Precepting in the Real World Bingo

Circle any squares you've experienced. Star 1 you want a tool for today.

We're short-staffed/busy today	Teaching happened in < 30 seconds	Expectations weren't aligned	Feedback got postponed because of workflow	There were multiple learners competing for attention
We talked through uncertainty ("I'm not sure yet")	Precepting occurred during verifying/processing /rounding	We realized we have different definitions of 'initiative'	We utilized a "micro-goal" rather than a full plan	We used a script/phrase to make feedback more efficient
We identified a safety 'stop point'	We recalibrated after a near-miss or confusion	Free Space	We ended with a 60-second debrief	We celebrated a small win
The level of independence was unexpected	The learner wasn't sure what 'good' looked like	We meant to debrief…but the shift ended	We set a check-in time (10:30, 1:00)	We had to teach while moving physically from room-to-room
There wasn't protected time for teaching	We postponed our topic discussion because it was busy	You realized that what was delivered didn't match what was requested	We practiced a concise recommendation	We used a quick check-in to reset

Precepting in the Real World

Teaching Clinical Thinking Without Slowing Down

Abbie Lyden, PharmD, BCPS
abbie.lyden@rosalindfranklin.edu
Associate Professor, Department of Pharmacy Practice
Lead Interprofessional Faculty, DeWitt C. Baldwin Institute
Rosalind Franklin University

Disclosures

ACPE Standard 5

- Dr. Lyden declares no conflicts of interest, real or apparent, and no financial interests in any company, product, or service mentioned in this program, including grants, employment, gifts, stock holdings and honoraria.
- Artificial intelligence-assisted editing tools were used for grammar/clarity check. All idea generation, content creation, and primary source review were completed by the presenter. Information last accessed February 2026.

Why This Matters Now

- Learners struggle more with judgment than knowledge
- Time pressure is real across all practice settings
- Preceptors teach constantly -- whether intentionally or not
- Clinical thinking is absorbed through observation and culture

What We'll Focus on Today

Segment	What It Is	Why It Matters to All
 Why Precepting Matters Beyond Students	Culture & professional Identity	Affects how people practice, not just how students learn
 Universal Clinical Reasoning	How pharmacists think through risk & insecurity	Everyone makes judgment calls daily
 Teaching Without Slowing Down	Workflow-integrated micro-teaching	Prevent inefficiency and errors in any practice setting
 Communication, Feedback	Reinforcing clinical judgment Useful tools Generational considerations	Shapes confidence and safety culture
 Case-Based Discussion	Practical strategies to take home	No single "right" answer -- focus on reasoning
 Reflection & Debriefing	Tools to learn during routine work	Improves future decisions Reduces repeat errors

Learning Objectives

At the completion of this activity, participants will be able to:

1. **Describe** key principles of effective precepting that promote safe clinical decision-making, professional judgment and readiness for practice across pharmacy settings.
2. **Apply** practical, time-efficient strategies to make clinical reasoning visible and guide learner reflection during routine patient care activities without disrupting workflow.
3. **Demonstrate** communication and feedback techniques that reinforce patient safety, professional accountability and confidence when working with learners and team members.
4. **Identify** approaches to align expectations and support effective communication between preceptors and learners across generations while maintaining high standards of clinical practice.

Pre-Seminar Questions (Baseline Check)

How confident are you in each of the following? (Choose A–D for yourself; no need to share.)

1. A learner says “I followed the protocol, so it should be fine.” Which micro-teaching move best surfaces their reasoning in <15 seconds?
2. Which prompt most directly teaches risk trade-offs (not recall) during a busy workflow moment?
3. Which feedback framework is best for brief, real-time feedback tied to patient safety (Situation–Behavior–Impact)?
4. What is the primary goal of naming a ‘red line’ safety threshold to a learner?
5. When a learner is silent during rounds, the most productive first move is usually to…

Precepting Shapes How People Practice

- Practice culture is learned, not taught
  - *…that hidden curriculum*
- Learners watch how decisions are made under pressure
- Silence, urgency, and tone all teach
- Precepting happens whether we intend it or not

What you are teaching in the moments:

- When to slow down
- When to escalate
- What "good judgment" looks like
- How to talk about uncertainty
- What safety actually means here

Break: **Think about a behavior you picked up from a preceptor or mentor early in your career -- something you still do today (30 seconds)**

