

CONCEPTUALIZATION OF FACTORS THAT HAVE MEANING FOR NEWLY
LICENSED REGISTERED NURSES COMPLETING NURSE RESIDENCY
PROGRAMS IN ACUTE CARE SETTINGS

Beverly Dianne Rowland

Submitted to the Faculty of the University Graduate School
in partial fulfillment of the requirements
for the degree
Doctor of Philosophy
in the School of Nursing,
Indiana University

November 2016

Accepted by the Graduate Faculty, Indiana University, in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

Deanna L. Reising, PhD, RN, ACNS-BC, FNAP, ANEF, Chair

Rebecca Feather, PhD, RN, NE-BC

Doctoral Committee

Barbara Manz Friesth, PhD, RN

July 20, 2016

Judith A. Halstead, PhD, RN, FAAN, ANEF

©2016

Beverly Dianne Rowland

Dedication

I dedicate this manuscript to my husband, Dave. Words can never express the appreciation I have for your love, encouragement and support during the dissertation process. You are not only “the wind beneath my wings,” you encouraged me to sprout those wings and take flight, and you nurtured me along the journey. If I soar, I soar only because of you. For all of your care and understanding throughout this process, I can only say *Thank You!*

Acknowledgements

Dr. Deanna Reising, my mentor and chair of the committee, has been a tremendous support during this process. I appreciate all of the time and guidance that you have given to this project. Thank you for preparing me with the skills and providing the systems needed to negotiate the world of research. I started the PhD journey only knowing that I wanted to be a better educator; but I have learned the significance of scientific inquiry in the educational process. I wish you continued success in all of your research endeavors.

Dr. Becky Feather has been a tremendous support. I appreciated your comments that helped me to take another look at my writing to improve the flow. I also appreciated your kind encouragement throughout the process. Thank you for agreeing to see me through this journey even though your path has taken a different direction.

Dr. Barb Friesth has been a wonderful instructor in addition to her service on this committee. I so enjoyed the discussions that we had in your class about online learning. The lessons learned there contributed to my growth as an online instructor. Thank you for your input into this dissertation and for advice along the way.

Dr. Judy Halstead was my original reason for attending Indiana University. Your work in nursing education drew me here to work with experts in that field, but I did not anticipate what a rich experience it would be. I thank you for encouraging me to participate in the LEAD program. I gained a great deal of understanding from that year of additional study. Thank you for your input and encouragement in the dissertation process.

I must add my appreciation for my personal librarian and my brother, Tim Hooper, for his persistence in finding all of those difficult-to-find articles that I *had* to have. Thank you for your encouragement along the way.

I would also like to say a special thank you to all of the clinical educators, preceptors, managers and directors who work with newly licensed registered nurses every day and provide support for them. While the extra work may sometimes feel burdensome, your support is building the future of nursing. Thank you for all that you contribute to the profession.

I also want to acknowledge the participants in this study (you know who you are). Thank you for sharing your stories with us. I hope that I have represented your meaning well. I enjoyed the time that we spent together and I relished your stories of your experiences. Thank you.

And finally, thanks to Kaiden, Noah, Kash, and Jaycie, for keeping me grounded and reminding me that there is life beyond books and study and for forgiving me the moments that I have stolen from our time together to spend on this research.

Beverly Dianne Rowland

CONCEPTUALIZATION OF FACTORS THAT HAVE MEANING FOR NEWLY
LICENSED REGISTERED NURSES COMPLETING NURSE RESIDENCY
PROGRAMS IN ACUTE CARE SETTINGS

Nurse residency programs (NRPs) have been identified as a means to promote transitioning of new nurses into the professional nursing role. Questions have arisen related to which elements within those programs are most meaningful to the development of new nurses. As the nursing shortage drives the need for quick transition and development of nurses to meet workforce needs, nursing must identify what is meaningful to nurses in their transition to practice. The purpose of this multi-site study was to explicate meaning from the experiences of newly licensed registered nurses (NLRNs) who have just completed NRPs. The research question was “What factors have meaning for NLRNs who have experienced transition to practice in nurse residency programs in acute care settings?”

Semi-structured interviews were used to collect data from six NLRNs from three different NRPs after completion of their programs. Using interpretative phenomenological analysis, themes and variations within those themes were derived from the descriptive narratives provided from participant interviews. Overarching themes identified were *Relationships*, *Reflection*, *Active Learning*, *Resources* and *Organizational Systems*. Findings have implications for practice and education as the nursing profession strives to find ways to transform nurses in an effective and efficient manner.

Deanna L. Reising, PhD, RN, ACNS-BC, ANEF, Chair

Table of Contents

List of Tables	xi
List of Figures	xii
List of Abbreviations	xiii
List of Definitions	xiv
Chapter One: Introduction	1
Easing Transition to Practice	5
Purpose.....	10
Research Question	11
Significance.....	12
Summary	13
Chapter Two: Review of the Literature	15
Historical Background of Factors Related to Transition to Practice	16
Transition to Practice within Nurse Residency Programs	18
Definitions of Nurse Residency Programs.....	21
Components of Nurse Residency Programs	23
Theoretical Framework: Benner’s Novice to Expert Theory	30
Summary	34
Chapter Three: Methodology.....	37
Theoretical Background of Interpretative Phenomenological Analysis	38
Method as Applied in this Study.....	40
Research Design.....	41
Establishing Rigor within the Study	58

Table of Contents

Summary	77
Chapter Four: Results	80
Overview of Themes.....	81
Relationships.....	82
Reflection.....	95
Desire for Active Learning	97
Resources	103
Organizational Systems Related to NRPs.....	108
Summary	115
Chapter Five: Discussion	119
Findings Reviewed in Context of the Literature.....	120
Implications for Education and Practice	136
Theory	144
Limitations of the Study.....	150
Future Research	151
Conclusions.....	155
Appendices.....	156
Appendix A: Comparison of Sites and Programs.....	156
Appendix B: Hospital Safety Scores for Participating Hospitals	158
Appendix C: Indiana University School of Nursing Study Information Sheet	161
Appendix D: Demographic Tool for Nurse Residency Program Study	164
Appendix E: Questions for Semi-structured Interview.....	165

Table of Contents

Appendix F: Indiana University Informed Consent Statement.....	166
Appendix G: Table of Emergent Themes	169
Appendix H: Indiana University IRB Approval	180
References.....	182
Curriculum Vitae	

List of Tables

Table 3.1 Minimizing Threats to Descriptive Vividness	59
Table 3.2 Minimizing Threats to Rigor in Documentation.....	61
Table 3.3 Minimizing Threats to Procedural Rigor	62
Table 3.4 Minimizing Threats to Ethical Rigor	67
Table 3.5 Minimizing Threats to Auditability	69
Table 3.6 Minimizing Threats to Analytical Preciseness	70
Table 3.7 Minimizing Threats to Theoretical Interconnectedness.....	73
Table 3.8 Minimizing Threats to Intuitive Recognition	75
Table 3.9 Minimizing Threats to Relationship to Existing Body of Knowledge	76
Table 4.1 Demographic Makeup of Participants	81
Table 5.1 Conceptualization of Factors Identified in the Study	121

List of Figures

Figure 4.1 Overview of Themes	82
Figure 5.1 Influencing Factors in NLRN Development in Nurse Residency Programs	149

List of Abbreviations

AACN	American Association of Colleges of Nursing
ANA	American Nurses Association
CCNE	Commission on Collegiate Nurse Education
HWE	Healthy Work Environments
IOM	Institute of Medicine
NCSBN	National Council of State Boards of Nursing
NLRNs	Newly Licensed Registered Nurses
NRPs	Nurse Residency Programs
UHC	University Health Systems Consortium
TTP	Transition to Practice

List of Definitions

Access to Seasoned Nurses— A subtheme identified in the study: Availability of experienced nurses who hold tacit information and can provide guidance and nursing expertise

The contrast to “access to seasoned nurses” is the presence of new nurses who are inexperienced and have limited understanding of systems and procedures.

Without clinical guidance, these nurses may have difficulty in critical situations with which they have no prior experience and may miss elemental changes in conditions.

Connectedness—A subtheme identified in the study: Making connections and feeling connected with other individuals as NLRNs developed their professional personas
Connections refer to actions that linked the nurses to professional development opportunities and to human capital within their practice arenas and promoted professional socialization.

The contrast “disconnectedness” referred to instances in which the NLRNs felt a sense of being physically distanced from the individuals who promote professional development opportunities and/or opportunities for discourse related to their new practice.

The actions to promote professional development identified in this subtheme are distinguished from the subtheme support which is more focused on emotional behaviors and clinical safeguards that are deemed important to the NLRNs.

Desire for Active Learning—A theme identified in the study: A distinct preference for active learning strategies with clinical relevance such as simulated learning experiences, hands-on experiences at the bedside with sufficient oversight by a preceptor, case studies

with interactive discussion, and off-unit experiences in which they could observe other nurses in their specific roles.

The contrast for active learning in this study refers to didactic coursework in a classroom without adequate clinical relevance for the practitioner.

Mentor—An experienced nurse who “helps the new nurse to develop as a professional, assists transition into the professional setting, provides constructive feedback and helps to work through difficult situations” (Remillard, 2013, p. 81); one who facilitates learning sessions.

Newly Licensed Registered Nurses (NLRNs)—Registered nurses who have graduated and passed their National Council Licensing Examination (NCLEX-RN) within the last year and have recently (within three months) completed a nurse residency program on one of the selected sites.

Nurse Residency Programs (NRPs)—“Programs that enhance traditional hospital orientation and are composed of structured experiences that facilitate the obtainment of clinical and professional skills and knowledge necessary for new graduate nurses to provide safe and quality care” (Lin et al., 2014, p.440).

Organizational Systems related to NRPs—A theme identified in the study: Structures, individuals, and processes within a healthcare organization that work interdependently to contribute to the functionality of that organization making it healthy or unhealthy (Stroh, 2015). Inherent within these systems is an organizational culture that contributes to how new nurses are received and transitioned into the profession.

Preceptor—“An experienced practitioner who facilitates and guides residents’ clinical learning experiences in the preceptor’s area of clinical expertise” (Commission on Collegiate Nursing Education, 2015, p. 25).

Ready Access to Seasoned Nurses— A subtheme identified in the study: Availability of experienced nurses who hold tacit information and can provide guidance and nursing expertise.

The contrast to “access to seasoned nurses” is the presence of new nurses who are inexperienced and have limited understanding of systems and procedures.

Without clinical guidance, these nurses may have difficulty in critical situations with which they have no prior experience and may miss elemental changes in conditions.

Reflection— A theme identified in the study: a deliberate thought process that takes into account an individual’s experiences and consequences of those experiences for the purpose of planning future action. A more concrete definition is offered by Sherwood & Horton-Deutsch, (2012) who referred to a mindful event designed to associate recent experiences with more complex representation of events in an effort to promote higher-level thinking skills.

Relationships— A theme identified in the study: Associations between two or more individuals established within a professional community for the purpose of providing support and connectedness for the less experienced individual within the association. The interactive experience may promote varying degrees of affinity, bonding, and dependence. Identified relationships noted in the study included:

Preceptor-Nurse Resident—the preceptor serves as a clinical coach to provide support and functions as a safety net for the nurse resident. In an ideal relationship, the preceptor will also promote interdisciplinary and intradisciplinary connectedness for the new nurse.

Mentor-Nurse Resident—the mentor facilitates learning sessions for the nurse resident, promotes guided reflection, sponsors professionalism and nursing leadership. In these activities, the mentor provides support and connectedness for the nurse resident.

Cohort-Nurse Resident—within the specified cohort of entry-level nurses, the nurse resident bonds with other nurse residents based on common experiences and mutual concerns and stressors. Through sharing of experiences and alternative solutions, the cohort develops supportive relationships and gains a sense of camaraderie, making connections with other new nurses.

Unit Staff-Nurse Resident—while developing professional acumen within the specific nursing unit, the nurse resident begins to formulate other potentially supportive relationships with unit staff. These relationships may be enhanced by the level of connectedness demonstrated by the preceptor or by the mentor. Further development of these relationships, in turn, can promote additional sources of support and connectedness.

Resources— A source of supply or support that is readily available in a time of need. As defined by the nurses in the NRP study, resources that were meaningful were ready

access to pertinent information, ready access to supplies/services for patients in need, and ready access to seasoned nurses.

The contrast for resources is the lack of a given supply or support at a time when needed related to poor planning and/or absence of funding to support the need.

Support—A subtheme identified in the study: Caring, nurturing and safeguarding behaviors contributors directly involved in the transition program (preceptors, mentors, other nurses); interactions with others who understand the nursing transition experience and contribute to a sense of shared experience.

Chapter One: Introduction

The nursing profession must identify ways to promote the development of the novice nurse who is transitioning into practice and ease the transition from the world of education into the real world of practice. Transition to practice generally refers to the period of adaptation and socialization to the professional nurse role that occurs in the first twelve months of nursing practice. Often without adequate support during this transition phase, nurses leave the profession. In the next five years, the registered nurse (RN) workforce faces dramatic shortages due to the retirement of baby boomer nurses combined with increased demand related to chronic disease management and increased health coverage options (Staiger, Auerbach & Buerhaus, 2012). Health care is more complex today and requires that nurses command sound clinical reasoning in order to meet the demands of the job. Medical errors with poor patient outcomes continue to grow as the complexities and pace of the job interfere with nurse judgment and supportive environments are needed to prevent such errors (Flynn, Liang, Dickson, Xie & Suh, 2012). Transition support is needed for new nurses entering the profession.

During transition to practice, nurses often note a period of confusion, doubt, disorientation, and loss of a support system with which they were comfortable (Duchscher, 2009). The stressors associated with this period of transition are frequently correlated with job dissatisfaction and nurse turnover. In a recent study of 861 nurses in southeastern United States, Dotson, Dave, Cazier and Spaulding (2014) identified factors related to nurse retention as job satisfaction, stress and value congruence with the organization. Dotson et al. (2014) noted that nurses no longer feel that they can accomplish satisfaction of their altruistic drives in patient care because of increased

pressures to increase productivity, as opposed to developing patient interactions through direct patient care. Stress related to perceived incivility and disrespect by physicians and colleagues contributed to decreased satisfaction. Additionally, sudden shocks associated with the job contributed to nurses leaving; examples noted were death of patients, extreme disrespect by physicians or managers, and mistakes that had dire patient outcomes (Dotson et al., 2014).

Studies have demonstrated the occurrence of “reality shock” among nurses as introduced by Kramer (1974). Reality shock is a noted phenomenon that frequently impacts nurses during their transition into professional roles and implies an “immediate, acute and dramatic stage in the process of professional role adaptation for the nurse graduate” (Duchscher, 2009, p. 1104). Reality shock may contribute to delays in the professional development of the new nurse in transition.

Graduates are now licensed within days after graduation, placing new nurses into nursing positions without the customary forced period of acclimation that occurred when the nurse was held in a nurse applicant status with limited responsibility (Roth & Johnson, 2011). Nurses now also enter a practice arena that holds increasing complexity of patient needs and patient care technologies, which results in greater than 40% of new nurses reporting making medication errors (National Council of State Boards of Nursing, 2014). The increased stress levels associated with these complexities impact patient care adversely as evidenced by poor safety outcomes and compounded patient errors in the workplace (Spector & Echternacht, 2010). In addition, newly licensed registered nurses (NLRNs) have indicated concerns about preparation for decision-making, skills performance and confidence related to safety for these complex patients (Duchscher,

2001; Spiva et al., 2013). NLRNs are defined for the purpose of this study as registered nurses who have graduated and passed their National Council Licensing Examination (NCLEX-RN) within the last year and have recently (within three months) completed a nurse residency program on one of the selected sites. New nurses reported “ability to handle unexpected crises” and “fear of missing something” as their greatest concerns during the first year of practice (Craig, Moscato & Moyce, 2012, p. 204). Issues related to anxiety for the quality care and safety of patients are mentioned as one impetus for changing jobs (Duchscher, 2001, 2009; Kramer, Halfer, Maguire, & Schmalenberg, 2012).

In other studies, NLRNs spoke of excessive patient workloads from the beginning of their transition period, without time to acclimate to the environment (Pellico et al., 2009). Pellico also noted workload factors that impacted nurses’ relationships with patients and ability to meet the demands placed by external forces such as payers, and regulatory and accrediting bodies. While causation remains in question, higher registered nurse staffing rates have been associated with lower incidence of poor patient outcomes such as urinary tract infections, pneumonias, shock and cardiac arrest, post-op respiratory failure, post-op deep vein thrombosis and pulmonary embolism, and failure to rescue (Spetz, Harless, Herrera, & Mark, 2013). In a study evaluating outcomes in nurse residency programs (NRPs), insufficient nurse staffing resulting in a lack of the nurses’ ability to administer safe and effective patient care, led to increased dissatisfaction among new nurses (Anderson, Linden, Allen & Gibbs, 2009).

Time pressures associated with the workloads and complex environments of care are incongruent with NLRN expectations and contribute to errors in patient care, as well

as decreased time to be with patients (Pellico et al., 2009). New nurses still think concretely (Benner, 2004) and without time to adequately process patient data may miss changes in patient status (Spector & Echternacht, 2013). Mindful practice is required to improve quality and safety indicators for patient care outcomes (Sherwood & Horton-Deutsch, 2012).

Incivility, lack of teamwork, and physician disrespect are also cited as reasons for dissatisfaction in the workplace among nurses as they transition to practice (Anderson et al., 2009; Spiva et al., 2013). NLRNs noted physician criticism and rudeness which added to the level of stress (Spiva et al., 2013). Some transitioning nurses expressed distress over observations of verbal abuse from doctors that was directed toward themselves and others on the nursing unit (Duscher, 2001). Spiva et al. (2013) also identified significant variability in preceptor relationships with NLRNs. A preceptor is defined as “an experienced practitioner who facilitates and guides residents’ clinical learning experiences in the preceptor’s area of clinical expertise” (Commission on Collegiate Nursing Education, 2015, p. 25). While some new nurses described preceptor experiences as nurturing and trusting, others noted responses ranging from limited feedback to inappropriate correction in the presence of patients, families and peers (Spiva et al., 2013). Still other novice nurses discussed the old adage of “nurses eating their young,” relaying experiences of being given the worst assignments, mistreatment by physicians and other nurses, and unsupportive behaviors from more senior nursing staff (Duchscher, 2001, 2009).

Communication is frequently discussed in relation to transitioning nurses. The Nursing Organizational Alliance included “communication-rich culture” as a priority in

defining healthy work environments for “fostering and retaining new nurses” (Ritter, 2011, p.30). Communication and teamwork are a central focus in the Transition to Practice Model proposed by the National Council for State Boards of Nursing (NCSBN) (Spector & Echternacht, 2010). Novice nurses indicated that learning to communicate with physicians was anxiety-producing and that they did not feel prepared to perform this communication adequately (Spiva et al., 2013). Equally important, good communication with preceptors during the transition phase was cited as a means to help overcome the anxiety associated with communication with others on the healthcare team (Spiva et al., 2013).

The factors that contribute to poor transition to practice are still evident in our healthcare systems today: education and practice have different expectations about the capabilities that new graduate nurses should possess; an ever-increasing complexity of patients creates burgeoning workloads and time management issues, and incivility and poor communication issues exist in the workplace. These factors must be examined to devise systems that promote seamless transition for nurses into the practice arena. By studying the lived experiences of new registered nurses who experience transitioning from education to practice in today’s acute healthcare environment, the nursing profession can more effectively design interventions to ease the transition into practice.

Easing Transition to Practice

Mariani (2012) noted that it is the responsibility of seasoned professional nurses to help new nurses navigate the complex world of the nursing profession. She cited the American Nurses Association Code of Ethics (ANA, 2016) with reference to nurses’

responsibility to the profession. Members of the profession must explore ways to ease this transition phase and to promote the growth and role development of the new nurse. Nurse residency programs (NRPs) have surfaced as one means of bridging students from the “ivory tower” of formal nursing education to the “real world” of the practice setting. The researcher has adopted the definition used by Lin, Viscardi and McHugh (2014) for NRPs: “Programs that enhance traditional hospital orientation and are composed of structured experiences that facilitate the obtainment of clinical and professional skills and knowledge necessary for new graduate nurses to provide safe and quality care” (2014, p.440).

Blegan, Spector, Ulrich, Lynn, Barnsteiner & Silvestre (2015) noted the importance of NRPs in supporting nurse transition to practice, discerning the importance of shared patient assignments between preceptors and NLRNs, assessment and evaluation of NLRN progression, and the significance of limited numbers of preceptees. Preceptors for the purpose of the NRP study will be defined as “an experienced practitioner who facilitates and guides residents’ clinical learning experiences in the preceptor’s area of clinical expertise” (Commission on Collegiate Nursing Education, 2015, p. 25).

Additionally, multiple studies have demonstrated the development and effectiveness of NRPs (Bratt, 2013; Cappell, Hoak, & Karo, 2013; Craig et al., 2012; Goode, Bednash, Lynn, Murray & McElroy, 2013; Kramer et al., 2013; Pittman, Herrera, Bass, & Thompson, 2013; Spector & Echternacht, 2010; Spector et al., 2015; Welding, 2011). In NRPs, nurses find a culture of support and understanding that helps to scaffold them as they transition into practice. The work environments of facilities that sponsor NRPs for new nurses offer support in areas that nurses deem most essential to their

development: clinical decision making, clinical autonomy, workload and patient assignments, interpersonal relationships with other health care providers, interdisciplinary collaboration and career development (Kramer et al., 2012).

In studies related to the concept of transition to practice (TTP), Kramer and others have identified the importance of the work environment in the phenomenon of nurse transition (Kramer et al, 2012; Kramer et al, 2013; Ritter, 2011). Kramer et al. (2012) identified that the single most consistent factor noted to have significance in nurse retention was that of a healthy work environment. The processes and relationships that were identified by clinical nurses as significant to a healthy work environment were: clinically competent peers, collaborative nurse-physician relationships, clinical autonomy, support for education, perception of adequate staffing, nurse manager support, control of nursing practice, and patient-centered cultural values within the workplace. Similar factors, such as patient-centered care, communications, teamwork, and specialty knowledge in the practice area, are deemed necessary to successful transition-to-practice programs (Spector et al., 2015). In Spector's study, researchers found that structured programs helped to improve quality and safety for patients, thereby improving nurses' job satisfaction with reduced stress and ultimately, reduced turnover was identified in those work environments.

The Future of Nursing Report includes a recommendation that "...state boards of nursing, accrediting bodies, the federal government, and health care organizations should take actions to support nurses' completion of a transition-to-practice program (nurse residency) after they have completed a prelicensure or advanced practice degree program or when they are transitioning into new clinical practice areas" (Institute of Medicine

[IOM], 2010, p. 3). Supporting The Future of Nursing Report, The National Council on State Boards of Nursing (NCSBN) conducted a multisite, longitudinal study over one year with surveys collected from NLRNs at 6, 9 and 12 months to assess the efficacy of nurse residency programs. The researchers noted that hospitals using established programs for nurse transition had higher retention rates, fewer reported patient care errors, and fewer negative safety practices (Spector et al., 2015). According to the findings of this study, participating NLRNs also reported higher competency levels, lower stress levels, and greater job satisfaction.

NRPs have been documented as far back as 1966 in varying formats (Kramer et al., 2012) and proliferated in the late 1970s and early 1980s in response to pervasive reports of unhealthy work environments and complex healthcare settings (Cappell et al., 2013; Kramer et al., 2012). Early models were hospital-defined and incorporated varying components based on individual hospital needs. As research related to HWEs was disseminated, more comprehensive models surfaced. The University Health System Consortium (UHC) and the American Association of Colleges of Nursing (AACN) joined forces in 2000 to develop a model for NRPs using Benner's (1984) Novice to Expert Model as the framework (UHC/AACN, 2014). This program is formally offered by 187 hospitals across the United States (AACN, 2016); however many hospitals have incorporated aspects of this model into their hospital-based programs. Versant® Nurse Residency Programs, formed by Children's Hospital Los Angeles in 2004, is another NRP designed to develop competent nurses for bedside through a formal mentoring and debriefing process, along with measurement of performance (Versant, 2014). These two programs are marketed commercially, and are accredited through the American Nurses

Credentialing Center's Commission on Accreditation through the Practice Transition Accreditation Program (Cappel et al., 2013). Other nurse residency programs have been developed in recent years and also seek this accreditation as a means of proving their quality (UHC/AACN, 2014; Spector et al., 2015). To date, 18 hospitals are listed on the website as achieving accreditation through this agency, with eight more in applicant status (CCNE, 2016).

The NCSBN has called for a regulatory model in order to promote consistency of transitional programs throughout the nation. The regulatory model is based on five components that have been identified as imperative for inclusion in the role development of new graduate nurses: patient-centered care, communication and teamwork, evidence-based practice, quality improvement, and informatics (Spector & Echternacht, 2010). An NCSBN-sponsored study recently concluded that many elements exist in TTP, but identification of specific elements or combinations of elements is needed to further the development of transition programs in the United States (Spector et al., 2015).

While NRPs have been identified as a means to ease the transition to practice, only 36.9% of hospitals surveyed in a recent study offer such programs (Pittman & Herrera, 2013). In rural areas, the rate of hospitals that promote nurse development in a NRP is even lower at 15.2% and in small hospitals (those with fewer than 100 beds) the rate becomes lower still at 14.1% (Pittman et al., 2013). One reason stated for reluctance to initiate such programs is the associated cost which has been projected at a little over \$2000 per graduate in the program (Goode et al., 2009). These costs are currently not reimbursed by the Centers for Medicare and Medicaid Services as in some other disciplines (physicians, pharmacy, and pastoral care). Even among hospitals that have a

NRP, the experiences associated with those programs vary significantly from one hospital to another (Spiva et al., 2013). Hospital-based NRPs are frequently constructed based on local identification of issues with current graduates without a strong theoretical presence in some cases.

Nurse residency programs are distinct from other onboarding programs in that they enhance traditional transition-to-practice programs by providing classes and activities designed to promote retention and improved patient outcomes (Remillard, 2013). Meetings are usually held monthly to review curriculum items such as patient safety issues and quality improvement initiatives (Barnett, Minnick, & Norman, 2014). The IOM encourages NRP participation in hospitals in addition to limited orientation programs as a means to promote better patient outcomes and greater job satisfaction with improved retention.

Healthy work environments are supported by the presence of NRPs for NLRNs and promote quality patient care (Kramer et al., 2013). Healthy work environments provide supportive atmospheres for nurses in transition to practice. The same type of healthcare systems that promote the elements of caring, educational support, evidence-based practice, and quality improvement within the workplace provide transition support for new nurses. Still there remains a vast difference in NRPs across the nation since many hospitals are reluctant to invest the necessary funding to construct an NRP (Trepanier et al., 2012).

Purpose

The purpose of this study is to further clarify the factors related to NRPs by examining the factors that have meaning for NLRNs experiencing transition to practice

within NRPs in acute care settings. Concept clarification requires extensive observation and description of the phenomenon (Rodgers & Knafl, 2000). Using interpretative phenomenological analysis as a research framework, the researcher will examine the meaning that NLRNs ascribe to transitional factors experienced in three different NRPs with similar, but varied components. Objectives related to this purpose will be to:

1. Identify factors that the NLRNs participating in NRPs believe to be valuable to the transition experience in acute care settings.
2. Examine the elements related to the work environment that have meaning within the NRP experience.

Research Question

The research question for this study is “What concepts have meaning for NLRNs who have experienced transition to practice in nurse residency programs in acute care settings?” The researcher will examine the experiences of novice nurses who have participated in one of three NRPs in acute care settings after one year of practice following graduation in an attempt to conceptualize the identified factors. Concept development is instrumental to developing theory related to a phenomenon; concepts are the “building blocks of theory” (Rodgers & Knafl, 2000, p. 9).

Rodgers and Knafl (2000) noted that concept development begins with analysis of the literature related to a specific phenomenon to identify factors, frequently followed by qualitative research in which the concepts become more refined. These authors address the Norris method of concept clarification:

- 1) Identify the concept of interest and describe the phenomenon.
- 2) Systematize the observations—establish categories, hierarchies.

- 3) Derive an operational definition for identified concepts with means for measurement of the impact of the phenomenon.
- 4) Produce a model of the concept, recognizing relationships between the categories.
- 5) Formulate hypotheses.

NRPs have not been fully operationalized. The components within NRPs are highly variable and inconsistent, making operationalization and measurement of associated outcomes difficult to assess (Barnett et al., 2014; Letourneau & Fater, 2015; Lin et al., 2014; Spector et al., 2015). The gap in the literature related to NRPs is the lack of clearly defined definitions of concepts in the programs with no direct link to outcomes.

Hypotheses cannot be established because there is no clear model with defined concepts to demonstrate potential effectiveness of the phenomenon. This study will attempt to identify and develop concepts that contribute to the assumed success of NRPs.

Significance

The influences that contribute to poor transition to practice are still evident in our healthcare systems today: mismatch of expectations between education and practice related to capabilities of new graduate nurses, an ever-increasing complexity of patients with burgeoning workloads and time management issues, incivility in the workplace, and poor communication. NRPs have been identified as a means to transition new registered nurses from education to practice (Letourneau & Fater, 2015). However, the definitions and concepts associated with NRPs are loosely defined and inconstant. This lack of clarity contributes to ill-defined outcomes. Further study is needed to isolate the concepts and definitions required for a standardized model of NRPs for the nation (Barnett et al.,

2014; Letourneau & Fater, 2015; Lin et al., 2014; Spector et al., 2015). By studying the lived experiences of nurses who experience transitioning from education to practice in today's healthcare environment, the nursing profession can more effectively design interventions to ease the transition into practice. The findings of this study will contribute to the body of knowledge and further the process of concept development for the future discussion of NRPs. The researcher strives to understand the meaning of each experience described in NRPs that will make a difference for improved patient care.

As the nursing shortage proliferates over the coming years, nurses must be prepared to take active roles in developing the next generation of the profession to become safe, effective and caring practitioners. Nurses should be actively involved in deciding the most effective components of education and early practice to establish evidence-based methods of holistic professional development in transition to practice programs. Through identification of the concepts associated with NRPs, the researcher will add to the gaps in the literature related to NRP development and understanding of the NLRN experience within the NRP.

Summary

Chapter one has established a brief overview of the problems associated with transition to professional nursing practice and a history of how nurse residency programs have developed over the past forty years. The introduction describes some of the patient outcomes that result from ineffective or inadequate transition of nurses into the profession. The chapter includes a brief synopsis of the role that work environment plays in support for the NLRN. The purpose, significance, and research question of the study are delineated in this chapter, demonstrating the purpose of the study which is to examine

the NLRN perspective of transition and to inform education and practice in developing a universal model for NRPs.

Transition to practice is a documented occurrence for nurses entering the profession. Inherent in that transition are factors that affect the professional role development of the nurse and ultimately impact patient outcomes. Poor transition has been linked to negative patient consequences associated with patient errors and poor clinical outcomes (NCSBN, 2014; Spector & Echternacht, 2010).

Optimal transition to practice has been associated with HWEs that provide key elements for transition (Schmalenberg & Kramer, 2013). HWEs include elements often found in NRPs: healthy nurse-physician relationships, close alignment with clinically competent peers, clinical autonomy, adequate staffing, patient-centered values, and support for education (Schmalenberg & Kramer, 2013). Healthy and supportive work environments have been associated with better outcomes for patients and higher levels of satisfaction and performance for nurses (NCSBN, 2014; Spector et al., 2015).

Nurses require a period of transition into the profession with clinical experiences and guided decision-making (Benner et al., 2010). This qualitative study will explore the factors that have meaning for NLRNs as they experience transition to practice within NRPs. The author will begin the process of conceptualizing those factors.

Chapter Two: Review of Literature

For purposes of this literature review, the researcher has examined materials describing the history of transition to practice and potential interventions related to transitioning the nurse to a professional role within nurse residency programs, such as nurse residency programs (NRPs), clinical orientation programs and educational interventions to enhance the transition experience. Chapter two will focus on the identified theoretical bases for and the definition of NRPs as defined in the literature. The researcher recognizes a gap in the literature related to clear conceptualization of factors that have meaning for newly licensed registered nurses (NLRNs) as they transition to practice in NRPs. Interventions employed in NRPs are varied and not clearly outlined from one study to another, as well as from one description of NRP to another. Factors associated with NRPs are poorly defined in NRP literature and do not support direct measurement of patient outcomes as they are linked to NRPs. This literature review will explain what is known about the factors identified in NRPs in an effort to promote further clarification of these factors for future research.

The researcher conducted a literature review in the Cumulative Index of Nursing and Allied Health Literature (CINAHL) in 2013, using key words “nurse residency programs, orientation, and transition to practice.” This initial review yielded 78 potential articles. Exclusion factors included specific unit orientations, transition to a new unit/new role/new healthcare setting, transition to advance practice roles, transitional experiences within other disciplines, transition from clinical area to academia, transition for cultural groups, international studies, narratives and editorials, and duplications.

After elimination of articles based on the exclusion factors, 30 articles from 2010 to 2015 remained for final review.

Historical Background of Factors Related to Transition to Practice

In the 1970's, much attention was focused on how nurses were transitioned into the workplace as a result of the discussion of "reality shock" (Kramer, 1974). Literature of the next four decades espoused the need for a consistent method to transition nurses into their professional roles. The Pew Health Professions Commission called for an interdisciplinary approach to education of the health professions with shared clinical training emphasis in 1995 (Hofler, 2008). Further dialogue of the need for transition programs developed as a result of the American Hospital Association's (AHA) discussion of the quality chasm (AHA, 2001) and the need to build a thriving workforce (AHA, 2002). In the early part of the 21st century, the American Association of Colleges of Nursing and the Institute of Medicine joined the American Hospital Association in calling for standardized nurse residency programs (Hofler, 2008). The National League for Nursing called for integration of education and practice with structured post-graduate programs (NLN, 2003, 2005). The American Nurses Association (2002) recommended innovative methods that encompassed education and practice to prepare the nurse for the professional role. Hofler (2008) summarized much of that data into a report that identified major themes of that time period: capacity and infrastructure of the nursing educational system; communication issues with collaboration and integration of nursing education; standards, credentialing, regulation, and accreditation with multiple entry points for education; and the transition to work environment.

In addition to these contributions to nurse transition, the American Association of Critical Care Nurses launched a concentrated effort to promote the socialization and transitioning of nurses who worked in critical care settings. Alspach (1995; 2013) contributed significantly to the development of new nurses in critical care through the development of core curriculum for critical care nursing. She augmented that transition process work with her efforts related to the training of preceptors (Alspach, 2000). Further examination by Myrick & Yonge (2003) added to the discussion of “warm body syndrome” (p. 95). This term described the assignment of the preceptor role to “whoever is available at the time” (Myrick & Yonge, 2003, p.95). In response to stakeholders such as the Joint Commission, early adopters of the preceptor model helped to initiate momentum toward a prescribed method of transitioning nurses into the profession.

In 2010, the Institute of Medicine (IOM) recommended the development of transition-to-practice programs across the nation in *The Future of Nursing Report*. This document called for action from the state boards of nursing and the Joint Commission to support nurses’ completion of nurse residency programs after completion of a prelicensure or advanced practice degree program (IOM, 2010). The IOM also proposed measurement of outcomes related to nurse retention, nurse competency, and patient outcomes. This overarching directive spurred action to meet the standards for transition programs within healthcare facilities across the nation.

