

THE CHALLENGE OF EVALUATION IN RURAL PRECEPTORSHIP

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ABSTRACT

The purpose of this article is to report preceptor perceptions of the process of evaluating nursing students in a rural setting. A grounded theory methodology was used to carry out this study to ascertain what is actually going on in the rural preceptorship experience. Twenty-six preceptors from rural areas in two western Canadian provinces participated in the study. These preceptors worked with fourth year nursing students in the final year of their baccalaureate programs. The core variable that emerged in this study was identified as “*the challenge of the formal evaluation process*”. The implications of the findings are that: evaluation should be characterized as the responsibility of the preceptor, student and faculty triad; the scope of each role should be clearly defined and; that preceptors require preparation for the evaluation process, which is specifically ‘rural’ in content.

INTRODUCTION

Today, nursing student placements in rural facilities are increasingly encouraged on the understanding that graduates are more likely to work in rural settings if they have had satisfying student experiences in those settings. In the year 2001, only 18% of the total number of Registered Nurses (RNs) employed in nursing in Canada worked in rural or small-town areas, compared with 21% of the general population (Canadian Institute for Health Information, 2007). The potential for rural preceptorship as a vehicle for the recruitment of nurses to underserved rural areas serves as a motivation for faculty and practitioners alike to create and maintain preceptorship programs at these sites (Sedgwick & Yonge, 2008; Shannon et al., 2006).

Owing to distance and the wide geographic dispersion of students, preceptors are often subject to professional isolation and are not provided physical onsite faculty support with the exception of infrequent visitation (if at all), email contact and telephone calls. Complex behaviours in the preceptorship experience such as performance evaluation can thus be a key challenge for these preceptors. One of the most demanding teaching expectations for any professional is performance evaluation. While this role is daunting for educators, it is even more so for practitioners. Preceptors are expected to formally evaluate students according to specified

guidelines. While many preceptors are comfortable in their role, many are unprepared for student performance evaluation and find the process quite challenging (Dolan, 2003; McCarthy & Murphy, 2008; Seldomridge & Walsh, 2006; Yonge, Krahn, Trojan & Reid, 1997).

The purpose of the study was to discern the process involved in preceptor evaluation of students in the rural setting and included how both preceptors and students perceive this process. In this article the authors report on preceptor perceptions of the process of evaluation in a rural setting. The student perspective is reflected in a second article (Yonge, Myrick & Ferguson, 2011). Both articles emanate from the first phase of a study entitled, "Developing an Evaluation Model with Rural Preceptors", funded by the Social Sciences and Humanities Research Council (SSHRC) in Canada.

BACKGROUND

Nurses who work in rural areas are described as having the ability to function autonomously, adapt nursing interventions to low-tech environments, be expert generalists (Bushy, 2001; 2005), and frequently be able to extend their practice into the domain of other health professionals (Weinert & Long, 1989). Rural nurses have higher than average turnover rates, while those who stay in the setting cite job satisfaction and team work as reasons for continuing in practice (Hegney, McCarthey, Rogers-Clark, & Gormann, 2002). Beatty (2001) noted that little has been done to investigate rural nurses' learning needs or the context of their practice setting. In addition, professional isolation prevents these nurses from networking with colleagues. The researchers thus selected this setting recognizing the challenges of rural nursing and appreciating the uniqueness of the setting for the preceptorship of nursing students, while recognizing the need to enhance rural preceptors' development as educators. Furthermore, in preceptorships, nursing faculties rely heavily on clinical preceptors to provide accurate evaluations of student performance (Dibert & Goldenberg, 1995). To be effective, preceptors must have an evaluation framework and appropriate tools that include formative and summative evaluation.

Evaluation

Kemper, Rainey, Sherrill, and Mayo (2004) describe a three-part process of student evaluation: the process; the impact; and the outcome. Prior to the evaluation process, it is essential that learning objectives be delineated (Glover, 2000; Kemper et al., 2004). Evaluation must be future and not past-oriented as the goal of evaluation is to: improve future behaviour, not to change the past; ameliorate poor performance; replicate good performance; and improve overall performance thus affording recipients a clear understanding of what is and is not working (Lee, 2005).

