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Intrinsic Benefits and Rewards of Precepting

Clinical Question

P (population) Among healthcare professionals
I (intervention) that precept
C (comparison) versus those that do not
O (outcome) what are the intrinsic benefits and rewards?

Definitions *for terms marked with * may be found in the Supporting Information section.*

Target Population

Healthcare professionals who precept* others

Recommendation

It is strongly recommended that healthcare professionals engage in precepting as a means of increasing professional growth*, personal and job satisfaction, morale, personal growth*, and quality of care *(Atkins & Williams, 1994 [2a]; Chen, Duh, Feng, & Huang, 2011 [2a]; Hartley, Macfarlane, Gandtley, & Murray, 1999[2b]; Baldor,Brooks, Warfield, & O'Shea, 2001 [4a]; Bizek & Oermann, 1990 [4a]; Cook, Griffith, & Sackett, 1995 [4a]; Dibert & Goldenberg, 1995 [4a]; Grayson, Klein, Lugo, & Visintainer, 1998 [4a]; Kumar, Kallen, & Mathew, 2002 [4a]; Lee, Tzeng, Lin & Yeh, 2009 [4a]; Scott & Sazegar, 2006 [4a]; Stevenson, Doorley, Moddeman, & Benson-Landau, 1995 [4a]; Usher, Nolan, Reser, Owens, & Tollefson, 1999 [4a]; Fulkerson & Wang-Cheng, 1997 [4b]; Yonge & Myrick, 2004 [4b]; Young, Theriault, & Collins, 1989 [4b]).*

> Note: Research states sufficient support and resources are necessary to maximize benefits and minimize the burden of precepting *(Atkins et al., 1994 [2a]; Chen et al., 2011 [2a]; Hartley et al., 1999 [2b]; Bizek et al., 1990 [4a]; Dibert et al., 1995 [4a]; Lee et al., 2009 [4a]; Stevenson et al., 1995 [4a]; Usher et al., 1999 [4a]; Yonge et al., 2004 [4b]; Young et al., 1989 [4b]).*

Discussion/Synthesis of Evidence Related to the Recommendation

There is strong evidence healthcare professionals engaging as preceptors experience intrinsic rewards and benefits as a result of this role *(Atkins et al., 1994 [2a]; Chen et al., 2011 [2a]; Hartley et al., 1999 [2b]; Baldor et al., 2001 [4a]; Bizek et al., 1990 [4a]; Cook et al., 1995 [4a]; Dibert et al., 1995 [4a]; Grayson et al., 1998 [4a]; Kumar et al., 2002 [4a]; Lee et al., 2009 [4a]; Scott et al., 2006 [4a]; Stevenson et al., 1995 [4a]; Usher et al., 1999 [4a]; Fulkerson et al., 1997 [4b]; Yonge et al., 2004 [4b]; Young et al., 1989 [4b])*. The intrinsic rewards and benefits experienced by preceptors are shown by category in Table 1.

Many studies found the act of precepting provided opportunities for professional growth. Preceptors often engage in professional learning, thus gaining increased professional knowledge and competence (*Atkins et al., 1994 [2a]; Chen et al., 2011 [2a]; Hartley et al., 1999 [2b]; Baldor et al., 2001 [4a]; Bizek et al., 1990 [4a]; Cook et al., 1995 [4a]; Dibert et al., 1995 [4a]; Grayson et al., 1998 [4a]; Kumar et al., 2002 [4a]; Lee et al., 2009 [4a]; Stevenson et al., 1995 [4a]; Usher et al., 1999 [4a]; Fulkerson et al., 1997 [4b]; Yonge et al., 2004 [4b]; Young et al., 1989 [4b])*. Items categorized as professional growth included concepts such as: stimulated thinking, reading literature, reciprocal learning with student, desire to keep up with the latest literature, clinical skills, and professional competence, ability, and growth.