In response to the IOM report and subsequent initiatives to improve nurse transitions, a significant increase was noted in the number of hospitals that offered NRPs in the time period from 2011 to 2013 (Pittman, Bass, Hargraves, Herrera, & Thompson, 2015). The sudden increase in NRPs warrants further study to evaluate the variable

methods used within these programs (Pittman et al., 2015). Inconsistency in components within NRPs, as well as the instruments used to measure outcomes has been noted across the nation (Anderson, Hair & Toderro, 2012; Barnett, Minnick & Norman, 2014; Letourneau & Fater, 2015). The literature demonstrates examples of existing NRPs and measurement of particular outcomes. However, the outcomes do not appear clear enough for replication from one program to another. Patient outcomes associated with NRPs as an intervention for transition are not clearly explained. Norris (in Rodgers & Knafl, 2000, p. 199) noted that “operational definitions may be difficult because of the imprecise use of terms, lack of clarification of nursing phenomena, and the lack of discriminatory skills needed to identify relevant aspects of the concept of interest.” Further study of the phenomena related to NRPs is needed to capture the operational definitions for related factors that have meaning as defined by the NLRNs in transition.

Transition to Practice within Nurse Residency Programs

The primary method identified to provide a supportive atmosphere in the workplace for newly licensed RNs (NLRNs) is that of nurse residency programs. In spite of the IOM (2010) report recommendations that nurses participate in a transitional program, only 36.9% of all hospitals in a selected study conducted in 2011 had such programs available to NLRNs (Pittman et al., 2013). The rate of institutions offering NRPs climbed to 41.6% in a subsequent study conducted from 2011-2013, following the IOM report (Pittman, Bass, Hargraves, Herrera & Thompson, 2015). These programs vary in nature since most are hospital-derived and have no established guidelines by which to set the bar for the organization (Pittman et al., 2013). Transition experiences differ across the nation and within varied clinical settings, as well as across levels of

education (Spector & Echternacht, 2010). Cappel, Hoak, & Karo (2013) define four models that are typical across the United States: academic NRPs; pre-licensure externships; internships; and residencies.

An *academic NRP* is based in the practice setting during the student's final semester in the college or university setting and involves a precepted experience in a given clinical setting. The Kentucky Board of Nursing uses such a model that entails 120 precepted hours in the clinical setting as a legislated requirement of graduation from a nursing program. From 2006 until 2011, a second 120-hour clinical internship was required within six months of graduation in Kentucky. Initially, this clinical internship was required prior to the registered nurse applicant being allowed to take the NCLEX (Kentucky Board of Nursing, 2014). This regulation was revised due to a noted decrease in first-time state NCLEX pass rates. The decrease was attributed to the length of time between graduation and testing, placing Kentucky graduates at a distinct disadvantage in comparison with other nurse graduates across the nation. The second required clinical internship program was conducted under the direction and at the full expense of hospitals without oversight by the colleges or universities. This requirement was eliminated by the legislature in 2011, in favor of a jurisprudence exam, which is an open-book, electronic exam designed to show basic knowledge of Kentucky nursing law and scope of practice, lacking the experiential nature of the internship (Kentucky Board of Nursing, 2014).

One recognized academic-practice partnership occurs in the state of Wisconsin under the direction of Marquette University (Bratt, 2009; Marquette University, 2016). The academic nursing capstone experience is common among colleges and universities across the nation. However; these experiences are not consistently mandated by the state

boards of nursing and have no specified framework for future development of programs. The experience varies dependent on the school, the hosting facility, and the interpretation of the regulations when present.

Some hospitals elect to provide *pre-licensure externships* (Cappel et al., 2013), usually offered to students beyond the foundational level of study, wherein the hospital assumes a role in guiding the student nurse through development while still in nursing school. The student refines nursing skills and develops professional relationships while still attending classes and clinical experiences in the academic setting. Often the externship is linked to some form of financial assistance for school and a potential job offer after graduation. The premise is that the hospital gains a valued employee and the nursing student becomes gradually acclimated to the professional environment.

Still other hospital-based programs focus on an *internship* model designed to orient the graduate nurse to a specific clinical area. These typically entail a brief orientation period to acclimate the NLRN to the specific hospital setting, followed by a brief period of guided practice under a designated preceptor with gradually increasing responsibility over a prescribed period of time that usually does not exceed three to six months. This type of transitional program is mentioned by Benner, Sutphen, Leonard & Day (2010) as a means for focusing on a specific area of clinical expertise.

One model for a *residency* is defined by The Commission on Collegiate Nursing Education (CCNE, 2015) as: “A series of learning sessions and work experiences that occurs continuously over a 12-month period and that is designed to assist new participants as they transition to their first professional nursing role” (p. 24). Often, these programs are offered in partnership with an academic nursing program in a college or

university setting (Cappell et al., 2013; Spector et al., 2015). These programs are usually designed for the acute care setting as a means of transitioning NLRNs to their new role.

The University Health Systems Consortium (2000) noted inconsistency in the design and length of NRPs. CCNE (2015) accredited NRPs now come from all entry-to-practice levels. Some of these programs are commercially available at a cost to the hospital or facility. The Joint Commission (2005) stated in a White Paper that NRPs “vary in length, structure and content... [with] no structured residency programs, no standards, no oversight body to assume that the standards are met and no funding” (p. 30). Other programs are developed internally within individual hospital settings and may be developed according to the institutional culture (Pittman et al., 2013). Inconsistency in the development and management of NRPs leads to inconsistency in outcomes associated with transition to practice as the literature demonstrates.

Definitions of Nurse Residency Programs

“Nurse residency programs were defined as programs that enhance traditional hospital orientation and are composed of structured experiences that facilitate the obtainment of clinical and professional skills and knowledge necessary for new graduate nurses to provide safe and quality care” (Lin et al., 2014, p.440).

For purposes of this study, the researcher has noted this definition of NRPs described by Lin et al. (2014) because it captures the general description of NRPs that is derived from the literature pertaining to the phenomenon. The definition is derived from descriptions by Goode and Williams (2004) and Olson-Sitki, Wendler, and Forbes (2012). This general definition captures the essence of NRPs, while pointing to the wide-ranging character of these programs across the nation. The planned experiences help new

nurses to identify their professional roles and the multiplicity of functions within that role. The variability within NRPs across the nation creates difficulty in pinpointing what exactly defines NRPs. After extensive study of NRPs, Spector et al. (2015) noted that the elements involved in various programs do not demonstrate clear causal relationships for potential outcomes, further complicating the definition of what constitutes the NRP mechanism of nurse transition.

One identified area of consistency for NRPs can be seen in the accreditation process through the Commission on Collegiate Nursing Education (CCNE). CCNE has recently updated its definition of NRPs to include Entry-to-Practice Nurse Residency Programs. The new definition is more inclusive allowing institutions to include registered nurses from associate degree or diploma programs to participate.

The CCNE expansion of focus on accreditation of NRPs to include all Entry-to-Practice NRPs, was based on the recommendations of the IOM (2010) that all nurses should participate in a NRP, regardless of educational preparation of the nurses involved. The stated purposes of NRPs, according to CCNE (2015) are to improve the quality of patient care and to support the development of competent professional nurses who will provide patient care leadership. The expansion to include all entry levels for nursing does not diminish the push toward higher education, but rather is designed to ensure that all nurses have adequate preparation for the complex needs of today's patient. Quality nurses are needed to meet the demands created by an aging nursing workforce and the increase health needs of society. In theory, NRPs are designed to enhance the development of nurses while improving retention and job satisfaction and strengthening the commitment to life-long learning necessitated by the profession of nursing.

The goals of the standards for NRP accreditation process are (CCNE, 2015):

- Transition from entry-level advanced-beginner nurse to a competent professional nurse, who provides safe, quality care.
- Develop effective decision-making skills related to clinical judgment and performance.
- Develop strategies to incorporate research-based and other evidence into practice.
- Develop clinical leadership skills at the point of patient care.
- Practice collaboratively as members of the interprofessional healthcare team.
- Formulate an individual career plan that promotes a life-long commitment to professional nursing.

The Commission on Collegiate Nursing Education also referred to the multi-stage development associated with NRPs: role transition and role integration (CCNE, 2015).

Kramer et al. (2012) referred to three stages: “knowing” associated with academic preparation; “becoming” related to the transition stage in which the nurse works with a preceptor in a dependent role; and “integrating/affirming” when the nurse becomes more independent and is integrated into the professional community (p. 149). Bratt (2013) noted similar comparisons of the multi-stage transition listing transition stage as the stage in which skills acquisition and function in practice are important; the integration stage focuses on professional role identity. These stages are recognized in the NRP community and demonstrate progression through stages of development within the NRP; the terms are used in discussion of components of NRPs.

Components of Nurse Residency Programs

Nurse residency programs lack clear definition of the varied components within the programs. Without specific operational definitions of the components involved, measurement of outcomes is not possible (Barnett et al., 2014). The literature gives limited information related to NRP variables. Trepanier et al. (2012) noted a brief

discussion of components commonly identified in NRPs in a health corporation with 49 acute care hospitals across the United States. These researchers listed didactic direct instruction, case studies, clinical immersion, competency validation, “looping,” mentoring, and debriefing as “nursing residency components” (Trepanier et al., 2012, p. 208).

Didactic direct instruction; case studies. Core concepts are taught including some specialty classes directed toward the practice setting of the individual nurses. This teaching methodology is one component of nurse residency programs. Case studies are utilized to provide a practical application of didactic materials taught. In some settings, this instruction is also couple with simulation experiences and problem-based scenarios (UHC/AACN, 2012; Remillard, 2013; Varner & Leeds, 2012). Problem-based education helps to promote clinical reasoning (Remillard, 2013). This teaching methodology, considered as a key component of the NRP, often focuses on specialty-specific elements of the residents’ learning.

Standard III of the accreditation document (CCNE, 2015) denoted key elements related to the expected NRP curriculum. The revised standards for Entry-to-Practice NRPs featured two main categories with subcategories for curriculum requirements. Under Management and Delivery of Quality Patient Care, the document outlined subject matter related to quality and safety; patient and family centered care; management of patient care delivery; management of the changing patient condition; communication and conflict management; and informatics and technology. Under Professional Role and Leadership, CCNE (2015) denoted topics related to professional development; performance improvement and evidence-based practice; ethical decision-making; stress

management; and business of healthcare. Suggested methods of delivery of the curriculum included case studies, examples from clinical practice and reflection activities designed to enhance understanding of related outcomes. Such attention to patient safety outcomes is consistent with Trepanier's (2012) recommendation to examine the association between NRPs and nursing quality indicators.

Clinical immersion and competency validation. Planned clinical experiences with an experienced preceptor are designed to reinforce the classroom experience and allow residents opportunity for application of the lessons learned in the classroom. Residents learn to be more efficient (time management and prioritization issues) and have opportunities to improve critical thinking skills. Experience in the clinical arena helps the new resident begin to build the clinical decision making process through reflection of those experiences (Remillard, 2013; Rhodes et al., 2013). During these clinical experiences, residents are evaluated for competencies based on regulations, core measures and practice standards (Trepainer et al., 2012). Other references did not describe these activities in detail.

Looping, also termed as alternate unit experiences. Looping allows residents to experience units other than their assigned unit. Often these experiences are planned with progression of patient care in mind. This offers residents opportunity to see what the patient experiences before admission to their unit or in other areas of the hospital. Alternate unit experiences contribute to a better understanding of varied workflow patterns and collaboration between units, as well as improved understanding of the patient experience (Varner & Leeds, 2012).

Mentoring. In the model described by Trepanier et al. (2012) nurse residents are paired individually with an experienced nurse or may participate in a “mentor circle group” (p. 208) that is facilitated by two experienced nurses. The mentor is described in this study as an experienced nurse who “helps the new nurse to develop as a professional, assists transition into the professional setting, provides constructive feedback and helps to work through difficult situations” (Remillard, 2013, p. 81); one who facilitates learning sessions. Mentors promote professional development of the nurse resident. The CCNE (2015) guidelines define the role of Resident Facilitator, who carries many of the same roles as a mentor with support in the classroom and clinical settings and development of professional practice. This study will define mentor according to these two definitions as an experienced nurse who “helps the new nurse to develop as a professional, assists transition into the professional setting, provides constructive feedback and helps to work through difficult situations” (Remillard, 2013, p. 81); one who facilitates learning sessions. Remillard (2013) makes a distinction between mentors and preceptors, noting the preceptor role as more focused on orientation to skills, responsibilities, rules and direct learning experiences in the clinical setting. The mentor role is also sustained over time to further promote professional development of the NLRN through the integrative phase of transition (Bratt, 2013).

Debriefing. Debriefing sessions are defined as scheduled and facilitated sessions to allow residents opportunity for voicing concerns and feelings related to their new practice settings. Trepanier et al. (2012) described specific high-stress situations which may necessitate opportunities for debriefing related to patient care, self-care, and situational stress in transitioning.

While the components listed above were described by Trepanier et al. (2012) as predominant elements of NRPs, they are not all-inclusive in the discussion of NRPs. Other components used within NRPs that were not mentioned in the Trepanier article included peer cohort relationships, preceptor roles, clinical narratives, interactions with clinical experts and clinical nurse managers, reflection activities, professional role development and evidence-based practice projects. These following paragraphs describe components noted as central to NRP's that were gleaned from the literature.

Peer cohort relationships. Goode et al. (2013) noted the importance of facilitated peer discussion in the UHC/AACN model of NRP. Monthly classes within the same peer cohort helped to promote bonding among nurse residents in programs (Remillard, 2013; Varner & Leeds, 2012). Anderson et al. (2012) noted the development of cohort relationships among the NLRNs as one of the best teaching strategies used in NRPs. Professional socialization develops from interactions such as these and may promote new nurse satisfaction and ability to manage work-related stress (Remillard, 2013).

Clinical narratives and reflection activities. In early reports of NRP development, journaling was frequently identified as a reflective activity. Guided reflection is now deemed more effective in the use of clinical narratives which have been defined by CCNE (2015) as “a written description of a clinical situation used to demonstrate understanding and application of essential concepts, as well as the ability to use the nursing process and critical thinking skills in a given situation. Sometimes referred to as an ‘exemplar,’ the narrative should include lessons learned from the situation, what was done well, and areas for improvement” (p. 24). This definition of the

activity provides clarity in how the activity should be conducted and directs resident facilitators and NLRNs in a more effective and consistent means of promoting guided reflection.

Interactions with clinical experts and clinical nurse managers. Planned experiences with unit leadership helps nurse residents to assess progress of the new nurses and helps the new nurses to feel a part of the team (Remillard, 2013). Nurse leaders present topics related to organizational involvement with emphasis on lifelong learning during some NRP sessions (Varner & Leeds, 2012). Anderson et al. (2012) noted the importance of scheduled time with clinical experts and nurse managers as a means to further promote critical thinking skills, problem solving and decision making in their systematic review of the literature pertaining to NRPs.

Professional role development. Sustained relationships with mentors and preceptors help to promote professional role development (Varner & Leeds, 2012). Remillard (2013, p. 81) addressed “professional role formation” citing evidence by Benner related to becoming a nurse in action, thoughts, and habits. Recommendations by CCNE (2015) devoted a significant portion of the curriculum to professional role and leadership development. Topics within that curriculum addressed evidence-based practice, ethical decision-making, stress management and healthcare business acumen.

Preceptors. While preceptors are not necessarily directly linked to NRPs, the importance of the preceptor is threaded throughout the literature related to NRPs. Preceptors are frequently associated more with orientation than with the actual activities within the NRP. Yet, their significance to the development and socialization of the new nurse is paramount. Spector and Echternacht (2010) described the importance of

preceptor training and development of the relationship between preceptor and NLRN.

Roth and Johnson (2011) noted a statistically significant correlation between the relationships between NLRNs and their preceptors and the NLRNs self-reported scores of competence. Bratt (2013) described the importance of the preceptor or clinical coach in developing new nurses. She called for sufficient education and training for these roles to promote role integration.

CCNE (2015) stated the definition for preceptors as “an experienced practitioner who facilitates and guides residents’ clinical learning experiences in the preceptor’s area of practice expertise” (p. 25). The preceptors’ role was defined by Remillard (2013) as an orientation role with activities of teaching, directing, explaining, and promoting nurses’ thinking process, in addition to skills development. Moore & Cagle (2012) noted the importance of identifying preceptors who have a recognized desire to teach, have excellent clinical skills, are respectful of the NLRNs’ needs, and demonstrate clinical competence and excellent critical thinking skills. Preceptors must also demonstrate concernful practices of caring, questioning and listening, coupled with the ability to know when to intervene and when to allow autonomy in new nurse practice (Moore & Cagle, 2012). A qualitative study designed to review perceptions of registered nurses in a NRP (Rhodes et al., 2013) also noted the importance of a primary preceptor assigned specifically to the NLRN who can review goals and assess progress. The NCSBN Transition to Practice study (Spector et al., 2015) noted the importance of the preceptor role in the transition experience. The TTP study reemphasized the need for training of preceptors to ensure consistency in use of adult learning theory, communication and feedback to the NLRNs (Spector et al., 2015).

Spiva et al. (2013) performed a qualitative study with NLRNs and noted significant variability among preceptors. NLRNs interviewed in this study noted that preceptors could enhance or hinder new nurse development. The new nurses indicated guidance through the process with feedback was very important, along with consistency and communication (Spiva et al., 2013). Spector and Echternacht (2010) noted the importance of the relationship between preceptor and new nurse. Preceptors in this study noted the need for additional preparation for the role in order to be successful and Kramer et al. (2013) reiterated this need recommending Preceptor Councils within hospitals to help develop training and education for preceptors. Preceptor training processes have been used for several years in critical care (Alspach, 1988, 2000; Myrick, Yonge & Billay, 2010). Remillard (2013) delineated the roles of preceptors and mentors in discussion of growth and development of new nurses noting the importance of preceptor-nurse relationships.

This section has provided a basic overview of the components associated with NRP activities. This is not an all-inclusive list as terminology related to NRP activities varies significantly and full descriptions of those activities are not always identified in the literature. The discussion provides a brief summary of the components as described by experts in the field. Most of the current resources for NRP attribute the foundational theoretical framework for NRP development to Benner's Theory of Novice to Expert, since this theory lends itself well to the discussion of progression of the new nurse.

Theoretical Framework: Benner's Novice to Expert Theory

Benner's Novice to Expert Theory (Benner, 1982, 2001, 2004) has been identified as the predominant theoretical underpinning for development of NRPs in the acute care

setting by many experts in nurse transitioning (Bratt, 2013; Roth & Johnson, 2011; Spector & Echternacht, 2010; Spiva et al., 2013). Benner studied the Dreyfus Model of Skill Acquisition (Dreyfus & Dreyfus, 1980) and further expanded the this model to identify the need for greater reliance on students' past, concrete experiences as a framework for developing nurse proficiency (Benner, 1982; Benner, Sutphen, Leonard & Day, 2010; Benner, Tanner, & Chesla, 1992). Benner denotes a fluid transition from one level of skill to the next that is built upon the "refinement of preconceived notions and theory by encountering many actual practical situations that add nuances or shades of differences to theories" (Benner, 1982, p. 407).

New nurses generally enter the practice arena as novice nurses or sometimes as advanced beginners, dependent on their prior experiences (Olson-Sitki et al., 2012). Novice nurses often rely on care plans and rules due to their lack of experience with patients (Benner, 1984). These nurses need extensive guidance and support. Advanced beginner nurses recognize the aspects of a situation, but may have difficulty recognizing subtle differences in patient care (Benner, 1994). These nurses have been noted to apply equal importance to competing tasks with a task-oriented approach to care. The nurse's fear of making a mistake may interfere with interactions with patients. The goal of NRPs is to bring nurses to that competent level of development (CCNE, 2015). At this stage of development, the nurse begins to rely more on concrete experience and less on the rules. The individual is developing a more response-based practice and clinical grasp of a situation. The competent nurse demonstrates an increased ability to advocate for the patient, with a sense of concern that may cause him or her to reexamine the situation (Benner, 1984).

Benner (2004) noted that the measure of transfer from one level to another is contingent upon the experiences to which the new nurse is exposed both in educational settings and in early practice experiences. Benner, Chesla and Tanner (1992) also noted that the degree of development within those experiences is dependent on the emotional component as the NLRN experiences that situation. Benner et al. (2010) addressed new NLRNs' attention to the "aspects" of given situations—the multiple variables that are different in every given situation of patient care. Newly licensed nurses frequently operate on memory of codes and rules and previous knowledge; thus the competing aspects create preoccupation with the multiple variables that surround a situation forcing inability to focus on the more salient features. NLRNs at the novice and advanced beginner levels cannot automatically focus on the whole of a given situation, but are absorbed in each aspect as an equally relevant piece of information (Benner, 2001, 2004; Benner et al, 2010). According to Benner (2001, 2004; Benner et al., 2010), gradually with more experience and interactions in situated learning environments, the nurses begin to recognize situations and advance thinking mechanisms to view the whole as opposed to the parts of a given scenario.

Benner et al (2010) further ascertained that situated cognition as initiated by Vygotsky (Cole, John-Steiner, Scribner & Souberman, Eds., 1978) and further developed by Lave and Wenger (1991) has implications for transformational education practices to develop nurses' attention to what is important in a given situation or context. Practice, according to Wenger (1998, p. 49), "involves... [an] embodied, delicate, active, social, negotiated, complex process of participation." Wenger further described the impact that

practice has on the learner's perspective of his or her role within the broader system, the learner's understanding of how he or she is influenced by the environment of practice.

In the call for transformation of current educational practices, Benner et al. (2010) described a shift from teaching decontextualized knowledge in the classroom to a focus on situated cognition. Some NLRNs may encounter this situated learning environment for the first time in the practice setting, where they continue to require a safe and supportive setting for an unspecified period of time to allow maturation of the decision-making process (Benner, 2001, 2004; Duchscher, 2001, 2009). Being in the actual patient care setting with an enhanced level of responsibility increases the nurse's awareness of the situation, but also can bring with this mindfulness a degree of anxiety which can interfere with learning (Benner, 2001, 2004). Such an atmosphere of anxiety creates a preoccupation with self and the juxtaposition of patients' needs and nurses' needs in the professional world (Duchscher, 2001, 2009). Benner et al. (1992) noted that this anxiety begins to abate at the proficient level of expertise.

A culture of support and patience in a sociocultural learning environment may help to overcome fears and anxieties encountered in the nursing work environment. Benner et al. (2010) refers to the fear that nursing students have of making a mistake and their recognition of the high stakes associated with nursing practice. Students come to rely on the feedback that they receive from clinical instructors. A supportive and safe environment with interactions between a preceptor and the NLRN has become the foundation of many NRPs being developed across the nation and internationally today to improve competency and confidence.

Benner (1994) addressed the importance of interpretive phenomenology to nursing science and nursing practice. She discussed the meaning that is ascribed to the narrative accounts of the nurse's experience. Benner (1994) noted that such interpretation can be utilized to explore the gaps between theory and practice. The significance of this study of transition to practice focuses on the gaps that may exist between theoretical understanding of the concept and the nurses' lived experiences within today's NRPs. The importance of the Benner theory to the current study lies in identifying a clearer understanding of how nurses are transformed from novice to expert, or more relevant to this study from novice to competent nurse. The researcher seeks to identify those factors that NLRNs perceive to have meaning for this transition period. By examining the lived experience of NLRNs and listening to their stories, the researcher strives to clarify those concepts associated with this transition in a NRP.

Summary

Since the 1970's, communities of interest have pointed to the need for a consistent method of transitioning new nurses into the profession (Kramer, 1974; Hofler, 2008; IOM, 2010). Highly implicated in the transition process are the workplace environment and the necessary support and structure needed to successfully transform nurses into safe, effective practitioners (Kramer et al., 2012; Kramer et al., 2013; Spector, 2015). Multiple healthcare organizations have studied workplace environment and the effect that it has on nursing and on generated patient outcomes (Hofler, 2008).

NRPs have been identified as a strong intervention for TTP. Still methods and outcomes associated with NRPs are unclear and lack consistency (Bratt, 2014; Anderson, 2012). Review of the literature points to the need for standardized nurse residency

programs (Spector et al, 2015; Spector & Echternacht, 2010). The IOM (2004, 2010) has called for consistent transitional programs to deploy nurses into the profession.

Trepanier et al. (2012) noted the importance of the varied components of a NRP that promote financial viability in terms of developing new nurses in their roles. Additional studies noted by Anderson et al. (2012), Moore & Cagle (2012), Varner & Leeds (2012) and Spiva (2013) explored the various elements of preceptor and cohort interactions, along with professional development. Subsequent studies by Goode et al. (2013) and Remillard (2013) also examined the curricular interventions within NRPs. The CCNE (2015) recognized such components as identified by research related to patient care outcomes in developing the standards for accreditation of NRPs. The NCSBN (2015) has further identified components of successful NRPs as development of nurse cohorts, integrated preceptorship programs, shared clinical narratives and guidance to promote reflective inquiry within the group' implementation of evidence-based practice projects, and specific curriculums that focus on leadership, patient outcomes, and professional role development with interdisciplinary communication (Spector et al., 2015; Spector et Echternacht, 2010). These elements are consistent with the underlying concerns identified in studies of HWEs that are being addressed through Magnet initiatives in some hospital settings (Kramer & Schmalenburg, 2012). CCNE (2015) further outlines expectations for NRPs in accreditation standards for organizations conducting NRPs.

Chapter two has provided a brief discussion of the components and the definitions or descriptions of each provided within current literature related to NRPs. The discussion points to the need for clearly delineated operational definitions which augment outcomes

measurement. The IOM (2010) calls for measured outcomes related to nurse retention, nurse competency, and patient outcomes.

The overwhelming choice of theoretical frameworks in discussions of NRPs is Benner's Novice to Expert Theory (Benner, 1982, 2001, 2004). Based upon the Dreyfus Model of Skills Acquisition (Dreyfus & Dreyfus, 1980), Benner's theory incorporates those elements of sociocultural learning theory that apply to nurses' learning. She addresses situated cognition associated with clinical learning (Benner et al., 2010).

The key stakeholder in the NRP discussion, the NLRN, has had very limited input into the discussion of what is needed for TTP and how the process works for the new nurse. This study will seek that perspective through narratives by NLRNs who are currently in programs in three different hospital settings with similar, but somewhat varied models of residency and varied work environments. The preliminary literature review has identified areas of concern within the workplace and helps to lay the groundwork for formulating a semi-structured interview format for the study. Those questions will be identified in Chapter 3 as methodology is outlined.

Chapter Three: Methodology

Chapter three presents a brief overview of methodology and the steps taken to ensure quality of data collection. The researcher has outlined methods for collecting data and instruments used for that collection process. The sample selection criteria and method have been discussed, as well as information related to the context of the study—the work environments of the participants. Ethical responsibilities related to informed consent for participants and information related to ensuring the quality of data have been reviewed. A detailed outline has demonstrated the strategies and processes to ensure data quality within the study.

The research question for this study is “What factors have meaning for NLRNs who have experienced transition to practice in NRPs in acute care settings?” For the purpose of this study, newly licensed registered nurses (NLRNs) are defined as those who have graduated and passed their National Council Licensing Examination (NCLEX-RN) within the last year and have recently (within three months) completed a nurse residency program on one of the selected sites. The research method selected for this study is interpretative phenomenological analysis (IPA). Interpretative phenomenological analysis is a methodology that seeks the answer to the question, “What is the lived experience of a given individual or group?” Individuals often cannot separate their understanding of meaning from the experiences and relationships shared with others around them. Interpretative phenomenological analysis helps to extract that meaning through open exploration of the phenomenon with the participant.

Theoretical Background: Interpretative Phenomenological Analysis

Interpretative phenomenological analysis (IPA) is a qualitative methodological psychological framework that is grounded in phenomenology, hermeneutics, and idiography (Smith, Flowers & Larkin, 2009). Interpretative phenomenology is sometimes also referred to as interpretive description (Thorne, 2008) or interpretive phenomenology (Benner, 1994). The method has evolved over time with input from different philosophers and psychological theorists and became very popular during the mid-1990s (Smith et al., 2009). Hermeneutic phenomenology refers to the interpretative segment of this methodology (Cohen et al, 2000). Hermeneutics is used by human science fields and has become increasingly popular in nursing research as nurses seek understanding of human response to conditions and subsequent interventions and care provided. More recently, interpretative phenomenology has become a valuable interpretative tool in looking at situated contexts within nursing education and in appraising the lived experiences of nurses in their professional roles (Leonard, 1994). Hermeneutic analysis helps to deconstruct everyday experiences in a manner that brings to light obscure meanings that are often taken for granted in the lived experience. The components of the framework are discussed here.

Phenomenology: Phenomenology ascribes its beginnings to the work of Husserl who recognized the basis of phenomenology as the essential qualities of the lived experience (Smith et al., 2009). Husserl noted a tendency of individuals to fit things into a pre-existing order. He established that examination of the human experience is necessary to identify the essential elements of that experience. Husserl described this evaluation of a situational phenomenon as a process of “stepping out” of the day-to-day

experience in order to fully examine the intricacies of the experience through reflection (Smith et al., 2009). Husserl's view held that while individuals are engaged in the day-to-day practices, they would not be able to fully measure or examine the experience. He suggested a series of reductions, as in peeling the layers of an onion, as a means of setting aside the taken-for-granted aspects of daily living within the world. He referred to this process as bracketing, using the concept from mathematical science (Smith et al., 2009). Just as certain aspects of a mathematical equation can be set aside through bracketing, allowing an individual to focus on the central core of the equation, Husserl noted that individuals could similarly bracket elements of the day-to-day in order to focus more clearly on the phenomenon of choice. Bracketing in this manner allows an individual to intentionally focus on the values, goals, and instrumentalities of the situation (Smith et al., 2009). Intentionality is a key component in this view of phenomenology.

Heidegger contributed to the work of Husserl, bringing in the factor of an interpretative stance (Smith et al., 2009). Heidegger noted the influence of the world in that experience occurred within the realm of the world around the individual. He noted a more interactive role of objects, relationships and language (Smith et al., 2009). Heidegger's position on the discussion of phenomenology included a "perspectival" stance; phenomenon was measured by the experience in relation to other influences within the world.

Hermeneutics in the study of the NRP experience. Hermeneutic phenomenology refers to the interpretation segment of this methodology or the theory of interpretation (Cohen et al., 2000, Smith et al., 2009). Interpretative phenomenology has become a valuable interpretative tool in looking at situated contexts within nursing

education and in appraising the lived experiences of nurses in their professional roles (Leonard, 1994). Hermeneutic analysis helps to deconstruct everyday experiences in a manner that brings to light obscure meanings that are often taken for granted in the lived experience (Smith et al., 2009).

Heidegger is credited with speaking of “this life doing this research this way with these people at this time and place in this mood with these possibilities” (Smythe, Ironside, Sims, Swenson, & Spence, 2008, p. 1390) indicating the temporal nature of phenomenological interpretation. The researcher will attempt to capture the experience of the newly licensed nurse at the end of the transition phase, after approximately one year of practice. Looking at the various hospital settings identified in the study, discussions of that experience will yield information related to the experience within specific contexts of transitional nurse residency programs.

Method as Applied in this Study

Interviews for this study were facilitated in a semi-structured manner using pre-selected study questions to elicit information related to the experience as noted by Smythe et al. (2008). The data retrieved from the interviews was reviewed in constant comparative analysis, weighing first one case against another and then another. The interviews were transcribed immediately following the interactions and were analyzed for potential themes. Information retrieved from transcripts was subsequently recorded on index cards to assist with the development of themes noted within the data collection. Those themes were then reviewed to establish similarities and variations within themes.

The researcher solicited the assistance of two respected experts who helped to ensure analytical preciseness. The selected individuals have experience with

transitioning new graduates in the practice setting and experience with nursing education. The first expert has served as a staff education director in an acute care setting and currently is the Director of the Registered Nurse to Bachelor of Science in Nursing Program (RN to BSN) at Campbellsville University. In this role, she works daily with new associate degree graduates who are in their first nursing positions and are pursuing higher education. In her role as clinical educator, she developed the preceptor training program for her former workplace. The second expert has prior experience in the acute care setting with precepting NLRNs. She currently serves as a clinical coordinator with responsibility for aligning preceptors with senior nursing students who are fulfilling their academic nurse residency as required by the state of Kentucky.

The researcher deconstructed the everyday experiences of the newly licensed nurses to identify obscure meanings from the reports of the lived experience of participating NLRNs. The expert reviewers reviewed the transcripts to determine that the common elements and themes developed by the researcher provided a whole picture and are inclusive of the data that exists. Review of themes by the content experts confirmed comprehensive and holistic analysis.

Research Design

Scope of literature review. The literature review has been outlined in Chapter Two as it relates to the identification of the problems related to new nurse transition to practice and the implementation of nurse residency programs (NRPs) to address some of the issues identified as most influential in the life of a new graduate in the workplace. The literature demonstrated a brief perspective of new nurse experiences and the importance of HWEs in the development of NRPs. The literature review also helped to

inform the development of study questions and provided a foundation of current knowledge for the researcher.

The study setting. Three sites were selected for this study. These sites have similar factors related to work environment and philosophy. Common threads noted on each of the hospital websites are: commitment to community, excellence, quality of life, innovation, and improved health. Each of these hospitals is aligned with a larger healthcare system; systems represented are Indiana University Health Systems, Baptist Health Systems, Inc. and Commonwealth Health Corporation, Inc. The emphasis of the study was focused on the meaning derived from the experiences of the NLRNs, not the individual processes utilized for transition to practice. However, as noted in the literature review, the presence of a healthy work environment impacts the experience of the NLRN (Bratt, 2013; Cappell, Hoak, & Karo, 2013; Pittman et al., 2013). A side-by-side comparison of the factors related to the study sites is listed in a table in Appendix A.

In addition to general aspects of the hospital programs, the most recent Hospital Safety Scores (in which the three hospitals participated) published by the Leapfrog Group are tabulated in Appendix B to demonstrate the safety climate of each of the selected hospitals (The Leapfrog Group, 2014). The scores provided demonstrate a comparison of the safety outcomes and measures for each of the hospital groups from July 1, 2010 to June 30, 2012. The first table in the appendix denotes outcomes measures related to errors, accidents, and injuries at each of the hospitals. The second table defines the process measures related to management processes and structures designed to prevent such errors, accidents and injuries in hospitals. The safety scores are based on standardized scores using these consistent measures in order to provide a more

dependable manner of benchmarking between hospitals (Austin et al., 2013). Some hospitals do not submit all of the information from which the final scores are derived and so these measures are excluded from the final calculation and the weights are recalibrated, using measures for which data is available (Austin et al., 2013). Two of the selected sites had missing data which is reflected in the tables. The hospitals in this study have respective scores of A, B and C and will be referred to as Site A, Site B, and Site C accordingly.

Site A. Site A is a 344-bed, regional hospital with a NRP in central Kentucky. The hospital is accredited by Joint Commission and has acquired Magnet designation from the American Nurses Credentialing Center. Upon hire, new graduates undergo an orientation period of approximately six weeks. After this, they are placed into the NRP. This program is a hospital-based program designed by nurse leaders within the facility, with input from previous participating new nurses. The NRP consists of case conferences at which NLRNs present, peer networking, and “Safe Haven” opportunities to share information with staff educators. “World Café” sessions are led by the NLRNs periodically and are described as “speed-dating sessions.” In these sessions, NLRNs are required to prepare a topic and act as the leader at a designated table as participants make the rounds to review the various subjects in a concentrated manner. NLRNs also participate in interdisciplinary group sessions that discuss such topics as lateral violence in the workplace, physician-nurse communications, and other concerns using evidence from research to substantiate the discussions. NLRNs remain in this program for approximately eight months. Initially leaders had designed the program for one full year,

but found that after about eight months, nurses were ready to be more self-sufficient and tended to lose interest in the designated activities.

