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A Clinical Teaching Technique for Nurse Preceptors: The Five Minute Preceptor

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Although preceptorship is the leading approach to the clinical education of senior undergraduate nursing students in the westernized world, few specific nursing preceptor-focused clinical teaching techniques are reported in the literature. One promising preceptor-specific teaching strategy is the Five Step "Microskills" Model of Clinical Teaching (J.O. Neher, K.C. Gordon, B. Meyer, & N. Stevens, 1992). This technique, also known as the One Minute Preceptor (OMP; J.O. Neher & N. Stevens, 2003), has been used for more than 15 years in clinical medical education. In this article, we trace the origins of the OMP and describe an adaptation to nursing education, referred to as the Five Minute Preceptor (5MP). The 5MP steps are the following: (1) get the student to take a stand, (2) probe for supporting evidence, (3) teach general rules, (4) reinforce the positives, and (5) correct errors or misinterpretations. In addition, we explore the relationship between the 5MP and experiential learning and provide a detailed example of the 5MP's use in undergraduate clinical nursing education. Recommendations are provided for the development of a 5MP educational package and the evaluation of the 5MP's use in baccalaureate nursing programs.

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Index words

Preceptor; One Minute Preceptor; Clinical teaching methods; Undergraduate nursing education; Experiential learning

NURSE PRECEPTORS HAVE a unique and essential role in the clinical education of nursing students. With the preceptorship model enduring as the leading approach to the clinical education of senior nursing students in westernized countries, such as Australia, Canada, the United Kingdom, and the United States (Billay & Myrick, 2008, Myrick & Yonge, 2005), nurse preceptors remain the key providers of individualized, experiential learning opportunities for students in professional practice courses.

Definitions of preceptorship appearing in the literature are varied, and the "learners" range from undergraduate (Myrick & Yonge, 2005) and graduate students (Myrick & Yonge, 2004) to professional nurses (Firtko, Stewart, & Knox, 2005). We define preceptorship as a largely experiential approach to clinical nursing education, in which a reciprocal teaching–learning relationship is established among a senior undergraduate nursing student, an RN (known as a preceptor) with whom the learner is partnered, and a faculty member. This triad assists the student in developing clinical competence and confidence in making the transition to the role of the professional nurse. Although the principal roles of the preceptor are as clinical teacher and role model, the faculty member provides the essential link between clinical practice and the academic program. The faculty member orients the student and preceptor to the preceptorship experience and each member's role and supports effective triadic function by acting as an educational resource and consultant throughout the duration of the professional practice course.

To maximize learning opportunities required for a successful transition to professional practice, nurse preceptors need skills in clinical teaching, role modeling, and socializing students to the professional nursing role (Baltimore, 2004). Yet, staff nurses, often expert practitioners in their clinical roles, typically do not have formal education in clinical teaching (Myrick & Yonge, 2005). Further to this, nurse preceptors require support in the execution of their educational roles (Myrick & Yonge, 2005, Yonge et al., 2002) and in developing their clinical teaching skills.

Although we found no discrete teaching techniques in the literature specifically for nursing preceptors, we identified two teaching techniques developed for use with medical learners (medical students, interns, and residents) in clinical settings. One of these, called SNAPPS, is a pneumonic for a student-initiated, student-led, stepwise technique upon which discussions between preceptors and students can be developed (Wolpaw et al., 2009, Wolpaw et al., 2003). SNAPPS is well suited to clinical medical education because of its medical focus on patient case presentation and diagnosis. The other technique, the Five Step "Microskills" Model of Clinical Teaching (Neher, Gordon, Meyer, & Stevens, 1992), more recently referred to in the literature as the One Minute Preceptor (OMP; Neher & Stevens, 2003), is teacher led. Intended originally for discussions about medical diagnosis and treatment, the OMP is a promising teaching technique that can be used with other clinically relevant topics.