In addition, many studies found an increase in personal satisfaction, job satisfaction, and morale as a result of precepting *(Atkins et al., 1994 [2a]; Chen et al., 2011 [2a]; Hartley et al., 1999 [2b]; Baldor et al., 2001 [4a]; Dibert et al., 1995 [4a]; Grayson et al., 1998 [4a]; Kumar et al., 2002 [4a]; Lee et al., 2009 [4a]; Scott et al., 2006 [4a]; Stevenson et al., 1995 [4a]; Usher et al., 1999 [4a]; Fulkerson et al., 1997 [4b]; Young et al., 1989 [4b])*. Personal and job satisfaction were

operationally defined throughout the literature by measures of job, personal, professional, emotional, and staff satisfaction. Morale was demonstrated by measures of enthusiasm, enjoyment of practice, altruism, and feelings of deep achievement.

Lastly, the studies found as a result of precepting there was an increase in personal growth and quality of care *(Chen et al., 2011 [2a]; Hartley et al., 1999 [2b]; Baldor et al., 2001 [4a]; Stevenson et al., 1995 [4a]; Usher et al., 1999 [4a]; Young et al., 1989 [4b]).* Personal growth was derived from the idea of confidence, self-esteem, and self-growth. Quality of care included concepts such as quality of practice and improved patient care.

Table 1 Intrinsic rewards & benefits experiences by preceptors

	Professional Growth	Personal & Job Satisfaction	Morale	Personal Growth	Quality of Care
Atkins, S., & Williams, A. (1995) [2a]	8	1			
Baldor, R. A., Brooks, W. B., Warfield, M. E., & O'Shea, K. (2001) [4a]	1		1		1
Bizek, K. S., & Oermann, M. H. (1990) [4a]	4				
Chen, Y., Duh, Y., Feng, Y., & Huang, Y. (2011) [2a]	5	4	1	2	1
Cook, D. J., Griffith, L. E., & Sackett, D. L. (1995) [4a]	1				
Dibert, C., & Goldenberg, D. (1995) [4a]	4	1			
Fulkerson, P. K., & Wang-Cheng, R. (1997) [4b]	1	1			
Grayson, M. S., Klein, M., Lugo, J., & Visintainer, P. (1998) [4a]	2	1	1		
Hartley, S., Macfarlane, F., Gantley, M., & Murray, E. (1999) [2b]	3		2	1	
Kumar, A., Kallen, D. J., & Mathew, T. (2002) [4a]	1	1	1		
Lee, T., Tzeng, W., Lin, C., & Yeh, M. (2009) [4a]	2	1			
Scott, I., & Sazegar, P. (2006) [4a]			2		
Stevenson, B., Doorley, J., Moddeman, G., & Benson-Landau, M. (1995) [4a]	1	1	1	2	1
Usher, K., Nolan, C., Reser, P., Owens, J., & Tollefson, J. (1999) [4a]	5	1	1	1	
Yonge, O., & Myrick, F. (2004) [4b]	2				
Young, S., Theriault, J., & Collins, D. (1989) [4b]	2	1		1	

*Number represents items mentioned in each category

LEGEND:

Professional growth: stimulated thinking, reading literature, reciprocal learning with student, desire to keep up with the latest literature, clinical skills, and professional competence, ability, and growth

Personal and job satisfaction: job, personal, professional, emotional, and staff satisfaction

Morale: enthusiasm, enjoyment of practice, altruism, and feelings of deep achievement

Personal growth: confidence, self-esteem, and self-growth

Quality of care: quality of practice and improved patient care

Reference List

Atkins, S., & Williams, A. (1995). Registered nurses' experiences of mentoring undergraduate nursing students. *Journal of Advanced Nursing, 21*(5), 1006-1015 [2a].

Baldor, R. A., Brooks, W. B., Warfield, M. E., & O'Shea, K. (2001). A survey of primary care physicians' perceptions and needs regarding the precepting of medical students in their offices. *Medical Education, 35*(8), 789-795 [4a].

Bizek, K. S., & Oermann, M. H. (1990). Study of educational experiences, support, and job satisfaction among critical care nurse preceptors. *Heart & Lung : The Journal of Critical Care, 19*(5 Pt 1), 439-444 [4a].

Chen, Y., Duh, Y., Feng, Y., & Huang, Y. (2011). Preceptors' experiences training new graduate nurses: A hermeneutic phenomenological approach. *Journal of Nursing Research (Lippincott Williams & Wilkins), 19*(2), 132-140 [2a].

