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Transition to the Professional Role for Graduate Nurses in a Hospital Orientation Program

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COLLEGE OF EDUCATION

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Abstract

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MSN, Drexel University, 2006

BSN, Eastern University, 2002

Doctoral Study Submitted in Partial Fulfillment

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Abstract

This study focused on the transitioning of graduate nurses (GNs) employed by a teaching hospital in the eastern United States to the professional role of registered nurse after a 6-week orientation was the focus of this study. Benner's novice-to-expert theory served as the framework for this qualitative case study. Twelve participants were chosen from 3 specific populations: GNs, nursing preceptors, and nurse managers. Three research questions asked about the perceptions of newly licensed nurses after completion of the orientation process related to their ability to make critical decisions in the professional role of RN, how the preceptor educational training program prepared staff nurses for the role of preceptor, and the beliefs of newly licensed nurses and nurse managers regarding the role of nurse mentor. Interviews and documents were the sources of the qualitative data collected from the participants and the organization. The data were coded manually in a comparative manner to extract the themes that emerged from the findings. Participants agreed that the orientation program did not provide sufficient time and education for GNs to learn and grow professionally and did not offer training to nurses serving as preceptors. Results identified the need for revisions to the orientation program that would offer consistency and relevancy to the needs of all stakeholders. The preceptor workshop and a transition-to-practice (TTP) program were developed based on the outcomes. The TTP program could benefit this teaching hospital as well as local, state, and national health care facilities that employ newly licensed nurses. Improving the training of preceptors and implementing the orientation program for GNs for a minimum of 6 to 12 months would improve patient outcomes and increase nurse competency.

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Dedication

I would not be at this point and ending this doctoral journey without the unconditional and unchanging love of my Savior Jesus Christ. Thank you for carrying me the entire journey. I dedicate this project to Florence: Thank you for my profession. To nurses, from novice to expert, you have a special calling to minister to those under your care. May you always receive the education that you need to excel in your ministry. To Dr. Patricia Benner, your work has been an inspiration to me throughout my entire career. Thank you for sharing your understanding that we need to care for the future of the profession.

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To my husband and my family, I absolutely must acknowledge your sacrifice over the years. Words cannot express how much each of you means to me. This degree is as much yours as it is mine. Thank you for your love and support. Thank you for your sacrifice. To God be the glory.

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Section 1: The Problem

Introduction

St. Holmes Medical Center (SHMC), a pseudonym, is an acute care, nonprofit health care facility specializing in cardiovascular care. It is located in a city on the east coast of the United States. Remaining true to its mission, SHMC (2011) is one of the two hospitals in this urban area serving individuals in the surrounding socioeconomically disadvantaged and disenfranchised communities. Although the patient population of SHMC is culturally diverse, the surrounding communities of SHMC are predominately Hispanic American and African American.

According to the administrative assistant to the chief executive officer of the organization at the time of the study, SHMC is licensed for 348 beds and is able to use 274 at any given time (personal communication, January 13, 2014). SHMC is regionally known as a cardiac hospital that has received local and national recognition for the care of patients with diseases of the cardiovascular system. SHMC is a teaching hospital that hosts medical residents, interns, and students enrolled in the school of radiology. It also has an adjacent school of nursing. The SHMC School of Nursing (SHMCSON) began in 1905 and remains one of the few diploma-granting schools of nursing in this multicultural area of the east coast. The school has a rich history of longevity and dedication to nursing education (SHMC, 2011).

After nurses graduate from the school of nursing and pass the National Council Licensing Examination for Registered Nurses (NCLEX-RN; National Council State Boards of Nursing [NCSBN], 2014), many of them accept employment with SHMC.