In this article, we describe the development of the OMP technique, which we have modified for nursing, and renamed the Five Minute Preceptor (5MP). We provide a 5MP application and relate it to a specific experiential learning framework. Finally, we make recommendations for developing a 5MP educational package as a teaching aid for nurse preceptors and suggest some directions for evaluating this technique in baccalaureate nursing education.

Background

In 1980, Koen and Vivian described a schema of discrete communication and teaching behaviors to assist clinical educators in improving specific teaching skills. They defined five teaching role modes: conceptualization, problem solving, teacher–learner relations, feedback, and role modeling–scholarship. The authors also analyzed teaching principles and techniques found in the medical literature and surveyed medical students and medical school faculty members about what they found to be the most important clinical teaching behaviors. From the generated list of 120 statements about effective clinical teaching, Koen and Vivian retained 18 clinical teaching behaviors (referred to as "microskills") and categorized each under the teaching role modes.

In 1992, Neher et al. used a number of these microskills to create the Five Step "Microskills" Model of Clinical Teaching. Now referred to as the OMP (Neher & Stevens, 2003), Neher et al.'s technique is a stepwise set of preceptor-led teaching behaviors designed to maximize the benefits of time-efficient, one-to-one, clinical preceptor–student teaching discussions in clinical settings. The steps of the OMP technique are typically performed in the following ordered sequence: (1) get a commitment, (2) probe for supporting evidence, (3) teach general rules, (4) reinforce what was done right, and (5) correct mistakes (Neher et al., 1992). See Table 1 for an examination of the relationship between Koen and Vivian's (1980) clinical teaching modes, the specific clinical teaching microskills, and the OMP steps.

Table 1. Relationship Between Koen and Vivian's (1980) Clinical Teaching Modes, Six Clinical Teaching Microskills (Koen & Vivian), and the OMP Steps (Neher et al., 1992)

Clinical teaching mode	Clinical teaching microskills	OMP steps
Problem solving	The teacher asks the learner for a plan or conclusion (without suggestions, hints, or clues).	Step1: get a commitment
Feedback	The teacher asks the learner for the reasoning or evidence relevant to a previous statement before commenting on the statement itself.	Step 2: probe for supporting evidence
Problem solving	The teacher directs attention to specific pieces of information, options, complications, probable outcomes, and criteria for making decisions without offering solutions or suggesting what to do.	
Conceptualization	Early in the discussion of a case, the teacher clearly identifies what he or she considers important about the case.	Step 3: teach general rules
	The teacher clearly states general rules, procedures, or concepts and relates them to the case or topic under consideration.	

Clinical teaching mode	Clinical teaching microskills	OMP steps
Feedback	In giving feedback on a learner's response or action, the teacher gives specific information on what was right and why and what needs improvement and why.	Step 4: reinforce what was done right and Step 5: correct mistakes

Originally, the OMP technique was developed for use in medical education with family medicine physicians and residents acting as medical preceptors in outpatient settings with more junior residents, interns, and medical students. In a compressed teaching–learning encounter, this straightforward teaching technique is appealing because the preceptor can address the student's knowledge and cognitive processes, guide appropriate teaching, and make use of immediate specific feedback, all in a time-efficient manner (Neher et al., 1992).

Features of the OMP are supported in the teaching–learning literature by others, including using student-centered teaching approaches (Edwards, 2001), fostering critical thinking (Alfaro-LeFevre, 2004, Myrick, 2002), providing immediate feedback (Bienstock et al., 2007, Ende, 1983), and teaching in a time-efficient manner (Spencer, 2003). Although the OMP does not replace or eliminate other methods of clinical teaching, it is intended to help preceptors to increase both the frequency and the quality of teaching occurring in complex clinical settings, where time constraints may limit the frequency and quality of preceptor–student teaching–learning encounters.