Cook, D. J., Griffith, L. E., & Sackett, D. L. (1995). Importance of and satisfaction with work and professional interpersonal issues: A survey of physicians practicing general internal medicine in ontario. *CMAJ : Canadian Medical Association Journal = Journal De l'Association Medicale Canadienne, 153*(6), 755-764 [4a].

Dibert, C., & Goldenberg, D. (1995). Preceptors' perceptions of benefits, rewards, supports and commitment to the preceptor role. *Journal of Advanced Nursing, 21*(6), 1144-1151 [4a].

Fulkerson, P. K., & Wang-Cheng, R. (1997). Community-based faculty: Motivation and rewards. *Family Medicine, 29*(2), 105-107 [4b].

Grayson, M. S., Klein, M., Lugo, J., & Visintainer, P. (1998). Benefits and costs to community-based physicians teaching primary care to medical students. *Journal of General Internal Medicine, 13*(7), 485-488 [4a].

Hartley, S., Macfarlane, F., Gantley, M., & Murray, E. (1999). Influence on general practitioners of teaching undergraduates: Qualitative study of london general practitioner teachers. *BMJ (Clinical Research Ed.), 319*(7218), 1168-1171 [2b].

Kumar, A., Kallen, D. J., & Mathew, T. (2002). Volunteer faculty: What rewards or incentives do they prefer? *Teaching & Learning in Medicine, 14*(2), 119-123 [4a].

Lee, T., Tzeng, W., Lin, C., & Yeh, M. (2009). Effects of a preceptorship programme on turnover rate, cost, quality and professional development. *Journal of Clinical Nursing, 18*(8), 1217-1225. doi:10.1111/j.1365-2702.2008.02662.x [4a].

Scott, I., & Sazegar, P. (2006). Why community physicians teach students (or not): Barriers and opportunities for preceptor recruitment. *Medical Teacher, 28*(6), 563-565 [4a].

Stevenson, B., Doorley, J., Moddeman, G., & Benson-Landau, M. (1995). The preceptor experience. A qualitative study of perceptions of nurse preceptors regarding the preceptor role. *Journal of Nursing Staff Development, 11*(3), 160-165 [4a].

Usher, K., Nolan, C., Reser, P., Owens, J., & Tollefson, J. (1999). An exploration of the preceptor role: Preceptors' perceptions of benefits, rewards, supports and commitment to the preceptor role. *Journal of Advanced Nursing, 29*(2), 506-514 [4a].

Yonge, O., & Myrick, F. (2004). Preceptorship and the preparatory process for undergraduate nursing students and their preceptors. *Journal for Nurses in Staff Development, 20*(6), 294-297 [4b].

Young, S., Theriault, J., & Collins, D. (1989). The nurse preceptor: Preparation and needs. *Journal of Nursing Staff Development, 5*(3), 127-131 [4b].

IMPLEMENTATION

Applicability Issues

When implementing a preceptor program it is important to provide adequate training, structure and support to reduce burden and fully realize the intrinsic benefits and rewards *(Atkins et al., 1994 [2a]; Chen et al., 2011 [2a]; Hartley et al., 1999 [2b]; Bizek et al., 1990 [4a]; Dibert et al., 1995 [4a]; Lee et al., 2009 [4a]; Stevenson et al., 1995 [4a]; Usher et al., 1999 [4a]; Yonge et al., 2004 [4b]; Young et al., 1989 [4b]).* First, a training program would have to be implemented and

available for those becoming preceptors. It should provide evidence-based education and support. This training would ideally be available throughout the year. Training should include opportunities for practice and critical thinking, as well as a section on evaluation theory and methods. A preceptorship program should provide support structures as part of the precepting experience. These support structures might include: flexibility in scheduling, time included in work load for precepting, appropriate staffing, awareness and support from colleagues (consultation, understanding of duty to students, and in reviewing workloads), financial support, and sources of guidance. Finally, there would have to be a system set in place to identify potential preceptors, match preceptors with preceptees based on adult learning theory, and monitor burn-out. Timing, competency, ability, and desire should be taken into consideration when identifying potential preceptors. It would be important to match learning and teaching styles amongst preceptors and preceptees. This would foster more efficient and productive growth throughout the preceptor experience. Burn-out could potentially be reduced by making precepting optional; giving preceptors an option enables them to feel empowered to put self-care first and reflect upon their current desire to be a preceptor.

