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Perceived Needs and Coping Resources of Newly Hired Nurses in Transition

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PERCEIVED NEEDS AND COPING RESOURCES OF NEWLY HIRED NURSES IN
TRANSITION

by

Catherine A. Schmitt

A Dissertation Submitted in
Partial Fulfillment of the
Requirements for the Degree of

Doctor of Philosophy
in Nursing

at

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ABSTRACT
PERCEIVED NEEDS AND COPING RESOURCES OF NEWLY HIRED NURSES IN
TRANSITION

By

Catherine A. Schmitt

The University of Wisconsin-Milwaukee, 2013
Under the Supervision of Professor Rachel F. Schiffman

Newly hired nurses who do not transition well often leave their first nursing position or nursing prematurely, at great cost to themselves, the profession, the hiring organization and patients. The purpose of this secondary analysis study was to better understand the experience of new graduate nurses (NGNs) and experienced nurses as each group transitions to a new setting in nursing practice and the contribution the preceptor role plays in that transition. Schlossberg's Transition Theory was the framework that guided the study. The original data were collected from 118 newly hired nurses who were predominantly female and Caucasian with the majority being under the age of 30 years and having less than one-year experience. The data available for secondary analysis were collected at three, six and twelve months after the date of hire and included all transcripts from structured debriefing sessions offered at the conclusion of educational offerings that were a part of an extended orientation program. Analytic coding and word count methods were used in the data analysis. Themes were identified and Schlossberg's

transition theory was mapped to the themes. Themes that were identified indicate that both groups of nurses rely on *Institutional Support* for transition. *Institutional Support* comes in the form of a Human Connection (preceptor, leadership, staff and others and a go to person) and a Process Approach (orientation and consistency). Both groups of nurses have a *Sense of Self* and a Self-Awareness that allows the nurse to articulate: What I Need, What I Know and Don't Know and What's Real, and Fear. Major findings suggest that preceptors are critical early in the transition of newly hired nurses but a different type of support is needed later on. Experienced nurses want a tailored orientation that takes into consideration prior knowledge and skill. Findings also suggest that newly hired nurses in transition continue to look for support beyond the first year of the transition. Hospitals should consider implementing transition to practice programs that support the newly hired nurse throughout the first year of transition and should also consider a mentorship program of support after the first year of transition. Hospitals need to recognize and acknowledge the experience and skill of the experienced nurse in transition and provide tailored orientation for those individuals. Educational programs need to acknowledge that the transition of new graduate nurses is difficult and design a capstone-nursing course to prepare the graduating nursing student for transition to professional practice. Further research should focus on the transition needs of the experienced nurse, and what type of additional support all nurses need following the first year of transition.

I dedicate this to my mother
who did not live long enough to see me complete my degree.

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Chapter One

Nurses can make many transitions during the course of a career. The first transition all nurses will make is from student nurse to professional nurse. After that first role transition other transitions for experienced nurses might include transitioning into a new role or specialty, or making the move to a new organization, or both (Ulrich, 2011).

Broadly defined, a transition is any event or life happening that results in changed routines, roles and assumptions (Anderson, Goodman & Schlossberg, 2012). Transitions include not only obvious life-changing events such as high school graduation, job entry or marriage but also subtle changes such as the loss of a career aspiration or a job promotion that never occurred (Anderson et al., 2012). Transition is an internal psychological process people go through to come to terms with a new situation (Bridges, 2004). A transition begins with letting go of what no longer fits for the life stage of an individual (Bridges, 2004). Individuals in transition separate from old roles and routines and work to embrace a new beginning (Bridges, 2004). New beginnings often take the form of external career changes (Bridges, 2004).

The transition from nursing student to new graduate nurse (NGN) to the role of experienced registered nurse (RN) can be difficult. NGNs report it takes them at least 12 months to feel comfortable and confident practicing in the acute care setting (Casey, Fink, Krugman, & Probst, 2004). This difficult transition is reflected in the poor retention rates of this vulnerable group of workers. Many NGNs leave the profession prematurely with 60 – 75% leaving nursing during the first year (Baxter, 2010; Welding, 2011).

The evidence that is available focuses on the transition experience of the NGN (Almada, Carafoli, Flattery, French & McNamara, 2004; Bratt, 2009; Casey, Fink, Krugman, & Probst, 2004; Friedman, Cooper, Click, & Fitzpatrick, 2011; Hatler, Stoffers, Kelly, Redding, & Carr, 2011; Lee, Tzeng, Lin & Yeh, 2009).

Although much is known regarding the transition process of the NGN little is known about the transition process of the experienced nurse who seeks to change nursing specialty or move to a different practice setting or health-care facility. Nursing is a unique profession in that it allows the nursing professional to make these types of practice moves without first obtaining additional education or training in the new specialty. It is unknown if the experienced nurse who seeks to change specialty or practice setting transitions in the same way a NGN transitions to the practice of professional nursing.

The evidence available that details the transition of the NGN suggests that the use of well planned and executed orientation programs and/or nurse residency programs (NRPs) can increase the retention of this vulnerable group of nurses (Bratt, 2009; Friedman et al., 2011; Hatler et al., 2011). Preceptors and structured orientation programs that employ preceptors have been used to ease the NGNs transition to professional practice (Beecroft, Kunzman, Taylor, Devenis, & Guzek, 2004; Young, Stuenkel, & Bawel-Brinkley, 2008). The preceptor's role in the successful transition of the NGN to practice cannot be underscored; preceptors play or can play a vital role in the effective orientation and retention of the NGN (Horton, DePaoli, Hertach, & Bower, 2012).

The nursing literature fails to describe the time frame for or type of transition experience the experienced nurse new to a practice setting will encounter during the transition process. It is also unclear if preceptors and mentors are used to assist the experienced nurse transition to a new specialty or practice setting. Evidence suggests that a well-organized transition to practice (TTP) program that uses preceptors to ease the transition to professional practice can increase retention rates of the NGN but little is known regarding the preceptor's contribution to the transition of the experienced nurse who is changing practice settings (Bratt, 2009; Friedman et al., 2011; Hatler et al., 2011). The nursing profession needs to understand the transition process of the experienced nurse when designing orientation programs for this population of health-care providers. Based on the evidence from the graduate nurse (GN) literature it can be postulated that an orientation program aimed at the successful transition of the experienced nurse can increase the retention rate of this valuable member of the health-care team.

A preceptor is described in the nursing literature as a nurse who teaches, counsels, inspires and supports the growth and development of the novice nurse in the work environment (Mills, Francis, & Bonner, 2005; Yonge, Billay, Myrick, & Luhanga, 2007). A preceptor is also described as an individual who serves as a role model and is responsible for socialization of the novice (Billay & Yonge, 2004; Bowen, Fox, & Burridge, 2012). Proper socialization includes actively integrating the NGN or experienced nurse new to a practice setting into the culture of the nursing unit and the entire nursing facility (Yonge et al., 2007). Other activities involved in socialization include introducing the new nurse to other members of the health care team, identifying

members of the ancillary resource and support staff and identifying the chain of command.

When the NGN and the experienced nurse enter into a clinical teaching relationship that relationship is referred to as a preceptorship (Smedley, 2008; Yonge et al., 2007). Preceptorships are short-termed planned, monitored, task oriented programs that are used by healthcare organizations as a method of preparing, orienting and socializing a NGN for practice (Smedley, 2008). This type of preceptorship usually employs a one-on-one working relationship which offers a period of support and access to a competent and experienced role model while attempting to ease the transition of the NGN into professional practice (Bain, 1995; Bowen, Fox & Burrridge, 2012).

This same type of preceptorship can also be used to orient the experienced nurse who is new to a practice setting. When the experienced nurse changes specialties or roles they are no longer proficient or the expert nurse in their new position (Ulrich, 2011). When the experienced nurse makes this career change they can feel vulnerable in the new position until they acquire the necessary skills and knowledge to once again be proficient or be considered the expert (Ulrich, 2011). Preceptors are needed to help the experienced nurse make this transition and be successful in the specialty or role change (Ulrich, 2011).

It has been recognized that due to the complexity and acuity of today's hospitalized patients it has become impossible for even the very best baccalaureate school of nursing to prepare the NGN to work independently upon graduation in today's acute care environment (Goode, Lynn, Krsek, & Bednash, 2009; Goode & Williams, 2004).

The educational process does, however, provide the NGN with a foundation upon which to build their clinical practice (Berkow, Virkstis, Stewart, & Conway, 2009; Goode, Lynn, Krsek, & Bednash, 2009; Goode & Williams, 2004). Because of the acuity and complexity of today's hospitalized patients, nursing and the health care industry can no longer expect the NGN to transition to their first professional nursing position without engaging in a TTP program.

TTP programs are referred to in the nursing literature by several names: nurse residency programs (NRPs) (Casey et al., 2004; Goode et al., 2009; Krugman, Bretschneider, Horn, Krsek, Moutafis & Smith, 2006), extended orientations (Friedman et al., 2011; Hatler et al., 2011), and preceptor programs (Almada et al., 2004; Lee et al., 2009; Myers et al., 2010). Although all programs are similar, differences are noted in structure and length. Most TTP programs are 4 to 12 months in length and share common curricular content (Hoffart, Waddell, & Young, 2011). Common curricular elements are designed to enhance critical thinking skills, improve communication and teamwork skills and strengthen the NGN's commitment to the profession of nursing (Goode & Williams, 2004; Spector & Echternacht, 2010).

Another similarity among TTP programs is the almost universal use of experienced staff nurses as preceptors (Almada et al., 2004; Bratt, 2009; Friedman et al., 2011; Hatler et al., 2011; Krugman et al., 2006; Lee et al., 2009; Myers et al., 2010; Spector, 2009). The preceptor role in the TTP program is to provide an atmosphere in which the NGN can learn and assume greater responsibility while making the transition to a contributing member of the nursing staff (Wright, 2002). TTP programs have been

shown to increase retention of this vulnerable group of professionals (Almada et al., 2004; 2004; Bratt, 2009; Friedman et al., 2011; Hatler et al., 2011; Krugman et al., 2006; Lee et al., 2009; Myers et al., 2010).

Nursing is not the only health care profession that uses preceptors as a tool to facilitate learning in the clinical setting. Jones-Boggs Rye and Boone (2009) describe the use of volunteer clinical preceptors to provide instruction to respiratory therapy students. Pharmacy also reports the use of preceptors to supervise pre-registration students (Marriott et al., 2006; McBane, Tyan, Karr, & Kelly, 2012). Fernald et al. (2001) report the use of preceptorships as a learning strategy for medical students who are in the third and fourth years of medical school. It is interesting to note that the aforementioned healthcare professions report the use of preceptors during the formal years of the educational process. The nursing literature also reports the use of preceptors as a learning strategy for prelicensure nursing students (Brammer, 2006; McGregor, 1999; Nehls, Rather, & Guyette, 1997; Rose, 2008) as well as post education in the practice setting (Bratt, 2009; Friedman et al., 2005; Hatler et al., 2011; Krugman et al., 2006; Lee et al., 2009; Myers et al., 2010).

The pharmacy, medicine and nursing literature all describe residency programs for the novice practitioner. Residency programs for physicians and pharmacists are required as a term of employment and are accredited by a national accrediting body (Goode et al., 2009). These programs also receive pass-through dollars from the Centers for Medicare and Medicaid that help to ease the financial burden these programs place on already cash-strapped acute care facilities. In contrast, nursing residency programs are

not required as a term of employment. Nurse residency programs are also expensive to fund and maintain and some acute care facilities struggle to expand an already tight budget to include these programs (Goode et al., 2009; Marcum & West 2004; Pine & Tart, 2007). Some hospitals with NRPs limit the number of slots available to NGNs in an attempt to rein in costs (Goode et al., 2009). The cost of all nurse residency programs is borne solely by the hospital that sponsors the residency program (Goode et al., 2009). Because nurse residencies are not required as a term of employment and very few are accredited by a national accrediting body these programs receive no federal funding (Goode et al., 2009).

NGNs are the employment pipeline for acute care hospitals (Goode et al., 2009). Early attrition from nursing during the first year of practice contributes to the nursing shortage and is costly to the organization that employs the NGN in terms of the lost human resource, health care dollars, patient safety and quality of care (Fink et al., 2008; Jones & Gates, 2007; Lee et al., 2009). Evidence suggests that a well-organized TTP program, which uses preceptors to ease the transition to professional practice can increase retention rates of this vulnerable population (Fink et al., 2008; Friedman et al., 2011; Halfer & Graf, 2011).

One specialty hospital in the Midwest developed a transition program for all nurses (NGN and experienced) entering the hospital system and modeled the program after the TTP programs described in the nursing literature. Program evaluation was conducted and served as the original study upon which the current study was based. The evaluation was broad in scope and included some information about preceptors, although

that was not the focus. The purpose of the current study was to better understand the experience of new graduate nurses (NGNs) and experienced nurses as each group transitions to a new setting in nursing practice and the contribution the preceptor role plays in that transition. The current study was framed using Schlossberg's Transition Theory. The application of a theoretical framework to guide the analysis of data lent a deeper understanding to the transition experience of nurses new to an organization.

Significance

The NGN needs to be prepared, upon completion of formal training, to practice safely and accurately in a variety of settings where innovation, technology and knowledge change rapidly. To enter practice safely the NGN must understand, among other things, a blend of nursing knowledge and science from pathophysiology, pharmacology to normal growth and development and the human experience of being ill (Benner, Sutphen, Leonard & Day, 2010). Often, experienced nurses who have changed practice settings or specialty can build on prior knowledge as they transition to the new role (Ulrich, 2011).

The ability of the NGN to practice safely and competently upon completion of formal training is an issue that is disputed among nursing school deans and hospital administrators (Berkow et al., 2008). Nearly 90% of academic leaders believe their graduates are fully prepared to provide safe and effective care upon completion of academic programs (Berkow et al., 2008). Conversely only 10% of hospital and health system nurse executives share this view (Berkow et al., 2008). The National Council of State Boards of Nursing (NCSBN) found that employers felt 35% of associate degree

nurses (ADN) and 40% of baccalaureate prepared nurses (BSN) were prepared to provide safe and effective care upon graduation (2002). Because NGNs comprise more than 10% of a hospital's typical staff it is imperative that hospital administrators and nursing school deans come together to improve the practice readiness of the NGN (Berkow et al., 2008).

It is thought that schools of nursing provide an adequate foundational platform upon which a NGN can build but that this is not enough for the NGN to transition successfully to independent practice (Goode et al., 2009). The NGN lacks entry level expectations for clinical judgement and critical thinking (Del Bueno, 2005). The NGN needs to possess critical thinking skills to accurately recognize and synthesize a patient's clinical data and then act upon that information to effectively manage the patient's problem in a safe and effective way (Del Bueno, 2005). Schools can begin to bridge the preparation-practice gap by increasing the curricular focus on the use or application of knowledge (Del Bueno, 2005).

Benner et al. (2010) offer recommendations to address the preparation-practice gap that are two-fold. First, Benner et al. (2010) recommend improving prelicensure nursing education. Benner et al. (2010) also recommend that all NGNs "be required to complete a one-year residency program focused on one clinical area of specialization so that the graduate has the opportunity to develop in-depth knowledge in that area" (pp. 228).

The report on the future of nursing also addresses the preparation-practice gap (Institute of Medicine, 2011). Recommendation Three of that report calls for the implementation of nurse residency programs and asserts 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 or nurse residency programs. These programs should be supported and available to the nurse upon completion of a prelicensure program, advanced practice degree or when the nurse transitions to a new clinical practice area (Institute of Medicine, 2011).

It is becoming apparent that TTP programs are needed to bridge the preparation-practice gap that currently exists today in nursing (Bratt, 2009; Friedman et al., 2005; Hatler et al., 2011; Jones, 2008). If nursing is to retain the human resource that is the NGN then TTP programs need to become a reality (Bratt, 2009; Friedman et al., 2005; Hatler et al., 2011). Nursing and society can ill afford to lose the NGN who should be considered a valuable member of the health care team (Almada et al., 2004; Bratt, 2009; Friedman et al., 2011; Hatler et al., 2011; Krugman et al., 2006; Lee et al., 2009; Myers et al., 2010). Nursing also needs to be sure that those new to a practice setting, regardless of prior experience, have the support they need for a successful transition.

Early attrition from nursing practice is costly and can be measured in terms of dollars, patient safety, quality of care and the lost human resource (Almada et al., 2004; Bratt, 2009; Friedman et al., 2011; Hatler et al., 2011; Jones, 2008; Krugman et al., 2006; Lee et al., 2009; Myers et al., 2010). The United States is facing a nationwide nursing shortage. Despite the current easing of the nursing shortage due to the recession, the U.S. nursing shortage is projected to grow to 260,000 RN's by 2025 (American Associations Colleges of Nursing, 2011). Although nursing has insufficient numbers entering the profession, many new nurses also leave the profession prematurely (Baxter, 2010; Casey

et al., 2004; Welding, 2011). The transition from student nurse to NGN is a stressful time and one in which a significant number of NGNs choose to leave the profession. Graduate nurse turnover has been estimated to range from 55%-61% (Casey et al., 2004). Welding (2011) asserts that 75% of NGNs leave their job within the first year of hire. Reasons cited for the early exodus from professional nursing include factors such as an unwelcoming clinical environment, high patient acuities and unfamiliar and advanced medical technology (Baxter, 2010). Other factors of discontent stem from the fact that the NGN is hired to work off-shift positions, have less support systems in place (Almada, Carafoli, Flattery, French & McNamara, 2004; Bowles & Candela, 2005) and have stress related to the transition period (Casey et al., 2004; Fink, Krugman, Casey & Goode, 2008; Halfer & Graf, 2006; Hatler et al., 2011; Schumacher, 2007; Welding, 2011; Yeh & Yu, 2009).

This transition is also a time when the role expectations of the novice nurse clash with the values learned during the educational process (Roberts, Jones, & Lynn, 2004). Adding to the values clash is the realization that the time-limited educational preparation of the SN makes it impossible for schools to prepare students for acute care practice upon graduation (Beecraft, Kunzman, Taylor, Devenis & Guzek, 2004). The end result is that NGN's are ill prepared to begin work in the clinical setting. These factors lead to significant stress and attrition from the practice and profession (Baxter, 2010). The experienced nurse in transition may also face a clash in values and culture as they move between practice settings and specialty areas in nursing making transition for this population stressful.

The failed orientation of NGNs and experienced nurses is costly in terms of dollars to the healthcare organization that employs them. It is estimated that the turnover cost per NGN who resigns from an acute care setting is \$33,841 (Casey et al., 2004). Jones (2008) conducted a study to determine the fiscal impact of nurse turnover for the year 2002. Jones (2008) calculated that costs per nurse turnover can vary from \$8,000 - \$64,000. Regardless of the methods used to calculate the cost of nurse turnover, two things are certain, replacing a nurse is costly and healthcare organizations can ill afford to spend valuable health care dollars in this fashion.

Retention of nursing staff is not only important to hospital organizations in terms of lost dollars and workers, it is also important in relationship to patient safety. The National Council State Boards of Nursing (NCSBN) (2012) asserts that more than 40% of NGN's report making a medication error. An experienced nurse not familiar with the hospital system or unfamiliar with the patient population is also capable of making a medication error. Organizations with lower turnover rates of nursing staff have reported shorter lengths of stays and lower mortality rates for patients (Jones, 2007). Lee et al. (2009) found evidence that linked the use of preceptors for orientation with improved quality of care and retention of new nurses. The indicators for quality of nursing care included medications error rate data, the number of patient falls, and the adverse event incident rates. Lee et al. (2009) found that after the introduction of a preceptor-based orientation program the patient falling incidents, adverse event incidents and medication error rates decreased significantly. Medication errors made by new nurses were

eliminated after the introduction of the preceptor-based orientation program (Lee et al., 2009).

Retaining NGNs among the nursing staff is essential if we are to turn the tide on the nursing shortage. Well-planned and executed TTP programs that utilize a one on one preceptor to NGN relationship can help provide both the NGN with the structure, support and guidance they need to transition to the practice of professional nursing. These types of TTP programs and one-on-one relationship with preceptors may also help the experienced nurse transition to a new practice setting. These programs may also position healthcare organizations to provide a better and safer quality of care while preserving valuable health care dollars.

Theoretical Framework

Schlossberg's Transition Theory can be used to frame studies that investigate the transition of the NGN or an experienced nurse new to practice setting or organization and the role preceptors play in that transition. Schlossberg's work and writings on the transition theory stem from a fascination with how adults develop and deal with life's ups and downs (Schlossberg, Waters, & Goodman, 1995). The interest in how adults develop led to study on how adults deal with the ordinary and the extraordinary process of living and how to help them do it. Grounded in the social sciences, Schlossberg's goal is to help counselors acquire the knowledge, skills and attitudes that will enable them to work more effectively with their adult clients who are in transition. Schlossberg, Lynch and Chickering (1989) define a transition as an event or process that results in change over time.

Schlossberg's Transition Theory provides a framework for counselors, friends, colleagues and others as they listen to the stories of others in transition. While the transition experience of individuals may differ, the model or theoretical framework for understanding the individual in transition is stable. The transition model can be used to assess where the adult is in the transition process and what his/her resources are for coping with the change (Anderson et al., 2012). Schlossberg's Transition Theory is the framework that guided the current study and framed the research questions. Schlossberg's Transition Theory as it applies to the transition of a NGN or experienced nurse new to a practice setting is presented in Figure 1. A detailed explanation of this model can be found in Chapter Two.

Conceptual Definitions

Preceptor. A preceptor is a nurse who is responsible for teaching, counseling, inspiring and supporting the growth of newly hired nurses. The preceptor is also an individual who serves as a role model and is responsible for the socialization of newly hired nurses. The preceptor also serves as an evaluator giving feedback to newly hired nurses that will support growth from that of a dependent to independent team member. The preceptor is also an advocate for the nurse, protecting them from harmful situations and seeking out learning opportunities needed for successful assimilation to the role of professional nurse in the organization (Baxter, 2010; Billay & Yonge, 2004; Bowen, Fox, & Burrige, 2012; Yonge et al., 2007). As such, the preceptor is part of the support and strategies the nurse in transition would have as a coping resource.

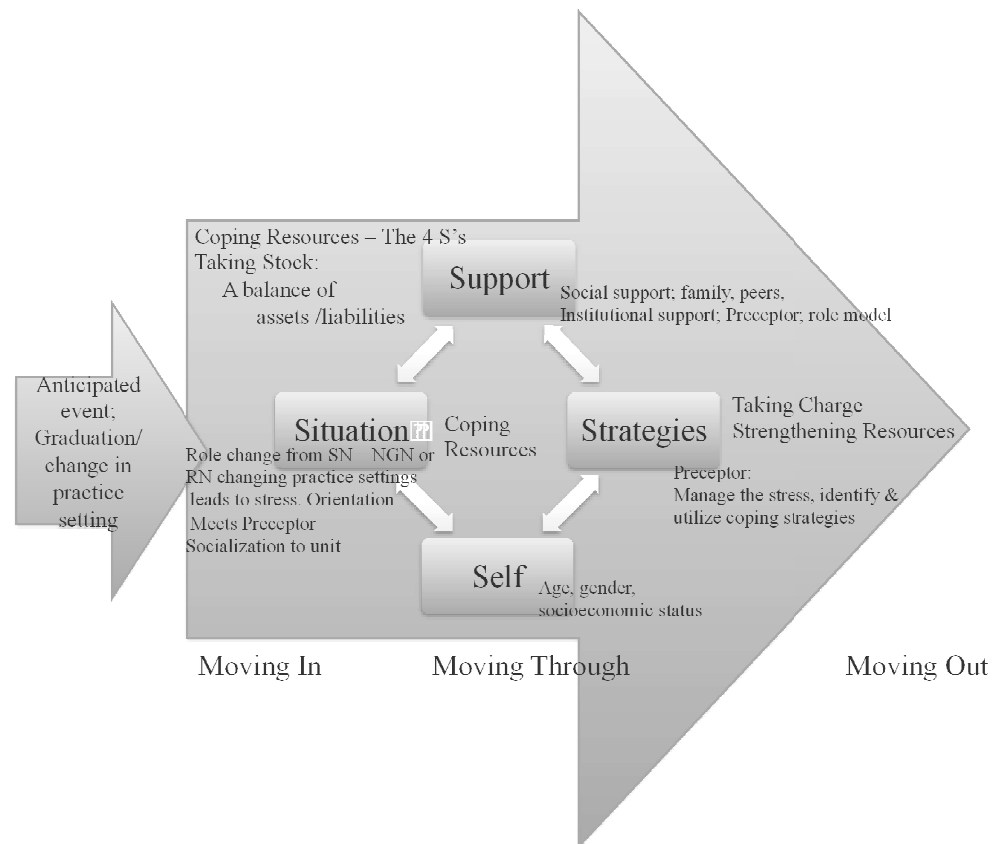


Figure 1. Schlossberg's Transition Theory and the transition process & the NGN or RN changing practice settings. Adapted from Figure 2.1 The Individual in Transition, Counseling Adults in Transition, Fourth Edition: Linking Schlossberg's Theory With Practice in a Diverse World Mary Anderson, PhD; Jane Goodman, PhD; Nancy Schlossberg, EdD Copyright 2011, Reproduced with the permission of Springer Publishing Company, LLC
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Transition. A transition is any event or non-event that results in changed relationships, routines, assumptions and roles (Schlossberg et al., 1995). A transition as defined for this study is the life change of graduation and role change from student nurse to professional nurse, or of moving to a new role or specialty in nursing or moving to a new organization.

Nurse in transition. For this study the nurse in transition is a newly hired nurse, either a NGN or an experienced nurse who is changing specialties or a physical work setting. A NGN as defined for this study is a nurse who has recently graduated from an accredited school of nursing, who has passed the National Council Licensing Examination – RN (NCLEX - RN) and has less than one year of experience in the role of RN. An experienced nurse is an RN who has passed the NCLEX – RN examination and has worked one year or more in the role of RN. The experienced nurse for the purpose of this study may or may not have prior experience working with the specialty patient population of the hospital of the current study.

Research Questions

The purpose of the current study was to better understand the experience of new graduate nurses (NGNs) and experienced nurses as each group transitions to a new setting in nursing practice and the contribution the preceptor role plays in that transition. The qualitative data used for this secondary analysis were collected to evaluate an expanded orientation program at a specialty hospital in the Midwest. The data were collected from newly hired nurses and included both the NGN and experienced nurse transitioning to a new practice setting. Schlossberg's Transition Theory provided the framework for the research questions that guided the current study and included the following;

- As NGNs and experienced nurses transition to a new professional practice setting how do their perceived needs for a successful transition change over the first year?

- As NGNs and experienced nurses transition to a new professional practice setting how do their coping resources change over the first year of practice?
- How do the NGNs and experienced nurses perceive the preceptors use of their knowledge and skills to help support them to explore, understand and cope with transition?
- How do NGNs and experienced nurses describe the change in the role of the preceptor over the first year?

Summary

The transition from nursing student to NGN to the role of experienced registered nurse is difficult and lengthy. It has been reported (Casey et al., 2004) that it takes a NGN at least 12 months to feel comfortable and confident practicing in the acute care setting. Because of this lengthy and stressful transition, the retention rate of this vulnerable group of nursing professionals is poor. Many NGNs leave the profession prematurely with 60-75% leaving nursing during the first year (Baxter, 2010; Welding, 2011). Evidence suggests that the use of well planned and executed TTP programs that are staffed with preceptors can increase the retention of this vulnerable group of nurses (Bratt, 2009; Friedman et al., 2005; Hatler et al., 2011; Jones, 2008). Little is known about the transition of the experienced nurse who transitions to a new practice setting. Retention of any nurse who is performing well results in improved quality and savings to the organization. Quality can be measured in terms of decreased falls and fewer medication errors (Lee et al., 2009). Savings can be measured in terms of dollars and avoided cost. Retention of NGNs is also essential if we are to turn the tide on the nursing

shortage. Well-planned and executed TTP programs that utilize preceptors can help provide this vulnerable group healthcare providers with the structure, support and guidance they need to transition to the practice of professional nursing. These same programs may also provide the experienced nurse transitioning to a new practice setting the structure and support they need to ensure a successful transition.

The purpose of this study was to better understand the experience of new graduate nurses (NGNs) and experienced nurses as each group transitions to a new setting in nursing practice and the contribution the preceptor role plays in that transition. Schlossberg's Transition Theory was used to frame the research questions and guided the secondary analysis of data collected as part of the program evaluation. Schlossberg's Transition Theory can be used, unchanged, to frame studies that investigate the transition of the NGN, a nurse new to a practice setting or organization and the role preceptors play in that transition.

Chapter Two includes a review of literature and a detailed description of Schlossberg's Transition Theory. Chapter Three details methods used to collect and analyze data in the original and current studies. Chapter Four details the findings of the current study and Chapter Five includes a discussion of those findings and their implications for theory, practice education, research and policy.

Chapter Two

Literature Review

This chapter begins with a description of Schlossberg's Transition Theory and includes evidence to support its use in this secondary analysis of data. This chapter also presents the review of literature that spans the years from 2002 to the present. There is a paucity of literature that examines the transition of nurses new to an institution or those changing focus and the use of preceptors to aid in their transition. Therefore, literature was examined that deals with the transition of the NGN to the role of RN and the use of preceptors in that transition. The business literature was also reviewed in an attempt to determine if other professionals transition to their role in the same way nursing professional's transition. Each study is critiqued after its review.

Upon completion of the review of literature the studies are compared and contrasted. The literature is then critiqued and problems across studies are discussed. The chapter concludes with a synthesis of the literature. Gaps in the literature are identified and a discussion regarding the current study's ability to fill those gaps follows.

Theoretical Framework

Schlossberg's Transition Theory is the framework that guided the study. Schlossberg's work and writings on the transition theory stem from her fascination with how adults develop and how they deal with life's ups and downs (Schlossberg et al., 1995). Schlossberg's interest in how adults develop led her to study how adults deal with the ordinary and the extraordinary process of living and how to help them do it. Grounded in the social sciences, Schlossberg's goal was to help counselors acquire the

knowledge, skills and attitudes that will enable them to work more effectively with their adult clients who are in transition (Schlossberg et al., 1995). Schlossberg, Lynch and Chickering (1989) define a transition as an event or process that results in change over time.

Schlossberg's Transition Theory provides a framework for counselors, friends, colleagues and others as they listen to the stories of other in transition. Although the transition experience of individuals may differ the model or theoretical framework for understanding the individual in transition is stable. The transition theory can be used to assess where the adults are in the transition process and what their resources are for coping with the change (Anderson et al., 2012).

Figure 2 is a model depicting Schlossberg's Transition Theory and the interrelationships found among the concepts embedded in the theory. The intersection of the small arrow imposed upon the larger arrow is where the transition experience of an individual occurs. The areas of support, strategies, self and situation are what Schlossberg describes as the 4 S's. Anderson et al. (2012) state that no matter where an individual is in the transition process and no matter what the transition is the individual will deal the transition differently depending on these 4 S's. The multi-directional arrows between the concepts of the 4 S's imply each has a relationship to the other as the individual tries to balance his/her assets and liabilities.