OMP Literature Review

An OMP literature search of the Medline, CINAHL, and PubMed databases from 1992 onward was completed using the search terms *Microskills Model of Clinical Teaching* and *One Minute Preceptor*. Review of the reference lists in each of the articles retrieved did not reveal other OMP articles. Of the 14 articles identifying the OMP, five described the technique and its use in clinical medical education (Durso, 2006, Ferenchick et al., 1997, Molodysky, 2007, Neher & Stevens, 2003, Parrott et al., 2006). The other nine were original research articles or included an evaluative component (Aagaard et al., 2004, Bowen et al., 2006, Eckstrom et al., 2006, Furney et al., 2001, Huang et al., 2004, Irby et al., 2004, Kertis, 2007, Neher et al., 1992, Salerno et al., 2002, Teherani et al., 2007). Four of these studies (Eckstrom et al.; Furney et al.; Kertis; Salerno et al.) tested the impact of one or more OMP workshops or educational sessions on clinical preceptors' educational behaviors and related outcomes.

In a randomized controlled trial of 57 internal medicine residents with teaching responsibilities for interns and medical students in two Michigan inpatient care facilities, Furney et al. (2001) found that the medical students' ratings of residents receiving the OMP training seminar showed statistically significant improvements in at least one effective teaching behavior related to all of the OMP steps, except for *teach general rules*. In a single-group before-and-after study, Salerno et al. (2002) examined the effect of an OMP workshop on the quality and amount of feedback that nine internist preceptors provided to medical students at the Walter Reed Army Medical Centre in Washington, DC. Salerno at al. found a statistically significant improvement in the specificity of preceptor feedback following the workshop, as well as increases in preceptors' self-reports of successful learning encounters on several variables: letting students reach their own conclusions, being more successful in evaluating learners, and more successfully helping students plan for postencounter learning. In an nonrandomized trial of 68 internal medicine faculty preceptors working in American outpatient clinics with residents, Eckstrom et al. (2006) found that resident learners' assessments of preceptors who received the OMP training showed a nonstatistically significant trend in improved use of the teaching behaviors, except for the provision of feedback to correct mistakes. Preceptor self-assessments in the intervention group revealed statistically significant improvements in change scores for behaviors in three of the OMP steps (get a commitment, probe for supporting evidence, and give positive reinforcement).

Most recently, in a Pennsylvania hospital, Kertis (2007) conducted a before-and-after single-group study of the impact of a 1-hour OMP workshop on 20 nurse preceptors providing orientation to novice nurses. The nurse preceptors rated their self-perceived teaching skills 1 month post workshop on topics, such as learning climate, control over the teaching session, goals of effective communication, promotion of understanding and knowledge retention in the student, evaluation, feedback, and self-directed learning. The study findings revealed statistically significant improvements in the preceptors' self-perceptions of their clinical teaching skills before and 1 month after the workshop.

In summary, with the exception of Furney et al.'s (2001) randomized trial, the study designs were not rigorous, the sample sizes were relatively small, and most outcome measures were based on self-perceptions. Furthermore, few curricular details about the educational sessions/workshops were provided, except for Eckstrom et al.'s (2006) study, which were outlined in detail by Bowen et al. (2006). Finally, the only evaluation of the OMP identified in the published literature that was applied to nursing examined OMP use by preceptors of postlicensure novice nurses (Kertis, 2007). Taking these weaknesses and criticisms into account, at present, this technique

should not be introduced into conventional educational practice. Methodologically strong studies showing positive educationally important outcomes in undergraduate education are needed.

Adaptation of the OMP for Nursing Education

The OMP has been promoted on nursing education Web sites, for example, the University of Alabama School of Nursing (n.d.); however, no reports were found in the published literature or on Web sites that examined the suitability of this medical teaching technique for nursing. Of particular interest were discipline-specific considerations that might need to be taken into account for undergraduate nursing education. After analyzing the OMP relative to the discipline of nursing and undergraduate baccalaureate nursing education, we made several modifications.