Relevant CCHMC Tools for Implementation

Center for Professional Excellence/Education: Preceptor Program
ELM Modules:

- Precepting: Adult Learners (CHEX) (CS 00929)
- Precepting: Roles and Responsibilities (CHEX) (CS 01032)
- Precepting: What is a Preceptor? (CHEX) (CS 00939)
- Preceptor Development Workshop (CS 00852)
- Preceptor Enrichment: Assessing Competencies for New RN Staff (CS 02698)
- Preceptor Enrichment: Closing the Loop on Feedback and Evaluation (CS 03045)
- Preceptors and the New Graduate RN Residency (CS 01080)
- RCNIC Preceptor Workshop (CS 00884)
- RN Preceptor Enrichment Program: Goal Setting for New RN Hires: How Important is it? (CS 03068)

Outcome or Process Measures

When implementing this recommendation it is vital measurements be taken to confirm effectiveness of increasing professional growth, personal and job satisfaction, morale, personal growth, and quality of care. Measures for quality of care might be decreased medication errors and patient fall rates and increased practicing of latest medical techniques, following of policies and procedures, and enhanced patient/family education (*Chen et al., 2011 [2a]; Baldor et al., 2001 [4a]; Lee et al., 2009 [4a]; Stevenson et al., 1995 [4a])*. Measuring preceptor's desire to continue, calculating the retention rate of preceptors would also be important. The Preceptor's Perception of Support Scale and the Commitment to the Preceptor Role (*Dibert et al., 1995 [4a])* is one tool to measure the benefits, rewards, support, and commitment experienced by those that precept others. It would also be important to measure the effectiveness of implementing a preceptor program. A simple measure for this would be to measure any increase/decrease in preceptors participating in the program.

SUPPORTING INFORMATION

Background/Purpose of BESt Development

Within healthcare professions there is an abundance of opportunities to participate in the preceptorship of those entering the field. With a growing demand for preceptors and simultaneous demand for increased efficiency and productivity, the value of participating in a preceptor role must be identified. Evidence is needed to validate that preceptorship programs are beneficial to an institution and an efficient, productive use of healthcare professionals' time.

Definitions

Precept: to facilitate the learning and increase the competence of a novice
Professional growth: increasing professional knowledge and capability
Personal growth: a positive increase in sense of self

Search Strategy

Terms: Retention, mentor, preceptorship, benefits, reward, professional development, precept*, personnel retention, skill retention, critical thinking, cognition, learning, problem solving, reflective learning, thinking, reciprocal learning, nursing knowledge, professional knowledge
Databases: PubMed, Cinahl, hand searched references of articles found in database
Date range: Limited to articles printed in English and between the years of 1980 through 2012
Last search: 4/3/12

Relevant CCHMC Evidence-Based Documents

None were found

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Conflicts of Interest were declared for each team member:

- ☒ No financial or intellectual conflicts of interest were found.
- ☒ No external funding was received for development of this BESt.
- ☐ The following conflicts of interest were disclosed:

Note: Full tables of the LEGEND evidence evaluation system are available in separate documents:

- Table of Evidence Levels of Individual Studies by Domain, Study Design, & Quality *(abbreviated table below)*
- Grading a Body of Evidence to Answer a Clinical Question
- Judging the Strength of a Recommendation *(dimensions table below)*

Table of Evidence Levels *(see note above)*:

Quality level	*Definition*
1a† or 1b†	Systematic review, meta-analysis, or meta-synthesis of multiple studies
2a or 2b	Best study design for domain
3a or 3b	Fair study design for domain
4a or 4b	Weak study design for domain
5a or 5b	General review, expert opinion, case report, consensus report, or guideline
5	Local Consensus

†a = good quality study; b = lesser quality study

Table of Language and Definitions for Recommendation Strength *(see note above)*:

Language for Strength	*Definition*
It is strongly recommended that… It is strongly recommended that… not…	When the dimensions for judging the strength of the evidence are applied, there is high support that benefits clearly outweigh risks and burdens. *(or visa-versa for negative recommendations)*
It is recommended that… It is recommended that… not…	When the dimensions for judging the strength of the evidence are applied, there is moderate support that benefits are closely balanced with risks and burdens.
There is insufficient evidence and a lack of consensus to make a recommendation…	

Given the dimensions below and that more answers to the left of the scales indicate support for a stronger recommendation, the recommendation statement above reflects the strength of the recommendation as judged by the development group.
(Note that for negative recommendations, the left/right logic may be reversed for one or more dimensions.)

