Extending the Synergy Model to Preceptorship

A Preliminary Proposal

Proposed Corollary for the Synergy Model

Webster[1] defines a corollary as "something that naturally follows" from something else. When I consider the American Association for Critical-Care Nurses (AACN) Synergy Model for Patient Care with a clinician's eye, I can immediately see the relevance and elegance of its central characteristic—that is, that optimal patient care can best be achieved when the patient's characteristics (expressed as needs) are matched by the nurse's characteristics (expressed as competencies). Because the patient and nurse interact within a healthcare system that both possesses and exhibits its own attributes, a third component of the model needs to be recognized that could affect outcomes in either or both of the other components (Figure 1).

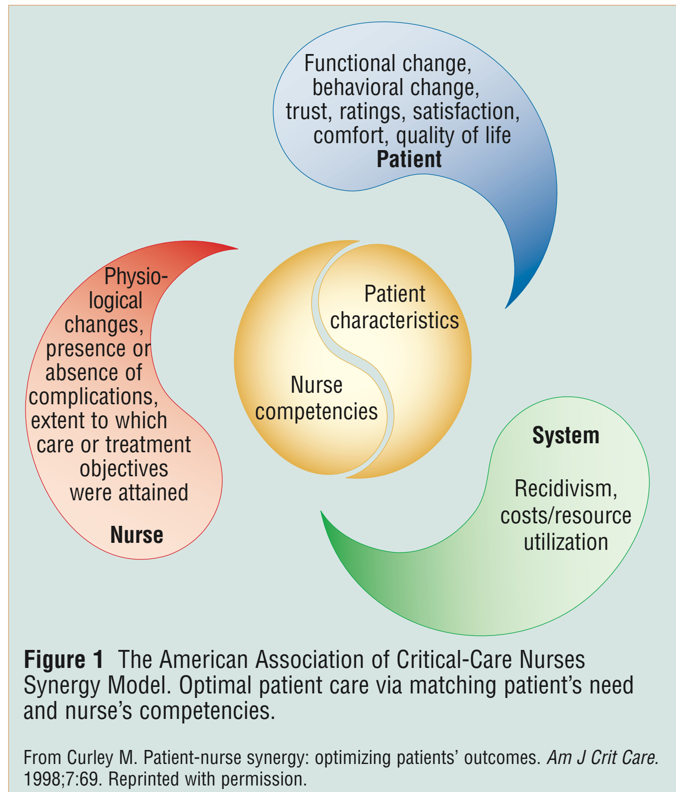

Figure 1 The American Association of Critical-Care Nurses Synergy Model. Optimal patient care via matching patient's need and nurse's competencies.

From Curley M. Patient-nurse synergy: optimizing patients' outcomes. *Am J Crit Care.* 1998;7:69. Reprinted with permission.

Optimal patient care can best be achieved when the patient's characteristics are matched by the nurse's characteristics.

When I view the Synergy Model from a staff development perspective, however, my mind's eye can quickly reconfigure 2 components of this triad—transforming *Nurse* to *Preceptor* and *Patient* to *Preceptee*—and then readily appreciate the relevance and elegance of its corollary attribute; that is, that optimal orientation of the preceptee can best be achieved when the preceptee's characteristics (expressed as needs) are matched by the preceptor's characteristics (expressed as competencies). Just as the patient and nurse interact within the healthcare system, the same holds true for the preceptee and preceptor, recreating a parallel triad of interacting components that could affect outcomes in the orientation process (Figure 2).

If the Synergy Model is transferable from patient care to preceptorship, the natural extensions of this model should evidence some degree of comparability and continuity throughout the major tenets of the model; for example, basic assumptions underlying the model and the respective sets of nurse (preceptor) and patient (preceptee) characteristics. In this Editorial, I will offer a proposed application for only the first of these structural beliefs.

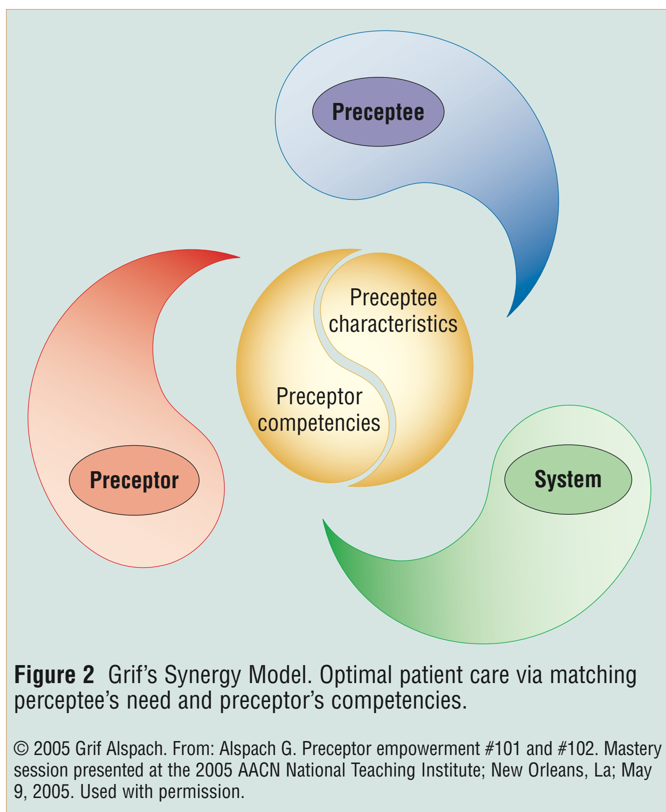

Figure 2 Grif's Synergy Model. Optimal patient care via matching perceptee's need and preceptor's competencies.

