivity are more likely to expand their capacity to engage with others in a healthy way and to think in ways that facilitate better problem solving (Fredrickson & Branigan, 2005).

It is often assumed that because we are caregivers, we have the skills to connect with patients, families, and coworkers in this way. What I have observed, and what is often apparent by low patient satisfaction scores, is that often we either do not have these skills, or due to various barriers, we are not consistently practicing them. In addition to being a skilled therapeutic practitioner, preceptors need to be able to teach these skills and evaluate them in others. The RBP framework embraces all practices that build capacity and inspire an authentic connection with others; however, the therapeutic practices contained in the *See me as a Person* work are the skills used to ensure that resiliency is addressed and are considered an interpersonal competency for both preceptors and preceptees. In the Relationship-Based Precepting framework, preceptors must be proficient in the skills of attuning, wondering, following, and holding and be able to assess and teach those skills to new staff during the precepted experience. The practices of attuning, wondering, following, and holding in the RBP framework are considered an advanced

curriculum to be introduced to preceptors who have already had formal instruction in basic preceptor concepts such as adult learning theory, how to facilitate basic critical thinking and clinical judgment skills, constructive communication skills, basic leadership, and how to facilitate a safe learning environment.

The RBP framework is a standalone framework that can be applied to any precepting process or method.

The Relationship-Based Precepting framework incorporates the change methodology of I_2E_2, which was developed by Jayne Felgen (Felgen, 2007) and is explained in more detail on pages 11-12 of this document. RBP functions best when it is applied within a comprehensive preceptor program that encompasses the following elements:

I_2 and I_2 = Inspiration and Infrastructure:

- Key leaders and stakeholders (CNO, directors, managers, and educators) are involved in setting the mission and vision for preceptor standards, processes, and outcomes through a consistent and ongoing method that is informed by preceptors and preceptees.
- Program processes and structures are revised on an ongoing basis, informed by program outcome evaluation data.
- Preceptor recognition is a core structure within the preceptor program.
- Standardized Preceptor Selection Criteria is a core structure within the preceptor program.

E_2 and E_2 = Education and Evidence:

- Program outcomes are identified and then evaluated at regular intervals on an ongoing basis.
- Program processes and structures are revised on an ongoing basis, informed by program outcome evaluation data.
- Preceptor professional development is addressed on a novice to expert continuum and is provided on an ongoing basis that includes basic and advanced curriculum.
- Basic and advanced preceptor course curriculum is evaluated on an ongoing basis and revised/ updated as needed.
- Preceptor/Preceptee needs assessment is incorporated on an ongoing basis to inform preceptor course curriculum revisions.

Many preceptor programs are focused only on the curriculum for basic precepting skills or the processes and structures used in the precepting process. My experience has led me to believe that you can have stellar preceptors who understand precepting best practices and attempt to do all the right things, but if you do not have managers and educators who know how their role aligns and is designed to support those best practices, you will not have the outcomes you are hoping for.

For example, one of the first organizations I assisted in developing a preceptor program decided they did not need manager education related to the manager's role in supporting the development of a standardized

organizational preceptor program. Resources were directed toward developing a basic preceptor course and a preceptor policy. Rollout consisted of educating all preceptors to the new policy and completing the new basic preceptor course. Educators were educated on the newest thinking related to creating healthy learning environments, facilitating critical thinking, and applying adult learning principles during the precepting process. These concepts were then incorporated into the basic preceptor curriculum. One of the best practices identified and educated to, was the importance of sitting down on a consistent basis with the preceptee, away from the clinical area, to provide feedback. When the preceptors attempted to apply this practice, they found that concessions to their assignment had not been approved by their unit managers and a tug of war ensued between preceptors and charge nurses who were responsible for making the preceptor/preceptee assignments. Ultimately, preceptors were unable to get away from patient care long enough to give meaningful feedback to their preceptee on a consistent basis. Evaluation of preceptee progress was done as a hoop that had to be jumped through, often meaning preceptors would complete the evaluations at the end of the precepted experience and turn them in to the educator as was required, but the evaluations had not been completed nor used with the intention for which they were designed: to identify, remediate, and facilitate learning in the preceptee.