Rationale for judgment and selection of each dimension:

1. Grade of the Body of Evidence	☒ High	☐ Moderate	☐ Low
Rationale:			
2. Safety/Harm (Side Effects and Risks)	☒ Minimal	☐ Moderate	☐ Serious
Rationale: Medication error rates of new staff were found to drop from 50% to 0% during the time of the preceptorship program study (Lee et al., 2009 [4a]).			
3. Health benefit to patient	☐ Significant	☒ Moderate	☐ Minimal
Rationale: Several studies found an increase in quality of care by those precepting (Chen et al., 2011 [2a]; Baldor et al., 2001 [4a]; Stevenson et al., 1995 [4a]).			
4. Burden on patient to adhere to recommendation	☐ Low	☒ Unable to determine	☐ High
Rationale: Research states sufficient support for precepting is necessary to minimize the burden on the preceptor. This may be different in each institution (Atkins et al., 1994 [2a]; Chen et al., 2011 [2a]; Bizek et al., 1990 [4a]; Dibert et al., 1995 [4a]; Lee et al., 2009 [4a]; Stevenson et al., 1995 [4a]; Usher et al., 1999 [4a]; Yonge et al., 2004 [4a]; Young et al., 1989 [4a]).			
5. Cost-effectiveness to healthcare system	☐ Cost-effective	☒ Inconclusive	☐ Not cost-effective
Rationale: Further research is needed to identify the cost-effectiveness of precepting on the healthcare system.			
6. Directness of the evidence for this target population	☒ Directly relates	☐ Some concern of directness	☐ Indirectly relates
Rationale:			
7. Impact on morbidity/mortality or quality of life	☒ High	☐ Medium	☐ Low
Rationale: Several studies found that there was an increase in preceptor satisfaction, morale, and personal and professional growth, indicating an increase in quality of life (Atkins et al., 1994 [2a]; Chen et al., 2011 [2a]; Hartley et al., 1999[2b]; Baldor et al., 2001 [4a]; Bizek et al., 1990 [4a]; Cook et al., 1995 [4a]; Dibert et al., 1995 [4a]; Grayson et al., 1998 [4a]; Kumar et al., 2002 [4a]; Lee et al., 2009 [4a]; Scott et al., 2006 [4a]; Stevenson et al., 1995 [4a]; Usher et al., 1999 [4a]; Fulkerson et al., 1997 [4b]; Yonge et al., 2004 [4b]; Young et al., 1989 [4b]). In addition, studies showed an increase in quality of care (of patients) and medication error rates decreasing as a result of a preceptorship program (Lee et al., 2009 [4a]).			

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This Best Evidence Statement has been reviewed against quality criteria by two independent reviewers from the CCHMC Evidence Collaboration. Conflict of interest declaration forms are filed with the CCHMC EBDM group.

Once the BESt has been in place for five years, the development team reconvenes to explore the continued validity of the guideline. This phase can be initiated at any point that evidence indicates a critical change is needed. CCHMC EBDM staff perform a quarterly search for new evidence in an horizon scanning process. If new evidence arises related to this BESt, authors are contacted to evaluate and revise, if necessary.

For more information about CCHMC Best Evidence Statements and the development process, contact the Evidence Collaboration at EBDMinfo@cchmc.org.

Note

This Best Evidence Statement addresses only key points of care for the target population; it is not intended to be a comprehensive practice guideline. These recommendations result from review of literature and practices current at the time of their formulation. This Best Evidence Statement does not preclude using care modalities proven efficacious in studies published subsequent to the current revision of this document. This document is not intended to impose standards of care preventing selective variances from the recommendations to meet the specific and unique requirements of individual patients. Adherence to this Statement is voluntary. The clinician, in light of the individual circumstances presented by the patient, must make the ultimate judgment regarding the priority of any specific procedure.