After completing the application and employment processes, all new graduate nurses (GNs) must enroll in a 6-week orientation program (SHMC, 2013). All newly licensed GNs with less than 1 year of nursing experience receive the same nursing orientation program, regardless of the number of years of experience in the professional role of registered nurses (RNs). However, the orientation program does not include the core competencies as criteria for GNs that would meet their educational needs, as defined by the National League for Nursing (NLN, 2012) and Quality and Safety Education for Nurses (QSEN; Mark, Lindley, & Jones, 2009; SHMC, 2011; Ulrich et al., 2010). The QSEN competencies are important elements of a nursing orientation program (Gantt & Webb-Corbett, 2010; QSEN Institute, 2013). To develop a comprehensive and effective orientation program that is inclusive of NLN, QSEN, and Institute of Medicine (IOM) standards, it is necessary to conduct formative and summative evaluations of each GN's progress during and after completion of the orientation program. It should be noted that for the purposes of this study, I use the term *GNs* synonymously with *new graduates* and *new nurses* and the term *RNs* synonymously with *nurses* where applicable.

Definition of the Problem

SHMC's orientation program lacks formative and summative evaluations for the progress of the GNs related to their individual and collective transitions from novice to beginner toward the professional role of RN (Benner, 1984). In addition, program outcomes are not integrated into the orientation program. The 6-week orientation program is fragmented and is based upon the length of time spent in the orientation period, not the completion of nursing competencies, as outlined by the NLN (2012); the

NCSBN (2011); QSEN; and the American Nursing Credentialing Center (ANCC, 2014; Mark et al., 2009; Ulrich et al., 2010).

Contributing to the inconsistency and fragmentation of the orientation process is the assignment of GNs during the orientation period to different hospital units on a weekly or daily basis to meet staffing needs, according to an administrator at SHMC. When the reassignments take place, preceptors also are reassigned, meaning that the GNs do not have single dedicated preceptors during the orientation period, which leads to a lack of congruency associated with experiential learning and skills mastery within the first year of nursing practice (Ellenbecker, 2010).

Along with the biweekly change come a lack of collaboration, a lack of communication, and a lack of documentation among the various preceptors regarding what the GNs have learned, have mastered, or need to continue to work on during the orientation process, according to a unit manager at SHMC. It also is problematic that the GNs are not orienting exclusively on the units where they will become full-time staff members (SHMC, 2011). GNs are not able to develop as team members on the units and are not able to develop the critical and analytical skills related to unit- and nursing-based practices that are necessary to be productive in a specialty care facility (Spector & Echternacht, 2010).

Rationale for Choosing the Problem

SHMC employs one part-time nurse educator. This individual is responsible for the educational needs not only of new GNs, but also of all other employees within the facility. Without the benefit of a full-time nurse educator to conduct the orientation

program, GNs must depend on their preceptors and nurse managers for guidance and leadership related to the goals of the program. In addition, without a standardized, consistent, and progressive orientation program, GNs might experience dissatisfaction, unpreparedness, and a sense of feeling overwhelmed with their responsibilities (Berkow, Virkstis, Stewart, & Conway, 2009).

The present orientation program is not centered on evidence-based practice and core competencies; rather, it is focused on the critical behaviors developed by the organization (SHMC, 2013). Some of these critical behaviors are the ability to (a) care for six patients during Week 6 of the orientation program, (b) administer medication using the Pyxis and Medication Administration Kart correctly, (c) use the unit communication system, (d) locate unit equipment and supplies, and (e) apply and remove restraints correctly (SHMC, 2013). Preceptors evaluate the GNs' progress toward meeting each of the critical behaviors during the orientation; however, the evaluations are subjective only and are documented as either met or unmet according to the orientation checklist (SHMC, 2013).

According to Spector and Echternacht (2010), orientation programs must offer GNs the support and long-term assistance that they will need to feel more secure and prepared in their professional role of RN. To meet the GNs' needs, the following components should be included in the orientation program: provision of a safe environment for increasing skills proficiency, assignment to one preceptor throughout the orientation, orientation assignment to one designated unit, and implementation of an orientation program that is not time limited to 6 weeks. In addition, the orientation period

should include the QSEN and NLN standards for GNs. Providing an adequate orientation will decrease GN errors, increase the number of safe patient outcomes, and decrease the turnover of nurses with less than 1 year of experience (QSEN Institute, 2013; Spector & Echternacht, 2010).