Yonge et al. (1997) differentiated between informal, ongoing evaluation and formal, documented evaluation. Informal or formative evaluation is a process of tracking, monitoring, adjusting and regulating through ongoing feedback. Daily, informal, immediate, 'on-the-spot' feedback is most effective for student learning and least challenging for the preceptor (Clynes & Raftery, 2008; Glover, 2000; Lee, 2005; Qualters, 1999; Yonge et al., 1997). Ongoing feedback should be informative, specific, and focused on behaviour the student can change (Glover, 2000; Lee, 2005). The 'feedback sandwich' is recommended as a successful feedback approach and it comprises a *positive comment*, followed by *ideas for improvement*, followed by *another positive comment* (Glover, 2000).

Summative evaluation involves measuring, ranking and formal grading. Preceptors report great difficulty with summative evaluation owing to: unwieldy evaluation forms, the challenge of

objectivity, time pressures, student challenges and the need for additional data (Yonge et al., 1997). According to Lee (2005), grading is an ineffective evaluation strategy because grades generally evoke an emotional response rendering the recipient less receptive to constructive feedback. Instead, what is suggested is the integration of self-evaluations into summative evaluation to encourage two-way dialogue that is more similar to the process of feedback (Lee, 2005).

Preceptor Challenges with Evaluation

Despite the literature on evaluating students, preceptors are often ill-prepared to assume the evaluative role. Evaluations can be inconsistent, inaccurate, and superficial, and preceptors continue to view them as onerous. In one of the first studies exploring the evaluation process in preceptorship, researchers examined the basis of preceptor evaluations and whether performance criteria were valued differently between preceptors and faculty (Ferguson & Calder, 1993). Ferguson and Calder (1993, p. 31) note that

if faculty who have preparation in educational theory and practice have difficulties with the evaluation process, this problem must be even greater for nurse preceptors, many of whom have little or no preparation in clinical teaching and evaluation of students.

Lack of consistency of ratings, instructor bias, concern about the reliability and validity of evaluation tools and a general reluctance to document poor performance were noted (Ferguson & Calder, 1993). In 1997, Yonge et al. discovered the discrepancy between how little preceptors are prepared for the evaluative role and yet how frequently they are expected to fulfill that role. Preceptors often feel unprepared to use strategies such as reflection-on-practice and evaluation taxonomies and instead rely on assessment of skills rather than on competencies, and lack the time for the evaluation process (Dolan, 2003; McCarthy & Murphy, 2008; Seldomridge & Walsh, 2006).

The need for faculty support of preceptors has been well documented (Dolan, 2003; McCarthy & Murphy, 2008; Seldomridge & Walsh, 2006; Yonge et al., 1997). Possible solutions to preceptor challenges regarding evaluation include preceptor selection criteria such as level of education, willingness to teach, student and preceptor matching of personality and learning styles, quality orientation to the preceptor role, ongoing faculty support, and opportunities for role recognition such as continuing education opportunities (Seldomridge & Walsh, 2006).

Rural Preceptorship and Evaluation

Owing to long distances from urban centres and a small number of students dispersed over a wide geographical area, faculty presence onsite during rural preceptorship is not often feasible. Yet, rural clinical placements are recognized as rich learning settings for students owing to the nature of the practice, the breadth of learning opportunities, and the leadership skills required in such a setting (Schoenfelder & Valde, 2009; Sedgwick & Yonge, 2008). Throughout the evaluation process, rural preceptors face unique challenges specific to the rural setting. Significant gaps exist in the literature regarding the evaluation process in the rural setting and the challenges specific to rural preceptorship. Thus the research question was, “What is the process of evaluation used by preceptors and how was it perceived by students in the rural setting?”

METHOD

Owing to the lack of research in the area of preceptorship and evaluation, and viewing evaluation as a process, the researchers began with a grounded theory methodology as it afforded the researchers a firsthand opportunity to deal directly with *what was actually going on* in the preceptorship experience; “the grounded theory method tells it like it is” (Glaser, 1978, p. 14).

