

# Identifying and Addressing Problems for Student Progression in Midwifery Clinical Education

CEU

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Identifying challenges to progression for a health care profession student who is not meeting expectations in a busy clinical practice can be challenging yet can lead to assisting the student toward success. Preceptor preparation includes acquiring knowledge about the student's education program, understanding federal regulations designed to protect students, gathering background information about a student, learning to provide feedback, structuring the clinical experience, and completing student evaluations. Students in health care professions may have difficulties with cognitive, affective, or psychomotor learning, and the clinical preceptor can identify problems for student progression within these learning domains. Subsequently, specific solutions that are tailored to the individual student's needs can be developed, implemented, and evaluated. A structured evaluation of the student's performance by the clinical preceptor, in accordance with the education program's parameters, is essential. Through a structured process, preceptors can assist many students to achieve success, in spite of challenges. This article describes how the preceptor can prepare, identify the type(s) of problem(s), and develop learning solutions for students who are experiencing difficulties in clinical settings. J Midwifery Womens Health 2016;61:S28–S36 © 2016 by the American College of Nurse-Midwives.

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## INTRODUCTION

Clinical preceptors can guide a health professional student who is not progressing as expected toward success with an organized approach to identifying and addressing each individual's problems in learning. A clinical preceptor may be the first to identify that a student is not performing as expected or may be the preceptor of a student already known to be performing at a suboptimal level in the clinical setting. The process of precepting a student is analogous to the diagnosis and treatment of a health condition. In other words, for a health concern, clinicians collect subjective and objective information (data collection), analyze the information to identify the issue (diagnose), select and apply the best evidence-based solution (treatment), and evaluate the effectiveness of the solution (evaluation). Approaching the clinical education of all health care students in the same systematic way can improve student performance. However, the importance of using a systematic approach becomes magnified when precepting a student who is not achieving expected outcomes. The purpose of this article is to assist clinical preceptors of midwifery students to identify problems with successful progression for students who are experiencing less-than-optimal performance in the clinical setting. Recommendations for individualized approaches to addressing problems are offered and discussed. This article focuses on a specific group of students: those who are not achieving expected clinical performance. Throughout the rest of the article, they will be referred to as *students*. It is beyond the scope of this article to address the midwifery education program's management of a student who is failing.

## PRECEPTOR PREPARATION

Prior to discussing problems that are barriers to student progression in clinical settings and identification of possible solutions for those problems, it is important to acknowledge the importance of preceptor preparation for working with midwifery students. Clinical preceptors assume the responsibility of assisting midwifery students to close the theory-practice gap and achieve competence and self-efficacy.<sup>1</sup> Since clinical knowledge often does not correspond well to theoretical knowledge acquired in the classroom,<sup>2</sup> preceptors will want to hone the skills necessary to become effective preceptors. This includes teaching clinical problem solving,<sup>3</sup> providing clinical supervision to midwifery students within a busy clinical practice,<sup>4</sup> and understanding some key principles of adult learning (Table 1).<sup>5–9</sup> The theory of adult learning is also known as *andragogy* and includes the premises that adults will learn only what they feel they need to learn, learn by doing, and focus on realistic problems, among others.

Providing effective feedback to midwifery students is an aspect of preceptor preparation that can be learned.<sup>10</sup> There are many opportunities for learning how to give effective feedback, and these can be found in professional journals, at professional meetings, on the American College of Nurse-Midwives (ACNM) national Web site, and through practice with mentors. Lazarus<sup>11</sup> review methods of providing feedback in more detail. New preceptors may find that a *critical friend* is a good way to develop preceptor competence. A critical friend is a colleague with a comparable educational background, trusted by the new preceptor, who asks thought-provoking questions of the preceptor, offers other perspectives, and provides observations about their precepting techniques.<sup>12</sup> Although it is beyond the scope of this article to review specific elements of preceptor training, the interested reader is referred to several helpful publications.<sup>13–15</sup>

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## Quick Points

- ◆ Clinical midwifery preceptors can assist a student who is not meeting expectations by systematically approaching the challenge as they would a diagnostic challenge.
- ◆ Data collection includes understanding the student's midwifery education program, the expectations, and the student's prior performance as well as reviewing documentation.
- ◆ Three categories of student problems or diagnoses are cognitive, affective, and psychomotor barriers.
- ◆ The plan should include a learning plan that addresses the student's problem(s) and is developed by the preceptor, student, and education program faculty.
- ◆ Finally, the student's progress is evaluated promptly to determine if the systematic approach has assisted the student in meeting expectations.