Although preceptors attempted to apply the strategies and best practices learned in their basic precepting course, they were unsuccessful due to managers not understanding their role in supporting the work of the preceptors.

At a different organization, managers attended a 3-day workshop called Leading an Empowered Organizations. This workshop was designed to give managers the tools necessary to manage any kind of change initiative, and focused specifically on empowering staff using the principles of responsibility, accountability and authority. This workshop was implemented prior to the rollout of their preceptor program. When it came time to implement the structures, processes, and specific unit-based strategies related to the day-to-day work of precepting, managers had a solid understanding of how to partner with preceptors and educators. When barriers were presented, such as finding time to teach, managers were engaged in the process with preceptors and educators in creating ways to address those barriers. The outcome for this particular unit was a shifting of the charge nurse role that provided the capacity to take over the preceptor/preceptee's assignment for a period of time to allow them to debrief their day, evaluate learning needs, and plan for new experiences.

No matter what precepting approach or methodology is used, attention to the four core elements and four relationships will yield best results in developing an empowered learning environment.

When educating preceptors on which precepting methodology they should use, it's helpful to weigh them against the four best practices contained within the Relationship-Based Precepting framework. It may be necessary to combine methods and add other practices to meet the requirements of diligent supervision, socialization, professional practice, and therapeutic practices. For instance, married STATE (a method found in the literature) paired with cognitive apprenticeship provides a solid foundation for incorporating strategies where supervision and professional practice are embedded, but may need additional thought to what therapeutic practices will be used and how a formal socialization process will be addressed.

The principles, philosophies, and practices described in the RBP framework pull from other theoretical frameworks and models such as Relationship-Based Care (RBC), the I_2E_2 change model, the Leading an Empowered Organization leadership framework, Primary Nursing, and the therapeutic practices outlined

in the *See Me as a Person Work,* which are grounded in attachment theory and human connection theory. Relationship-Based Care, which is the primary model on which Relationship-Based Precepting is based, incorporates all the other previously mentioned frameworks and models. RBC has been applied and tested in the health care industry with improved outcomes related to patient satisfaction scores (HCAHPS), employee engagement and satisfaction, employee retention, and clinical outcomes. Other conceptual models and/or frameworks used in the development of the Relationship-Based Precepting model are:

- The Broaden and Build theory by Barbara Fredrickson
- Theory of Interpersonal Relations by Hildegard Peplau
- Attachment Theory by John Bowlby
- Theory of Caring by Kristen Swanson

Relationship-Based Precepting leverages best practices in change management, leadership development, team building, and communication, and it applies them to the learning environment, operationalized in the day-to-day work of precepting.

Outcomes related to the implementation of Relationship-Based Precepting will vary depending on specific organizational goals and how they choose to implement the concepts and practices of RBP.

Relationship-Based Precepting Program Implementation

Program implementation uses the change methodology of I_2E_2. I_2E_2 stands for Inspiration, Infrastructure, Education, and Evidence.

Inspiration speaks to engaging the mindset of others to embrace the vision, values, and goals of any program initiative. When organizations embark on developing new processes or ways of doing things, they will encounter speed bumps along the way that impair the progress of embedding new practices or ways of thinking into the culture. Knowing how to engage others in the phase of inspiration is an important part of any program implementation. During the inspiration phase leaders learn how to articulate program expectations, inspire participation from others, and direct the action of others by articulating roles, responsibilities, and levels of authority at each stage of a change process. As Jayne Felgen, the developer of the I_2E_2 change process, writes: "Inspiration helps others to see that the benefits of change outweigh the risks of upsetting the status quo. Inspiration ignites our passion—it creates energy in us. At its best, it helps us to see that it is our unique talents that make us valuable contributors to change" (Felgen, 2007).

