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Two Key Roles of Preceptors: Situated Coaching and Teaching Local Knowledge

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Health care institutions are complex organizations with many moving parts and players who must coordinate and share their local work knowledge (Geertz, 2000). Geertz points out that a study of local knowledge is necessarily a study of the particular, concrete in relation to the general, or what is generalizable. New recruits to a different specialty unit require skilled preceptors, whether they're changing unit specialties, coming from a different organization, or newly graduated nurses. These preceptors must skillfully provide situated coaching in clinical situations that fall outside the range of the orientee's experience and clinical knowledge. This teaching and learning meet at the juncture of the particular and general. All clinicians need to develop a dialogue in actual practice between the particular and the general.

Vickie Sattler provides excellent situated clinical coaching to new orientees in an emergency department in Spokane, Washington. She's a Clinical Coordinator at Washington State University. Patients come to the ED with vague complaints and seldom have a diagnosis or clear evidence in place.

Sattler's situated coaching demonstrates the uniqueness of the thinking and knowledge work required in the emergency department. She uses real clinical puzzles that the emergency nurse encounters and must solve for clinical care to proceed.

In our conversation on [EducatingNurses.com](#), she describes the situated coaching she uses in complex, fast-paced clinical situations. She contrasts the knowledge work of the nurse with the knowledge work of nurses on other units. When working with a nurse experienced in medical-surgical or orthopedic nursing, Sattler articulates the new perspectives that are required. The ED nurse must figure out the most urgent and most compelling clinical aspects of a newly arrived, undiagnosed patient. Trauma patients do not come with clear and evident lists of injuries or mechanisms of injury. Nurses, as part of their clinical reasoning, engage in clinical detective work. The ED nurse must use 'modus operandi' thinking of the chain of events that led the patient here in order to figure out the likely cause and effects of patient injuries. Given the nature of the accident, what is the likelihood of internal injuries, and how best to investigate the possible or likely injuries? Likewise with patients with multiple chronic illnesses, the nurse must figure out what precipitated the patient's coming to the emergency room for treatment. In one of the video examples, the orientee is coached to figure out why the patient's symptoms stand out differently than a typical patient with pneumonia.

What else could be causing the patient so much respiratory distress and pain? The nurse must stay open to multiple clinical possibilities and not jump to early conclusions. The nurse must stay curious, open and attentive to what else might cause the patient's clear distress. In

her precepting, Vickie Sattler spends time in explanation and situated coaching; teaching the new recruit how to think to solve clinical puzzles like an emergency department nurse.

Teaching Orientees the Local Knowledge about how the System Works

Preceptors provide this local experientially gained knowledge with practical experience in how the local system and its inter-related parts work. Such local knowledge unique to a particular care setting is usually poorly articulated, often not available in “procedure books” or even included as part of the planned recruit orientation program. Preceptors and orientees depend on the occasion of particular situations, where this local knowledge becomes visible during breakdowns or problems. Preceptors are prompted by necessity to do immediate, informal teaching of the missing knowledge about how the system works. Out of context, this knowledge is so situated and taken for granted by the experienced local, that it rarely occurs to the preceptor to teach how to make the system work smoothly, and the orientee doesn’t know enough about the system to ask questions.

The need for understanding how the system works locally becomes visible as the orientation or residency proceeds. This practical local knowledge includes how the systems and its sub-units, routines, expectations, and culture interface. Often this local knowledge gets uncovered when the orientee finds that their approach isn’t working smoothly or quickly. Local institutional knowledge held by preceptors is invaluable to new recruits, who would have the frustration of trying to figure out things on their own, wasting time, and incurring frustration over their inability to make the system work.

The Limits of Formalism

Every complex organization runs into the problem of “the limits of formalism,” which refers to the inherent problem of spelling out explicitly everything about how the organization works. This includes the culture, unwritten expectations, pockets of expertise, and what is often a maze of “temporary workaround solutions” that need system re-design and articulation. Every nurse runs into the problem of the “limits of formalism” when the bureaucratic response to complex, contextualized knowledge work is to create too many checklists, and recipes. When done to excess, these checklists that ignore timing, context, and particularities can hinder situated clinical reasoning. These lists are often superficial, too general and typically lack sufficient detail to provide guidance for contextual variations that occur with the particular needs of patients/families. For example, a checklist for every clinical condition simply cannot supply the background understanding of how to understand the particulars of a clinical situation in relation to the general. Nowhere is this more evident than in the emergency department where the nurse meets the patient with ambiguous and multiple symptoms that may indicate one medical diagnosis or etiology.