Ideally, preceptors are well prepared clinically, work in an environment that is conducive to student learning, have demonstrated clinical teaching expertise, and have an established relationship with the education program and faculty.

### Coordination With the Student and Education Faculty

Prior to the clinical experience, the preceptor will also want to understand the clinical course expectations for the student, the program-specific evaluation process, explicit responsibilities of the preceptor, and the responsibilities of the program and program faculty.<sup>16</sup>

At the time of the student's actual clinical experience, the preceptor coordinates with the student to identify learning objectives and establish a learning plan for the day. Preceptors may find it helpful to follow the recommendations of Logan et al<sup>14</sup> for preceptor and student time management, such as reviewing the clinical day's patient list prior to the start of the clinic, assigning the most appropriate cases to the student, and opening space in the clinic schedule to devote to teaching and learning conversations.

It is especially important to set clear expectations for both the student and preceptor at the beginning of each clinical experience. The preceptor ensures that the student is oriented to the setting, describes a preference for how they like the day to unfold, and works with the student to align expectations. Some busy clinical days do not allow this conversation to happen at the beginning of the experience; however, this conversation should take place as soon as possible.

Information and data about the student's performance should be collected throughout the clinical experience. Clinical preceptors may find it useful to make confidential notes structured around their observations of the student's performance that are linked and compared to the learning objectives. These notes can be used to complete the evaluation process at the end of the experience, according to education program expectations, and then destroyed. Careful implementation of a well-developed plan for the student clinical experience paves the way for the evaluation of competencies, learning domains, and expectations.

### IDENTIFYING STUDENT LEARNING PROBLEMS

Collection of information is the first step in assisting students experiencing problems in the clinical setting. Careful preceptor observations can be used to identify the learning domain(s) that challenge the student, providing information to assist with planning for solutions.

#### Learning Domains

Prior to identifying problems that may be preventing student success and recommending specific solutions, a brief review of competency (learning) domains will assist the preceptor to more fully appreciate how to identify the problems preventing student success and how to best address them. Three learning domains are widely accepted among clinical educators: cognitive, psychomotor, and affective (Table 2).<sup>17</sup> The cognitive domain typically encompasses acquisition and integration (application) of knowledge, as well as intellectual ability, while the psychomotor domain includes development of motor and muscular skill (ie, hand skills) and coordination of neuromuscular actions. The affective domain is much more difficult to interpret and evaluate because it is not well defined or easy to measure. The affective domain deals with feelings, emotions, and values, as well as a student's ability to internalize values and demonstrate those values through behaviors.<sup>18</sup> Clinical learning often requires all 3 domains in order to learn evidence-based care and acquire new skills and abilities. An example is the prenatal care visit in which a student requires cognitive skills to formulate and implement midwifery management, psychomotor skills to perform Leopold's maneuvers, and affective skills to communicate with the pregnant woman.

#### Data Collection

After achieving sufficient preparation, organizing the clinical experience for students, and understanding learning domains, preceptors can begin to collect the data necessary for assisting students who are performing at less-than-expected levels in the clinical setting. Midwifery education program faculty and preceptors may have already identified that a student is not achieving expected progress prior to placement with a new preceptor. Conversely, a preceptor may be the first faculty to identify that a student is not meeting clinical