Universal Clinical Reasoning

> ***“Use your clinical judgment…”***
>
> - Probably every preceptor, everywhere

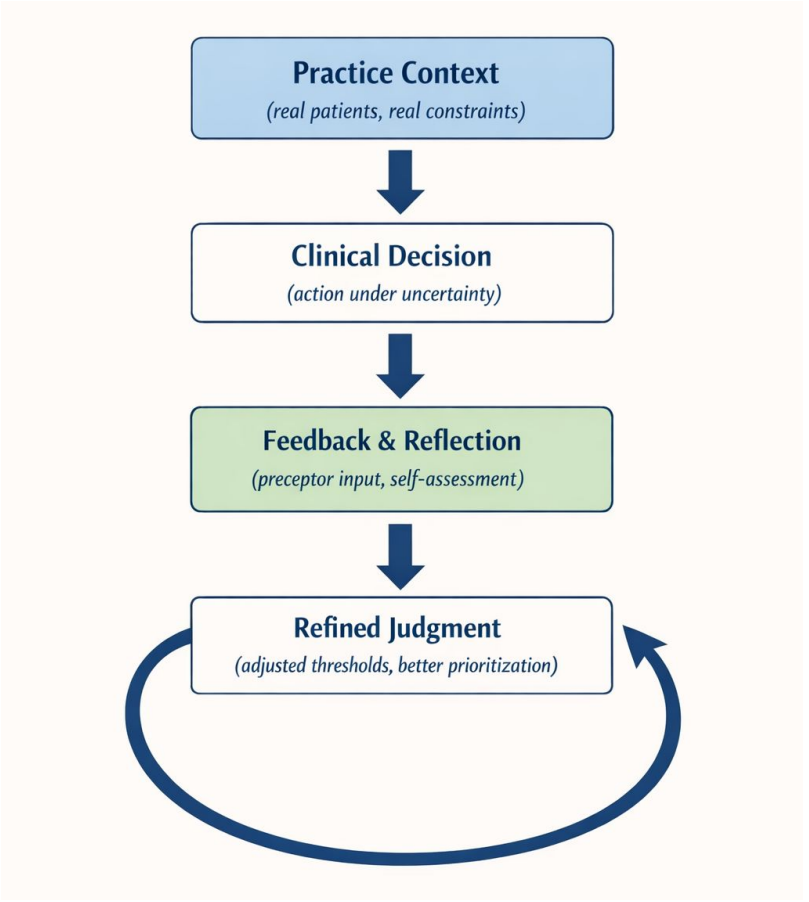
Pharmacists: ***How confident are you that learners know what this actually means?***

Learners: ***How clear do you feel on what this means in actual practice?***

How Clinical Judgment Develops in Practice

Established learning theories

- Situated learning: learning embedded in practice
- Cognitive apprenticeship: making expert thinking visible
- Deliberate practice: focused feedback on decisions
- Experiential learning cycles: action > reflection > adjustment



Lave J, et al. *Situated Learning.* Cambridge, UK: Cambridge University Press; 1991.
Collins A, et al. In: Resnick LB, ed. *Knowing, Learning, and Instruction Cognitive Apprenticeship.* Hillsdale, NJ: Lawrence Erlbaum Associates; 1989:453-494.
Kolb DA. *Experiential Learning: Experience as the Source of Learning and Development.* Englewood Cliffs, NJ: Prentice Hall; 1984.

What Does Good Clinical Judgment Look like?

"Clinical Thinking" Is….

- ✅ Recognizing what matters *right now*
- ✅ Managing uncertainty and incomplete information
- ✅ Weighing risk versus benefit in real time
- ✅ Prioritizing problems with limited time
- ✅ Knowing when to pause, escalate, or ask for help
- ✅ Explaining decisions clearly to others
- ✅ Reflecting on decisions after the fact

"Clinical Thinking" Is NOT…

- ⛔ Memorizing facts
- ⛔ Following rules without context
- ⛔ Getting to the answer the fastest
- ⛔ Never asking questions

Making Thinking Visible

"Knowing" isn't the same as "thinking"

- Knowledge = facts, guidelines, recall
- Thinking = prioritization, trade-offs, risk assessment
- Most struggles live in thinking, not facts

What preceptors can easily see…and what they can't…

- Visible: correct vs. incorrect answers, missing knowledge, errors in dosing or calculations
- Rarely see: what the learner considered but dismissed, why a plan "felt right" --- where uncertainty lives