Assumptions of Schlossberg's Theory

The three underlying assumptions of the Schlossberg theory that are based on adult development theory and the helping skills influenced the framework:

- Adults in transition are often confused and need assistance. Often times they can identify the troubling issues and in turn these issues relate to the individuals' ability to love, work and play. When the individual is able to explore the issue more fully and understand its meaning and develop a plan they are more likely to be able to effectively cope and resolve the problem (Anderson et al., 2012).

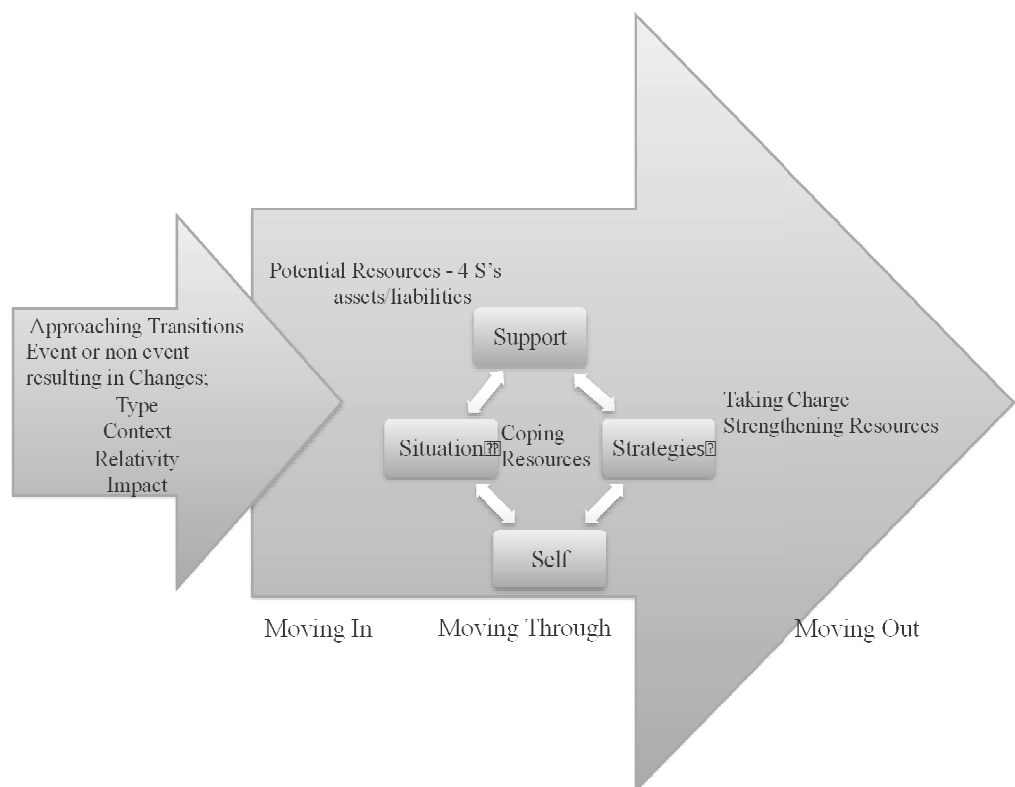


Figure 2. Generic model of Schlossberg's Transition Theory. Adapted from Figure 2.1 The Individual in Transition, Counseling Adults in Transition, Fourth Edition: Linking Schlossberg's Theory With Practice in a Diverse World Mary Anderson, PhD; Jane Goodman, PhD; Nancy Schlossberg, EdD Copyright 2011, Reproduced with the permission of Springer Publishing Company, LLC. ISBN: 9780826106353

- Friends, co-workers, helpers and professionals can learn about issues of major concern to most adults. They can listen to the adult in transition in such a way that it facilitates exploration and they can provide that adult with a framework to help them understand the situation and they can influence the adult to cope in more creative ways (Anderson et al., 2012).
- To help adults explore understand and cope, helpers need to be able to weave their knowledge and skills at each phase of the helping process. This will enable adults to explore, understand and cope with transition (Anderson et al., 2012).

The transition theory has three major parts:

- Approaching Transitions: Transition Identification and Transition Process
- Taking Stock of Coping Resources: The 4 S System
- Taking Charge: Strengthening Resources.

Approaching Transitions

A transition is any event or non-event that results in changed relationships, routines, assumptions and roles (Anderson et al., 2012). Anderson et al. (2012) further state that a transition is only a transition if it is defined as such by the person experiencing the change. Approaching Transitions identifies the nature of the transition and provides an understanding of which perspective is best for dealing with it and it is identified in the arrow to the left in Figure 2. Transitions include obvious life changes or events like marriage, graduation and job entry. Subtle changes such as the loss of career

aspirations or loss of a job promotion are termed events or non-events. If the event or non-event results in change it can be termed a transition.

Types of transitions. The first step in approaching a transition is to identify what type of transition has happened or is happening (Anderson et al., 2012). Types of transitions include anticipated, unanticipated and non-events.

Anticipated transitions include those that occur in the course of the life cycle and that are associated with major gains and losses. Examples of these expected events include marriage, the birth of a first child, leaving home and starting a first job (Anderson et al., 2012). Unanticipated events are non-scheduled events and they are unpredictable. They usually involve crisis and eruptive circumstances that are not a consequence of life-cycle transitions. Unanticipated occupational events include being fired, laid off or demoted, or being promoted and leaving a familiar job. Personal, parental unanticipated events include divorce, separation, sudden illness or the unexpected death of a child or spouse (Anderson et al., 2012). Non-event transitions are the events that never occurred and thus alter the course of a life. Examples include the marriage that never occurred, a promotion that never happened or the child that was not born. The realization that something did not happen that was expected to happen can alter the way an individual views themselves and might alter the way they behave (Anderson et al., 2012). Four types of non-events can be identified: personal, ripple, resultant and delayed. Types of transitions are represented in the first arrow of Figure 2.

Personal non-events refer to individual personal aspirations that never occurred. Personal non-events include things such as not having a baby or never marrying

(Anderson et al., 2012). Ripple non-events refer to the unfulfilled expectations of someone close to us, which in turn alter the course of our own roles, relationships, and assumptions. For instance, if adult children marry but never produce offspring the parents of those children are upset because they are not the grandparents they had hoped to be (Anderson et al., 2012). Resultant non-events begin with an event that leads to a non-event. Failing NCLEX is an event; the resultant non-event is a delay in becoming an RN or never becoming an RN. Delayed non-events are those like marriage that can still occur (Anderson et al., 2012). It is not the transition that determines the meaning it holds for the individual, it is whether the transition was expected or unexpected that determines the meaning.

Relativity. Transition and the change it brings to an individual are relative. An anticipated change for one person might be an unanticipated change for another. The same change can have different meanings for different people. For example, one person might feel that retirement is just wonderful; another person might typify it as the worst thing that ever happened to them (Anderson et al., 2012). An individual's appraisal of the transition is key. Is the experience a positive or a negative one or is it seen as benign? How a person appraises the event will clearly influence how they feel and cope with the transition or non-event (Anderson et al., 2012). Relativity is represented in the arrow to the left in Figure 2.

Context. The relationship of the individual to the event or non-event resulting in change is central to our understanding of transitions (Anderson et al., 2012, p. 44). If the event or non-event is happening to the individual they can mobilize resources that will

affect the transition process in a positive fashion. But if the event or non-event is happening to someone else that affects the individual they can do little else but sit by and feel the tragedies or excitement as if it were happening to them (Anderson et al., 2012). Context is represented in the arrow to the left in Figure 2.

Impact. It is not the event or non-event that is important to an individual undergoing transition, it is the impact, or the degree to which the transition alters ones daily life that is important (Anderson et al., 2012). The assessment of a transition's impact on relationships, routines and roles is probably the most important consideration in understanding a given situation (Anderson et al., 2012). The larger the transition either good or bad the more it will pervade and impact an individual's life (Schlossberg et al., 1989). Impact is represented in the arrow to the left in Figure 2.

The Transition Process

While the onset of transition may be linked to one identifiable event, transitions are really a process over time (Anderson et al., 2012). Anderson et al. (2012) describe the actual transition process as one of moving in, moving through and moving on. This relates to the timeframe needed to successfully transition.

In any transition the first stage can be thought of as either moving in or moving out. All individuals who use moving in as a starting point have common agendas and needs. These individuals need to become familiar with the rules, regulations and norms of the profession as well as the new institution (Anderson et al., 2012). Institutions need to devote a great deal of time to the individual who is moving in. This is the period of time during which orientation occurs, a process designed to help individuals in transition

know what is expected of them (Anderson et al., 2012). Moving in is represented at the bottom of Figure 2 and is placed near the tip of the arrow on the left, or where the transition process begins.

Once in, individuals in transition begin the long process of moving through. Moving through begins once those in transition know the ropes (Anderson et al., 2012). At this point in the transition, individuals will require help sustaining their energy and commitment to the process. Moving through is an in-between time when questions about the transition occur. Those in transition may ask themselves if they've done the right thing or if they have the inner resolve to commit to the transition (Anderson et al., 2012). Moving through is represented at the bottom of Figure 2 and placed below the area in the second larger arrow to the right that represents the 4 S system of coping resources. The individual in transition needs to employ the 4 S system and balance assets and liabilities in order to successfully transition.

Moving out can be seen as ending one series of transitions and asking what comes next (Anderson et al., 2012). Grieving can be used to explain the emotion and behavior that accompany this phase of the model. People grieve when they feel loss. Changing jobs, moving or returning to school are all situations in which individuals in transition mourn the loss of former goals, friends and structure (Anderson et al., 2012). In actuality a transition has no endpoint. A transition is a process over time that includes phases of assimilation and continuous appraisal as those individuals in transition move in, move through and move out of transition (Anderson et al., 2012). Moving out is represented in

Figure 2 and can be found near the bottom and toward the tip of the larger arrow on the right. Its place in the figure represents a move toward the end of the transition process.

Taking Stock of Coping Resources

Studies of change have shown that people in transition have both strengths and weaknesses. The potential resources or deficits for coping with change in the transition model are clustered into four major categories and are referred to as the 4 S's, or situation, self, supports and strategies (Anderson et al., 2012). The 4 S component employs a ratio of assets to liabilities and allows for changes in the ratio as an individual's situation changes. This approach helps to answer the question of why some people cope differently to the same type of transition or why the same person reacts differently at different times (Anderson et al., 2012). The difference may be that the balance of assets and liabilities has changed. By looking at the balance between assets and liabilities it is possible to predict how the person will cope with the transition (Anderson et al., 2012). The 4 S system can be seen in the center of the larger arrow to the right in Figure 2. The multi-directional arrows between the concepts indicate an interrelationship among the concepts as the individual in transition tries to balance the ratio of assets and liabilities.

Situation. Every individual's situation varies according to a number of factors. These factors need to be considered because they influence the way an individual approaches transitions. The trigger is one of those factors. Triggers cause an individual to look at their lives in a new way. A trigger is a life event that precipitates the transition.

Timing refers to an individual's built in social clock that gauges whether a transition happens 'on time' or 'off time' with respect to family, career and social issues. Transition events or non-events are also described as happening at a 'good time' or a 'bad time' (Anderson et al., 2012).

The source of some transitions is an internal, deliberate decision on the part of the individual; they have control. Other times the transition is forced upon the individual and they have no control. In this instance the transition is external. Even if the transition is beyond the control of the individual his/her response to the change can be within his/her control (Anderson et al., 2012).

Most transitions involve a role change. Regardless of role gain or loss some degree of stress will accompany this change and the change will be difficult. The degree of difficulty will depend on whether the new role is a loss or a gain, is positive or negative or has explicit norms and expectations attached to it (Anderson et al., 2012).

The time it takes to experience the transition can be referred to as duration. Duration of change affects the ease or difficulty of assimilating to the change. A change that is perceived as permanent will be perceived differently than one that is only temporary. Uncertainty about the duration is connected with the greatest degree of stress and negative effect (Anderson et al., 2012).

If an individual has had a prior experience with a similar transition in the past he/she will probably be successful assimilating to another transition of a similar type. If he/she has had a negative and unsuccessful transition to a particular experience in the

past, when confronted with a transition of a similar nature they may become more vulnerable and less able to cope.

“Often transitions in one area stimulate other stresses and transition” (Anderson et al., 2012, p. 77). This is referred to as concurrent stressors and it can upset the balance of assets and liabilities when dealing with transition and stress.

How the individual views who or what is responsible for the transition affects how that individual appraises the transition. Does the individual assess the transition as positive, negative or benign (Anderson et al., 2012).

Self. Another element of an individual’s coping assets and liabilities is what that individual brings to the transition. Individual characteristics such as socioeconomic status, gender, age and stage of life and state of health, bear directly on how the individual perceives and assesses life (Anderson et al., 2012). Men and women handle transition differently. Women have a greater capacity for intimacy and mutuality and this may make it easier for them to assimilate certain transitions. Men are more distressed by the ups and downs of emotional strife because it has been suggested that they have been socialized to hide emotion and deny problems (Fiske & Chiriboga, 1990). Psychological age is more important than chronological age when it comes to dealing with transitions. Complicating age is the process of aging. The process of aging constitutes a series of events that require adaption on the part of the individual. Life stage, not chronological age may be an even more useful concept in examining transitions. The individual’s state of health also affects his/her ability to assimilate to transition and may be a source of stress. Ill health constitutes a transition in and of itself.

Demographics and personal characteristics are important as filters and mediate whether or not an individual's life will be altered or not in ways basic to the individual. When examining self and transitions these variables need to be explored.

Psychological resources are the personality characteristics people draw upon to help them withstand threats. Psychological resources include ego development, self-efficacy and commitments and values (Anderson et al., 2012). Ego development refers to a person's level of maturity and frame of reference. Optimism refers to an individual's outlook on life. Does this person see the glass half full or half empty? If the individual is an optimist he/she is able to bring to the transition the greatest resource of all, a strong sense of self (Schlossberg et al., 1989).

Self-efficacy is a related concept and it can predict how well an individual will negotiate transitions. Self-efficacy is a person's belief in his/her capability to exercise control over their own motivations and behaviors and environmental demands (Anderson et al., 2012).

An individual's major commitment whether it is interpersonal, altruistic, self-protective or one of mastery determines that person's level of vulnerability. An individual's reaction to and assimilation of transitions are influenced by their commitments. Commitments change over time and with this change so comes a change in that individual's area of vulnerability (Anderson et al., 2012).

A person's value system also contributes to assimilation to transition. Values change over time and a value system that contributes to assimilation at one stage of life may be dysfunctional at another (Anderson et al., 2012).

Support. The importance of social support is said to be the key to handling stress. The support people receive when assimilating to transition are classified according to the source: intimate relationships, family units, friends and institutions or communities (Anderson et al., 2012).

Intimate relationships that involve trust, support and understanding are an important resource during a stressful transition. The family unit can also ease the stress incurred during transition, those who receive support from the family unit adapt better to a new situation than those who don't receive the support. A network of friends is also an important social support system. The absence of friends may exacerbate the difficulties of those in transition. Conversely, the presence of friends can cushion the shock associated with stressors of transition. Religious institutions and community support groups can also help an individual assimilate to transition (Anderson et al., 2012).

External supports and options include the potential emotional support from family, intimate friends and co-workers. To be able to deal with transitions successfully requires that those close to the individual in transition offer more support than sabotage (Anderson et al., 2012).

Strategies. Strategies refer to the way people do things, or cope in order to avoid being hurt by life's strains. Coping strategies are also related to a person's psychological resources of self-esteem and mastery (Anderson et al., 2012). Strategies for coping with stress can be grouped into three areas: (a) strategies to modify the situation; (b) strategies to modify the meaning of the situation; and (c) strategies to manage the stress (Anderson et al., 2012).

Strategies to modify the situation are aimed at altering the source of the strain. This includes tactics like negotiation; trying to find a fair compromise or sitting down to work things out. Another strategy is optimistic action, taking action to get rid of the difficulties. Self-reliance versus advice seeking is another strategy used to modify the situation. Lastly one can helplessly resign and decide there is really nothing that can be done to change things (Anderson et al., 2012).

Strategies to modify the meaning of the situation aim to control the meaning of the problem in order to cognitively neutralize the threat (Anderson et al., 2012). Strategies include the use of positive comparisons, selective ignoring of the situation and a substitution of rewards.

Strategies to manage the stress include activities such as an emotional discharge or yelling crying or laughing (Anderson et al., 2012; Charner & Schlossberg, 1985). Other approaches to manage stress include running, walking, meditating or other forms of relaxation (Schlossberg et al., 1989). Self assertion and passive forbearance are other strategies aimed at managing the stress after it has occurred (Anderson et al., 2012).

Most individuals when faced with a transition try to control the situation control the meaning of the situation or try to control the stress the situation has caused them. What is important to remember and to recognize is that those individuals who do effectively cope use more than one coping strategy at a time.

Taking Charge and Strengthening Resources

An individual's ability to cope with transition depends on the changing interaction and balance of assets and liabilities. Strengthening resources demonstrates the use of the

new coping strategies. Even though some transitions are out of an individual's control, they can control the ways in which they manage the situation. They can strengthen their resources by employing the 4 S system. Taking Charge and Strengthening Resources is seen toward the tip of the larger arrow on the right in Figure 2 and it's placed before moving out. When an individual in transition takes charge and manages the situation of transition they are near the conclusion of the transition and moving out.

Application of Schlossberg's Theory to the Nurse in Transition

Schlossberg's Transition Theory can be used to frame studies that investigate the transition of the NGN, a nurse new to a practice setting or an organization and the role preceptors play in that transition. Most of what is known regarding the transition of the NGN to professional nursing comes from the study of traditional age graduates; those individuals in their early 20's. Little is known about the transition to practice of the older adult; the individual who chooses nursing as a second career or the experienced nurse new to a specialty or practice setting. Assumptions of the model can be applied unchanged to either demographic of the NGN population and the nurse with practice experience.

Figure 1 was first presented in Chapter 1 to enhance the understanding of the theoretical context of the study. It is reproduced here to assist the reader to follow the explanation of the framework as it is applied to the current study.

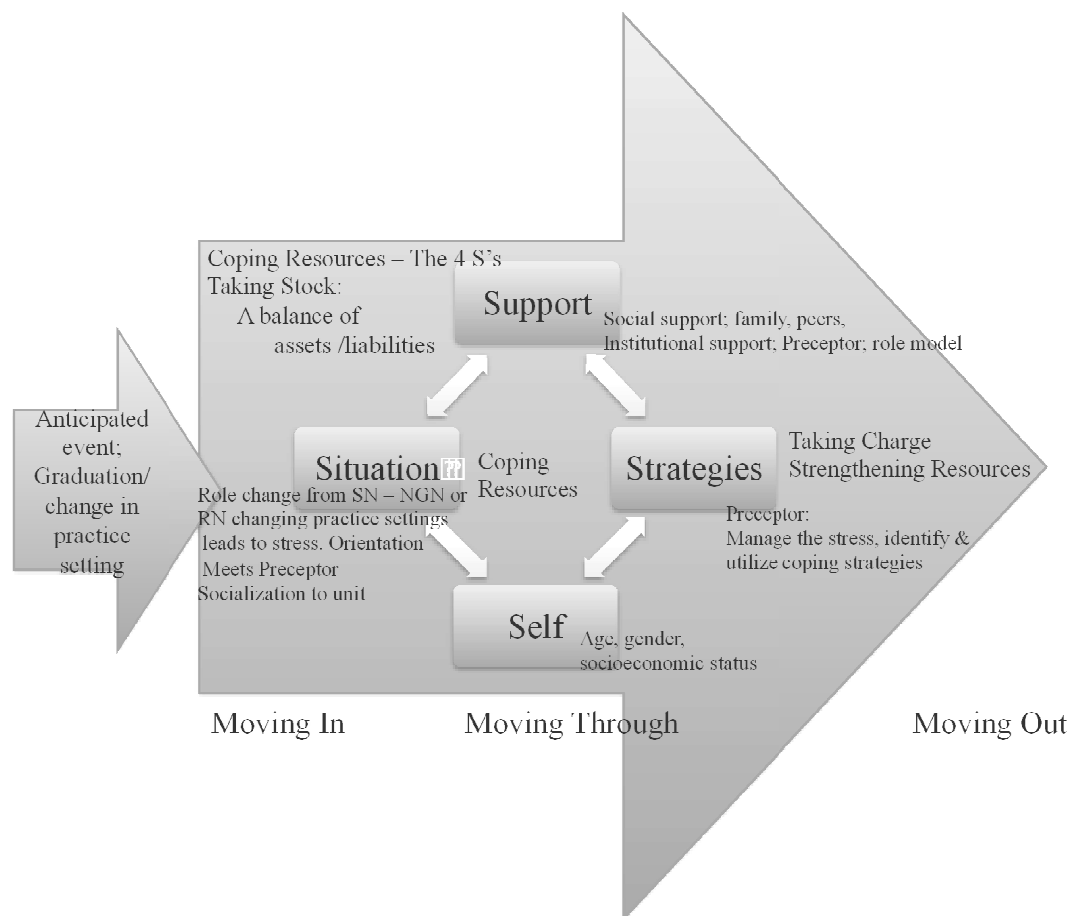


Figure 1. Schlossberg's Transition Theory and the transition process & the NGN or RN changing practice settings. Adapted from Figure 2.1 The Individual in Transition, Counseling Adults in Transition, Fourth Edition: Linking Schlossberg's Theory With Practice in a Diverse World Mary Anderson, PhD; Jane Goodman, PhD; Nancy Schlossberg, EdD Copyright 2011, Reproduced with the permission of Springer Publishing Company, LLC
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Figure 1 is a model of Schlossberg's Transition Theory as it represents the nurse in transition, whether they are a NGN or a nurse with practice experience, and the preceptors' involvement in that transition. The components of the 4 S' s influence the

ability of an individual to cope during a transition. These four components can be regarded as either potential assets or liabilities and the multi-directional arrows within the model suggest an interrelationship among those concepts. The preceptor's role in the transition of the NGN is weighted more heavily among the concepts of support and strategies and this may be true for other nurses as well. The preceptor provides institutional support to the NGN and other nurses during the transition. The preceptor is in place to share knowledge and skill and to provide an atmosphere in which the NGN can learn while he/she makes the transition to a contributing member of the health-care team. Another role of the preceptor is to help the NGN identify and utilize coping strategies to effectively manage the stress related to the transition to the practice of professional nurse. The NGN has both assets and liabilities as they experience the transition to role of an experienced nurse, as might the nurse changing practice settings; the preceptor is in place to help each group balance the two.

Approaching Transitions: the Preceptor and the Nurse

The NGN in this model is experiencing what Schlossberg describes as an anticipated event. Starting a first job or embarking on a nursing career upon graduation from a program of study is what Schlossberg refers to as an anticipated transition. This is represented in the arrow on the left of the model in Figure 1. How the NGN views the change will be key to his/her transition. In most instances this long anticipated event and transition is viewed as a positive. This view supports Anderson et al. (2012) concept of relativity. Impact refers to the degree to which the transition alters a person's daily life (Anderson et al., 2012). The impact this transition imposes upon the daily life of the

NGN or an experienced nurse moving to a new setting is considered to be major by most. All of the NGNs are moving from a role that is comfortable and familiar to one that is different, requires a different skill set and carries a different level of responsibility and accountability. The same can be said for the experienced nurse who is transitioning to a new specialty in nursing. Most NGN's also face the added impact of a maturational change that sees them leave school and the school community and at the same time establishing a home of their own (Ulrich, 2011).

The Transition Process: the Preceptor and the Nurse.

Transition is a process over time and the onset of that transition is usually linked to one identifiable event (Anderson et al., 2012). Anderson et al. (2012) describe the actual transition process as one of moving in, moving through and moving on, and this relates to the timeframe needed to successfully transition. A relationship with a preceptor is also limited and measured in terms of time; it has a beginning and an end point. Using Schlossberg's theory one could postulate that the relationship of preceptor and nurse begins when the NGN moves in and ends when the NGN moves out of transition.

Moving in is the first stage in any transition (Anderson et al., 2012; Schlossberg et al., 1989). It is at this time that the NGN will begin the process of orientation and will most likely meet their preceptor. This is when the NGN will become familiar with the rules and regulations, norms and expectations of the new organization. Schlossberg et al. (1989) also states that, in an attempt to reduce turnover, this is the time to have clear expectations about what is in store and to be socialized into the explicit norms, roles and culture of the organization. The experienced nurse transitioning to a new practice setting

will also follow the same orientation trajectory as the NGN. The preceptor is in place to help both groups of new nurses move in and begin the transition. The preceptors are the individuals who will serve as role models and are also responsible for socializing the novice to the role of professional nurse. Proper socialization includes actively integrating the new nurse into the culture of the unit and the organization (Baltimore, 2004; Murphy, 2008). Moving in is represented in Figure 1 where the tip of the arrow on the left intersects with the larger arrow to the right of the figure.

Once in, the newly hired nurses begin the long arduous task of moving through. Schlossberg et al. (1989) assert that moving through begins once the newly hired nurses “...know the ropes” (p. 16). Successful transition to the role of professional nurse is known to be a lengthy process. The NGN reports the first three to six months as being the most stressful (Almada et al., 2004; Fink et al., 2008) and that the level of stress declines between nine and twelve months (Fink et al., 2008). Little is known about the timeline of transition for the experienced nurse transitioning to a new practice setting or specialty. Moving through is the time in the transition when the NGN begins to wonder if they’ve made the right choice regarding career (Ulrich, 2011). At this time some decide to leave their first position and in some instances nursing altogether (Welding, 2011). Welding (2011) states that 75% of NGNs leave their job within the first year. Because of the difficulties encountered at this point in the process the preceptor is needed to help the NGNs map a successful course of transition that begins with an orientation to the culture and facility and navigates the transition process with success to ensure longevity in career. The preceptor can be used to help the NGNs sustain their energy and

commitment to the process during the long process of moving through (Schlossberg et al., 1989). Moving through is represented in Figure 1. This phase of the transition process is centered in the second larger arrow on the right that represents the 4 S system of coping resources.

Moving out can be seen as ending one set of transitions and asking what comes next (Anderson et al., 2012). For the NGNs this is the time when they sense they have ‘made it’ (Schlossberg et al., 1995, p. 45). They are regaining their confidence, are realizing that they can care for very ill patients, are organized and can answer most questions that are posed to them (Goode et al., 2009). This phase of the transition process is located at the tip of the second larger arrow on the right of the figure.

The 4 S System: the Preceptor and the Nurse

The preceptor is in a unique position to be a part to of the 4 S system and to help the newly hired nurse employ the 4 S system to effectively navigate the transition process. The situation for the NGN is one of transition to the role of professional nurse that is an event that is triggered by graduation from nursing school. If the transition involves a practicing nurse then the event would be triggered by a move to another unit or another organization. Regardless of the trigger the transition involves a role change accompanied by concurrent stress. The concepts of the 4 S system are represented in the center of the second larger arrow on the right in Figure 1.

The self is what the individual in transition brings to the situation. Self is concerned with factors such as age at time of transition, gender and socioeconomic status. A preceptor will need to forge a strong relationship with the newly hired nurses to help

ensure them a successful transition. If relationships are to be formed and a bond established then the preceptor will need to have an awareness of the newly hired nurses self. Support is said to be key to handling stress. Anderson et al. (2012) states that stress is associated with transition and that most individuals experiencing transition have multiple sources of stress. In this instance the preceptor can be viewed as a source of support; a role model who teaches, instructs, supervises and socializes the newly hired nurses.

Strategies allow newly hired nurses to cope with the transition. Coping strategies include those that seek to modify the situation, modify the meaning of the situation or manage the stress. Preceptors are in place to help the newly hired nurses directly manage the stress of a transition. But the overarching goal of the preceptor relationship should be to help the newly hired nurses strengthen their resources and demonstrate the use of successful strategies to successfully transition to practice or a new role in professional nursing. Coping strategies for an experienced nurse new to a practice setting may be different than those employed by a NGN but regardless, the preceptor is in place to help the experienced nurse strengthen their resources to help ensure a successful transition to a new practice setting.

Taking Charge, Strengthening Resources: the Preceptor and Nurse

The preceptor is in a position to bond with newly hired nurses and help them manage the stress associated with the role transition. The preceptor can step back and take inventory of the NGN's assets and liabilities as defined by the 4 S system. By assisting the NGNs to strengthen coping assets the preceptor can support the NGNs to

seek the balance they need to successfully manage the stress of role transition. The same holds true for experienced nurses who are transitioning to a new setting. Taking charge and strengthening resources is seen near the tip of the second larger arrow to the right. Taking charge and strengthening resources is placed before moving out near the tip of the second larger arrow on the right in Figure 1. When an individual in transition takes charge and manages the situation of transition they are near the conclusion of the transition and moving out.

Rationale for Choice of Model

Schlossberg's Transition Theory is relevant to nursing and the nurse in transition in several ways. Nurses experience transitions throughout their career. The first and most formidable of those transitions is the one that finds them leaving the safe and secure environment of nursing school and transitioning to the role of professional nurse. The difficulty that the NGN will experience when making the transition to professional nurse is well documented. The NGNs face unwelcoming clinical environments, high acuity patients and advanced medical technology (Baxter, 2010). Little is known about the transition of the experienced nurse to a new practice setting but the transition of either group holds the potential for growth or deterioration. The transition of NGNs often times results in deterioration; it is estimated that as many as 60% of NGNs will leave their first nursing position within the first year of employment (Halfer & Graf, 2006). The use of a preceptor to help guide the nurse through the transition process may be viewed as a type of support. When the preceptor can help the transitioning nurse understand the Self they can provide Support and help the transitioning nurse employ effective coping Strategies

to successfully navigate the transition. Schlossberg's theory is well suited as a framework for this study and analysis of data. This theory can be applied unchanged to this body of work.

Review of Relevant Literature

Methods

The CINAHL, MEDLINE, ERIC and Cochrane Library databases were searched for literature addressing the issue of NGNs in transition, TTP programs and Schlossberg's Transition Theory and its application to nurses in transition. Separate searches were conducted for each broad topic. Terms used for literature that detailed NGNs in transition and TTP programs included: new graduate nurse, orientation, transition, preceptor, nurse residency and transition to practice program. The search spanned from 2002 - 2012. The rationale for the selection of this time frame corresponds to the Joint Commission on Accreditation of Hospitals (JCAOH) call for the establishment of standardized, structured, post-graduation training programs for nursing (Fitzpatrick, 2003). An abundance of literature is available that details TTP programs and the use of preceptors in those programs. The search yielded 4,777 hits. A review of relevant nursing literature was chosen that focused on preceptors and their role in the transition process of the NGN and that represented the three types of TTP programs described in the literature: preceptor programs, orientation programs and nurse residency programs. This body of literature was limited to six articles.

Other literature included in the review was chosen if it measured stress of those in transition, across key points in time and utilized preceptors to facilitate the transition.