Infrastructure speaks to the roles, practices, standards, and systems that actively advance the realization of your organization's vision for change. Infrastructure is the framework that facilitates the operationalization of practices into the day-to-day work of clinicians. Infrastructure helps guide the strategic planning of any program to produce the philosophical directives that in turn shape the action planning at the operational and tactical levels (Felgen, 2007).

Education speaks to the design, planning, and implementation related to the organization's educational offerings. Educational methods using this approach address the technical, critical thinking, and interpersonal skills necessary to develop both formal and informal leaders necessary to move any program or change initiative forward. "When you offer a truly comprehensive staff development program to your workforce, employees feel they are competent not only to "do their jobs," but to manage their own relationships, do their own critical and creative thinking, and make their own decisions on the job" (Felgen, 2007, page 60).

Evidence speaks to how organizations assess how successful their efforts in the areas of inspiration, infrastructure, and education were in advancing the organization's new vision. Related to program development, it looks at outcomes from each area described in I_2E_2. This process creates a cycle of reviewing stages of success and highlighting areas that need to be revised as the change process is taking place. This phase of change addresses the questions of how organizations will determine that they have sustained their focus on the vision for change, and it helps direct the thinking towards what key process and outcomes measures**—**strategic, operational and tactical indicators—are most important to capture (Felgen, 2007, page 64).

Relationship-Based Precepting borrows the implementation strategy used in the Relationship-Based Care delivery system. This strategy uses shared governance philosophies and structures to empower staff to operationalize the vision and best practices of Relationship-Based Precepting into their day-to-day precepting practices. Whether preceptors link to existing shared governance councils and committees or organizations choose to form separate councils and/or committees that are comprised of only preceptors, the goal is to empower those who do the work of precepting to participate in the decision making of how precepting is carried out at the unit level. This ensures program sustainability over time and creates a structure where new best practices unique to the organization's culture are given a creative platform to grow, develop, and mature.

If your organization does not currently have an active or robust shared governance structure, it is still possible to apply the principles when implementing the Relationship-Based Precepting framework.

How does an organization start on this journey?

There are many ways an organization can begin the process of bringing Relationship-Based Precepting into their organization.

The first step is to understand what elements of a preceptor program currently exist in your organization and how they link or do not link to other critical onboarding programs such as an orientation, residency, and/or competency program. The second step is to assess what key program elements need to be developed and implemented and what level of internal resources are available to assist you with this.

If you would like to bring Relationship-Based Precepting to your organization, or you would like a free consultation on building a robust preceptor or orientation program, contact Traci Hanlon at thanlon@chcm.com or call her directly at 503-453-0253.

References

Amos, D. (2001). An evaluation of staff nurse role transition. *Nursing Standard, 16*(3), 36-41.

Avillion, A., Buchwach, D., Brunt, B., Swihart, D., Hanlon, T., & Byrne, J. (2008). Nursing orientation program builder: Tools for a successful new hire program. HcPro Inc.

Bauer, T., & Green, S. (1994). Effect of newcomer involvement in work-related activities: A longitudinal study of socialization. *Journal of Applied Psychology. Vol 79*(2).

Beeman, K. L., Jernigan, A. C., & Hensley, P. D. (1999). Employing new grads: A plan for success. *Nursing Economy. 17*(2).

Beecroft, P. C., Kunzman, L. & Krozek, C. (2001). RN internship outcomes of a one-year pilot program. *The Journal of Nursing Administration, 31*(12), 575-582.

Boekaerts, M. (1993). Being concerned with well-being and with learning. *Educational Psychologist, 28*(2), 149-167.

Boychuk, J. (2002). Bending a habit: Critical social theory as a framework for humanistic nursing education. *Nurse Education Today. Vol 20*(6).

Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology, 28*(5), 759.

Baumann, A., O'Brien-Pallas, L., Armstrong-Stassen, M., Blythe, J., Bourbonnais, R., Cameron, S., Doran, D., Kerr, M., Hall, L., Zina, M., Butt, M. & Ryan, L. (2001). Commitment and care: The benefits of a healthy workplace for nurses, their patients and the system. Canadian Health Services Research Foundation and The Change Foundation.