Setting

The settings for this project were rural areas in two western Canadian provinces. Statistics Canada (2009) defines a rural area as a place having a population of less than 1000 and a density of less than 400 persons per square kilometre. In Canada, the term *rural* might be perceived as referring to areas where access to health care services is limited by distance and lack of qualified care providers, particularly physicians (Alberta Physicians Resources Planning Group, 1997). Rural placements were located from 1 to approximately 16 hours driving distance from the urban centres where the universities were located.

Students and preceptors were recruited from two nursing programs at two western-Canadian universities. Both programs require students to complete a structured preceptorship (one-to-one pairing of a student with a Registered Nurse) in the final semester of their four year program. One program is a nine week, full- time preceptorship in a setting of the student’s choice during which the preceptor and student are visited theoretically twice (distance permitting): at midterm and at the culmination of the preceptorship by a faculty member. If problems arise during the preceptorship, faculty may visit more frequently. Evaluation takes place at midterm and at the end of the rotation. The preceptor and student each complete a student evaluation using a tool provided by the university which is based on the professional competencies outlined by the regulatory body. The faculty member takes these into account and assigns a pass/fail rating on the clinical component. A letter grade is derived from written assignments. The second program is a six week preceptorship, three weeks in a community setting (with one preceptor) and three weeks in an acute care setting (with a second preceptor). For this program, faculty do not visit preceptors at all during the preceptorship. The formal evaluation is completed at the end of the rotation. Preceptors in both programs are prepared for the experience through optional preceptor courses, a preceptor manual and are guided by the course outline and final evaluation form provided them. Interactions with faculty via telephone or email are also available at the student, preceptor and/or faculty member’s initiative.

Sample

The sample for this study consisted of 26 rural-based preceptors in two provinces in western Canada. Recruitment of the preceptors was facilitated by clinical placement coordinators who provided the names of fourth year nursing students assigned rural placements. Students were approached in class, provided an information letter, asked to provide their preceptor a letter of invitation and the research team followed up with an introductory phone call.

Preceptors worked in rural hospitals (including medical, surgical, and obstetrical nursing), public health clinics and community health centres. Two preceptors were male and 24 preceptors were female. Preceptors ranged in age from 27.5 years to 58.5 years, with a mean age of 42.3 years. Fourteen (53.8%) preceptors were baccalaureate-prepared, and 12 (46.1%) preceptors were diploma-prepared practitioners. The preceptors ranged in experience from first time precepting to having precepted over 10 students in a rural setting.

Data Collection

Researchers collected data, including demographic data, in their respective settings primarily through individual interviews, and supplemented data from field notes. An interview guide consisting of open-ended questions such as “How would you describe the process that you go through in guiding nursing students during their preceptorship experience”? was used for initial interviews (90 minutes) with follow-up interviews guided by emerging categories (Strauss & Corbin, 1990). Nearly all interviews were completed face-to-face, though a few were done via telephone due to distance constraints. All interviews took place near the end of the structured clinical preceptorship.

Data Analysis

Data analysis began concurrently with data collection. Open coding, the first stage of analysis, began with the generation of substantive categories and their attributes which were coded, clustered and compared to determine relationships (Stern, 1980). Dimensions of categories were determined by organizing data around the interrelation of substantive codes (Glaser, 1978). Data saturation transpired when only recurring themes emerged and further incidents did not help explain the emerging theory. The core variable that resulted from the study was “*the challenge of formal evaluation*”. For preceptors, their lack of role clarity as evaluators, absence of a framework to conceptualize evaluation, and the need for greater support in this role function made the formal, or summative, evaluation an onerous task.

Rigour

Rigour was addressed by establishing credibility, fittingness, auditability and confirmability (Guba & Lincoln, 1989). After the interviews were completed, the interviewees were sent a summary of the transcripts asking participants to validate the findings as their own experience (Streubert & Carpenter, 1999). Fittingness or transferability was built into the design of the project. Two universities collected data so all the interviews were done by two people. The audit trail can be accessed and provided guidance to the researchers when they moved to the second stage of the research project which involved establishing a framework for evaluation. When all of the previous three criteria were ensured, then confirmability was also achieved.