Review of literature that measured stress of those in transition, across key points in time and utilized preceptors to facilitate the transition, focused on the University Health System Consortium (UHC) and the American Association of Colleges of Nursing (AACN) Nurse Residency Program (NRP). The UHC/AACN NRP was a major initiative and a significant body of literature surrounds the measured outcomes of the program. The body of literature that surrounds the UHC/AACN program outcomes includes a great deal of quantitative data and one piece of literature that reports on qualitative data collected. The piece of literature that reports on the qualitative data will be included in the review of literature because it briefly touches on the role of the preceptor and the preceptor's contribution to the NGN in transition.

A description of the Casey-Fink Graduate Nurse Experience Survey is also included in the review of nursing literature because it lays the groundwork for most of the research that surrounds TTPs and the NGN in transition. Both the quantitative and qualitative findings will be included in the review of literature.

Terms used for literature that detail the transition of experienced nurses included: experienced nurse, transition and transition to practice. Search dates corresponded to those outlined above. The search generated 57 hits. One piece of literature was found that detailed a transition to mental health practice program in Australia for both the NGN and the experienced nurse (Cleary, Matheson, & Happell, 2009). The aim of the study was to evaluate the program developed to help with the transition and not the transition process of the nurse. For this reason this piece of literature was not included in the review. Other literature was excluded because it measured the experience of the NGN,

the transition of the internationally educated nurse, or measured the experience of the Advanced Practice Nurse in transition. For these reasons no literature is reviewed that details the transition of the experienced nurse.

Terms used for literature that utilized Schlossberg's Transition Theory as a framework for nursing research included: Schlossberg's Transition Theory, nurse and nursing. This search did not generate any hits.

The ABI/Inform database was searched to review literature that describes the professional in transition. Search terms used included: transition to professional practice, career transition, transition and new graduates. The search was limited to scholarly journals and dates corresponded to dates used for the search of the nursing literature. The search generated 1041 hits. Literature was selected that detailed the transition process of students who were transitioning to a professional role in the working world and that used a preceptor or mentor to facilitate that transition. Only two research articles fit that description and were included in the review of literature. Literature was found that described the transition of the experienced worker, but that literature was excluded because it focused on the experienced worker, job loss and/or the transition to retirement. In addition, some literature described the transition of worker to entrepreneur. The nursing literature was also represented in this search. No literature could be found that described the transition of the professional worker to a new job setting or career.

In all a total of ten pieces of literature are reviewed: eight that describe the transition of the NGN and two that detail the transition of students who are transitioning to a professional role in the working world. Missing from the literature is a description of

how the experienced nurse transitions to a new specialty or practice and how the preceptor plays a role in that transition.

Review of Literature

The review of nursing literature begins with a review of the six articles that closely match the current study and detail the role of the preceptor involved in the transition of the NGN (Almada et al., 2004; Bratt, 2009; Friedman et al., 2011; Hatler et al., 2011; Lee et al., 2009; Schumacher, 2007). Casey et al. (2004) will be examined next because this study and the tool developed, used and revised lays the groundwork for most of the research that follows which measures the NGN and their transition experience. A brief description of the UHC/AACN NRP follows. The findings from the qualitative data gathered from the first two cohort groups from the UHC/AACN NRP follow (Fink et al., 2008). The UHC/AACN NRP used the Casey Fink Graduate Nurse Experience Survey to collect data and evaluate outcomes of the program. The business literature is then reviewed. The literature is then critiqued and theoretical and conceptual challenges are addressed. A methodological critique of the literature follows and the chapter concludes with a synthesis of all literature and gaps are addressed.

Nursing literature that focuses on the transition of the NGN and programs that use preceptors to facilitate that transition reveals three different programs that use preceptors to help the NGN transition to professional nursing practice: nurse residency programs, orientation programs and preceptor programs. All programs are similar with differences noted in structure and length. Most TTP programs are 4 to 12 months in length and share common curricular components (Hoffart et al., 2011). Common curricular elements are

designed to enhance critical thinking, improve communication and team work skills and strengthen the NGN's commitment to the practice of professional nursing (Goode & Williams, 2004; Spector & Echternacht, 2010). One similarity among all programs described is the use of a single preceptor model or a 1:1 relationship between the staff nurse (preceptor) and the NGN. As stated earlier, absent from the literature is a description of how the experienced nurse transitions to a new specialty or work setting therefore, this review of literature will also focus on the NGN. Preceptor programs will be reviewed first.

Preceptor Programs

Almada, Carafoli, Flattery, French, & McNamara (2004). Almada et al. (2004) describe a 12-week education-based preceptor program for NGNs. The goal was to provide the NGN with orientation and support as they transitioned into the new role. All preceptors in this program were required to attend a one-day preceptor-training program that included content on learning styles, communication techniques personality traits and conflict resolution. The unique feature of this preceptor program was the working relationship between NGN and preceptor. This model matched the preceptor and the NGN and together they worked in a "married state" (p. 269) for the entire 12-week orientation period (Almada et al., 2004). This model finds the preceptor and NGN working side by side with the experienced nurse acting as a resource when needed. This model allows the preceptor to be immediately available to demonstrate organizational skills if unexpected changes in an assignment occur. This contradicts the usual method

of the NGN gradually assuming responsibility for more patients as orientation progresses (Almada, et al., 2004).

Benner's Novice to Expert was used as the theoretical framework. Design was one of mixed methods that used a convenience sample of 40 NGNs who were entering practice in a small community hospital (Almada et al., 2004). The survey tool included yes/no questions, a visual analog scale (VAS) and open-ended questions. The survey return rate was 89%.

The yes/no questions asked the NGNs if they had heard about the preceptor program before coming to the facility and if it had influenced their decision to seek employment with the facility. Of the 35 NGNs who stated they had heard about the program, all 35 stated that it did influence their decision to seek employment with the facility. The NGNs were also asked to rank various aspects of the program and three aspects were rated as most important. Those aspects included: length of orientation, the matching of the preceptor with the preceptee and the availability of the professional development staff (Almada et al., 2004).

A VAS (0-100) was used to answer three questions regarding overall satisfaction with the preceptor program. The results indicated a high satisfaction rate with the program. The average of the VAS mean scores was 93.7. The facility also noted that the retention rate of NGNs was 93% compared to a 25% baseline rate (Almada et al., 2004).

The open-ended questions were aimed at helping the professional development staff make changes to the program that might improve it. No theme could be identified

among the three negative remarks (Almada et al., 2004). When asked what more the professional development staff could do to prepare and support the NGN three themes emerged: hands-on learning, instructions on systems/paperwork and education/support from professional development staff (Almada et al., 2004). Comments on the education/support theme were most common and included, “this program with professional development and preceptor support has made me very secure” (Almada et al., 2004, p. 272).

The tables used to highlight findings were well developed and easy to follow. Despite this, the results of this study must be viewed with caution. The authors note that it was difficult to monitor the new style of precepting and could not guarantee 100% compliance. The sample size was small as was the 150-bed community hospital setting (Almada et al., 2004). There are other limitations that must be considered and that are absent from the author’s remarks. The use of a VAS is also considered a limitation of the study. Disadvantages associated with VAS include problems related to inaccurate reproductions and scoring (Burns & Grove, 2005). The author states that Benner’s Novice to Expert theory served as a framework for the study; however, neither the analysis of data nor findings of the study are tied to Benner’s framework.

Lee, Tzeng, Lin, & Yeh (2009). Lee et al. (2009) set out to design a preceptor program and to evaluate its effect on NGN turnover, turn over cost, quality of nursing care and satisfaction of the preceptor’s teaching. The preceptor program was designed to establish the roles and responsibilities of the preceptor when instructing NGN’s. The preceptor program provided a nine-hour training course to all preceptors. A post-training

exam was administered at completion of the program and only those nurse preceptors who had passed the written exam could move on to become preceptors. Content of the nine-hour course was not provided. The 1:1 preceptorship program for NGNs was 3 months in length. The authors did not provide information on use of a theoretical framework. A quasi-experimental design was used to evaluate the preceptorship program. Two groups of participants were recruited from among the convenience sample of those who had completed the training program; nurses accepted to train as preceptors ($n = 24$) and NGNs ($n = 34$) accepted for a 1:1 preceptorship to ease transition to practice. All participants, in each group were female. The mean age of the preceptor was 33.5 years and the mean age of the NGN was 23.4 years. The setting of the study was an 1800 bed teaching hospital in Taiwan.

Many tools were used to collect data. Satisfaction of the preceptor's teaching behavior was measured with a scale modified from the Teaching Encounter Card and Residency and Residency Programme Evaluation tool. This is a 20-item questionnaire that used a 4-point Likert scale and it allowed NGNs to evaluate the preceptor's performance. Reliability of this tool was reported as Cronbach alpha of 0.90 (Lee et al., 2009). The preceptor's perception of benefits, rewards and commitment to the preceptor role was measured with a scale modified from the Preceptor's Perception of Benefits and Rewards Scale and the Commitment to the Preceptor Role Scale. This 20-item questionnaire utilized a 4-point Likert scale. Internal consistency and reliability of this questionnaire was reported by the authors as Cronbach alpha level 0.89 (Lee et al., 2009). Patient satisfaction was measured using the Patients' Satisfaction Towards Nursing Care

Instrument: 10 questions measured with a five-point Likert scale with a Cronbach alpha of .86 (Lee et al., 2009).

Indicators of quality nursing care included medication error rate, the number of falls and the incident rate. Nurse demographics were also collected and turnover rate and turnover cost were calculated.

Lee et al. (2009) found evidence that links the use of preceptors for orientation with improved quality of care and retention of new nurses. Medication errors, falling incidents and adverse event incidents decreased significantly. Medication errors decreased from 50%-0% when compared to the same time period the year prior to the introduction of a preceptor based orientation program. Turnover rate after the program was 46.5% less than the previous year and the turnover cost decreased by \$186,102. Patient satisfaction scores during the study were satisfactory and did not statistically differ from the year prior (Lee et al., 2009).

This study must be viewed with caution. The authors cite that uncontrolled variables such as job satisfaction organizational commitment and quality management perception may account for turnover rates and indicators of nursing quality. They also recognize that selection and assignment bias of the sample pose threats to the validity of the study. They also acknowledge that the setting of only one large hospital is a limitation in terms of generalizability of findings (Lee et al., 2009).

Other limitations not mentioned by the authors must also be considered. The setting for this study is Taiwan and the reader must ask if cultural differences hinder the generalizability and/or transferability of the findings. Questionnaires used to collect data

have also been significantly modified: the original instruments utilized a 6-point Likert scale and the reliability of the modified scales is reported to be identical to those of the original scale (Dibert & Goldenberg, 1995). The cautious reader must question if the reliability of the scales were reevaluated after changes to the original instruments were made. The authors also fail to utilize a theoretical framework for the study and this must also be considered a limitation. TTP programs that are categorized as orientation programs will be reviewed next.

Orientation Programs

Friedman, Cooper, Click, & Fitzpatrick (2011). Friedman et al. (2011) set out to determine the retention and costs associated with the employment of NGN's before and after the initiation of a specialized year-long critical care orientation program (CCNFP). Benner's Novice to Expert theory served as the theoretical framework for the study. A retrospective, descriptive design was used to evaluate retention between two independent groups of NGN's in critical care units of two tertiary hospitals before and after the initiation of the CCNFP. The fiscal impact was also calculated by comparing total annual expenditures for advertising costs, travel and agency nurse cost for the critical care units and critical care turnover for both hospitals before and after the initiation of the CCNFP (Friedman et al., 2011).

The CCNFP was a year long educational endeavor which was divided into 3 semesters. Semester one was nine weeks long and included web based curriculum, professional seminars and clinical simulation. Semester two was 12-16 weeks long and paired the NGN with a single preceptor who worked in the NGN's unit of practice. The

preceptor was an experienced critical care nurse with education in the art of preceptorship (Friedman et al., 2011). The NGN shadowed the exact schedule of their preceptor during that time period. During semester three the NGNs recieved their own patient assignment and had a nurse educator available to respond to issues that might arise (Friedman et al., 2011).

The standard orientation (SO) from 2004 consisted of two weeks of general hospital orientation and a five day core critical care course. Following the core course the NGN's worked on their assigned units three days a week, 12 hours per day. During those 12 weeks the NGN received classes in other components of critical care nursing and received help from the nurse educator only if it had been requested by the nurse manager. Orientation concluded at the end of 15 weeks and the NGN was counted in the nursing pool and included in staffing the unit (Friedman et al., 2011).

Annual retention rates for the group of individuals who attended the SO was 53.3% and 78.3% for those who attended the CCNFP. There was a significant difference in length of employment by orientation programs (SO versus CCNFP), and the length of employment was measured in days. Length of employment for the CCNFP was significantly higher ($M = 321.67$, $SD = 92.74$) than that of SO ($M = 262.90$, $SD = 126.38$) (Friedman et al., 2011).

Analyses were conducted to determine savings based on turnover. Critical care turnover was 12% in 2004 and 6.2% post CCNFP in 2007. The results were not statistically significant, however, decrease turnover yields significant cost savings. A 5.8% change in turnover rate from the 2004 SO to the 2007 CCNFP resulted in the

retention of 9.8 nurses in the critical care units studied. This decrease in turnover yields a potential savings of \$1,367,100 annually when turnover was calculated to be 1.5 – 2 times a nurse's salary. Although the turnover between the groups was not statistically significant the results were significant financially and in terms of practicality (Friedman et al., 2011). Results support the idea that specialized orientation programs which utilize preceptors help retain NGNs and that retention reduces cost to health-care organizations.

Sample size for the study was adequate. Methods used to determine financial savings related to a decrease in nurse turnover were well described. Limitations of this study include the use of a convenience sample and a retrospective comparative descriptive design. Although Benner's theory served as the foundation for the CCNFP, results were not framed in reference to the theory. Other variables that might influence a NGN's retention could not be accounted for and this must be considered a weakness of the study. A replication of the study is warranted.

Hatler, Stoffers, Kelly, Redding & Carr (2011). Hatler et al. (2011) set out to discover if using a dedicated transition unit (DTU) that included a preceptor model of orientation would attract and retain NGNs. The project used Donabedian's paradigm of structure-process-outcome as a guide. The unit used for this study was a 21-bed medical/surgical telemetry unit in a large, urban hospital in Phoenix Arizona. The unit is staffed with 35 RN's, 2 unit secretaries and seven unlicensed assistive personnel. In this study, experienced nurses and NGNs worked with only one or two preceptors while on the dedicated transition unit (DTU). NGNs worked on the DTU for a period of 4 weeks with a preceptor. During these four weeks the NGN worked with a preceptor and

shadowed their assignment. Seasoned staff nurses who had a passion for teaching were selected to be preceptors. They were given the title of Clinical Scholar (CS) to distinguish the role. All CSs had prior preceptor training but received five additional lessons that were aimed at advancing clinical teaching skills with an emphasis on being able to facilitate the clinical judgment skills of the NGN. A master's-prepared nurse educator (APN) was hired to facilitate the professional growth of both the NGN and the CS (Hatler et al., 2011).

This project incorporated the use of high fidelity human patient simulation (HPS). HPS laboratory experiences provided the NGN's interactive learning in a risk-free environment. Four scenarios were selected based on their relevance to the hospital patient population. NGNs participated in HPS experiences every two weeks and the complexity of the scenarios gradually increased over time. The CS guided the experience and evaluation occurred after each session (Hatler et al., 2011).

A daylong retreat was held to welcome new employees, to introduce the project and to obtain informed consent. Introduction of the DTU process occurred as part of new employee orientation. Each NGN shadowed a CS for one shift then over time the NGN assumed responsibility for patients with numbers increasing until each NGN was able to manage a four patient load. This process occurred over a four-week time frame and took place on the DTU. To ensure consistency the NGN worked with only one or two CS's while on the DTU. The APN facilitated weekly updates with each NGN and CSs with an emphasis on evaluating confidence with clinical skills, decision-making ability, communication with providers and ability to manage workload. The APN then tailored a

learning plan specific to the needs of each NGN. HPS experiences occurred every two weeks and were evaluated after each session through the use of videotapes, debriefing and reflection. After four weeks on the DTU NGN's completed orientation with a preceptor on their home base unit. This period of orientation lasted another 8 - 12 weeks depending on the abilities and development of each NGN. The APN met monthly with each NGN for at least one year (Hatler et al., 2011).

Staff nurse and NGN outcomes were measured at the completion of the program. The Essentials of Magnetism (EOM) scale was used to evaluate staff nurses' work satisfaction. The EOM is a 65-item scale with demonstrated validity and reliability ($\alpha = 0.89, 0.90$). Concepts measured include; RN - MD collaboration, autonomy and control over practice. The results show increases in each area from pre to post implementation. RN absenteeism was included as a component of evaluation because other investigators (Hall, 2007; Stone, Du & Gershon, 2007) have demonstrated a link between absenteeism and work related stress. The absentee rate for DTU RNs was reduced by 19% or 504 hours versus 624 hours the previous year. The authors suggest this indicates a decreased work stress (Hatler et al., 2011).

NGN outcomes and monitoring took many forms. CSs assessed the NGN weekly in terms of confidence in clinical skills, decision-making, ability to manage a workload and comfort in receiving feedback and communicating with physicians. Specific areas for growth were identified each week. At the end of the DTU clinical experience Lasater's Clinical Judgment Rubric (Hatler et al., 2011) was used as part of the evaluation of each NGN's development (Hatler et al., 2011).

Patient outcomes of satisfaction with care and condition-specific quality goals showed slight improvements over the course of the project. The project focused on patient satisfaction with nursing care, anticipating that any changes to the nursing care process might influence satisfaction levels. Nearly 300 patients responded and results suggest that satisfaction with nursing care improved slightly (pre = 91%, post = 93%) with greatest improvement in the item, “The nursing staff anticipated my needs very well” (91% before, 98% very satisfied after) (Hatler et al., 2011, pg. 92).

At the time of the publication 94% of the NGN’s involved in the study remained with the employer. Total estimated cost of the project was \$150,000 and resulted in the retention of 10 more NGN’s than seen with the previous orientation process. The estimated savings to the organization totaled \$800,000 providing an estimated ratio of cost to benefit at 1:5, and is attributed to orientation strategy that utilizes a DTU and preceptors (Hatler et al., 2011).

Results of this study must be viewed with caution. Except to state that the EOM is a 65-item scale the authors fail to further describe the tool and the scale: was it a five point or a seven-point scale, did it allow for a neutral answer? Staff nurse outcomes were poorly reported and while the authors state that there were increases in each area from pre to post implementation the authors fail to provide the reader with any evidence of statistical significance for the measure or the statement. The reader must also question the assumption the authors make that there is a link between absenteeism and work-related stress. New graduate outcomes were also poorly reported being described in vague and general terms. Lasater’s Rubric, while mentioned, was never described nor

detailed leaving the reader to wonder what it actually measured. Patient outcomes were described in the same fashion and again no statistical testing was reported to bolster the suggestion that patient response scores improved pre and post implementation of the program.

Schumacher (2007). Caring is a central component of nursing and it is a central phenomena of nursing practice (Schumacher 2007). What happens to caring ideas and concepts once the NGN leaves the sheltered environment of a school of nursing that has a caring nursing curriculum? Schumacher (2007) postulated that preceptors who role model caring behaviors can help NGN orientees to continue to construct caring practice frameworks. She focused on the orientees' perceived perceptions of caring interactions with their preceptor. This qualitative study used a phenomenological approach.

The setting for the study was a medical center located in the Midwestern United States and was made up of three facilities: two large hospitals and a clinic. A purposeful sample of ten NGNs was chosen from all NGNs who attended the 2004 – 2005 central nursing orientation. All participants were female, white and had a baccalaureate degree in nursing. The average age of the participants was 23 years (Schumacher, 2007).

Data were collected from two sources: the participants daily reflective journal and from in-depth interviews. Only seven of the participants participated in the in-depth interviews. Participants for in-depth interviews were chosen based on journal entries that gave specific examples and rich descriptions of caring and noncaring preceptor behaviors (Schumacher, 2007). In-depth interviews lasted from 30 – 70 minutes each (Schumacher, 2007).

Data from the daily reflective journals were read carefully and core themes and subthemes were extracted. After each journal was individually analyzed all extracted core themes and subthemes were reviewed collectively to extract common core themes and subthemes from the entire group of participants.

Participants who were a part of the in-depth interviews used their journals during the interview process as a resource to refresh their memories and recall feelings that had been experienced during the weeks of orientation. The interviews took place at the conclusion of the ten-week orientation period. All transcripts of the participants' interviews were analyzed using Colaizzi's technique of analyzing phenomenological data (Schumacher, 2007).

The results of this study indicated that both caring and noncaring interactions between preceptors and orientees occurred during orientation (Schumacher, 2007). The data revealed six themes of caring behaviors: advocating, welcoming, including, appropriate preceptor presence, making human connections and genuine feedback; and, four themes of noncaring behaviors: unwelcoming, preceptor over presence/preceptor under presence and feedback that was confusing and nongenuine (Schumacher, 2007). Caring themes will be reviewed first.

When preceptors took the time to make sure assignments facilitated a good learning experience and when the preceptors took the time to ask the orientees how they learned best, those caring behaviors had been identified as advocating. Orientees felt welcomed when preceptors warmly greeted them, were open approachable and demonstrated a friendly attitude. When preceptors introduced the orientee to other staff, included them

in unit activities such as unit meetings and committee meetings, the orientee felt included. Feeling included and a part of the team made the orientee less anxious and opened the door to better learning (Schumacher, 2007).

When preceptors were physically and emotionally present to help orientees with complex nursing procedures and tasks, this was interpreted as the caring theme of appropriate preceptor presence. Orientees also described exceptional preceptors who took extra time to make a deeper human-to-human connection with the orientee. As one orientee stated, “She shared things I needed to know to survive...these are things that are not listed on an orientation check off sheet” (Schumacher, 2007, p. 190).

In order for orientees to understand what they are doing well and what areas of practice they need to improve upon the orientee must be given feedback that is timely, constructive and nonpunitive. The orientees characterized caring feedback as being continuous, concise and specifically focused. The following statement from one orientee helps sum up the importance of caring feedback. “I did not even know I was improving and progressing until my preceptor pointed it out to me!” (Schumacher, 2007, p. 191).

The four themes of noncaring behaviors were the antithesis to the caring behaviors. The four noncaring themes included: unwelcoming, preceptor over presence/preceptor under presence, and feedback that was confusing and nongenuine (Schumacher, 2007). The first noncaring theme that emerged was that of unwelcoming preceptor behavior. When preceptors failed to welcome the orientee to the unit, did not smile or make eye contact with the orientee these behaviors were interpreted as unwelcoming (Schumacher, 2007).

The noncaring theme of autonomy with under presence of the preceptor occurred when the preceptor did not gauge the orientees' learning needs and abilities, did not check on them, which in turn allowed the orientees to make serious patient errors. The noncaring theme of preceptor over presence occurred when preceptors did not take the time to gauge and assess the orientees abilities and went ahead and completed tasks and nursing skills without the orientees. Other times the preceptor hovered and watched the orientee's every move. Most examples of over presence occurred when the orientees had more than three preceptors or when the preceptors had not worked with the orientees before. The noncaring theme of feedback was described as feedback that was not clear, specific or constructive. This type of feedback left the orientees feeling frustrated because they could not learn from feedback (Schumacher, 2007).

Results of this study can be used to teach preceptors about caring and noncaring behaviors (Schumacher, 2007). Positive, caring relationships can assist new nurses to feel that they are an integral part of their nursing unit and have been cited as the most important reason why nurses stay in the hospital facility in which they are oriented (Schumacher, 2007). Anxiety, fear, and stress during the first year of a new nurse's career lead to early attrition from the organization and the profession of nursing. A new nurse may decide to leave nursing altogether if this orientation period to nursing proves to be too stressful an experience. The importance of preceptors modeling caring behaviors to new orientees can support new nurses to develop caring practices with patients; help them to feel a part of the nursing team; decrease anxiety, fear, and stress, and boost retention (Schumacher, 2007).

The author failed to describe any limitations associated with the study, however, rigor in the process of data analysis must be questioned. It is not clear if the author was the sole researcher or if a team of researchers assisted with the project and analysis of data. If the author was the sole researcher then trustworthiness must be called into question and one can ask if the findings can be believed (Riessman, 2008, p. 184). The author does describe member checking for validation and credibility but does not provide any other detail about how the checking was done. The author fails to describe if sampling to saturation occurred. The author also fails to describe the use of a theoretical framework, which can be considered another limitation of the study.

Nurse Residency Programs

Bratt (2009). The Wisconsin Nurse Residency Program (WNRP) was designed to promote the effective transition of NGN's into professional practice (Bratt, 2009). Through an innovative program that provided educational and psychosocial support for newly licensed RNs the programs goal was to retain and sustain the future WI nurse workforce. The WNRP provided a comprehensive support system to NGN's which spanned a total of 15 months of practice. The program included day long educational sessions for the NGN which occurred on a monthly basis. It provided mentoring to NGN's by a designated clinical coach. Clinical coaches met with NGN's every 2 -4 weeks to offer continual support and provide the NGN with a safety net for the first 6 -12 months (Bratt, 2009).

Preceptor training was mandatory for preceptors who participated in the program. It was noted that the preceptor is pivotal in building clinical competency in the NGN.

Preceptor training was geared toward empowering the preceptors to effectively engage in their role and provided them with tools to use in real-time practice. No other description of the preceptor was provided by the author (Bratt, 2009).

Qualitative data from NGNs who had completed the program demonstrated the profound ability of the residency program to ease the transition to the role of professional nurse. Statements such as "...this was the support group I needed for my career... the education days helped the light go on" (Bratt, 2009 p. 421-422).

The WNRP was successful in terms of boosting NGN retention. One year following completion of the yearlong program 90% of nurse residents were still employed at their hospital of hire; 83% remained employed and with the same hospital after 2 years. What follows is a description of the Casey-Fink Graduate Nurse Experience Survey because it lays the groundwork for most of the research that surrounds TTPs and the NGN in transition.

Casey-Fink Graduate Nurse Experience Survey

Casey, Fink, Krugman, & Probst, (2004). The Casey Fink Graduate Nurse Experience Survey repeats in the literature in relationship to NGN population and transitions. The Casey-Fink Graduate Nurse Experience Survey is particularly useful when studying transition programs and the NGN population. This tool was designed to measure graduate nurses rather than the nursing population as a whole. The original Casey-Fink tool also included four open-ended questions about work environment and difficulties in role transition. The qualitative data analysis increases the

comprehensiveness of the study by providing a detailed description of the phenomenon which compliments the quantitative findings (Fink et al., 2008).

Casey et al. (2004) set out to identify stresses and challenges of NGNs at acute care facilities in Denver. Measures were taken at baseline, three, six and twelve months and longer in specific groups. NGNs were surveyed to determine if there were similarities or differences in demographic profiles, skills or procedures they found difficult to perform. The survey also sought to determine the NGNs level of comfort and confidence in their new role, organizational support and differences in self-reported job satisfaction. Qualitative themes of their perceived challenges during the first year of employment were also recorded (Casey et al., 2004).

Measure. The instrument used to survey participants, the revised Casey-Fink Graduate Nurse Experience Survey, was developed by the investigators and pilot tested during Phase 1 of the study. The revised Casey-Fink Graduate Nurse Experience Survey consists of five sections. The first section gathers demographic information. The second section consists of three open-ended questions that gather information about skills and procedure performance. The next section measures comfort and confidence with 25 items measured with a Likert scale. The fourth section measures job satisfaction and the fifth and final section is a series of four open-ended questions that elicit data about the work environment and difficulties with role transition.

Design. The investigators used a descriptive comparative design using a survey questionnaire to collect data at the time periods referenced above. The research was approved by the appropriate IRBs before investigation began. There were two phases of

data collection. Phase 1 of data collection spanned a time period from July 1999 to July 2001, the authors did not detail a timeframe for Phase 2 of data collection.

Sample. A convenience sample was used and a total of 784 surveys were distributed to NGNs at six acute care facilities that included one academic teaching hospital, three private for-profit facilities and two not-for-profit facilities (Casey et al., 2004). A total of 270 respondents agreed to participate for a response rate of 34%. During Phase 1 of data collection surveys were distributed to various cohorts of NGNs at all six facilities. During Phase 2 of data collection the revised survey tool was distributed only to NGNs who were entering an expanded NRP at the academic teaching hospital (Casey et al., 2004). All data during both phases were collected using confidential practices (Casey et al., 2004).

Demographic profiles for Phase 1 and 2 of data collection were reported together. The average participant was 35 years or younger, white, female and with previous health care experience. Ninety five percent of the respondents at the academic teaching hospital had baccalaureate degrees at entry to practice than did other respondents at other five sites (71%). The number of preceptors assigned to a NGN varied widely between Phase 1 and 2. More than 59% of NGNs at the academic teaching hospital had more than three preceptors during their orientation period compared to 39% of respondents at other sites.

Findings. Casey et al. (2004) reported that only 4% of NGNs felt comfortable performing all skills and procedures. Most respondents were able to identify 54 different skills and procedures that were uncomfortable to them upon hire. Of these skills more than 15% of respondents identified seven over time as the most challenging. Those skills

included, code blues, chest tubes, IV skills, epidurals, central lines, blood administration and patient controlled analgesia. All skills from both phases of data collection were combined and analyzed over time (Casey et al., 2004). Casey et al. (2004) combined results from Phase 1 and 2 of data collection on the comfort/confidence section of the survey. When the subject's results were combined, of the 25 total statements related to comfort/confidence, only five were statistically significant using chi-square analysis. Those statements dealt with communication, delegation, prioritization and organization. Initially NGNs felt less confident communicating with interns and residents but gained confidence between six months and one year. Similar findings were found related to communicating with attending physicians. The NGN comfort/confidence significantly improved between six months and one year in the areas of delegating to ancillary personnel, setting priorities for and organizing patient care needs, and making suggestions for changes to care plans (Casey et al., 2004).

Of the 270 participants who returned the survey, 100 (37%) respondents were uncomfortable caring for dying patients and that finding did not change over time. Nearly all (99%) of respondents were comfortable communicating with patients and their family members and felt support by their own family and friends in their work. However, 127 (47%) of the NGN respondents stated they were experiencing stressors in their personal lives. Twenty five percent stated that their stress was caused by finances and student loans (Casey et al., 2004).

Casey et al. (2004) also surveyed all NGN respondents ($n = 270$) regarding job satisfaction. Casey et al. (2004) discovered that 39% of NGN respondents were satisfied

with their salary, 70% were satisfied with their benefit package and 65% were satisfied with their vacation time.

The last portion of the survey is a series of four open-ended questions that allow the NGN respondents to give voice to their own personal experiences. In response to the question, “What difficulties if any are you experiencing with the transition from ‘student role’ to the ‘RN role’” six overall themes were identified. These six themes were consistently identified across all institutions and all time periods by all four investigators. The list of themes in order of how frequently and intensely the NGN respondents reported them to be most difficult in their transition are: (1) lack of confidence in skills, critical thinking and clinical knowledge, (2) peer and preceptor relationships, (3) dependence and independence, (4) work environment, (5) organization and priority setting and, (6) communication with physicians (Casey et al., 2004).