<b>Table 1. Principles and Assumptions of Adult Learning<sup>5,6,9</sup></b>	
<b>Principle/Assumption</b>	<b>Description</b>
Adult learners are self-directed and must want to learn.	Adults learn effectively when they are free to direct their own learning and have a strong inner motivation to develop a new skill or acquire a particular type of knowledge. Adults prefer responsibility for their decisions and desire to be viewed as capable of self-direction.
Adult learners need to know the reasons for learning something.	Adults need to understand the relevance of learning before they are ready and willing to learn. Adults are practical in their approach to learning and want to know how the learning will apply to them.
Adult learners have a foundation of life experience.	Adults have rich life experiences, which can be a resource for learning or a liability. Necessitates individualization of learning strategies. Experience (including error) provides the basis for learning activities.
Adults learn by doing.	This is also true for children, but this is more important among adults. Active participation is valuable.
Adult learning is problem-focused, less content/subject-oriented.	Adults are life-centered (task-centered) and desire immediate application of knowledge. They become ready to learn when the need to cope effectively with real-life situations is present. Problems must be realistic.
Adults learn best in an informal situation.	Rather than following a curriculum, adults learn by taking responsibility for the value and content required to understand. An inviting environment and active participation in the learning process makes learning efficient.
Adult learners want guidance.	Adults want information that will help them improve their situation or that of their children. They do not want to be told what to do. They want to choose options based on their individual needs.
Adult learners are driven by internal motivation.	Adults respond better to internal versus external motivators. Learning has intrinsic value and has a personal payoff.

expectations. Review of documentation about a student's lack of expected progress provides the preceptor with valuable information. If available, previous evaluations for the student will contain observations about the student's performance, prior feedback given to the student, and plans made to help the student become successful. There may be other documentation available for preceptor review including descriptions of meetings between faculty or preceptors and the student, letters to the student, student performance in didactic coursework, documentation from student advisors, past or current learning contracts, or e-mails between the student and faculty.

#### *Student Documents and the Family Educational Rights and Privacy Act*

Review of student documents must be completed in accordance with institutional policies with respect for student rights and privacy regulations. For example, preceptors need to be aware of and abide by the Family Educational Rights and Privacy Act (FERPA),<sup>8</sup> a federal law passed to protect student privacy and provide regulations about the disclosure of personally identifiable education records. Preceptors should also understand all FERPA-related education program and institution policies guiding management of student documentation,

who has a legitimate educational interest in student records, how to secure electronic student records on encrypted devices, and what paper records need to be shredded.

Some educators advocate for a fresh start when working with a student who has not met expectations, avoiding preconceived perceptions by declining to gather information from others before working with a specific student. However, a disadvantage to this approach is that it can waste time and effort, delaying or missing opportunities to assist the student's improvement.

#### **Cognitive Learning Problems**

Identifying cognitive learning problems as opposed to problems in the psychomotor or affective domains is usually not difficult for clinical preceptors.<sup>17</sup> Cognitive learning problems that are a barrier to student progression may include insufficient didactic knowledge or inability to understand and apply knowledge in the clinical setting. Knowledge recall deficits are often identified by poor grades in didactic courses. However, a student having difficulty understanding and applying knowledge will often have solid didactic grades but will be unable to transfer that knowledge to the clinical setting. Preceptors can elicit responses from students to questions about knowledge,

**Table 2. Learning Domains**

Domain	Description	Examples
Cognitive	Thinking—acquisition and integration (application) of knowledge, as well as intellectual ability	Applying Analyzing Creating Evaluating Remembering Understanding
Psychomotor	Physical or kinesthetic—development of motor and muscular skill (ie, hand skills), and coordination of neuromuscular actions	Perception Physical abilities Reflexes Skilled movements Nonverbal communication
Affective	Emotion or feeling—attitude, professional behaviors, communication, interpersonal interaction, reliability, accountability, preparedness, commitment, ethics, and values	Receiving feedback Responding Valuing Internalization of values Organization of values and beliefs

as well as observe the student's application of knowledge in a specific clinical circumstance. While preceptors may not be aware of a student's didactic course grades, gathering that data may be helpful when trying to identify a cognitive or knowledge problem.

Another problem may be student unfamiliarity with the clinical setting, routines, or preceptor expectations. Many students have no exposure to the prenatal or women's health care outpatient settings, or may have never witnessed a birth. Likewise, students may have functioned as a nurse in a tertiary care setting but have no familiarity with or understanding of physiologic or out-of-hospital birth. Preceptors also have clinical routines that are well known to them and staff. A student's unfamiliarity with clinical setting and routine can contribute to a sense of or the appearance of a knowledge deficit, and anxiety may further confound their progress.