The Core Teaching Challenge

- If thinking is invisible, coaching is guesswork
- Preceptors default to telling instead of teaching
- Time pressure reinforces this

Where NAPLEX Fits -- and Where It doesn't

Where it Fits:

- ☑️ Measures readiness for practice
- ☑️ Emphasizes decision-making and judgment
- ☑️ Reflects real-world uncertainty

Where is Doesn't:

- ⊘ Not trivia recall or disease-state memorization
- ⊘ Not something preceptors "teach to"
- ⊘ Not a substitute for real practice

Instead of…*"What's the correct dose?"*
"What guideline applies?"

Try…"*What are you worried about"*
"What information matters to you most right now?"

Teaching Without Slowing Down

Why Traditional Teaching Models Break Down in Clinical Workflow

- Time-limited, high-stakes environments
- Uncertainty and incomplete information
- Decisions must be made *before* full understanding
- Retrospective teaching misses decision points

Managing Your Own Cognitive Load

Teaching is a “Second Task”:

- Precepting adds a mental tax to an already heavy clinical load

Narrate Your Practice

- Don’t find extra time to teach
- Unmute your internal monologue

The 80/20 Rule:

- Focus your teaching on the 20% of decisions that require high judgment,
- Not the 80% that are routine

Give Yourself Grace

- Okay to say you don’t have time to teach at a given moment
- Set expectations

What Slows Workflow -- And What Doesn’t

Actually slows workflow

- Re-teaching after mistakes
- Correcting decisions late
- Unclear expectations
- Learners waiting for approval

Does *not* slow workflow

- Naming priorities out loud
- One-question pauses
- Brief think-alouds
- Clear safety thresholds

Teach Within Your Workflow:
Do More With Less

Teaching Without Slowing Down: A Learning Problem, Not a Time Problem

- Expertise is built through repeated, contextual decisions
  - Most teaching happens in seconds, not minutes
  - Can simply be one well-placed question -- “microteach”
- Teaching is best when it occurs inside authentic workflow
  - Goal is to slow thinking, not operations
- Feedback closest to the decision has the highest impact
  - Small, repeated moments matter more than long explanations

Micro-teaching: not a compromise -- a necessity

Chinai S, et al. *W J Emer Med*. 2018;19(1):28-34.

Precepting Methods What is Your "Move"?

"One-Minute Preceptor" (5 skills)

- Get a commitment
- Probe for supporting evidence
- Reinforce what was done well
- Give guidance about errors/omissions
- Teach a general principle

Great, but assume:

- *Recognizable "presentation moment"*
- *Conversational space*
- *Relatively linear interaction*

Micro-teaching Moves

- Think-alouds
- One-question pauses
- Naming safety thresholds
- 30-second debriefs

Advantages:

- *Occur **inside** real workflow*
- *Are not always sequential*
- *Can be used independently*
- *Map to safety-critical moments*
- *Feel natural to pharmacists*

Neher et al. *Am Board Fam Practice*. 1992;5: 419-424.

Emergency Medicine Reality Check

Our rotation:

- ~ 24 students (several universities), PGY1 and PGY2 residents
- Students work staggered shifts: 8am-4pm, Noon-8pm
- 6-8 different preceptors throughout the rotation

How do we make sure things don't 'slip through the cracks?'

Learners often see 'answers' but miss prioritization and risk thresholds

Barriers to impactful precepting:

- ED is non-linear: interruptions, parallel tasks, and rapid decisions
- Teaching moments may be 10-30 seconds (between pages, orders, consults)
- 1:1 preceptor models are hard to execute reliably

Goal: slow thinking, not operations -- make judgment visible under pressure

Team-Based ED Precepting
When There Isn't 'One' Preceptor

Team preceptorship model: collaborative education

- Multiple pharmacists working together to provide rotation experiences that effectively teach and facilitate growth of learners

Benefits

- May decrease preceptor burnout
- For learners: gain knowledge, skill, and experience from a larger number of practitioners with unique skills
- Enhances team collaboration
- Allows for increased opportunities for feedback
  - For struggling learners: helpful to get a 'second opinion'

Keys to Success:

- Make it explicit on Day 1: learners must adapt to different styles -- it's the real world
- Use shared tools: competency checklist (what topics/skills were covered) + shared feedback doc
- For struggling learners: proactive, rapid communication within the preceptor team

⏱️ Micro-Teaching Move #1: Think-Alouds

- 10 - 30 seconds
- Verbalize *why,* not how
- Especially powerful in uncertainty
- Models expert reasoning
- Helpful to distinguish *unsafe* from *suboptimal*

“I’m pausing here because this combination raises my risk threshold.”