Throughout the first year of practice NGN respondents felt inadequate regarding clinical knowledge and felt themselves to be incompetent to care for their patients. Many wrote, “I was expected to have all the answers for my patient’s questions” (Casey et al., 2004, p. 307). Toward the end of the first year of practice many felt they were beginning to gain confidence in their ability to critically think and reported an increase feeling of comfort in their role (Casey et al., 2004).

Many NGN respondents voiced concerns about their relationships with peers and preceptors. Many felt peers did not respect them when they continued to refer to the NGN nurse as a “new grad”. They verbalized frustration with preceptors who did not seem to be “in tune with” what it was like to be a NGN (Casey et al., 2004, p. 307).

Many stated that the lack of consistent preceptors during orientation contributed to their lack of proficiency. Other NGN respondents described positive relationships with their preceptors. This group of respondents stated they felt comfortable asking their preceptors for help (Casey et al., 2004).

The theme dependence and independence refers to the NGN respondents' abilities to handle their new level of responsibility. NGNs struggle with needing to be independent while relying on the expertise of others to carry out their role as a nurse. This struggle was identified across all three time frames. Others struggled with delegating asks to ancillary personnel. They verbalized feelings of guilt and frustration when they were not comfortable delegating to this group of individuals (Casey et al., 2004). Many NGN respondents also voiced concerns about the work environment. They felt the work setting was "understaffed" and expressed concerns regarding nurse to patient ratios. Others voiced concerns about the "nursing shortage and retention of unit staff" (Casey et al., 2004, p. 307). Most comments during the first six months were related to the difficulty transitioning to shift work, a perceived lack of time off or no vacations and frustrations with pay. At the nine-month mark a few of the NGN respondents described being placed in the charge nurses or preceptor role. They expressed concern about assuming this level of responsibility so soon in their new career (Casey et al., 2004).

Casey et al. (2004) also discovered that most NGN respondents with less than six months experience indicated that a lack of organizational skill was a key barrier to optimal performance in their new role. They described having a difficult time finding a "routine of their own" and of "being disorganized and task oriented" (Casey et al., 2004,

p. 308). NGNs also had high expectations of what could be accomplished in an eight to twelve hour shift and described difficulty leaving work on time. As time progressed they became more proficient in time management and prioritizing patient care needs.

The NGN respondents identified a lack of experience communicating with physicians on their nursing units. Throughout their first six months the NGN felt insecure about knowing who to call, when to call and report difficulties deciphering orders and signatures and interpreting orders. The NGN also noted a lack of respect from physicians and were hampered by their difficulties communicating patient problems. These difficulties were not expressed during the last six months of practice (Casey et al., 2004).

In Phase 2 of data collection four additional qualitative questions were asked of the NGNs at the academic teaching hospital. The survey tool was revised to assess job satisfaction with the current work environment, level of unit support for the NGN and an opportunity for the NGN to share any concerns they might have with the nurse residency program. Most of the respondents from the Phase 2 data collection that included the additional questions were in the group that was in the time period of 6 to 12 months after hire. When this group was asked, “What could be done to help you feel more supported or integrated to the unit”? (Casey et al., 2004, p. 308) many replied that the staff was great and very inclusive and welcoming. Some identified that one consistent preceptor would have been helpful and others desired a mentor be available to answer ongoing questions. Some respondents asked for more feedback and encouragement especially surrounding issues of time management and mastering new procedures. When the NGNs

in the residency program were asked about their perceptions of the NRP some stated that they appreciated the longer orientation period. Many reported that having too many didactic classes at the beginning of the program was overwhelming. When asked about satisfaction with the work environment some NGNs described satisfaction with patient/family interactions, others enjoyed staff support and teamwork. The least satisfying aspects of the work environment included frustrations with a perceived increased workload, generational differences in the nursing team and poor pay.

Critique. Casey et al. (2004) identified several limitations associated with the study. A decreased response rate and attrition over time is cited as a limitation that may have affected the validity of the results. Another limitation was the instrument used to collect data. Casey et al. (2004) note that the instrument used was under construction and changed frequently with multiple revisions during the time of the study. Those results are intermingled and reported leaving the reader to question if the structure and format of multiple surveys interfered with or skewed the results and report of findings. This study must be viewed with caution and interpreted carefully.

Other limitations of the study not noted by the author but should be considered by the reader include sample and setting. The sample is homogeneous and represents a predominantly white female population. A more diverse sample may yield different results. The sample was also drawn from one large metropolitan center in the western United States. One has to question if results would be different if different sections of the country were sampled and represented. While Casey et al. (2004) suggested that the

preceptor's role was significant and important the authors failed to describe the preceptor's role and how that role changes over time.

What follows is a description of the University Health System Consortium (UHC) and the American Association Colleges of Nursing (AACN) Nurse Residency Program (UHC/AACN). The UHC/AACN NRP used the Casey Fink Graduate Nurse Experience Survey to collect data and evaluate outcomes of the program.

UHC/AACN Nurse Residency Program

The UHC/AACN NRP is considered the gold standard of NRPs. It is a yearlong program, pairs one preceptor with one NGN and it is the only NRP accredited by a national accrediting body: Commission on Collegiate Nursing Education (CCNE). Since March 2000 the UHC/AACN have worked to develop strategies to address the nursing shortage. A major goal of this partnership was to develop a nurse residency program to take the novice learner from NGN to a more competent provider. The program spans one year and uses a series of learning and work experiences to support NGNs as they transition into their first professional position.

The UHC/AACN nurse residency program is designed for direct care roles in the acute care setting and only graduates from baccalaureate nursing programs are eligible to apply (American Association of Colleges of Nursing, 2011a). The nurse resident must also be within six months of graduation, be licensed in nursing or hold a work permit (license pending), and be willing to commit to work fulltime for the entirety of the one year program (Krugman et al., 2006). The program is built on a baccalaureate foundation as described in the Essentials of Baccalaureate Education and the conceptual framework

of Dreyfus as described by Benner (Krugman et al., 2006). The curriculum of UHC/AACN NRP has been designed to enhance critical thinking and the ability to use outcome data to promote patient safety (Goode, 2009; Williams, 2007).

The UHC/AACN NRP was a major project that resulted in a number of publications (Fink et al., 2008; Goode et al., 2009; Goode & Williams, 2004; Krugman et al., 2006; Pine & Tart, 2007; Williams, et al., 2007) that documented the design, implementation and outcomes of the program. Williams et al. (2007) report on the quantitative findings from the first 12 sites that participated in the program, and the outcomes for those that participated in the program between September 15, 2004 and September 15, 2005 were reported by Goode et al. (2009). A report of the qualitative findings from the Casey-Fink instruments open-ended questions from the first 12 sites that participated in the UHC/AACN post baccalaureate residency program (Fink et al. 2008) follows and are included because those findings help to detail the contribution of the preceptor in the transition of the NGN. The findings of Williams et al. (2007) and Goode et al. (2009) do not detail the preceptor's role in the transition process of the NGN and they do not contribute to understanding or answering the research questions and therefore will not be included in the review.

Fink, Krugman, Casey & Goode (2008). Fink et al. (2008) report on the qualitative data outcomes from the Casey-Fink instruments open-ended questions using the first two cohort groups from the UHC/AACN post baccalaureate residency program. The purpose of this study was twofold. The first purpose was to analyze qualitative data to give voice to the respondents and determine if that voice could further enrich the

quantitative data. The second purpose was to determine if the analysis of the themes mined from the qualitative data could be used to convert open-ended questions on the Casey-Fink Graduate Nurse Experience Survey into quantitative questions to ease the test administration and analysis of data (Fink et al., 2008).

Design. The investigators used data previously collected by survey methods from the NGN respondents on their answers to the Casey-Fink Graduate Nurse Experience Survey (Casey-Fink Survey). Data analyzed were the series of five open-ended questions contained in the Casey-Fink survey that allowed the NGN to voice their personal experiences about the work environment and role transition (Fink et al., 2008).

Sample. The convenience sample consisted of 1,058 nurse residents hired between May 2002 and September 2003 that had completed the full one-year residency program. Of the 1,058 respondents, 434 completed surveys for all three-time periods for a response rate of 41%. The average respondent was a 26-year-old Caucasian female, with a baccalaureate degree in nursing as per the requirement of the UHC/AACN program. The nurse residents included in the sample are those from the first 12 academic hospital sites in the UHC/AACN post baccalaureate nurse residency program as described by Williams et al. (2007).

Measures. Verbatim comments of the residents were categorized by site and period. Two investigators, the first author and a research assistant, independently identified keywords from the narratives. Each comment was coded tallied and entered into an Excel file by question. The investigators compared findings and identified common themes across institutions and time periods. Findings were validated with an

independent team of investigators. A total of 5,320 separate qualitative comments were analyzed (Fink et al., 2008).

Findings. Residents were asked to identify the top three skills or procedures they were uncomfortable performing independently. None of the respondents believed they were independent in all skills at baseline; 10% of the sample felt they were independent in performing all skills at 6 months; and, only 7% of the sample answered the same at 12 months.

Fink et al. (2008) report that 24% of respondents report being stressed at baseline, 11% were stressed at 6 months and 18% were stressed at 12 months. The top three stressors during the first six months include preparing and waiting for the results of the licensure exam, moving away from home to a more independent lifestyle and adjusting to the expectations of the new working environment and role. Stressors during the second six months include, family responsibilities, being newly married or starting a family and entering graduate school.

In response to the question, “What difficulties, if any are you experiencing with the transition from the student role to the RN role”?, 8% reported no difficulties at baseline, 28% reported no difficulties at 6 months and 58% reported no difficulties at 12 months. Five overall themes were identified for those residents who reported transition difficulties: role changes, lack of confidence, work load, fears and orientation issues. Comments included concerns about, “feeling alone and overwhelmed” and “being nervous about being the only one who is ultimately responsible for my patients” (Fink et al., 2008, p. 344). Graduates also wanted to be respected by more experienced nurses and

found it difficult to delegate tasks to nursing assistants they used to work with (Fink et al., 2008). Residents also identified concerns with communication skills. A typical comment was, “I need to work on my communication and assertiveness with physicians” (Fink et al., 2008, p. 344). Residents also felt overwhelmed with the workload and nurse to patient ratios. Residents expressed feeling of being disorganized and “needing to find a routine of their own” (Fink et al., 2008, p. 344). They were also concerned with the amount of time it took to complete patient care assignments and described it being difficult to leave work on time. Over time skills surrounding time management and prioritization improved.

When residents were asked what could be done to make them feel more supported or a part of their nursing unit, 24% of respondents at baseline, 34% at six months and 43% at 12 months stated they already felt supported (Fink et al., 2008). Four overall themes were identified that outlined the type of support residents perceived would have improved their transition: increased support, improved orientation, work environment and socialization. It is interesting to note that over the three-time periods nurse manager support and feedback was identified as one the top three ways in which their transition into practice could have been facilitated. Many said that they would like to have had more feedback, a sense of belongingness and a connection with their manager (Fink et al., 2008). Residents also stated that during orientation a consistent preceptor would have been helpful. Post orientation residents felt that it would have been helpful to be assigned a mentor or a safe person to answer ongoing questions.

When describing the work environment support, residents identified additional areas for further growth. They identified needing to develop skills and confidence when directing assistive personal. One NGN stated, “it gets so complicated getting help I just do it myself” (Fink et al., 2008, p. 345). The NGN also wanted to feel a stronger sense of belonging to the work group stating, “It would have been neat to feel a part of the team from the very beginning” (Fink et al., 2008, p. 345).

In response to the open-ended questions on aspects of the work environment that are most and least appealing many themes emerged. The top most satisfying aspects of the NGN residents’ work environment included support, camaraderie and caring for patients. NGNs expressed satisfaction with patient/family interactions and enjoyed “listening to patient stories” (Fink et al., 2008, p. 346). One NGN summed it all up when stating, “Knowing that a patient and family appreciate what you’re doing for them, completing the assignment and workload on time, providing good patient care and getting positive feedback. That’s what nursing is all about” (Fink et al., 2008, p. 346).

There were fewer dissatisfied respondents but of those who did comment three themes emerged: frustration with the nursing work environment, dissatisfaction with the hospital system and interpersonal relations. Frustrations with the work environment included factors such as unrealistic ratios; a tough schedule and futility of care in certain patient care situations. One nurse stated, “The patient population on my unit is usually bound for a nursing home or withdrawal of care. It’s very depressing. If the patient makes it their quality of life is usually not that high” (Fink et al., 2008, p. 346). Dissatisfaction with hospital systems included dimensions such as outdated facilities and

equipment and aesthetically unpleasing work setting. Interpersonal relations dealt with generational differences within the nurse group, lack of respect and recognition from coworkers and grumpy gossipy staff (Fink et al., 2008).

When the residents were asked to share comments about their perceptions of the graduate nurse residency program, most respondents at baseline stated that they looked forward to getting started and participating. At both six and twelve months they believed it was a “great program” and “liked the positive peer support” (Fink et al., 2008, p. 346).

Critique. Fink et al. (2008) report few limitations of the study. The one limitation reported is in response to a diminishing number of qualitative respondents over time and over timed collection data periods. Other limitations the reader must consider include the use of a convenience sample. While the sample is large for a qualitative study it is neither diverse nor inclusive. The sample consists of predominantly young white females who are prepared at the baccalaureate level. All residents were employed at academic hospital sites. One must question if the results would have been different if the sample were more diverse, or included smaller community not-for profit facilities.

The literature that details the transition experience of professionals from other practice settings must also be reviewed. It would be interesting to note if other professionals experience the same type of transition that the nursing professional encounters. What follows will be a review of the business literature for studies that detail the transition of other professionals and programs that help in the transition process.

Review of Business Literature

The business database ABI/INFORM was searched for literature that details the transition experience of other young professionals. Two articles are included here. The first details the transition experience of library and information professionals in Australia (Hallam & Newton Smith, 2006). The second piece of business literature examined is a case study that details the aims and outcomes of a transition program for allied health professionals (Smith & Piling, 2008).

Library and Information Professionals in Transition

Hallam and Newton Smith (2006). Hallam and Newton-Smith (2006) report on the findings of the comparative evaluation of two transitional mentoring programs developed for new library and information professionals in Australia; one as a group program the other with pairs of mentors/mentees. The aim of the mentoring program was to bridge the entry into profession and ease transition to the workforce. The aim of the study was to evaluate the role of the program for the participants in transition from education to employment and to consider the learning outcomes, professional development outcomes and the success of the program. The study obtained data from three key areas; career related, learning related, and professional development.

Sample. The sample is composed of two groups of library and information professionals in transition. The participants were in either the Western Australian Australian Library and Information Association Group Mentoring Program (WA ALIA GUMP) or the Queensland University of Technology (QUT) Australian Library and Information Association (ALIA) (QUT/ALIA) student mentoring program (Hallam &

Newton-Smith, 2006). Of the 20 WA ALIA GUMP participants who attended the first meeting a total of 10 members were eligible to be a part of the evaluation and returned the surveys (Hallam & Newton-Smith, 2006). A total of 25 mentors and 25 mentees participated in the QUT/ALIA program. The survey was distributed to all participants in June 2003. In total 12 responses were received from mentees (48%) and 14 from mentors (56%) (Hallam & Newton-Smith, 2006).

Design. A comparative study was undertaken and a survey approach was used to collect data from participants.

Findings. When mentees from the QUT/ALIA program were asked to consider the career, learning and personal development outcomes of the program three mentees indicated they had gained nothing from the program because they had never really formed a relationship with the mentor. In contrast to the QUT/ALIA the WA ALIA GUMP mentees had a greater recognition of how the program helped to focus their future through the development of a career plan. The WA ALIA GUMP mentees also reported a greater awareness of professional ethics and social responsibility in the LIS arena and half had been encouraged to play an active and engaged role in ALIA (Hallam & Newton-Smith, 2006).

The mentees in both groups felt that they had acquired new skills and knowledge through the relationship with mentors. Each group of mentees saw value in having a professional role model. Specific learning outcomes for both groups of mentees included the ability to establish a pattern of self-directed learning and a commitment to life-long learning (Hallam & Newton-Smith, 2006).

An evaluation of the mentoring program yielded the following results. The level of satisfaction was higher among mentees than mentors. The match between mentee and mentor was critical to the level of satisfaction recorded. There was a very high level of support for the program with most of the mentors expressing a desire to remain active mentors in the student program (Hallam & Newton-Smith, 2006).

Critique. The authors did not identify any limitations associated with the study. The reader however, must consider several limitations not identified by the authors when interpreting and applying the findings of this comparative study. The sample size for both groups of mentees examined was small. The mentor group was also a small sample and the group of three convenors/mentors was not surveyed. The reader must question what this group of participants (convenors) might have added to the findings and discussion. The authors did not identify a theoretical framework but state that the goal of the program supports the views of Kolb (1984) in that an excellent education should extend beyond the classroom. The next piece of literature reviewed will be a case study that reports on the implementation and outcomes of a structured program for allied health practitioners making the transition from student to professional.

Allied Health Professionals in Transition

Smith and Pilling (2008). The allied health executive team at an outer metropolitan health service in Australia identified the need to better support allied health graduates transition from student to allied health professional. In response to this need the allied health executive team developed and implemented an interdisciplinary team-oriented approach to supplement the current discipline-specific induction to professional

practice. Smith and Pilling (2008) describe the process and outcomes of the first three years of the program.

The aims of the program was to support new allied health graduates (NAHGs) through transition from student to professional, to provide a “health-service wide” context for work, to foster interdisciplinary working and collaboration and to help the NAHGs develop critical thinking reflection skills (Smith & Pilling, 2008).

Study design. Smith and Pilling (2008) utilized a case study design to report on the implementation and outcomes of a structured program for allied health practitioners making the transition from student to professional. Case studies are an in-depth investigation of a single entity or a small number of entities (Polit & Beck, 2008).

Sample. The participants included a mix of allied health graduates and included graduates from a mix of disciplines to include dietetics, exercise physiology, speech therapy, podiatry, social work and occupational therapy. Between 11 and 13 graduates entered the program and all graduates were engaged in his/her first professional role since graduation (Smith & Pilling, 2008).

Measures. Evaluation was based on participant feedback, facilitator observation and feedback from the allied health executive. Retention rates after completion of the program were also monitored.

Findings. Inspection of data collected on feedback from participants over the course of three years identified major strengths of the program. Participants identified that the program is a good forum for sharing with others who are in the same situation. The sessions are supportive and reduce the feelings of isolation associated with those of

being in a new team or department. The sessions also provided the NAHGs with an opportunity to get to know more about other disciplines' work. The sessions also provide a safe forum for asking questions. The participants also found the mix of information/teaching and debriefing to be a positive opportunity and although reflective exercises were useful they were considered time consuming (Smith & Pilling, 2008).

Areas participants found challenging included the number of session included in the program. Some participants felt that two hours, every three weeks, for eight sessions was a large time investment. Some participants felt the follow-up tasks were burdensome and time consuming. Some participants also had difficulty managing competing demands of their time.

Attendance in the program is encouraged and graduates are expected to participate. Participation rates are high and after the program was shortened no drop off in participation was noted. Retention rates improved from pre-program rates of 42%-46% at two years post employment to 75% at two years post employment after program induction. It is noted that retention rates cannot be solely attributed to participation in the program but it is clear from participant comments that many perceive the program to be an important source of support especially during the early months of employment (Smith & Pilling, 2008).

Data from the program revealed that the challenges faced by graduates during the transition from student to professional are remarkably consistent. The biggest challenges reported across the program each year involve challenges with time management,

managing a full patient load, personal and professional responsibility and a lack of confidence in skills and critical thinking.

This case study mirrors findings that are consistent with the nursing literature reviewed (Casey et al., 2004; Fink et al., 2008; Goode et al., 2009; Williams 2007). The NAHG struggles with confidence, organization and prioritization much the same as the NGN (Casey et al., 2004; Fink et al., 2008; Goode et al., 2009; Williams 2007). The NAHG like the NGN also finds value in a structured transition program (Casey et al., 2004; Fink et al., 2008; Goode et al., 2009; Williams 2007). The transition program for NAHGs is inclusive of multidisciplinary groups.

Critique. The authors did not identify any limitations with the study. However, the cautious reader must consider several. The participants were never described and demographic information was not provided. The evaluation of the program must also be called into question; facilitator observation is highly subjective. It is unknown if the same individual or individuals observed and served as facilitators over the course of the three years or if those facilitators changed each time the program was presented. Feedback from the allied health executive is never detailed and no description of how that feedback is prompted or collected is provided to the reader.

A critique of all literature follows. Theoretical and conceptual challenges associated with the literature are discussed first. Challenges associated with methodology, sampling, and design are examined next and weaknesses of studies is discussed.

Critique of Literature

Theoretical and Conceptual Challenges

Benner's theory, From Novice to Expert (Benner, 1984), is a theoretical framework that is used extensively in literature that describes and examines TTP programs. Because Benner's theory is so often linked to the concept of TTP programs (Almada et al., 2004; Fink et al., 2008; Friedman et al., 2005) it is important for nursing to critically examine this theory and determine if it provides nursing with an appropriate framework for TTP program construction and study.

Theory Description. To understand Benner's theory of From Novice to Expert one must be familiar with the Dreyfus Model of Skill Acquisition. The Dreyfus Model of Skill acquisition was developed by Stuart Dreyfus a mathematician and system analyst and Hubert Dreyfus, a philosopher. The Dreyfus model postulates that as a student develops and acquires a skill they pass through five levels of proficiency; novice, advanced beginner, competent, proficient, and expert. These different levels of skill acquisition reflect changes in three general aspects of skill performance. The first change occurs as the student moves from a reliance on abstract principles to the use of past concrete experience as paradigms. The second change occurs when the student's perception of the situation changes. They move from "seeing" the situation in parts to being able to "see" the situation as a whole. The third stage sees the learner as an "involved performer" (Benner, 2004). The Dreyfus Model was originally developed in research designed to study pilots' performance in emergency situations (Benner, 2004). As pilots move through the stages of skill acquisition they first rely on rules to guide

behavior. As the pilots progressed to expert, rules were no longer considered a part of the decision making process. Decisions regarding flight were based on an intuitive grasp of the situation, saving time while not considering worthless alternatives and solutions (Benner, 2004).

Using the Dreyfus model Benner postulates that as the nurse moves from novice to expert their behavior regarding practice changes. The novice nurse relies on rule-governed behavior to guide practice. The expert nurse's practice is no longer rule governed. The nurse's move from novice to expert is marked by the transition from explicit rule governed behavior to intuition. The expert nurse has an intuitive grasp of the nursing situation presented. They rely on similar and dissimilar situations and embodied intelligence or skill for decision making. Intuitive grasp is never a wild guess, but relies on perceptual capacity based on prior experiences (Benner, 2004). Intuitive grasp only occurs when the nurse has a deep background and understanding of the situation as it exists and it is based upon a broad base of knowledge and experience. Intuitive grasp is not possible without a sufficient background of similar and dissimilar experiences (Benner, 2004). Skill attainment requires an orderly progression through the stages of skill acquisition. The advancement through the stages is discrete and is dependent upon a combination of depth and range of clinical experiences (English, 1993).

Critique of Theory. A theory is an organized and systematic set of interrelated concepts that specify the nature of the relationship between two or more variables with the purpose of understanding a problem (Fain, 2004). The critique of this theory will follow the process outlined by Meleis (2007).

Benner's theory contains five major concepts that are clearly defined and that are utilized throughout the theory. Those five concepts are novice, advanced beginner, competent, proficient and expert. The definitions provided are theoretical definitions not the operational definitions that are necessary for empirical measurement (Altman, 2007).

Benner's theory is simple; it contains five major concepts, those of skill acquisition. Those concepts are arranged along a continuum, from novice to expert. Five concepts are considered few and those concepts are easy to grasp and explain (Altman, 2007). Complexity in Benner's theory arises when the researcher tries to determine how a nurse advances along the continuum of novice to expert (Altman, 2007).

Benner does not provide a visual representation of her theory. However, the stages of skill acquisition can be thought of as existing along a continuum. Progression along the continuum occurs in sequence but it is important to remember that it is possible for a nurse to digress when introduced to an unfamiliar nursing situation or setting (Benner, 2004).

Benner's Model, Novice to Expert has been adopted in many countries and has been used by many institutions (Altman, 2007). This theory has been used by hospitals and career ladders have been fashioned using the concepts. Benner's theory has also been adopted by social agencies and by developers of programs for continuing education in nursing (Altman, 2007). It has also been selected UHC/AACN NRP as a framework for the NRP program (Almada et al., 2004; Fink et al., 2008; Friedman et al., 2005; Goode et al., 2009; Krugman et al., 2006; Williams et al., 2007).

Analysis of Benner as a Theory. The researcher must question if Benner's theory is truly a theory. While Benner's theory can be used as a framework for qualitative work it can't be used as a guide for quantitative study, the concepts are not operationally defined and cannot be measured. Furthermore a nurse may move about or regress on the continuum of Novice to Expert depending upon the clinical situation or setting. If a situation or setting is unfamiliar to the expert they may regress to novice status. The theory also fails to explicate how a nurse transitions from one stage to another; no defining criteria are given. The researcher must ask if a nurse can be in two stages at one time.

The focus of this theory also appears to be centered on the Novice or the Expert. Little is mentioned regarding the three stages that fall between those of Novice and Expert. Are the stages of Novice and Expert the most frequently cited stages of this theory because there is such an apparent difference in the behaviors that describe nursing action and the decision making process which make them easier to define and conceptualize? Benner's theory only provides the researcher with a method to label the nurse and describe where they fall on the continuum as they transition to professional practice or change specialties or settings in nursing practice.

Benner's theory and the concepts embedded within that theory do not provide a suitable framework for understanding or studying the nurses' transition to practice. Benner's theory could be considered a philosophy of nursing. A philosophy is defined as the exploration of effects, which underlie reality by questioning the nature of things using logic instead of empirical methods (Altman, 2007).

Conclusion. TTP programs and the body of literature that address them are about more than labeling where the nurse is in the process of transition. Although Benner's theory is adequate for labeling the level of skill acquisition of the nurse who is transitioning, the cognizant researcher, who is interested in studying TTP programs, must question the repeated use of a theory that focuses on only two concepts embedded in a theory. Nursing and nursing scholars must move from their overreliance on Benner's theory and find one that more closely aligns with the phenomenon of interest, transitions. The current study employed Schlossberg's Transition Theory.

Other theories of transition to consider include Meleis's Transition Theory (Im, 2010) and Kramer's theory of Reality Shock (Kramer, 1974). Meleis Transition Theory is generalizable to all people in transition, is relevant for any population and has been widely accepted by the nursing community (Im, 2010). Transition Theory can provide a comprehensive perspective on transition experiences and because of its comprehensiveness, applicability and affinity with health it can be applied to many human phenomena of interest to nurses such as illness, recovery, birth death and loss as well as immigration (Im, 2010). It can be applied to diverse populations or groups of people like the elderly, psychiatric populations, family caregivers and people with chronic illness (Im, 2010).

Kramer's Theory of Reality Shock is often used to describe the reaction experienced when a NGN moves into the workforce after several years of educational preparation. Kramer's Theory describes the situation of moving from a familiar, comfortable educational environment and into a new role in the workforce in which the

expectations are unclear and may or may not be realistic (Zerwekh & Claborn, 2006).

Kramer's theory has also been widely embraced by nursing.

Transition to Practice: Conceptual Challenges

If the concept, transition to practice (TTP), is to be used by nursing to reference a program that aids the NGN or experienced nurse transition to practice or change practice setting or specialty, then nursing needs to examine the basic elements of the concept. An accurate description of a concept helps to distinguish that concept from other ones that are similar but not the same concept (Walker & Avant, 2005).

The concept, TTP is conceptually ambiguous with the only common feature among the literature reviewed being that of a preceptor to help facilitate learning and transition. There is no consensus in the nursing literature on the meaning of and characteristics that constitute the concept TTP. There is no identified time frame for describing a transition to practice. There are no measurable benchmarks described in nursing literature that would determine when transition to practice has occurred or if a successful transition to practice has been made. In the absence of a common and clearly defined concept, nursing scientists who wish to study TTP programs and the contribution TTP programs make to the transition of the NGN or the experienced nurse who is changing specialty or setting, cannot assume they are talking about or measuring the same thing. Therefore, literature that reports on TTP programs may be compromised by the lack of clarity in the conceptual meaning of the phrase, TTP.

Method Critique

Literature that reports on TTP programs must be examined for methodological strengths and weaknesses. Poorly constructed studies and program designs can add to the confusion that surround the intentions and usefulness of these programs.

Casey et al. (2004) used a comparative descriptive design. This is an appropriate design but more diversity in research design may yield a richer and deeper understanding of the concepts under study.

Convenience sampling was reported as a sampling method by all but one of the studies (Almada et al., 2004; Casey et al., 2004; Fink et al., 2008; Friedman et al., 2011; Lee et al., 2009; Schumacher, 2007), and some convenience samples were described better than others. Hatler et al. (2011) did not describe a sampling plan. Convenience sampling is considered a weak approach to sampling because it provides very little opportunity to control for biases (Polit & Beck, 2008). However, convenience sampling can yield a large sample size which is considered a strength. None of the aforementioned authors described measures taken to identify and describe known biases in the sampling.

Data in Casey et al. (2004) and Fink et al. (2008) were also collected over three points in time. Data collection at more than one point in time can also be considered a strength and a weakness of the study. Attrition and mortality are especially great when the length of time between points of data collection is long (Polit & Beck, 2008).

However data collected over time, from the same group of participants, can yield a richer data set and a greater understanding of the concept under investigation. Attrition from the study were reported by Casey et al. (2004), and was a problem for some studies.

Casey et al. (2004), Fink et al. (2008), Hatler et al. (2011) and Lee et al. (2009) all used surveys to collect data. Surveys are used to collect data through self report. This can be considered a limitation in data collection as this is sometimes viewed as a shallow data collection technique (Burns & Grove, 2005). However, the advantage to survey research is its broadness of scope (Polit & Beck, 2008). Surveys can be applied to many populations, can focus on a wide range of topics and information obtained through use of surveys can be used for many purposes (Polit & Beck, 2008). The use of the Casey Fink Graduate Nurse Experience Survey can also be considered both a strength and weakness because it was not well developed at the beginning of the data collection for the UHC/AACN NRP.

Another strength of the surveys reported in the review of literature was reliability. Reliability of all surveys used by Casey et al. (2004) and Fink et al. (2008) were detailed and reported as Cronbach alpha. The assessment of the tools as reported is that all are in reliable ranges. Lee et al. (2009) reported reliability for the surveys administered and the questions regarding reliability of the surveys used have been reported elsewhere and will not be repeated here.