Another problem that affects the cognitive domain may be a learning disorder (diagnosed or undiagnosed), which can become initially evident despite previous years of successful completion of other types of education. Preceptors should always consider a learning disorder as a contributor if a student continues to have difficulty meeting clinical expectations, even after the implementation of a learning plan tailored to the individual student's needs. Students who do well clinically, but have had difficulties academically, may have a learning disability that interferes with cognitive learning.<sup>19</sup>

### Psychomotor Learning Problems

Difficulty accomplishing hand skills in the provision of patient care can prevent student progress and may simply be an indication of lack of experience.<sup>20</sup> Has the student had ample time to observe and practice hand skills, such as sufficient simulation practice? Has the student had adequate opportunity to engage with real clients and to practice the skills they have learned in simulation? Have they had sufficient opportunity to observe, practice, and demonstrate psychomotor

skills with guidance from instructors and preceptors? For example, the inability of a student to complete an accurate bimanual examination to determine uterine size likely reflects a need for additional practice and preceptor guidance. Conversely, if psychomotor skills are adequate, but the student cannot accurately interpret the findings, this indicates a cognitive learning deficit, rather than a psychomotor learning problem.

### Affective Learning Problems

Affective domain learning problems may be evident as problems with emotions and professional behaviors. They are considered the more difficult to identify and address, primarily because these are often difficult to define.<sup>17</sup> Some students have difficulty in specific situations due to discomfort with unfamiliar surroundings or in settings such as obstetric emergencies that require quick decision making. A lack of professionalism may be evidenced by not maintaining confidentiality, attendance issues, poor record keeping, or not being receptive to feedback.

Problems with interpersonal communication are often associated with other learning difficulties but may be the major individual problem for some students. By identifying a pattern of specific situations in which the student has a problem, through a review of the student's evaluations or other documents, preceptors can begin to address the student's performance in a particular setting. A review of previous student evaluations or direct observation by the preceptor may reveal that a student has difficulty communicating with all patients, a specific group of patients only, or with faculty only. Difficulty in communicating with others on a health care team, including peers, midwives, nurses, or physicians, might also be observed. These difficulties may be a reflection of issues around culture, religion, diversity, anxiety, or problems outside of school, or may be an indication of a learning disability.<sup>19</sup>

Are there patterns of similarities and differences between the preceptor, the student, practice sites, patients, and inter-professional team members that create difficulties for student interaction? Do cultural differences (eg, country of origin, language, race, ethnicity) exist between the student and the preceptor, patients, or team members? Students may not have previously been in a clinical site that included components of care that required affective domain skills outside their experience or comfort zone, and this would be a site-specific difference.

Preceptors, faculty, and students are likely aware of the names of generations of people currently in the health care workforce—Traditionalist, Baby Boomers, Gen Xers, and Millennials. Fewer may have considered that generational diversity can lead to differences in learning styles that require different approaches to learning, interaction, and giving and receiving feedback.<sup>21</sup> Just as midwives tailor health care to the needs of individual women, preceptors must acknowledge their own generational learning style and tailor their teaching to the student's generation. Traditionalist and Baby Boomer preceptors are often the experienced clinicians and teachers but may be less comfortable with new technology, being challenged, or learner dependence. Gen Xers approach learning as an individual activity, are comfortable with technology, and enjoy a fast-paced learning experience but may appear skeptical and challenge authority. Millennials learn best by doing, prefer individually tailored information, and use technology with ease, but they are less independent than other generations, require more structure and feedback, and may not communicate effectively. Preceptors can educate themselves about these differences to improve their teaching and, as a result, may benefit from a reciprocal teaching and learning experience.<sup>22,23</sup>

A preceptor may also need to assess whether a student has accepted responsibility as an adult learner (Table 2).<sup>8</sup> For example, is the student self-directed, taking initiative to identify their own knowledge deficits? Are they internally motivated to take steps to remedy these deficits, rather than rely on instructors and preceptors to give them answers? Resistance to accountability for their own learning and performance, as well as difficulty accepting feedback, may be hallmarks of failure to take responsibility as an adult learner in higher education.<sup>7</sup>

Student and/or preceptor stress and sleep deprivation can magnify the challenges of clinical performance. Indeed, sleep deprivation and high levels of stress and anxiety can result in unsafe practice behaviors, hinder the ability to learn, and significantly impact affective and interaction abilities.<sup>24</sup> Is the student overextended with work, school, family, and other obligations? Preceptors can ask the student directly about these contributors to affective learning, in addition to cognitive learning.