Firstly, although medical and nursing education shares the overall goal of fostering the growth and development of professionals to provide safe, ethical, and effective client care, the two are not synonymous. For medical education, getting a commitment, as it was intended for OMP Step 1, involves discussions where the student would commit to a particular course, usually to a diagnosis or a therapy (Neher et al., 1992). For nursing, with its broad mandate and scope of practice, the phrase "get a commitment" is too restrictive for the different types of learning situations that nursing students would encounter. These types of teaching–learning encounters include assessment, nursing diagnosis, patient management, coordination of care, and other important discipline-specific content, such as professionalism. For nursing education, Step 1 is better reflected by the phrase "get the student to take a stand" because it encourages the student to make a judgment about an aspect of the learning situation at hand, irrespective of its content.

Secondly, the wording of the two feedback steps has been modified. Rather than using the OMP Step 4 wording, *reinforce what was done right*, Step 4 has been relabeled as *reinforce the positives*. This terminology encourages the preceptor to comment on strengths in critical thinking and other cognitive processes, as well as decisions or actions. At OMP Step 5, *correct mistakes*, the terminology has been broadened to encompass errors and also the misinterpretations (including partially correct interpretations) that learners may make because of limited knowledge and skills or lack of experience.

Finally, a more realistic time frame for execution of the technique is five minutes (Neher et al., 1992). Given the time constraints in busy, complex practice settings, it is important to offer a teaching technique to preceptors that can credibly be undertaken in the time declared; therefore, the OMP was renamed the 5MP. In summary, the steps, as adapted for nursing, in the 5MP are the following: (1) get the student to take a stand, (2) probe for supporting evidence, (3) teach general rules, (4) reinforce the positives, and (5) correct errors and misinterpretations (see Table 2).

Table 2. Example of a 5MP Clinical Teaching Encounter: Preceptor and Student Dialogue

5MP steps	Clinical teaching encounter
Step 1: get the student to take a stand	Preceptor: Tell me what's happening with your patient. Student: Mrs. Brown has Alzheimer's disease. This morning she's refusing to take her medication. Yesterday, my first day with Mrs. Brown, she took all of her medication without any problems. I think I should call the doctor.
Step 2: probe for supporting evidence	Preceptor: Tell me more about why you've made the decision to call the doctor at this point in time. Student: Well, I know that patients who are competent (that means, patients who have insight into the consequences of their choices), have a right to refuse treatment or medication. Because Mrs. Brown is cognitively impaired, I am not convinced that she is capable of making good decisions about her own health, in this case, making the decision not to take any of her medications. Preceptor: What else might you want to consider here, say in relationship to her antihypertensive medication, before calling the doctor? Student: Well, I can't force her or trick her into taking take her medications, but I'm worried that she really needs her antihypertensive before her blood pressure gets out of control, as this could lead to serious medical problems. I'm not really sure what else you are getting at.
Step 3: teach general rules	Preceptor: First of all, the most appropriate initial action here with Mrs. Brown is to behave in a nonconfrontational manner. Quietly leave the patient's room and come back after about 15 minutes or so. People with Alzheimer's disease have periods short-term memory loss and may become irritable during care. They often become more cooperative after a cooling down period. Student: What if this doesn't work?

5MP steps	Clinical teaching encounter
	Preceptor: If this approach doesn't work, and she continues to refuse the medications, particularly her blood pressure meds, take her blood pressure and document it. Then, notify the physician.
Step 4: reinforce the positives	Preceptor: You have shown a good understanding about competent patients' rights to make choices about treatment and medications. I also really like your proactive thinking about Mrs. Brown's blood pressure; planning to prevent problems before they occur indicates that you are thinking critically about your patient's care.
Step 5: correct errors or misinterpretations	Preceptor: You wouldn't have been wrong by reporting Mrs. Brown's refusal of medication to the physician. However, a word of advice based on my experience, always ensure that you have done a complete assessment and exhausted all possible nursing interventions prior to calling the doctor to report an issue. You might have jumped the gun on this one, had you called the doctor prior to approaching the patient a second or third time with her medications, and prior to checking her blood pressure. For further learning, it might be valuable for you to do some research regarding the process of formally determining competency in cognitively impaired patients.

Note. Content adapted from The Canadian RN Exam Prep Guide (Canadian Nurses Association, 2000).