Evidence of the Problem at the Local Level

SHMC is experiencing turnover of new GNs after a period of employment of approximately 6 to 12 months (Preceptor, personal communication, February 20, 2014). Poor retention of newly licensed GNs is a growing financial problem for health care organizations. Health care facilities spend approximately $50,000 to orient GNs. In addition, health care organizations lose approximately $145,000 annually by not being able to retain GNs after they complete their orientations (Bratt, 2009). With this cyclical turnover, new GNs leave health care organizations feeling unprepared, stressed, and overwhelmed (Bratt, 2009; Spector & Echternacht, 2010; Welding, 2011).

Past research has shown that longer orientation programs yield safer practitioners of care, decreases in nurse turnover, and decreases in nursing errors by newly licensed GNs (Bashford, Shaffer, & Young, 2012; Reid & Catchpole, 2011). Nursing research has provided evidence that a standardized nursing residency or transition-to-practice program (TTP) that is a minimum of 1 year provides newly licensed GNs with the support, training, and time necessary to transition to the professional role of RN (Anderson, Hair, & Todero, 2012; Goode, Lynn, Krsek, & Bednash, 2009; QSEN Institute, 2013; Spector & Echternacht, 2010; Welding, 2011). The world of nursing has changed, so the methods being used to orient GNs must keep pace with the changes in health care and the

complexities of the health care needs of patients. To provide a progressive orientation program that meets the needs of GNs, SHMC must respond to changes within the health care system, the increased responsibilities of RNs, and the research-based evidence supporting a well-structured orientation program for GNs (QSEN Institute, 2013; Spector & Echternacht, 2010).

Evidence of the Problem From the Professional Literature

The professional literature has provided an increasing body of work dedicated to the need for longer and standardized orientation programs for newly licensed GNs. The QSEN competencies, commonly recognized by the nursing profession as client-focused responsibility, combined effort, partnership, alliance, performance improvement, security, information studies, reflection, mirroring, and practice rooted in evidence within the patient care setting, are salient components of an effective, compelling, and competent orientation program (QSEN Institute, 2013). These competencies provide a foundation for experiential learning through a longer and more rigorous orientation for GNs, as outlined by QSEN and the NLN (Gantt & Webb-Corbett, 2010; QSEN Institute, 2013). According to the literature, the present orientation of SHMC is based not upon nursing competencies, but on the length of time spent in the orientation program, which is predetermined by SHMC (2011). An evidence-based orientation program that supports the transition from the role of nursing student to the professional role of RN would include the option for a longer individualized orientation that is recommended by nursing regulatory bodies such as the NLN, the NCSBN, QSEN, and the ANCC (Mark et al., 2009; Ulrich et al., 2010).

Facilities that offer longer orientation programs, nurse residency programs, or TTPs with an average length of 6 to 12 months are experiencing less turnover of nurses, increases in patient safety, and a rise in integrated clinical reasoning (Bratt, 2009; Kramer et al., 2012; Welding, 2011). The predetermined time frame of 6 weeks for all nurses (i.e., GNs and RNs) does not provide the experiential learning that is necessary in an individualized orientation for beginner GNs to obtain skill mastery in competent and effective manners (Benner, 1984; Bratt, 2009; Clark & Springer, 2011; A. Y. Kolb & Kolb, 2008).

Ellenbecker (2010) reported that when newly licensed GNs left health care facilities, they experienced feelings of being overwhelmed, a lack of safety, a lack of autonomy, and being unsupported by the employing organizations. In addition, with the constant turnover of GNs throughout the health care system, Ellenbecker asserted that a gap was developing within the nursing profession related to bedside nursing expertise. To achieve outcomes for beginner GNs that are evidence based, learning must begin at the level of the learner and should be experiential in nature, provide support, offer a program that is a minimum of 6 months long, and not go beyond the individual's present level of knowledge (Gaberson & Oermann, 2007).