Some authors (Almada et al., 2004) report the use of a VAS to measure satisfaction. This measure is easy administer. Problems with the VAS are related to inaccurate reproductions of the scale and scoring of the measure (Waltz, Strickland & Lenz, 2005).

Despite the limitations of each study, all contribute to the increased understanding of the transition process of the NGN. Despite an increase in the understanding of the

transition process of the NGN there remain significant gaps in the literature. Little is known about the transition process of the experienced nurse who is changing practice settings or specialties.

Synthesis

Most investigators who report on the transition of the NGN focus on the retention during the first year of employment and the loss of dollars related to the early attrition of the NGN (Almada et al., 2004; Bratt, 2009; Friedman et al., 2011; Hatler et al., 2011; Lee et al., 2009; Schumacher, 2007). Although these investigators identify the first year as a difficult one filled with stress there is a paucity in the literature that captures and measures the stress levels of the NGN over time and the role the preceptor plays in the transition at certain points in the transition. Although limited, the literature does identify the first six months of transition as one that is especially stressful for the NGN. Little is known about happens in the first three months of transition.

Absent from the literature is a description of the NGNs perceived needs for a successful transition and the role the preceptor plays in that transition and how the preceptors role changes over time. The literature indicates that the majority of TTP programs use preceptors to help the NGN transition but little else is noted about the preceptors' contribution to the transition process and the preceptors' contribution is not measured in the instruments used. The business literature also mentions the use of a mentor to help young library and information professionals. Hallam & Newton-Smith (2006) provides a definition of a mentor that is very similar to the definition of preceptor that is noted in the nursing literature. Hallam & Newton Smith (2006) also fail to clearly

define the mentors' role and the mentors' contribution to the transition of the new library and information specialist.

The literature also mentions that more than one preceptor interferes with the forward progress and smooth transition of the NGN (Casey et al., 2004; Schumacher, 2007). The critical reader must question how many preceptors are enough and how many are too many. Does the concept, preceptor change over time as the NGN transitions to professional practice? What are the implications of the NGN having more than one preceptor during the first three to six months of practice? How does nursing capture, measure and quantify this concept?

The Casey-Fink survey is frequently used in studies in relationship to NGN population and transitions. The Casey-Fink Graduate Nurse Experience Survey is particularly useful when studying transition programs and the NGN population. This tool was designed to measure graduate nurses rather than the nursing population as a whole. The Casey-Fink tool also includes four open-ended questions about work environment and difficulties in role transition. The qualitative data analysis increases the comprehensiveness of the study by providing a detailed description of the phenomenon that compliments the quantitative findings (Fink et al., 2008). Although the Casey-Fink Graduate Nurse Experience Survey is widely used to measure the NGN transition and changes over time, it fails to measure the role the preceptor plays in that transition. Some of the data that surround the transition and the role preceptors' play have been captured by the analysis of qualitative data from the UHC/AACN studies. But again a gap exists:

a limited amount of the qualitative data collected by the Casey-Fink Graduate Nurse Experience Survey has been analyzed and reported in the literature.

There are other noted gaps in the literature related to the transition of NGNs. Current studies account for and gather data on the demographics of the NGN population. However except to report differences seldom is one group investigated separately. The transition experience of an experienced nurse new to a practice setting or an organization is missing from the literature. Questions about their transition experience are left unanswered by today's current body of literature.

The purpose of the current study was to better understand the experience of new graduate nurses (NGNs) and experienced nurses as each group transitions to a new setting in nursing practice and the contribution the preceptor role plays in that transition. The qualitative data from a mixed methods study was reanalyzed to gain a better understanding of the role the preceptor played in the transition process of the NGN or an experienced nurse new to the specialty hospital. The study attempted to discover the role the preceptor played in that transition and if that role changed over time. The preceptor's role in the transition was examined from the vantage point of the NGN or experienced nurse in transition. This study addressed a gap in the current literature as it examined data from three time points in the transition process of the NGN and the experienced nurse new to the specialty hospital setting. Data from the original study were collected at three, six and twelve months during a twelve month extended orientation program. These points of data collection differ from that represented in the literature. Most data that were used to evaluate an extended orientation program or a NRP was collected at baseline, or

entry to the program, six months and twelve months, with most studies omitting the measure at the three month mark.

Evidence suggests that a well-organized TTP program that uses preceptors can ease the transition of the NGN to professional practice can increase the retention of this vulnerable and valuable population (Fink et al., 2008; Friedman et al., 2011; Halfer & Graf, 2011). Nursing would be well served to better understand the role the preceptor plays in this transition and if that role changes over time. When nursing leadership, nursing organizations and health care facilities better understand the relationship between the preceptor and the new nurse they will be better positioned to support each group as they navigate the course of a successful transition to nursing practice.

Summary

In this chapter Schlossberg's Transition Theory was described and detailed. A rationale for the choice of the theory as a framework for the current study was provided. A review of the relevant nursing followed. Nursing literature was examined that dealt with the transition of the NGN to the role of RN and the use of preceptors in that transition. Nursing literature that examined TTP programs that utilized preceptors to aid the nurse in transition were reviewed first. Casey et al. (2004) was the next body of literature reviewed because the study and the tool developed, used and revised laid the groundwork for most of the research that followed which measured the NGN and their transition experience. A brief description of the University Health System Consortium (UHC) and the American Association Colleges of Nursing (AACN) Nurse Residency Program (UHC/AACN) followed. The literature reviewed the qualitative findings from

the first two cohort groups from the UHC/AACN Nurse Residency Program. Business literature was briefly reviewed. Literature selected detailed the transition process of professional students who were transitioning to a professional role in the working world and who were engaged in transition programs that are similar to those used by nursing. The methods used in the current study are described in Chapter Three.

Chapter Three

Methods

This chapter begins with a description of the original study and includes a description of the content and timing of the Professional Development Program (PDP), the sampling plan and the data analysis procedures. After detailing the original study, the current study is described including details of the design, sample plan and data analysis procedures. Included in that description is a discussion of the doctoral student's access to the data prior to the secondary analysis. The chapter concludes with a description of protection of human subjects and limitations of secondary analysis as a research method.

Original Study

Professional Development Program and Rationale for Timing

The purpose of the original study was to evaluate a newly designed and expanded orientation program for all newly hired nurses, including both NGNs and experienced nurses changing practice settings, at a specialty hospital located in a large metropolitan city in the Midwest. Central to the expanded orientation program were three Professional Development Days (PDDs) that spanned the first year of employment.

The newly designed and expanded orientation program is referred to as the Professional Development Program (PDP). The PDP was a 12-month program that included a central orientation, de-briefing sessions and three PDDs. The PDP was developed based on a review of the nursing literature. The focus of the evaluation was the newly hired nurses' perception of stressors and supports during the PDP at three, six

and twelve months with a follow up at 18 months. During the course of the study and data collection period the PDP was offered six times to six different groups of nurses.

Transitioning to new employment is especially stressful for NGNs (Casey et al., 2004). This difficult transition is reflected in poor retention rates of this vulnerable population of new professional nurses, with many leaving their first position and sometimes the profession within the first year of employment (Baxter, 2010; Welding, 2011). Realizing this alarming statistic and being troubled with poor retention rates among new newly hired nurses, a group of Clinical Nurse Specialists (CNS) at a specialty hospital located in the Midwest designed and instituted a Professional Development Program (PDP) aimed at easing the transition and increasing retention rates of the new nurse entering the hospital system.

Prior to the reorganization of the orientation and development of the PDP, hospital orientation occurred over two weeks and focused on the overview of policies, procedures and core-mandated education. The PDP was based on the theoretical framework of Meleis Transition Model (Meleis, Sawyer, Im, Messias, & Schumacher, 2000) and reflective practice. The program was not specific to NGNs and was inclusive of experienced nurses who entered the specialty hospital system. Because this is a specialty hospital, unique aspects of the practice that were relevant to all new nurses who transition to the specialty hospital were provided in the PDP. The program provided foundational education, resources and an opportunity to process the transition experience during de-briefing sessions and journaling. The program also informed and reinforced the hospital resources available to the newly employed nurse. The program included

three education sessions and debriefings held at three, six and twelve months post hire date or the date that the employee transitioned to the role of registered nurse.

Preceptors were used throughout the extended orientation period to help the nurse new to the specialty hospital transition to the new work environment. Many of the preceptors assigned to the new hires, who were participants in the original study, would have attended a basic preceptor preparation course designed and implemented by the specialty hospital within which the original study took place. Employees who enjoyed long term working relationships with the specialty hospital may not have attended any sort of formal preceptor training but instead were chosen based on the recommendation of supervisors.

The PDP consisted of a central orientation and three professional development days (PDD). The central orientation focused on core institutional competencies. This orientation took place over a five-day period and employed a blended learning platform of instructor lead and on-line education. Topics covered in the five-day period included clinical care, assessment, intervention, safety, service excellence and clinical basics related to the specialty.

The first Professional Development Day (PDD 1) occurred at approximately three months after the date of hire. It was a four-hour session during which addressed practice issues that have been reported as being stressful were addressed (Fink et al., 2008). Topics covered included issues that surround death and dying, boundaries of care and ethical dilemmas. The second professional Development Day (PDD 2) occurred approximately six months after the date of hire. This was another four-hour session,

which focused on skills related to challenging communication. PDD 1 and 2 were each offered a total of six times during the period data were collected.

The third Professional Development Day (PDD 3) occurred approximately 12 months after the hire date. This four-hour session provided the attendees with the fundamental principles of the preceptor role; a role they would be expected to fulfill soon. By offering the fundamental principles of the preceptor role (coach, educator, evaluator) the intention of this PDD was to create a standard culture of expectations for preceptors within the hospital system. PDD 3 sessions were also offered a total of six times during the period of data collection. A debriefing occurred after each educational session and was the point in time during which qualitative data were collected and will be described in detail later in the chapter.

Data Collection Points/Rationale

Qualitative and quantitative data were collected at approximately three, six and twelve months after the date of hire and these time frames corresponded with the timing of the three PDDs. Time intervals for data collection and PDDs were selected based on a review of the literature that suggested that these points in time were ones that are significant as a peak interval of stress for the NGN (Fink et al., 2008; Schoessler & Waldo, 2006; Williams et al., 2007).

Little is known about the transition experience of experienced nurses who are changing practice settings and it is unclear if their transition experience mimics that of NGNs in terms of high stress levels and key points in time. Because of this uncertainty time intervals for data collection and PDDs were chosen based on what is known about

the transition experience of NGNs. Quantitative data were collected during each PDD, at the start of the day and before the curricular content were delivered. Qualitative data were collected at the conclusion of the delivery of the curricular content.

The first stage of a transition, using Schlossberg's Theory of Transition is referred to as the moving in stage. PDD 1 occurred near the end of the moving in stage or approximately three months after the date of hire. It is at this point in time and transition when the newly hired nurses are involved in orientation to the organization. This is the point in time when NGNs should let go of the familiar role of student nurse and transition to the role of professional nurse. The NGNs struggle with organization, prioritization and the development of new skills (Halfer & Graf, 2006; Schoessler & Waldo, 2006). This point in time during the transition of NGNs has been identified as stressful (Schoessler & Waldo, 2006). It is uncertain if the experienced nurse who is changing practice settings or specialties also identifies this time in the course of transition as a stressful one.

PDD 2 occurred approximately six months after the date of hire and during the moving through stage identified in Schlossberg's Transition Theory. The six-month marker has been identified as an especially stressful time for NGNs (Casey et al., 2004; Fink et al., 2008; Williams et al., 2007). It is also at this time in the transition of NGNs that scores on the Casey-Fink Graduate Nurse Experience Survey have been reported to decline indicating an increased level of stress (Casey et al., 2004; Fink et al., 2008; Williams et al., 2007). Little is known about transition of experienced nurses who are moving to a new practice setting or specialty and if experienced nurses also identify the six-month marker during transition as one associated with an increased level of stress.

At this point in time the both groups of newly hired nurses have completed orientation to the nursing organization and nursing unit. During this stage NGNs expressed concerns about not being able to answer questions posed to them by patients or patients' families (Schoessler & Waldo, 2006). The NGNs also reported that professional relationships with physicians remain problematic. The NGNs cite that their inability to effectively communicate and advocate for their patient is the reason for their troubling relationship with medical providers (Schoessler & Waldo, 2006). At this point in the transition the NGNs may benefit from the blended group of nurses participating in central orientation and PDDs. The experienced nurses may have overcome the elements of transition that the NGNs described as stressful and the experienced nurses may provide the NGNs with insight as to how best manage the situation and deal with the associated stress.

PDD 3 occurred at approximately 12 months after the date of hire and during the time in the transition process Schlossberg refers to as moving out. At this time in the transition process the NGNs are beginning to ask what comes next. This time was chosen because previous studies suggest that the NGNs are beginning to feel more comfortable and confident in their role (Casey et al., 2004; Fink et al., 2008; Williams et al., 2007). They are more organized and are able to answer most questions posed to them by patients, family members and peers (Goode et al., 2009). They also have a sense of knowing what is likely to occur and in turn know what would be needed to care for their patients. At this point in the transition the both groups of newly hired nurses begin to assume additional organizational roles (Schoessler & Waldo, 2006). With this in mind,

the focus of PDD 3 was to prepare the both groups of newly hired nurses to assume the role of preceptor. The fundamental principles of the preceptor role (coach, educator, and evaluator) are taught with the intention of creating a standard culture of expectations for all nurses within the specialty hospital system.

Research Questions and Hypothesis: Original Study

The purpose of the original study was to evaluate the 12-month PDP for newly hired nurses employed at a specialty hospital located in the Midwest. The focus of the evaluation was the newly hired nurse's perception of stressors and supports during the PDP at three, six, twelve months with a follow-up questionnaire distributed electronically at 18 months, or approximately six months after completion of the PDP. The investigators of the original study sought to explore four specific research aims.

1. To determine if the 12 month PDP addresses the transition needs of newly hired nurses and if it is sustained for six months after completion of the program.
2. To determine the employment retention rate of nurses after their participation in the PDP.
3. To determine if there is a difference in response to the PDP between NGNs and nurses with work experience.
4. To explore the themes identified in the debriefing sessions and compare them to the experience of the transition as measured by the Casey-Fink Graduate Nurse Experience Survey (revised).

Design: Original Study

The design of the original study was mixed methods. A pretest-posttest design with repeated measures was used to analyze the first and third aims. The second aim was addressed using a retrospective analysis of retention data from the Human Resource department. A qualitative design was used to address the fourth aim. The study design for the qualitative component used by the research team is consistent with Sandelowski's (2000) description of a qualitative descriptive design. Qualitative description is useful when the researchers seek to obtain "straight and largely unadorned (i.e., minimally theorized or otherwise transformed or spun) answers to questions of special relevance to practitioners and policy makers" (Sandelowski, 2000, pg. 337).

Instrument: Original Study

The Casey-Fink Graduate Nurse Experience Survey (revised) is an instrument used to measure the transition experience of NGNs and track changes over time. This instrument provided the framework for the instrument used to capture the quantitative data. The primary investigator (PI) of the original study revised The Casey-Fink Graduate Nurse Experience Survey (revised) to more closely match the specialty institution where the original study took place. The instrument used by the specialty hospital consists of four parts: (1) a demographic section, (2) comfort/confidence while functioning as a professional nurse (25 item scale in Likert format), (3) job satisfaction, (9 Likert type items), and (4) a series of 26 questions in which the NGN can indicate what difficulties if any he/she is experiencing with the transition.

The Casey-Fink Graduate Nurse Experience Survey (revised) tool used by the specialty hospital contains two items that minimally address the role of the preceptor. When the tool was administered at PDD 1 the tool also had one fill in the blank question that asks the participant how many preceptors they have had during the period of orientation.

The survey was administered at the start of each PDD before any curricular content were delivered. The survey was administered in paper and pencil format for all three PDD's and administered electronically at approximately 18 months post-hire date or six months after completion of the PDP. Because the focus of the current study is on the collection of qualitative data from the original study the emphasis is placed on describing that process.

Sample: Original Study

The original study took place over the course of two years, 2010-2012. The last data collection point for qualitative data was March 2012. All nurses who were hired between January 2010 and February 2011 were invited to participate in the study. There were no exclusion criteria. There were 140 nurses who attended one or more of the PDDs; 66 of those attended all three. There were 118 nurses who participated in the first Professional Development Day and who completed the demographic survey. The 118 nurses who participated in the first PDD had a mean age of 28 (6.7) years; were predominately female (92.5%), Caucasian (92.5%), and BSN prepared (75.2%). There were 76 (64.4%) nurses with less than one year of experience. Of those with more than one year of experience ($n = 42$; 35.6%), a majority (53%) had between one and four

years with a mean of 7 (7.8) years. The sample shows attrition over time: of the 118 participants who attended PDD 1, 96 of those provided information at PDD 3. There was a slightly higher proportion of NGNs ($n = 76$; 79.2%) than nurses with greater than 1 year of experience, ($n = 20$; 20.8%) at PDD 3 than at PDD 1. Sixty-six nurses attended all three PDDs.

Human Subjects: Original Study

Informed consent was obtained at the first PDD the participants attended. The known risk for participating in the study was considered minimal. Investigators reviewed the consent process with each group at the start of each PDD and reminded participants that they could opt out of the study at any time they wished with no penalty to them.

Prior to each debriefing trained facilitators reminded all participants of the purpose and ground rules for the debriefing session and read the following script to them:

There are two purposes of the debriefs. The first is to allow the new hire to reflect on how things are going which in itself is known to support their first year transition. The second is to look at system practices that can improve or change. We ask that what is said in the group be respected as confidential and should not be shared without the consent of the person that it is related to. If something comes up that needs follow up, try to discuss that with the person privately at the end of the session.

If broad and disturbing themes emerged during the debriefing session the facilitator initiated an immediate member check. Those themes or areas of concern were

then shared with unit specific leadership by the facilitator and every effort was made to ensure that participants' identities were kept confidential.

Contact information for the Employee Assistance Program and internal resources such as Advanced Practice Nurses and Supervisors were provided to all participants at the beginning of each debriefing session if participants felt stressed by the debriefing sessions.

Data Collection Procedures: Original Study

Qualitative data collection. Qualitative data were gathered through structured debriefing sessions offered at the conclusion of the three educational offerings that were presented at the PDDs. There were four open-ended questions posed to the group by the trained facilitators. Each debriefing followed the same pattern and the four open-ended questions were asked in order:

- What went well?
- What didn't go well?
- Any surprises?
- What one thing would you change?

Prior to the debriefing and the asking of the four open-ended questions all participants were assured that what information was shared in the group would be respected and kept confidential. The large group of attendees was then randomly divided into smaller groups and each group was assigned a trained facilitator and scribe.

Facilitators and scribes all had training prior to participating in data collection. All facilitators had Collaborative Institutional Training Initiative (CITI) prior to assuming the

role as a part of the study. Facilitators lead the debriefings and posed the broad open-ended qualitative questions. Facilitators had also been instructed to use probing questions for clarification or to add depth to statements made by participants. Probing, open-ended questions were also to be used if there was a lull in the discussion. Facilitators had also been taught to avoid the use of leading questions as probes. In an effort to increase reliability, facilitators were a small and consistent group of CNSs.

Most (90%) but not all scribes had completed CITI training prior to the study. Scribes had been instructed to capture as much verbatim response as possible and to enclose those remarks with quotation marks.

Participants spoke freely and were allowed to speak at will. Facilitators attempted to ask probing questions to help clarify statements. Trained scribes who were not involved as facilitators or discussants captured the conversation with paper and pencil, taking extensive notes as participants spoke. At the conclusion of the debriefing a short amount of time was allowed for the facilitator to summarize the content of the debriefing session with the participants to ensure that the meaning of the participants' remarks was accurately recorded. Participants were then dismissed and the facilitators and scribes met to share content from each group, to debrief among themselves and to discuss key findings and next steps.

Upon completion of the debriefing the scribe's notes were transcribed verbatim for analysis later. Before analysis began the scribe and the facilitator met and reviewed the transcribed material to ensure that the transcript accurately reflected the participants' remarks.

Data Analysis Procedures: Original Study

Qualitative data analysis. Qualitative data were analyzed in the order in which they were collected. All data from the six PDD 1s were analyzed individually and then collectively. When the analysis of all PDD 1s was complete the team moved onto data from PDD 2 and then PDD 3 in like manner. Data from the PDD debriefs were analyzed as stand-alone data from each time point in the extended orientation. Data were then analyzed across all three points in time to assess for similarities in themes.

The research team consisted of seven Clinical Nurse Specialists (CNS), one doctoral student and one research consultant. The team met twice a month for the purpose of qualitative data analysis. The research consultant did not participate in all team meetings and qualitative data could be analyzed in the consultant's absence. A minimum of three CNSs was required to be in attendance at any given team meeting in order to be able to proceed with data analysis. Before the research team met all transcribed notes, that is the raw data, were read by three members of the research team; the PI and two other CNSs. They placed the quotes and statements from the participants into broad categories. As they did this they were careful to analyze each question separately and then assign responses to a broad category for that particular question before moving onto the analysis of the next open-ended question. The material was then transcribed again to include the categories. These transcripts were available in electronic format to all members of the research team. This process enabled research team members to review transcripts prior to team meetings. This process was followed for each transcript of every PDD.

When the team met they reviewed the transcripts line by line. Pre-assigned categories were reviewed to determine if material placed in that category was a fit. If the team agreed that the statement or quote did not fit, together they determined what other category it should be placed to ensure a better fit. After the data from individual questions had been reviewed the team counted and recorded the number of times a specific statement had been identified. The team then composed a summary statement to capture the meaning of each category. A member of the research team who acted as the recorder for the team made all changes in real time. Whenever possible the same member of the research team acted as the recorder.

By using the data analysis method described above the research team attempted to bolster validity of findings through the process of investigator triangulation. Investigator triangulation uses more than one investigator to collect and analyze raw data. The findings emerge through consensus of the investigators (Giacomini & Cook, 2000). The underlying premise is that through collaboration investigators can reduce the possibility of bias based decisions. Conceptually investigator triangulation is analogous to inter-rater reliability in quantitative research and it is a strategy often used in coding qualitative data (Polit & Beck, 2008).

The data analysis procedure used by the research team is consistent with Sandelowski's description of qualitative content analysis (2000). Qualitative content analysis is aimed at summarizing the informational content of the collected data. The analysis is "reflexive and interactive as researchers continuously modify their treatment of the data to accommodate new data and new insights about the data" (Sandelowski,

200, pg. 338). Qualitative content analyses involve counting responses and the number of participants in each response category. Counting provides a description of the patterns or the regularities that have been discovered in the data and the counting confirms the discovery (Sandelowski, 2000). Qualitative content analysis yields a straight descriptive summary of the informational contents of the data organized in a way that best fits the data (Sandelowski, 2000).

Current Study

Secondary data analysis involves the analysis of data that were gathered in a previous study in order to pursue a research interest that is distinct from the original work (Heaton, 1998; Hinds, Vogel, & Clarke-Steffen, 1997; Szabo & Strang, 1997).

Secondary analysis of data is a valid mode of inquiry and is a cost effective and convenient method of generating knowledge that will contribute to nursing (Szabo & Strang, 1997). While the phenomena of interest, preceptors, emerged from the original study, research questions for the current study differed significantly from research questions asked in the original study.

The qualitative data from the original study were the only data included in the process of secondary analysis. The quantitative data did not focus on the role the preceptors played in the transition experience of the new nursing hire. However, it was realized during review of findings of the qualitative data that the preceptor played an important role in the transition of new nursing hires and that the preceptor role required further exploration and explanation. The qualitative data set generated by the original

study supported the secondary data analysis and further exploration of the preceptors' role in the transition experience of new nursing hires at a specialty hospital.

Research Questions: Current Study

Schlossberg's Transition Theory provided the framework for the research questions that guided the analysis of collected data and included the following;

- As NGNs and experienced nurses transition to a new professional practice setting how do their perceived needs for a successful transition change over the first year?
- As NGNs and experienced nurses transition to a new professional practice setting how do their coping resources change over the first year of practice?
- How do the NGNs and experienced nurses perceive the preceptors use of their knowledge and skills to help support them to explore, understand and cope with transition?
- How do NGNs and experienced nurses describe the change in the role of the preceptor over the first year?

Sample: Current Study

It is essential that the original data set be large enough so that data analysis in the secondary study can proceed. The use of four open-ended questions during the debriefing sessions generated a large and rich data set. In the current study the doctoral student had access to all transcripts or raw data from all PDD debriefings that were conducted by the research team in the original study. The original study provides a rich data set that was large and an excellent fit with the research questions in the secondary

study. All transcripts from all PDD's were included in the analysis of data; no qualitative data were excluded.

Data Access: Current Study

The researcher in the current study was in a unique position as a doctoral student to participate in the data collection process in a limited way. The research consultant for the team also serves as the doctoral student's Major Professor. The doctoral student had an opportunity to and did attend two PDD 3s. As an observer, the doctoral student was able to appreciate the interview setting and contextual flow of the dialogue between the participants and the facilitators. The doctoral student also had an opportunity to participate in the analysis of data from the original study as a member of the research team. As a member of the team the doctoral student in the current study helped to analyze a majority of the data from the debriefing sessions following PDD 1 and 3 and all of the data generated from the debriefing sessions of PDD 2.

The opportunity to participate as a member of the original research team allowed the doctoral student and the Major Professor to assess the original data set and the extent to which that data set would be able to address the doctoral student's research interest in preceptors. After it was determined by the doctoral student and Major Professor that the data set did indeed contain rich descriptions of the phenomena of interest the research team was approached by the Major Professor and asked if the data set could be used by the doctoral student for secondary analysis of data for dissertation. The PI gave permission for the data to be utilized in this fashion and for this purpose.

Data Analytic Procedures: Current Study

Qualitative analysis is an iterative process that begins immediately following the first interview. Researchers must immerse themselves in the data to bring order and meaning to the narrative. Qualitative analysis is also a cyclical process and more than one method of analysis can be employed to make meaning of the transcribed interview (Gillis & Jackson, 2002). Analytic coding and word count were the two methods of qualitative analysis used to conduct the secondary analysis of the data collected in the original study. Schlossberg's Transition Theory served as the framework for the analysis.

Because this was a secondary analysis of data, qualitative analysis in its purest form is impossible, meaning data could not be analyzed as they were collected. In an attempt to capture the essence of the iterative process data were coded in a certain order. Data from each separate point in time were analyzed before moving onto the next time point. Data from all PDD 1's were coded first and in the order the data were collected. Data from all PDD 2's were coded next and in the order collected and the same pattern was maintained for data from PDD 3. Once data from each PDD were coded the doctoral student analyzed data across PDD's to determine if there were any commonalities in themes and subthemes across points in time.

Analytic Coding

Analytic analysis was completed using manual techniques. Research questions, a pictorial model of Schlossberg's Transition Theory and a table containing the components and definitions contained in Schlossberg's theory (refer to Appendix A) were posted near the researchers work area. These items served as a constant reminder of

the framework that drove the analysis of data. Two copies of the transcribed notes were kept. The first copy was a “clean” copy without any coding or marks on the transcript. The second copy was a working copy and contained codes and emerging themes.

The first step in the analysis of the qualitative data was to print the transcripts in such a fashion as to leave wide margins on either side of the text. This allowed the doctoral student to write codes and emerging themes in the spaces next to the transcription of the scribe’s notes. A wider margin was assigned to the right side of the text and codes were written in this space. A narrower margin was to the left of the text and emerging themes were written in this space.

The next step in the process was a thorough reading of the transcripts. The transcripts were read with the research questions and Schlossberg’s Transition Theory in mind. This allowed the doctoral student to become immersed in the data and to gain a greater appreciation for the context of the transcribed dialogue as it related to the research questions and guiding framework. A second reading followed and an analytical approach to data management was employed to make sense of the data (Charmaz, 2010; Ryan & Bernard, 2000). During this second reading of the data, the transcripts from each of the PDDs were read and analyzed in the order in which they were collected. As transcripts were read line-by-line during the second read, small bits of text and key words and phrases were identified (Ryan & Bernard, 2000). These key words and phrases were hand written in the left hand margin of the transcript. When rereading, the words and phrases that were hand written and placed in the left hand margin were analyzed for

emerging themes. Emerging themes were then written in the right hand margin of the transcript. Emerging themes were reread in an attempt to identify subthemes.

Word Count

Words that appeared to be used frequently and that were identified as being relevant to Schlossberg's theory and the research questions were underlined and counted. Each word that was identified for word count was underlined using a color specific to it. Word counts are useful for discovering patterns of ideas in the body of the text of the transcription (Ryan & Bernard, 2000).

Rigor: Current Study

Demonstrating trustworthiness in this study was a challenge. The current study employed a single researcher. Bosk (as cited in Riessman, 2008, p. 184) stated, "All field-work done by a single field-worker invited the question, why should we believe it?" For this reason two levels of trustworthiness were employed to demonstrate rigor in analysis of data.

As a novice qualitative researcher, trustworthiness can be established by carefully documenting the processes used to collect and interpret data (Riessman, 2008). Documentation of procedures used to collect and analyze data is referred to as creating an audit trail. A well-kept audit trail will allow an independent researcher to use the same data, follow the logic of the original researcher and come to the same conclusions (Burns & Grove, 2005). The audit trail for this study included all raw data; the "clean" copy and the working copy. Transcripts of raw data were stored by the researcher and were

available for collaboration with a member of the doctoral student's dissertation committee and for review if the analysis process is questioned.

Thematic memos were collected and recorded throughout the secondary analysis process. Thematic memos capture the cognitive process and capture ideas about the connections between the data and emerging codes or themes as they relate to the research questions and Schlossberg's Transition Theory. All memos and rules regarding decisions for categorizing data were written down and stored in a reflective journal kept by the doctoral student. As data analysis progressed the doctoral student documented the rules on which each decision was based and the reasoning that went into that decision. The process of memo writing and journaling ensures that evidence is kept to support the emerging theories of the analytic process (Burns & Grove, 2005). Again, all decisions were recorded in the reflective journal kept by the doctoral student.

Data analysis was completed in a sequential and staged fashion. The doctoral student coded all of the raw data from PDD 1. After coding this predetermined amount of data, the doctoral student met with a member of the dissertation committee who is familiar with qualitative data analysis and coding. Together they reviewed the working copy of the raw data, collaborated and reached a consensus on the meaning of the raw data. If questions arose as to decisions made by the doctoral student during initial coding they referred to the journal kept by the doctoral student for clarification. The same process was repeated for PDD's 2 and 3.

After the initial round of coding a second member of the doctoral student's dissertation committee read all raw data. After data were reviewed by the second

member of the committee the doctoral student and the second committee member met to review themes and subthemes that had emerged from the data and discuss findings.

The process of staged data analysis and collaboration with dissertation committee members allowed for investigator triangulation. Triangulation has a role in the trustworthiness of findings in qualitative research. The purpose of triangulation is to provide a basis for convergence on the truth (Ritchie & Lewis, 2005). Investigator triangulation was another method employed to help establish trustworthiness of findings. Investigator triangulation uses more than one investigator to collect and analyze raw data. The underlying premise is that through collaboration investigators can reduce the possibility of bias based decisions.