Originally the educational team assigned mentors from a pool of volunteers. This method of assignment has changed and NLRNs are no longer assigned to mentors in the program, but are allowed to establish their own informal relationships with peer mentors on the unit. This change came about as a result of feedback from the residents who indicated that they preferred to choose their own mentors within their assigned units. Leaders within the program noted that assigned mentors came from a pool of volunteers who were usually more mature than many of the NLRNs and often from leadership positions, while NLRNs indicated a preference for someone closer in age and in a more lateral level or position. Preceptors are assigned to orient NLRNs to their specified units within the hospital. Preceptors and mentors alike had training in the beginning of the program, but with the realignment of the mentoring selection process, some have had prior training in their specific roles, but some may not have participated in this activity. With this more informal process, there is no specific compensation or recognition of mentors. Compensation for the preceptorship positions is usually in the form of recognition for hours served as a preceptor. Documentation of 120 preceptor hours served is provided to the Kentucky Board of Nursing (KBN) and can substitute for annual continuing education requirements with that regulatory body.

The Hospital Safety Score assigned to Site A was an A (The Leapfrog Group, 2014). This hospital had lower than average measures on most of the errors, accidents and injuries surveyed. The report also showed higher than average scores on all process

measures that were reported. Several items were not reported by Site A and were subject to the missing data calculation as defined above.

Site B. Site B is a 355-bed, regional hospital in south central Indiana. This hospital is also accredited by Joint Commission and has acquired Magnet designation from the American Nurses Credentialing Center. The hospital utilizes a NRP that encompasses the first year of the NLRNs transition to practice. All nurses at this hospital who have less than six months experience are automatically enrolled in the NRP. Similar to the experience described for Site A, this hospital begins the program with a six-week orientation period. Week one is performed with staff educators and the following five weeks are performed under the direction of a preceptor in the specified assignment area. Each cohort is assigned a facilitator who coordinates activities and ensures that participants and mentors have everything that is needed to ensure a positive experience. Initially the cohort meets weekly with the facilitator for discussion groups with topics ranging from transition (laying the ground work for the NRP) to peer support and collegiality. Later these meetings are tapered to every other month for the first year. NLRNs are administered the Casey-Fink survey tool early in the NRP. In this program, NLRNs are assigned to a specific mentor, as well as a preceptor. Both preceptors and mentors undergo a period of training in combined classes so that each understands the role of the other. This training is known as “Bridging the Gap between Orientation and Practice through Preceptorship and Mentoring.” Mentors and preceptors are compensated for their extended roles through a reimbursement program for educational purposes and are awarded points in the clinical ladder program. Like the NRP at Site A,

this program is continually being updated according to evidence-based practice and feedback from participants.

Site B also had relatively high marks on the Hospital Safety Score and received an overall score of B (The Leapfrog Group, 2014). This facility reported on the same items as Site A under the process measures and had relatively similar scores on other process measures. As for the outcomes measures, this hospital demonstrated some rates of poor outcomes that were lower than the national average and other areas of outcomes that exceeded the average.

Site C. Site C is a 337-bed, regional hospital in south-central Kentucky with a relatively new NRP that was started four years ago. This hospital is Joint Commission accredited. When one of the key nurse educators arrived on the scene in 2006, the hospital conducted a two-week long orientation that consisted of introduction to electronic health records, policies and procedures, and speakers from other departments throughout the hospital. The hospital administration wanted to establish a program that would enhance the development of new nursing staff and help to prepare new graduates for positions in the critical care units. The educational staff performed a literature review of programs (NCSBN model and the UHC/AACN model were specified) and developed their own program within the hospital based on models within the literature, taking elements that they liked from different programs and working within the boundaries set by the hospital.

Newly hired NLRNs are placed in a two-week orientation with the Staff Education department which entails videos and review of hospital policies and procedures, along with review of specific skills. After completion of this centralized

orientation period, NLRNs are assigned to preceptors for orientation to their assigned units in the hospital for approximately three months. Each cohort now attends “Progression Classes” during that three-month period to review topics such as stress management, new graduate concerns, adjusting to shift work, and interpreting lab results. Peer sessions were added to the program in which the NLRNs are provided a safe environment in which to discuss clinical narratives or topics that concern them without fear of reprisal.

The unit managers assign the preceptors to each NLRN. These preceptors must attend a one-day training course and have access to four one-hour online modules annually to further develop the preceptor each year. The modules are voluntary. This year’s topic for the modules was simulation, but only about 15% of the preceptors participated in the additional training. Preceptors are compensated with documentation of the hours served for KBN purposes.

Site C has recently entered into a collaboration with the local university to share some classroom space and simulation equipment in the school’s new facility which is now located on the hospital campus. Faculty and staff work together to provide a more seamless transition from the education setting into the practice setting.

Site C received a score of C on the Hospital Safety Score (The Leapfrog Group, 2014). As noted with the others, rates for individual outcomes of errors, accidents, and injuries varied with some higher and some lower than the national average; many rates were very near the national average for that data measure. Site C was the only site to provide information for all of the elements on the Leapfrog Hospital Survey for process measures. In nearly all of these areas, the hospital scored very near the average for the

nation. Two significant areas of weakness were computerized prescriber order entry (CPOE)(5/100) and ICU physician staffing (15/100). Points for these criteria are awarded based on the level of implementation within the hospital. In the case of CPOE, measures include the use of electronic prescribing systems to check for potential errors and to integrate with laboratory information. The physician staffing score accounts for the availability of board certified intensivists in critical care areas, response when off site, and the availability of physicians, physician assistants, and nurse practitioners who can reach the patient immediately when needed (The Leapfrog Group, 2014).

Recruitment and selection of participants. IPA usually relies on a relatively small sample, since the richness of the individual experience is the ultimate outcome of the research, not necessarily congruency among large numbers of participants (Smith et al, 2009). IPA also necessitates finding homogeneous samples that embody similar traits which are significant to the phenomenon being studied (Smith & Osborn, 2007; Thorne, 2008). Still each participant brings a unique perspective to the discussion and will have individualized experiences that will add to the discussion of the experience associated with TTP.

Selection of participants was based on the following criteria: the NLRNs were graduates of a pre-licensure nursing program, had passed their National Council Licensing Examination (NCLEX-RN) within the last year, and completed a nurse residency program within the last three months in one of the selected hospital sites. Additionally, the participants all spoke English. The exclusion criteria were that the nurse could not be a former student of Campbellsville University School of Nursing, the current workplace of the researcher, and that the nurse could not have prior experience as

a licensed practical nurse (LPN). Experience as an LPN might have provided a differing viewpoint of the phenomenon that is not relevant to this study. The participants were each given a \$50 gift card from Wal-Mart, Target or Lowes upon completion of the interview, as an incentive to participate in the study. This amount was considered sufficient to compensate participants for their time and to encourage participation in the interview process without being coercive. Some of the participants declined to receive the incentive, but the researcher insisted that each receive the proffered gift card to maintain consistency among participants. The gift cards were distributed to each individual immediately following the interview.

Study participants in the NRP study were selected in a purposive manner, consistent with qualitative methodology (Streubert & Carpenter, 2011). Initial contact was made with the education directors responsible for NRP activities in three acute care hospitals in southcentral Indiana and in central Kentucky. Tentative permission was obtained to work with these directors to identify NLRNs who met the specified selection criteria as outlined in the study. After initial approval was obtained from Indiana University Institutional Review Board, further information was provided to the IRBs at each hospital site for subsequent approvals from each location. The approval from Indiana University is noted in Appendix H. All other approvals are maintained by the researcher to protect the identity of those participating.

The researcher then contacted clinical education personnel within the sites to initiate contact with NLRNs who meet the selection criteria. The clinical educators contacted NLRNs that had just completed the NRP within those organizations. Potential participants were given the Study Information Sheet (see Appendix C) with contact

information for the researcher. The candidates were asked to contact the researcher through the staff educators or directly by phone or email if they were willing to share their experiences and thoughts about the NRP process. As candidates indicated an interest to participate, the investigator sent additional information related to the study, as requested. When the willing participants were identified, the researcher scheduled appointments for the interviews. Informed consent was given at the time of the interview, allowing for questions related to the study and the consent process. Signatures were obtained at the time of the consent and gift cards were given at that time.

Participants did not respond as quickly as the researcher had anticipated. Due to the limited response from the first effort to recruit participants, the original IRB protocol was amended to include a secondary recruitment strategy. This approach yielded three additional interviews.

No specific number or sample size is identified in IPA studies (Smith et al., 2009). The final sample size was determined by saturation of the data within the interviews. The researcher sought a minimum of two participants from each site, with the ultimate goal of 6-10 participants for the study.

Thorne (2008) identifies three areas that the researcher must use to determine saturation: What knowledge is needed from the study? How can the researcher get as close as is reasonable to this knowledge base? And finally, how can the researcher conduct the study in a manner that is respectful and ethical with regard to guidelines for research and practice? The knowledge to be gained from this study pertains to those experiences of NLRNs in transitional practice. When the researcher identified the meaning ascribed to these experiences using concurrent data collection and analysis,

saturation was determined to be achieved. No new information was noted within the discussions to add to the development of themes and sufficient information was gleaned to note meanings of differences and similarities between participants (Smith et al., 2009).

IPA typically uses samples of four, five or six homogeneous participants and homogeneity can be determined by demographic similarities or by similarities in the factors surrounding the experience (Braun & Clarke, 2013). The unique experiences of individual nurses brought into this study contributed deeply to the meaning of NRPs and the role that NRPs play in the lives of NLRNs. The number of participants produced satisfactory richness in the interviews, while keeping the analysis manageable by one investigator within the projected time frame of the study. Benner (2004) and Thorne (2008) noted that time and resources are a legitimate concern when determining the sample size within the study.

Demographic data was collected from the participants in order to establish basic information related to age, gender, and ethnic background. Additional sociodemographic data requested for this study is information about previous healthcare experience and level of education. These data help to identify homogeneity of the sample (Smith et al., 2009) and are deemed pertinent to the study in light of other research (Pittman et al., 2015; Rhodes et al., 2013; Spiva et al., 2013). As part of the audit trail, information will be recorded about who took part in the study, specifically how they were recruited, and who selected not to participate in the study. (See Appendix D for the demographic tool.)

Qualitative data collection procedures. Data was collected by semi-structured interviews with attention to the NLRNs' perspectives and descriptions of the experiences. Questions that were used in the semi-structured interview are listed in Appendix E. The

investigator occasionally was prompted to ask other questions as questions arose within the interview (Benner, 1994). Every effort was made to establish rapport with the individual nurses and to help them to open up in dialogue with stories related to their experiences. The investigator refrained from interjecting personal observations, but used a hermeneutic approach to prompt participants to visit themes identified from other experiences.

The interviews were conducted at the completion of participation in the NRP. This timing allowed participants to have adequate time to experience the professional practice setting and to develop sufficient clinical narratives to demonstrate the experience. For purposes of this study, the transitional experience is defined as the period of adaptation and socialization to the professional role that occurs within the first twelve months of nursing practice.

Data for this study was collected in a retrospective fashion. Questions were phrased in such a way as to delineate for the participant that the investigator is looking at the past eight to twelve months related to the professional transition period. Answers were phrased accordingly in the past tense. The semi-structured interview served to elicit the real lived experience of the participant, allowing participants to elaborate on the experience in personal terms.

The researcher utilized the method known as constant comparative analysis. This entails reviewing data case by case during the conduct of the study to identify common meanings. This method enabled the researcher to constantly compare and contrast meanings noted within the interviews (Thorne, 2008). From the initial interview, the process built and helped to construct meaning from subsequent interviews. The

researcher maintained self-awareness to ensure that throughout this thought process the ideas that surface are not influenced by prior knowledge.

The investigator attempted to elicit a one-sided conversation from the participants. By allowing adequate time for response, the researcher encouraged talking at the participant's own pace. Occasionally responses were somewhat brief, but the use of prompts allowed for further discussion. The use of slow, clear and deliberate speech encouraged participants to use the same manner in answering if questions are phrased clearly and in a way to elicit a broader response (Smith et al., 2009). Smith et al. (2009, location 1435) recommended the approach of "highly engaged listening" along with a sensitivity for the participant's experience, while setting aside empathetic coaching, judgment or personalization. The researcher attempted to present this listening methodology with occasional nods and murmured encouragement ("okay" or "good, tell me more") in an effort to help the conversation flow and to demonstrate understanding of the narrative.

Interview times were selected at convenient times for the participants during non-working hours. The length of the interviews was roughly 55 minutes, with some ranging from 45 minutes to 70 minutes in length. The location of each interview, and the time and duration was recorded as part of the audit trail (Braun & Clarke, 2013; Burns, 1989). The settings for the interviews were quiet, private places away from the workplace of the participant and were mutually agreed upon by researcher and participant. Settings included conference rooms on college campuses and small restaurants during non-peak hours. One such interview in a restaurant actually started during the non-peak hour, but became somewhat noisy before the conclusion of the interview. The participant did not

seem deterred from the discussion by the surrounding noise; instead, the noise seemed to create a more collegial atmosphere lending itself to deeper discussion. The voice quality on the recorder was still acceptable and transcription was not affected by this factor. The participants' privacy and confidentiality was maintained, allowing participants to gather their thoughts about the experience of transition and to elaborate on the contexts within their particular experience. The researcher requested permission to contact the participants one additional time by telephone to clarify meaning, but did not find this necessary after deconstruction of the transcripts.

Discussions were recorded by the researcher and these recordings were transcribed for thematic analysis. The researcher elected to transcribe the data as a means of data immersion. Recordings were deleted immediately after the transcription process was completed and accuracy of the transcribed information had been verified by the researcher. As the investigator collected data, that data was reviewed and notations made related to variations in language or terminology between the different groups. After transcription, the data was deconstructed for analysis. Index cards were utilized as a mechanism for regrouping and reorganizing thought patterns and identified codes within the data. Color coded tabs were used to help group the different codes.

Any publication or presentation of data for research purposes will focus on aggregate data. Excerpts from transcripts have been used to portray specific themes and exemplars, but the information has been de-identified before reporting. Any resulting account of the research contains only de-identified information that cannot be related back to specific individuals or institutions. All efforts have been made to ensure that information remains private.

Analysis of data. Jonathan Smith (Smith et al., 2009), who developed IPA, gives a detailed account of recommended steps to use in analysis of data in IPA. In this account, he cautions beginning IPA researchers that the steps can become more fluid and less prescribed with subsequent projects, but recommends the steps initially as a way to learn the process.

Step 1: Immersion in the data. Just as with all qualitative data, it is necessary to familiarize oneself with the transcript of the interview by reading and re-reading the data. Smith et al. (2009) also suggest listening to the recorded interview while reading it, so that the researcher hears the voice and the details more clearly. The researcher in this study used this process of familiarization with the narrative of the first interviews before progressing to subsequent narratives while awaiting additional responses. The researcher created notes about the memories associated with the interview and the first impressions that were noted during the interview.

These notes were then applied in brackets within the transcripts to indicate perceptions of the attitudes and emotions displayed by participants during the narrative accounts. These notes are maintained as a part of the audit trail to track the researcher's thought process as she developed the themes.

Step 2: Initial noting. The researcher read the transcripts, maintaining an open mind, noting thoughts and comments that came to mind from the interview. By reviewing the notes on facial expressions, pauses within the narrative, and emotional quality of speech, the researcher became gradually more familiar through this stage with the true meaning and understanding of the participant. This involved looking at the specific language used to describe meaning as denoted by the participant and also

identifying the contextual nature of the description of experiences and perceptions within the NRP process.

Step 3: Identification of emergent themes. Gradually different types of themes began to emerge as the researcher began to identify the core meaning of the participants. After completing all of the interviews, the coding process became more interpretative. As the researcher created index cards through a deconstruction process, using excerpts from the interviews, the emergent themes began to form in the mind and became more and more real. By viewing and reviewing the varied items from the transcripts, the researcher became increasingly more familiar with the narrative and the thoughts expressed by participants. As indicated by Smith et al. (2009), this process initially felt uncomfortable through the revisions and de-contextualization of narratives as they were presented by participants. But gradually the pieces began to make sense, as though working a puzzle.

Step 4: Searching for connections across emerging themes. Superordinate themes are higher order themes under which others will cluster. Usually under each superordinate theme, two to four subthemes will capture and develop the aspect of the one main theme (Braun & Clarke, 2013). The researcher must map the themes to see how they fit together.

By utilizing the index cards with various aspects of the transcripts, the researcher began to visualize the patterns within the data. The emerging theme clusters seemed to make sense and were supported by previous literature identifying some of the concepts identified. At this point, the researcher stopped to review the narratives with the experts who had agreed to review the data for comprehensiveness and holistic representation of

the themes presenting in the process as noted in Step 6 of this review process. As indicated by Smith et al. (2009), the steps within this process are not necessarily linear, but evolve differently within each case.

Step 5: Moving to the next case. Usually these themes will be identified for first one case and then across other cases as the patterns begin to emerge according to Smith et al. (2009). A structure should evolve after this review, with hierarchal relationships between the themes. This process occurred across cases as review of narratives was in process. Themes emerged with noted patterns within the experiences described.

Step 6: Collaboration or audit. According to Smith et al. (2009), at this point, the researcher should enlist the assistance of two expert nurses who have understanding of the transition experience to review the first two or three transcripts and participate in the Hermeneutic process to help test the plausibility of emergent themes related to the meaning of the participants. As noted earlier, this step occurred sooner in the process. This helped to ensure greater credibility to the interpretative account (Smith et al., 2009). See the reference above in Step 4 to how this process naturally evolved within the accounting of themes. Throughout the process of analysis, the themes were continually revisited and the index cards noting the identified concepts were regrouped to validate the understanding of the researcher.

Step 7: Development of full narrative. Using the data elements and the notes, the researcher was then ready to develop a narrative account of the findings. A visual guide was developed in the form of a diagram, to portray the relationships of the themes to the overarching theory associated with most NRPs (Benner, 1984).

Step 8: Reflection of perceptions, conceptions and processes. Smith et al. (2009) recommended that there are different levels of interpretation and encourages researchers to “take it deeper” (Location 2035) through deep reflection. This deliberate reflection affords a time to allow the pieces of the puzzle to fall into place. By reviewing the individual narratives and applying the conceived theme emergence within those discussions, the researcher tested the themes identified within this process.

Smith also noted how one might overanalyze; interjecting previously conceived information or theory relevant to the researcher. Reflection is necessary to determine if the extrapolation is actually from the participant’s perspective and denotes true meaning or whether the researcher is stretching beyond the true meaning to import a different epistemological perspective. Another means to avoid over-analysis is consultation with experts who can help to clarify the meaning without prejudice. The researcher used discussion with colleagues to ensure non-biased analysis of the data. Smith noted that theoretical connections are not usually the pattern with IPA, but rather are made after the completion of the analysis. The theoretical connection made in this study denoted influencing factors in transition to practice in nurse residency programs as identified by the participants.

Establishing Rigor within the Study

The predominant and most comprehensive guide for critique of a qualitative study remains Burns’ Standards for Critique (Sandelowski & Barroso, 2003). Burns (1989) outlined the elements of qualitative research in a clear and concise manner and developed the standards for review that can be utilized in development of projects to establish rigor and maintain internal validity in documentation, procedures, ethics and auditability. This

comprehensive guide established five standards by which the researcher can ensure rigor as the project is developed.

Standard I: Descriptive vividness. The researcher in this study has attempted to establish a vivid report of the potential participants and of the contexts of their environments in order to establish a representation of the world surrounding transition to practice for readers of the study. The addition of the Leapfrog reports lends a degree of objectivity to the description of the selected facilities, demonstrating further credibility of information gleaned with regard to the contextual environment. As participants were selected and interviewed, the demographic tool helped to detail the specifics related to individual participants. Transparency was maintained in the selection process and in the description of the requirements for participation. Burns (1989) shared the following potential threats to descriptive vividness and those threats are addressed in Table 3.1 below.

Table 3.1 Minimizing Threats to Descriptive Vividness

Potential Threat to Descriptive Vividness	Strategies to Minimize Threat
Failure to include essential descriptive information.	The researcher has performed a preliminary literature review to identify background material to support the description. Researcher utilized information related to context from those who established the selected programs and from a objective source: The Leapfrog Group.
Lack of clarity in description.	Additional rewrites after feedback processes have established greater clarity. Continue to strive for absolute clarity of purpose and objectives.
Lack of credibility of description.	Utilized literature from those who are established in the field of transition to practice to verify credibility of description.

	Also utilized the Leapfrog reports to establish credibility in the description of the workplace setting.
Inadequate length of time at site to gain familiarity necessary for vivid description.	Did not observe in the workplace—description based on elements of the NRP as described by those who established it. Workplace environment/experience was described by residents within the programs and their description is paramount in the study.
Insufficient depth to description.	Reviewed with team of two nurses who have experience in the transition process.
Inadequate skills in writing descriptive narrative.	Reviewed with team of two nurses who have experience in the transition process.
Reluctance to reveal self in written material.	Through self-reflection no identified issues. Reviewed with team of two nurses who have experience in the transition process to determine any inadequacies.
Inadequate self-awareness.	Reviewed with team of two nurses who have experience in the transition process to determine any inadequacies.
Poor observational skills.	Reviewed with team of two nurses who have experience in the transition process to determine any inadequacies.

Standard II: Methodological congruence. The researcher has utilized information related to the state of the science that is currently associated with studies of transition to practice and the development of nurse residency programs. A detailed description of the methodology (IPA) being used is listed for the reviewer to see. The resources for this information are listed in the reference sections, so that others can follow the same course to validate information provided. Burns (1989) stated that methodological excellence must be established in four dimensions as noted below.

Rigor in documentation. All elements of the qualitative study must be presented: “phenomenon; purpose; research question; justification of significance of the phenomenon; identification of the assumptions; identification of meta-theories; researcher credentials; the context; role of the researcher; ethical implications; sampling and subjects; data-gathering strategies; data analysis strategies; theoretical development; conclusions; implications and suggestions for further study and practice; and a literature review” (Burns, 1989, p. 48). The aforementioned items in this list have been satisfied with the proposal. The latter has now been met within the study and will be presented in Chapters four and five. The preliminary literature review has been performed with explanation as to how the literature review will be completed within the duration of the study. Threats to rigor in documentation are listed (Burns, 1989) and addressed in Table 3.2.

Table 3.2 Minimizing Threats to Rigor in Documentation

Potential Threat to Rigor in Documentation	Strategies to Minimize Threat
Failure to present all elements of the study.	All elements were established and presented in the proposal. Conclusions, implications and suggestions for further study and practice have been included as appropriate, along with a more in-depth literature review.
Failure of presentation of elements to meet standards.	Reviewed with team of two nurses who have experience in the transition process to determine any inadequacies.
Inadequate clarity in presentation of elements.	Reviewed with team of two nurses who have experience in the transition process to determine any inadequacies.

Procedural rigor. Steps must be taken to ensure balanced representation of information and accurate recording of interviews. The researcher needs to outline all

procedures as clearly and thoroughly as possible in the early stages to ensure appropriate management of all data. Many threats can occur to this aspect of the study (Burns, 1989) and are denoted in Table 3.3 with procedures to prevent occurrence within this study.

Table 3.3 Minimizing Threats to Procedural Rigor

Potential Threat to Procedural Rigor	Strategies to Minimize Threat
Inadequate questions for the interview.	<p>Questions were predetermined and reviewed by team of nurses who have experience in the transition process to determine any inadequacies and were sample with three non-participating recent graduates with recent experience in a NRP.</p> <p>Smith et al. (2009) suggested that by sampling the questions with a small sample group of similar participants, the investigator can identify closed or leading questions which can be adjusted prior to the study. The researcher sampled the questions with three recent graduates who were not participants in the study to assess the ability to elicit open responses from participants.</p>
Questions couched in theoretical terms, not conducive to the participants.	<p>Questions were reviewed by three recent graduates who were not participating in the study to determine appropriate level of comprehension in wording. Researcher tested the questions with a small group of non-participating recent graduates of similar preparation as participants to determine appropriateness.</p>
Informant lies to researcher (ulterior motive, response bias, inhibiting presence of others).	<p>Researcher attempted to ensure participant at enrollment that answers are neither <i>correct</i> nor <i>incorrect</i>, that the personal perspective of the participant was solicited and that if they chose not to answer a given question, this was okay. These guidelines were established during the informed consent process.</p>

Informant substitutes information for missed event/details or poor recall.

Questions were designed to instill that participants need not address a situation/event that the participant did not personally experience or does not recall. Participants were allowed to give neutral responses. No penalties were involved and the participant's other responses were no less valued as a result.

“Elite bias”—researcher places more emphasis on data of specific types of participants.

The researcher recognized that each individual experience is a separate and unique case. All experiences described were deemed relevant to the study of NRPs, regardless of circumstances.

Presence of researcher distorts event being observed.

The events discussed in the interview did not occur in the presence of the researcher. Some unintentional distortion of the events possibly could have occurred as a result of reflection of the participant on past occurrences; however, the lived experience and perspective of the participant is unique to that person and no less valued.

Researcher's involvement with participant distorts the data.

The researcher attempted to set aside prior assumptions and presented the questions in a balanced manner without bias in an effort to solicit the true response of the participant.

Biases are present on part of researcher and/or participants.

To the extent that one can; researcher biases were set aside. Participants may have carried some bias into the discussion, but these were described and noted in reporting data. Detailed field notes of the researcher were maintained to denote reflection on subjectivity (Rajendran, 2001).

Atypical events are interpreted as typical.

In this particular instance with NRPs, atypical events offered rich, detailed data related to the subject matter. Participants' response to events which may seem extraneous to the new graduate helped to provide information about the experience. This was monitored carefully by the

	researcher and discussed with the team of experts to identify what was relevant to the study.
Data distortion due to inaccurate assumption of equivalence of situations.	Researcher ensured that each transcript received equal attention and as codes were set up, that specific guidelines were established and utilized for coding and derivation of themes and that these were used consistently. Procedures for data collection were uniform: asked questions in the same way, asked questions in same order with a relatively easy question first, conducted all interviews in a comfortable location, ensuring interviewees' privacy. (Gredler, 2009)
Informants lack credibility.	Participants were the only informants and their experience was credible as only they were able to report that experience.
Data-gathering process is inappropriate for particular research method.	Semi-structured interviews were appropriate for interpretative phenomenological analysis.
Insufficient amount of data is gathered.	Data was gathered until the themes begin to repeat and the patterns were established.
Insufficient length of time is spent in data gathering.	A rough estimate of 60 minutes was established for the length of individual interviews; however, this time was somewhat flexible as topics were developed from the interview schedule.
Training of data collectors is insufficient.	Not applicable to this study, as one researcher conducted all interviews. The researcher used the same interview schedule with each participant and did not vary the approach to participants. Every effort was made to ensure that participants were treated in a similar fashion throughout the process.
Approach to gaining access to the site is inappropriate.	Notes of the conversations with all staff educators involved were recorded and remain as part of the audit trail. Hospitals

were selected with availability in mind, but also looking at that work environment to establish similar backgrounds with some variation in order to gain richness of data as it related to the NRP experience. Contact was established with the education departments of each proposed hospital. The researcher spoke with staff educators to determine the guidelines for each NRP and how the NRP was developed and implemented. Later external sources were utilized (Leapfrog Group, 2014) to establish an objective comparison of the hospitals' culture of safety and workplace environment.

Approach to gaining access to participants is inappropriate.

Potential participants were contacted through the staff educators at the hospital and information sheets as included in the proposal were used to outline the information given to potential participants and how they were solicited for participation. One amendment was made with the IRB to allow personal contact with a given cohort as participants were not responding to the Study Information Sheets. This contact elicited more interest in the study, but did not coerce participants in any way.

Use of bracketing is ineffective.

Assumptions related to transition to practice have been outlined in the proposal and were reviewed as the study progressed.

Imputation of motives of participants is incorrect.

Every effort was made to ensure that attribution of motives of participants was accurate. The stipend for participation in this project was designed to be enticing without being coercive in an effort to interest participants in participation.

Selection of participants is inappropriate.

Participants for this study were selected from a purposive sample to capture the rich descriptions of the transition to practice experience.

With regard to the various types of biases that are noted here, Rajendran (2001) stated that biases can never be completely eliminated. Rajendran advised that the researcher must maintain detailed field notes to eliminate the appearance of bias and to maintain self-awareness through reflection at all times. Another suggested way of reducing bias was identified in provision of additional checks with other colleagues to ensure that one's viewpoint does not become slanted in one direction or another. The use of daily memos related to communications with participants, interactions in the course of obtaining the interviews/data, and any problems or circumstances encountered in setting up interviews. Detailed notes were maintained during the interviews to help the researcher to sort through feelings and thoughts that occurred during the process as described by Rajendran (2001).

In the NRP study, the researcher did not encounter evidence of response bias from participants. In one instance, the researcher became aware of a personal sense that the participant seemed to embellish an element of the story. Later discussion with a second participant in the same facility confirmed the same experience, noting similar details. The researcher discussed this potential bias with the team of experts who reviewed the data and both experts determined that the experience was validated through the second iteration of the event. This process helped to further assure theoretical connectedness through balanced reporting of the findings without potential bias.

Ethical rigor. Burns (1989) noted that the researcher must be cognizant of the possible ethical implications involved in the study and be transparent about that potential. The researcher must make every attempt to ensure that rights of the participants are protected and establish procedures to safeguard those rights throughout the process. The

researcher must obtain informed consent from each participant and document that process within the study. Threats to ethical rigor (Burns, 1989) are noted in Table 3.4, along with procedures for addressing these possibilities.

Table 3.4 Minimizing Threats to Ethical Rigor

Potential Threat to Ethical Rigor	Strategies to Minimize Threat
Researcher failed to obtain consent from participants.	Researcher obtained informed consent from each participant as noted in the section related to ethical rigor.
Researcher failed to ensure rights of participants.	Researcher completed the Collaborative Institutional Training Initiative with Indiana University. Researcher recognized the rights of participants and informed the participants about their rights in the study.
Researcher failed to inform participants of their rights.	Researcher informed participants of their rights.

Informed consent (See Appendix F for this document.) was obtained from each participant according to IRB specifications for this qualitative study. Minimal risk for harm to participants was involved in this study meeting Category 2 for exempt status as outlined by the Indiana University IRB. Category 2 requires that information gained in the interview process will be protected in a manner that will not identify participants either directly or indirectly and disclosure of participants' responses will not place them at risk for civil or criminal liability. Subsequent IRB approval was obtained from all participating facilities and the informed consent process was used consistently between all participants.

Participants were apprised of the right to decide whether they would participate in the study or not. The researcher had no fiduciary ties to any of the selected sites and no personal ties which would interfere with the privacy and confidentiality of information

disclosed by participants. To protect the quality of the data, the researcher ensured participants at enrollment that answers would be neither correct nor incorrect, that the personal perspective of the participant was solicited. The researcher also advised participants that if any question involved a situation or event that the participant did not personally experience or did not recall, the participant should simply state that (s)he did not participate in that specific activity. No penalty was involved and the participants' other responses were no less valued as a result of a possible decline to respond. No participant within the study declined to answer any of the questions.

The researcher obtained permission from each participant to record the interviews, advising each participant of the process of recording, collection of field notes during the interview, transcribing the discussion, and de-identification of all interviews to avoid disclosure of identity. Recordings were destroyed after transcription of the data was completed. All subsequent written accounts of the discussions address aggregate data and make no reference to individuals, hospitals or their entities or any other identifying information. All raw data reports will be destroyed within three years of completion of the study. If a particular account of a circumstance deems it to be too personal or specific so as to reveal the participant, the investigator will not use that information in a manner that might subject the participant to exposure. In one instance, the participant gave an account that was potentially revealing of patient information that was not deemed pertinent to this study. The researcher omitted the specific statements using the following bracketed comment: [Participant gave additional details related to patient that are not pertinent to this discussion...] Also when NLRNs used specific

names in the narratives, the researcher supplied pseudonyms indicated in brackets to de-identify the individuals.

Auditability. Auditability is the ability to clarify the decision-making process of the researcher throughout the process of developing and implementing the research project. In order to meet this standard, the researcher must maintain a detailed account (an audit) of the decision trail. A second researcher should be able to follow this trail, using the original data and come to the same decisions as the original researcher. As with other standards, threats exist (Burns, 1989) and are noted in Table 3.5. The steps were followed by the researcher as outlined in the table to ensure auditability.

Table 3.5 Minimizing Threats to Audibility

Potential Threat to Auditability	Strategies to Minimize Threat
Description of data-gathering process is inadequate.	The description of the data-gathering process was clearly delineated. No variation from intended procedures was noted.
Records of raw data were not sufficient to make a judgment.	Researcher maintains copies of all transcripts of interviews and will continue to do so for a period of three years beyond the completion date of the project for perusal.
Rationale for development of categories or themes is not provided.	A detailed account of the process was maintained in the researcher's notes. The researcher used index cards to aid in the development of categories and themes. Further verification was established in discussion with the nurse experts.
Researcher failed to develop and/or identify decision rules for arriving at ratings or judgments.	Researcher maintained these decision rules in the notes.
Other researchers are unable to arrive at similar conclusions after applying decision	Reviewed with team of two nurses who have experience in the transition process to

rules to data.	establish that recognizable patterns do exist.
Researcher failed to record the nature of decisions, data upon which they were based, and reasoning that entered into decisions.	Researcher recorded in the notes.
Evidence for conclusions is not presented.	Researcher reported the evidence for conclusions within the study.
Theoretical statements are not linked to data.	Researcher has utilized the final chapter to pull all evidence together, making the connection to theoretical statements.

Standard III: Analytical preciseness. Burns (1989) cautioned that without analytical preciseness, the researcher is prone to make premature or poorly-fitted links between data and the theoretical representation. Frequently, as that thought process takes place, it is easy to neglect documentation of the transformational process by which the themes arise. For this reason, the process is often omitted from reports of qualitative research. This process is inherently important in establishing the understanding of how the fit occurs between the data and the theory. Attention to the threats listed in Table 3.6 will be essential to ensuring this standard.

Table 3.6 Minimizing Threats to Analytical Preciseness

Potential Threat to Analytical Preciseness	Strategies to Minimize Threat
Interpretive statements do not correspond with findings.	Researcher has made a conscious effort to justify interpretive statements with findings. Reviewed findings with team of two nurses who have experience in the transition process to determine appropriateness of findings and statements.
Categories, themes, or common elements are not logical.	Researcher sought the opinion of two nurses to validate logical decisions related to categories and themes.