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Basic Assumptions Underlying the Synergy Model

The Synergy Model is rooted in a total of 9 assumptions. The first 5 were identified in 2000[2] and the last 4 were added by the AACN Certification Corporation[3] a few years later. Most of these assumptions relate to the patient and/or the nurse, although the hospital system is addressed directly and indirectly in others. If this model can legitimately apply to a preceptorship, many, most, or all of the same set of assumptions should hold true. The Table identifies the 9 assumptions upon which the Synergy Model of Patient Care is based and offers a preliminary set of corollary assumptions that might be proposed for the preceptorship format of orientation.

Before suggesting any additional applications of the Synergy Model to preceptorship, I'd like to solicit your reactions, critique, and suggestions related to this initial proposal; that is, that the basic assumptions underlying AACN's Synergy Model of Patient Care can be applied with comparable relevance to describe basic assumptions that underlie a synergy

Assumptions guiding the American Association of Critical-Care Nurses Synergy Model

Assumption	(Proposed) **corollary assumption**
Synergy Model for Patient Care	*(Proposed) synergy model for preceptorship*
1. Patients are biological, psychological, social, and spiritual entities who present at a particular developmental stage. The whole patient (body, mind, and spirit) must be considered.	1. Preceptees are biological, psychological, social, and spiritual entities who present at a particular developmental stage. The whole preceptee (body, mind, and spirit) must be considered.
2. The patient, family, and community all contribute to providing a context for the nurse-patient relationship.	2. The preceptee and community contribute to providing a context for the preceptor-preceptee relationship.
3. Patients can be described by a number of characteristics. All characteristics are connected and contribute to each other. Characteristics cannot be looked at in isolation.	3. Preceptees can be described by a number of characteristics. All characteristics are connected and contribute to each other. Characteristics cannot be looked at in isolation.
4. Similarly, nurses can be described on a number of dimensions. The interrelated dimensions paint a profile of the nurse.	4. Similarly, preceptors can be described on a number of dimensions. The interrelated dimensions paint a profile of the preceptor.
5. A goal of nursing is to restore a patient to an optimal level of wellness as defined by the patient. Death can be an acceptable outcome, in which the goal of nursing care is to move a patient toward a peaceful death.	5. A goal of orientation is to ensure the preceptee demonstrates an optimal level of competency as defined by the hospital. Rescinding an offer of employment can be an acceptable outcome, in which the goal of preceptorship is to move preceptee toward an alternative position or employer.
6. The nurse creates the environment for the care of the patient. The environment of care also affects what the nurse can do.	6. The preceptor creates the environment for the orientation of the preceptee. The environment of the orientation program also affects what the preceptor can do.
7. There is an interrelatedness between impact areas, which may change as the experience, situation, and setting change.	7. There is an interrelatedness between impact areas, which may change as the experience, situation, and setting change.
8. The nurse may work to optimize outcomes for patients, families, healthcare providers, and the healthcare system.	8. The preceptor may work to optimize outcomes for preceptees, healthcare providers, and the healthcare system.
9. The nurse brings his or her background to each situation, including various levels of education/knowledge and skills/experience.	9. The preceptor brings his or her background to each situation, including various levels of education/knowledge and skills/experience.

that can be achieved in the relationship between a nurse preceptor and preceptee.

Please send your thoughts (reactions, critique, suggestions) on this (whether the Synergy Model's assumptions are transferable to Preceptorship) no later than June 15, 2006, to Grif at synergy_assumptions@comcast.net.

References
1. Merriam-Webster Online Dictionary. Available at: http://www.m-w.com/cgi-bin/dictionary?va=corollary. Accessed February 14, 2006.
2. American Association of Critical-Care Nurses. *Standards for Acute and Critical Care Nursing Practice.* 3rd ed. Aliso Viejo, Calif: American Association of Critical-Care Nurses; 2000.
3. Muenzen PM, Greenburg S, Pirrol KA. Final Report of a Comprehensive Study of Critical Care Nursing Practice. Available at: http://www.certcorp.org/certcorp/certcorp.nsf/certcorp/ccrn?opendocument#Role%20Delineation%20%2F%20CCRN%20Validatio_1. Accessed February 14, 2006.

Grif Alspach, RN, MSN, EdD
Editor