“This is low risk, so I’m comfortable moving forward.”

Micro-Teaching Move #2: One-Question Pauses

- Replace “Is this okay?” with one question
- Forces articulation of reasoning
- Reveals gaps quickly
- Works in < 15 seconds

“What’s your main concern?”
“What would change your mind?”
“What’s the worst plausible harm?”
“What’s your backup plan?”
“What do you think is happening with this patient?”

Teaching to Think, NOT Memorize

Micro-Teaching Move #3: Safety Thresholds

- Makes implicit rules explicit
- Calibrates learner judgment
- Reduces silent risk-taking
- Builds confidence
- Improves judgment
  - Make a plan with multiple reasonable options

Learners don’t know your thresholds unless you say them.

“If potassium was higher, I’d stop and reassess.”

“If the patient was hypotensive, I’d escalate therapy”

“This is where I'm comfortable proceeding”

The “Red Line” Drill - What is one of Your Safety Thresholds?

- **The exercise**: think of a high volume task in your practice (e.g. verifying vancomycin, counseling on a new inhaler, checking a pediatric dose)
- **The question**: What is *one* specific clinical data point that, if changed, would make you stop the entire process?
- **The goal**: practice naming that threshold out loud to your learner *before* the shift starts
- **Example**: I am ok with this dose unless the heart rate is <60

Next time you have a learner --- say your “line” out loud

Micro-Teaching Move #4: The 30-Sec Mini-Debrief

- Happens *after* the decision
- Reinforces judgment
- Prevents repeat errors
- No paperwork required

“What went well?”
“What would you do differently next time?”
“What should we remember from this?”

Reflection is how experience turns into judgment.

⏱️ Micro-Teaching Move #5: Accountability Bridge

- **The goal**: move from “I do, you watch” to “You do, I watch” without compromising safety
- **Step 1:** The “Dry Run” (mental commitment)
  - Prompt: have the learner verbalize a decision before hearing or seeing yours
  - Removes hindsight bias
- **Step 2:** Scaffolding Autonomy (bounded tasks)
  - Assign “micro-ownership” of specific, repeatable tasks (e.g. all renal dose adjustments for a patient/team)
  - Builds decision-making muscle in controlled environment
- **Step 3**: Defining the “Red Line” (safety net)
  - Discuss specific parameters whether they MUST stop and call you
    - “If the level is > 20 or the SCr jumps by 0.5, do not enter the dose”
- **Step 4:** Active Observation (the long leash)
  - You are physically present but silent
  - You intervene if the “red line” is crossed

ED “Pocket Card” for Preceptors

One-liners for micro-teaching

- **Move 1** -- Think-aloud
  - “She is hypotensive and the lactate i 3.8, so I’m worried about septic shock -- let’s give 30 mL/kg fluids and start broad-spectrum antibiotics now.”
- **Move 2** -- One-question pause
  - What’s the worst plausible harm if we are wrong, or do nothing?”
- **Move 3** -- Safety Threshold
  - “I’m pausing because the harm here is high even if likelihood is low.”
  - “What’s your threshold to escalate if MAP <65 after 2L, do we start norepinephrine?”
- **Move 4** -- 30-second mini debrief
  - “Quick debrief -- what clue pushed you toward sepsis, and what would you do differently next time?
- **Move 5** -- Accountability bridge:
  - “What’s your plan and backup plan if patient worsens?”