<p>Samples are not representative of the class of joint acts referred to by the researcher. Prioritizing processes are not logical.</p>	<p>Reviewed with team of two nurses who have experience in the transition process. Researcher sought the opinion of two expert nurses to validate logical decisions related to prioritizing processes.</p>
<p>Categories or common elements are not consistent.</p>	<p>Researcher sought the opinion of two nurses to validate logical decisions related to development of categories in relation to common elements.</p>
<p>Set of categories, themes or common elements fail to set forth a whole picture.</p>	<p>Reviewed with team of two nurses who have experience in the transition process to test plausibility of all elements.</p>
<p>Set of categories, themes or common elements are not inclusive of data that exists.</p>	<p>Reviewed with team of two expert nurses who have experience in the transition process to test plausibility of all elements.</p>
<p>Data are inappropriately assigned to categories, themes or common elements.</p>	<p>Researcher reviewed each assignment for appropriateness at a time when the patterns established had “cooled” (after taking a break from the materials). When one pattern was in question, the researcher sought additional opinions from persons with experience in transition process.</p>
<p>Inclusion or exclusion criteria for categories, themes or common elements are not consistently followed.</p>	<p>Researcher established and followed guidelines for inclusion/exclusion criteria.</p>
<p>Working hypotheses or propositions cannot be verified by data.</p>	<p>Reviewed with team of two who have experience in the transition process to test plausibility of all elements.</p>
<p>Working hypotheses or propositions are not presented.</p>	<p>Reviewed with team of two nurses who have experience in the transition process to test plausibility of all elements.</p>
<p>Pattern codes are not provided.</p>	<p>Reviewed with team of two to three nurses who have experience in the transition process to test patterns within the codes.</p>
<p>There is evidence of premature analytical closure.</p>	<p>Researcher tried to maintain an open mind to new patterns as they developed.</p>

	Discussion with the expert nurses helped to establish a finite end to the development of patterns.
Conclusions are not data-based.	Reviewed with team of the two expert nurses to ensure that the conclusions were supported by the data.
Various sources of evidence fail to provide convergence.	Researcher reviewed when fresh to avoid errors that can be created by exhaustion.
There is incongruence of evidence.	Reviewed with team of two nurses who have experience in the transition process to determine congruency of elements.
Subject-participants fail to validate findings when appropriate.	Researcher did not deem it appropriate to further validate findings through checking with participants. Discussion with the experts helped to ensure validation of findings.
Proposed relationships among observed phenomena are spurious.	Researcher was ever vigilant to potential for errors in making connections and avoided “creating” patterns that did not exist.
Conclusions do not contain all data well.	Researcher ensured that all data was included appropriately.
Data are made to appear more patterned or regular or congruent than they are.	Researcher again avoided creating patterns that did not exist.

The researcher sought triangulation of data analysis techniques through colleagues who have experience with nurses in transition and are familiar with the transition process.

The researcher used reflection throughout the process of data retrieval and data analysis to ensure that her thought processes were “on-point” and patterns were not being generated where none existed. Review with the team of experts was very beneficial in confirming the credibility of patterns and themes as identified.

Standard IV: Theoretical connectedness. Burns (1989) states simply, “...theoretical connectedness requires that the theoretical schema developed from the study be clearly expressed, logically consistent, reflective of the data, and compatible with the knowledge base of nursing (p. 50).” Smith et al. (2009) defines theory development in interpretative phenomenological analysis (IPA) as being idiographic. The authors stated that theory is developed as a result of consistent commonalities between cases. Super-ordinate themes are developed only when the elements apply to each participant (case) with possible exceptions which should be clearly defined and set apart. These themes may also present in different ways in different participants. With those elements in mind, solutions for potential threats to theoretical connectedness are listed in Table 3.7.

Table 3.7 Minimizing Threats to Theoretical Interconnectedness

Potential Threat to Theoretical Connectedness	Strategies to Minimize Threat
Findings are trivialized.	Researcher ensured a balance in reporting of all findings regardless of how minor they may have seemed.
There is inadequate clarification of concepts.	Concepts identified in the study have been fully explained in the report of findings.
There is inadequate refinement of concepts.	Concepts identified in the study were fully explained in the report of findings.
Concepts are not validated by data.	Researcher ensured that data supported the concepts discussed through discussion with two expert nurses.
The set of concepts lack commonality.	Researcher ensured that data supported the concepts discussed and that commonality was articulated.
Relationships between concepts are not	Relationships have been clearly articulated.

clearly expressed.

Theoretical statements are not internally consistent.

Researcher has attempted to make the connection for the reader to identify theoretical statements.

Proposed relationships between concepts are not validated by data.

Researcher has demonstrated the connections within the data for the reader.

Themes fail to give accurate expression of original values.

Researcher ensured that there is congruency between the original values of the participants and themes and that the true meaning was expressed.

There is inadequate integration of relationships among meanings brought together by the theoretical schema.

Researcher clarified the relationships of meanings and identified that integration.

Working propositions are not validated by data.

Clarity has been sought to ensure that the data supports the propositions.

There is a distortion of data in development of theoretical schema.

Reflection on the part of the researcher has helped to ensure that the data was utilized correctly in establishing the theory. Frequent checks with other colleagues helped to ensure that the researcher has not been tangential.

The theoretical schema fails to yield a meaningful picture of phenomena under study.

The researcher feels that the theoretical schema is a true representation of the meaning ascribed by participants.

A conceptual framework or map is not derived from the data.

Researcher used the data derived to create a map and conceptual framework related to the phenomenon.

There is no clear connection made between the data and existing nursing frameworks.

Narrative report has established a clear picture of those relationships.

Standard V: Heuristic relevance. Heuristic relevance is measured by the significance of the study to readers (Burns, 1989). Do readers recognize the phenomenon that is featured in the study? In order to build on that relevance, the researcher needs to emphasize the theoretical significance, applicability to the profession of nursing, and the

impact that the study has for future nursing research. Three dimensions apply to measurement of heuristic relevance: intuitive recognition, relationship to existing body of knowledge, and applicability (Burns, 1989).

Intuitive recognition. In this dimension of heuristic relevance, a member of the profession of nursing should be able to automatically recognize elements of the theoretical schema related to transition to practice from their personal knowledge base of nursing. They should immediately recognize how this relates to the practice of nursing. Threats (Burns, 1989) to intuitive recognition are listed in Table 3.8.

Table 3.8 Minimizing Threats to Intuitive Recognition

Potential Threat to Intuitive Recognition	Strategies to Minimize Threat
The phenomenon is poorly described.	The researcher was aware of the terminology and utilized terms in the description of the phenomenon that are integral to nursing and have meaning for nurses. This was a natural occurrence as nurse participants were involved and the terminology flowed from their descriptions of the phenomenon.
The reader lacks familiarity with the phenomenon.	For nurses, the phenomenon should be universal. For other readers, the terminology may not be relevant.
Description is not consistent with common meanings.	Review with the team of nurse experts helped to ensure that the language is representative of the phenomenon.
Theoretical connectedness is lacking.	Procedures were maintained to ensure theoretical connectedness.
Analytical preciseness is lacking.	Procedures were utilized to ensure analytical preciseness.

Relationship to existing body of knowledge. The researcher must explore the findings in relation to the existing body of knowledge and clarify relationships identified for the reader (Burns, 1989). These relationships need to be identified and justified within the study. Prior knowledge associated with the existing body of knowledge can be utilized to identify similarities and differences that have surfaced in the current study. Burns (1989) has again identified potential threats to the relationship to existing knowledge of a given phenomenon and the researcher has outlined possible solutions to prevent these occurrences in Table 3.9.

Table 3.9 Minimizing Threats to Relationship to Existing Body of Knowledge

Potential Threat to Relationship to Existing Body of Knowledge	Strategies to Minimize Threat
The researcher fails to examine the existing body of knowledge.	The preliminary literature review established an overview of the current state of the phenomenon in the literature. Subsequent literature review confirmed interim findings as data was collected and helped to correlate findings.
The process studied was not related to nursing and health.	Transition to practice mechanisms such as NRPs are directly related to nursing and to health. That has been established in the study.
The researcher fails to identify existing relationships.	Existing relationships have been established.
There is a lack of correspondence with existing knowledge base in nursing.	At the time of the final literature review, elements within the study were extrapolated to demonstrate the links between existing knowledge and findings.

Applicability. Burns (1989) noted that in addition to the findings being articulated as appropriate for certain nursing practice situations, the study should also

prove relevant to the discipline and point to future research applications. The study of transition to practice is highly relevant to nursing from the perspective of preparing new nurses effectively as they enter the profession. The findings should be significant in explaining the perceptions of nurses as they navigate the transition to practice in acute care settings.

The review of threats to internal validity in a qualitative study allows the researcher to think proactively in planning and preparing the design of this study. Preferred discussion of internal validity in qualitative studies relates to credibility, transferability, dependability, and conformability, as noted by Guba (1981). Specific references to factors relating to IPA informed the design of this study and helped to promote implementation of strategies to ensure rigor within the study. The importance of the audit trail is dominant in the discussion of these strategies.

Summary

The study of concepts within NRPs has many competing variables that have been examined in other studies. This study focused on the insider perspective of the NLRN within the first year of practice. The study sought to identify themes that capture the new nurses' attention in the myriad of concepts associated with this transformational period. The research attempted to identify ways in which nursing leaders and other entities involved in the development of nurses can positively affect change in the way that nurses are introduced to the profession. Questions within the study reviewed ways in which the work environment impacts the nurse in the performance of the professional role. These questions were best answered by the nurses within the transition period in NRPs.

Interpretative phenomenology is said to be a “double hermeneutic” or “dual interpretive” process (Smith et al., 2009; Braun & Clarke, 2013). IPA is so named because of the perspective of the participant, superimposed with the perspective of the researcher. IPA also is embedded in the context of the participant and so the participant cannot be separated from the many variables associated with the action. All of the actions and interactions associated with transition to practice are a part of the milieu and complete the experience for new nurses. Discussions and reflections throughout the process of interpretation and analysis made the researcher continually aware of the significance of the dual interpretative process.

The researcher interviewed registered nurses in their first year of practice to ascribe meaning to the experiences of NLRNs in NRPs. The researcher utilized a list of questions to prompt discussion of those experiences in a semi-structured interview. The data will has been analyzed to identify themes that may give new information related to the concepts associated with the transformational period within a NRP. The selection process for the sample of participants has been denoted. The context or environment of each of the cohorts has been outlined with noted information relating to their safety scores. Ethical issues have been discussed. Tools related to the study are included in the appendices and have been noted within the narrative. Analysis of the data and resultant themes are further discussed in Chapter Four.

Every effort has been made and measures taken to identify potential barriers and threats to successful processes in this project. An audit trail has been maintained to ensure that rigorous procedures have been utilized along the way and the process has been conducted in an ethical and responsible manner. Burns’ Standards for Qualitative

Research, the cardinal reference identified for critiquing qualitative research (Sandelowski & Barroso, 2003), was utilized to establish a framework for ensuring rigor in this study. All aspects of the study have been maintained in the audit trail with frequent reference to the critique to ensure procedures are followed closely.

Chapter Four: Results

In Chapter Four, the results of the study are presented. The demographic make-up of the study participants are described and noted in a table. Rich, descriptive narratives from the participants' experiences are reviewed and interpreted using Interpretative Phenomenological Analysis. The themes identified in the study are noted with supportive dialogue. The factors that have meaning for these NLRNs will be used to further describe concepts within the NRP experience in transition to practice.

Demographics

Six participants responded to the investigator after receiving the Study Information Sheet that was circulated by clinical educators at three hospital sites. Demographics of the group are illustrated in Table 4.1. The average age of the participants was 24.8 years. Of those participating, 83% were female and Caucasian. One participant was male and listed his ethnicity as African. Five of the six participants held BSN degrees, while one held an associate degree, but was currently enrolled in an RN-to-BSN program. As noted in Table 4.1, three of the six participants had prior healthcare experience before becoming a registered nurse: one as a state-registered nurse aid (SRNA), one as a hospital extern, and one as a paramedic. One participant had completed a bachelor's degree in an unrelated field prior to enrollment in nursing school.

Table 4.1 Demographic Make-up of Participants

Participants	Age	Gender	Ethnicity	Education Level	Prior Health Care Experience
P1	24	M	African	BSN	None
P2	23	F	W	BSN	SRNA
P3	23	F	W	BSN	Extern
P4	31	F	W	ADN	Paramedic
P5	24	F	W	BSN	None
P6	24	F	W	BSN	None*

*Had a prior baccalaureate degree in an unrelated field.

Overview of Themes

Participants in the study produced rich dialogue related to the experiences within the three NRPs in the study. The investigator identified five basic themes relevant to the participants' discussions: Relationships, Reflection, Desire for Active Learning, Resources, and Organizational Infrastructure. These themes along with related subthemes are further defined and described in this chapter.

Subthemes were noted within the themes, as noted in Figure 4.1. Within the theme of relationships, two subthemes were noted: connectedness and support. These factors seemed to resonate with each of the participants' dialogue about the relationships that developed between NLRN and the preceptor, the mentor, the cohort and other staff respectively. The theme of resources was further explained with a separate subtheme of "access to seasoned nurses." This interaction with seasoned or experienced nurses was distinct from the relationships theme. The discussion suggested a less intimate interaction designed to obtain technical information or assistance that differed from the connectedness and support described in relationships. A synopsis of excerpts from the transcripts is listed in a table in Appendix G. Examples are provided within the narrative to demonstrate the essence of NLRNs' meaning related to the identified factors.

Figure 4.1: Overview of Themes



Relationships. The theme “Relationships” is defined for the purposes of this study as associations between two or more individuals established within a professional community for the purpose of providing support and connectedness for the less experienced individual within the association. The interactive experience may promote varying degrees of affinity, bonding, and dependence. Identified relationships noted in the study included:

Preceptor-Nurse Resident—the preceptor serves as a clinical coach to provide support and functions as a safety net for the nurse resident. In an ideal

relationship, the preceptor will also promote interdisciplinary and intradisciplinary connectedness for the new nurse.

Mentor-Nurse Resident—the mentor facilitates learning sessions for the nurse resident, promotes guided reflection, sponsors professionalism and nursing leadership. In these activities, the mentor provides support and connectedness for the nurse resident.

Cohort-Nurse Resident—within the specified cohort of entry-level nurses, the nurse resident bonds with other nurse residents based on common experiences and mutual concerns and stressors. Through sharing of experiences and alternative solutions, the cohort develops supportive relationships and gains a sense of camaraderie, making connections with other new nurses.

Unit Staff-Nurse Resident—while developing professional acumen within the specific nursing unit, the nurse resident begins to formulate other potentially supportive relationships with unit staff. These relationships may be enhanced by the level of connectedness demonstrated by the preceptor or by the mentor. Further development of these relationships, in turn, can promote additional sources of support and connectedness.

Relationships were inherent in every dialogue about what NLRNs found most meaningful in the NRP experience. Participants described interactions with mentors, preceptors, their peers within the cohorts, and other nursing staff within their units as noted above. These discussions were accompanied by body language and conveyed feelings that spoke to the importance that the NLRNs attached to the experiences

described. Interviewer notes described broad smiles combined with brighter tones of voice, sometimes accompanied by joyful laughter. In most cases, the participants' posture changed as they sat tall and discussed the interactions with others. Two noted sub-themes within relationships revealed themselves in review of the data:

Connectedness and Support.

Connectedness. The new nurses noted the importance of making connections and feeling connected with other individuals as they developed their professional personas. This phenomenon linked the nurses to professional development opportunities and to human capital within their practice arenas and promoted professional socialization. The preceptor role was highly regarded in discussions by participants. It became clear that for most of the participants, this relationship was of utmost importance as they journeyed into the new profession. Most NLRNs associated the preceptor role with orientation only. The mentors, who were also referred to as instructors by some participants, were the practitioners who guided the experience within the NRP. NLRNs noted the importance of the connections made within that setting with both the mentors and the other new nurses within their cohort. When asked about the relationship that they had with the preceptor and or the mentor, the following responses demonstrated connectedness that the NLRNs felt with their preceptors. (Expressions related to the mentor relationships are described later in this section.)

Participant 1: "Oh, [my relationship with my preceptor] was the best relationship I've ever had! She was so excited that she was going to be my preceptor. When I met her, she told me that she was excited to work with me and said, 'I am going to be your friend. Always ask me what you want to know.'

"And she had me ask questions of other people on the floor. And they told me to ask questions...And she introduced me to the doctors and made

me talk to them. Every time the doctors came onto the floor, she called them over and introduced us and helped me not to be afraid of them.

Participant 5: “I still feel like I have a tighter connection with them [her four preceptors] than the other nurses...because they helped me become who I am, and I still always feel more comfortable going to them than I would other people...”

These participants identified development of new relationships or connections as important to their transition experience. For Participant 1, the preceptor’s enthusiasm and welcoming attitude made the new nurse feel comfortable asking questions in his new position. This preceptor further helped the resident to make connections with doctors and other staff, helping him to overcome his fear of interacting with physicians. The participant told of how his preceptor exceeded expectations in helping him to develop relationships with the physician staff and other nursing staff. Participant 5 shared how she valued the connections made with her preceptors while resourcing others within her network.

Participant 5: “I think we were supposed to be [assigned to a particular preceptor], but then...you know [shrugging her shoulders]...so I ended up having four preceptors –two night preceptors and two day preceptors. But for instance, you would show up for work and your preceptor was supposed to float for that day ...or your preceptor called in sick; you would still go to work and precept with somebody else.

“I still feel like I have a tighter connection with them [her four preceptors] than the other nurses...because they helped me become who I am, and I still always feel more comfortable going to them than I would other people...”

While there were disruptions to the preceptor/NLRN relationship due to circumstances that occurred within the orientation period, this NLRN noted a stronger relationship with those nurses whom she identified as her primary preceptors. The connections forged in these relationships allowed the NLRN to feel a certain sense of

comfort. The importance of sustained relationships and connections was further described as noted below:

Participant 5: "...it was kind of nice having multiple [preceptors] in a way and then it was kind of not...because in one way, you could learn a lot of different things from all of them because they all do things in different ways. But each time you got a new preceptor for the first time, they didn't really know where you were at on the ability spectrum and, like, what you had learned so they would have to kind of start fresh, like, 'Do you know how to give this medication?' You know, so it kind of felt like you were backpedaling in that sense sometimes."

Participant 3: "I actually got the opportunity to do my capstone on this unit which I'm working on now, which was like the actual physical clinical that you do in school. So I actually got to work with one of my preceptors for when I was on my day-shift orientation. And then I had one of the charge nurses for my night-shift preceptor...I had those two who are both pretty experienced nurses who have worked on our floor for a long time...I liked that I had the same people to follow, just because I felt more comfortable with them...Now that I'm not on orientation anymore, I feel comfortable enough to go and talk with them or ask them about something."

These NLRNs describe two different experiences with sustained relationships. The first discussion relates to multiple preceptors with different methods and ways of accomplishing tasks. This NLRN also describes the experience of limited clarity between the varied preceptors related to her transition experience; there seemed to be no transfer of information between the preceptors to augment her experiential learning. The second refers to the consistency that was established in the formative stages within her academic capstone course and carried into the practice setting, even into her transition from orientation on days to orientation to night shift. Other NLRNs discussed similar differences in their relationships with their mentors.

In the NRP study, mentors also provided a sense of connection for NLRNs. The NLRNs referred to these mentors frequently as instructors. The terms were used

interchangeably by many of the participants. The primary role of mentors is to facilitate learning sessions, so instructor is an appropriate term for that role. One NLRN had the following to say about one of the mentors.

Participant 5: “I don’t know if all the mentors meet this status; he’s been extremely helpful. He doesn’t really wait for you to reach out to him. He just kind of anticipates that you’re having the same kind of feelings that he had as a new grad and he makes me feel confident.

[Later] “...my mentor works on a completely different unit. And if I needed him...we might not work any of the same days—he might actually have three totally different days that week than what I do. So he was more like a contact that we could seek out and meet with, if we wanted to.”

And in another excerpt from the conversation, she described how the opportunities for networking that were presented in the NRP sessions were meaningful to her:

“The networking resources were the things that I actually used the most—like when we discussed [in an NRP session] ways to be involved...in committees outside of this [NRP] or outside of your own unit...ways to network.” [In response to what was most meaningful to this participant in the program]

The mentors made connections with the NLRNs and helped them to understand how they could develop other networking or connections outside of their current assignments.

Although this NLRN noted that her mentor was physically located on a different unit and they worked on different days, she still felt connected to him because he reached out to her. He sought out the NLRN and demonstrated caring. In his normal routine in a supervisory role, he found time to inquire about the NLRN’s needs and to ensure that the transition experience was positive. The mentors within the study met with the NLRNs in monthly sessions and participated in the presentations and discussions that occurred, but

mentors also helped to develop relationships outside the classroom setting to provide clinical guidance and opportunities for discussion.

In another dialogue related to mentors, one NLRN noted:

Participant 3: (regarding mentor assignments) “At the beginning [of NRP] they were sort of split into assignments, because we had a bigger group, but now it’s more narrowed down. I just see [one mentor] more, especially now that he is assigned as a [supervisor role]...but I don’t see [the other mentor in our cohort] at all, because she works on a totally different floor, totally different elevator, totally different access to where she even works...”

This NLRN did not seem to have a clear understanding of who was assigned to her, but she noted that she felt comfortable with either mentor and had greater access to the one, just by virtue of their locations. So in addition to the instructor role within the NRP structure, the mentor relationship just developed naturally in the course of day to day activities.

Connectedness within the confidential and safe environment created within the cohort sessions resulted in opportunities to share and discuss problems safely.

Participants described the interactions within the small group setting as a means to share experiences and problem-solve. Examples of those discussions are noted:

Participant 2: “Well, we were a small group—just 14 of us. And going through the process together, knowing that you’re not alone. I bonded with others in the cohort.

“I really liked [the classes]; it was helpful just being there with the others and discussing things.

“I went through a low period in September, but I talked to the other grads and they said that is typical. I think the NRP helped me to get through it—being able to talk with others who felt the same way and just knowing that it happened with other people and took time.”

Participant 6: [When asked what was most important?] “... a time when we were permitted to sit around at a table and all the doors were closed

and the nurse residency instructors and the new nurses got to talk about experiences that they had on the floor... And...honestly, getting to bounce off ideas and stories and explain, you know, experiences that we had—I think that was one of the most meaningful aspects of the nurse residency program.”

Participant 5: “I felt that it was a good way to connect with other people that were also new and then to have our mentors that could help us through it...”

“[In the NRP sessions] Honestly, I think the less organized days, where it was just conversation...like, the older, more experienced nurses sharing stories about you know, things that happened to them and how they had dealt with that situation...and then hearing stories from some of the other new nurses about things that they had encountered. I feel like that always sticks with me more than people just presenting things to me.”

Connectedness with other staff, both nursing staff and other disciplines, was also noted by participants in the interviews. Most participants spoke highly of the connections made with other staff. Excerpts from transcripts demonstrate those discussions:

Participant 2: “We receive a lot of help and support from the other nurses...”

“I can call respiratory or lab anytime and they are always ready to help...we have a great relationship.”

Participant 6: “It’s a very nurturing and helpful environment. If one nurse is having trouble, someone else will always come out and be there to support them. It’s a beautiful...uhhh, nine times out of ten, I really think it’s a beautiful environment. We’ve got the best nurses; I really do believe that!”

Participant 1: “And [the preceptor] introduced me to the doctors and made me talk to them. Every time the doctors came onto the floor, she called them over and introduced us and helped me not to be afraid of them...”

The NLRNs learned to communicate with the other nursing staff and other disciplines through their interactions within the NRP. Preceptors promoted interactions with others that helped to make this transition smoother. They helped the NLRNs to feel more comfortable, helping them to make connections with others on the unit.

Connections within the NRP were valued by all participants, with noted variations of experiences among the NLRNs. Even within three homogenous programs and, at times, within one program, differences occurred. The participants reported a predominantly positive experience with these relationships, but at times disruptions to connectedness occurred within the NRP and these will be further discussed in the section related to organizational infrastructure.

Support. Support for NLRNs is of substantial importance as they transition into the professional nursing role. Nurses in the study spoke of caring, nurturing and safeguards within practice as support systems in the nurse residency programs. Therefore for the purposes of this study, support is defined as caring, nurturing and safeguarding behaviors from contributors directly involved in the transition program (preceptors, mentors, other nurses); compassionate interactions with others who understand the nursing transition experience and contribute to a sense of shared experience. NLRNs in this study described their experiences with preceptor support in the NRPs. Five of six participants in the study articulated some variation of the idea “I am not alone.” This element of support resonated throughout the interviews:

Participant 1: “I wanted to learn how to do my job...how to have confidence in what I was doing from school into clinical. I wanted someone to go to and not be alone.”

Participant 2: “It meant a lot to just know that you were not going through the process alone...For me, the most important thing was having other people going through the same thing and building relationships throughout the hospital.

“I went through a low period in September, but I talked to the other grads and they said that is typical. They had kind of warned us about this in the NRP, saying that it occurs after about six months usually—and I finished my orientation in March and started the NRP, so that was about right...I guess it lasted a little over a month. I mean, I dreaded going to work every

day and tried to think how I could change or do something else. I thought I had made a terrible mistake going through everything I did to become a nurse...but I love my job now. I think the NRP helped me to get through it—being able to talk with others who felt the same way and just knowing that it happened with other people and took time.”

Participant 3: “It made me feel like it wasn’t just me that was having these horrible days, issues on the floor and that kind of thing.”

Participant 5: “I felt like it would be a good support system. I felt alone in my struggles and I didn’t expect it to be easy, but I wanted to feel like I was normal whenever I was struggling with it and have people to talk to about it, so I felt like it was a good way to connect to other people that were also new and then to have our mentors that could help us through it... And it’s helpful...it’s comforting to know that no matter what situation you come up against, I guess there’s always going to be somebody that you can reach out to that’s gonna know what to do.”

Participant 6: “And... getting to bounce off ideas and stories and explain, you know, experiences that we had—I think that was one of the most meaningful aspects of the nurse residency program, simply because you realized that you weren’t alone...”

Support in this context is strongly related to the connectedness subtheme. NLRNs developed those connections with their peers in the NRP groups and gained support from them. Many participants expressed that they did not frequently get to see other NLRNs on the hospital units, since individual units only hired a limited number of new nurses. Thus planned occasions to interact with one another within the NRP promoted support. The NRP group sessions afforded the NLRNs opportunities to share and to recognize similar hurdles to overcome, helping them to make sense of the distinct experiences within their separate units. They provided support for one another through discussions facilitated by the mentors in a safe and nurturing environment without fear of judgment.

Another means of identified support for the NLRNs came from preceptors as the new nurses encountered the clinical aspect of their new professional role. Participants in the study expressed approval related to the undergirding that preceptors provided in the

workplace to allow opportunities for exploration of practice. The NLRNs described their perceived support from preceptors who provided a safe environment for new practice:

Participant 6: “It was amazing! My preceptor on days... just handed me the reins and said, ‘Here you go; you’re going to do this and I’m going to be here to make sure that you don’t make any mistakes.’...And my preceptor on nights was the same way...I mean, I was carrying a full load very, very quickly.”

Participant 5: “So I found the preceptors that were most helpful to me were the ones that were always there for support when I needed them, but they didn’t tell me how to do it before I asked or before I tried it on my own.”

Participant 1: “[The preceptor] helped me learn to be organized. She taught me how to plan...she taught me how to prioritize, but not like they teach you in school, on paper. She had her own system and she taught me how to do it, so that I could be organized. And she taught me that assessments are the most important thing—assess, assess, assess. That’s important. And the most important thing she taught me was to call the patient by their name, gain their trust...

“...The preceptor helped us to see what was done at the bedside. It was continuous from school. Just being able to see that it was done that way and that it was, like, for real—not just reading about it on the paper or listening.”

Participants noted several different levels of support: from preceptors, mentors and other nursing staff. Participants also described the sustained relationships even beyond the timeframe of the formal nurse residency program and how that helped them to assimilate their new professional roles and to feel a part of the professional team, as noted in these narratives:

Participant 1: “I think the thing that is important is that they are still caring. My preceptor and my mentor still come around and ask me how I am doing, ask me if I need anything. It makes it easy to open up and talk to them about what I might need. They make me feel that they still care about me and that is important.”

Participant 2: "...the instructors were wonderful. I know that I can always call on them. I mean, to this day, if I call and ask a question, they will still help me."

Participant 5: [In reference to a challenging experience] "My mentor made sure to check on me to see if I needed anything. Other units were supportive...it was a struggle, but I really did have good support from my team.

[Later...] "I think that the most important way to deal with the stress of the job is to have a really good support system in place.

"The instructors were so approachable. That was—I really felt comfortable talking with them. And being able to be very honest with what was going on—in my mind, in my heart, the way I felt, the fears that I had. And that made for...an outstanding experience, because you know, I honestly felt like I could go to them.

[When asked, did you discuss that situation with your group?] "Yeah... most of them were like 'You can do it; you should be a charge nurse.' But some people—some of the feedback I get—you know even from nurses who have been nurses a long time is that...they say, 'I would not charge on your unit.' So it's—I mean, that makes me feel accepted."

Participant 6: "Well, my preceptor and I are no longer on the same floor, but I feel I can call her on my work phone at any time, because she taught me how to be a nurse."

The NLRNs in the study described caring and nurturing behaviors that translated as preceptor support provided to them in their clinical endeavors. Of prime importance to them was the idea of safety in patient care; knowing that the preceptor was available to provide a safety net, while allowing the NLRNs some degree of autonomy in their new roles. Others expressed satisfaction with the supportive roles demonstrated through caring and openness to interactions beyond the formal relationship within the assigned roles of their preceptors or mentors. And some participants confirmed supportive relationships that were beneficial in times of challenging experiences.

Participant 3 described the experience of transitioning while remaining on the unit where she had performed her academic practicum experience. She was able to retain the same preceptors as she entered practice and found this to be a positive experience. The preceptors already knew her capabilities and consistency was maintained in the transition experience. She described the experience in the following manner:

Participant 3: “I mean I liked that I had the same people to follow, just because I felt more comfortable with them. And the ones I had, you know, like if I was uncomfortable with doing something at all, they would like make me do more of it; that kind of helped me get more comfortable with it, and it’s good because now I know that I can ask them. Now that I’m not on orientation anymore, I feel comfortable enough to go and talk to them or ask them about something.”

The participants noted how their peers on the nursing units provided support for them as well:

Participant 6: [Discussion of peers on unit] “We all help one another. It’s a very nurturing and helpful environment. If one nurse is having trouble, someone else will always come out and be there to support them.”

Participant 5: “I attribute a lot of it to my coworkers who taught me everything I know. But I think I’m on a really good unit for learning...”

Participant 2: ‘[On my unit], we receive a lot of help and support from the other nurses.’

Participant 3: [Describing the most beneficial aspect of the NRP for her] “I think honestly, [it was] the support of other nurses on my floor. I think that with the really hard times we’ve had on our floor this last year, it would have been really hard to stay if I hadn’t had those people on my floor.”

Participant 1: “People who weren’t even my preceptor... would come to me if they had something that I had not seen before and say, ‘Come with me, I want you to be able to do this.’ So I would go with them and they would share with me. I learned everything that way.”

The NLRNs appreciated the support that was gleaned from their peers in the nursing units. Participant 3 noted that this support prevented her from leaving the unit or leaving nursing. Relationships formed with their peers were more casual, without a formal foundation as the preceptor and mentor relationships, but meaningful to the NLRNs at the same time.

Through discussion of relationships, NLRNs in the study identified the meaning attached to their relational experiences in the NRPs. Participants described experiences with the mentors and the functions that this role provides within the NRP. They also spoke enthusiastically about the meaning attributed to preceptor relationships and the clinical support that their preceptors conveyed in the transition experience. The participants further noted the importance of relationships with other nurses on their units and specifically, those other nurses within their NRP cohort. NLRNs valued relationships that were developed in the NRPs and derived support and connectedness from the interactions within those relationships.

Reflection. Reflection is defined here as a deliberate thought process that takes into account an individual's experiences and consequences for the purpose of planning future action. Participants in the NRP study did not refer to the term reflection specifically very often, but they talked about reflective types of experiences. In the NRPs, the participants frequently used reflection to process situations in their clinical arenas. The following demonstrated their understanding of how the reflective process worked within the NRPs:

Participant 1: "And then they gave us time to reflect on [the simulation experience] and to talk about what we had learned. That was helpful. You got to work on the team... Then after a few days with the preceptors, we would come back and spend the day with our mentors and they would

ask us “What trouble are you having on the floor? What is the thing that you need the most?” They helped us to reflect on what we were doing.”

Participant 2: [After describing a challenging experience in which the patient “fired” her] “It [the NRP] definitely prepared me with resources. They had told us this could happen, but I never thought it would happen to me and I had never had a problem with a patient. The other staff was very supportive and they told me to just take it in, but don’t be too hard on yourself.” [Encouragement from others to “take it in” or review the situation]

Participant 3: “...and we had a debriefing after it so that we knew how to be better prepared for it on our floor because something like that we just had never had on our floor before.”

Participant 4: [In reference to a bad patient outcome] “We had a debriefing the next day. And then we had a root cause analysis.”

Participant 5: [When asked about debriefing or opportunity to reflect after a specific incident] “I did reach out to [my boss], because I wanted her to know that I did have to charge that day, because I don’t even think she knew, you know, because someone just called in... And I told her I didn’t feel ready for it... So she was very understanding and apologetic that I had to do that obviously, but ...other than that I don’t think I really did anything.”

Participant 6: “...well, I got to talk about that in the sharing time...and then one of the nurse residency instructors—I don’t know if she really ...Well, I talked to my boss, you know, and said well, I’m really, really struggling with this...I don’t know if I can do this...it’s just the way my heart was feeling...so the nurse manager and the nurse residency instructor, I think... maybe together, ...got me into this class so that I could hopefully be better at it [palliative care].”

NLRNs were encouraged primarily by their mentors and preceptors, and at times by their nurse managers, to reflect on their learning based on experiences with both patient simulation and actual patient care situations. Participant 6 reflected on the experiences that she had in palliative care to determine a solution for her angst in a new care setting. In her case, this translated not only as a means for internal reflection, but also as a collaborative effort between nurse manager and mentor to help her to develop a

strategy for overcoming a specific concern that she experienced in the workplace setting. The NLRN was able to express her feelings with her peers in the NRP sessions and through her ability to discuss the issue was guided to develop a strategy for coping with this aspect of her role. Guided reflection offered the participants opportunity to process the experiences and use critical thinking to devise a plan for future actions.

Throughout the narratives, the NLRNs told of struggles that they encountered in their settings and how they were able to take these experiences back into the safe zone of the NRP classroom and share their feelings and reflect on the experiences that they had encountered in practice. Individualized reflection within their practice setting enabled NLRNs to work through the emotions and the problem-solving aspect of the situations that they experienced. As presented in the narratives, it seemed that the NLRNs were able to resolve the associated feelings and to derive meaning from interactive discussions within their peer groups.

Desire for Active Learning. The participants seemed eager to discuss the didactic learning sessions that occurred in the NRP classes. The general theme of these discussions involved active vs. passive learning. “Desire for active learning” is defined as a distinct preference for active learning strategies with clinical relevance such as simulated learning experiences, hands-on experiences at the bedside with sufficient oversight by a preceptor, case studies with interactive discussion, and off-unit experiences in which they could observe other nurses in their specific roles.

Contrasted with the discussion of active learning in this study is the discussion of didactic coursework in a classroom that did not hold clinical relevance for the practitioners. The NLRNs expressed clearly the topics that they found “redundant” or

repetitive of what they had recently learned in the academic classroom. Topics that were deemed unnecessary by the NLRNs were ethics, cultural diversity, and safety (as in the discussion of hospital codes for specific disaster situations). Some excerpts from the narratives are noted here:

Participant 1: "... it was like being in school again. Some of [the classes]...I didn't like how they made them...different departments came and talked and it was just another lecture...that was hard sometimes, because we just got out of school and we are having lectures again."

Participant 3: "I think it would have helped us a little bit more to have a little more hands-on... because some of the presenters that we had took up a lot of time with things that we already had learned... in like, our [nursing] programs? So I think that it was a little bit redundant and I wish that it would have been...like what relates to our work in the hospital and like more 'hands-on' things."

Participant 4: "...there was a lot of redundancy, like we had an entire day that was nothing but ...culture... cultural diversity, and that's a huge part of nursing school now... I think it could have been more like a topic that you would discuss within your own area...[For example,] I work with labor and delivery, so I had no idea that Asian women are going to labor in bed and not get up; whereas, white women...are up and all over the place. So I wondered why...and that was just a cultural thing that I picked up on. It was not something addressed in my...orientation."