Ethics

Ethical approval was obtained from the universities’ health research ethics boards in the two provinces in which the research took place. To ensure confidentiality, the names of the participants were replaced with randomly assigned code numbers and data were retained in a locked cabinet. Upon completion of the study, code sheets containing participants’ demographic information were destroyed.

FINDINGS

The Challenge of the Formal Evaluation Process

Preceptors found the process of evaluation, culminating in the formal evaluation, onerous and challenging. One preceptor explained: “the hardest thing I find is evaluating a student, and putting it down on paper and communicating it to them. I don’t want to ever hurt somebody’s feelings”. The core variable was found to encompass seven key aspects: preceptor role perception; the necessity of clear learning goals and objectives; the variety of evaluation criteria;

the ease of formative evaluation and strategies used; the challenge of summative evaluation; adaptation of the evaluation process when dealing with an unsafe student; and the student role in evaluation.

Perceived Role of the Preceptor. Preceptors described their role as a teacher who: provides information and knowledge; facilitates learning needs; supports the student; gives encouragement; acts as a supervisor who monitors learning; serves as a guide; orients the student; provides the student with positive learning experiences; helps students reach their goals; acts as a role model; and provides students with alternate perspectives on nursing practice. As one preceptor summarized: “I view my role as a preceptor as to provide an encouraging and safe environment for a student to engage in advanced nursing student level practice, to provide optimum learning experiences and positive learning experiences for students — my student”.

Learning Objectives. Preceptors acknowledged the necessity of setting out specific learning goals and objectives for the preceptorship experience. Most preceptors, however, did not do so and were unclear about the purpose of the placement and what had to be accomplished to constitute a ‘pass’. Preceptors who were successful in setting out clear goals and objectives did so by familiarizing themselves with the formal evaluation tool prior to commencement of the preceptorship. Some used student self-evaluations to set individualized learning goals and to gauge “where we’re starting from”, creating learning plans and outlining expectations collaboratively with the student.

Criteria for Evaluation. Preceptors listed a variety of criteria upon which they based their student evaluations. Each preceptor had a different set of behaviours that were used as indicators for how a student would be rated at the final evaluation. One preceptor stated: “I do have in my mind definite things that I would like to see”, yet for each preceptor these “definite things” were criteria based on behaviours they personally valued. The following criteria were reported as being “the most important” a student must display during a rural preceptorship: ability to work as a colleague; attitude; critical thinking; enthusiasm for learning; medication knowledge; awareness; organizational abilities; proficiency; safety; adaptability; basic knowledge; caring; patient interactions; professionalism; confidence; and punctuality.

Use of Formative Evaluation. Preceptors were able to outline various strategies they used to evaluate students. The most commonly cited was the use of immediate, daily, honest, verbal feedback. As one preceptor described: “I’m honest and straightforward. . . I try and be specific”. Preceptors described feedback as an informal, ongoing evaluation strategy that occurred spontaneously, in a variety of settings (anywhere from the bedside to in the car to during coffee breaks). Feedback was much easier to deliver than the formal written evaluation and was most successful when delivered as close in time to the event as possible. In reference to a student who had performed poorly, one preceptor explained: “You don’t want to hear about it in two weeks. You want to hear about it now”. Opportunities for feedback had to be actively created and, not surprisingly, feedback was more prevalent in community settings where preceptors and students had built-in debriefing sessions in the car between appointments. Preceptors admitted that it was difficult to deliver negative feedback in a constructive manner and gauged the success of their feedback on the students’ reactions. One preceptor emphasized the importance of constructive feedback saying: “But occasionally you have to be critical and constructive, cause ultimately, you have to imagine that this person could easily be your teammate. . . What kind of nurse do you want to work with”? Other nursing staff and members of the health care team were used as

sources of feedback during the rotation and for the final evaluation. Lastly, preceptors acknowledged the importance of documenting feedback along the way in order to create a basis for the final, formal evaluation.