Human Subjects Protection: Current Study

Participant consent is an ethical issue that needs to be considered in secondary data analysis. The risk to participants in the current study was minimal and mirrors those of the original study. Before being added to the original research team as a member, the doctoral student completed the required Collaborative Institutional Training Initiative (CITI) and supplied the institution with the curriculum completion report. The doctoral student also signed a letter that outlined the responsibilities and obligations of being a member of the original research team, before being added to the original team as a member.

The Primary Investigator (PI) then sought approval for the current study through submission of request to the Institutional Review Board (IRB) at the University in which the student is enrolled. After reviewing the application the University waived the IRB

process and deferred IRB approval to the specialty hospital where the original study took place. An amendment to the original IRB was then submitted and approved by the specialty hospital (Appendix B).

Limitations: Current Study

Secondary analysis of data has a number of limitations (Szabo & Strang, 1997). Disadvantages associated with secondary analysis of data include a lack of control in generating the data set (Szabo & Strang, 1997). The researcher is also unable to ask questions that arise when reviewing the transcripts of the interview. The opportunity to conduct subsequent interviews to help clarify information does not exist. This method of research also makes it impossible to simultaneously collect and analyze data.

Another limitation of the original study that impacted the current study was the way in which data were collected. Qualitative data were not audiotaped but instead collected by scribes who captured the spoken word of those interviewees participating in the debriefing with paper and pencil. An audiotape provides an accurate, verbatim recording of the interview while capturing the language the participants used including tone and hesitations in far more detail than would be possible with note taking or scribing (Ritchie & Lewis, 2008). An audiotaped interview is also more neutral and less intrusive than note taking or scribing. Note-taking can give participants unintended cues, such that they should slow down or pause if the researcher is writing or that they have said enough if the researcher is not writing (Ritchie & Lewis, 2008).

Another limitation of the original study was the absence of field notes. Field notes provide an opportunity to record what the researchers see and hear outside of the

immediate context of the interview. Field notes also help the researcher recall the dynamics of the encounter that may be relevant at the analytical stage (Ritchie & Lewis, 2008). The absence of field notes finds the researchers relying on memory to recall the dynamics of the interviews during analysis of data.

There were limitations associated with both the methods of the original study and those of the current study. Despite these limitations the data set was large, rich and adequate for secondary analysis.

Conclusion

Secondary analysis of data was the method used to re-examine data collected by a specialty hospital to evaluate a newly designed 12-month Professional Development Program for all newly hired nurses entering the organization. Research questions asked during the secondary analysis focused on the contribution of preceptors to the orientation program and the perception of the preceptor's ability to support the NGN and experienced nurses' new to the organization as they transitioned to their new role as described by the NGN and experienced nurses new to the organization. Schlossberg's Transition Theory was the framework that guided the analysis and framed the research questions. While the method of secondary analysis has disadvantages and limitations the advantages associated with this method cannot be overlooked. This method of analysis maximised the use of an existing data set and added to nursing's increasing body of knowledge regarding the role preceptors play in the transition of NGNs and experienced nurses new to a practice setting or organization. What follows are the results of that analysis of data.

Chapter Four

Results

In this chapter the findings from the current study are presented. Findings for all four research questions are presented first. The first, second and fourth research questions address change that occurred across the first year of practice. Those three research questions are answered first and the change is tracked over time and across PDD's. Themes and subthemes are used to answer research questions one and two, and those two research questions are answered together. Research questions three and four are answered using the words of the participants that help to illustrate the transition. The chapter concludes with a synthesis of the findings.

Overview of Data Analysis

The data were analyzed in the order in which they were collected and Schlossberg's Transition Theory served as the framework for analysis. All data from PDD 1 were coded first and in the order in which the data were collected. Data were then coded from PDD 2 and 3 and analyzed in the same fashion as the data from PDD 1. All data were read line-by-line and small pieces of text and phrases were identified and recorded on the transcripts. Words that appeared frequently in the transcripts were also identified and counted. Data were reread and the key words and phrases that had been identified were then analyzed for emerging themes. The emerging themes were reread and subthemes were identified. As data were analyzed, a table was created in an attempt to organize the emerging themes and subthemes. The table (Table 1) created a visual representation of the themes and subthemes as they occurred across PDDs.

Table 1

Themes, Subthemes (Word Count) & Schlossberg's Transition Theory

PDD 1	PDD 2	PDD 3	4 S System	ASSET			LIABILITY		
INSTITUTIONAL SUPPORT	INSTITUTIONAL SUPPORT	INSTITUTIONAL SUPPORT		PDD1	PDD2	PDD3	PDD1	PDD2	PDD3
Human Connection	Human Connection	Human Connection	Support Strategy						
Preceptor (154)	Preceptor (32)			XXX	X		XXX	X	
	Go to Person (27)	Go to Person (18)			X	X		X	X
Staff/Others (28)				X					
	Feedback (15)	Feedback (17)			X	X		X	X
Leadership (12)				X			X		
Communication (17)	Communication (6)	Communication (23)		X	X	X	X	X	X
Process Approach	Process Approach	Process Approach	Support Strategy						
Orientation (81)	Orientation (60)	Orientation (28)		XXX					
Consistency (22)	Consistency (13)	Consistency (8)		X	X	X	X	X	X
Resources	Resources	Resources					X	X	X
SENSE OF SELF	SENSE OF SELF	SENSE OF SELF	Self Strategy						
Self-Awareness	Self-Awareness	Self-Awareness							
What I need (15)	What I need (33)	What I need (25)		X	X	X			
	What I Know/Don't Know (8)				X				
	What's Real (13)				X			X	
Fear	Fear	Fear	Self Strategy						
Budget/job security (9)	Budget/job security (4)	Budget/job security (6)					X	X	X
		Floating (30)							X
		Losing skills (7)							X

Key: XXX greater degree of asset/liability

Thematic memos were also kept and recorded throughout the process of data analysis. All memos and rules regarding decisions for categorizing data were written down and stored in a reflective journal. For example, the subtheme Resources had originally been a part of the subtheme, Orientation. However, after reviewing Schlossberg's definition of strategies it was determined that Resources was a separate subtheme.

Once the themes were identified they were analyzed for congruence with Schlossberg's Transition Theory, specifically the 4S's. Schlossberg's Transition Theory mapped onto the identified themes and the 4S coping resources of support and self were predominantly represented.

Major Themes and Subthemes

When the data were analyzed for all three PDDs two main themes emerged: Institutional Support and Sense of Self. Each of these themes is consistent with the 4S system. Both themes are present across all PDDs; however, the degree of emphasis of each theme varies across PDDs. There are also negative and positive aspects of each theme. The negative and positive aspects are consistent with Schlossberg's description of assets and liabilities related to the 4S coping resources. The themes Institutional Support and Sense of Self also represent strategies both groups of nurses in transition used to manage the stress caused by the transition to a new practice setting or specialty.

Institutional Support as identified by both groups of newly hired nurses is the support that the hiring institution provided. The support needed for transition comes in

the form of a Human Connection (preceptor, leadership and staff and others and “go to” person) and a Process Approach (orientation and consistency) and Resources (competing for opportunities).

Sense of Self as described by the NGN and the experienced nurse is an internal awakening or an awareness of self. Sense of Self also allowed participants to identify fears and uncertainty that lie within the self that serve to undermine successful transition.

Research Questions One and Two: Perceived Needs and Coping Resources

After the data were analyzed and Schlossberg’s Transition Theory was mapped to findings it was noted that the majority of the findings answered both research questions one and two. Perceived needs were identified through coping resources of support and self. The theme, Institutional Support, described perceived needs and coping resources that were identified by the participants for successful transition to independent practice. One of the subthemes of Sense of Self, Self-Awareness: What I Need, also answered both research questions. Other themes and subthemes under Sense of Self, such as Self-Awareness: What I Know and Don’t Know and Fear only apply to coping resources and therefore are only applicable to Research Question Two. However, these findings are not as prominent in the data.

Because of the similarities in research question one and two and the overlap of findings related to perceived needs and coping resources, research questions one and two are answered together. Coping resources not related to perceived needs, that only address research question two, are addressed separately.

Research Questions and One and Two

In response to the research question, “As NGNs and experienced nurses transition to a new professional practice setting how do their perceived needs for a successful transition change over the first year”? and the research question, “As NGNs and experienced nurses transition to a new professional practice setting how do their coping resources change over the first year of practice”, two themes emerged: Institutional Support and Sense of Self. Several subthemes also emerged in relationship to each theme. Subthemes associated with the theme Institutional Support include: Human Connection, Process Approach and Resources. Subthemes associated with the theme Sense of Self include: Self Awareness and the phrase, What I Need. The NGN and the experienced nurse all used Institutional Support and a Sense of Self to help them transition over the course of the first year of employment. The theme and subthemes associated with Institutional Support are discussed first followed by those associated with Sense of Self. Each of the subthemes identified under Institutional Support and Sense of Self is described in detail and their tendency to be both positive and negative are identified and discussed.

Institutional Support

The newly hired nurses looked to the hiring institution to provide the support needed for a successful transition to independent practice. Subthemes of the theme Institutional Support include, Human Connection, Process Approach and Resources.

Examples of the Institutional Support offered to the newly hired nurses included the preceptor, staff and others, members of the leadership team, a go to person and feedback.

Institutional Support: Human connection. The newly hired nurses perceived that a Human Connection was needed to make a successful transition to practice. Four groups of individuals were identified by the newly hired nurses, as being critical to a successful transition. Those individuals or groups of people have been labeled as, preceptors, staff and others, leadership and a go to person. The findings as they relate to preceptors are examined first.

Human connection: Preceptor. The newly hired nurses perceived preceptors as important and necessary for successful transition to practice. Preceptors were considered to be a major asset under certain conditions: when numbers were small, a trusting relationship had been established and communication between multiple preceptors was evident. The preceptor could also be identified as a liability. The preceptor became a liability when there were too many or when the communication between preceptors was poor or missing. Preceptors were most relevant to the nurse during the first three months of the transition and that relevance decreased over the course of the first year.

The number of preceptors who interacted with the newly hired nurses made a difference in the progression or lack of progression during transition. Many participants commented that a consistent and small number of preceptors during the transition were preferred. A small and consistent group of preceptors can be considered an asset. One participant remarked, "...a total of six preceptors so far. It's much better with less

variability”. Another participant remarked, “... great preceptors...had two main preceptors...”. Yet another participant remarked as to why a smaller number of preceptors had been preferred and stated, “I liked having two to three preceptors to work with toward the end of orientation...different perspectives...see different things to focus on...I had reached a point where I was ready to be off orientation and feeling there was not much more I could learn from my preceptor, but having different people toward the end they saw what I still needed”. Another participant stated “I had the opposite...three preceptors at the beginning...I was able to take the best from all”. A participant from PDD 2 stated, “One consistent preceptor has been nice...I didn’t have to bounce between a couple and I worked with her well”. An experienced nurse participant from PDD 2 who came from an adult care setting stated that it was easy to learn pediatric nursing and gave the credit for the ease of learning to the preceptor and stated, “everything’s been good”.

Establishing a trusting relationship with multiple preceptors could also pose a problem or be considered a liability for some of the newly hired nurses. An experienced nurse participant from PDD 1 remarked and explained why too many preceptors can be thought of as a liability, “Too many preceptors...double digits... hard to be consistent, each one does things differently, no communication between preceptors so it felt like starting over or moving backwards each time”. Another participant from PDD 1 remarked, “I’ve had a lot of different preceptors. You spend a lot of time catching people up on what you know and establishing trust. That really sets people back”. A participant

from PDD 1 noted something similar and added additional comments related to numbers of preceptors and trust by stating, “I bounced between five and six preceptors, I spent the first half of the shift getting the trust level up... it hurts the day when you spend time trying to find the right level... its often repetitious when you have many preceptors...you don’t want to sound like a know it all and say I that already know that...”. Another participant from PDD 2 remarked,”...have had multiple preceptors, resulting in conflicting information regarding expectations and roles, each has a different style and don’t know where I’m at so some hover, some not as available”.

Participants from PDD 1 also spoke of the lack of communication among multiple assigned preceptors as being another problem or liability that interfered with forward progress during orientation. A participant from PDD 1 stated that being told the same thing, “...over and over” from multiple preceptors interfered with progression toward independence. Another participant from PDD 1 expressed a need for more communication from the assigned preceptor stating, “...want more feedback from preceptors...hearing no news is good news is not desirable”.

Preceptors who were involved and committed to the transition of the newly hired nurses were considered an asset when they advocated for the learning needs of the nurse in transition. A participant from PDD 1 stated, “My preceptor is an advocate for what I need to learn. If I have not had a certain type of patient, she will try to get that assignment for me”.

Participants from PDD 1 were also able to identify those nurses whom they considered to be good preceptors and those who were disinterested or ill prepared for the role. The disinterested or ill-prepared preceptor can be considered a liability to the nurse in transition. A participant stated that it was easy to discern those nurses who were not interested in the preceptor position and remarked, “ Really can notice if they don’t want to precept. On our unit they have to either be charge or precept”. Another participant made a similar remark and stated, “Not everyone is meant to be a preceptor but it seems like they say you either precept or take charge. It shouldn’t work that way”. Other participants from PDD 1 felt that preceptors should be asked if they were still interested in the role when they stated, “...some preceptors have been doing it a long time but doesn’t necessarily go well...need to touch base with preceptors and ask, ‘are you still interested in developing new staff on the unit’”? Other participants from PDD 1 identified novice preceptors as a liability and an impediment to forward progress and stated that a preceptor who remarked, “This is my first time precepting so I don’t know what I’m doing” were not helpful.

Human connection: Staff/Others. During PDD 1 the newly hired nurses who were changing practice settings also perceived Staff and Others as another part of the Human Connection needed for a successful transition to practice. Staff and Others were described in positive terms by the participants and were considered a major asset by the nurse in transition. Staff and Others were more important to the nurse during the first three months of transition and that importance decreased over the course of the first year.

An experienced nurse who was changing practice settings and specialty from PDD 1 stated, “I’m not a new nurse...came from the adult world...nurses were very helpful to me and identified resources”. Another participant from PDD 1 noted “...staff always have an answer for me...they know where to look”. Other participants from PDD 1 made general comments when describing Staff and Others as an asset, “Everyone recognized you were on orientation so asked have you done this before? ...Looked out for experiences for me”. Another participant remarked, “Everyone tries to make sure I get the experiences I need. For example, they called me when an intubation was going to be done so I could observe and called me in to help with other procedures”.

Human connection: Leadership. The participants also perceived a connection with Leadership as being essential to a successful transition during PDD 1. The early connection with members of Leadership was most important to participants during the first three months of transition and became less important over time. An early connection with Leadership can be viewed as an asset. The participants expressed a desire to connect with their manager and were concerned when that meeting was delayed or did not happen.

One participant noted, “I haven’t met my manager yet”. Another remarked, “No one came to talk to me and I didn’t meet my supervisor. I had to go meet my manager after four months”. Other participants who had met members of the leadership team remarked in positive tones about that meeting and thought that supervisors and the leadership team were open and listened to suggestions and needs. Other participants

noted that the Unit Orientation Coordinators (UOCs) were good support and good at checking in. Still other participants didn't find communication "so great" with supervisors or UOCs.

Human connection: Go to person. Perceived needs for a successful transition in relationship to the theme Human Connection changed over time for the participants. As the data about preceptors decreased over time different support persons emerged. Participants from PDD 2 and 3 perceived the need for a "go to" person to help support them with the transition. A go to person was described using terms such as mentor and resource person. Mentors were support persons who had a more formal role and were identified by the hiring institution as such. A resource person was not formally identified by title but provided the nurse in transition the same type of support a mentor provided. The role of a go to person differs from that of a preceptor. A preceptor is in place to support and inspire the nurse in transition and the relationship is time sensitive and goal directed. A go to person is also in place to support and inspire the transitioning nurse but the relationship is not limited by a predetermined length of time and lacks a formal agenda. Go to persons as described by participants can be viewed as both an asset and a liability. The findings as they relate to a mentor are examined first.

Participants from PDD 2 and 3 dialogued about mentors and a mentor program in relationship to a go to person and had both positive and negative remarks in relationship to that role. Several participants from PDD 2 remarked that, "...mentor programs nice...both new and old employees use the program". Two other participants from PDD

2 also mentioned the mentor program and stated that a mentor or someone was needed once orientation was completed. These participants perceived the mentor as... “some sort of bridge between orientation and being off”. Still others from PDD 2 perceived a mentor or resource person was needed to ... “help you find your way”. Another participant from PDD 2 stated that, “Having a mentor on the floor is really helpful. Having someone who isn’t burned out on precepting available is great. Normalizes that asking questions is OK even after orientation is over. Having a resource person is really helpful, advanced practice nurses (APNs) could serve as that or connect you with people”. Participants from PDD 2 identified problems or liabilities associated with mentors. One participant stated, “...mentor idea is a good idea but depending on who it is...can’t find them, they’re down the hall talking with friends”.

A participant from PDD 3 explained why they perceived the mentor was important asset to transition by stating, “...mentor is experienced and will talk about educational topics”. Another participant from PDD 3 provided examples of how the mentor helped the experienced nurse who is changing practice settings or specialty nurse transition to more independent practice when they stated, “...helps a lot, mainly with higher acuity kids” and went on to explain that the mentor fosters a sense of teamwork with a co-worker versus the teacher/learner situation of orientation. When mentors were not available participants requested a mentor and stated, “... identify a mentor and even several to help us transition.”

Participants from PDD 2 and 3 also identified a resource person as being needed for successful transition to professional practice. A participant from PDD 2 remarked that they would like a scheduled resource person available on all shifts after completing unit-based orientation. A participant from PDD 3 shared a similar sentiment and remarked that, "...need to identify more resources across the board and have them available all the time". Another participant from PDD 3 remarked that "..."resource RN is needed. Need that extra support to take challenging assignments once off orientation".

Human Connection: Feedback. Participants also perceived that feedback from preceptors and leadership was needed for a successful transition to professional practice. The need for constructive feedback from preceptors and leadership was noted at PDD 2 and 3. Participants desired feedback to be timely at PDD 2 and wanted an increase in positive feedback at PDD 3. Feedback that was rushed or lacked thoughtful consideration was considered a liability. The nurse in transition considered feedback that was timely and constructive to be an asset.

A participant from PDD 2 wanted more constructive criticism and described the evaluation process in terms of a liability when they stated they felt like the evaluation process was ..."cut and paste...I know I need to improve as a new RN so tell me". Another participant from PDD 2 remarked that it felt that the performance evaluation was something they had to get done and it didn't feel like "decent feedback" and another participant from PDD 2 stated they had not even had a 90-day evaluation.

Participants from PDD 3 perceived a need for more feedback from leadership, either written or verbal and felt that feedback was better from co-workers than from leadership. Participants from PDD 3 who worked the weekend night rotation stated they, "... didn't want to be forgotten...started out on the weekend nights and didn't hear anything from leadership on how I was doing". Another participant from PDD 3 described the evaluation process as an asset because the evaluation process was organized and concise; supervisors were prepared and helped the experienced nurse who is changing practice settings or specialty set goals.

Participants from PDD 3 also remarked about positive feedback noting that there was "not enough". A participant remarked about the content and delivery of feedback, "...need more positive feedback person to person, not by e-mail from leadership. The face to face encouragement is what matters most not the electronic feedback". Another participant from PDD 3 also remarked that more positive feedback was needed, "Our unit does family callbacks. I actually received an e-mail giving me positive feedback from a family. This made me feel really good and I was glad it wasn't about some incident report...".

Human Connection: Communication. Participants from all PDDs wanted "honest" communication and ongoing dialogue from the hiring organization and departmental leaders about policy and change within the organization. Honest communication was relevant to the nurse throughout the entire first year of transition. Participants from PDDs 1, 2 and 3 found open accurate communication with

representatives from the hiring institution to be a perceived need for successful transition to practice. Participants expected certain policies to be implemented based on choices discussed during the hiring process. When policies and choices were not implemented on their unit, communication was viewed as a liability.

Participants from PDD 1 and 3 remarked about accurate communication during the hiring process especially regarding mandatory hours, shifts and the holiday schedule. A participant from PDD 1 stated regarding mandatory hours, “Would have liked to know that during the interview process, I work a 1.0 now and do not want to work extra hours, this may have changed my decision on working this position”. A participant from PDD 1 remarks about the schedule, “My schedule is 1.0 and I was told I would get to choose from Sunday-Thursday or Monday-Friday for my schedule. I have not had the choices and it continues to change”.

Participants from PDD 3 also wanted more information shared with them during the hiring process. A participant remarked, “More information when being hired...ambulatory program is based on all grant money...didn’t know much of the job would entail data entry and reporting for the grant money versus actual patient care. Now I understand the need for that but wish I was told during the hiring process”. A participant from PDD 3 also remarked about information sharing during the hiring process and stated, “...surprised it takes five to six years to get on the day shift... this was not discussed during the hiring process”.

A participant from PDD 2 describes communication in positive terms and states, "...manager open/honest despite having difficult things to share. For example, "...wanted a full time position and the manager continued to update the status and whether it would be possible or not...really appreciated the honesty". A participant from PDD 3 expressed a need for open communication and remarked, "...would like to understand the rationale for changes on the unit". This remark was in reference to why forms used on the units were changed and how it would improve the process.

Participants also described how information trickles down from administration to unit staff. A participant from PDD 3 stated, "...want to hear the news whether good, bad or neutral. If you don't have answers due to unstable economic climate then tell us that too". Another participant from PDD 3 remarked, "Communication about changes is absolutely necessary, and also other than e-mail...want the conversation about these changes".

The both groups of newly hired nurses feel that open honest communication is a perceived need for successful transition to nursing practice. Participants desire answers to questions and changes as they occur and some prefer the communication to be face to face and not via electronic format. Participants also desired consistency between information provided during the hiring and what practices are implemented. The findings indicated that participants from all three PDDs perceived honest communication as an asset and necessary for successful transition to nursing practice.

Institutional Support: Process Approach. The newly hired nurses perceived that a Process Approach was needed to ensure a successful transition to professional practice. A Process Approach, or a step-by-step method of doing something, provides the nurse in transition with a structured approach to transition. Using a structured approach to transition provides the nurse an opportunity to construct a solid foundation upon which to grow as they move to a new career, specialty or work setting and is another way the hiring institution can provide institutional support to the nurse in transition. Terms associated with the subtheme Process Approach include Orientation and Consistency. The findings as they relate to Orientation are examined first.

Process Approach: Orientation. Both groups of newly hired nurses perceived that a well-structured unit based orientation was an asset and was essential for successful transition to professional practice. The need for a well-structured, unit-based orientation is noted throughout the first year of the transition and little change is noted across the three PDDs. The NGN and the experienced nurse each acknowledge that a well-structured orientation is needed; however, each group had different needs and perceptions related to a well-structured orientation. Both groups of nurses found staged orientation to be an asset and helped to increase independence. Staged orientation moves the nurse through orientation in an organized and orderly fashion. A staged orientation provides the nurse with a graduated progression of increasingly difficult patient care assignments, which allows the nurse to gain skill and confidence before moving on to the next more difficult stage. The experienced nurse who was changing practice settings or specialty

also wanted an acknowledgement of prior experience and a tailored orientation based on that experience. Remarks as they relate to a staged orientation are presented first.

The benefits of staged orientation were noted at all three PDDs. Participants from PDD 1, 2 and 3 all remarked that, "...staged orientation was good...was going well". A nurse from PDD 1 remarked, "...loved the staged orientation. Nice not to be terrified all the time". Yet other nurses from PDD 1 remarked that, "...staging gives you confidence to allow to progress better...lets you know where you're going next". A participant from PDD 2 remarked that they liked staged orientation; it made sense and helped them to focus on specific things. Another participant from PDD 2 noted that staged orientation "...was good...liked structure, different level of acuity, hit all competencies". The participants also felt that they would not miss out on anything before being off orientation because orientation was adjusted as necessary to capture stage experiences as they came up.

Staged orientation could also be considered a liability. An experienced nurse who was changing practice settings from PDD 2 felt they were moving her too fast through the stages of orientation and questioned why. One participant from PDD 3 remarked, "...staged orientation was good, but it was hard with so many on orientation".

Although staged orientation is an asset for the experienced nurse it is also a liability for the experienced nurse when prior experience is not recognized. Experienced nurses who were changing practice settings or specialty perceived that a tailored orientation based on prior experience was needed to help them successfully and quickly

transition to the new professional practice area. An experienced nurse who was changing practice settings from PDD 1 remarked and appreciated that prior experience was recognized. Another experienced nurse who was changing practice settings or specialty from PDD1 remarked that orientation for the experienced nurse was too long and needed to be shortened.

Orientation for the experienced nurse is a liability when preceptors or the hiring organization fails to recognize the differences between the NGN and the experienced nurse. One experienced nurse participant from PDD 1 perceived that, "... orientation was aimed more toward NGNs ...need something more formalized for experienced RNs". Another experienced nurse participant from PDD 2 made a similar remark when it was stated that prior experience needs to be recognized, "...they sometimes treat us like new grads". Another experienced nurse participant from PDD1 stated regarding orientation, "Honor my previous knowledge". An experienced nurse participant who was changing practice settings from PDD 3 stated that there was a quick orientation and was happy about that, "...I was at [another specialty hospital] so I had peds experience".

Another experienced nurse participant who was changing practice settings and specialty from PDD 2 explained that the orientation was individualized. The participant understood that he/she had been an expert prior to coming to the specialty hospital but was no longer considered to be an expert. Despite the change the participant acknowledged that the transition was difficult but felt that prior knowledge was

respected. This tailored orientation was an exception; tailored orientation rarely happened.

Two other experienced nurse participants from PDD 3 commented that despite prior experience assumptions about that experience should not be made during orientation... “don’t assume that an experienced nurse knows things”. Another experienced nurse participant from PDD 3 remarked that, “...assumptions are not a good thing when working with experienced new staff, they need to be sure to give us more information, not less”. The experienced nurses did not want their experience or skill based on prior experience assumed. Assumptions regarding skill and experience do not lend themselves to a tailored orientation and can be considered a liability.

Process Approach: Consistency. Perceived needs for a successful transition in relationship to the theme Process Approach included the need for consistency and this need appeared and was noted throughout the first year of the transition. Both groups of newly hired nurses expressed a need for consistent practice habits, shifts and schedule during PDD 1 and consistent schedule or unit during PDDs 1, 2 and 3. A consistent approach to shifts, scheduling and practice habits can be considered an asset; lack of consistency, a liability.

The newly hired nurses perceived a need for consistent practice habits among all staff and were able to notice and remarked when practice habits waivered. One participant from PDD 1 noted, “...preceptors don’t always follow or see a need to follow policies and procedures (P & Ps), orientees reference them and follow them. Parents

notice new staff are doing things differently and ask why and state that no one else does it that way. Expectations seem to be different for new staff...”. Another participant from PDD 1 remarked that, “...a lot of the RNs don’t know the P & Ps...it makes you feel dumb when you want to do it by the P & P and they argue with you”. Another participant from PDD 1 noted a difference in practice habits and adherence to P & Ps between “older” nurses and new nurses stating, “Older nurses do the old practices, not current...”. Not following P & P’s and inconsistent practice habits were considered a liability to the nurse in transition.

The NGN and the experienced nurse participants also perceived that consistent schedules or shifts would help with a successful transition to professional practice. Orientation to the day shift when staffing on the night shift was considered a liability. A participant from PDD 1 noted that they had been hired for the night shift but had completed orientation on the day shift, “...would have liked to have some orientation on the shift hired for”. Another participant from PDD 1 made a similar remark, “ If hired on days should be oriented on days for better preparation...”

Participants who had been hired to staff the neonatal intensive care unit (NICU) were also expected to orient and staff the newborn progressive care unit (NPCU). NPCU is an extension of NICU and is staffed by NICU. Participants found it difficult to move between these two similar units during and after orientation. Participants perceived that a consistent schedule in the NICU during orientation was essential to successful transition and perceived that moving between the two units during orientation was a liability and a

deterrent to successful transition to practice. Participants from PDD 1 and 2 stated they did not like transitioning between NICU and NPCU stating that the schedule was not consistent and the participant did not know which unit they were expected to staff on a given day. Participants from PDD 2 remarked that the transition related to NICU and NPCU was time consuming, confusing and unsettling.

Other participants from PDD 2 and 3 expressed unhappiness with the split orientation and considered it a liability. Participants from PDD 2 noted that split orientation for NPCU staff is taking a long time, noting that assignments have been, "...mostly appropriate but unorganized with no clear plan or finish date for orientation". Another participant from PDD 2 remarked that the scheduling on NPCU needs to be consistent and stated, "I've been off orientation for three months but have spent five weeks on the NPCU...feels like I could lose my ICU skills". A participant from PDD 3 noted that, "...flipping from NICU to NPCU half way through orientation was a bad idea. I'm now 10 months out have been off orientation for one day of staffing as of this week and now the next schedule I'm staffing NPCU. How will I keep up my ICU skills this way"?

Institutional Support: Resources The newly hired nurses also perceived that open access to high acuity patients was needed for a successful transition to professional practice. When access to high acuity patients and needed experiences were denied, the transitioning nurse became frustrated and several of the experienced nurses contemplated leaving the organization. This perception is a liability, was evident and noted throughout

the first year of the transition and little change was noted in that perception and need across the three PDDs. The phrase associated with the subtheme Resources is: Competing for Resources and Opportunities.

Resources: Competing for Resources and Opportunities. Competing for access to resources and opportunities were noted to be a problem and liability for the NGN and the experienced nurse. The participants were able to see the inherent problem with large groups of new hires starting orientation and professional practice at essentially the same time. A participant from PDD 1 stated that, "...it makes it hard that a group starts all at the same time...they all need the same experiences". A participant from PDD 2 had a similar observation and remarked, "30 plus new hires make things hard". A experienced nurse participant from PDD 2 remarked that lack of access to high acuity patients has given rise to thoughts of leaving the organization when stating, "...so bored I could kill myself by the end of the shift...makes me think about leaving". Another participant from PDD 3, "...wishes there were higher acuity patients...now we have to fight over the sick kids". A participant from PDD 3 also noted a problem when competing for a specific patient population during orientation by stating, "...some nurses are trauma junkies and try to take all the traumas and the we (orienteers) do not get the experience".

Competing for a particular patient population or experience continues to be a problem and liability for both groups of nurses once orientation has been completed. The NGN and the experienced nurse changing practice settings or specialty perceive they have to compete with one another for high acuity patient assignments and often times

they have to compete with established, older, primary care nurses for the same assignment. A participant from PDD 1 remarked ... “competing for patients if other staff need orientation in that stage is difficult...sometimes you get bumped from caring for a patient if the primary nurse comes in...this is frustrating and doesn’t help learning...”. A participant from PDD 2 commented, “..now off orientation...want sick experiences but more experienced RNs want to take those kids and usually gets them first”. Another participant from PDD 3 also stated that the number of trauma patients was down in general so many people were fighting over those experiences. Although unrealistic, a participant from PDD 3 summed things up this way, “Don’t hire a bunch of new RNs all at the same time. This causes issues for over a year down the road”.