Detailed Description of the 5MP Steps

5MP Step 1 requires the preceptor to *get the student to take a stand*. At this point, the preceptor purposefully withholds any initial input and uses a general (vs. specific) question or comment to stimulate the student to process information from a clinical experience and provide some interpretation and/or judgment. After listening to the student's response, at 5MP Step 2, *probe for supporting evidence*, the preceptor asks clearly framed, higher order questions to elicit evidence or rationale relevant to a previous statement made by the student.

At Step 2, the preceptor encourages the student to display more knowledge and think about the particular issue at hand (Neher & Stevens, 2003), although occasionally, an astute learner may not need much probing. Through probing, the preceptor more thoroughly assesses and then diagnoses the student's learning needs and knowledge gaps. Then, with awareness of what the student knows and how the learner is interpreting the situation, the preceptor can attend to the student's learning needs. At this point, the opportunity is taken to briefly *teach general rules* (5MP Step 3), including a maximum of three key points or "pearls." Unlike Kertis (2007), who suggests that Step 3 may not be necessary, we view the teaching of general rules as the "heart" of the 5MP technique. Without this important teaching step, the technique is little more than an assessment or evaluation that can be handled through questioning.

The last two steps of the 5MP involve giving feedback. Specifically, in Step 4, *reinforce the positives*, the preceptor provides positive feedback with rationale or explanations that reinforce the student's strengths and competencies (knowledge, skills, and/or attitudes), so that the positives can be applied reliably in future related situations. At Step 5, *correct errors and misinterpretations*, in the same vein as with Step 4, the preceptor provides constructive feedback that is intended to help the student improve understanding and future clinical performance. See Table 2 for an example of a 5MP teaching encounter.

Experiential Learning as the Underlying 5MP Conceptual Framework

During our analysis of the 5MP, we recognized a strong parallel between the 5MP and the process of experiential learning. David Kolb (1984) described experiential learning as a process whereby knowledge is created through the transformation of an experience. He depicts this in his well-known cyclical process that includes the following ordered elements: concrete experience, reflective observation, abstract conceptualization, and active experimentation (Kolb, 1984). As an extension of Kolb's work, Burnard (1987) provides an experiential learning framework to which the 5MP steps can readily be applied (see Figure 1). Using the example of the 5MP teaching discussion (see Table 2), we illustrate the relationship between the 5MP and Burnard's stages in the Experiential Learning Cycle for Nurse Education.

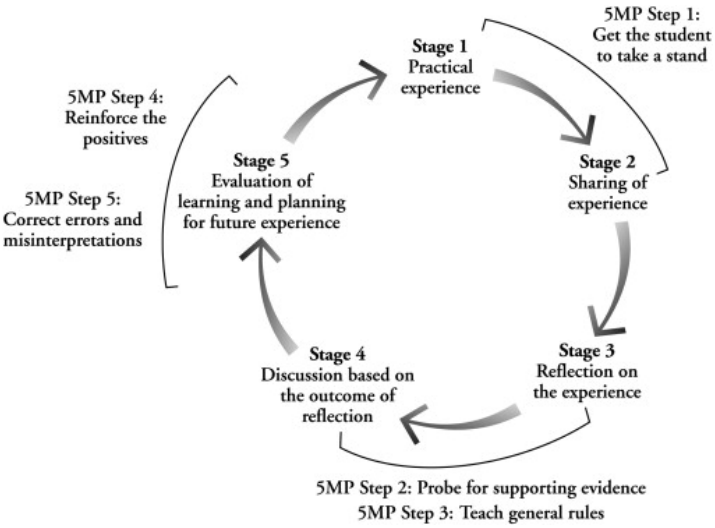

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Figure 1. Application of the 5MP steps (adapted from Neher et al., 1992) to Burnard's stages in the Experiential Learning Cycle for Nurse Education (adapted from Burnard, 1987).