Successful evaluation strategies also included questioning and supervision. Many preceptors employed questioning to determine the student's level of knowledge but most importantly to determine the student's perception of their own abilities. Preceptors were alert to the types of questions students posed, affording them insight into the student's critical thinking, attitudes towards learning and the extent of their knowledge. One preceptor expressed that "a mixture of confidence/knowledge and questioning behaviours is the best" because it displays proficiency and yet a willingness to continue learning. It is a strategy that is described as helping students to "guide themselves". Such supervision ensured for accurate evaluation in which preceptors observed students intently, evaluating their level of practice, gradually allowing for greater independence. Two unsuccessful strategies were found to include the use of quizzes and written assignments to test a student's knowledge.

Use of Summative Evaluation. The final step in the evaluation process was the completion of the formal, written evaluation at the culmination of the preceptorship to be submitted to the nursing faculty. Preceptors were divided on their reactions to the evaluation tool, however, there was general consensus that the tool was the most difficult aspect of their preceptorship experience and they concurred as to why it may not work very well. One preceptor summarized several viewpoints in saying:

"At first, I guess, [the evaluation form is] a bit overwhelming; I mean, they're your standard professional jargon-type, nursing-type things. But if you read through the criteria that they give you, it becomes clearer. . . but I think their real evaluation is just what I'm writing in-between. Like, the feedback I'm writing, I think that's where the real evaluation is".

Preceptors who had few challenges with the formal evaluation process had documented their feedback throughout the experience and had familiarized themselves with the student's learning objectives at the start. Specific challenges preceptors cited regarding the formal tool were found to be: too much work, tedious and wordy; too vague, lacking in guidelines as to what kinds of behaviour constituted standards such as "acceptable", "exceeds acceptable" etc.; too constraining without enough room for writing comments; and inappropriate for community nursing, but better applied to acute care. In one case the nature of the rural setting prevented an objective evaluation because the student was related to one of the preceptor's superiors. Conversely, one preceptor felt it was effective in, "that they actually get you to sit down with the person, like once a month we sit down with them".

Evaluation of the Unsafe Student. Preceptors described the need to significantly adapt their evaluation strategies when faced with an unsafe student, a process described as a very difficult and the most challenging type of student to evaluate. The term unsafe student refers to those students whose level of practice is questionable in the areas of safety or to students with marked deficits in knowledge and psychomotor skills, motivation, or interpersonal skills (Scanlan, Care & Gessler, 2001). The feedback strategy continued to be employed however, it became time-consuming and did not guarantee positive results. Feedback that was "gentle, but firm", immediate, positive and ongoing remained consistent. It was described as "unfair" if a

student did not have the benefit of receiving quality feedback regarding poor performance. Preceptors had to rely much more heavily on teaching rather than evaluating. The role of the faculty rose to a much higher level of importance. One preceptor explained: “As a preceptor, I’m a guide and I’m an assistant, but I’m not a professor. . . Personally, I would be in contact with their clinical instructor, identify the problem, and go from there”. Many preceptors abandoned their typical evaluation strategies to rely heavily on faculty support for management of unsafe student behaviours which in turn created serious dilemmas for preceptors at rural sites where faculty presence is typically diminished, if not absent.

Role of the Student. Data revealed students play an integral part in the evaluation process. Preceptors stated that typically ‘strong’ students are generally sent to rural placements and this impacted the time and effort they spent on evaluation. They described the evaluation of strong students as being “easy”. Because the formal evaluation was difficult for many preceptors, however, it was often the student to whom they turned to guide them through the process, the student being familiar with the university’s expectations and evaluation tools. Alternatively, preceptors used student self-evaluations to help with their final evaluation and viewed this approach as a more appropriate way of involving students in the evaluation process. Student self-evaluations were helpful in setting learning goals, ensuring accuracy of the preceptor’s final evaluation and in providing the preceptor with feedback on the experience.

Summary. In the process that emerged in this study, preceptors clearly outlined the functions of their role, yet did not include the role of evaluator. They described in detail the evaluation process, commenting on successful strategies as well as what they would do differently in the future, such as the delineation of learning objectives at the beginning of the rotation. Preceptors described the evaluation process as self-directed, and identified areas in which they required greater support such as completing summative evaluation and evaluating the student with unsafe behaviours.