Sense of Self

The second theme that emerged from the data was Sense of Self. As participants transitioned to a new role they experienced an internal awakening or an awareness of self. The participant identified with himself or herself as a new person with an inner resolve to be successful. The Sense of Self enabled participants to identify what they needed for a successful transition and is considered an asset. Subthemes associated with the theme Sense of Self include: Self-Awareness.

Sense of Self: Self-Awareness. The subtheme associated with Sense of Self, included Self-Awareness. Participants across all three PDDs had a Sense of Self and used this Sense of Self and Self-Awareness as a coping resource to manage the transition to professional nursing practice. The phrase, What I Need is associated with the subtheme

of Self-Awareness and is present in the data throughout the first year of transition. The findings and quotes as they relate to the phrase What I Need, follow.

Self-Awareness: What I Need. Participants were able to verbalize a self-awareness that surrounds needs and what the nurse in transition thought was needed for a successful transition to independent nursing practice. The ability to verbalize needs is a coping resource utilized by both groups of nurses in transition and is viewed as an asset. The ability of the nurse in transition to identify and verbalize needs did not change over time and was noted throughout the first year of transition.

Participants from PDD 1 were able to identify what type of patient experiences they thought they needed in order to make a successful transition. A participant from PDD 1 stated, “...don’t need any more grower and feeder experience...need the surgical oscillator patients”. Another participant from PDD1 stated, “...need to take the same patients more than once to build skills with that patient and build skills by repetition”. The ability to identify needs in relationship to patient care experiences is seen as an asset.

Participants could also identify unit based learning opportunities that they determined would be helpful and necessary for a successful transition. Two participants from PDD1 remarked about floating and being able to float to another unit with the preceptor. One participant stated, “ I wish I could have had a chance to float to another unit with a preceptor”. The other participant stated, “Would be helpful to float during orientation to get accustomed to the process”. A participant from PDD 2 remarked, “Float while on orientation either with a preceptor or a Clinical Resource Unit (CRU)

RN...who knows the ins and outs of floating”. A participant from PDD 2 commented, “Need more time with experienced preceptor...need more one on one time...my preceptor was resourced out during my orientation so she wasn’t available as she should have been”. A participant from PDD 3 noted, “We all need a lot more cross-training across the intensive care units (ICUs)”.

In relationship to learning opportunities, participants could also verbalize when they felt they needed a longer orientation to be successful with the transition to professional nursing. A participant from PDD1 stated, “Yesterday I had my preceptorship extended at my request because I felt I needed more time...”. A participant from PDD 2 stated he/she would like orientation continued when it applies, for instance in the care of the trauma or dying patient. A participant from PDD3 stated he/she asked for more time orienting in the NICU and it was granted. These are overt examples of coping strategies that are aimed at altering the source of the strain of transition.

Participants were also able to identify and state what types of formal education they felt they needed to successfully transition to professional practice. Participants from PDD 2 commented, “...need more education related to unit patient populations...been asking for more education related to cardiac kids...work nights so don’t feel like there are any resources available to me...” . Participants from PDD 3 identified and stated, “...need more information on different diagnoses, surgeries recovery periods...”. Another participant from PDD 3 made a bold declaration stating, “...Need more education...have a wide variety of very sick patients and are not adequately trained to

care for these patients. Have lots of patients transferred from the Pediatric Intensive Care Unit (PICU)... are not pediatric advance life support (PALS) or pediatric emergency assessment recognition and stabilization (PEARS) trained and would like to be. We feel we need this training to care for our patients...". Participants from PDD 3 also perceived the need for trauma training and curriculum. A participant stated, "I work on the trauma floor and haven't taken a trauma course. Trauma season is coming. These kids come to us a jumbled mess, we need the training".

Additional Coping Resources Not Related to Perceived Needs

The theme Sense of Self also generated coping resources that were not related to perceived needs. The theme Sense of Self and subtheme Self-Awareness allowed the participant to identify what they knew and didn't know and what they considered was real when caring for high acuity patients. This Sense of Self and increased awareness can be considered both an asset and a liability. Sense of Self also allowed the participants to identify fears and uncertainty that lie within the self that serve to undermine successful transition and this fear and uncertainty is considered a liability.

Sense of Self: Self-Awareness. Participants had a heightened Sense of Self and Self-Awareness that emerged in the findings and presented at the second PDD or the six-month mark of the transition. Phrases associated with the subtheme Self-Awareness that and viewed as a coping resource includes: What I Know and Don't Know and What's Real. The phrases What I Know and Don't Know are present only at PDD 2. The

phrase, What's Real is present at PDD 2 and 3. The findings as they relate to the phrases What I Know and Don't Know examined first.

Self-Awareness: What I Know/Don't Know. Participants from PDD 2 were able to express a Self-Awareness that surrounds knowledge and what they knew and what they didn't know. They were able to verbalize this in relationship to what they still needed to learn to make a successful transition to professional nursing practice. This Self-Awareness and realization can be referred to as a coping resource and is considered an asset. Self-Awareness and the ability to express what they knew and what they didn't know, was used as a coping resource by the nurse in transition and was only noted six months after the date of hire or at PDD 2.

A participant from PDD 2 states, "...May need some orientation outside of 'normal patient population seasons'". This participant had orientation during the summer months when trauma patient census was high and had little exposure to patients with respiratory ailments. The same participant went onto say, "...don't know patient population or how to treat them...wasn't captured during orientation". Another participant from PDD 2 remarked about knowledge gained and stated, "I like to figure things out now". Another participant from PDD 2 commented in the same vein and stated, "...can figure things out now...trusting intuition...know who needs to be seen first". Another participant from PDD 2 realizing knowledge gained added, ... "big picture starting to come together".

One participant plainly stated what she did not know, “...was half way through orientation ...don’t know what to do with some kids”. An experienced nurse from PDD 2 made a similar remark and stated how much she still questioned herself.

Another participant from PDD 2 realizing what he/she knew and didn’t know accepted a challenging patient assignment and asked a colleague for help. The participant remarked, “...I haven’t taken a sick baby since February...she (colleague) asks if this an appropriate assignment instead of recognizing I need this assignment for professional growth ...Just answer my questions, I’ll be fine I want to grow”.

At this point in time and measure participants from PDD 2 and 3 also recognized and were able to verbalize what was real in terms of taking care of the specialty patient population in the hospital setting served, and the issue of difficult nurse-to-nurse work relationships that occur in the practice of professional nursing. The Self-Awareness that surrounds the phrase, What’s Real is presented next.

Self-Awareness: What’s Real. Participants from PDD 2 were coming to terms with the realities associated with the care of critically ill pediatric patients. Participants confronting the reality of the situation and setting expressed what made the care of the critically ill child difficult. Self-Awareness and confronting and embracing reality can be viewed as an asset and a coping resource necessary for successful transition to a new professional practice setting. The ability of the nurse in transition to identify the reality of caring for critically ill children is only evident in the data at the six-month mark or at PDD 2. All remarks that follow come from PDD 2 participants.

Acknowledging the realities of the family dynamic that sometimes surround the critically ill patient can be viewed as a coping resource used by the NGN and the newly hired experienced nurse. A participant remarked that the social aspect of the job was very surprising and added, "...the social stuff is hard to deal with...social issues become stress you're not prepared to deal with".

Participants were also facing the reality that not all patients cared for will survive the hospitalization. Facing the reality that life is sometimes cut short is another coping resource used by participants to successfully transition to new professional practice setting. A participant states, "...was part of an ugly code, bereavement issues discussed but this was nothing I expected. Don't sugar coat the experience that children will die during orientation...give us the ugly details". Another participant added, "...be less gentle when this information is presented".

Difficult nurse-to-nurse work relationships are real and present in nursing today. Fink et al. (2008) defines difficult nurse-to nurse working relationships as a "lack of respect from coworkers, gossipy and grumpy staff and lack of team work" (p. 346). Participants from PDDs 2 and 3 also faced the reality of difficult nurse-to-nurse work relationships and identified its presence in the workplace. Difficult nurse-to-nurse work relationships are considered a liability as identified by participants from PDDs 2 and 3.

A participant from PDD 2 remarked, "...seasoned nurse eats her young but that's how she is". A participant from PDD 2 shared an experience about asking a coworker for

help and explained how they were met with an instance of a difficult nurse-to-nurse work relationship when stating, “It’s not that staff won’t help but when they do they make it clear they are not helping you out, but helping the baby”. Participants from PDD 3 shared similar experiences of the realities of encountering difficult nurse-to nurse work relationships and some stated that it was, “...difficult watching new nurses get trashed...”.

In addition to the subtheme Self-Awareness the subtheme Fear also emerged and is another coping resource the newly hired nurses use to transition to a new professional practice setting. Fear as a coping resource was relevant to the nurse during the first three months of the transition and that relevance increased over the course of the next nine months. The subtheme Fear, used by participants as a coping resource, is a liability and is discussed in the section that follows.

Sense of Self: Fear. Fear was a subtheme that emerged from the data in relationship to the theme Sense of Self. Participants at all three PDDs expressed a sense of Fear. Fear is a coping resource used by participants that added to the stress of the transition. Fear can be thought of as a state of internal chaos that creates a state of negative energy. The internal chaos and negative energy can be considered a liability when used as a coping resource. Words and phrases associated with the subtheme fear include: Budget/Job Security, Losing Skills and Floating. The phrase Budget /Job Security is discussed first.

Fear: Budget/Job Security. The participants who took part in the PDDs were all employed during a time of organizational change within the hospital system. These changes lead to concerns among staff about budget in relationship to job security. Participants used fear as a coping resource, but it was a liability. Fear, regarding budget and job security were important to the nurse in transition throughout the first year.

Participants from all PDDs were able to tie budget cuts to concerns about job security. The following remarks detail that relationship. A participant from PDD 1 remarked, “Budget cuts affect the unit in a negative way...people talk about it and we’re getting canceled”. Another participant from PDD1 remarked, “Cuts scared us...the operating room (OR) slowed down, so then the post anesthesia care unit (PACU) was slow”. Another participant from PDD 2 remarked that in light of the budget cuts and organizational change they were happy that they, “...still have a job”. A participant from PDD 3 noted, “Cuts in September were a big surprise...makes everyone edgy”.

Fear: Floating. Participants from PDD 3 had real concerns and fear in relationship to floating. Floating is a practice used by hospitals to ensure that all areas of the institution are adequately staffed. Floating staff involves moving staff from a unit that is temporarily overstaffed due to low patient census or low patient acuity to units that are less well staffed for the acuity level. The fear associated with the practice of floating is considered a liability and was relevant to the nurse in transition after one year of practice. All remarks that follow, in relationship to floating, are from PDD 3 participants.

A participant stated, “Sometimes it feels so unsafe to float...” Other participants shared concerns with bad float experiences related to what they considered to be inappropriate assignments. Nurses who had to float to other units were often times concerned and perceived that patient care assignments weren’t appropriate because primary nurses chose their patient assignments without regard for the comfort level of those nurses floating. One stated, “...primary RNs take assignments first and the float person got the ‘leftovers’...” Another similar remark, “...They shouldn’t be choosing assignments with the primary nurse first when there are so many new people floating...”

Fear: Losing Skills. Participants from PDD 3 were fearful that nursing skills would be lost because of staffing concerns and working between different units. The fear that surrounds the loss of skills is considered a liability. The fear of losing skills was most relevant to the nurse in transition after one year of practice. All remarks are from PDD 3 participants.

One participant noted and stated, “Acuity of kids in some ICUs is lower so not getting critical care kids or keeping critical care skills”. A NGN remarked that the patient census had been slow and, “...difficult to keep up on skills and knowledge since I’m a new grad and feel like I’m losing my skills”.

Summary: Research Questions One and Two

When the data were analyzed for all three PDDs two themes emerged: Institutional Support and Sense of Self. Subthemes that emerged in relationship to the theme Institutional Support included: Human Connection, Process Approach and

Resources. Participants, across all three PDDs viewed the Human Connection, Process Approach and Resources as both a perceived need and as a coping resource to transition to a new professional practice setting. Institutional Support and all related subthemes answered both research questions one and two. The theme Sense of Self and subtheme Self-Awareness: What I Need, also answered both research question one and two and apply as both a perceived need and a coping resource. However, other phrases associated with the subtheme Self-Awareness: What I Know and Don't Know and What's Real and the subtheme Fear, only apply as a coping resource and therefore only answered research question two. All subthemes were identified as findings were presented and were also identified as an asset, liability or both. The theme Institutional Support and the related subthemes are also coping strategies that the participants used to modify the situation and they were aimed at altering the source of the strain caused by the Situation of transition.

All participants felt a need for a Human Connection as they transitioned to professional practice, and that perceived need changed over time throughout the first year. During PDD 1 participants relied upon preceptors and staff and others to help them successfully transition. However, preceptor support for the nurse in transition at PDD 1 was prominent in the findings. Data from PDD 2 supported the findings that while participants still relied on the preceptor to help them transition that reliance on the preceptor was starting to shift and participants were moving toward a go to person for support. Mentors and preceptors were both mentioned at PDD 2 but a change in the balance of that support were occurring. During PDD 3 it was noted that the participants

no longer relied on a preceptor but spoke mainly of a go to person for support and direction with the transition to professional practice. The participants also perceived an early connection with Leadership as being essential to a successful transition during PDD 1.

Participants from PDD 2 and 3 thought that timely and constructive feedback were necessary for successful transition to professional practice. Participants from PDD 3 also looked for an increase in positive feedback. Participants from all three PDDs also considered honest communication as a perceived need that helped to ease the stress associated with the process of transition to a new practice setting.

Participants perceived a Process Approach supported them with successful transition. Participants perceived that a well-structured unit based orientation was needed for successful transition and that need did not change over the three points of time and measure. Although the identified need for a well-structured unit based orientation were expressed by both groups of transitioning nurses, the definition of that orientation differed between groups; the experienced nurse who was changing practice settings or specialty called out for a tailored orientation that was fashioned with consideration given to prior knowledge and experience. Consistency in practice habits was necessary for successful transition to practice for the participants in PDD 1. Over time that perception changed and participants considered that a consistent shift, schedule and unit during orientation were needed to make a successful transition to professional practice.

Data across all three points in time suggest that participants competed for resources and high acuity patients and that need did not change over time. Participants perceived that unlimited exposure to high acuity patients was essential for successful transition to professional practice. Data also support the findings that interrupted exposure to challenging patient assignments lead to frustration and a concern among participants that valuable skills would be lost.

The data suggest that participants across all three point of time had a Sense of Self and that Sense of Self and Self-Awareness about what the participants needed, what they knew and didn't know and what they perceived as real were an effective coping strategy for successful transition to professional practice. The greatest time of self-awareness occurred at PDD 2 when participants verbalized all three elements of self-awareness as a coping resource. Participants from all 3 PDDs viewed the self and the element of, "What I Need" as both a perceived need and a coping resource.

Participants used fear as a coping resource across all three points of time. Participants across all three PDDs were fearful regarding the hospital budget and job security. As the transition progressed participants from PDD 3 were also expressed fear regarding floating and losing skills.

Using fear as a coping resource can only be regarded as a liability. The negative energy and internal chaos created by a sense of fear is counterproductive but must be acknowledged as a coping strategy used by both groups of nurses in transition. Fear as a

coping strategy was used as a response to untoward situations that arose during the process of transition.

Participants relied on a mix of support and self and strategies to manage transition to a new professional practice setting. Whether the perceived needs and coping resources were seen as an asset or liability, participants used many during the course of the first year's transition to a new practice setting.

Research Question Four

In response to the research question, "How do NGNs and experienced nurses describe the change in the role of the preceptor over the first year"? it is not always possible to determine which remarks were made by which group of nurses in transition: the NGN or the experienced nurse who was changing practice settings or specialty. The scribed notes did not consistently identify the origin of the quotes and remarks that were used to support the findings.

The first PDD occurred approximately three months after the date of hire and during the period that encompassed orientation to the new practice setting. The newly hired nurses were paired with a preceptor or preceptors during orientation and the preceptor offered a period of support and guidance during this time of orientation and transition. Both groups of nurses initially saw the preceptor as an asset or a valuable tool and ardent supporter in the process of transition to professional practice and/or a new practice setting. While participants also mentioned staff and others as being helpful and supportive during PDD 1 the availability of a consistent preceptor was deemed vital as a

support for successful transition to professional practice. Participants from PDD 1 described the preceptor using terms such as: advocate, role model, knowledgeable, welcoming and great. It is to be noted that the word preceptor appeared in the scribed notes from PDD 1 a total of 154 times.

Participants from PDD 1 noted that preceptors on the unit were very knowledgeable and welcoming. Participants described how the preceptor advocated for them by recognizing and seeking out experiences needed for successful transition to practice in a specialty hospital setting. A participant states, "...moved me along in orientation and preceptors advocated for my needed experiences". Another participant from PDD1 elaborated when stating, "I have a great preceptor in that she created other experiences for me; she had me shadow a respiratory therapist for four hours and I'm going to see the lactation nurse next". Another participant described the help her preceptor had been and states, "My preceptor helps me determine what to delegate to my Care Partner and is a role model on how to delegate". Another participant from PDD 1 described the preceptor as, "good...challenged me, was available for questions, instilled confidence in me". One participant from PDD 1 noted that one or two consistent preceptors "moved me along in orientation and preceptors advocated for my needed experiences".

As time passed the newly hired nurses relied less and less on the preceptor for support as they transitioned to professional practice or to a new practice setting. The move from reliance on the preceptor was due in part to the time sensitive nature of the

relationship. The second PDD occurred approximately 6 months after the date of hire and at this time during the transition the preceptor was being replaced by a go to person or mentor. At the time of PDD 2 the newly hired nurse was also gaining insight into the role the preceptor played during orientation and in some instances questioned the preceptor's real helpfulness during orientation. A participant from PDD 2 stated that he/she realized a lot of knowledge was missed in orientation once he/she had completed orientation and wondered if preceptors had, "...done stuff for me while I was in orientation and I didn't know it". Another participant from PDD 2 realized that during orientation the preceptor sometimes, "took over" and families looked to the preceptor for the information they needed and saw the preceptor as the resource and not the newly hired nurse. Another participant from PDD 2 stated that the preceptor only served as a resource at the end of orientation and served as bridge between dependence and independence during the process of transition. It is to be noted that the word preceptor appeared in the scribed notes from PDD 2 a total of 32 times.

The third PDD occurred approximately 12 months after the hire date. At this point in the transition to independent practice the newly hired nurses had moved even farther away from a relationship with a preceptor. Participants had become more independent in practice were relying on self more and when looking for a bridge to independence a mentor or resource were the individuals mentioned. The preceptor was no longer mentioned as a support needed for transition to independence. References to the preceptor in the scribed notes from PDD 3 referred to the preceptor in past tense terms.

One participant stated, “I had a bunch of preceptors”. Another participant remarked that they had connected well with the preceptor. It is to be noted that the term preceptor appeared in the scribed notes for PDD 3 a total of 9 times.

The role of the preceptor changed over time as the as the NGN or the newly hired nurse with experience transitioned to independent practice. The preceptor moved from being a constant in the transition process to becoming less and less visible and vital as time passed. A mentor or a resource person gradually replaced the preceptor as support strategy for transition. The role of the preceptor during the first three months is defined by the findings of the current study and fills a gap that has been identified and is missing from the current body of nursing literature.

Research Question Three

In response to the research question, “How do the NGNs and experienced nurses perceive the preceptors use of their knowledge and skills to help support them to explore, understand and cope with transition”? a majority of the answer is identified in the answer to research question one.

At PDD 1 the newly hired nurses view the preceptor as an asset or a vital component for successful transition to independent practice. Both groups of nurses are eager to learn whatever the preceptor is willing to teach. At this point in time both groups are anxious to learn the tasks and acquire the skill sets that are required when caring for the high acuity, specialty patient population. Both groups of nurses in transition look to the preceptor to share knowledge and bits of wisdom, which will help

them, learn and build the required skill set. At this point in time the participants consider the preceptor as the individual that is responsible for their successful transition to the role and the practice setting. As time in transition passes the newly hired nurses come to rely less and less on the preceptor for a transfer of knowledge and come to view them more as a system of support to reinforce the knowledge that has been gained.

Participants are aware that a relationship with a preceptor is time sensitive and with that in mind can identify preceptor based learning opportunities and experiences they will need before being able to transition to independent practice. A participant from PDD 1 stated, “ I wish I could have a chance to float to another unit with a preceptor”. A participant from PDD 2 stated, “Want to float across critical care/acute care units while in orientation with my preceptor to feel more comfortable when the time comes to float on my own”.

Being assigned multiple preceptors helped participants build relationships with other staff members. A participant from PDD 2 remarked, “Had one preceptor on days, more on nights...but that worked to my advantage as my scheduled shift was nights...so having more than one [preceptor] on my scheduled shift helped to build trust and relationships between my coworkers”. Multiple preceptors also helped the participants from all three PDDs explore nursing practice from different perspectives. A participant from PDD 1 stated, “ ...had several preceptors from the beginning but welcomed that to see things from different perspectives, saw different ways of doing things”. A participant from PDD 2 stated, “...one senior and one new preceptor, nice to get different sides of

things”. A participant from PDD 3 remarked in a similar fashion and stated, “ had a bunch of preceptors, but liked this to see different perspectives”.

Preceptors used their knowledge and skills to help the newly hired nurses explore and assimilate to the role of professional nurse. Multiple preceptors also help the nurse in transition view the world of nursing through different lenses. The multi focal view of nursing practice allowed the transitioning nurse to glean the best practice habits from all and adopt those they considered to be the best as their own.

Synthesis of Findings

Nurses who are transitioning to a new practice setting or specialty in nursing have a number of needs and use a variety of coping resources to assist in the transition. Throughout the transition the NGN or the experienced nurse all relied on others to help them make the transition. Early on in the transition the NGN and the newly hired experienced nurse relied upon the preceptor to help them with the transition. At PDD 1 or at about three months into the transition both groups of nurses reported the transition experience in positive terms; everything is good, everyone is helpful and preceptors are the best. As time passed or at approximately six months into the transition change occurred and the nurse in transition no longer relied almost exclusively on the preceptor for aid in transition. The newly hired nurses moved away from reliance on the preceptor and looked to a mentor or another resource person to provide them with the personal support needed for successful transition. The reliance on a mentor or other assigned resource nurse is still evident one year after the hire date indicating the newly hired

nurses still required a go to person for questions and help with unfamiliar patient care situations. The newly hired nurses also felt a relationship with the leadership team was essential to a successful transition to professional practice or a new practice setting. The need to connect with leadership is noted early in the transition or at approximately three months after the hire date.

Throughout the process of transition the newly hired nurses looked to the structure orientation provides and consider orientation another bridge to successful nursing practice at this hospital. Both groups of newly hired nurses found a staged orientation to be helpful; however the experienced nurses also expected orientation to be tailored to their skill set and comfort level. The experienced nurses longed for a more personalized approach to orientation and wanted prior knowledge and experience recognized, but not assumed.

The newly hired nurses also wanted open and honest communication throughout the entire first year of transition. Both groups wanted open and honest communication with leaders and expected that this type of dialogue begin during the interview process. As time passed or at approximately six months after the date of hire, the newly hired nurses also sought timely and constructive feedback as a method to successfully transition to practice. Feedback was viewed as a necessary way to identify professional practice shortcomings and a means to identify areas of nursing practice that needed to be honed and developed.

The nurse in transition also expected a degree of consistency in practice. At three months the NGN and the experienced nurse are rule governed and find that strict adherence to policy and procedure provided a necessary framework for transition to practice. As time passed the nurse in transition viewed a consistent schedule, unit and shift as necessary for successful transition. Throughout the entire first year of practice the NGN and the experienced nurse also perceived that unobstructed access to high acuity patients was vital to successful transition. Without this degree of access both groups of nurses feel they will either not develop needed skills or skills gained will be lost.

The newly hired nurses also had a sense of self and throughout the transition were able to articulate and make personal learning needs known. At six months the nurses in transition had a heightened Sense of Self and Self-Awareness and were able to identify what they know and what they don't know in addition to what they need for successful transition to practice. They also have a sense of "What's Real" within the specialty population they have chosen to care for and can express that realization. Both groups of newly hired nurses could identify and articulate examples of difficult nurse-to-nurse work relationships in the workplace.

Both groups of newly hired nurses who were in the process of transition all identified fear as a liability for a coping resource throughout. Fear regarding organizational change and the budget and job security shadowed both groups of nurses throughout the entire first year of practice and transition. One year into the process of

transition fear still loomed large for the nurse in transition. Both groups of newly hired nurses in transition were fearful to float to unfamiliar nursing units and could give rationale for the degree of concern associated with the practice of floating.

As nurses transition to professional practice or transition to a new professional practice setting, they use many coping resources to make a successful transition. The participants from the current study described and used a number of different methods and resources to cope with the process of transition. Although some aspects of the transition for the NGN and the newly hired experienced nurse were out of their control both the NGN and the newly hired experienced nurse were able to utilize the two major components of the 4 S system, support and self, and to a lesser degree strategy to transition to professional nursing practice or to a new practice setting.

Summary

The data were analyzed in the order in which it were collected and Schlossberg's Transition Theory served as the framework for the analysis. Research questions one and two were answered using themes and subthemes that had been identified during the analysis of data. Research questions three and four were answered using the words of the participants. When appropriate, available quotes from participants were used to add depth and richness to the findings. Statements specific to the experienced nurse who is changing practice settings or specialty were called out when those statements were available and supported the findings.

Chapter Five is a discussion of findings and implications for practice and policy change and further study. Findings from the current study are also applied to Schlossberg's Transition Theory and a new figure is created which applies those findings to the theory.

Chapter Five

Discussion

Findings from the current study are discussed in this chapter. The main findings and implications that have been gleaned from Chapter Four are discussed. The findings are then reviewed in relationship to the nursing literature in an attempt to determine if those findings support, add to or contradict what is currently known about the transition experience of newly hired nurses. The findings are then applied to Schlossberg's theory of transition. Appropriateness and limitations of the Schlossberg's theory are also discussed. Implications of the study's findings for practice, policy and research will be explored. The chapter concludes with a discussion surrounding the next steps in research regarding preceptors and the transition of newly hired nurses.

Overview of Major Findings

The nurses who participated in the Professional Development Program and who were transitioning used a variety of coping resources to aid them with the transition to a new practice setting or specialty in nursing. Coping resources used by the NGN and the experienced nurse were identified and are consistent with two of the 4 S's: support and self. Although many of the coping resources were viewed as assets, some were identified as a liability. The secondary analysis of data also revealed a Sense of Self or Self-Awareness among nurses in transition. This is a new finding that has not been described in the literature. The findings also suggest that the newly hired nurses never moved out

of transition but continued to move through transition for the entire first year of practice. Major findings will be presented as they appeared in the emerging themes and subthemes.

Literature Review in Relationship to Major Findings

The nursing literature is replete with information about the transition experience of the NGN. The NGN is often described as, Caucasian, female, with a baccalaureate nursing education and being less than 30 years of age (Casey et al., 2004; Fink et al., 2008; Goode et al., 2009; Krugman et al., 2006; Lee et al., 2009). This sample description also adequately describes the majority of nurses who participated in the PDP. However, the nurses who participated in the PDP also included experienced nurses who were changing practice settings, specialties in nursing, or both. Another major difference to be noted when discussing the findings from the current study is the time points at which measures were taken. The current study collected data at three, six and twelve months. Most studies that detail the transition experience of the NGN omit measurement at three months (Fink et al., 2008; Goode et al., 2009; Krugman et al., 2004; Williams et al., 2007).

Institutional Support: Human Connection

The nurses in transition all look to a Human Connection to support them with the transition. Preceptors were one component of this and they are mentioned repeatedly in the nursing literature as a tool used to help the newly hired nurse transition. Literature consistently describes a 1:1 relationship between the nurse in transition and the preceptor and state that pairing with one consistent preceptor with a newly hired nurse is the

preferred method (Almada et al., 2004; Bratt, 2009; Casey et al., 2004; Fink et al., 2008; Friedman et al., 2011; Lee et al., 2009; Schumacher, 2007). Findings from the current study refute the literature and suggest that the nurse in transition prefers a small and consistent group of preceptors.

The literature also suggests that when more than three preceptors are involved with a transitioning nurse trust becomes an issue and learning and the progress in orientation were hindered and transition to independent practice were impeded (Casey et al., 2004; Schumacher, 2007). This supports findings from the current study.

The literature also suggests that as the relationship between preceptor and the newly hired nurse ends the newly hired nurse continues to seek support from others and identifies a mentor or mentorship as a vehicle for that support (Casey et al., 2004; Cleary, Horsfall, Jackson, Muthulakshmi & Hunt, 2013; Fink et al., 2008; Thiesen & Sandau, 2013). The newly hired nurses who participated in the PDP also describe a mentor or go to person as an essential support once the time-limited relationship with a preceptor came to a close. The shift away from the reliance on the preceptor as a support emerged in the data at PDD 2. Findings from the current study suggest that the need for a some type of human support persists throughout the first year of practice and beyond. Remarks from PDD 3 found that both groups of nurses in transition had moved away from the preceptor as a support; however, they continued to look for a go to person when questions with unfamiliar patient care situations presented.

What the literature fails to describe is the relationship or importance of the preceptor at the three-month mark of the nurses' transition to practice. The findings from the current study suggest that the preceptor is pivotal to successful transition of the newly hired nurse before and at three months.

The literature also describes preceptors as being sometimes less than supportive or a liability to the nurse in transition (Fink et al., 2008; Schumacher). Nurses who participated in the PDP also described the preceptor as both an asset and liability but overall remarks from the nurses who participated in the PDP describe the preceptor in positive terms.

Preceptors are also described as being experienced staff nurses (Almada et al., 2004; Bratt, 2009; Friedman et al., 2011; Hatler et al., 2011; Meyers et al., 2010; Spector, 2009). Newly hired nurses' who participated in the PDP contradict this description. Preceptors as described by participants in the current study were not always experienced staff nurses but rather inexperienced nurses who had not precepted prior to the reported experience. Participants from the current study also noted that the nurse sometimes had to choose between being a preceptor or being a charge nurse and simply chose the role of preceptor because it was considered the more desirable of two perceived undesirable roles. Schumacher (2007) describes a similar situation.

The literature also identifies feedback as a type of support newly hired nurses seek (Casey et al., 2004; Schumacher, 2007). Fink et al. (2008) reported that NGNs identified nurse manager support and feedback as ways that would have facilitated

transition into practice. Newly hired nurses' who participated in the PDP desired timely and constructive feedback and as time passed participants also expressed a need for an increase in feedback. Schumacher (2007) also discovered that newly hired nurses could tell when feedback was genuine and constructive. This is similar to findings from the current study when participants described performance evaluations as "...cut and paste..".