### **Problems Mastering the Midwifery Management Process**

Some students may have difficulty with mastering one or more elements of the midwifery management process.<sup>25</sup> This is a cognitive problem that usually becomes evident when a more advanced student is unable to assimilate one or more elements of midwifery management, including knowledge,

psychomotor skills, critical thinking, evaluation, and assuming the responsibility of implementing a safe plan of care in partnership with the client. Preceptors can identify the areas that are a challenge for a student by reviewing and discussing the midwifery management process before, during, and after a clinical experience. Challenges with synthesizing the information may be especially obvious among students who are unable to develop a plan of care. Implementation of a plan of care may also be difficult for students who are unable to apply information learned, are unfamiliar with routines, or who have communication problems.

### **SOLUTIONS TO PROBLEMS THAT ARE BARRIERS TO STUDENT SUCCESS**

Once a problem has been identified and is related to cognitive, psychomotor, or affective skill acquisition, a plan can be developed (Figure 1).

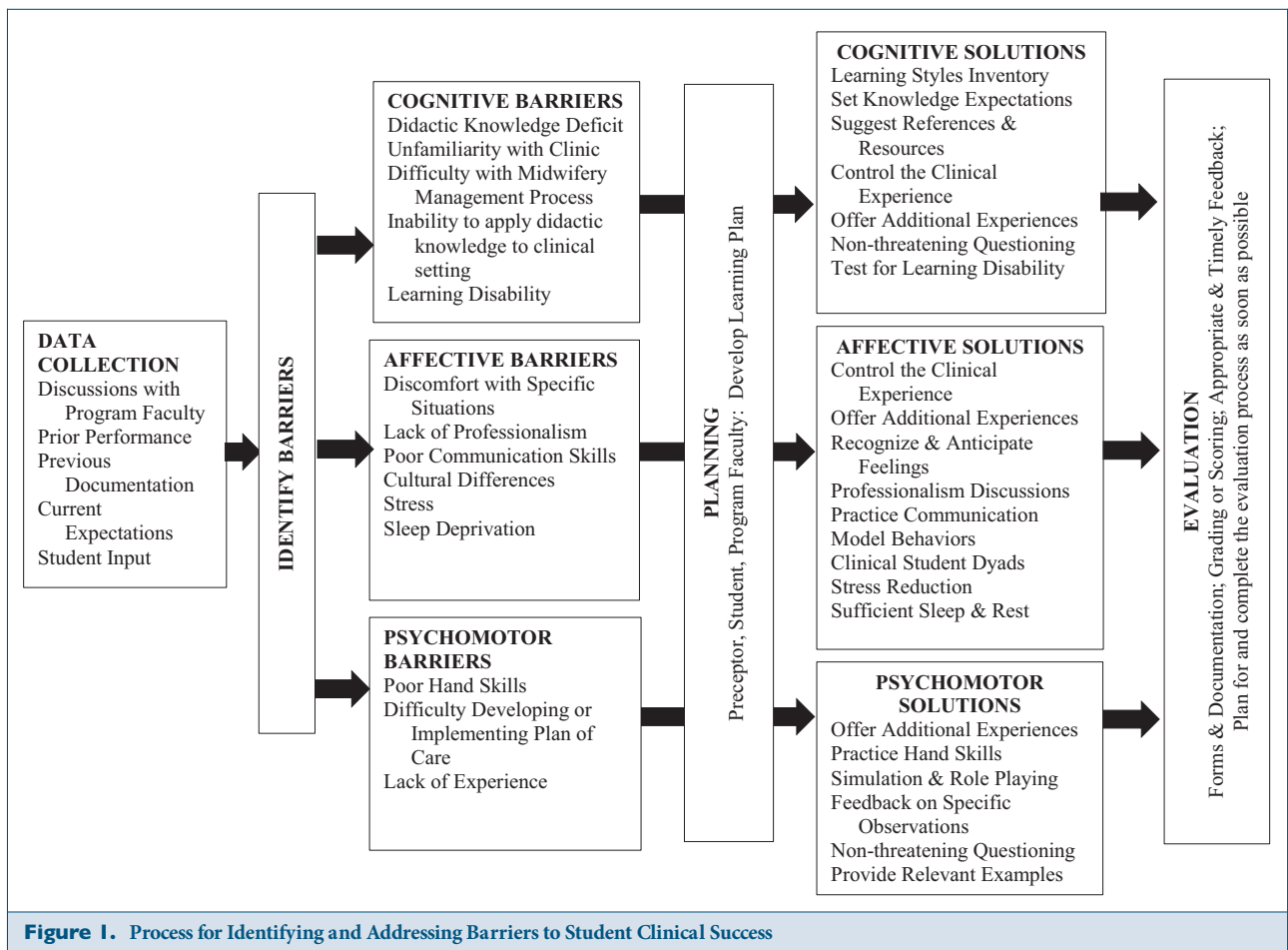
#### **Planning Solutions**

Once problems have been identified and discussed with the student, a plan to address those problems must be developed jointly between student and preceptor.<sup>26</sup> Education program faculty and a student advocate may be involved, depending on the situation and the education program's processes. Therefore, preceptors should discuss the situation with the education program director or preceptor supervisor and share the plan with them. Again, care should be taken that the student's performance documentation and plans to support their success be shared only in accordance with institutional policies and federal law (ie, FERPA).<sup>8</sup>