Situated Coaching: Using Actual Clinical Situations to Teach Clinical Problem Solving

All of the preceptors in this series on clinical teaching and learning give excellent examples of their coaching of orientees through difficult clinical situations.

Preceptor Vickie Sattler is clear that it is a best practice to provide anticipatory help and guidance, rather than letting the orientee fail or put the patient at risk. Unfortunately, this kind of set-up for “learning from failure” happens too often in orientation, perhaps because the need isn’t supported. Situated coaching and orientee support are key in a situation likely to be fast-paced, ambiguous and complex. Success is a powerful way to teach for best practices. Failure, while often providing a type of crisis learning, just in the nick of time or too late, erodes confidence and even openness to learning where anxiety over failure blocks future learning. Lack of coaching for success shows a lack of respect for patients, the orientee’s plight, and the complexity of the situated learning required in all settings. This is avoided by recognizing when a clinical situation is fraught with possible complications or need for urgent interventions.

By the very nature of the emergency department, not every critically ill or injured patient can be saved. Vickie Sattler gives such an example, where a patient comes in critically ill for a pulmonary embolus that is late in its evolution. The patient quickly moves toward approaching death. Sattler reframes the situation and provides support for the patient and his sons. She explains and demonstrates that this too is the role of the emergency department nurse to recognize and come to terms with the situation as it evolves, making the most of what it is possible to help the patient. She explains that this “doing what can be done in the situation” is always the goal of the emergency department nurse. Working with family, providing an acknowledgment, and comfort for family members is central to her role here, and she actively shows this part of her practice to the orientee. She draws a comparison with a patient with a pulmonary embolus earlier in the day. The interventions for this patient had been effective because the pulmonary embolus was new and thus more treatable. Then, she points out that both situations were effectively met as they unfolded. This kind of scenario and narrative teaching to frame the practice is an essential role of the preceptor. Learning how to do this as a preceptor requires clinical imagination and a goal of helping to frame and form the orientee’s identity and notions of good practice in the emergency department.

In our last newsletter, we pointed out the significance of the preceptor’s role in increasing the reliability of an organization. Through situated coaching and teaching how to proceed in high-risk, unpredictable situations, the preceptor does more than teach for the moment. The preceptor creates a narrative understanding of the present situation and shows how to anticipate risky possibilities, and intervene early in future situations. The preceptor teaches vigilance and quick puzzle solving and interventions, a hallmark of highly reliable organizations (Weick and Sutcliff, 2007). This kind of pre-emptive safety work is at the heart of reliable organizations. Situated coaching is essential for high reliability, and all nurses not just preceptors, are required to participate when occasions of clinical teaching arise. Expectations are essential for anticipating the need for support and clinical teaching, but expectations must not be held too tightly as noted in [a previous EducatingNurses.com newsletter](#).

High-Reliability Organizations (HRO), (Weick and Sutcliff (2007, 2nd Edition) point out that 'expectations can get you in trouble unless you create a mindful infrastructure that continually does all the following:

- *Tracks small failures*
- *Resists oversimplification*
- *Remains sensitive to operations*
- *Maintains capabilities for resilience*
- *Takes advantage of shifting locations of expertise.'*

Weick and Sutcliff (2007) go on to point out that, "Moving toward a mindful infrastructure is harder than it looks because it means people have to forgo the 'pleasures of attending to success, simplicities, strategy, planning, and superiors.' Shortcuts, snap judgments, incomplete information, and inattentiveness are enemies of high reliability. It is notable that preceptor Alyssa Boldt incorporates mindfulness in her precepting practice. She is always aware of attending to the performance of the new nurse, while deliberately fostering independence and allowing the new nurse to practice and extend his or her clinical reasoning skills (Weick & Sutcliff, 2007).

We also pointed to the importance of facilitating the orientee's participation in the clinical situation to the extent of their particular preparation and abilities. For example, Alyssa Boldt had the orientee take vital signs, a task already mastered, and this participation enhanced the student's engagement and learning in a patient crisis. Lave and Wenger (1991) explain the importance of peripheral participation in learning any new complex practice.

Conclusion

Expert precepting is essential to safe and reliable transitions to new areas of practice, and for all newly graduated nurses. This requires planning and continuity by the preceptor. The preceptor must assess what kinds of experiential learning the new recruit needs to function in the specific specialty. This is a situated assessment based upon the orientee's actual performance in clinical situations.

Vickie Sattler demonstrates how in-depth knowledge and the ability to articulate that knowledge are essential to effective precepting. She demonstrates clinical imagination, as she uses what happens and evolves in the emergency department to enrich and help the recruit build new ways of thinking required for effectiveness. She demonstrates how situated coaching and the teaching of experientially learned local knowledge are essential to learning in a new area of practice.

References

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