Participant 6: "...there was a class that we did and it was about safety in the hospital. And... the head of security came and talked to us. And I don't know if it was just the way that he... approached the subject, but I really felt like it was exactly what we had gotten previously in just our general hospital orientation."

Other presentation topics were deemed in a more positive light by the participants. One topic that all participants seemed to appreciate was that of professional development with emphasis on clinical ladders and networking with other professional nurses. This topic had relevance for the nurses as a direct application to the professional role. Another participant indicated that information related to stress management and

life balance was important to him. When asked about a session that was particularly helpful to the NLRNs, comments included:

Participant 4: “When [one of the nurse managers] came and spoke to us about all of the different opportunities within the hospital. I felt like that was the most beneficial day we have had...I just learned a lot more about the organization—things that I was already aware of, but like the minute details that I hadn’t been aware of at the time...I think opportunities for development. Now we can work on that. Like the program has ended, but what’s next? Sort of, where do we go from here?”

Participant 5: “I actually thought the presentation [about professional development within the organization] was pretty entertaining...it was good.”

Participant 1: “We had stress-free activities. Just did things for fun to take the stress out. They [the mentors] taught us how to destress and told us to have friends outside of work and nursing. Because if you cannot manage it [stress], then you can have burnout. You have to learn to deal with the stress, so that you can be a normal human being.”

These didactic sessions held meaning for the participants. Other participants did not specify favorite planned presentations, but demonstrated preference for the more interactive discussions that led to interaction with facilitators and other members of the cohort. Discussions about interactive learning experiences have been outlined in previous sections related to support and reflective qualities associated with the themes of Support and Reflection. Participants seemed to derive significance from the sessions held in the cohort.

In conjunction with discussion of didactic classes, participants expressed a preference for the more active learning methods. These activities held clinical relevance for the NLRNs. One of those active methods was that of simulated bedside experience. The NLRNs voiced appreciation for simulated learning experiences as noted in the following excerpts:

Participant 1: [What was most useful?] Oh, the simulations—you get to take care of the patient in groups together. You know, they tell you the scenario and you have the patient there and sometimes you just freeze—your mind is running, running, running and you are remembering all the things they told you in school, and you just freeze and can't do anything. But we did the simulations in groups...it helps you to learn to rely on others somewhat and know that you are not an island.

“I would like to have shorter periods of class time with more simulations or active things to do in the afternoon. Most of our simulations were at the end of the residency—I think it would have been more useful to have those in shorter segments with the classes.”

Participant 2: “We did do one simulation—I think, or was that in school? ...I think it was the first or second class in the NRP when we did a simulation scenario to see how we worked as a team. I think that sim's are great! You can explore what it is like before you encounter it in real life.”

Participant 6: “...the very first day...they ran a respiratory arrest scenario—which was really good, cause we were all new grads and we were all standing around this dummy thinking, ‘Oh my God, this dummy has stopped breathing; what do we do now?’ And the nurse goes, ‘We have an ambu bag...’ And I was like, ‘Oh yeah, we can bag this patient.’”

Clearly the NLRNs in this study demonstrated a preference for more active learning in their transition to practice experience. As one of the participants noted, some of the scenarios were similar to the classroom studies that the NLRNs experienced in their academic days. But the circumstance of performing it in a clinical setting with different peers and different instructors created a heightened sense of anxiety causing them to momentarily forget prior knowledge. The investigator noted the descriptions of “freezing” by Participant 1 and Participant 6. The NLRNs articulated that they would rather have this experience occur in a simulated setting than at the bedside. In the words of one participant,

Participant 6: “Clinical application was tough for me, so doing that in the hospital setting and learning on somebody while trying to save their life—that was really, really hard for me. I struggled with that every day.”

Participant 6 also made a revealing statement in her discussion of the simulation scenario in the practice setting, when she commented that “the nurse [said]...” At that point in the transition, the participant still did not identify herself as a nurse. For many NLRNs arriving in the hospital setting, the reality of being the nurse has not yet emerged in that new nurses’ identity. The enactment of action-oriented learning in a situated cognition environment helped the NLRNs to develop the clinical reasoning that promotes them into nurses. All of the NLRNs noted that they appreciated the opportunities to have scenarios or simulated experiences in the laboratory setting to ease them into the nursing role before practicing on patients. This moved them closer to the realization that they were the nurses, or as one participant quoted her preceptor, “You’re a nurse now, so do it!”

Some simulation experiences were described as seemingly an element of competency evaluation, performed on specific units within the orientation period as noted:

Participant 3: “I think it would have helped us a little bit more to have a little more hands-on (earlier reference to simulation)... You would have competencies where you would demonstrate specific competencies through simulation.

[After discussion of the didactic component of the skills review] “...and then you get into more specific stuff for dressing changes and like for heparin drip and narcotic drips that we have on our floors. That was more the focus this time. But in past years, like when I was a tech, we did do the codes and that kind of thing—those kinds of simulations.”

Participant 4: “Our [Sim days] were focused on some critical care things ... like the rapid infusor and art lines and things that we don’t always use. We use them, but not that frequently.”

These NLRNs described a simulation experience that seemed to focus on review of skills competencies that were performed with all nursing staff on the units, as opposed

to sessions specific to the activities of the NRP. Both had prior healthcare experience and Participant 3 made reference to previous simulation scenarios that were utilized in her specialty area. She had expressed a preference for more simulation early in the interview and then later expanded the discussion of that topic. She seemed disappointed that the competencies presented in her first year as a nurse did not meet her expectations based on her prior experience during her externship.

Participants also sometimes compared their new practice experience with some of their academic experiences in active learning. This particular NLRN indicated that she would have benefited from more in depth learning experiences while in school in preparation for the practice arena:

Participant 6: [Describing the academic simulation experience] “We’d get in the lab about once a week and we’d do, you know, our skills and our check-offs and all that stuff, but when it came back to like, running codes or running simulations or...running crisis situations, then we probably only did that three times.”

“But I don’t feel like the clinical setting [while in academia] the nurses really give you enough responsibility so that you can really know what it’s like. I mean, like, I only passed meds about twice a semester my last semester of school before my preceptorship. But then I precepted in the ER, so that was a little different...But I felt like I was really green when I got on the floor.”

The discussion of clinical scenarios in the academic setting has meaning in pointing to the need for progressive difficulty in mock situations or simulated activities in the nursing programs. Another assignment described by participants that led to active learning was shadowing in other departments or off-unit experiences. See discussions below:

Participant 1: “Getting to go to other departments...that was helpful, then we did the presentation of what we saw in other departments and seeing that helped you understand it [other departments] better.”

Participant 2: “Well, one of the assignments was that we were allowed to shadow in the unit of our choice; then we had to do a presentation for the others about that unit. So you not only learned about your unit, but you learned about what others did, too. That turned out to be a good experience for me. I chose ER because I always thought that I would like to work there, but after shadowing, I changed my mind...the atmosphere was different from what I had seen on my unit. We receive a lot of help and support from other nurses, but in the ER, the nurses did not have time to help or explain and it just seemed different.”

The observation experience afforded the opportunity to observe how other units interacted and to compare differences between the units on which the participants worked. As opposed to sitting in the classroom, listening to others present information about their units in a lecture format, the NLRNs appreciated the opportunity to see other units firsthand. The assignment required that they have a focused observation period, followed by thought process required to prepare a presentation and then present to others in a professional format. Participants expressed that it was more meaningful to hear those direct presentations from other NLRNs who held a similar frame of reference to their own than from hearing others outside of their group.

Resources. In discussing experiences within the NRP, the participants communicated meaning attached to the concept of resources. Resources are defined here as a source of supply or support that is readily available in a time of need. As defined by the nurses in the NRP study, resources that were meaningful were ready access to pertinent information, ready access to supplies/services for patients in need, and ready access to seasoned nurses. A subtheme identified under this theme was that of Access to Seasoned Nurses. This resource also has meaning for the discussion of the theme Organizational Infrastructure which follows this section. Many nurses in the study

portrayed positive experiences regarding available resources for learning and for transitioning into their new roles.

Participant 6: "...that was one thing that they did in the nurse residency program—to teach us where the hospital polices were and how to access them and how to search for them."

As novice nurses, NLRNs rely strongly on rules and standards. This individual was very excited to learn exactly how she could search for specific topics within the hospital policy manuals to verify policies and protocols quickly. She used the example of administering a drug that she had never given before. None of the other nurses on the floor knew what to do either, but she knew exactly where to go to find the protocol because of her experience in the NRP. With a scarcity of experienced nurses to guide NLRNs, an alternative method to verify knowledge that is needed quickly becomes very important to the newer nurses.

Participant 2: "Oh, I really wish I had my NRP binder with me... we had a binder that we kept all of our material in and that was a good way to keep up with things. I still refer to it from time to time."

This NLRN wanted to share with the investigator information that she could easily access. Again, the reliance on quick access to information needed becomes a foundational need for new nurses. The facilitators in the NRP had recognized this need and supplied the residents with a mechanism for organizing and maintaining the information that would be significant to them in the early weeks of independence. The new nurse had determined this tool to be a much needed resource.

In other scenarios, NLRNs noted lack of access to specific supplies needed in a code situation and inability to obtain needed lab tests and blood products in a timely manner for a patient in crisis. In these situations, the resource issue was keenly linked to the NLRNs' lack of knowledge of hospital systems and the absence of knowledgeable

personnel to advise the NLRNs. The need for personnel resources is more fully described in the discussion of the subtheme related to access to experienced nurses.

Ready access to seasoned nurses. The primary resource that some of the NLRNs described as missing for them was experienced or seasoned nurses. “Seasoned nurses” are those experienced nurses who hold tacit information and can provide guidance and nursing expertise. The contrast to “ready access to seasoned nurses” is the presence of new nurses who are inexperienced and have limited understanding of systems and procedures. Without clinical guidance, these nurses may have difficulty in critical situations with which they have no prior experience and may miss elemental changes in patient conditions.

Four of six nurses interviewed expressed a need for greater ease of access to nurses who could provide information, expertise or both. The term “seasoned nurse” was introduced by one of the participants in a discussion of the lack of seasoned nurses that occurs in the summer months. “... the seasoned nurses that I work with refer to the summer as the most dangerous time to be a nurse [due to the influx of new graduate nurses and unavailability of more experienced nurses],” said one participant. Whether through attrition created by retirements of more mature nurses, nurses changing jobs and going to other healthcare sites, or nurses who transferred to other units within the same hospital, vacancies were created in some of the hospitals during this time period. This created a high risk environment. At least one nurse expressed that the absence of a knowledgeable and qualified nurse contributed to poor outcomes for her patients. Some exemplars are shared here to demonstrate the anxiety described by the NLRNs in the study.

Participant 5: “Okay, so our unit has been struggling with staffing just like every other unit. So our grid is 3to1; each nurse is supposed to have three patients and sometimes we have four; it’s not unusual to have four. But on this particular day, the charge nurse had called in sick, and they forgot to let me know that I was like next on the totem pole, kind of? Like everyone on that day happened to be newer than me, which was not super rare, but it does occasionally happen where there’s like one charge nurse who has like three to five years’ experience and then a bunch of brand new nurses. So I had been on the unit for less than a year, but everyone else had only been on the unit for like, six months. So, ‘tag, you’re it!’ You know? I showed up to work—like, charge nurses are supposed to be there at 6:30—I showed up at 7:00 like normal, cause I didn’t know I was charging and then they told me I was charging and my heart just like dropped! And I was like...at that point in time, I didn’t think I could make the best of that situation. And because I was taken back by it; I was not trained, I was very uncomfortable being in charge of an entire unit. And...but, you know, sometimes you just have to do what you’re told to do and... So I think ... my mentor might have actually been working that day...and he made sure to check on me to see if I needed anything. Other units were supportive. Like, even the PCD [patient care director] made sure that I was doing okay, but it ended up being the worst day; like, six admissions... eight discharges, it was pretty high turnover, even for our floor, and so it was a struggle, but I did have really, really good support from my team, and after it was all said and done, I learned a lot from it, but I also learned that I don’t want to be a charge nurse, ever, at this point in time. And I guess that the challenge was that it was just so sprung upon me and, you know, I wasn’t adequately prepared.”

In this particular scenario, nurses from neighboring units and the mentor stepped in to support the younger nurse. Still the nurse did not feel fully supported and expressed a degree of anxiety associated with the experience. And then this narrative was described by another participant:

Participant 4: “Well, that surgery was...I was by myself and the lady required an urgent C-section—she had pushed for two hours and the baby was showing signs of distress. The heartrate got really low and wasn’t coming back up. So it wasn’t a stat C-section, but an urgent C-section and really nothing with the surgery—we didn’t do anything wrong—there were just a lot of things that played into a disaster. Well, not really a disaster, but it definitely could have gone better... Uhmmm, so we had every specialty surgeon—I mean, I’ve never seen the OR so filled with so many people; like there were nine surgeons in that little cavity at one point, and I was just like, ‘Oh, my gosh!’ And I was standing there, and I

had ten years in emergency medicine. So I was standing there thinking, ‘I have no idea what’s going on, but when she codes, I know how to do CPR. I’ve got this!’ [nervous giggle] [Participant gave additional details related to patient that are not pertinent to this discussion...] So in the meantime...we’re giving blood like crazy; we called a Code O-neg—they didn’t bring any blood. Uhmmm, come to find out, you have to put it in the computer if you want blood—like lots of things were learned because of that, we were sending labs...she got an art line and we were getting labs off the art line like every ten minutes. And they weren’t running them stat, even though they were ordered stat. And like, [the surgeon] ordered platelets, but the hospital was out of platelets. And it ended up there was a unit of platelets in the hospital and [the patient] needed the platelets, but they wouldn’t give them to her, because they were holding them for a cancer patient. Her CBC was in the normal range, even though she was hemorrhaging, so the cancer patient got the platelets, instead of her and she needed the platelets. So it was just a really, really awful thing. So we done (sic) a rapid improvement event and changed policies and changed the lab policies on who gets platelets. ... Like the charge nurse was my preceptor in that situation, but she really didn’t offer as much guidance as I felt like a new nurse should have received.”

Whether through a lack of knowledge or loss of composure in a time of crisis, this NLRN did not seem to have adequate personnel support in the situation. When asked what could have been more helpful in this situation, the participant replied:

“Like, just someone to make sure that I was getting through my charting okay—we didn’t really have anyone—it was like a 10-hour surgery and no one really took a step back to say that the surgeon, that the anesthesiologist, that the nurse, haven’t left the room—like, they haven’t peed, they haven’t eaten. Like the surgeon, we were feeding her gummy bears...the surgeon’s blood sugar dropped in that situation. We were obviously providing care for the patient, but we weren’t providing care for ourselves.”

And another story of deteriorating conditions when no seasoned nurses were available was described by Participant 3:

“And I had to just deal with it on the spot—I had to end up telling this man on the phone that his wife had just passed. And so that was like kind of a cluster, not even close to the extreme of what he had to deal with, but I was kind of like petrified, there was blood just everywhere. I had never seen a code like that and we definitely weren’t prepared on our floor for anything like that.”

NLRNs expressed the desire to have seasoned nurses available for consultation and guidance in times of need. This need seemed to be distinct from the earlier discussion of relationships as built between the preceptors and the mentors. The discussion of seasoned nurses is more related to specific informational pieces such as how to order specific labs and get them performed “stat,” how to negotiate systems when things are not working in the favor of the patient, and how to notify family of adverse events. The lack of seasoned nurses also relates to systems functions as noted in the next theme related to organizational infrastructure.

Organizational systems related to NRPs. One emergent theme that arose from the data was the importance of organizational systems that impact NRP functions. Organizational systems are defined as structures, individuals, and processes within a society (in this case, a healthcare organization) that work interdependently to contribute to the functionality of that group, making it healthy or unhealthy (Stroh, 2015). Inherent within these systems, again noted as a healthcare organization, is an organizational culture that contributes to how new nurses are received and transitioned into the profession. Stroh (2015) further discusses systems as they are defined with language and stories that explain the complexity of problems. The participants in this study contributed rich dialogue to define the problems that they experienced within the NRPs.

Hierarchy and integration of activities. Among the participants at one location there were some criticisms related to the structural organization of the program and the role relationships of preceptors, mentors and nurse managers. Some participants indicated that at times disorganization existed in terms of the leadership within the NRP, contributing to confusion about meeting times. Based on stories of participants,

sometimes miscommunication about NRP activities may have triggered some discord between the units and the NLRNs, resulting in moderate distress for the NLRNs. As described by the participants, the organizational culture seemed inconsistent in terms of support related to the implementation of the NRP. While the NLRNs described a supportive and collegial environment in most situations, there existed a dissonance between the goals of the NRP and the needs of the unit in some situations.

At times, participants noted a sense of discord between unit and NRP related to the role expectations of the preceptor. NLRNs voiced a preference that the preceptor role be more included in the activities of the NRP, or at least have additional knowledge and understanding of the activities and scheduling of the NRP. None of the NLRNs in this study had preceptors who participated in any of the off-unit experiences ascribed to the NRP. Participants described this phenomenon in the following manner:

Participant 4: “To me, it’s like you do your orientation on the floor and the nurse residency program is, like, completely separate from that. It would be nice if [the orientation] was more involved in [the NRP]...maybe if your primary preceptor came with you—at least to the first one [meeting]. That would be beneficial, because my primary preceptor had no idea what nurse residency was. Because ... I missed four hours of the shift for the first meeting and she was like ‘Where have you been?’ And I [said], ‘At nurse residency,’ and she [said], ‘What’s that?’”

Participant 3: “I think for future nurse residency programs, the actual floor that you work on needs to be more involved in it and more incorporated, because they are completely separate from everything. I feel, at least for my manager, she was not involved in the process at all...I think that at least an experienced nurse or a manager or a specialist on your floor should be somehow incorporated in this [the NRP].”

Participant 6: [In response to: Did you also have what was termed as a preceptor?] “Yes! But that wasn’t really part of the nurse residency program. That was more just orientation. In hospital orientation, we were given a preceptor—a preceptor on days and a preceptor on nights.”

These NLRNs did not see the connection across the transition experience; none appeared to exist based on participant descriptions of the structure within the NRP. It seemed that the orientation with the preceptor and the NRP were on parallel tracks that never converged and this had meaning for the NLRN. Participants expressed that it might have been more meaningful to complete that circle, synergizing the process.

Accountability for commitment to the NRP. Two participants described a systems failure within their program that suggested a lack of support for the NRP participants or program. These comments related to some degree of disorganization or lack of communication within the program. The participants' observations are noted:

Participant 3: "The very first class we had, [the facilitator]—who used to be the educator for our floor—she was switching roles, and so I don't know if it fell off because of that or what happened, but like, no one ever took the facilitator role for our group... So it was like she was just kind of unorganized."

Participant 4: "I think, when this program first started, it was really unorganized, like with our cohort. We were supposed to have this facilitator, [but] I don't know who she is; I have never seen her; she never showed... Our first three [sessions], she was supposed to be here. And we would get here and the door was locked. We were locked out... So I just felt like it was completely unorganized... and embarrassing. One of the days, I was having to leave [the floor] during my [specified] training... So like, it wasn't even my department, and I had to leave that to come here to find a locked door with the lights out. And then there were a couple of times when the clinical director came in and apologized... and said, 'I'm sorry, we failed you.'"

The investigator notes that this instance was unique to one program and not described by other participants. The participants affected by the perceived disorganization seemed upset by the disruption to their transition experience. As described by Participant 4, she felt that the interruption caused by the failed meeting time interrupted her planned clinical experience for the day. She expressed discomfort related

to leaving the unit for a mandated classroom experience that did not happen as planned. Fortunately, this experience did not seem to be the norm, but it does point to the importance of solid infrastructure and administrative support from all aspects of NRP development.

Outcomes related to staffing issues. Staffing issues within the facilities also contributed to a lack of consistency in preceptor and resident pairing. While these conditions were not consistent across all of the narratives, cumulative results indicated a relevant issue in the discussion of NRP systems. In the emergence of a nursing shortage, a commitment to staffing levels that support the mission and goals of the NRP is imperative to success of the program. In conjunction with numbers of staff required to meet unit needs, nursing leaders must also ensure that qualified and seasoned nurses are in adequate supply to provide guidance to inexperienced nurses.

In some situations, NLRNs were required to step up to a level with which they felt uncomfortable, due to inadequate staffing. In spite of the NRP guidelines related to preceptor assignments or charge nurse roles, the NLRNs were placed in positions for which they felt unprepared. The NLRNs noted a sense of despair in that they saw no alternative to being placed in this position; or as one participant stated, “Sometimes you just have to do what you’re told...” While some degree of support from the NRP mentor was noted in one situation, another nurse stated that she did not feel supported. Another nurse shared that she reached a low point in the transition phase related to staffing shortages:

Participant 3: “When I had six high acuity patients on PCU and so did the rest of the staff on the floor [I questioned my decision to become a nurse]. I was pretty much done that day... We’ve had a lot of changes on that floor, so there have been some large staff ratios, but at that time I was

pretty much guaranteed to have no more than five patients on my workload and I didn't like going home knowing that I didn't do for my patients all that I could have done. So that's why I didn't like it [nursing] then."

Inexperienced nurses leading inexperienced nurses. Some study participants told the interviewer that they have been approached about becoming preceptors. Others have already been incorporated into roles as preceptors. As in the discussion of the NLRN who noted that she was "low man on the totem pole," these nurses find themselves in situations where they are now the most senior nurse in a given unit. The young nurses seem resigned to the fact that they must step into this role. The NLRNs rationalized that the need is so great, and they have just completed their residencies and feel that they have something to contribute to the process. The participants described it this way:

Participant 4: "I've been precepting people to that role...when they asked me to do it the first time...it was just an agency nurse who was just coming up there to see how we did things and I was like, 'Are you sure? Like isn't there anyone else?' And they were like, there really is no one else. But it was surprising to me that they asked."

Participant 6: "We've had a lot of people leave to go to other units. So they're not leaving the hospital; they're leaving the unit...the nurses that are remaining are a bunch of new grads. We really don't have...anyone to precept the new nurses we are hiring, so we have to help with the precepting and we've all been there less than a year."

Stories of this magnitude point to the serious impact that the nursing shortage seems to have on nurse transition. As baby-boomer nurses retire and nurses leave the acute care setting for other nursing opportunities, a significant void is being left with the need for rapid replacement from the pools of NLRNs who are coming out of nursing schools. In the settings within this study, that void combined with the influx of NLRNs

into the workforce, has created an environment of young, inexperienced nurses who are called upon to assist in the transition of other young, inexperienced nurses.

Use of young, newly transitioned nurses as preceptors points to the need for consistent training guidelines for preceptors. The participants expressed concerns about deficits in their professional role as they contemplate preceptor roles. The participants in the study also noted deficiencies in some of the young preceptors that they had witnessed on their units and in their training:

Participant 3: “Well, I didn’t have this type of preceptor, but I saw other people with preceptors that they just kind of let you do what you want to do and just follow along. And they kind of just feel like letting people do things more... independently...but then [the preceptors] don’t see when someone is doing something wrong and then [the NLRNs] don’t have the opportunity... maybe to learn the right way or maybe a better way to do something. So I think I would want a preceptor that would be there with me; and I want my independence—don’t get me wrong, but I feel like some of them let them go and do their independent things a lot sooner than they should.”

Participant 4: “...the charge nurse was my preceptor in that situation, but she really didn’t offer me as much guidance as I felt like a new nurse should have received.”

The preceptor may not have adequate training or predisposition to serve in the role. While the NLRNs liked having a guarded amount of autonomy, they recognized the need for direction by the preceptors. In order to accomplish safe and effective outcomes, NLRNs expressed the need for adequate feedback and coaching to ensure professional development.

Another point to be noted in the discussion of the charge nurse as preceptor is the prearranged assignment of preceptors. The investigator derived a sense that in some situations, intentional designation of the preceptor assignment was somewhat arbitrary.

In addition to the observation of Participant 4 above, a noted example came from the following discussion:

Participant 5: “Usually the charge nurse would say, ‘Okay, you can be with her...and are you okay with that?’”

[Later] “...it does occasionally happen where there’s like, one charge nurse who has like 3-5 years’ experience and then a bunch of brand new nurses.”

Random assignment of preceptors to NLRNs may detract from the purpose of the preceptor role. As noted in an earlier comment by one of the participants, the use of alternate preceptors seemed to promote inconsistent progression as preceptors strived to determine the level of competency for the NLRN transitioning into the professional role. When managed effectively, the preceptor can provide support to NLRNs through providing safety for patient care. NLRNs in the study expressed a desire for the preceptors to allow some degree of autonomy, extending the relationship as the NLRNs gradually become more independent and providing support in times of challenge. Preceptor training and assignments are relevant to the discussion of organizational systems that impact the NRP. Without clearly defined preceptors, the NLRNs do not meet their objectives effectively or efficiently.

The problems noted within organizational systems related to NRPs require in-depth systems analysis. Many systems have been implicated in discussions with the participants. Noted among these are individuals such as hospital leadership: CEOs, CFOs, and CNOs; human resources and nurse recruitment teams; strategic planning personnel; NRP leaders and developers; nurse managers; preceptors; unit staff; scheduling managers; nurse educators; community stakeholders and patient advocates;

and NLRNs. These individuals are among those who can evaluate the issues and apply systems thinking to promote improved methods and processes.

The concepts noted were identified by the NLRNs in the study as factors that had meaning for their transition in NRPs. Further interpretation of the data yielded the themes as noted. These themes are relevant to future study of NRPs as will be demonstrated in Chapter Five.

Summary

Chapter four has described the findings of the narratives delivered by NLRNs participating in the study. The interviewer looked at both factors within the NRP that NLRNs believe have meaning for their transition experience and work environment variables that NLRNs experience in various NRPs within acute care settings. Four primary themes emerged: Relationships, Reflection, Desire for Active Learning, Resources and Organizational Systems. Noted subthemes related to Relationships were Connectedness and Support; and a subtheme that was associated with Resources was Access to Experienced Nurses.

The NLRNs portrayed pictures of how relationships helped them to make connections with other nurses and other disciplines in a way that contributed to their learning and their professional transition. Relationships have been defined in this study as associations between two or more individuals established within a professional community for the purpose of providing support and connectedness for the less experienced individual within the association. The relationships that were forged between NLRNs and their preceptors contributed to their sense of confidence and

competence in the workplace. Connectedness was further identified in creating networking opportunities with other nurses, other disciplines and other units.

Very closely interrelated with the subtheme of connectedness is the concept of support. The distinctions between the two subthemes has been clearly outlined in this chapter. Early support was noted in experiences with faculty and with preceptors in academic practicums. In transition, NLRNs described supportive relationships that allowed them to explore their new roles and functions with a safety net provided by preceptors, mentors and other nursing personnel on their units. The participants in this study told of ways that participation in the NRPs helped them to “not feel alone” as they entered into the professional arena. The ability to share situations and feelings in the safe setting provided within the NRP cohort enabled NLRNs to gain a further sense of connection with peers and with mentors. The NLRNs also delineated some tough situations in which they did not perceive adequate support, related to various factors which were discovered in these discussions.

Reflective activities within the NRP were somewhat covert in the experiences of the NLRNs. One NLRN spoke of the reflection that occurred with simulation experiences and then later as mentors helped students to review their experiences with their preceptors. In this participant’s experience, guided reflection seemed tangible. Other students spoke of reflective activities such as sharing of case studies and floor experiences with opportunities for processing those situational activities, but did not actually refer to this as reflection. Still another student discussed debriefing activities after an incident that occurred in her work setting and referred to this as an avenue for learning how to be better prepared for similar circumstances in the future. NLRNs

seemed to experience the elements of reflection on practice, but in some cases, without apparent dialogue to promote further development of clinical judgment.

Another theme that developed in the narratives was the Desire for Active Learning. NLRNs spoke at length of the various activities in the NRP composition. They seemed most enthusiastic about those activities that produced active learning, such as simulation experiences or case studies, particularly those personal narrated stories shared by the mentors and instructors. The NLRNs in the study spoke often of the redundancy and repetitive quality of the didactic sessions, noting that they were reminiscent of lessons recently learned in the academic classroom. Active learning was also noted in the manner with which the preceptors approached teaching in the clinical setting. NLRNs noted a preference for those preceptors who allowed some degree of autonomy in carrying out nursing functions, while providing a safety net for the new nurses.

An additional theme identified in this study was that of Resources. Some NLRNs told of resources related to accessible knowledge in the clinical setting, such as access to policies and protocols. One discussed the use of NRP binders to gain quick access to facility-specific information that the new nurse needed in her early practice. Another NLRN spoke of the discussions of EBP in the workplace and the need to avail oneself of access to learning and to participation in quality studies. Some discussion also related to those items or resources that NLRNs felt were deficient in their clinical practice experiences. Some told of patient care related items not available in times of need. But the most significant discussion of resources was linked to the lack of available access to seasoned nurses and the subsequent impact on new nurses in their practice. Transitions

within the facilities and retirements of more experienced nurses seemed to create situations that made the NLRNs feel unsafe and insecure in their new roles.

The discussion of nursing shortage and the resultant lack of access to seasoned nurses was also implicated in the discussion of the final theme: Organizational Systems related to NRPs. Problems associated with organizational systems have been outlined as hierarchy and integration of activities, accountability for commitment to the NRP, outcomes related to staffing issues, and “the blind leading the blind.” These problems point to the need for further analysis of systems that contribute to the outcomes (positive and negative) of NRPs. The importance of engaging key stakeholders in the evaluation of systems will be further explored in Chapter five.

Chapter five demonstrates how the findings in this study are consistent with some earlier studies with nuances related to the individualized experiences of the participants in the study. The meanings credited to specific elements within the NRPs by the participants also have implications for education and practice related to TTP. The results also point to implications for further research which will be discussed in the final chapter.

Chapter Five: Discussion

Complexity of nursing care and the increased demand for nurses imposed by the needs of an aging society requires that nurses can transition to practice in a seamless and efficient manner. The transition period can be traumatic and hazardous with poor patient outcomes as new nurses (Spector et al., 2015) undertake their new professional roles in a real-life setting. NRPs have been identified as a means to assist NLRNs transition into practice. The *Future of Nursing Report* (IOM, 2010) calls for participation in transition programs to improve nurse retention, job satisfaction, and patient outcomes. NRPs vary across the country in design and outcomes. Outcomes related to participation in NRPs are inconsistently measured due to this variability and poorly defined concepts (Barnett et al., 2014). In order to better understand the effectiveness of NRPs on nurses' transition to practice, the profession must understand the complexities of nurse development into the professional role and the elements of transition that have meaning for NLRNs.

The study question in this qualitative study was "What factors have meaning for NLRNs who have experienced transition to practice in nurse residency programs in acute care settings?" The results of the study have identified factors that have meaning for the NLRN in the transition experience and variables in the workplace that impact that experience. Five main concepts identified through interpretative phenomenological analysis of themes were noted as: Relationships (connectedness and support), Reflection, Desire for Active Learning, Resources (more specifically, access to experienced nurses), and Organizational Infrastructure.

Findings Reviewed in Context of the Current Literature

After data collection, the researcher returned to the literature to further develop concepts identified during data collection. This enabled the researcher to contextualize findings from the data by denoting what has been identified in prior studies that may support or conflict with current findings (Braun & Clarke, 2013). The final literature review also helped to further concept analysis and definition (Rodgers & Knafl, 2000). Table 5.1 summarizes the attributes, antecedents and consequences associated with the meaningful factors identified in this study in an effort to establish conceptualization of those factors.