DISCUSSION

Rural preceptors revealed strategies that were effective (informal feedback, ongoing documentation, and development of learning objectives) and areas where they required a great deal more support (formal evaluation, evaluation of a student with unsafe behaviour, and need for a framework for evaluation). There is considerable inconsistency reflected in the evaluation process undertaken by rural preceptors. This inconsistency is apparent in how the role of the preceptor is defined, the variety of criteria upon which evaluation is based, steps taken (or not) in the evaluation process, evaluation strategies employed, and the variable role of the student and instructor in the evaluation process.

First, not a single preceptor in this study acknowledged the function of preceptor as ‘evaluator’ on behalf of the university or profession, although the others roles reported were consistent with those described in the literature for urban preceptors (Dibert & Goldenberg, 1995; Usher, Nolan, Reser, Owens & Tollefson, 1999). The majority of preceptors in this sample were, at the very least, expected to give their student a pass or fail recommendation at the culmination of the preceptorship. Blum (2009) developed a preceptorship model derived from a participatory action research project that emphasizes the contributions of all stakeholders in student evaluation and in particular greater preceptor participation in evaluation. Implications for nurse educators include incorporating formal recognition of the preceptor role and specifically,

the evaluator role in preceptor recruitment, preparation and development, in order to raise awareness of the responsibilities inherent in this role and preparation required to execute it.

Preceptors assume multiple role relationships in that they are related to their employer as recruiter, to the student as a mentor and guide, and to the faculty as an evaluator. These multiple roles may conflict and without recognition of this conflict, preceptors have little support with which to navigate such roles and responsibilities (Seldomridge & Walsh, 2006). In a rural setting, such conflict could be compounded by multiple role relationships and high visibility within the community (Yonge, 2007). Thus, it is important to characterize the evaluation process as the responsibility of the preceptorship triad: preceptor, student and faculty member, and to clearly define the scope of each role throughout the preceptorship.

The evaluation process must include both a framework (to determine what is being observed) and a tool (a method to record what has been observed) (Qualters, 1999). In this study it became apparent that preceptors lacked an evaluation framework and thus inconsistencies exist in “what is being observed”. Preceptors recognized, in retrospect, the need for delineating learning objectives at the beginning of the placement (Glover, 2000; Kemper, et al. 2004). In the process of developing learning objectives students can identify their learning needs and their strengths and limitations, preceptors can begin to identify learning activities at the clinical site, and faculty can help to link learning objectives with outcome competencies. Seldomridge and Walsh (2006) discuss the faculty’s role in translating broadly stated course objectives into meaningful learning experiences and student-centered learning goals. Preceptors in this study who perceived themselves successful in the evaluation process had familiarized themselves with the formal evaluation tool at the beginning of the preceptorship. A ‘working backwards’ approach could be encouraged to make the preceptorship more comprehensive from initial learning goals through to evaluation.

The lack of a framework for evaluation in rural preceptorship has caused preceptors to be especially self-directed, especially given their professional isolation and decreased access to faculty support and professional development as compared to their urban counterparts (Beatty, 2001; Yonge, 2007). Preceptors explained that they had devised personal criteria for evaluation, and sought guidance from students and colleagues when navigating the evaluation process. This process, however, resulted in a lack of reliability in student evaluation. It also points to a lack of preceptor preparation for the evaluation role (McCarthy & Murphy, 2008; Yonge, et al. 1997). Face-to-face workshops and other forms of preceptor preparation have been used successfully to encourage preceptor-faculty dialogue, to orient preceptors to the evaluation role and to furnish preceptors with strategies for evaluation (Hallin & Danielson, 2009; Riley-Doucet, 2008; Walsh, Seldomridge & Badros, 2008). Based on the findings from this grounded theory, the authors developed a framework to guide rural preceptors through the evaluation process. This model may prove useful to rural preceptors in other settings (Yonge, Myrick & Ferguson, 2011).