Edgecombe, K., & Bowden, M. (2009). The ongoing search for best practice in clinical teaching and learning: A model of nursing students' evolution to proficient novice registered nurses. *Nurse Education in Practice, 9*(2), 91-101.

Elsevier MC Strategies. (2010). White paper: Preceptor preparation improves retention rates. http://www.mcstrategies.com/media/MosbysPreceptor_WP.pdf. Accessed November 1, 2013.

Felgen, J. (2007). *I$_2$E$_2$: Leading lasting change.* Minneapolis, MN: Creative Health Care Management.

Fey, M. K. & Miltner, R. S. (2000). A competency-based orientation program for new graduate nurses. *Journal of Nursing Administration, 30*(3), 126-132.

Figueroa, S., Bulos, M., Forges, E., & Judkins-Cohn, T. (2013). Stabilizing and retaining a quality nursing work force through the use of the Married State Preceptorship Model. *Journal of Continuing Education in Nursing,* 1-9.

Fredrickson, B. L. (2004). The broaden-and-build theory of positive emotions. *Philosophical Transactions-Royal Society of London Series B Biological Sciences,* 1367-1378.

Fredrickson, B. L. (2001). The role of positive emotions in positive psychology: The broaden-and-build theory of positive emotions. *American Psychologist, 56*(3), 218.

Fredrickson, B. L., & Joiner, T. (2002). Positive emotions trigger upward spirals toward emotional well-being. *Psychological Science, 13*(2), 172-175.

Fredrickson, B. L., & Branigan, C. (2005). Positive emotions broaden the scope of attention and thought-action repertoires. *Cognition & Emotion, 19*(3), 313-332.

Fredrickson, B. L., & Losada, M. F. (2005). Positive affect and the complex dynamics of human flourishing. *American Psychologist, 60*(7), 678.

Fredrickson, B. L. (2000). Cultivating positive emotions to optimize health and well-being. *Prevention & Treatment, 3*(1), 1a.

Hagerty, B. M., Williams, R. A., Coyne, J. C., & Early, M. R. (1996). Sense of belonging and indicators of social and psychological functioning. *Archives of Psychiatric Nursing, 10*(4), 235-244.

Hagerty, B. M., & Patusky, K. L. (2003). Reconceptualizing the nurse-patient relationship. *Journal of Nursing Scholarship, 35*(2), 145-150.

Hanlon, T. (2009). *Difficult conversations in precepting, from eating our young, to nurturing our young.* Germany: Lambert Academic Publishing.

Koloroutis, M., & Trout, M. (2012). *See me as a person: Creating therapeutic relationships with patients and their families.* Minneapolis, MN: Creative Health Care Management.

Koloroutis, M. (2004). *Relationship-Based Care: A model for transforming practice.* Minneapolis, MN: Creative Health Care Management.

Pellico, L. H., Djukic, M., Kovner, C. T., & Brewer, C. S. (2010). Moving on, up or out: Changing work needs of new RNs at different stages of their beginning nursing practice. *The Online Journal of Issues in Nursing 15*(1). http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol152010/No1Jan2010/Articles-Previous-Topic/Changing-Work-Needs-of-New-RNs.aspz. Accessed November 17, 2013.

Levett-Jones, T., & Lathlean, J. (2009). The ascent to competence conceptual framework: an outcome of a study of belongingness. *Journal of Clinical Nursing, 18*(20), 2870-2879.

Levett-Jones, T., Lathlean, J., McMillan, M., & Higgins, I. (2007). Belongingness: A montage of nursing students' stories of their clinical placement experiences. *Contemporary Nurse, 24*(2), 162-174.

Levett-Jones T., Lathlean J. (2008). Belongingness: A per-requisite for nursing student's clinical learning. *Nursing Education in Practice,* 36.

Lyndon, A. (2006). Communication and teamwork in patient care: How much can we learn from aviation?. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 35*(4), 538-546.