Initially, in Burnard's (1987) Experiential Learning Cycle, at Stage 1, the student has a practical clinical experience that can range from an observation to fairly autonomous practice, under either direct or indirect preceptor supervision. In this example (in Table 2), the student experienced the refusal of medication by a patient with Alzheimer's disease. Based on indirect supervision and knowledge about the student's patient assignment, the preceptor actively plans to initiate a one-to-one, 5-minute or less teaching encounter.

Then, at Burnard's (1987) Stage 2, the preceptor uses a student-centered approach to engage the student (5MP Step 1) by encouraging the sharing of a practical experience. In this example, the statement "Tell me what's happening with your patient" provides the preceptor with an opportunity to hear the student's views, perceptions, and initial interpretations of what occurred and gain some insights about what was important to the learner, which in turn helps the preceptor to assess the student's knowledge and learning needs. Together, these interactions reflect Burnard's Stages 1 and 2 and correspond to 5MP Step 1 (get the student to take a stand).

At Burnard's (1987) Stage 3, based on the preceptor's knowledge and clinical expertise, the preceptor continues the process of identifying the student's learning gaps and needs. To help the student reflect on the experience, the preceptor asks clearly framed questions to further assess what the student understands about the situation. Through probing (5MP Step 2), the preceptor ensures that the exploration is both relevant and related to the student's level of knowledge, skill, and/or attitudinal development.

5MP Step 2 might involve statements that challenge the student's thinking. Looking at the example in Table 2, the preceptor "probes" twice: "Tell me more about why you've made the decision to call the doctor at this point in time?" and "What else might you consider here, say, in relationship to her antihypertensive medication before calling the doctor?" The back-and-forth discussion (Burnard's, 1987, Stage 4) helps the preceptor to confirm or refute the initial judgments about the student's learning needs. The preceptor–student dialogue also permits the student to demonstrate related knowledge and skills. With this information, the preceptor has sufficient data about the student's learning needs to teach no more than three general rules (points or "pearls") (5MP Step 3). These important short lessons are pertinent to the particular experience and generalizable to related situations that the student may encounter in future clinical practice. In this example, the preceptor gives two pearls, one about the most appropriate initial action (including the rationale), and the second about alternate planning should the initial action not be successful.

Once the practical experience has been explored through discussion, in Burnard's (1987) Stage 5, the preceptor and the student evaluate the learning and plan for future experiences. Feedback is used to encourage the development of the student's future performance in similar situations and may involve modification, revision, or increasing challenge. At 5MP Steps 4 and 5, positive and constructive feedback must (a) be based on the student's behavior, (b) provide specifics about the improvements or changes required in the student's performance, and (c) include rationale for any cognitive or performance changes. In this case, the preceptor verifies that the student has a good understanding about the decision-making rights of competent patients and also comments on the value of the student's proactive critical thinking around patient care (5MP Step 4). The preceptor provides constructive criticism (5MP Step 5), indicating the importance of conducting a thorough assessment and the use of nursing interventions. Finally, the iterative nature of both Burnard's

experiential learning cycle and the 5MP encourages reexamination of clinical issues, as the student's knowledge and skills develop, and professional attitudes evolve.

Future Directions for 5MP Development in Nursing Education

Before recommending that the 5MP, or other OMP variants, be accepted as an effective teaching technique for nursing preceptors, approaches to 5MP education need to be developed and then tested in evaluative research. It is important that any educational package serving as an intervention for evaluative research of the 5MP be well grounded in educational theory and principles; otherwise, when conducting evaluative research, it would be unclear whether negative research outcomes were due to a weak educational package or an ineffective teaching strategy. The interventions used to date in the OMP evaluative literature have been preceptor workshops (Eckstrom et al., 2006, Furney et al., 2001, Kertis, 2007, Salerno et al., 2002). As stated earlier, overall, little detail about these interventions was presented.