What This Looks Like in Daily Practice

Brief teaching moments embedded in routine work

Community:

- Pausing counseling to name a key risk or tradeoff
- Verbalizing why an interaction *does or doesn't* change the plan
- Asking one question before verification
- Reflecting briefly after a near-miss or complex encounter

Inpatient:

- Think-alouds during order verification or rounds
- Naming thresholds for escalation or additional monitoring
- Coaching learners through prioritization under time pressure
- Short debriefs after high-risk decisions or consults

Ambulatory:

- Framing shared decision-making conversations
- Asking learners to articulate their recommendation and rationale
- Modeling follow-up planning and contingency thinking
- Reflecting on patient responses and next steps

These teaching moments apply in transitions of care, long-term care, specialty practice, telepharmacy, industry, leadership

Communication & Feedback

Generations

Silent Generation	Baby Boomers	Generation X	Millennials	Generation Z	Generation Alpha	Generation Beta
1928 - 1948 Ages 81-98	**1946 - 1964** Ages 62-80	**1965 - 1980** Ages 46-61	**1981 - 1996** Ages 30-45	**1997 - 2012** Ages 14-29	**2013 - 2024** Ages 1-13	**2025 - 2039**

What generation are you?

What generation are today's pharmacy learners, mostly?

One assumption for this section: generational = influences, not stereotypes

Why Generational Differences Show Up in Precepting

Generations reflect shared training contexts, not individual capability or motivation

- Different training environments shape default expectations
- Different feedback norms influence how guidance is received
- Different comfort with uncertainty affects when learners speak up
- Shared goal across generations: safe, effective patient care

Different Training Contexts, Same Standards

Earlier-Trained Pharmacists

(often Boomer / Gen X)

- Learned through immersion and observation
- Less explicit feedback early on
- Judgment developed implicitly over time

Boomer: goal-oriented, motivated, preference for structured communication, value clear hierarchy & defined roles

- Interactions: provide structure, respect experience, communicate expectations

Gen X: resourceful, self-sufficient, problem-solver, model independence

- Interactions: offer autonomy, trust their expertise, tie feedback to outcomes

Newer-Trained Pharmacists & Students

(often Millennial / Gen Z)

- Learned in highly organized curricula
- Trained with structured feedback and assessment rubrics
- Judgment expected to be articulated

Millennial: team-oriented & collaborative, multitaskers, expect frequent, real-time feedback, respond well to positive reinforcement and mentor-style leadership

- Interactions: frequent feedback, explain the “why”, foster collaboration

What We're Seeing with Many Gen Z Learners

Training Context & Learning Habits

- Entered practice through highly structured curricula
- Frequent rubrics, checkpoints, explicit expectations
- Digital-native learning habits: fast info access, variable info quality
- Less early "workplace socialization" prior to professional training: ~19% 15-17-year-olds Gen Z vs ~30% same-age millennials

Feedback & Communication Preferences

- Expect frequent, specific, actionable feedback
- More comfortable with feedback framed as coaching
- May interpret silence as disapproval or lack of clarity
- Benefit from explicit success criteria
- Value well-being and psychological safety

Judgment, Confidence & Accountability

May hesitate to commit without clear safety boundaries

Questions often reflect risk awareness, not insecurity

Accountability improves with clear decision ownership

Confidence grows when reasoning expectations are explicit

Same Standard. Different Starting Point.

- **The goal is the same: independent, safe, clinical decision-making**

- **What differs is the path to get there:**
  - Prior training environments vary in structure, autonomy and feedback
  - “Initiative” may look different across learners
  - Silence may reflect uncertainty, not disengagement
  - Early clarity accelerates independence -- it does not delay it

- **Our role: translate expectations into observable behaviors**

When Expectations are Clear, Independence Develops Faster

- **Example: Day 1 Orientation**
- **Less explicit approach** (e.g. Gen X)
  - “Here’s the patient list -- let me know if you need anything.”
  - Signals trust + initiative
- Gen Z may hear: “You’re on your own.”
  - Signals risk without a safety net
- **More explicit approach**:
  - “Start by reviewing these two patients. Bring me your assessment and recommendation. Check in with me by 10:30am”
- Both expect initiative -- only one makes the path visible
- Mutual benefit: clearer expectations reduce rework and build confidence faster

Communication Style Affects Performance -- Just Preference

Ambiguous expectations slow progress and increase anxiety

- “Be proactive” ***may land as*** “guess without a safety net”
- “Use your judgment” ***may land as*** “I don’t know what you want”
- “Ask fewer questions” ***may land as*** “don’t speak up”

Your goal: translate expectations into observable behaviors

Translating Expectations Without Diluting Standards

- **Preceptor Tip**: Clear expectations and brief, frequent feedback build confidence and performance
- Ask for the components of judgment:
  - Concern
  - Rationale
  - Safety net
  - Follow-up plan
- Name the reasoning you expect
- Make safety thresholds explicit:
  - Escalate when X/Y happens
- Normalize questions without removing accountability:
  - Learners can ask early, but then propose a plan
- Replace “use your judgment” with scripts that show how to judge