When developing a learning plan for students, preceptors may choose to seek further assistance from education program faculty, as education experts. As for any student, a learning plan should begin with clearly stated, issue-specific learning objectives. Figure 2 presents a sample learning plan. The learning objectives can be structured using the traditional SMART (specific, measurable, attainable, relevant, and time specific) mnemonic<sup>27</sup> first described more than 30 years ago by Doran in the business management literature or any other tool that ensures a comprehensive approach. Each objective should address the specific actions to be taken, how success will be measured, who is responsible for the actions, the realistic results, and when the objective will reasonably be achieved. The plan should be in writing, signed by both the student and the preceptor or course faculty. The plan should be stored in a secure manner, reviewed periodically for progress, modified as necessary, and used during the final student evaluation.

#### **Solutions for Cognitive Learning Problems**

When a student appears unable to apply a particular piece of knowledge, preceptors will first need to determine that the student has had the didactic content by working with program faculty to understand the student's program of study. Program faculty and preceptors may ask the student to complete a learning style inventory, such as the Kolb Learning Style Inventory or Motivation Strategies for Learning Questionnaire,<sup>28</sup> to determine the learning style preference. While there is disagreement whether use of learning styles



**Figure 1. Process for Identifying and Addressing Barriers to Student Clinical Success**

inventories is evidence-based,<sup>29</sup> these might provide additional guidance for developing solutions. Students may have preferences for how they learn, and that information may help the faculty or preceptor provide knowledge in the preferred way for that student.

It is important for all students to be oriented to clinical sites and practices. However, students with problems may need additional orientation. Explaining practice routines and ensuring that the student is introduced to other staff, as a learning professional, can reduce anxiety that impedes learning. Preceptors can provide additional appropriate learning opportunities, facilitate additional unique experiences, and offer extra case studies to the student to increase their confidence and thinking skills.