An example of one approach, using the principles of active training, in particular, skills training (Silberman, 2006), is applicable to the development of 5MP educational packages. Active training engages the learner as an active participant in gaining new knowledge, skills, and/or attitudes (Silberman). Active training strategies vary depending on time, resources, and content, but what distinguishes active training from other teaching–learning methods is a commitment to a variety of learning approaches. For instance, learners are encouraged to question, discuss, and practice the new learning, in contrast to more traditional methods, where the learner is merely presented with the knowledge, skills, and/or attitudes to be learned (Silberman). A form of active training, skills training involves a sequential course of actions in which the learner gains knowledge about the skills, observes skill demonstrations, practices, receives feedback about the skills' execution, and reapplies the skills postfeedback (Silberman). The active training and skills training approaches would likely help to overcome diversity issues among preceptors (for example, educational preparation, clinical and preceptorship experience, age cohorts, and learning styles) that might interfere with learning.

Building on this, we propose the development and use of a standardized 5MP educational package that includes “Train, Review, and Practice” strategies to provide a strong process for 5MP skill acquisition. *Train* could be carried out as an interactive workshop. Elements for this approach, including role-playing, are found in Bowen et al.'s (2006) description of an OMP workshop. *Review* might be achieved in the form of an independent postworkshop review of an interactive DVD, allowing the preceptor to “participate” in hypothetical 5MP examples that instruct the learner to pause the DVD and provide a response before resuming the DVD. *Practice* would occur with the preceptor putting the learning from the train and review components into action with the student.

Other considerations that would impact on the potency of the preceptors' education include the type of offering (for example, face-to-face sessions or distance education with self-directed modules and online innovations), educational techniques (for example, simulation and role-playing), and time frame for completion of the educational package. Developing an approach to engage faculty in the process of delivering the educational package would be important, as faculty members traditionally provide preceptors with support and informal education about clinical teaching–learning processes (Yonge, Ferguson, Myrick, & Haase, 2003). During triadic meetings or impromptu discussions, faculty members could reinforce the content delivered in the train component and consult on issues experienced by preceptors during the execution of the review and practice components. As can be seen in the discussion of possible approaches to developing an educational package, this area is ripe with innovative potential.

Some might question the need to conduct research to examine the applicability of the OMP to nursing education and to demonstrate 5MP effectiveness before accepting it as a useful teaching strategy. However, as with any education, preceptor-focused offerings incur costs to the academic and health care institutions, as well as to the nurses who participate and the students with whom it is used. For these reasons, it is important to know that the 5MP is worth implementing, before it is accepted as conventional wisdom. With a potent educational package on hand, a number of evaluative objectives can be addressed. First, feasibility should be shown, and then, a key objective would be to use a randomized trial to determine if the preceptors who received the educational intervention actually use 5MP teaching behaviors more than their counterparts who did not receive the intervention. Other outcomes of interest might be the quality and frequency of the preceptor behaviors, time required to complete an encounter, measures of student learning, and student and preceptor satisfaction and confidence in the clinical teaching role. Beyond that, there are evaluative questions about different types of educational delivery, especially those that could be offered to rural or distant preceptors.

Conclusion

Nurse preceptors are the primary clinical teachers for senior undergraduate nursing education programs in most of the westernized world, yet they receive relatively little educational preparation or support to master the preceptor role. One promising preceptor-focused five-step teaching technique is the 5MP, modified from medical education's OMP in 1992 (Neher et al., 1992). Appealing because

of its simple set of important clinical teaching behaviors, the technique is reported to be relatively easy to use in a time-efficient manner. As such, it may be helpful to preceptors in providing more frequent, high-quality, educational experiences to students in complex clinical settings. Little high-quality OMP research exists, and only one preceptor study of nurses teaching novice professional nurses is reported in the OMP literature (Kertis, 2007).

In this article, we have reviewed the OMP background and literature, examined it for suitability to nursing education, presented our modifications for use in undergraduate education (the 5MP), and explored the 5MP in relation to an experiential learning framework. Before accepting the 5MP, or any other variant, into nursing education, we recommend that strong educational offerings be developed and then evaluated rather than prematurely accepting this promising teaching technique as a part of conventional educational practice.

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