The Translation Table

"Use your judgment" ⛔	
	"Pick a plan, then tell me: what are you worried about and what's your safety net?" ✅
"Be more proactive" ⛔	
	"Bring me your recommendation plus one alternative." ✅
"That's wrong" ⛔	
	"Walk me through your reasoning; where did you feel uncertain?" ✅

Change language to set a specific, observable behavior

Forces the clinical thinking process we want to see

Practice Scenarios

Case 1: The Question-Master 

The scenario: A high-volume Saturday. A student is processing a pediatric amoxicillin suspension. They've asked you three times if the dose is "okay" based on different online calculators that vary by 2 mg/kg. Workflow is busy (the line is 10-people deep and the parent is staring at the student), and you're concerned they aren't developing independence.

What factors might be driving this behavior?

How could you respond in a way that builds judgment <u>without lowering standards</u>?

Scenario B: The Silent Strategist 

A PGY1 resident on their Internal Medicine rotation is rounding on a patient with a history of epilepsy. The patient's phenytoin level came back at 2.8 mcg/mL (target 1-2 mcg/mL). The resident accurately enters a "hold" order and a dose reduction, but says nothing during the multidisciplinary team discussion. When you ask why they didn't speak up, they say: "I knew what to do, but I wanted to make sure the attending didn't want a different target before I sounded 'wrong' in front of everyone.

What factors might be driving this behavior?

Is this a lack of knowledge or a lack of "psychological safety"?

Effective Feedback Starts With Diagnosis

- Name the issue you are addressing
  - Be specific, not global
- Tie feedback to reasoning, not traits
- Adjust approach based on the gap
- Limit feedback instead of lumping
  - One target at a time
- If constructive, provide examples of how they can improve
- If significantly constructive, choose an appropriate location to deliver

Feedback That Builds Clinical Judgment

- Powerful teaching tool
- Focuses on thinking, not correctness
- "SBI" Framework: simple structure for real-time feedback
  - **S**ituation -- Name when and where it happened
  - **B**ehavior -- Describe what you observed (no judgment)
  - **I**mpact -- Explain why it matters for safety, care, or learning

"I noticed X. I was concerned about Y. Next time, consider Z."

"During that counseling session (S), you paused to check the potassium level (B), which helped reduce the risk of harm (I)."

Feedback That Builds Clinical Judgment

- Advocacy-Inquiry Framework: feedback that invites thinking
  - Advocacy: Share what you noticed and why it concerns you
  - Inquiry: Ask the learner to explain their thinking

"I noticed you recommended the antibiotic without mentioning their allergy and was concerned about a potential reaction. Can you walk me through your thinking?"

Matching Feedback to the Problem

Observed Gap & Intervention	What It Often Sounds Like	Feedback that Helps
Knowledge > Clarify Content	“I didn’t know that protocol” “I wasn’t aware of that interaction”	“Let’s clarify the key facts here.” “What resource would help you next time?”
Reasoning > Probe Thinking	“That just seemed right” “I followed the algorithm”	“Walk me through how you got there.” “What alternatives did you consider?”
Prioritization > Force Trade-offs	“There were a lot of issues” “I wasn’t sure what to focus on”	“What’s the most important problem, though?” “What can safely wait?”
Confidence > Normalize Uncertainty	“I didn’t want to be wrong” “I wasn’t sure enough to say it”	“Uncertainty is expected -- say your thinking anyway” “What made you hesitate?”

Case-Based Discussion

How to Listen to These Cases

- Not looking for a single “right” answer
- We’re listening for how decisions are framed
- Unsafe decisions should be named
- Among safe options, reasoning matters most

What We Mean by “Focus on Reasoning”

Scenario:

Borderline drug-drug interaction, stable patient, limited history

Reasonable approaches might include:

- Proceed with counseling and monitoring
- Call the prescriber
- Adjust timing or formulation

What matters is how the decision is justified and monitored

Case-Based Discussion: The Reassurance Trap

A patient comes to the counter to pick up a new prescription for sulfamethoxazole/trimethoprim for cellulitis. During counseling, the patient says: *“My cardiologist told me to be careful with new meds because of my blood thinner. I’ve been on it forever, so it should be in my profile.”* The student identifies the patient is on warfarin and quickly checks the interaction software, which flags a risk for increased anticoagulant effect. The student says:

“I think this should be okay,”

then looks to you for confirmation as the line grows behind the counter.