As described, daily, informal, immediate, ‘on-the-spot’ feedback is most effective for student learning and also least problematic for the preceptor (Clynes & Raftery, 2008; Glover, 2000; Lee, 2005; Yonge et al., 1997). Preceptors also reported the use of observation and questioning as successful strategies for evaluation. However, they were described as being more intuitive than conscious— activities that occurred automatically. Myrick and Yonge (2002), in an article on preceptor questioning and its impact on student critical thinking explain,

Preceptors are in a prime position to challenge the way preceptees think, encourage them to justify or clarify their assertions, promote the generation of original ideas,

explanations, or solutions to patient problems, provide mental and emotional tools to help resolve dilemmas, and provide a more personal environment with the one-to-one relationship (p. 176).

The theory underlying questioning and the skill itself could be promoted through preceptor education and workshops. Effective questioning can help determine a student's knowledge base, the process involved in their clinical decision making, and their critical thinking skills, ultimately providing the grounds for evaluation (Myrick & Yonge, 2002). The finding that the use of quizzes and written assignments was unsuccessful as a teaching strategy could be attributed to the fact they are ostensibly designed for a more didactic approach to teaching and learning and would not be particularly appropriate or useful in their application to the practical realm of teaching in preceptorship.

The challenges preceptors reported regarding formal evaluation are consistent with those reported by urban preceptors in other studies (Seldomridge & Walsh, 2006; Yonge et al., 1997). Strategies that ensured success included documentation of feedback throughout the preceptorship together with delineation of learning objectives at the outset. Interestingly, the rural setting itself created additional challenges as the multiple role relationships preceptors had within the rural community occasionally interfered with the objectivity of the final evaluation. Thus, nurse educators should consider preceptor preparation for the evaluation process that is specifically 'rural' in content. This could be very beneficial for rural-based preceptors in dealing with the unique challenges of this setting.

It was interesting to note that strategies for evaluation and teaching were dramatically adapted when preceptors had to work with a student who had unsafe behaviours. In a study by Luhanga, Yonge and Myrick (2008), preceptors reported that it is much easier to make critical decisions about a student's performance when ensured the support and guidance of a faculty member. Rural preceptors could greatly benefit from the integration of strategies to work with such students during preceptor orientation as they may not have the benefit of the physical presence of a faculty member during the experience. Additionally, faculty presence in the form of phone calls, e-mails and site visits greatly influenced preceptor perception of faculty support (Luhanga et al., 2008), thus faculty need to be encouraged to maintain an ongoing presence at the rural site through phone calls, Skype and emails.

From another perspective, preceptors perceived that rural placements were generally the recipients of "strong" students and perceived the evaluation of such students to be "easy". This perception may be misguided inasmuch as the placements in these two particular programs are coordinated through a modified lottery system whereby students' choice of placement, home address, and grades are sometimes taken into account. This perception could lead to inflated evaluations if students are perceived as naturally "strong," or students may miss out on the benefits of feedback for growth in clinical practice if they are perceived as such. Even strong students need to be challenged in their practice, thus preceptors could be taught strategies such as the questioning as previously discussed (Myrick & Yonge, 2002). Lastly, although preceptors perceived the evaluation of "strong" students to be easy, they often still relied on the student for guidance during the evaluation process. This approach suggests that the respective roles and responsibilities of the preceptorship triad may be poorly defined and require clarification so that appropriate teaching-learning boundaries can be maintained.

Limitations

Since the participants of this study were recruited from two large western Canadian universities and their affiliated nursing programs, the findings may be unique to these nursing programs and the geographical regions which they span.

CONCLUSION

Rural-based preceptors require greater role clarification and recognition to support their responsibility as evaluators on behalf of an educational institution. This process includes the need to emphasize evaluation as an important component of the preceptors' roles and responsibilities, including the provision of a framework for evaluation, and finally increasing faculty support for the functions of this role. Students are currently guiding preceptors as to how to fill out the evaluation forms and this rightly is the responsibility of the faculty. The rural setting provides rich learning experiences with positive recruitment outcomes, thus preceptor support and development could ensure sustainability of these valuable placements.

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