The literature also discusses the importance of the newly hired nurses' early connection with members of leadership. Fink et al. (2008) identified that participants felt that nurse support and feedback throughout the first year of transition would have facilitated the participant's transition to practice. Nurse participants from the PDP identified an early connection with members of the leadership team as being an asset and essential to successful transition to independent practice. However, newly hired nurses who participated in the PDP only identified the three-month mark as important.

Institutional Support: Process Approach

The literature suggests that the use of well-planned and executed orientation programs can increase the retention of newly hired nurses (Bratt, 2009; Friedman et al., 2011; Hatler et al., 2011). Newly hired nurses who participated in the PDP also described orientation and staged orientation and considered both to be a support and an asset as they transitioned to a new practice setting or specialty. What is missing from the literature is a description of what the experienced nurse who is transitioning to a new specialty or practice setting expects from an orientation program.

Orientation: Newly hired experienced nurse. Evidence from the current study suggests that the experienced nurses who are changing practice settings or specialty also experience a transition when they move to the new setting or undertake a new specialty. The experienced nurses bring with them basic nursing knowledge and experiences and the evidence from the current study suggests that the experienced nurses want the prior knowledge and experience to be recognized and acknowledged. What the experienced nurse does not want is for prior knowledge and experience to be assumed. Evidence from the current study suggest that the experienced nurse who is changing practice settings desires an orientation that is tailored to the learning needs of each individual experienced nurse. The evidence from the current study also suggest that if the experienced nurse and the NGN are offered the same orientation at the same pace, the experienced nurse may become bored and disinterested and entertain thoughts of leaving the organization within the first year of hire. The experienced nurses request for a tailored orientation has not been reported in the literature and should be considered a new finding.

Sense of Self: Self-Awareness

The NGN and the newly hired nurse with experience have A Sense of Self that is evident early on in the transition. At the three month mark a Sense of Self and a Self-Awareness are beginning to develop in the nurses who participated in the PDP. Both groups of newly hired nurses in transition can identify and articulate the support they need in terms of learning opportunities. By the six month mark of transition both groups of newly hired nurses have a heightened Sense of Self and in addition to finding a voice

and being able to identify what they need they can also identify what they know, what they don't know and the realities associated with caring for a high acuity patient population. At twelve months after the date of hire or at PDD 3 the nurse in transition is still able to and continues to articulate the type of support they feel they need to continue to transition to independent practice. There were no studies (quantitative or qualitative) that identified the growth of the individual in transition and their ability to articulate their needs. The Sense of Self and the ability to articulate: What I Need, What I Know and Don't Know have not been reported in the literature and should be considered a new finding.

The ability to sense and voice: What's Real, has two aspects: the harsh reality of dying patients especially children and the unfortunate reality that not all nurses are 'team players'. Fink (2008) identified difficult nurse-to-nurse work relationships when participants described, "lack of respect from coworkers, gossipy and grumpy staff and lack of team work" (p. 346). Blair (2013) described lateral violence in the nursing workplace or difficult nurse-to-nurse work relationships as those that include rude comments, verbal attacks, condescending language, a lack of collaboration and blaming. Stanley, Martin, Michel, Welton & Nemeth (2007) describe difficult nurse-to-nurse work relationships as rude, criticizing and negative co-worker behavior.

Nurses who participated in the PDP were also able to identify difficult nurse-to-nurse work relationships as: What's Real. What's not apparent is the interpretation by the newly hired nurses about the staff nurses. The newly hired nurses perceived the

behaviors by the staff nurses as negative but there may have been other explanations for the negative perception such as cultural and generational differences.

Fink et al. (2008) also suggests that participants were able to identify: What's Real when caring for patients at end of life and dealing with futility of care. This finding is also evident in the data from the current study and only presents in the data at the six-month mark or at PDD 2. Participants from PDD 2 faced the reality that not all patients cared for would survive and that the family dynamic that surrounds a critically ill child is often times difficult to deal with.

Schlossberg's Transition Theory: Application of Current Findings

It is evident upon analysing the data in the current study that Schlossberg's Transition Theory is relevant to nursing and the nurse in transition. Refer to Figure 3. The theory mapped onto the themes that were identified for the data but not all of the 4S's were apparent. This may be due to the questions that were asked at the time data were collected for the original study (What went well? What didn't go well? Any surprises? What one thing would you change?).

The first stage in the transition process of the NGN or the newly hired experienced nurse can be thought of as moving in. Data from the current study suggests that the moving in period for the participants began at the date of hire and carried through to PDD 1. Once in the newly hired nurse began the long process of moving through. Moving through begins at about the time PDD 1 occurs, or at three months after the date of hire and continues throughout the remaining nine months of the transition process.

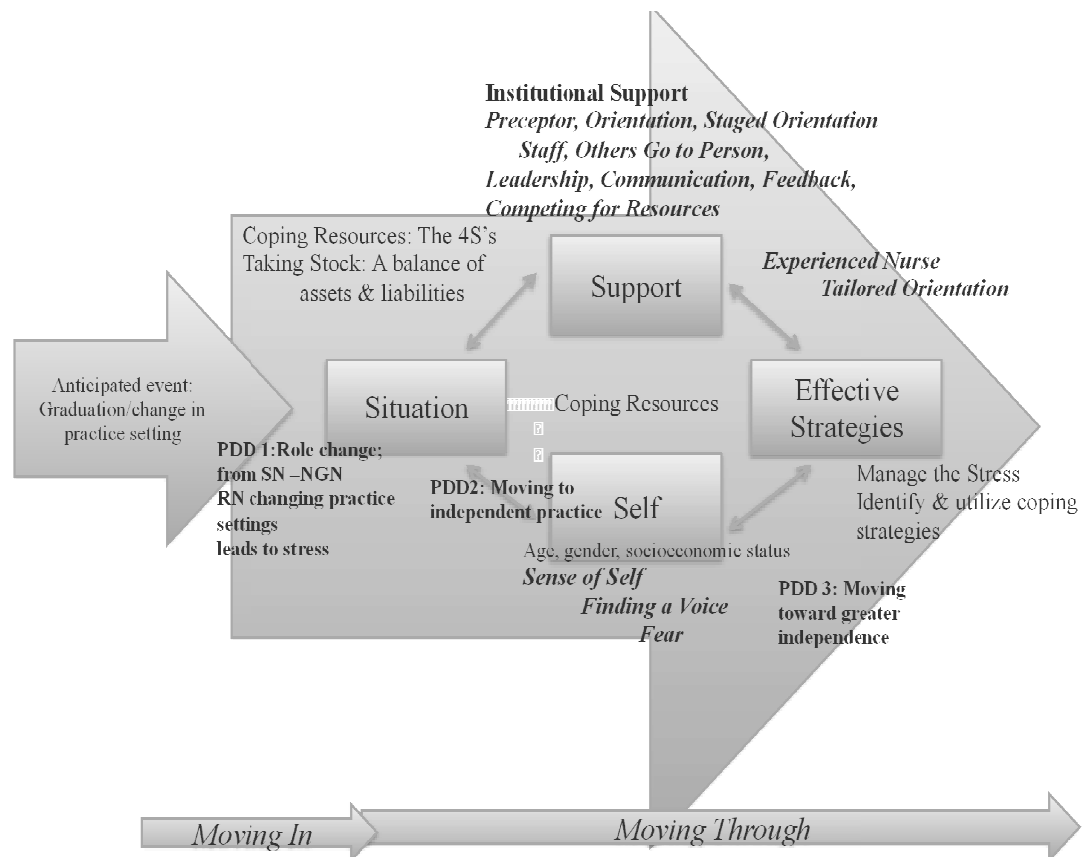


Figure 3. Schlossberg's Transition Theory with insertion of findings from current study. Adapted from Figure 2.1 The Individual in Transition, Counseling Adults in Transition, Fourth Edition: Linking Schlossberg's Theory With Practice in a Diverse World Mary Anderson, PhD; Jane Goodman, PhD; Nancy Schlossberg, EdD Copyright 2011, Reproduced with the permission of Springer Publishing Company, LLC ISBN: 9780826106353

As data were analyzed it became apparent that both groups of newly hired nurses never arrived at moving out, or wondering what comes next. The newly hired nurse were mired in the process of moving through and at PDD 3 were still using coping resources to navigate the transition to independent practice.

The 4 S system was used by both groups of newly hired nurses to navigate the transition process but only two of the coping resources emerged: self and support. This may be attributed to the questions that were asked by facilitators during the debriefing sessions. Of note, the organization was also undergoing a transition during the time of the original study, that could have influenced responses. However, the full nature of that transition is unknown. As the newly hired nurse moved in and moved through transition they turned to coping resources to help them navigate the process of transition to independent practice. Coping resources as described by newly hired nurses' who participated in the PDP were described as both assets and liabilities and the balance of coping resources changed over time.

The NGN and the experienced nurse relied upon the support of a structured orientation and the help of the preceptor to navigate the process of transition to independent practice. While the experienced nurse desired an orientation built around personal learning needs the experienced nurse still utilized orientation as a coping resource. Other coping resources used by both groups of newly hired nurses included: the use of a go to person, consistency in practice habits, shift, schedule and unit for orientation, constructive and timely feedback and a sense of self. The use of these coping

resources are all effective strategies that help both groups of newly hired nurses manage the stress of transition. Schlossberg's theory can be used, unchanged as a framework to study the nurse in transition. Findings from the current study help to provide more depth and differentiation for 2 of the 4 S's of Self and Support as applied to this transition experience.

What Schlossberg's Transition Theory fails to identify are ways in which a preceptor or mentor or support can help the individual in transition find a better balance or ratio of assets to liabilities. If an individual in transition could find a better balance of assets and liabilities would there be a need for coping strategies? Is an individual in transition left to deal with a negatively skewed balance of assets and liabilities or should finding a better balance be an addition to the coping strategies Schlossberg identifies?

Implications for Education, Practice and Policy

Implications for Undergraduate Nursing Education

The SN who is about to graduate and become the NGN is poised to make the transition to a new practice setting and independent practice. It has been well studied and documented that this group of nurses struggles with the transition from student to NGN. Knowing this, nursing educators should make an overt effort to prepare the soon to be graduating nursing student for transition to professional practice. A capstone course that includes a frank discussion about the difficulty of the transition experience should be had with every last semester nursing student. The discussion should include a dialogue that describes the length of time needed to successfully transition to independent practice.

The discussion should also include dialogue about the emotional aspect of transition to include fear as an aspect of transition. A heightened awareness of the long transition process may help the NGN conceptualize and better manage the process of transition.

A capstone course that includes a precepted clinical experience have also been cited as a way to help the NGN make a swift and successful transition to the role of professional nurse (Zerwekh & Claborn, 2006). The course, however, should come with clear learning objectives, benchmarks to meet and must include outcome objectives that can be measured to mark a student's progress or lack of progress with the process. Learning activities that are designed to have the student begin to see the patient as a whole or "see the big picture" versus a plethora of small bits also helps the student begin to think like a nurse and may make the transition to NGN easier. The faculty involved in these types of learning experiences has an obligation not only to the student but also to the preceptor. Faculty should also visit the clinical site often and offer support to the preceptor. Continued and ongoing preceptor support from members of nursing faculty may help to build relationships that recruit and maintain willing and eager nurse preceptors for the senior level nursing student.

The faculty who are involved in these types of capstone courses also have a duty to the profession of nursing to help bring about a culture change. The SN needs to understand the importance of learning from a seasoned, professional nurse preceptor. The student needs to understand that the role of preceptor is an inherent part of the practice and profession of nursing, and that one day, much sooner than they expect, it will

be a role they are asked to assume. Planting the seed early may help bring about a cultural change in nursing whereby becoming a preceptor will be an expected part of the profession. Faculty is in a position to plant this seed and help create a cultural change that is needed to sustain programs of learning and transition.

Implications for Nursing Practice

Evidence from the current study suggests that the preceptor is a key factor to the successful transition of the NGN and the experienced nurse who is changing practice settings or specialty. Another key to successful transition identified by the current study is a well structured orientation program. Another element to successful transition is the conveyance of expectations and the culture of the organization to the newly hired nurses.

During the first six months of transition, healthcare organizations need to realize that the newly hired nurses focus is on “me”. With this in mind, healthcare organizations should provide staged orientation for both the NGN and the experienced nurse who is transitioning to a new specialty or practice setting. The staged orientation for the experienced nurse should be tailored based on an assessment of what they specifically need and identify as essential for successful transition. Orientation programs should be six months in length to provide the transitioning nurse with support during times that have been identified by the current study and the literature (Casey et al., 2004; Fink et al., 2008; Goode et al., 2009; Krugman et al., 2006) as especially stressful.

A small (no more than three) group of consistent preceptors should be assigned to the nurse in transition during the first six months of orientation. The literature suggests a

1:1 pairing is preferred method (Almada et al., 2004; Bratt, 2009; Casey et al., 2004; Fink et al., 2008; Friedman et al., 2011; Lee et al., 2009; Schumacher, 2007) but findings from the current study do not support that strategy. The preceptor will be in place to help the nurse in transition learn the skills and tasks associated with the role of the professional nurse.

Because of the importance of the preceptor role, healthcare organizations must make wise choices when they select individuals to fill the role of preceptor. Individuals must be selected and prepared for the preceptor role and supported by the organization, the nursing unit and nursing peers. The nurse in transition is able to identify preceptors who are reluctant and poorly prepared for the role of preceptor. A preceptor who begrudgingly accepts the role can be considered a liability and a detriment to the nurse in transition.

During the second six months of the transition the newly hired nurses focus is moving away from “me” and moving to “us”. During this timeframe the newly hired nurses will be supported by a group of well-placed mentors. Mentors and resource persons will be in place to help the newly hired nurse navigate unit based situations and patient care scenarios they identify as difficult. The mentor will be in place to help the newly hired nurse see the “bigger picture” of patient care. Mentors will also be expected to continue to convey the organizations expectations and culture to the newly hired nurses. Mentors will be in place to support, inspire and nurture having no specific agenda to adhere to or to accomplish and will act as a bridge between dependence and

independence for the newly hired nurse. The help of the mentor would be voluntarily sought by the NGN or the experienced nurse and no formal relationship would exist. Mentors would be identified and present on all nursing shifts to offer support as needed when called upon and would be available to the transitioning nurse beyond the first year.

The structure of the orientation program would include honest, timely and constructive feedback. The preceptors or mentors would offer immediate feedback to the transitioning nurse. A member of the unit leadership team would provide formal evaluation of the nurse in transition with input from the preceptors or mentor. Evidence from the current study suggests that healthcare organizations must include regular and scheduled feedback to the newly hired nurse to mark progress or lack of progress in the transition to independent practice. Feedback can then be used to formulate a plan toward practice changes or improvements that will help to move the NGN or the experienced nurse to independent practice.

The structure of the orientation program also needs to include an element that acknowledges the newly hired nurses developing Sense of Self. Allowing the newly hired nurse to voice what they need may help to identify areas for potential growth as well as areas of concern. Allowing the newly hired nurse an opportunity to be heard should be included in the structure of the orientation program.

Understanding the Culture

Nurses who participated in the study all competed for high acuity patients as they transitioned to independent practice. Newly hired nurses noted that often times they were

denied access to the high acuity patient population because the primary care nurses relationship with the patient and family superceded their request and desire to be exposed to the nursing care situation. Newly hired nurses felt this nurse patient relationship robbed them of the opportunity to learn and grow while on orientation.

Because of the conflict that may arise between primary care nurses and newly hired nurses, hospitals that use a primary care model of nursing may want to consider an additional element to the orientation of newly hired nurses. Hospitals that use this nursing model may be wise to consider pairing a primary care nurse who is caring for a high acuity patient with a newly hired nurse who has a demonstrated orientation need with that particular patient population. This pairing would create a safe atmosphere within which the newly hired nurse could learn, grow and mature in the role of professional nurse, while maintaining the bond between patient, family and primary care nurse.

In addition to pairing a primary care nurse with a newly hired nurse, hospitals may also want to consider a simulation lab which provides the newly hired nurses with simulated high acuity patient experiences. Learning in a simulated setting may better prepare the newly hired nurse for pairing with an experienced primary care nurse, and thus help create an atmosphere of trust before the actual pairing. If this were to occur primary care nurses may be more willing to teach and share their primary patients with newly hired nurses.

If these additional orientation strategies are to be implemented by hospitals, unit leadership and nursing administration need to understand and support the staffing implications created by these strategies. Additional unit staff will need to be in place to support the extended orientation of newly hired nurses who are paired with primary care nurses. Additional staff will also be needed if newly hired nurses spend working hours away from the unit in a simulation lab.

National Policy Implications

The nursing shortage in the U. S. is real and is expected to worsen over time. Despite the easing of the shortage due to the current recession the nursing shortage is expected to grow to 260,000 registered nurses by 2025 (American Association of the Colleges of Nursing 2011b). While nursing has insufficient numbers entering the profession it also sees many new nurses leave the profession prematurely; 60 – 75% of new graduate nurses (NGN's) leave nursing during the first year (Baxter, 2010; Welding, 2011). This early departure from nursing is costly and is measured in terms of dollars, patient safety and quality of care (Casey et al., 2004). Factors, which contribute to the early exodus, include:

- Unwelcoming environment
- Inability to handle the intense workload
- Advanced medical technology
- Stress related to situational transition

The overarching issue regarding this revolving door on the new graduate nurse in the acute care setting is one of public safety. NGNs report it takes them at least 12 months to feel comfortable and confident practicing in the acute care setting (Casey et al., 2004). Evidence suggests that the use of well planned and executed orientation programs and/or nurse residency programs (NRP) can increase the retention of this vulnerable group of nurses (Bratt, 2009; Friedman et al., 2005; Hatler et al., 2011; Jones, 2008). Retention of the NGN results in savings to the organization. Savings can be measured in terms of dollars and avoided cost. Avoided costs in relationship to a higher quality of patient care include factors such as; shorter lengths of stays, reduction in medication errors and fewer patient falls (Friedman et al., 2005; Jones, 2008; Lee et al., 2009).

For these reasons it is time that the public and the profession of nursing call for the adoption and implementation of NRPs. There are many descriptions of structured orientation and nurse residency models in the nursing literature. However, The University Health Systems Consortium (UHC) formed a partnership with the American Association of Colleges of Nursing (AACN) and developed a residency program that has been built on an evidence-based framework to provide a national model for graduate nurse transition (Krugman et al., 2006). It is a well-organized NRP, which pairs preceptors in a 1:1 relationship with NGNs to ease the NGN into professional practice.

Why mention the UHC/AACN NRP? This program positions nursing and NRP's to step to the next level, that of Federal Funding, which will ease the financial burden

these programs place on already cash strapped acute care facilities. Unlike physician, pharmacy and pastoral care residency programs, which receive pass-through dollars from the Centers for Medicare and Medicaid (CMS), the cost for a NRP is borne solely by the hospital (Goode et al., 2009). Federal funding must be considered because NRPs are expensive to initiate, facilitate and maintain (Goode et al., 2009). An infusion of federal funds would help with finances associated with increased staffing needed for pairing and mentoring.

The UHC/AACN NRP should be the focus of those interested in adopting NRPs for the NGN because this program has already met one of the two essential requirements a program of this type must meet to be eligible for federal dollars: it is accredited by a national accrediting body (Goode et al., 2009).

NRPs should also be required for the nurse who is transitioning to a new nursing specialty. The Report on the future of nursing, Recommendation Three calls for the implementation of NRPs and asserts 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 or nurse residency programs (Institute of Medicine, 2011). These programs should be supported and available to the nurse not only upon completion of a prelicensure program but should also be available and required for advanced practice degrees or when the nurse transitions to a new clinical practice area (Institute of Medicine, 2011).

NRPs for the nurse who is changing specialties should be modeled after the UHC/AACN NRP for undergraduate nurses. This modeling would again allow for federal funding and ease the financial burden healthcare organizations would encounter. The NRP for the experienced nurse should be different and apart from that NRP structured for the NGN. Evidence from the current study suggests that despite changing specialties or settings the experienced nurse brings knowledge and experience to the situation and setting that needs to be recognized and acknowledged.

Implications for Future Research

The transition experience of the NGN, during the first year of practice, has been well documented in the literature (Almada, Carafoli, Flattery, French & McNamara, 2004; Bratt, 2009; Casey, Fink, Krugman, & Probst, 2004; Friedman, Cooper, Click, & Fitzpatrick, 2011; Hatler, Stoffers, Kelly, Redding, & Carr, 2011; Lee, Tzeng, Lin & Yeh, 2009). However, little is known about what happens to that nurse after the first year. Evidence from the current study suggests that the NGN still seeks guidance up until the end of that first year. Nursing should change research focus and examine what happens to the NGN after the abrupt end of TTP programs or the first year of practice, whichever comes first. If nursing were to realize what the NGN struggles with upon completion of these programs the structure or content of the programs could be changed or altered to facilitate a better transition experience. Nursing must also seek to understand what type of support the NGN needs upon completion of the TTP program. Nursing research should be designed to answer the “what is needed next” question.

Little is known about the transition experience of the newly hired experienced nurse or the experienced nurse who changes practice specialties. Questions about the transition experience of this group of nurses are left unanswered by today's current body literature. It is time for nurse researchers to call out this group and determine what it is they need to make a successful transition to a new specialty or setting. Nursing would serve itself and the public well to develop a NRP for the nurse transitioning to a new clinical specialty that is built upon a foundation of research. Despite the recommendation by the IOM there is a paucity of literature that describes a NRP program such as this.

Research available to date focuses on the transition experience of the nurse in the acute care setting. There is a lack of evidence to describe or detail the transition experience of the nurse who transitions to an extended care facility or to a community health setting. As the population ages and healthcare delivery systems move from the acute care setting to the community it would serve nursing well to understand if the nurse who transitions to these settings experience the same strife as those who transition to an acute care setting. Are preceptors and other known supports available to these individuals as they are to the nurse in the acute care setting?

There is an opportunity for future research using Schlossberg's Transition Theory as a framework to study the transition of newly hired nurses, adding appropriate developmental theories such as Kegan's Cognitive Developmental Theory (Bridwell, 2012) to address the emotional process that accompanies the transition. A better understanding of the nurses ability to cope with transitions based on the balance of the

individuals assets and liabilities might give nursing an opportunity to identify early on those nurses who are most likely to struggle with or fail the process of transition. If these individuals could be identified, using Schlossberg's theory as a framework, efforts could be made to help the individual at risk nurse in transition identify coping strategies that could be used in response to stressful or challenging situations. This early identification and assistance might prevent early attrition from the hiring employer and perhaps the profession of nursing. A program of research such as this could be taken to the next level. If the nurses were followed longitudinally, nursing could learn if early intervention and help with coping strategies would provide the nurse with the tools needed to deal with other transitional changes throughout the course of a career.

It is a time for nursing to take the next step regarding the research that surrounds TTP programs. Nursing needs to look beyond the first year and explore what the NGN needs after the traditional TTP program ends. Nursing also needs to explore the needs of the experienced nurse who transitions to a new practice specialty or setting. Nursing also needs to explore the transition experience of the nurse who transitions to an extended care setting or community health setting; this is the direction of healthcare. Nursing needs to investigate the efficacy of TTP programs for the experienced nurse who transitions to a new clinical specialty. The IOM has made the call, now it's up to nursing to investigate the value of such a program for this group of nurses.

Additional research questions to consider when investigating the nurse in transition include:

- How does the NGN describe the support needed to continue to successfully transition to independent practice beyond the first year of nursing practice?
- What is the retention rate of the NGN 18 and 24 months post completion of a TTP?
- At what point in the process of transition to independent nursing practice does the experienced nurse move from reliance on a preceptor and move toward the support of a mentor or go to person?
- How does the experienced nurse who is transitioning to a new setting or specialty describe the support needed to continue to successfully transition to independent practice beyond the first year in the new setting or specialty?
- How does the newly hired nurse explore and use Sense of Self to successfully transition to a new setting in nursing?

Limitations

One of the distinct limitations of secondary analysis of data is the fact that the researcher is unable to ask participants additional questions. If the doctoral student had been able to ask additional questions of the nurses who participated in the PDP other coping resources used by participants may have been discovered. Coping resources unrelated to Institutional Support may have demonstrated and supported other strategies used by the NGN or experienced nurse. The ability to ask additional questions may have

also helped to identify and define differences in the coping strategies used by the NGN and the experienced nurse.

Lack of an audiotaped interview in this instance has limitations and advantages. An audiotaped interview would have also provided a more detailed data set. However, it would have been impossible to identify which remarks the experienced nurse made. The scribe could only capture those details, as individuals were identified as experienced or not during the debriefings.

Another limitation that must be considered when interpreting the findings is the study site. The study from which the current data originated took place at a single specialty hospital located in the Midwest. The sample was predominantly white females who had been prepared at the baccalaureate level. Data collection for the original study occurred during a time of hospital reorganization and change, all of which could have affected the participants and influenced the response to research questions posed during the debriefs. If the organization had not experienced upheaval and change during the time when data were collected the serious researcher must consider if a sense of fear would have been as prevalent in the findings. If a changing situation induced fear, did fear influence Sense of Self and heighten Self-Awareness. Was a greater Sense of Self responsible for participants finding their voice and being able to express needs? Therefore, findings from the current study represent only those participants who took part in the original study and cannot be generalized to different programs in other organizations.

Summary

The NGN and the experienced nurse who is changing practice settings or specialty share a similar path as they transition to independent practice. They each value the Human Connection and support offered by a limited number of preceptors. As each group of transitioning nurses moves from reliance on a preceptor they look for a mentor or go to person as another coping resource and Human Connection to help them when questions or difficult patient care situations arise. Both groups enjoy the Institutional Support that a well-planned orientation program provides during transition. The experienced nurse not only expects a Process Approach by way of a well-planned orientation program, they also expect an orientation tailored to individual learning needs that acknowledge prior experience. Both groups of nurses in transition expect honest communication and timely, constructive feedback and an early relationship with members of the leadership team and see these elements as a coping resource of support. Both groups also have a sense of self and can identify what they need, what they know and don't know and what's real when caring for a high acuity specialty patient population.

The tone of transition is positive at PDD 1 or at three months post hire date, when the nurse in transition has moved in and begun the long process of moving through. The preceptor is mentioned often and repeatedly and is considered a key to successful transition. PDD 2 or six months post date of hire is an especially stressful time for the NGN and the experienced nurse who is changing practice setting or specialty. PDD 2 is

the point in transition when the time sensitive relationship with the preceptor is coming to or has ended. It is at this time that newly hired nurses look for a mentor or go to person to provide the continued support and Human Connection needed for successful transition. PDD 3 falls after the nurse in transition has been employed for nearly one year. PDD 2 marks a time when the nurse in transition is mired in the moving through stage of transition. Evidence from the current study suggest that although both groups of nurses in transition were expected to practice independently at PDD 3 each group continued to seek the support of a mentor or go to person. At the time of PDD 3 one could expect the nurse in transition would be moving out and asking what comes next. To the contrary; this group of participants remained bogged down as they moved through the transition while seeking independence in practice.

Fear as a coping resource also followed the nurse throughout transition. Fear as a coping resource should be viewed as a liability but was a real response to situations that occurred during transition to independent practice.

Most of what nursing knows about the nurse in transition is centered on the NGN; little is known about the transition of the experienced nurse who is changing practice settings or specialties. Although the current study did shed light on the expectations of the experienced nurse and orientation, more work is required to understand other transition needs of the experienced nurse. Nursing also needs to explore the needs of the nurse in transition past the first year.

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Appendix A

Table A
Schlossberg's Theory of Transition

Component	Definition	Code(s)	Notes
Moving In	Starting point of Transition individuals have common agendas/needs Orientation to a new setting		
Time frame	First 1-3 months of transition		
Types of transitions	Anticipated Unanticipated; Unscheduled unpredictable, crisis Nonevent; it never occurred		
Context	The relationship of the individual to the event/nonevent		
Impact	The degree to which the transition alters one's life		
Moving Through	long process. In between time when questions arise about transition. Individuals need help sustaining energy & commitment to process		
Time frame	3- 6 months of transition process may last longer up to 1 year		
Coping Resources, 4S system; situation, support, self, strategies	Self What the individual brings to the situation. Individual characteristics; socioeconomic status, age, gender, stage Support Key to handling stress. Social support; friends, family, intimate relationships.		

Component	Definition	Code(s)	Notes
	Strategies The way people do things to avoid being hurt. Strategies for coping grouped into 3 areas; modify situation, modify meaning of situation, manage the stress. Successful ind use more than 1 strategy. Situation Varies by individual.		
Moving Out	Role change Ending and asking what comes next		
Taking Charge strengthening Resources;	balance of assets and liabilities. Demonstrates the use of new coping strategies		

Appendix B



IRB APPROVAL AMENDMENT

March 14, 2013

Lynn Doyle, MS, RN, CPNP
C230

Dear Ms. Doyle:

Administrative approval has been granted on behalf of the Institutional Review Board for the following amendment to the protocol **Evaluation Of Nurse Transition In Their First Year Of Employment At A Pediatric Hospital** which was requested on February 25, 2013. This will be known as **Amendment 2**.

The following was approved on March 14, 2013:

Addition of Catherine Schmitt, Ke Weimang and Ashley Stelter as co-investigators.

Revised purpose of the protocol: "The purpose of this study is to better understand the experience of NGNs and experienced nurses as each group transitions to a new setting in nursing practice and the contribution the preceptor role plays in that transition." –

Revised methods: "Secondary analysis of qualitative data collected at the debriefs."

Extending the analysis for both Hypothesis #2 and #3 to look at the employment retention rate of experienced vs new graduate participants in the sample based on demographics collected in the PDDI data. Will ask HR to divide the retention data based on experienced vs new grads in the sample.

Additional questions to the study: As NGNs and newly hired experienced nurses transition to a new professional practice setting how do they perceive the transition process over the first year? As NGNs and newly hired experienced nurses transition to a new professional practice setting how do their coping resources change over the first year of practice? How do the NGNs and newly hired experienced nurses perceive the preceptors use of their knowledge and skills to help support them to explore, understand and cope with transition? -. How do NGNs and newly hired experienced nurses describe the change in the role of the preceptor over the first year?

These changes do not alter the risk to subjects.

The following protocol numbers will remain unchanged: CHW 10-43.

Any changes in the protocol and any severe upward reactions must be reported immediately to the Board. Changes in approved research, during the period for which Board approval has already been given, may not be initiated without Board review and approval except where necessary to eliminate apparent, immediate hazards to the human subjects.

When the above work is completed or discontinued, the Board must be notified in order to maintain an accurate record of all current projects.

Sincerely,

A handwritten signature in blue ink, appearing to read "J.P. Scott".

J.P. Scott, MD, Chair
Institutional Review Board #1

cc: Carol Klingbeil
Norah Johnson
Joan Tonka

Curriculum Vitae

Catherine A. Schmitt

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