1. **Where’s the uncertainty in the learner’s thinking? *(interaction vs clinical risk)***
2. **What’s the trade-off? *(harm of reassuring too quickly vs. escalating too quickly?)***
3. **What would change your mind?**

Case-Based Discussion: The “Protocol” Trap

A hospitalized patient with fluctuating worsening renal function (SCr increased from 1.0 to 2.1 in last 24 hours) is ordered for enoxaparin. A learner looking at the order says,

“It follows the hospital protocol for weight-based dosing, so I guess it should be okay”

They seem uneasy but aren’t sure how to articulate why.

1. **Think about the accountability bridge -- what can you ask to encourage clinical thinking?**
2. **Name a threshold -- how would you verbalize your “red line” for dose-adjusting?**
3. **The move: Use a think-aloud to explain why you are overriding the “standard” protocol in this high-risk moment**

Reflection & Debriefing

> ***“ Readiness for practice is hard to define -- but easy to recognize ”***

When do you *know* a learner is ready?

- **When they ask fewer, more focused questions**
- **When they ask better questions**
- **When they catch their own mistakes**
- **When they explain their decisions clearly**

Reflection & Debriefing

What Debriefing Is (and Is Not)

Debriefing is:

- ☑ A chance to surface thinking
- ☑ NOT a full post-mortem
- ☑ NOT a performance review
- ☑ Focused on decision points
- ☑ Short by design
- ☑ Centers uncertainty, not error

Reflection: Where Experience Becomes Judgment

- Experience alone does not build judgment
- Reflection turns actions into learning
- Brief reflection is more effective than delayed feedback
- Reflection improves safety, confidence, and lifelong learning

Fitting Reflection Into Real Practice

- ✅ Immediately after a decision
- ✅ Takes 30-60 seconds
- ✅ Focuses on thinking, not performance
- ✅ Can occur at the counter, workstation or hallway

Reflection Tools

Plus / Delta

Plus: What went well?
Delta: What would you change next time?
Emphasizes improvement, not blame
Works for learners AND teams

The One-Minute Debrief

2-3 focused questions
Anchored to a specific decision
Reinforces clinical judgment and prevents future errors
“What was the hardest part of that decision?”

Near-Miss Learning

Powerful learning moments
Focus on *how* risk was identified
Reinforces safety culture, avoiding shame and defensiveness
“What safety net caught this? How would we recognize this earlier next time?”

Example -- Using Reflection in Real Time

Scenario 1: Plus/Delta

Patient with HFrEF admitted with pneumonia, MAPs 65-68. Creatinine up slightly from baseline but trending down. Currently receiving home lisinopril.

Student recommendation: “I’d hold the ACE inhibitor for now.”

Plus/Delta Questions:

“What went well in your thinking?”

“What factors would push you toward restarting sooner or perhaps not holding?”

Scenario 2: Near Miss Learning

Patient presents to ambulatory care clinic with 3 days of cough, congestion, low-grade fever. No shortness of breath. Lungs are clear. Chest x-ray, COVID, and flu are negative.

Student recommendation: “I’d start azithromycin just in case they get worse.”

Near-Miss Questions:

“What made the antibiotics feel like the safer option in the moment?”

“What’s the downside of prescribing ‘just in case’?”

Real-World Constraints

When You're Busy

You won't fix everything
Choose one teachable moment
Let other things go

When You're Tired

Teaching defaults to telling
Awareness alone helps
Small shifts still matter

At the End of the Rotation

Emphasize patterns seen
Name growth clearly
Frame next steps

Precepting in the Real World

Precepting is culture-building, not just supervision

Small moments matter

- Learners absorb how we think, speak and decide -- often implicitly

Precepting = stewardship

Practical Moves you Can Use Immediately

- Replace “use your judgment” with structured prompts
- Ask for a recommendation before giving input
- Name safety thresholds and escalation points out loud
- Use brief reflection after high-risk or near-miss moments
- Check-in when silence appears -- without assuming why
- Feedback is timely, specific and tied to clinical judgment

Thank You. Questions?

abbie.lyden@rosalindfranklin.edu