Table 5.1 Conceptualization of Factors Identified in Study

Concept	Antecedents (according to literature)	Antecedents (identified in study)	Consequences/Outcomes (according to literature)	Consequences/Outcomes (identified in study)
<p><i>Relationships</i> -Preceptor</p> <p><u>Attributes</u> Clinical coach Support Safety net</p>	<p>Ability to teach Good communication skills Nurturing attitude Knowledgeable Experienced Helpful Personable Informative Support (Moore & Cagle, 2012; Blegan et al., 2015; Spiva et al., 2013)</p>	<p>“Excited” to be in the role Expressed friendship Encouraged interactions with others (intra- and interdisciplinary) Provided networking opportunities Skills coaching Assessment of learning Promoted ease in seeking help</p>	<p>Increased self-perceived competence Increased confidence Increased job satisfaction Improved safe practices Autonomous practice (Moore & Cagle, 2012; Blegan et al., 2015; Spiva et al., 2013)</p>	<p>Improved self-perceived competence (Desire to serve as a preceptor for newer nurses declared by some) Increased job satisfaction Networking connections— intra- and interdisciplinary noted Autonomous practice with some degree of support</p>
<p><i>Relationships</i> -Mentor</p> <p><u>Attributes</u> Facilitator Instructor Support Connectedness Sponsor of nursing</p>	<p>Provides guidance and support in classroom/clinical settings Facilitates learning sessions Provides expertise Promotes clinical reasoning Acts as a clinical resource Links to other resources (AACN, 2015; Kramer et al., 2013; Olson-Sitki, 2012; Remillard, 2013)</p>	<p>Perceived as “instructors” Facilitated passive/active learning Anticipated concerns/needs Available even when not physically present Offered opportunities for reflection Promoted professional role development</p>	<p>Guided reflection Clinical reasoning Professionalism/leadership Networking (Kramer et al., 2013; Olson-Sitki, 2012; Remillard, 2013)</p>	<p>Reflection reported within the groups; debriefing Interest in professional development, potential leadership positions Networking</p>

Concept	Antecedents (according to literature)	Antecedents (identified in study)	Consequences/Outcomes (according to literature)	Consequences/Outcomes (identified in study)
<p><i>Relationships</i> -Unit staff</p> <p><u>Attributes</u> Nurturing;helpful Present</p>	<p>Acceptance by care team Good role models (Craig et al., 2012)</p> <p>Peer support (Olson-Sitki et al., 2012; Spiva et al. 2013)</p>	<p>Informal relationships Preceptor involvement to promote interactions with others</p>	<p>Positive feedback “Part of the team” (Craig et al., 2012)</p> <p>Supportive environment (Olson-Sitki et al., 2012; Spiva et al., 2013)</p>	<p>Supportive environment Interdisciplinary connections</p>
<p><i>Relationships</i> -Cohort</p> <p><u>Attributes</u> Entry-level nurses Connectedness</p>	<p>Similar but distinct backgrounds New to facility/nursing Fear of making mistakes Mutual concerns/stressors (Craig et al., 2012; Olson-Sitki et al.; Myers et al., 2010)</p>	<p>Bonding with others in group Common fears/concerns Sense of “not being alone” Building relationships Sharing of experiences/solutions Good support system Making connections</p>	<p>Socialization Expressed feelings of “normality” Opportunity to share struggles Comforting Interchange of ideas (Craig et al., 2012; Olson- Sitki et al.; Myers et al., 2010)</p>	<p>Forming connections with others; socialization Feelings of normalcy Opportunity to share struggles Comforting Interchange of ideas</p>
<p><i>Reflection</i></p> <p><u>Attributes</u> Guided reflection Reflection-in- action Reflection-on- action Critical reasoning Integration of knowledge with experience</p>	<p>Intentional review of situations within practice Exploration of experience with analysis of thoughts/feelings (Sherwood & Horton- Deutsch, 2012)</p> <p>Facilitated debriefing (Trepanier et al., 2012)</p> <p>Feedback with reflection (Spector et al., 2015)</p>	<p>Sharing with cohort Examining situations Debriefing after critical situation Adequate feedback from preceptors</p>	<p>Transformative learning Adaptive knowledge Application of learning to new situations (Benner et al., 2010; Sherwood & Horton- Deutsch, 2012)</p>	<p>Opportunities within cohort groups to examine work experiences and reflect on practice for future action Debriefing</p>

Concept	Antecedents (according to literature)	Antecedents (identified in study)	Consequences/Outcomes (according to literature)	Consequences/Outcomes (identified in study)
<p><i>Desire for Active Learning</i></p> <p><u>Attributes</u> Experiential learning Learning in context Problem-based Learning</p>	<p>Situated cognition Simulated experiences Integration of clinical/classroom Use of unfolding case studies</p> <p>(Benner et al., 2010; Beyea, Slattery, & von Reyn, 2010; Lioce et al., 2015)</p>	<p>Simulation Off-unit experiences or looping; presenting those findings Learning at bedside with preceptor and other staff</p>	<p>Critical thinking Clinical reasoning/judgment Ethical development</p> <p>(Benner et al., 2010; Beyea, Slattery, von Reyn, 2010; Lioce et al., 2015)</p>	<p>Situated cognition Learning in a safe environment Promoted critical thinking</p>
<p><i>Resources</i></p> <p><u>Attributes</u> Informational resources Physical resources Access to seasoned nurses</p>	<p>Program oversight/delivery Learning resources/affiliations and partnerships Organizational components: Work schedule Staffing ratios/workload Infrastructure</p> <p>(Bratt, 2013; Kramer et al., 2012)</p>	<p>Information related to policies and procedures for quality patient care Access to needed physical resources (i.e., blood products, hazmat items for blood spill, etc.) Access to knowledgeable, seasoned nurses</p>	<p>Safer, quality patient care Reduced work stress Increased job satisfaction</p> <p>(Bratt, 2013; Kramer et al., 2012)</p>	<p>Access to information which contributed to safe and quality patient care Access to materials and services needed for patient care At times, noted limited access to knowledgeable, seasoned nurses</p>

Concept	Antecedents (according to literature)	Antecedents (identified in study)	Consequences/Outcomes (according to literature)	Consequences/Outcomes (identified in study)
<p><i>Organizational Systems Related to NRPs</i></p> <p><u>Attributes</u> Stakeholder buy-in (including all levels of nursing leadership and staff nurses) Financial/human resource allocation Planning team/coordinator with clearly defined roles Accountability for program deliverables Comprehensive evaluation plan Strategic planning Systems thinking (Stroh, 2015)</p>	<p>Involvement of strategic administrators/educators/frontline staff Strategic scheduling to allow full participation Clear expectations of all Capitalization of partnerships/networks Access to learning technologies Collaboration with academic partners Training of preceptors/coaches/mentors Evidence-based design (Bratt, 2013)</p> <p>Clear delineation of preceptor obligations/responsibilities to NLRNs Partnerships with academia Simulation use Formal mentoring beyond the NRP experience (Spiva et al., 2013)</p> <p>Support for NLRN preceptors Shared shift and patient assignments for NLRN/preceptor (Blegan et al., 2015)</p>	<p>Identified need for bridging the experience to include nurse managers, preceptors, and unit staff in the NRP loop Identified need for specific roles for preceptors, coaches and mentors Identified need for training for all involved to enhance the experience Identified need for specific shared assignments for residents/preceptors Identified need for communication with all parties involved in NRP</p>	<p>Avoidance of obstacles in the NRP Cultures of nurse retention and quality care Transformation of work environments Mitigation of reality shock (Bratt, 2013)</p> <p>NLRNs report a more positive experience with nurse transition NLRN self-perceived improvement in skills, decision-making, time management, communication Stronger commitment to organization (Spiva et al., 2013)</p> <p>In hospitals with high preceptor support: Improved self-perceived NLRN competence and confidence Improved retention Both preceptors and NLRNs rated experience higher (Blegan et al., 2015)</p>	<p>Narratives indicated higher satisfaction among nurses with closer preceptor relationships and more consistent scheduling strategies Administrative support was not consistently available (this was only noted in one facility): examples, facilitator did not show for meetings; appearance of lack of communication between NRP and preceptors or managers; random assignment of preceptors with disruptions to the NLRN transition experience; apparent limited support for preceptors; lack of NLRN access to seasoned nurses.</p>

Relationships promote connectedness and support. NRPs in this study seemed very proficient at helping the NLRNs to develop new relationships and this was meaningful for the new nurses in two identified ways: connectedness and support. Connectedness with preceptors, mentors, peers, and other healthcare providers helped the new nurses to gain confidence and understanding of the professional role. Anderson, Hair & Toderò (2012) noted the importance of identifying appropriate preceptor matches to improve NLRN self-image, to promote new nurse performance behaviors, and to impact the organization through improved retention and satisfaction of new nurses. The concept of connectedness in the current NRP study also enabled participants to develop affiliations with other individuals beyond the limitations within the NRP.

Supportive relationships occurred within the clinical environment in interactions with preceptors and mentors in this study. NLRNs described these relationships as most supportive when the preceptor created an environment conducive to learning with supported autonomy, while providing safety for the NLRN in the new practice role. In a study by Moore and Cagle (2012), participants also noted the importance of the preceptor as a guardian of safety within the transition experience. Much like the nurses in the current NRP study, those new nurses found graduated independence within practice supportive of building confidence and competence while supported by a safety net provided by the preceptor. Myers et al. (2012) identified one of the concerns of NLRNs as “figuring out” who to go to for information and how to access needed resources (p. 166). Craig, Moscato and Moyce (2012) noted the greatest concerns of NLRNs were related to safety: ability to handle unexpected crises, fear of missing a critical aspect of patients’ needs, inability to provide safe care, and fear of making mistakes. As NLRNs

became more independent in their roles, sustained relationships with preceptors promoted interactions that helped the NLRNs to practice effectively and safely. Having a preceptor who provides a cushion of patient safety and opportunity to build critical thinking skills with supportive back-up is important to new nurses.

NLRNs in the current NRP study noted the importance of the preceptor in helping to promote their confidence and competence in the workplace. The preceptor role was defined by the Commission on Collegiate Nursing Education (CCNE) (2015) as “An experienced practitioner who facilitates and guides residents’ clinical learning experiences in the preceptor’s area of practice expertise” (p. 25). The NCSBN study related to preceptor support noted higher rates of self-perceived and preceptor-identified competence among NLRNs in hospitals that gave high preceptor support. Higher preceptor support was evidenced in the study through reduction in clinical assignments, coordinated scheduling of preceptor and NLRN, shared patient assignments between the dyad, and low numbers of NLRNs assigned to each preceptor (Blegen et al., 2015). NLRNs in this study evaluated the preceptor related to concepts such as time spent with the NLRN, support, continuity, feedback, determining patient priorities, NLRN learning from errors and development of clinical reasoning. Spiva et al. (2013) noted preceptor qualities that contributed to the effectiveness of the preceptor in assisting to transform the new nurses. These qualities were listed as ability to teach, good communication skills, nurturing attitude, knowledgeable, experienced, helpful, personable, informative and supportive. Spiva also reported the importance of strong preceptor relationships in the development of NLRN confidence and competence. Kramer et al. (2013) noted the importance of the preceptor role for providing feedback to support self-confidence in the

NLRN. Participants in the Kramer study similarly subscribed to the correlation between emotional connection with preceptors and NLRNs' perception of competence. This is similar to the findings of Roth and Johnson (2011) who found that ratings of the nurse-preceptor relationship were positively correlated with new nurse perception of competence. These aspects of the preceptor relationship were demonstrated in narratives by the participants in the current NRP study.

Mentors or instructors within the NRPs in this study also demonstrated supportive roles in the development of the new nurses. For this study, the definition of a mentor is an experienced nurse who “helps the new nurse to develop as a professional, assists transition into the professional setting, provides constructive feedback and helps to work through difficult situations” (Remillard, 2013, p. 81); one who facilitates learning sessions. The CCNE (2015) description for this role is Resident Facilitator and is defined as “an experienced registered nurse with a baccalaureate or graduate degree in nursing who guides and supports nurse residents in classroom and clinical settings to achieve the goals of the nurse residency program. Other roles of mentors may include, but are not limited to, providing expertise to develop residents' clinical judgment and decision-making, reviewing clinical narratives to further develop residents' nursing practice, and acting as a clinical resource” (CCNE, 2015, p.26). The roles of mentors within the NRP study has been fully described in Chapter Four and closely emulates the definition as noted. The mentors in the study acted in a consulting and supportive role while acting as facilitators within the groups and providing an off-unit resource for each NLRN.

Remillard (2013) distinguishes between preceptors and mentors in the following manner: the nurse mentor contributes to the professional development of the nurse by

assisting with transition and constructive feedback, while providing support in difficult circumstances. Preceptors, on the other hand, are more closely linked to clinical orientation and the policy and procedural aspects of the clinical setting. NLRNs in the NRP study seemed to validate this description of the mentor and preceptor roles within their programs.

NLRNs in the current study expressed the common idea of shared experience with others in the cohort. This is consistent with the findings of Olson-Sitki, Wendler and Forbes (2012). In that study, nurses also expressed the theme of “I see that I am not the only one.” This was repeated several times among the NLRN participants in the current study. NLRNs seemed to draw a sense of security from being able to identify with peers within their cohorts and their mutual experiences. Peer support and connections within the NRP sessions were important, as most participants noted that without the NRP, they would not have had opportunity to interact with other NLRNs. Peer relationships were supportive and demonstrated connectedness, as the NLRNs identified that others were having similar experiences to their own.

In other discussions of support and connectedness, the participants in the study noted interactions with other staff on the nursing units. The NLRNs conveyed that the relationships garnered with other nursing staff helped them to overcome some difficult times in their transition. This was evidenced during times of feeling overwhelmed or upset by the circumstances surrounding their workday. References to interdisciplinary relationships indicated that NLRNs also valued the ability to rely on physicians, physical and respiratory therapists to support their needs on the floor. These relationships helped the young nurses to better understand their roles within the health care system.

Reflection. Reflection seemed inherent in the discussions of experiences by participants in the current NRP study. However, it seemed to be a poorly defined and covert concept for the NLRNs. Reflection-on-action is defined as “a retrospective process that occurs after an incident with the aim of making sense and using process outcomes to influence future actions” (Sherwood & Horton-Deutsch, 2012, p. 9). Participants in this study seemed to articulate the functions of reflection without outwardly addressing it as a concept. Sherwood and Horton-Deutsch (2012) discuss reflective learning as a mindful event designed to associate recent experiences with more complex representation of events in an effort to promote higher-level thinking skills. This process occurs through increased awareness of surroundings and relationships through an intentional thought process (Sherwood & Horton-Deutsch, 2012). These authors relate reflection to patient outcomes in terms of teaching the NLRNs about quality and safety practices. Trepanier et al. (2012) discussed the use of facilitated debriefing as a means to promote critical thinking and clinical reasoning. Goode et al. (2013) list opportunities for professional reflection as a key element in the NRP curriculum. In the most recent study of transition to practice, Spector et al. (2015) cited the importance of feedback from preceptors with opportunity for reflection as a means of developing new nurses. While participants in the current study described some activities that promoted reflection on practice, most were not cognizant of the process which may hinder further reflection in future scenarios.

Benner et al. (2010) describe the process of reflection as transformative in the development of the new nurse and refer to the importance of developing a questioning mind through reflective learning. Reflective learning takes into account the unfolding

situations that can escape the understanding of the new nurse. NLRNs often require a process by which to review and place into context factors within their experiences. This reflective process should begin in the academic setting, but must be bridged into the professional practice of the NLRN.

The CCNE (2015) standards for accreditation of entry-to-practice nurse residency programs call for evidence of reflective activities to demonstrate compliance with all elements of the NRP curriculum. One suggested method for demonstrating this standard is an activity known as clinical narratives. This activity helps to promote reflection on practice through written narratives utilizing nursing process and critical thinking skills, allowing the NLRNs to process situations in a meaningful way. Higher level learning occurs as NLRNs consciously process the factors within experiences in their clinical practice (CCNE, 2015). No such intentional activity was described in the NRPs in the study based on participants' narratives.

Desire for active learning. Active learning opportunities were described by NLRNs in the current NRP study as significantly important to their transition. In deference to the didactic sessions, participants expressed a preference for active learning sessions. NLRNs deemed the lectures or presentations redundant, too much like being back in the academic classroom, and repetitive of academic studies. NLRNs in this study noted that they learned best from the simulation activities, case studies and other active clinical events that allowed them to think critically. In a study discussing the outcomes of clinical simulation in a NRP, Beyea, Slattery, and von Reyn (2010) noted significant increases in NLRN confidence, competence and readiness for practice. The importance that NLRNs placed on active learning is consistent with the emphasis on situated

cognition that Benner et al. (2010) promote in discussion of transformational educational activities.

Some of the NLRNs told of how they “froze” when faced with their first simulated patient scenario in the clinical education classroom during their early phase of the NRP. They expressed relief to get this initial experience in the presence of their mentors behind them, and described the anxiety that occurred in that setting. One of the NLRN participants in the study noted that her preceptor said to her on the first day, “Now you are the nurse...” and the NLRN noted incredulity at the idea. Active learning whether in the classroom setting or on the unit in practice helped to push the participants into realization of their role, mobilizing them as they began their professional practice.

NLRNs in the NRP study described limited experience in the academic lab setting with problem-based learning presented in a realistic manner. Some participants in the study noted simulations that focused on specific skills attainment in both academic settings and in competency assessments within their specific units. The NLRNs noted that these simulations did not extend to critical thinking scenarios. Recent updates to the standards of best practices with simulation (Lioce et al., 2015) stress the importance of clinical progression within the scenarios to meet learning objectives. In evaluation of the results of simulation used in an NRP, Beyea et al. (2010) noted outcomes related to early discovery and remediation of problems, identification of problem employees with resolutions, and higher retention related to greater job satisfaction of employees. NLRNs in the Beyea study benefited from enhanced simulation activities to promote critical thinking and problem-solving.

Instructional resources needed by NLRNs. “Resources” was another theme identified in the NRP study. The NLRNs in the study indicated a need for ready access to information related to protocols for care. Some still relied closely on the rules and checklists that provided a means for fact-checking. Other resource issues related to needed items to provide safe and effective care. Inaccessible patient care supplies and services was at times linked to the NLRNs inexperience or lack of knowledge about hospital systems. In times of crisis situations, resource access became critical lending itself to chaotic events within the experience as described by the participants.

The discussion of inadequate resources leads to the most important resource that NLRNs deemed inaccessible in some situations—seasoned nurses. Narratives demonstrated that the nursing shortage has impacted nurse transition in a way that was not anticipated at the beginning of this study. In some circumstances, NLRNs do not have access to seasoned nurses in their clinical settings. Whether due to attrition, transfers, illness or other circumstances, many of the NLRNs in this study spoke of situations that were impacted because they did not have adequate support due to staffing shortages on their units. Most of the nurses in the study had served in a preceptor role or charge position already, even though they were just completing their first year. Others indicated that they had been asked to precept or take charge within their units while still in the NRP.

The current nursing shortage was predicted in a discussion of workforce (Staiger et al., 2012) related to the economic impact of the national recession in 2007-2008. As the economy returned to baseline, the authors projected that registered nurses who had postponed projected retirements due to the recession would begin to exit the workforce in

large numbers. The anticipated shortage was projected to create increased demand for nurses coupled with improved access to healthcare for millions of Americans and increased health needs of an aging population (Staiger et al., 2012). The predictive model indicated a shortage beginning between 2010 and 2015, with significant decreases in nursing workforce occurring closer toward the end of the decade around 2020. Based on the narratives of the participants in this study, that more significant nursing shortage appears to be approaching with a strong influence on how nurses transition into practice.

Organizational systems. Nurses in this study noted the importance of the organizational systems of the hospital as it related to the development and support of the NRP. While all concerns were not specified at all sites, there was enough data to suggest a review of system practices and the organizational cultural atmosphere inherent in NRP development and sustaining forces. Problems were noted by participants that suggested a need for evaluation of systems inherent in NRP development and management.

Examples of non-support given by the participants occurred when preceptors did not understand the goals and activities within the NRP and when staffing shortages constrained the progress of goals. Indicators suggested that preceptors needed additional training and support to ensure a positive experience for nurses in transition. Assignments of preceptors to preceptees did not seem to be consistent or made purposefully in all NRPs. And participants from one facility identified a need for greater communication between all areas of the NRP. Spector and Echternacht (2010) established the need for institutional support for the NRP for the full first year of new nurse transition to practice. Bratt (2013) further noted the importance of full institutional support when discussing best practices in NRP programs.

Bratt (2013) prepared an analysis of best organizational practices for developing NRPs. She emphasized the importance of resource allocation and support from all stakeholders including administrative personnel, educators, human resources and unit staff. She noted that buy-in from all parties involved is instrumental in developing a solid framework for the NRP. Bratt (2013) further suggested capitalizing on existing partnerships with larger health care systems and academic colleagues to ensure the best experience.

Much has been written about the importance of preceptor selection, training and continued support. Alspach (2000) and Ortiz (2015) provided guidelines for training and support of preceptors in the critical care setting. Subsequent studies related to preceptors in nurse transition suggest that preceptors and mentors must have clearly-defined expectations with specified roles in the NRP environment (Blegan et al., 2015; Bratt, 2013; Olson-Sitki, 2012; Spiva et al., 2013). Bratt (2013) pointed to the importance of careful recruitment and selection of preceptors, with face-to-face training to outline the organizational goals related to the NRP. Blegan et al. (2015) denoted the importance of shared shift and patient assignments, which eliminates the confusion of what has been accomplished and promotes a better experience for the NLRN. The Blegan study also recommended specified time for the preceptor to assess, guide and evaluate each NLRN, along with fewer preceptees per preceptor. Such practices could be utilized to reduce or eliminate the confusion and disruptive practices described in the current NRP study.

NLRNs who participated in this study expressed a desire for a more integrated experience between the activities within the NRP and their preceptors. At times the participants noted some confusion among preceptors and managers related to the

activities of the NRP. Bratt (2013) suggested means to keep preceptors engaged and informed of NRP events. She encouraged regular meetings between the preceptors and the coordinator of the NRP, along with informational newsletters to detail the upcoming events associated with the cohort. The organizational infrastructure should have mechanisms in place to ensure that all parties are well-informed and to hold accountable those individuals who are charged with the functions of the NRP.

The lack of available nursing staff to support the program was inherent at some sites in the NRP study. This data is not supported in the literature to date. The dawning nursing shortage which seems to be emerging across the country may be impacting the availability of experienced nurses to support NLRNs in transition. Bratt (2013) stressed that human capital is as important as financial capital when planning a program. Hospital administrations must be supportive of NRP goals and make human infrastructure a priority to ensure that those goals are accomplished. Evaluation of programs must inform further quality initiatives to improve the function of the NRP.

In a systems thinking approach, Stroh (2015, location 3134) notes the importance of assessing all systems using the following evaluative process:

- Set realistic goals
- Define clear key indicators and metrics
- Think differently about the short and the long term
- Look for consequences along multiple dimensions
- Commit to continuous learning.

It is imperative that nursing leaders include all key stakeholders in the systems evaluation. Evaluation must be conducted in an ongoing manner. One finite method for determining the evaluation priorities would be to utilize the standards established by the CCNE (2015) to ensure that all systems are effectively analyzed. CCNE (2015) clearly

delineates the systems and processes that are deemed best practices in NRPs. The standards note elements associated with program delivery, program quality (institutional commitment, resources, and curriculum), and program effectiveness (assessment and achievement of program outcomes).

Implications for Education and Practice

The concepts identified based on factors that are meaningful to NLRNs in NRPs in acute care settings hold implications for the most effective methods to transition new nurses into practice. The challenges identified within this study point to some interesting ways in which education and practice can collaborate to enhance professional development of new nurses. Recommendations of the IOM (2010) that support nurse residency programs call for the development of a model that works consistently for all stakeholders. Participants in the current NRP study have identified concepts within their programs that held meaning for them and the implications of those meanings are noted.

Selection and training of preceptors. Participants in this study have validated the importance of solid relationships with preceptors. Preceptors need to be selected very carefully. Not only must preceptors be clinical experts in their fields, but they must also demonstrate qualities of nurturing and caring for new nurses. NLRNs in the study denoted the importance of feedback in a caring manner to help guide reflection on practice. Other studies have also demonstrated the correlation between caring, nurturing behaviors of preceptors and the confidence and competence levels of NLRNs (Blegan et al., 2015; Spiva et al., 2013). Preceptors should be trained for this important new role to ensure effective assessment and feedback for the NLRNs. Best practices have been

defined for training of preceptors which include the elements of caring behaviors (Alspach, 2000; Myrick & Yonge, 2003; Ortaliz, 2015).

The first finding in the study pointed to the importance of preceptor relationships for support and connectedness. The literature related to preceptors indicated a need for consistent preceptor criteria (Blegan et al., 2015; Moore & Cagle, 2012; Spiva et al., 2012; Spector et al., 2015). Preceptors should be selected with the overall mission and vision of the facility in mind. When selecting preceptors for academic residencies, clinical nurse educators must collaborate with nurse leaders in the care settings to determine that preceptors are a good fit for the student. The concept of fit with relation to preceptors is identified by those preceptors who affirm the values of the institution, model best practices in nursing, and engage in dialogue with new nurses to support future clinical success (Moore & Cagle, 2012). The researchers suggest that true fit can be established through preceptor assessment. Moore and Cagle (2012) noted the importance of creating a personal fit within the dyads to establish a sense of being a part of the professional community for the student or the new graduate. Preceptors hold a significant responsibility in forming the new nurse into a competent nurse, but also in socialization of the new nurse to the practice community. During the selection phase, preceptors must be screened for certain characteristics that predict successful relationships. Moore and Cagle noted the following characteristics inherent in exemplary preceptor relationships: “a passion for teaching...optimal listening skills and respect for new nurses’ learning...know[ledge of] workplace resources...and expert clinical practice and thinking skills” (p. 562). In the Moore study, noted importance was placed on preceptors holding NLRNs accountable for learning and encouragement of reflective

thinking to promote development, similar to the ideas expressed by participants in the NRP study.

Academic residency programs utilize preceptors in hospital settings. This approach provides an opportunity to work closely with these practice partners to bridge the training needs for preceptors. Nurse educators have a vested interest in determining that preceptors are well-prepared and should be actively involved in the preparation of new nurse preceptors to improve effectiveness of those preceptors. This collaboration helps to create a connection between the academic needs and the socialization needs of students initially, and then later of NLRNs. Objectives for training should address significance of the preceptor role, characteristics of clinical nurse leaders, adult learning theory, experiential learning, interpersonal relationships and evaluation (Ortiz, 2015). Nurse educators are equipped to guide this interaction between student and preceptor which will ultimately translate into well-prepared preceptors and enhanced relationships with NLRNs as they transition into practice.

Mentor relationships are also important to NLRNs and similar details have been noted with regard to mentors as with preceptors. Mentors, also noted as facilitators or instructors, are generally nurse leaders or nurse educators within the hospital settings. Initially, these relationships may resemble a formal mentoring model, but may later evolve into a more informal model as NLRNs develop other relationships in their practice setting. Moore and Cagle (2012) noted the importance of the clinical educator role within the NRP structure and advised similar guidelines for selection of these individuals. However, the emphasis of most NRP literature and the prominence of the discussion within the NRP study focused on the relationship with the preceptor. While the mentors

guide the activities within the NRP, the preceptors are more closely engaged in the day-to-day learning of the NLRNs and seem to have a more significant role in their development and transition. Therefore, primary attention is devoted to the role of the preceptor in NLRN transition to practice. Further discussion related to the preceptor and mentor roles will be discussed in the section related to structure of NRP systems.

Active learning with opportunities for reflection. Participants in the current study showed a distinct preference for active learning strategies. Whether through simulation, guided practice at bedside or shadowing within specific units, the nurses seemed to glean more from activities that required them to think and produce an outcome. Nurse educators and clinical practice partners must collaborate to create a learning experience that enhances clinical reasoning. Educators must utilize lifelike simulations and design clinical experiences with measurable objectives to better prepare students for the realities of the clinical workplace and promote quality patient care. Facilitators within residency programs can utilize simulation experiences to assess learning needs of NLRNs and to establish higher level learning needs prior to placing NLRNs in high-stakes practice environments. A concentrated effort between education and practice can promote better transition for new nurses.

Carefully designed clinical and simulation experiences promote reflection on practice. Reflection on practice is an effective tool to help students and NLRNs develop self-awareness and clinical reasoning practices. Both education and practice need to promote higher learning experience through intentional reflective thought processes. In education, faculty may rely on care planning and the nursing process while omitting guided opportunities for reflection. This omission may carry over into the transition to

practice setting, where NLRNs may not glean as much from the experience without opportunities for intentional reflection. Healthcare organizations need to reconsider the impact of providing opportunities for guided reflection within NRP activities. This strategy may help to develop reflective practices which the nurse carries into the practice setting.

In the academic setting students can benefit from graduated problem-based learning activities. The participants in this study referred to a lack of scenarios demonstrating critical or “crisis simulations” in the academic setting. It is better to test the developing nurses’ response to critical situations in a controlled setting without potential for harm than in a real-life situation. By gradually increasing the acuity level of learning scenarios and utilizing debriefing appropriately in academic settings, faculty can help to gradually advance students from novices to advanced beginners (Benner, 1984). Using simulated experiences in transition, NRP faculty can help to further advance NLRNs and promote higher thought processes. A collaborative effort in active learning scenarios between education and practice can help ease the transition for NLRNs. Practice nurses can contribute significantly to the development of meaningful scenarios to help students expand their horizons and to prepare them for the demanding aspects of clinical practice.

Organizational systems related to NRPs. Multiple systems within a hospital organization are required for successful implementation of a NRP. Bratt (2013) noted the importance of stakeholder buy-in from the top down within a given organization. Participants in the NRP study noted concerns with specific systems that impacted their development. Among those factors were information systems, integration of various

elements of the programs, scheduling systems related to preceptor roles and time allotment, and staffing issues.

Information access. NLRNs in the NRP study noted the importance of easy access to information in the hospital setting. Information needs included facts related to medications and treatments, policies and procedures within the setting, and other patient care data. While some nursing schools utilize point-of-care information systems in a personal electronic device at bedside, the NLRNs in this study had not utilized such technology. One NLRN within a given facility described a system that was composed of an electronic board in patient rooms that enabled patients, visitors and caregivers to access key information at bedside related to patient care and staff assigned to that room. This technology was maintained through the unit computer system and updated by support staff at the desk; the electronic board replaced the typical whiteboard that is commonly used in hospital rooms for this purpose. However, most of the nurses in the study did not have access to electronic information systems at bedside and relied on some paper source of information, such as a notebook, manual, drug book, or other source.

When appraising resources that contribute to the need for easy access to information, hospital leaders might consider an electronic reference system such as those used to access quick information at point of care in educational settings. Current digital tools on the market provide immediate access to reference materials such as pharmacology information, clinical laboratory values, assessment information, and other relevant clinical references. Customized programs may allow for facility-specific data, such as policies and procedures, to be uploaded for immediate retrieval on the unit or at bedside. Many of today's students are accustomed to having information readily

available through informatics systems while in nursing school. Such systems packages are renewable for a fee after graduation. Hospitals could purchase a site license to enable all nursing staff access to this information. This enables new nurses to receive real-time information from updated resources. Most hospital database systems may already have needed information related to patient care policies and procedures built into the organization's computer system to allow easy access for health care staff.

Ready access to pertinent information for patient care is essential to new nurses. Such information contributes to safe and efficient patient care. Consistency in delivery of information promotes satisfaction among nursing staff.

Integration of NRP components. Organizational infrastructure issues related to NRP structure and function identified in the study contributed to a lack of integration of NRP activities. Descriptions of preceptors not knowing about scheduled NRP activities and facilitators who did not show up for scheduled sessions demonstrated a lack of organization within the NRP structure. Reports of these behaviors were isolated to one facility within the study, but have implications for NRPs. Bratt (2013) signified the importance of stakeholder buy-in at all levels. If preceptors, mentors, facilitators, nurse managers and nursing staff are not in tune with the mechanisms of the NRP, the level of commitment to the goals of nurse transition is diminished. Bratt suggested one-on-one dialogue with all involved to ensure that the team maintains consistency and is successful in supporting the NLRN.

Resource allocation. Administrative commitment is necessary to ensure adequate financial and human resource capital to accomplish the goals of the NRP. Blegan et al. (2015) noted the importance of shared shift assignments and patient care assignments

when teaming preceptor-NLRN dyads. Protection of the preceptor-NLRN relationship did not always occur in the NRP study. Disruptions in the continuity of the transition experience seemed to be a normal occurrence in the study due to lack of staff. Not only was the flow of learning disrupted, but preceptors were not afforded the time for assessment of learning, for guiding the new graduate through new or difficult procedures or for evaluation of NLRN progress as recommended by Bratt (2013). Random assignment of preceptors also did not allow time for adequate psychosocial support for the NLRNs. When alternate preceptors were used in the NRP, there did not seem to be a system for changeover with shared information about the NLRNs progress to date. Assurance of administrators to support the purpose and goals of the NRP is vital to ensure positive outcomes of nurse satisfaction, retention and improved patient care.

In the longitudinal, multi-state study conducted by the National Council on State Boards of Nursing, Blegan et al. (2015) reviewed NLRN self-report of competence, along with preceptor report of competence in each of five areas: overall competence, patient-centered care, quality improvement/evidence-based practice, technology, and teamwork/communication. These results were contrasted in hospitals deemed to have low preceptor support (LPS) and those designated as high preceptor support (HPS). HPS hospitals were defined as those hospitals that reduced the preceptor's workload, scheduled same shifts for preceptor-NLRN, had shared assignments for the dyad, and maintained a low number of concurrent preceptees for each preceptor. Self-perceived competence scores showed no significant differences across the spectrum of the study, but preceptors identified higher gains in specified competence areas in the HPS hospitals at 9 months and at 12 months of the transition programs. Retention rates were higher in

HPS hospitals than in LPS hospitals: 86% compared with 80%. The results are consistent with discussions by Bratt (2013) and Spiva et al. (2013), who call for building NRPs on the best evidence with attention to the needs of NLRNs.

Clear assignments of NLRNs to specific preceptors and to specific mentors seemed to create a more positive experience among participants in the current NRP study. In those experiences where preceptor assignments were seemingly left to chance depending on who was working a given shift, the experience seemed to be less effective than in settings where relationships were purposefully formed. The roles of mentors and preceptors need to be clearly defined and intentionally assigned in a manner that is made explicit to all stakeholders in the NRP, including nurse managers charged with determining scheduling and patient-nurse ratios. Staffing patterns must take into account the purposeful placement of preceptors and NLRNs in shared assignments.

Staffing concerns. Scheduling to accommodate the needs of NLRNs requires availability of well-trained, experienced nurses who precept the NLRN throughout the transition experience. NRP leaders must work closely with unit leaders to confirm that NLRNs are appropriately teamed with qualified preceptors in a manner that is effective for the transition experience. Availability of experienced staff to guide NLRNs was a serious concern for nurses in the NRP study. In times of unit absences or other conditions that resulted in high patient-nurse ratios, the objectives of the NRP seemed to diminish in the more immediate need for a “warm body” or whoever was available to fill the vacant spot, as described by Myrick and Yonge (2003, p. 95). Hospitals and other healthcare facilities must make a commitment to maintaining the sanctity of the preceptor-NLRN relationship. The priority for sustaining these relationships must be

communicated to all staff. This obligation will require strategic planning and innovation to retain qualified staff.

Related to the absence of seasoned nurses to fill the roles of preceptors is the discussion of NLRNs serving in the preceptor role. Although the participants in this study were just completing their residencies (most at about 8 to 12 months experience in nursing), some facilities were asking them to serve in preceptor roles. At least two nurses in the study had already served in some capacity as a preceptor, and others had been asked to consider that role. The NLRNs expressed some concern about serving as preceptors and yet described that they felt compelled to give back to the profession.

To date the literature has not addressed this aspect of new nurses leading new nurses. The implication of this phenomenon makes preceptor training more imperative in the discussion of NRPs. If recent participants in NRPs are beginning to serve as the new preceptors, adequate training must be supplied to prepare them. As suggested by the participants in this study, a more collaborative effort between the NRP component of transition and the orientation element may enhance communication between those entities, facilitating the path for NLRNs to develop more quickly and efficiently. Institutions must commit fully to the NRP concepts and provide adequate infrastructure in a time when staffing shortages may threaten the principles underlying the NRP goals and components.

Systems analysis. Participants in the study denoted problems that were associated with systems failures. Systems failures require a different mindset to get at the root of the problems and find solutions that are impactful. Often, the relationships between the problems and causative factors are not clearly defined and can be imperceptible.

Sometimes problems can be created inadvertently through well-meaning actions. Organizations must seek actions to change behaviors so that the trajectory can be redirected to solve problems. Consequences of actions taken can actually worsen the situation if proper evaluation of the situation does not occur. Coordinated change between systems must be negotiated to make effective, long-term change (Stroh, 2015). Critical systems analysis is indicated to ensure that the problems associated with nurse retention and nurse development within NRPs are effectively managed.

Collaboration of education and practice. The Commission for Collegiate Nursing Education recommends “a collaborative partnership between a healthcare organization and one or more academic nursing programs” (CCNE, 2015, p. 5). Academic practice partners can help to bridge the gap for NLRNs. Bratt (2013) suggested that hospital organizations utilize academic partners by inviting a member of faculty to participate in planning and design of the program. Nurse educators are well-versed in teaching strategies and adult learning theory and can contribute to the development of NRPs thereby easing transition for the new nurse.

NLRNs in the study described the advantages of active reflective learning strategies that held clinical relevance for them. Participants gained understanding from narrative pedagogies and case studies used in the NRP safe haven, where they could share experiences and discuss situations without fear of reprisal. The NLRNs expressed a preference for opportunities to explore situated cognition in simulated experiences with low stakes outcomes. This enabled them to learn without fear of harming patients and made the transition to bedside less threatening for the new nurse. Nurse educators have experience in developing and running simulated scenarios to promote learning in this

setting. Colleges and universities also have the equipment and the laboratory settings to moderate such activities. Faculty members frequently provide informal support for former students during their early transition to practice. Perhaps a more formal program that links NLRNs to university faculty could provide an added element of support for the new nurses as they negotiate the practice arena. Through shared resources, academia and practice can create a learning environment that will support nurses in transition.

Nurse managers hold implicit information related to the needs and concerns of new nurses as they assume early leadership roles. Educators teaming with nurse managers in practice can bridge the gap in learning, creating mechanisms to prepare graduating seniors for the rigors that they will face in practice. Active learning strategies must be developed to address expectations for new nurse development in the field. These strategies can be employed in leadership courses.