Malouf, N., & West, S. (2011). Fitting in: A pervasive new graduate nurse need. *Nurse Education Today, 31*(5), 488-493.

Mariani, B. (2002). The effect of mentoring on career satisfaction of registered nurses and intent to stay in the nursing profession. *Nursing Research and Practice.* Vol 2012.

Marks, N., & Shah, H. (2004). A well-being manifesto for a flourishing society. *Journal of Public Mental Health, 3*(4), 9-15.

Mellor, D., Stokes, M., Firth, L., Hayashi, Y., & Cummins, R. (2008). Need for belonging, relationship satisfaction, loneliness, and life satisfaction. *Personality and Individual Differences, 45*(3), 213-218.

Miles, K. (2011). Using attachment theory in mentoring. *Nursing Times, 107*(38), 23.

Nash, R., Lemcke, P., & Sacre, S. (2009). Enhancing transition: An enhanced model of clinical placement for final year nursing students. *Nurse Education Today, 29*(1), 48-56.

Nelson, D. L., & Quick, J. C. (1991). Social support and newcomer adjustment in organizations: Attachment theory at work?. *Journal of Organizational Behavior, 12*(6), 543-554.

Noseworthy, T. & Harnett, L. (2002). Perceptions of graduate preparedness in the health sector Newfoundland and Labrador. St. John's, NL: Health andCommunity Services Human Resources Sector Study.

Oermann, M. H. & Garvin, M. F. (2002). Stresses and challenges for new graduates in hospitals. *Nurse Education Today, 22,* 225-230.

Peplau, H. E. (1997). Peplau's theory of interpersonal relations. *Nursing Science Quarterly, 10*(4), 162-167.

Peplau, H. E. (1992). Interpersonal relations: A theoretical framework for application in nursing practice. *Nursing Science Quarterly, 5*(1), 13-18.

Reising, D. L. (2002). Early socialization of new critical care nurses. *American Journal of Critical Care, 11*(1), 19-26.

Remus, G., Smith, B., & Schissel, B. (2000). Creating supportive environments for registered nurses in Saskatchewan. Saskatoon, SK: University of Saskatchewan.

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist, 55*(1), 68.

Sedgwick, M., & Yonge, O. (2008). 'We're in it,' 'we're a team,' 'we're family' means a sense of belonging. *Rural and Remote Health, 8,* 1021.

Swanson, K. M. (1993). Nursing as informed caring for the well-being of others. *Journal of Nursing Scholarship, 25*(4), 352-357.

Tanner, A. (2002). Professional staff education: Quantifying costs and outcomes. *Journal of Nursing Administration, 32*(2), 91-97.

The Advisory Board Company. (2008). Justifying the onboarding investment. Published September 26, 2008. Accessed September 16, 2013.

The Studer Group. (2009). Moving to Magnet: reduce RN turnover. *Hardwired Results.* 2009: 11. http://www.studergroup.com/newsletter/Vol1_Issue11_article4html. Accessed January 18, 2010.

The New Economics Foundation. (2010). Five ways to wellbeing. *NHS Confederation.* Accessed Jan 1, 2013 at: http://www.nhsconfed.org/Publications/reports/Pages/Five-ways-to-wellbeing.aspx

Warren, A., & Denham, S. (2010). Relationships between formalized preceptor orientation and student outcomes. *Teaching and Learning in Nursing, 5.*

Watkins, C. (2013). The effect of preceptor role effectiveness on newly licensed registered nurses' perceived psychological empowerment and professional autonomy. *Dissertations, Theses and Capstone Projects.* Paper 595. http://digitalcommons.kennesaw.edu/etd/595

Whitehead, J. (2001). Newly qualified staff nurses' perceptions of the role transition. *British Journal of Nursing, 10*(5), 330-339.

Winter-Collins, A. & McDaniel, A. (2000). Sense of belonging and new graduate satisfaction. *Journal for Nurses in Staff Development, 16*(3), 103-111.

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