Setting knowledge expectations before beginning the clinical experience provides the student with an expected knowledge baseline. Preceptors can facilitate acquisition of knowledge by suggesting best readings, references, and resources—not by acting as the source of the knowledge. Selecting appropriate patients to be seen by the student, rehearsing data collection conversations, practicing hand skills, simulating clinical emergencies, suggesting an observation experience with the preceptor, or asking the student to complete one patient's visit from beginning to end, including completing the medical record, are ways the preceptor can structure the clinical experience for the student. When language or cultural factors are suspected challenges to

cognitive learning, alternative learning approaches may be very helpful, such as multimedia, e-learning, and Web-based technologies.<sup>30,31</sup>

Finally, the preceptor may discuss with program faculty the idea of testing for learning disabilities. Many colleges and universities offer testing at no or low cost to enrolled students. This testing could identify a learning disability that requires reasonable accommodations for the student and can contribute to their ultimate success.

### Solutions for Psychomotor Learning Problems

Structuring the learning environment is again important to reduce difficulties for students having problems in the psychomotor domain. Finding opportunities for the student to repeatedly practice hand skills will support them in developing their own routines with specific skills. Practice should include first having the preceptor model the skill without interruption, then provide directions as the student completes the skill without modeling, and, finally, observe as the student performs the skill independently with supervision. It is helpful if preceptors can find additional clinical experiences to increase psychomotor repetition. Simulation is an excellent approach to addressing psychomotor learning problems, where students can achieve psychomotor learning objectives in a less threatening learning environment.<sup>32,33</sup>

## Identification of Problem and Documentation of Examples

Professional communication

Patients and faculty have had concerns about the professionalism of \_\_\_\_\_'s communication. Student used slang terms instead of anatomical terms on 3 separate occasions, resulting in patients voicing confusion and lack of understanding. With 2 other patients, \_\_\_\_\_ failed to recognize/be respectful of cultural differences by making comical remarks about traditional dress and not taking steps to preserve the woman's modesty.

## Domain of Learning

Affective

## Goals (specific, measurable, attainable, relevant, time specific)

\_\_\_\_\_ will:

1. Review the language she plans to use by practicing with preceptor to ensure all communication is professional and culturally appropriate, prior to each patient encounter.
2. After each patient encounter, ask for feedback from the preceptor about her communication with the patient to ensure all communication is professional and culturally appropriate.
3. Once each day, observe the preceptor during a patient interaction and discuss this communication role-modeling experience after the encounter.

## Consequences

By the end of semester, \_\_\_\_\_ will not be allowed/be allowed to progress to the next clinical course, if she has not successfully completed these goals.

## Signatures of Preceptor and Student With Date

\_\_\_\_\_

Preceptor

\_\_\_\_\_

Date

\_\_\_\_\_

Student

\_\_\_\_\_

Date

Figure 2. Sample Learning Plan

### Solutions for Affective Learning Problems

If students are not meeting expectations in one particular setting, such as an ambulatory setting, preceptors can seek ways to increase the number of experiences and structure the learning environment to reduce stress. Preceptors can verbally recognize or anticipate student's feelings and assist the student with an appropriate response. This requires that the preceptor ensure that the student has a safe physical and emotional space to express their feelings. If a student is demonstrating a lack of professionalism, preceptors should discuss their concern with program faculty and determine the professionalism content the student has already received. Existing content on professionalism can be reviewed with the

student and new professionalism content introduced by the preceptor. Discussions between student and preceptor about professional beliefs, behaviors, and values can be scheduled as part of the student's experiences and should be documented in the student's evaluation.<sup>34</sup>

Other discussions and learning can include information and experiences with other cultures, including generational cultures. Additional communication practice can also be scheduled using case studies, with the preceptor acting the part of the patient or other professional. Most importantly, preceptors must model the behaviors they are asking the student to exhibit, identify these behaviors to the student at an appropriate time, and make careful observations on the

student's own affective behaviors to the student. One approach to enhance affective learning is the Clinical Learning Dyad Model proposed by Cohen, Thomas, and Gerard,<sup>35</sup> in which student pairs are assigned to one preceptor. The model pairs 2 beginning midwifery students with a preceptor in the clinical setting and may also include a more advanced student as a near-peer mentor. Students have the opportunity for one-on-one mentorship from the preceptor during provision of clinical care, as well as peer support in a collaborative, supportive learning environment. Use of this model may increase student accountability, enhance socialization, provide important role modeling, and improve affective learning.