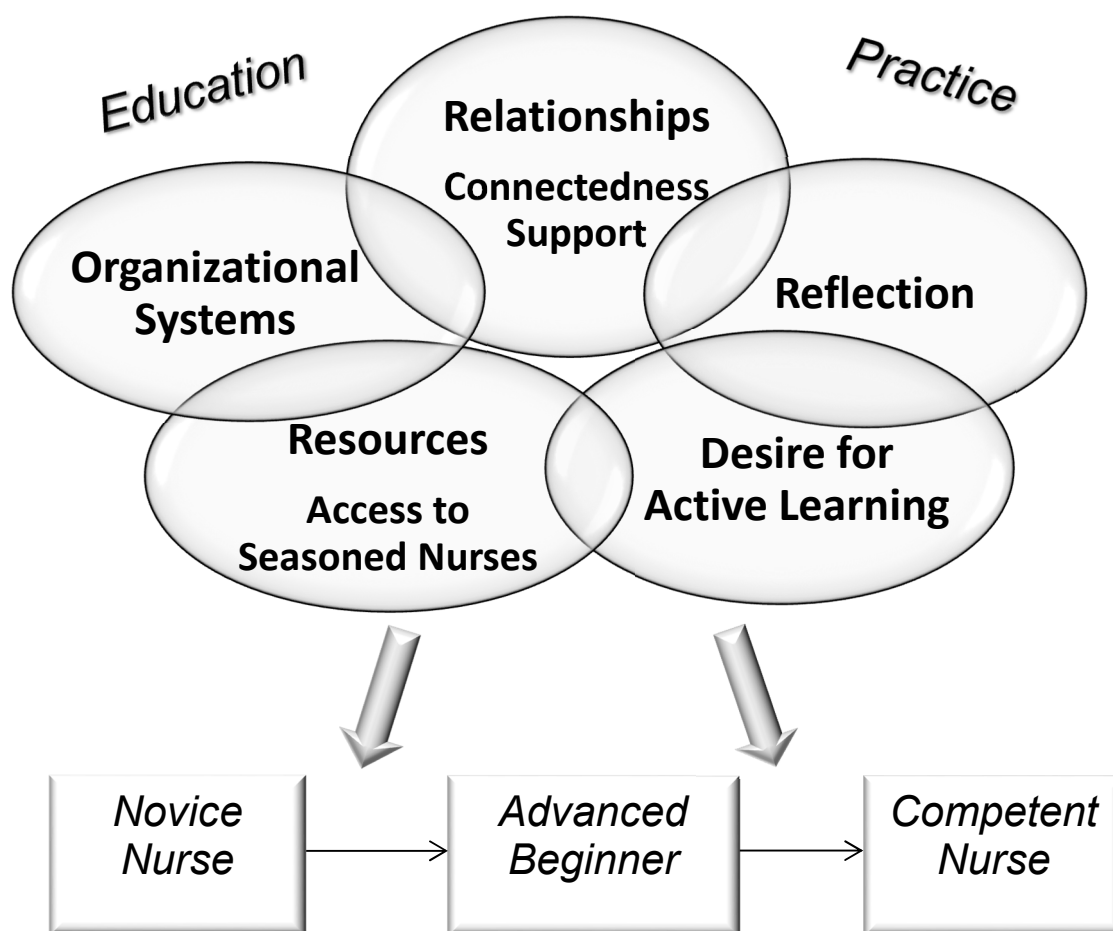
NLRNs in the NRP study noted five factors that had meaning for them in nurse transition within a NRP: relationships, reflection, desire for active learning, resources, and organizational systems. The implications for those meaningful factors have been discussed here. The findings in this study are not considered to be generalizable, since all experiences are unique to the individual. However the findings are transferable and demonstrate common experiences described by NLRNs completing NRP rotations. Experiences described here mirror findings from previous qualitative studies as noted.

Theory

Benner's Novice to Expert Theory is appropriate for NRP development as noted in much of the research and development with NRPs. Specifically, the early phase of development of the nurse is captured in the transition phase within NRPs. The transition

from novice nurse to advanced beginner to competent nurse is the goal of NRPs. Many nurses today enter practice at the novice level, but some may be at advanced beginner the level upon graduation from nursing programs (Benner, 2001). The goal of the NRP is to bring nurses to the competent level. The factors that have meaning noted by participants in the current NRP study are suggestive of concepts that impact the process of development for NLRNs. These concepts may influence the development of new nurses as they transition into practice within a NRP. Figure 5.1 below notes the potential for these influencing factors in education and as new nurses enter practice.

Figure 5.1 Influencing Factors in NLRN Development in Nurse Residency Programs



A myriad of factors impacts the transition of the nurse as noted in previous research; however, the factors noted in the figure above are those deemed most meaningful to nurses in the NRP study as they exited a nurse residency program. Nurses enter practice from their prelicensure nursing programs at varying levels of proficiency, and thus the influence of education and practice on the process is noted, but without specific attachment to other concepts in the figure. Education and practice should bridge the development of the nurse collaboratively.

Limitations of the Study

Limitations of this study related to the selection of participants. The inability to have direct contact with potential participants as stated in the original methodology hindered the attainment of interested participants. Participants were self-enrolled through indirect contact with the investigator through clinical educators in the participating hospitals. Study Information Sheets were distributed to 45 nurse residents in three programs by the clinical nurse educators in those facilities. Response to the Study Information Sheets was slow and inequitable in terms of representation of all facilities. At least two participants at each site were initially proposed to add to the richness of the description for those sites. However, the researcher was unable to achieve the goal of two participants per site. The ultimate goal of the study was to identify the components of NRPs based on individual experiences of participants, so comparison within and across cohorts was not relevant to this study.

After attempting to solicit responses for three months from one facility, the investigator received an invitation from the clinical educator to attend the final session of the upcoming graduating cohort. The investigator submitted an amendment for the recruitment protocol to the IRB and received approval to deliver the Study Information Sheets in person. The face-to-face contact did elicit a favorable response and additional NLRNs elected to participate in the study.

After a total of six interviews, saturation was achieved and no further participants were sought. The final distribution of participants was 3-2-1 respectively from the three facilities. The investigator would have preferred to have at least one more NLRN from the facility with only one participant. After repeated communications with the clinical

educator at this facility who sent emails to her NLRNs, no additional interest was noted in the study. However, through subsequent review of the data, it became clear that saturation had been reached and the richness of the data received from the participants was adequate. Data collection was ended at this point.

IPA, by virtue of its distinctive interpretative methodology, invites a layered perspective of the phenomenon under study. While the participants delivered their stories of experiences within the NRPs, the researcher developed initial impressions of the concepts of interest. Further review of the phenomenon as themes were developed through constant comparison and perpetual review of the data revealed rich experiences. These multiple impressions spoke to the development of subthemes within the themes in the original analysis. Further review with the designated team of experts yielded additional perspectives that are reflected in the final analysis of the data.

Future Research

The gap in the literature related to NRPs is that there are not clearly defined concepts that can be linked to outcomes measurement. This study has initiated the discussion of definitions as interpreted from the narratives of the participants. Those definitions are noted in the Definitions List beginning on page xiii of this document, and reiterated throughout the narrative discussion. The components of the NRPs that have meaning for NLRNs have been identified through phenomenological interpretative analysis. Future research for NRPs needs to focus on further refinement of operational definitions used in NRPs for outcomes research to address the concerns outlined by Barnett et al. (2014), Letourneau & Fater (2015), and Lin et al. (2014).

Common operational definitions for components within NRPs need to be defined and adopted by nursing organizations across the nation. Variability was noted even among three programs that demonstrated similar characteristics in the study. Standardization of components among programs would aid in benchmarking among NRPs and identifying causal factors that contribute to nurse transition outcomes. Such work has begun with the national accreditation process. However, very few NRPs are accredited to date, leaving the majority of programs across the United States without consistent developmental guidance.

The association of NRPs and positive patient outcomes remains an unsolved mystery. Again, it is noted that without acceptable operational definitions that link NRPs and successful nurse transition to patient outcomes, the measurement of specific outcomes cannot begin in earnest. Spector et al. (2015) performed analysis of error rates and patient safety factors within the longitudinal study of nurse transition programs. However, these researchers noted limitations since actual data is sacrosanct and they had to rely on self-report of the participants. A model must be developed with care to link patient outcomes with the use of NRPs.

The way is now paved for all entry level nurses to participate in NRPs. This nuance will require additional study to determine how these different education levels may respond to NRP strategies and what modifications may be required to assist transition for these nurses. Little has been published about the transition of nurses with associate degrees, since the primary emphasis has previously been focused on baccalaureate-prepared nurses. Letourneau et Fater (2015) suggested that curriculum may need to be altered to include more content related to critical thinking, continuing

education and life-long learning. However, no research to date has confirmed this assertion.

Studies related to job satisfaction and retention among registered nurses has demonstrated a pattern of decreased satisfaction and increased potential to leave the profession at six to nine months of practice. Four nurses in this study identified similar experiences at about six months into the NRP. Further study is needed to identify what factors contribute to this dissatisfaction and the mechanisms that contribute to the decision to stay or leave the hospital setting. Statements in the current NRP study and previous qualitative work would suggest that relationships may contribute to support and connectedness that ease this experience, but further study is needed to determine how effective this may be. As the nursing shortage continues to impact hospitals and health care organizations across the nation, it is imperative that nurses be successfully transitioned into their roles and that early attrition is abated.

Letourneau and Fater (2015) also describe the importance of organizational culture, leadership and organizational commitment in the identified dip in nurse satisfaction at six months. Organizational infrastructure was identified as meaningful to the nurses in the current NRP study. While best practices point to the importance of stakeholder buy-in, studies have not fully demonstrated the degree of administrative commitment compared with the outcomes associated with NRPs. Consistency in proportionate resource allocation, training and support of preceptors, and curriculum development is important to the development of future programs. Assessment of existing programs to identify levels of administrative commitment across the spectrum will contribute to measurement of success or lack of success based on infrastructure.

One topic worthy of mention in the discussion of future research is that of new nurses leading new nurses. This phenomenon was not noted in the literature related to NRPs. The predominance of NLRNs in the study who were asked to assume leadership or preceptor roles calls to question how prevalent this occurrence is in NRPs across the nation. The prevailing nursing shortage and related staffing issues seems to have created noticeable vacancies in hospitals, with new nurses making up the majority of the staff in some instances. Further research is needed to identify the frequency of this occurrence and the impact on the development of NLRNs.

Participatory action research may be a valid method of further establishing what influencing factors contribute to positive outcomes within NRPs. Participatory action research “affirms that experience can be a basis of knowing and that experiential learning can lead to a legitimate form of knowledge that influences practice...; it is collective, self-reflective inquiry that researchers and participants undertake, so they can understand and improve upon the practices in which they participate and the situations in which they find themselves” (Baum, MacDougall, & Smith, 2006). The emerging nursing shortage suggests a necessary urgency for a mechanism to quickly transform nurses into competent and proficient practitioners. By involving all stakeholders in a real-time, comprehensive research project, researchers may be able to better ascertain how actions within the NRP culminate to produce outcomes for nurse transition. The project should begin with a thorough systems analysis that includes academic and practice partners in an effort to evaluate current systems through focus groups and interdisciplinary collaboration. Then in a concentrated effort to pool resources and bridge learning across

the continuum of academia and practice, new systems can be implemented targeting short term successes for long-term benefits.

Conclusions

The impending nursing shortage is unavoidable. Demand for nurses will wax and wane with societal changes. But the continued need for nurses makes action toward safe and effective nurse transition necessary. Hospital facilities and academic centers must collaborate to find solutions for professional development of nurses that is effective. This study has described concepts that have meaning for NLRNs in NRPs in acute care settings. These concepts were based on the experiences of a select group of NLRNs. The experiences described serve to demonstrate the variability across different facilities.

The purpose of this study was to identify those variables that have meaning for NLRNs within NRPs. In the process of reviewing those factors, variations were noted in the programs along with many similarities. Variations noted from participants within the three NRPs served to demonstrate a need for greater standardization of NRP activities across the nation to achieve consistent outcomes. Operational definitions for interventions and for expected outcomes must be fully established in order to consistently measure the effects of NRPs on nurse transition.

Appendix A: Comparison of Sites and Programs

Factors	Site A	Site B	Site C
Hospital Size/Setting	344 beds; regional outreach	264 beds; regional outreach	337 beds; regional outreach
Accreditation/Awards	Joint Commission ANCC Magnet Status for Nursing	Joint Commission ANCC Magnet Status for Nursing	Joint Commission
Health Systems	---Comparable Sizes and Characteristics---		
Components of Transition Program	<p>Hospital Orientation -6 weeks</p> <p>Nurse residency program begins after an initial orientation period within the hospital.</p> <p>Case Conference Presentation by NLRNs</p> <p>World Café Sessions led by participants (described as “speed-dating”—NLRNs act as leaders at table discussions highlighting various topics like lateral violence in the workplace, physician-nurse communication)</p> <p>Peer Networking</p> <p>Safe Haven with Educators</p>	<p>Centralized Orientation -1 week with all disciplines in staff education; 5 weeks with preceptor in specific assigned area.</p> <p>All nurses with less than 6 months experience are entered into NRP: Casey-Finke Survey</p> <p>Meet weekly in cohorts, then every other month for one year</p> <p>Each cohort is assigned a facilitator</p> <p>Discussion topics: Transition—lay the foundation for NRP</p> <p>Peer support</p> <p>Collegiality</p>	<p>Hospital Orientation -2 weeks with Staff Education</p> <p>-Videos/manuals</p> <p>Assignment to Preceptor for orientation to the assigned unit (Approx. 3 months)</p> <p>“Progression Classes” with discussion of topics such as:</p> <ul style="list-style-type: none"> Stress New graduate concerns Shift work Interpreting lab results
Mentor/Preceptor	Mentors are selected in an informal manner by the graduates. (Initially, mentors were assigned, but feedback from NLRNs indicated that they preferred to seek their own.)	Assigned both a preceptor and a mentor Hospital recognizes differences in purpose of each	Assigned a preceptor.

Factors	Site A	Site B	Site C
Training for Mentor/Preceptors	Originally had training at beginning of program—no additional training	Now have combined classes for training preceptors/mentors so that each recognizes the role of the other. Program entitled: “Bridging the Gap Between Orientation and Practice through Preceptorship and Mentoring”	Training for preceptors
Incentives for Mentor/Preceptors	Credit for preceptorship hours-noted with Kentucky Board of Nursing; 120 hours substitutes for annual continuing education requirement	For each hour spent with GN, receive one hour credit=\$1 toward educational purposes Also, awarded points for clinical ladder program	Credit for preceptorship hours-noted with Kentucky Board of Nursing; 120 hours substitutes for annual continuing education requirement

Appendix B: Hospital Safety Scores for Participating Hospitals (Leapfrog Group, 2014)
 --Outcomes Measures (includes errors, accidents and injuries)

Measure*	Site A	Site B	Site C
Foreign object after surgery	0.000	0.000	0.000
Air embolism	0.000	0.000	0.000
Pressure ulcer	0.000	0.000	0.394
Falls/Trauma	0.988	0.197	1.050
CLABSI	0.000	0.000	0.86
CAUTI	2.069	1.904	0.05
SSI Colon	0.430	1.324	1.985
Death among surgical inpatients with serious treatable complications	106.68	128.46	128.45
Collapsed lung due to medical treatment	0.14	0.29	0.25
Breathing failure after surgery	11.24	7.54	14.09
Postoperative PE/DVT	2.53	1.86	3.00
Wounds split open after surgery	0.31	1.28	0.41
Accidental cuts or tears from medical treatment	1.31	2.33	1.13

* Measured as “per 1000 patient discharges”

Abbreviations:

CLABSI—central line-associated bloodstream infections

CAUTI—catheter associated urinary tract infections

SSI Colon—colorectal surgical site infection, reported using a standardized infection ratio

PE—pulmonary embolism/ DVT—deep vein thrombosis

--Process Measures (includes management structures and procedures a hospital has in place to protect patients from errors, accidents and injuries)

Measure [†]	Site A	Site B	Site C
Computerized prescriber order entry (0-100)	N/A	65	5
ICU Physician Staffing (0-100)	85	5	15
Leadership structures and systems (0-120)	Did Not Report [‡]	Did Not Report [‡]	102.86
Culture measurement, feedback and intervention (0-20)	Did Not Report	Did Not Report	20.00
Teamwork training and skill building (0-40)	Did Not Report	Did Not Report	40.00
Identification/mitigation of hazards and risks (0-120)	Did Not Report	Did Not Report	109.09
Nursing workforce (0-100)	Did Not Report	Did Not Report	71.43
Medication reconciliation (0-35)	Did Not Report	Did Not Report	28.00
Hand hygiene (0-30)	Did Not Report	Did Not Report	27.00
Care of the ventilated patient (0-20)	Did Not Report	Did Not Report	18.33
Patients received antibiotic within 1 hour prior to surgical incision (%)	84	98	98
Patients received the right antibiotic (%)	62	99	97
Antibiotic discontinued after 24 hours (%)	70	99	98
Urinary catheter was removed on post-op day 1 or 2 (%)	49	97	94

Surgery patients received appropriate treatment to prevent blood clots at the right time (%)	65	98	95
--	----	----	----

†Measured according to a designated points system; points noted in parentheses OR as a percentage of patients receiving recommended care; noted with % in parentheses

‡Did Not Report—the Leapfrog Group elected to exclude measures with missing data and re-calibrate the weights for the affected hospitals, using only those measures for which data were provided. (Austin et al, 2014)

**INDIANA UNIVERSITY SCHOOL OF NURSING
STUDY INFORMATION SHEET**

The Lived Experience of Newly Licensed RNs in Transition to Practice in Three
Different Nurse Residency Programs

Deanna Reising, Principal Investigator, and Beverly Rowland, Co-Investigator and a student from the School of Nursing at Indiana University are conducting a research study.

You were selected as a possible participant in this study because you have recently completed your first year in practice as a registered nurse. Your participation in this research study is voluntary.

Why is this study being done?

The purpose of this study is to explore the lived experience of the newly licensed RN (NLRN) in transition to practice, to identify factors that NLRNs believe to be valuable to the transition experience, and to examine elements related to the work environment that NLRNs experience in their residency and how they make sense of those factors.

What will happen if I take part in this research study?

If you volunteer to participate in this study, the researcher will ask you to do the following:

- Participate in a single interview that will last approximately 60 minutes (more or less) in a quiet setting within your workplace facility with only you and the interviewer.
- Describe to the best of your ability the experience that you have had in transitioning to nursing practice.
- Answer a few questions about this experience related to your expectations of nursing practice, your relationship with your preceptor(s), and your workplace environment.

How long will I be in the research study?

Participation will take a total of about 60 minutes; the interviewer may call you or email you on one other occasion to clarify any meaning related to your discussion.

Are there any potential risks or discomforts that I can expect from this study?

While participating in the study, minimal risks may be involved. Risks that could arise, but are not anticipated, are associated with potential emotional response during data collection as the participant recalls events. Minimal potential exists that a participant's story could be recognized if the study is published, but individual data will be de-identified. Every effort will be made to maintain confidentiality of all participants.

Are there any potential benefits if I participate?

Benefits to participation may occur, but it is not the purpose of the research to bring about such benefits. The participant may enjoy a sense of being heard, may feel that this is an opportunity to express his or her viewpoint, and/or may have the opportunity to influence policy or practice through participation in the study.

The results of the research will contribute to the knowledge base concerning nurse residency programs and the role of these programs in transitioning nurses into practice.

Will I be paid for participating?

You will receive a \$50 gift card from Walmart, Target or Lowe’s (your choice) as an honorarium for your participation in this study.

Will information about me and my participation be kept confidential?

Any information that is obtained in connection with this study and that can identify you will remain confidential. It will be disclosed only with your permission or as required by law. If the study is published, there is minimal potential that a participant’s story could be recognized, but every effort will be made to prevent this occurrence. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. Your identity will be held in confidence in reports in which the study may be published and in databases related to demographic information.

What are my rights if I take part in this study?

- You can choose whether or not you want to be in this study, and you may withdraw your consent and discontinue participation at any time.
- Whatever decision you make, there will be no penalty to you, and no loss of benefits to which you were otherwise entitled.
- You may refuse to answer any questions that you do not want to answer and still remain in the study.

Who can I contact if I have questions about this study?

- **The research team:**

If you have any questions, comments or concerns about the research, you can talk to the one of the researchers. Please contact:

Beverly Rowland

- **IU Human Subjects Office:**

For questions about your rights as a research participant or to discuss problems, complaints or concerns about a research study, or to obtain information, or offer input, contact the IU Human Subjects Office at (317) 278-3458 or for Indianapolis or (800) 696-2949.

Appendix D: Demographic Tool for Nurse Residency Program Study

Please answer the following questions related to demographic information. All information will be reported in aggregate format with no specific individual information revealed.

1. Age _____ (stated in years)

2. Gender: _____ Male
 _____ Female

3. Educational level: _____ BSN
 _____ ADN
 _____ Diploma

4. Ethnicity: _____ American Indian/Alaska Native
 _____ Asian
 _____ Black/African American
 _____ Hispanic/Latino
 _____ Native Hawaiian/Pacific Islander
 _____ White
 _____ Other, specify: _____

5. Prior Healthcare Experience:
 _____ Certified Nurse Aide/State Registered Nurse Aide
 _____ Licensed Practical Nurse
 _____ Emergency Medical Technician/Paramedic
 _____ Medical Technician
 _____ Military Medic
 _____ Medical Office Assistant
 _____ Unit Secretary/Ward Clerk
 _____ Other, please specify:

Thank you for taking the time to participate in this study. Your information is very valuable to the understanding of Transition to Practice.

Appendix E: Questions for Semi-structured Interview

These questions are to be used to prompt responses from participants at the early phase of orientation or nurse residency. General questions are designed to establish a rapport with the participant and to develop trust. Additional questions may arise with development of interview.

Question 1: When you entered the nurse residency program one year ago, how would you describe the expectations that you had for the nurse residency program?

Question 2: Tell me a little bit about the transition period from school to practice.
[Comparison with clinical experiences in school?]

Question 3: How did your transition period compare with your expectations of what you would be doing in the workplace?

Question 4: Describe for me a typical experience that you had in your transition to nursing?

Question 5: Tell me about the relationship that you had with your mentor or preceptor in the nurse residency program.

Question 6: Can you describe for me what the workplace environment is like for you?
[Probes: Safety? Collegiality? Interactions with other disciplines?]

Final Question: What else would you like to share with me about your experience that perhaps we have not touched on in this conversation?

Appendix F: INDIANA UNIVERSITY INFORMED CONSENT STATEMENT

Conceptualization of Factors that Have Meaning for Newly Licensed Registered Nurses Completing Nurse Residency Programs in Acute Care Settings

You are invited to participate in a research study of current nurses' transition to practice. You were selected as a possible subject because you are a practicing nurse in one of the selected facilities in which the study is being conducted and meet the criteria for participation. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

The study is being conducted by Beverly Rowland, MSN, RN, a student in doctoral studies at Indiana University at Indianapolis, under the direction of Deanna Reising, PhD, RN, ANEF. It is funded by the student researcher and no companies or other entities are involved.

STUDY PURPOSE

The purpose of this study is to examine the factors of nurse residency programs (NRPs) that have meaning for newly licensed registered nurses (NLRNs) experiencing transition to practice (TTP) in acute care settings.

Objectives related to this purpose will be to:

1. Identify factors in NRPs that NLRNs believe to have meaning during the transition experience in acute care hospital settings.
2. Examine work environment variables that NLRNs experience in various nurse residency programs in acute care hospital settings.

NUMBER OF PEOPLE TAKING PART IN THE STUDY:

If you agree to participate, you will be one of approximately six to ten subjects who will be participating in this research.

PROCEDURES FOR THE STUDY:

If you agree to be in the study, you will do the following things:

You will attend one meeting, approximately 60 minutes in length with the researcher in a quiet setting to be determined with the researcher. The researcher will have some questions for you related to your transition to the nursing profession. You are asked to respond to these questions as fully and truthfully as you can. The interview will be recorded by the researcher and later transcribed for the purposes of this research.

The interview questions are very general and basic questions about things that you consider were helpful/not helpful to your transition into practice. There are no correct or incorrect responses to the questions asked in the interview, rather the perspective of the participant is important to the study, so please answer all questions freely. While your discussion is very valuable to the study, you may elect to answer or not to answer any specific question(s). The researcher asks that if you did not observe or participate in what the question addresses, that you simply state that you did not experience that event.

RISKS OF TAKING PART IN THE STUDY:

While participating in the study, minimal risks may be involved. Risks that could arise, but are not anticipated, are associated with potential emotional response during data collection as the participant recalls events. If the study is published, there is minimal potential that a participant's

story could be recognized, but every effort will be made to prevent this occurrence. (See “confidentiality” below.)

BENEFITS OF TAKING PART IN THE STUDY:

Benefits to participation may occur, but it is not the purpose of the research to bring about such benefits. The participant may enjoy a sense of being heard, may feel that this is an opportunity to express his or her viewpoint, and/or may have the opportunity to influence policy or practice through participation in the study.

ALTERNATIVES TO TAKING PART IN THE STUDY:

Participation in this research is purely voluntary, if you elect not to participate, there is no alternative activity.

CONFIDENTIALITY

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. Your identity will be held in confidence in reports in which the study may be published and in databases related to demographic information.

Discussions will be recorded by the researcher and these recordings transcribed for thematic analysis. Transcriptionists will be bound to confidentiality of information. Recordings will be deleted immediately after the transcription process is completed and accuracy of the transcribed information has been verified by the researcher. Any publication or presentation of data for research purposes will focus on aggregate data. The names of the participating institutions will be held confidential when reporting data. Excerpts from transcripts may be utilized to portray a specific theme, but the information will be de-identified before reporting. Any resulting account of the research will contain only de-identified information that could not be related back to specific individuals or institutions/facilities/agencies. All efforts will be made to ensure that information is maintained as private.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the study investigator and his/her research associates, and the Indiana University Institutional Review Board or its designees.

COSTS

You will not be responsible for any study-specific costs.

PAYMENT

You will receive a gift card valued at \$50.00 as a token of appreciation and to compensate for your time spent in this research. You may elect to have the gift card from one of the following: Walmart, Target or Lowe’s.

COMPENSATION FOR INJURY

No injury is anticipated as a result of this study.

FINANCIAL INTEREST DISCLOSURE

The researcher will receive no financial benefit as a result of this study.

CONTACTS FOR QUESTIONS OR PROBLEMS

For questions about the study, contact the researcher Beverly Rowland at [redacted]. If you cannot reach the researcher during regular business hours (i.e. 8:00AM-5:00PM EST), please call the IU Human Subjects Office at (317) 278-3458 for Indianapolis. After business hours, please call the researcher at [redacted].

For questions about your rights as a research participant or to discuss problems, complaints or concerns about a research study, or to obtain information, or offer input, contact the IU Human Subjects Office at (317) 278-3458 or for Indianapolis or (800) 696-2949.

VOLUNTARY NATURE OF STUDY

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty. Your decision whether or not to participate in this study will not affect your current or future relations with the researcher in her capacity at Campbellsville University, with Indiana University or with the workplace in which you were recruited for the study.

SUBJECT’S CONSENT

In consideration of all of the above, I give my consent to participate in this research study.

I will be given a copy of this informed consent document to keep for my records. I agree to take part in this study.

Subject’s Printed Name: _____

Subject’s Signature: _____ **Date:** _____

Printed Name of Person Obtaining Consent: Beverly Rowland, MSN, RN, CNE

Signature of Person Obtaining Consent: _____ **Date:** _____

Appendix G: Table of Emergent Themes

Research Question: What concepts have meaning for NLRNs who have experience TTP in NRPs?

Emergent Theme 1: Relationships

Subtheme: Connectedness vs. Non-connectedness	Investigator's reflections
<p>Participant 1: "Oh, that [my relationship with my preceptor] was the best relationship I've ever had! She was so excited that she was going to be my preceptor. When I met her, she told me that she was excited to work with me and said, 'I am going to be your friend. Always ask me what you want to know.'"</p>	<p>The NLRN was smiling broadly, excited to discuss this relationship. The enthusiasm that the preceptor brought to the experience helped the participant to feel connected.</p>
<p>"And she had me ask questions of other people on the floor. And they told me to ask questions...And she introduced me to the doctors and made me talk to them. Every time the doctors came onto the floor, she called them over and introduced us and helped me not to be afraid of them."</p>	<p>The NLRN further noted connections that occurred as a result of this relationship; the preceptor helped the participant to feel a part of the team.</p>
<p>Participant 5: "I still feel like I have a tighter connection with them [her four preceptors] than the other nurses...because they helped me become who I am, and I still always feel more comfortable going to them than I would other people..."</p>	<p>The connections forged in this relationship allowed the NLRN to feel a certain sense of support and comfort. The idea of sustained relationships/connections was carried across with other participants.</p>
<p>(Continued discussion related to mentoring role) "I don't know if all the mentors meet this status; he's been extremely helpful. He doesn't really wait for you to reach out to him. He just kind of anticipates that you're having the same kind of feelings that he had as a new grad and he makes me feel confident.</p>	<p>Though the NLRN noted that her mentor was physically located on a different unit and they worked on different days, she still felt connected to him because he reached out to her.</p>
<p>Participant 4: "To me, it's like you do your orientation on the floor and the</p>	<p>This NLRN noted that her primary preceptor was</p>

nurse residency program is, like, completely separate from that. It would be nice if it [the orientation] was more involved in it [NRP]...maybe if your primary preceptor came with you—at least to the first one [meeting]. That would be beneficial, because my primary preceptor had no idea what nurse residency was.”

Participant 3: “I think for future nurse residency programs, the actual floor that you work on needs to be more involved in it and more incorporated, because they are completely separate from everything. I feel, at least for my manager, she was not involved in the process at all...I think that at least a experienced nurse or a manager or a specialist on your floor should be somehow incorporated in this [the NRP].”

Participant 3: (regarding mentor assignments) “At the beginning [of NRP] they were sort of split into assignments, because we had a bigger group, but now it’s more narrowed down. I just see [one mentor] more, especially now that he is assigned as a [supervisor role]...but I don’t see [another mentor] at all, because she works on a totally different floor, totally different elevator, totally different access to where she even works...”

surprised when she was off the unit for NRP activities; there seemed to be no connection, creating some degree of discord between NLRN and preceptor.

These NLRNs did not see the connection across the transition experience. It seemed that the orientation with the preceptor and the NRP were on parallel tracks that never converged and this had meaning for the NLRN. Both expressed that it might have been more meaningful to complete that circle, synergizing the process.

The NLRN felt disconnected from one of the mentors, but indicated that her needs were met by the other mentor.

Subtheme: Supported vs. Not supported

Investigator’s reflections

Participant 5: “I felt like it would be a good support system. I felt alone in my struggles and I didn’t expect it to be easy, but I wanted to feel like I was normal whenever I was struggling with it and have people to talk to about it, so I felt like it was a good way to connect to other people that were also new and then to have our mentors that could help us through it.”

This NLRN expressed right from the start that she did not want to be alone. NLRNs indicated that these expectations were met in the NRP. This thought resonated throughout interviews with participants, as noted here.

Participant 2: “Well we were a small group...and going through this

The NLRNs seemed to draw strength from

process together, knowing that you're not alone. I bonded with others in the cohort...It meant a lot to just know that you were not going through the process alone."

shared experiences and this helped them to cope with the challenges that they faced.

Participant 1: "I wanted to learn how to do my job...how to have confidence in what I was doing from school into clinical. I wanted someone to go to and not be alone."

Participant 6: "And...honestly, getting to bounce off ideas and stories and explain, you know, experiences that we had—I think that was one of the most meaningful aspects of the nurse residency program, simply because you realized that you weren't alone."

Participant 3: "It made me feel like it wasn't just me that was having these horrible days, issues on the floor and that kind of thing."

Participant 6: "We all help one another. It's a very nurturing and helpful environment. If one nurse is having trouble, someone else will always come out and be there to support them."

This NLRN spoke of a supportive team within her unit.

Participant 5: "And it's helpful...it's comforting to know that no matter what situation you come up against, I guess there's always going to be somebody that you can reach out to, that's gonna know what to do."

Again, NLRNs relied upon those more mature nurses within the unit who were available in times of distress.

Participant 1: "My preceptor and my mentor still come around and ask me how I am doing, ask me if I need anything. It makes it easy to open up and talk to them about what I might need. They make me feel that they still care about me and that is important."

Most of the NLRNs referred to sustained support from their preceptors and mentors (also referred to by some as instructors).

Participant 5: [In reference to a challenging experience] "My mentor made sure to check on me to see if I needed anything. Other units were

This NLRN faced a significant challenge and was successful because of the support from her

supportive...it was a struggle, but I did have really good support from my team.”

Participant 4: “...the charge nurse was my preceptor in that situation, but she really didn’t offer me as much guidance as I felt like a new nurse should have received.”

team.

This variation on the theme indicated that the NLRN did not feel supported in a particular situation.

Emergent Theme 2: Reflection	
Excerpts from transcripts	Investigator’s reflections
<p>Participant 1: “And then they gave us time to reflect on [the simulation experience] and to talk about what we had learned. That was helpful. You got to work on the team... Then after a few days with the preceptors, we would come back and spend the day with our mentors and they would ask us “What trouble are you having on the floor? What is the thing that you need the most?” They helped us to reflect on what we were doing.”</p>	<p>NLRNs were encouraged to reflect on their learning through guided reflection based on their experiences—simulated and patient-centered .</p>
<p>Participant 5: “I think the less organized days, where it was just conversation...like, the older, more experienced nurses sharing stories about you know, things that happened to them and how they had dealt with that situation...and then hearing stories from some of the other new nurses about things that they had encountered. I feel like that always sticks with me more than people just presenting things to me.”</p>	<p>This NLRN learned from opportunities to hear narratives of experienced nurses, such as mentors or instructors and being given opportunity to reflect on how those situations impacted her current practice. Many of the NLRNs discussed the learning experiences from hearing case studies, other nurses experiences (including those within the cohort), but rarely couched it in terms of “reflective activity.”</p>
<p>Participant 4: “ ...and we had a debriefing after it so that we knew how to be better prepared for it on our floor because something like that we just had never had on our floor before.”</p>	<p>When asked about reflection time related to a specific incident, this NLRN responded with discussion of the debriefing for the unit. Never</p>

Participant 6: "...well, I got to talk about that in the sharing time...and then one of the nurse residency instructors—I don't know if she really uhmmm... Well, I talked to my boss, you know, and said well, I'm really, really struggling with this...I don't know if I can do this...it's just the way my heart was feeling."

discussed reflection in specific terms.

Through discussion with her peers in the NRP, this NLRN was able to work through her feelings about providing a specific kind of care and then able to express those feelings to the nurse manager.

Emergent Theme 3: Active Learning

Excerpts from transcripts

Participant 1: "... it was like being in school again. Some of [the classes]...I didn't like how they made them...different departments came and talked and it was just another lecture...that was hard sometimes, because we just got out of school and we are having lectures again."
[What was most useful?] Oh, the simulations—you get to take care of the patient in groups together. You know they tell you the scenario and you have the patient there and sometimes you just freeze—your mind is running, running, running and you are remembering all the things they told you in school, and you just freeze and can't do anything. But we did the simulations in groups...it helps you to learn to rely on others somewhat and know that you are not a island."

"I would like to have shorter periods of class time with more simulations or active things to do in the afternoon. Most of our simulations were at the end of the residency—I think it would have been more useful to have those in shorter segments with the classes."

Participant 6: "We'd get in the lab about once a week and we'd do, you know, our skills and our check-offs and all that stuff, but when it came back to like, running codes or running simulations or...running crisis situations, then we probably only did that three times."

Investigator's reflections

The NLRN went on to say that he had simulation in school, but not critical situations like this. He would have liked to see a mix of didactic materials with simulation in the NRP classes to break up the long day, because he learns better with active, hands-on learning and becomes bored with long presentations.

This NLRN expressed that she would have liked to see more interactive sessions like the skills lab and patient scenarios. She described the same experience related to "freezing" in front of the

Participant 2: “Well, one of the assignments was that we were allowed to shadow in the unit of our choice; then we had to do a presentation for the others about that unit. So you not only learned about your unit, but you learned about what others did, too. That turned out to be a good experience for me.”

Many participants related that certain topics in the classes were redundant:

Participant 3: I think it would have helped us a little bit more to have a little more hands-on... because some of the presenters that we had took up a lot of time with things that we already had learned... in like, our [nursing] programs? So I think that it was a little bit redundant and I wish that it would have been...like what relates to our work in the hospital and like more “hands-on” things.