### **Solutions for Problems With the Midwifery Management Process**

Preceptors may ask that a student not participate in care of a patient that, while interesting, may not contribute to achievement of the day's established goals. If a student has difficulty developing a plan of care, observing the preceptor developing a plan for a woman with a complicated pregnancy may be a more effective learning experience than attempting to develop one themselves. Again, a preceptor should make clear observations about the student's performance and ask the student for their perspective about their application difficulties. These same principles can be used in helping students practice and apply their communication skills.

### **EVALUATION PROCESS**

Preceptors must be familiar with the education program's standard evaluation process and forms.<sup>16</sup> Evaluations should occur at intervals specified by the program and can also be conducted as often as needed and helpful. Beginning by asking the student what they thought went well for them, areas they would improve, and plans for further improvement often reveals that the preceptor and student are in agreement on their performance. Providing effective feedback to students is a learned skill and facilitates self-directed learning and progress.<sup>10,36</sup> It is helpful for preceptors to focus on observed behaviors. Preceptors should not ask questions that have a "yes" or "no" answer and avoid the words *but* or *however* so that the feedback is not negated. The preceptor and student can discuss whether the learning objectives are being met, and plans should be made for the next clinical experiences or the final evaluation. Finally, the evaluation form should be completed, with any additional student comments and plans for the next experience, and signed by both. After the completion of the evaluation, the preceptor should review the plan to ensure it is still appropriate and evaluate their own performance as a preceptor and evaluator. Written and oral communication to the education program faculty about the student's performance will assist the program in counseling the student. Consequences of not meeting expectations can be discussed between the student and course faculty.

The evaluation process should contain documentation about the student's performance, including professionalism, data collection, hand skills, assessment and diagnosis abilities, development of plans of care, implementation of plans of care, evaluation of plans of care, and communication and

documentation skills. This evaluation and documentation process becomes even more important for a student who is having challenges to progression. Evaluation documentation includes dates and signatures of the student and preceptor indicating that they both have participated in the evaluation process, a place for student comments, and completion of any ranking. One example of an assessment approach is the Midwifery Assessment and Feedback Framework<sup>7</sup> (MAFI) by Embo et al. The MAFI is a tool developed to facilitate self-directed learning and is based on expected student midwifery competencies. The instrument's framework integrates written feedback and assessment. Preceptors will want to understand how and where the evaluation documentation is to be stored and with whom it will be shared. Program faculty are responsible for assigning a score or grade to the student's performance based on evaluations and other documentation, with additional input from preceptors.

Additionally, preceptors should plan to conduct an evaluation at the end of a complete clinical experience. The evaluation should be in person and take place in a quiet, private setting. The documentation completed throughout the experience should be available for review with the student in the program-specific format. Preceptors can model good communication skills, including describing their observations and listening to the student during the evaluation process. Personal communication between the preceptor and program faculty is often helpful to discuss the student's performance. Final evaluations and documentation are submitted to the program faculty, who make the determination of the student's course grade and, ultimately, the student's success or failure to progress.

Assisting a student in the clinical setting is very rewarding for preceptors, no matter what the outcome. Just as determining an accurate diagnosis and assisting a woman to achieve her best health outcome can be a positive experience for a midwife, so can helping a student overcome challenges. Similarly, when a student is not successful, preceptors may experience the same emotions as when they experience a poor health care outcome. Preceptors may feel like a failure, worry about consequences, or be afraid the student thinks they do not care.<sup>37,38</sup> As with caring for women, preceptors will experience a variety of feelings as a result of the outcome.

### **CONCLUSION**

Assisting a student to success is among the most rewarding precepting experiences. When a preceptor follows a structured plan, provides appropriate feedback, and makes an honest evaluation, many students who experience problems with progression can go on to meet or exceed expectations, in spite of problems. It is important that any midwife precepting a student who is not meeting clinical learning outcomes is interested in teaching and is willing to accept the student. However, it is a midwife's professional responsibility to help educate the next generation of midwives as safe beginning practitioners.

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## CONFLICT OF INTEREST

The authors have no conflict of interest to disclose.

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