Participant 4: “...there was a lot of redundancy, like we had an entire day that was nothing but, uh...culture...uh, cultural diversity, and that’s a huge part of nursing school now... I think it could have been more like a topic that you would discuss within your own area. Like I work labor and delivery, so...I had no idea that Asian women are going to labor in bed and not get up; whereas, like white women, that are natural, like they’re up and all over the place. So I had always wondered why they stayed in bed, and that was just a cultural thing that I picked up on.”

Participant 6: “...there was a class that we did and it was about safety in the hospital. And... the head of security came and talked to us. And I don’t know if it was just the way that he... approached the subject, but I

mentors/instructors.

The NLRNs who had experiences of shadowing with another unit or another discipline with shared presentations from others in the cohort for the assignment told the investigator that they learned more about the other area in this manner than by listening to someone presenting from specific areas.

NLRNs did not like having topics that were still fresh in their minds from school—they felt that this took away from the more meaningful activities such as simulated experiences or interactions with actual patients.

One NLRN made a suggestion that it should have been linked more closely with the actual experience within the assigned unit—this would have been more meaningful to the NLRNs.

really felt like it was exactly what we had gotten previously in just our general hospital orientation...and I didn't feel like I learned anything new...I didn't feel like I needed it; it was everything that had already been said."

I like that the professional development presentation was good... I don't remember which ones, but I like the ones that were more open discussion and story-sharing vs., like, I remember that there were a couple that were just a little bit dry... there was an ethics speaker and some of them were lengthy and I would have opted out of those most likely.

Participant 6: "...the very first day...they ran a respiratory arrest scenario—which was really good, cause we were all new grads and we were all standing around this dummy thinking, 'Oh my God, this dummy has stopped breathing; what do we do now?' And the nurse goes, 'We have an ambu bag...' And I was like, 'Oh yeah, we can bag this patient.'"

All of the NLRNs seemed to show a preference for sharing and meaningful narratives that brought them closer to practice situations.

Emergent Theme 4: Resources

Excerpts from transcripts

Participant 6: "...that was one thing that they did in the nurse residency program—to teach us where the hospital polices were and how to access them and how to search for them."

Participant 2: "Oh, I really wish I had my NRP binder with me... we had a binder that we kept all of our material in and that was a good way to keep up with things. I still refer to it from time to time."

Participant 2: "Well, the computer system is outdated, but they are switching to...a much newer system and it will be better."

Investigator's reflections

For this NLRN, the ability to access policies and protocols quickly was one of the key elements of the NRP.

This NRP provided the NLRNs with a binder that enabled them to keep the new information handy for retrieval. This NLRN found that very helpful.

Computer information systems changes impacted two of the three sites.

<p>Participant 3: "...we definitely weren't prepared for anything like that (a patient coding with significant bleeding), I mean we didn't have any masks or anything like with face shields on it or anything."</p> <p>Participant 4: "...we're giving blood like crazy; we called a Code O-neg—they didn't bring the blood...we were getting blood off the art line like every ten minutes—and they weren't running them stat, even though they were ordered stat. And like she ordered platelets, but the hospital was out of platelets. And it ended up there was a unit of platelets in the hospital, but they wouldn't give them to her, because they were holding them for a cancer patient...so even though she was hemorrhaging, the cancer patient got the platelets, instead of her..."</p>	<p>The NLRN shared a story of the patient changing rapidly with massive hemorrhaging and coding on oncology unit; no one had anticipated this or had proper equipment to deal with situation.</p> <p>The NLRN tells that after this incident, a Root Cause Analysis was conducted and policies were changed, but at the time, she did not have the staff or the resources to get things done.</p>
<p>Subtheme: Access to Experienced Nurses</p>	
<p>Investigator's reflections</p>	
<p>Participant 4: "It was so busy that day. And I mean our staffing was bad in June. Like the experienced nurses that I work with refer to the summer as the most dangerous time to be a nurse."</p>	<p>The NLRN shared a story of a bad day related to poor staffing that resulted in her questioning the decision to be a nurse. (At five months)</p>
<p>Participant 3: "I had six high acuity patients on PCU and so did the rest of the staff on the floor. I was pretty much done that day."</p>	<p>Another discussion of low morale at five months related to staffing issues.</p>
<p>Participant 4: "I've been precepting people to that role...when they asked me to do it the first time...it was just an agency nurse who was just coming up there to see how we did things and I was like, 'Are you sure? Like isn't there anyone else?' And they were like, there really is no one else. But it was surprising to me that they asked."</p>	
<p>Participant 5: Okay, so our unit has been struggling with staffing just like every other unit... So I had been on the unit for less than a year, but</p>	<p>NLRNs told of staffing issues with having enough experienced nurses to fill charge nurse</p>

everyone else had only been on the unit for, like, six months. So, ‘tag, you’re it!’ You know?

Participant 6: “We’ve had a lot of people leave to go to other units. So they’re not leaving the hospital; they’re leaving the unit...the nurses that are remaining are a bunch of new grads. We really don’t have...anyone to precept the new nurses we are hiring, so we have to help with the precepting and we’ve all been there less than a year.”

and preceptor positions. They told of situations where they were supposed to have assigned preceptors, but at times, preceptors are just arranged at the last minute, based on seniority of nurses on the units.

Emergent Theme 5: Organizational Structure

Participant 4: “To me, it’s like you do your orientation on the floor and the nurse residency program is, like, completely separate from that. It would be nice if [the orientation] was more involved in [the NRP]...maybe if your primary preceptor came with you—at least to the first one [meeting]. That would be beneficial, because my primary preceptor had no idea what nurse residency was. Because ... I missed four hours of the shift for the first meeting and she was like ‘Where have you been?’ And I [said], ‘At nurse residency,’ and she [said], ‘What’s that?’”

Participant 3: “I think for future nurse residency programs, the actual floor that you work on needs to be more involved in it and more incorporated, because they are completely separate from everything. I feel, at least for my manager, she was not involved in the process at all...I think that at least an experienced nurse or a manager or a specialist on your floor should be somehow incorporated in this [the NRP].”

Participant 6: [In response to: Did you also have what was termed as a preceptor?] “Yes! But that wasn’t really part of the nurse residency program. That was more just orientation. In hospital orientation, we were given a preceptor—a preceptor on days and a preceptor on nights.”

Participants in the study indicated a need for greater communication between the facilitated sessions with assigned mentors and facilitators and the unit experiences with preceptors and nurse managers.

Participant 3: “The very first class we had, [the facilitator]—who used to be the educator for our floor—she was switching roles, and so I don’t know if it fell off because of that or what happened, but like, no one ever took the facilitator role for our group... So it was like she was just kind of unorganized.”

Participant 4: “I think, when this program first started, it was really unorganized, like with our cohort. We were supposed to have this facilitator, [but] I don’t know who she is; I have never seen her; she never showed...Our first three [sessions], she was supposed to be here. And we would get here and the door was locked. We were locked out...So I just felt like it was completely unorganized... and embarrassing. One of the days, I was having to leave [the floor] during my [specified] training...So like, it wasn’t even my department, and I had to leave that to come here to find a locked door with the lights out. And then there were a couple of times when the clinical director came in and apologized...and said, ‘I’m sorry, we failed you.’”

In this particular facility, participants noted a lack of attention to the structure within the NRP which resulted in some degree of confusion or miscommunication about the NRP sessions. The participants indicated that this was distressing on some level to them.

Participant 3: “When I had six high acuity patients on PCU and so did the rest of the staff on the floor [I questioned my decision to become a nurse]. I was pretty much done that day... We’ve had a lot of changes on that floor, so there have been some large staff ratios, but at that time I was pretty much guaranteed to have no more than five patients on my workload and I didn’t like going home knowing that I didn’t do for my patients all that I could have done. So that’s why I didn’t like it [nursing] then.”

Participant 4: “I’ve been precepting people to that role...when they asked me to do it the first time...it was just an agency nurse who was just coming up there to see how we did things and I was

Some participants noted staffing issues that related to the flow of the NRP activities. It seemed that preceptors were not specifically assigned to the NLRNs, leaving some discrepancy about progression of the NLRNs and inconsistencies in promoting their transition.

In some cases, inexperienced nurses seemed to be called upon to serve as preceptors, leaving questions related to the training and preparation

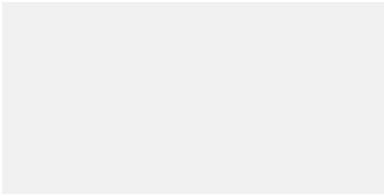
like, ‘Are you sure? Like isn’t there anyone else?’ And they were like, there really is no one else. But it was surprising to me that they asked.” of preceptors.

Participant 6: “We’ve had a lot of people leave to go to other units. So they’re not leaving the hospital; they’re leaving the unit...the nurses that are remaining are a bunch of new grads. We really don’t have...anyone to precept the new nurses we are hiring, so we have to help with the precepting and we’ve all been there less than a year.”

Participant 3: “Well, I didn’t have this type of preceptor, but I saw other people with preceptors that they just kind of let you do what you want to do and just follow along. And they kind of just feel like letting people do things more... independently...but then [the preceptors] don’t see when someone is doing something wrong and then [the NLRNs] don’t have the opportunity... maybe to learn the right way or maybe a better way to do something. So I think I would want a preceptor that would be there with me; and I want my independence—don’t get me wrong, but I feel like some of them let them go and do their independent things a lot sooner than they should.”

Participant 4: “...the charge nurse was my preceptor in that situation, but she really didn’t offer me as much guidance as I felt like a new nurse should have received.”

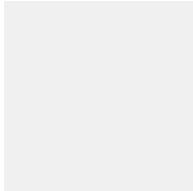
Appendix H: Indiana University IRB Approval



Protocol Id



Protocol Id



Protocol Id:	13239094
Protocol #:	<u>1506174139</u>
Protocol Type:	<u>Exempt</u>
Reference ID1:	
Protocol Status:	<u>Exempt</u>
Title:	Conceptualization of Factors that Have Meaning for Newly Licensed Registered Nurses Completing Nurse Residency Programs in Acute Care Settings
Summary/Keywords:	
Initial Submission Date:	09/18/2015
Submission Date:	09/25/2015
Approval Date:	09/25/2015
Expiration Date:	
Last Approval Date:	

Sequence Number:	1
FDA IND or IDE #:	
Reference ID2:	
Special Review Indicator:	Y
Vulnerable Subject Indicator:	
Key Study Person Indicator:	
Funding Source Indicator:	
Correspondent Indicator:	
Reference Indicator:	
Related Projects Indicator:	



[ORA Office Information](#) |
 [Institutional Information](#) |
 [MyRA](#) |
 [prd - Version 5.1.2](#)
[Contact GRANTS System Admin](#) |
 [Contact IRB System Admin](#)

References

- Alspach, J.G. (1995). *The Educational Process in Critical Care Nursing*. St. Louis: Mosby.
- Alspach, J.G. (2000). *Preceptor Handbook: From Staff Nurse to Preceptor Training Program*. Alisa Viejo, CA: AACN Critical Care Publications.
- Alspach, J.G. (2013). *Core Curriculum for Critical Care Nursing*. Atlanta, GA: Elsevier Health Sciences.
- American Association of Colleges of Nursing. (2013). Report of the UHC/AACN post-baccalaureate nurse residency program, October, 2013. Retrieved from <http://www.aacn.nche.edu/members-only/meeting-highlights/2013/fall/UHC-Nurse-Res-Report.pdf>
- American Nurses Association. (2016). ANA Code of Ethics. Retrieved from <http://nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses>
- Anderson, G., Hair, C. & Toderò, C. (2012). Nurse residency programs: An evidence-based review of theory, process, and outcomes. *Journal of Professional Nursing*, 28(4), 203-212.
- Anderson, T., Linden, L., Allen, M. & Gibbs, E. (2009). New graduate RN work satisfaction after completing an interactive nurse residency. *Journal of Nursing Administration*, 39(4), 165-169.
- Austin, J.M., Andrea, G.D., Birkmeyer, J.D., Leape, L.L., Milstein, A., Pronovost, P.J., ... Wachter, R.M. (2013). Safety in numbers: The development of Leapfrog's

- composite patient safety score for U.S. hospitals. *Journal of Patient Safety*, 10(1), 64-71.
- Barnett, J.S., Minnick, A.F. & Norman, L.D. (2014). A description of U.S. post-graduation nurse residency programs. *Nursing Outlook*, 62(3), 174-184.
- Baum, F., MacDougall, C. & Smith, D. (2006). Participatory action research. *Journal of Epidemiology and Community Health*, 60(10), p. 854-857.
- Benner, P. (1982). From novice to expert. *American Journal of Nursing*, 82(3), 402-407.
- Benner, P. (1994). *Interpretive phenomenology: Embodiment, caring, and ethics in health and illness*. Thousand Oaks, CA: Sage Publications
- Benner, P. (2001). *From novice to expert: Excellence and power in clinical nursing practices, commemorative edition*. Upper Saddle River, NJ: Prentice Hall Health.
- Benner, P. (2004). Using the Dreyfus model of skill acquisition to describe and interpret skill acquisition and clinical judgment in nursing practice and education. *Bulletin of Science, Technology & Society*, 24(3), 188-199. DOI: 10.1177/0270467604265061.
- Benner, P., Tanner, C. & Chesla, C. (1992). From beginner to expert: Gaining a differentiated clinical world in critical care nursing. *Advanced Nursing Science*, 14(3), 13-28.
- Benner, P., Sutphen, M., Leonard, V. & Day, L. (2010). *Educating nurses: A radical call for transformation*. San Francisco: Jossey-Bass.
- Berkow, S., Virkstis, K., Stewart, J. & Conway, L. (2008). Assessing new graduate performance. *Journal of Nursing Administration*, 38(11), 468-474.

- Beyea, S.C., Slattery, M.J. & von Reyn, L.J. (2010). Outcomes of a simulation based nurse residency program. *Clinical Simulation in Nursing*, 6(5), e169-e175.
- Blegan, M.A., Spector, N., Ulrich, B.T., Lynn, M. R., Barnsteiner, J., & Silvestre, J. (2015). Preceptor support in hospital transition to practice programs. *Journal of Nursing Administration*, 45(12), 642-649.
- Bratt, M.M. (2013). Nurse residency program: Best practices for optimizing organizational success. *Journal for Nurses in Professional Development*, 28(2), 102-110.
- Bratt, M.M. (2009). Retaining the next generation of nurses: The Wisconsin Nurse Residency Program provides a continuum of support. *The Journal of Continuing Education in Nursing*, 40(9), 416-425.
- Braun, V. & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Los Angeles: Sage Publications.
- Burns, N. (1989). Standards for qualitative research. *Nursing Science Quarterly*, 2(1), 44-52.
- Cappel, C.A., Hoak, P.L., & Karo, P.A. (2013). Nurse residency programs: What nurses need to know. *Pennsylvania Nurse*, 68(4), 22-28.
- Cohen, M.Z., Kahn, D.L., & Steeves, R.H. (2000). *Hermeneutic phenomenological research: A practical guide for nurse researchers*. Thousand Oaks, CA: Sage Publications.
- Cole, M. John, Steiner, V., Scribner, S. & Souberman, E. Eds.(1978) *Mind in Society: The Development of Higher Psychological Processes*. Cambridge, MA: Harvard University Press.

- Commission on Collegiate Nursing Education. (2015). CCNE-accredited nurse residency programs. Retrieved from www.aacn.nche.edu/ccne-accreditation/CCNE-Entry-to-Practice-Residency-Standards-2015.pdf.
- Craig, C., Moscato, S., & Moyce, S. (2012). New BSN perspectives on the transition to practice in changing economic times. *Journal of Nursing Administration, 42*(4), 202-207.
- Dotson, M.J., Dave, D.S., Cazier, J.A., & Spaulding, T.J. (2014). An empirical analysis of nurse retention: What keeps RNs in nursing? *Journal of Nursing Administration, 44*(2), 111-116.
- Dushscher, J.E. (2001). Out in the real world: Newly graduated nurses in acute-care speak out. *Journal of Nursing Administration, 31*(9), 426-439.
- Dushscher, J.E. (2009). Transition shock: The initial stage of role adaptation for newly registered nurses. *Journal of Advanced Nursing, 65*(5), 1103-1113. DOI: 10.1111/j.1365-2648.2008.04898.x.
- Flynn, L., Liang, Y., Dickson, G.L., Xie, M. & Suh, D.C. (2012). Nurse practice environments, error interception practices, and inpatient medication errors. *Journal of Nursing Scholarship, 44*(2), 180-186.
- Goode, C.J., Bednash, G.D., Lynn, M.R., Murray, B., & McElroy, D. (2013). Lessons learned from 10 years of research on a post-baccalaureate nurse residency program. *Journal of Nurse Administrators, 43*(2), 73-79.
- Goode, C.J. & Williams, C.A. (2004). Postbaccalaureate nurse residency program. *Journal of Nursing Administration, 34*(2), 71-77.
- Guba, E.G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries.

Educational Communication and Technology Journal, 29(2), 75-91.

Haggerty, C., Holloway, K., & Wilson, D. (2012). Entry to nursing practice preceptor education and support: Could we do it better? *Nursing Praxis in New Zealand*, 28(1), 30-39.

Hofler, L.D. (2008). Nursing education and transition to the work environment: A synthesis of national reports. *Journal of Nursing Education*, 47(1), 5-12.

Institute of Medicine. (2010). Future of nursing: Leading change, advancing health.

Retrieved from

http://www.thefutureofnursing.org/sites/default/files/Future%20of%20Nursing%20Report_0.pdf

Kentucky Board of Nursing. (2014). Elimination of the clinical internship. Retrieved from <http://kbn.ky.gov/license/jpci.htm>

Kramer, M. (1974). *Reality shock: Why nurses leave nursing*. St. Louis: Mosby.

Kramer, M., Halfer, D., Maguire, P. & Schmalenberg, C. (2012). Impact of healthy work environments and multistage nurse residency programs on retention of newly licensed RNs. *Journal of Nursing Administration*, 42(3), 148-159.

Kramer, M., Maguire, P., Schmalenburg, C., Halfer, D., Budin, W.C., ... & Lemke, J. (2013). Components and strategies of nurse residency programs effective in new graduate socialization. *Western Journal of Nursing Research*, 35(5), 566-589.

Lave, J. & Wenger, E. (1991). *Situated learning: Legitimate peripheral participation*. New York: Cambridge University Press.

- Leonard, V.W. (1994). A Heideggerian phenomenological perspective on the concept of person. In P. Benner (Ed.), *Interpretive phenomenology: Embodiment, caring and ethics in health and illness*. Thousand Oaks, CA: Sage Publications.
- Letourneau, R.M. & Fater, K.H. (2015). Nurse residency programs: An integrative review of the literature. *Nursing Education Perspectives, 36(2)*, 96-101. DOI: 10.5480/13-1229.
- Lin, P.S., Viscardi, M.K. & McHugh, M.D. (2014). Factors influencing job satisfaction of new graduate nurses participating in nurse residency programs: A systematic review. *The Journal of Continuing Education in Nursing, 45(10)*, 439-455.
- Lioce, L., Meakim, C.H., Fey, M.K., Chmil, J.V., Mariani, B., & Alinier, G. (2015). Standards of best practice: Simulation standard IX: Simulation design. *Clinical Simulation in Nursing, 11(6)*, 309-315.
- Mariani, B. (2012). Our ethical responsibility in the transition to practice for new RNs. *Pennsylvania Nurse, 67(2)*, 4-7.
- Marquette University (2016). Wisconsin Nurse Residency Program. Retrieved from www.marquette.edu/nursing/nursing-residency-program/index.shtml
- Moore, P. & Cagle, C.S. (2012). The lived experience of new nurses: Importance of the clinical preceptor. *The Journal of Continuing Education in Nursing, 43(12)*, 555-565.
- Myers, S., Reidy, P., French, B., McHale, J., Chisholm, M. & Griffin, M. (2010). Safety concerns of hospital-based new-to-practice registered nurses and their preceptors. *The Journal of Continuing Education in Nursing, 41(4)*, 163-171.

- Myrick, F. & Yonge, O. (2003). Preceptorship: A quintessential component of nursing education. In Oermann, M.H. & Heinrich, K.T. (Eds.), *Annual Review of Nursing Education, Vol. 1*, 91-108. New York: Springer Publishing Company.
- Myrick, F., Yonge, O. & Billay, D. (2010). Preceptorship and practical wisdom: A process of engaging in authentic nursing practice. *Nurse Education in Practice, 10*(2), 82-87.
- National Council of State Boards of Nursing. (2014). Nursing regulatory research at NCSBN: Transition to practice. Retrieved from: <https://www.ncsbn.org/686.htm>
- Olson-Sitki, K., Wendler, M.C. & Forbes, G. (2012). Evaluating the impact of a nurse residency program for newly graduated nurses. *Journal for Nurses in Staff Development, 28*(4), 156-162.
- Pellico, L.H., Brewer, C.S., & Kovner, C.T. (2009). What newly licensed nurses have to say about their first experiences. *Nursing Outlook, 57*(4), 194-203.
- Pittman, P., Bass, E., Hargraves, J., Herrera, C. & Thompson, P. (2015). The future of nursing: Monitoring the progress of recommended change in hospitals, nurse-led clinics, and home health and hospice agencies. *The Journal of Nursing Administration, 45*(2), 93-99.
- Pittman, P., Herrera, C., Bass, E. & Thompson, P. (2013). Residency programs for new nurse graduates: How widespread are they and what are the primary obstacles to further adoption? *Journal of Nursing Administration, 43*(11), 597-602.
- Rajendran, N.S. (2001). Dealing with biases in qualitative research: A balancing act for researchers. Paper presented at the Qualitative Research Convention 2001:

- Navigating Challenges. University of Malaya, Kuala Lumpur. Retrieved from <http://nsrajendran.tripod.com/Papers/Qualconfe2001.pdf>
- Remillard, A. (2013). Developing a nurse residency program curricular framework. *Journal for Nurses in Professional Development, 29(2)*, 79-83.
- Rhodes, C., Radziewicz, R., Amato, S., Bowden, V., Hazel, C., McClendon, S.,...McNeil, M. (2013). Registered nurse perceptions after implementation of a nurse residency program. *Journal of Nursing Administration, 43(10)*, 524-529.
- Ritter, D. (2011). The relationship between healthy work environments and retention of nurses in a hospital setting. *Journal of Nursing Management, 19(1)*, 27-32.
- Roth, J.W. & Johnson, M.P. (2011). Transition to practice: The North Carolina initiative. *Journal of Nursing Regulation, 2(3)*, 56-60.
- Sandelowski, M. & Barroso, J. (2003). Writing the proposal for a qualitative research methodology project. *Qualitative Health Research, 13(6)*, 781-820.
- Smith, J.A., Flowers, R. & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method, and research* [C&M Digitals version]. Los Angeles, CA: Sage Publications.
- Smith, J.A. & Osborn, M. (2007). Interpretative phenomenological analysis. Chapter in J.A. Smith's *Qualitative psychology: A practical guide to research methods*. Los Angeles, CA: Sage Publications.
- Smythe, E.A., Ironside, P.M., Sims, S.L., Swenson, M.M. & Spence, D.G. (2008). Doing Heideggerian hermeneutic research: A discussion paper. *International Journal of Nursing Studies, 45*, 1389-1397.

- Spector, N., Blegan, M.A., Silvestre, J., Barnsteiner, J., Lynn, M.R., Ulrich, B. ... & Alexander, M. (2015). Transition to practice study in hospital settings. *Journal of Nursing Regulation, 5(4)*, 24-38.
- Spector, N. & Echternacht, M. (2010). A regulatory model for transitioning newly licensed nurses to practice. *Journal of Nursing Regulation, 1(2)*, 18-25.
- Spiva, L., Hart, P.L., Pruner, L., Johnson, D., Martin, K., Brakovich, B., McVay, F., & Mendoza, S.G. (2013). Hearing the voices of newly licensed RNs: The transition to practice. *American Journal of Nursing, 113(11)*, 24-32.
- Staiger, D.O., Auerbach, D.I. & Buerhaus, P.I. (2012). Registered nurse labor supply and the recession—Are we in a bubble? *The New England Journal of Medicine, 366(16)*, 1463-1465.
- Streubert, H.J. & Carpenter, D.R. (2011). *Qualitative research in nursing: Advancing the humanistic imperative, 5th ed.* Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins.
- Stroh, D.P. (2015). *Systems Thinking for Social Change: A Practical Guide to Solving Complex Processes, Avoiding Unintended Consequences, and Achieving Lasting Results.* White River Junction, VT: Chelsea Green Publishing.
- The Leapfrog Group (2014). Hospital safety score. Retrieved from <http://www.hospitalsafetyscore.org/>
- Thorne, S. (2008). *Interpretive Description.* Walnut Creek, CA: Left Coast Press, Inc.
- Trepanier, S., Early, S., Ulrich, B. & Cherry, B. (2012). New graduate residency program: A cost-benefit analysis based on turnover and contract labor usage. *Nursing Economics, 30(4)*, 207-214.

University Health/Systems Consortium/American Association of Colleges of Nursing.

(2014). Nurse residency program. Retrieved from

<http://www.aacn.nche.edu/education-resources/nurse-residency-program>

Varner, K.D. & Leeds, (2012). Transition within a graduate nurse residency program.

The Journal of Continuing Education in Nursing, 43(11), 491-499.

Versant. (2014). Transitioning new graduates to practice. Retrieved from

<https://versant.org/professional-services/versant-new-graduate-rn-residency.html>

Welding, N.M. (2011). Creating a nurse residency: Decrease turnover and increase

clinical competence. *Medsurg Nursing, 20(1), 37-40.0*

CURRICULUM VITAE

Beverly Dianne Rowland

EDUCATION:

<u>Institution</u>	<u>Degree</u>	<u>Date</u>
Indiana University Indianapolis, IN	PhD in Nursing Science	2016
Western Kentucky University Bowling Green, KY	MSN Post-Master's FNP	2007 2007
McKendree University Radcliffe, KY	BSN	2005
Henderson Community College	ADN	1973

ACADEMIC APPOINTMENTS:

<u>Institution</u>	<u>Title</u>	<u>Date</u>
Campbellsville University Campbellsville, KY	Dean of the School of Nursing	July, 2015-present
	Interim Dean	Jan, 2015-Jul, 2015
	Director of RN-to-BSN Program	2012-Jan, 2015
	Assistant Professor	2011-present
	Nursing Instructor	2009-2011
	Interim Dean	2008-2009
	Nursing Instructor	2007-2008

CLINICAL APPOINTMENTS:

<u>Employer</u>	<u>Title</u>	<u>Date</u>
Lindsey Wilson College Columbia, KY	Director of Student Health Services	2001-2007
Tim Horton's Children's Foundation	Camp Nurse	Summer, 2002

Campbellsville, KY

Westlake Home Health Agency Columbia, KY	Quality Improvement Coordinator	1999-2002 1992-1997
Medshares Home Care Lexington, KY	Operations Director	1998-1999
Nurses Registry and Home Health Lexington, KY	Director of Total Quality Management	1997-1998
Lifeline Home Health, Inc. Russell Springs, KY	Team Leader	1990-1992
Family Home Health Care Columbia, KY	Nursing Supervisor	1988-1990
Montgomery County Board of Education Mt. Sterling, KY	School Nurse	1987-1988
Mary Chiles Hospital Mt. Sterling, KY	Staff Nurse	1985-1987 1981-1982
Kentucky Peer Review Organization Louisville, KY	Utilization Review Coordinator	1982-1984
Community Methodist Hospital Henderson, KY	Unit Director of Med-Surg Unit Assistant Director of Nursing Staff Nurse ER Technician	1980-1981 1976-1980 1973-1976 1972-1973

LICENSURE: State of Kentucky

PROFESSIONAL MEMBERSHIPS:

2007-present	National League for Nursing
2007-present	Kentucky League for Nursing
2005-present	Sigma Theta Tau International Honor Society of Nursing
2003-present	American Nurses Association
2003-present	Kentucky Nurses Association
2005-2007	Kentucky Coalition for Nurse Practitioners and Nurse Midwives
1996-2000	Home Care Nurses Association
1989-2006	Kentucky Home Health Association
1973-1976	American Nurses Association

HONORS:

National League for Nursing Lead Scholar, 2013
Kathryn M. Mershon Nurse Faculty Award, Kentucky League for Nursing, 2010
McKendree College Nursing Honor Society, 2005-2006
Freshman Nursing Award, Henderson Community College, 1972

TEACHING ASSIGNMENTS—Campbellsville University—2007-present

NUR 103 Medical Surgical Nursing I
NUR 102 Pediatric Nursing
NUR 204 Pharmacology for Nurses
NUR 205 Advanced Pharmacology
NUR 202 Professional Trends and Issues
NUR 370 Community Health Nursing I
NUR 371 Community Health Nursing I
NUR 203 Professional Nursing & Applications to Practice
NUR 380 Gerontological Nursing I
NUR 381 Gerontological Nursing II
NUR 410 Professional Nursing Leadership Capstone

ADMINISTRATIVE SERVICE—Campbellsville University—2007-present

Dean of the School of Nursing, January, 2015-present
Director of RN-to-BSN Program, 2012- 2015
Acting Dean of the School of Nursing July, 2013-October, 2013 (during the absence of the Dean)
Team Leader for Accrediting Commission for Education in Nursing Self-Study
Interim Dean of the School of Nursing, 2008-2009

UNIVERSITY SERVICE—Campbellsville University—2007-present

2015-2016	University Council, Academic Council, Deans Committee, University Strategic Planning Committee
2014-2015	Title III Grant Committee: Engagement and Retention of Students, University Strategic Planning Committee—funded for Faculty Resource Center and Academic Coaching System
2013-2014	Executive Search Committee for Vice President of Academic Affairs, University Strategic Planning Committee
2012-2013	SACS Committee for Core Requirement 4.4-Program Length
2009-2015	University Strategic Planning Committee
2010-2012	Allied Health Strategic Task Force
2009-2010	Steering Committee for SACS Fifth-Year Interim Report
2009-2010	Subcommittee for Core Requirement 4.1, Chair
2009-2011	Graduate Council

2014-2015, 2008-2009 University Council
2014-2015, 2008-2009 Academic Council
2008-2009 Library Committee
2007-2009 Title III Grant Committee—funded for Badgett Academic Support
Center

School of Nursing Service:

2014-present Curriculum Committee, Admissions/Readmissions Committee, Outcomes
Committee
2011-present Continuing Education Committee
2008-present Pinning Ceremony Committee, faculty representative
2007-present Curriculum Committee
2007-present Admissions Committee
2009-2011 Testing Committee

PROFESSIONAL SERVICE:

Secretary, Board of Directors, 2013-2015; 2015-2017; Kentucky Nurses Association
ANA Delegate for Kentucky Nurses Association, 2011-2014
Education Role, Professional Nursing Practice and Advocacy Cabinet, 2009-2011 and
2011-2013, KNA
Planning Committee for “Surviving Your First Year” presentation for students across the
state, KNA
Kentucky Home Health Association Reimbursement Committee, 1996-1998, KHHA

NURSING EDUCATION ACCOMPLISHMENTS:

NLN LEAD Candidate--Was selected for the National League for Nursing LEAD
program and studied with nursing leaders across the United States for one year. Received
executive coaching and training as a nursing leader in the nursing education arena, while
networking with others in similar leadership roles. Discovered a greater understanding of
my role and unique qualities that prepare me for that role.

Developed RN-to-BSN curriculum and then developed courses for the curriculum.
Worked closely with members of Distance Education and with Learning House Learning
Management System to establish courses and then mentored faculty as the program was
implemented.

BSN Program Accreditation--Achieved Candidacy status with the Accreditation
Commission for Education in Nursing (ACEN) for the RN to BSN Program, Hosted site
visit February 2-4, 2016.

“*Surviving Your First Year*” seminar-- Through my work with the Kentucky Nurses
Association, I was instrumental in the development of the “*Surviving Your First Year*”
seminar which we have presented annually since 2010 for senior nursing students across

the state of Kentucky. This offering brings experienced nursing experts together with impending graduates to teach them nuances of transitioning into their professional nursing roles.

COMMUNITY SERVICE:

Columbia Baptist Church

Sunday School teacher, 1st and 2nd grade children

Church Council

Personnel Committee

Liaison with area schools to provide services for underprivileged students

Health Promotion Project with Taylor County Public Health Department

President's Club, Campbellsville University, 2007-present

Russell Creek Society, Campbellsville University, 2012-present

Adair County Women's Giving Circle, 2012-present

Western Kentucky Alumni Association, Lifetime Member

Arrive Alive Coalition, Taylor County

Area Health Education Centers, Host for Health Professions Students

Kentucky Cancer Consortium, Lake Cumberland Area Chapter (2002-2007)

Adair County Substance Abuse Coalition (2002-2007)

Cooper-Clayton Smoking Cessation Facilitator for Adair County (2002-2007)

Member of International Host Parents Community for Lindsey Wilson College (2002-2007)

RESEARCH STUDIES:

Conceptualization of Factors that Have Meaning for Newly Licensed Registered Nurses Completing Nurse Residency Programs in Acute Care Settings. (2016)

Professional Nursing Values: Perceptions of Today's Working Nurses. (Unpublished, 2013)

PRESENTATIONS:

Rowland. B.D. (2012). Professional Transformation of Nurses. Presented at Bowling Green Regional Medical Center, Bowling Green, KY, Oct., 2012.

Rowland. B.D. (2012). Professional Transformation of Nurses. Presented at Ephraim McDowell Regional Medical Center, Danville, KY, Sept., 2012.

Rowland. B.D. (2012). Professional Transformation of Nurses. Presented at Personal Touch Home Care, Columbia, KY, Sept., 2012.

Rowland. B.D. (2012). Professional Transformation of Nurses. Presented at Taylor Regional Hospital, Campbellsville, KY, Sept., 2012.

- Rowland, B.D. (2012). Professional Transformation of Nurses. Presented at Springview Hospital, Lebanon, KY, Sept., 2012.
- Rowland, B.D., Vale, R.G. & Atwood, A.G. (2012). Role Play as a Teaching Strategy. Presented at Campbellsville University Faculty Workshop, Aug., 2012.
- Rowland, B.D., (2006). Empowerment: Can Self-directed behavior changes improve outcomes for diabetic patients? Poster presented for Sigma Theta Tau Research Day, Kappa Theta Chapter on November 17, 2007, in Bowling Green, KY.
- Rowland, B.D. (2006). Empowerment: Can Self-directed behavior changes improve outcomes for diabetic patients? Adapted for classroom presentation at Western Kentucky University on November 16, 2007, in Bowling Green, KY.
- Rowland, B.D. (2005). Sexual responsibility and safety. Presented to Upward Bound Program, Lindsey Wilson College, on Dec 10, 2005, in Columbia, KY.
- Rowland, B.D. (2005). Use of alternative medicines in the community. Presented to medical staff at Jane Todd Crawford Medical Center, for the South Central Kentucky Area Health Education Center.
- Main, E., Rowland, B.D., & Mortimer, B.(2005). Prevention of AIDS and other STIs. Presented to the Bowling Green Housing Authority, Bowling Green, KY.
- Rowland, B. (2005). Storytellers and birth rituals: A study of cultural attitudes about childbearing. Classroom presentation, McKendree University, Radcliffe, KY.
- Rowland, B. (2005). Facilitation: Mock steering committee. Classroom presentation and teaching tool, McKendree University, Radcliffe, KY.
- Rowland, B. (2005). Community assessment: A windshield survey. Video presentation and statistical analysis for classroom presentation, McKendree University, Radcliffe, KY.
- Rowland, B. (2004). Trends in health care cost containment. HTML presentation for classroom use, McKendree University, Radcliffe, KY.