Definitions of Terms

The following terms are found throughout this study:

Mentor: A trusted advisor, educator, guide, guardian, and/or tutor ("Mentor," 2013).

Nurse educators: RNs with advanced degrees who work in hospitals, colleges, and schools of nursing that educate future generations of nurses.

Nursing orientation: A time-limited period that provides new nursing employees with information related to the health care facility's policies and procedures as well as employees' specific job descriptions.

Nurse residency program: A year-long program designed for newly licensed GNs to transition them into the professional role of RN (Kramer et al., 2012).

Preceptor: RNs with more than 5 years of nursing experience who have the academic, directed, explicit, and recognized training that make them competent staff nurses to function as nursing models and resources for preceptees (Swihart, 2012).

Transition-to-practice program (TTP): A 1-year transition program that can be broken down into 6-month increments (NCSBN, 2011).

Significance of the Study

This issue of providing orientation programs is being experienced at the local, national, and international levels. The study was conducted to find ways to meet the needs of all stakeholders involved in the orientation process of beginner GNs. Improving the ease of GNs' transition from nursing school into the profession is a challenge for hospital-based educators, nursing administration, and the profession of nursing in general. It has become a challenge to provide evidence-based orientation programs supported by health care organizations (Mark et al., 2009; Ulrich et al., 2010). National nursing organizations believe that the best proposal to target this need is to employ orientation and qualification programs for GNs that offer supplementary education after

graduation from schools of nursing and once currently employed within a health care facility (Ellenbecker, 2010; Fink, Krugman, Casey, & Goode, 2008).

The responsibilities faced by beginner GNs include, but are not limited to, careful and precise medication administration; nationally recognized safety actions related to all patients; knowledge of all levels of governmental regulations analogous to patients and patients' rights; and the capability and resourcefulness to reason, operate, and decipher consumer health care problems critically in interdisciplinary ways (Welding, 2011). It is crucial that the orientation programs offered by health care organizations speak to the needs of beginner GNs to ensure that they are prepared to provide safe and competent care that will consistently yield positive patient outcomes. Increasing the experiential learning of GNs with longer standardized and well-developed TTPs can accomplish this goal (Goode et al., 2009).

Research Questions

The intent of this study was to understand how the orientation program provided by SHMC prepares newly licensed GNs with less than 18 months of nursing experience for the professional role of RN. Exploring the perceptions of GNs who have completed the orientation program through personal interviews and the examination of documents related to preceptor training provided the necessary information to answer the three research questions (RQs):

RQ1. What are the perceptions of newly licensed nurses after completion of the orientation process related to their ability to make critical decisions in the professional role of RN?

RQ2. How does the preceptor educational training program prepare staff nurses for the role of preceptor?

RQ3. What are the beliefs of newly licensed nurses and nurse managers regarding the role of the nurse mentor?

A TTP will be developed based on the research results. Past researchers have shown that newly licensed GNs who have been given longer orientation periods have felt more supported in the professional role of RN (Reid & Catchpole, 2011; Welding, 2011). In addition, when they were given the necessary time to assimilate into the professional role of RN, they were more confident, more competent, and more likely to stay employed longer in their health care organization (Reid & Catchpole, 2011; Welding, 2011).

Conceptual Framework: Stages of Professional Growth

The conceptual framework in this study was Benner's (1984) model of the stages of professional growth experienced by RNs. The model explains the interconnectedness of experiential learning and nursing education with support from experiential learning. Benner stated that an individual could learn skills and acquire knowledge without a related theory. Benner also explained that practical knowledge and clinical experience would help RNs to acquire knowledge and understand the profession. Experiential learning is closely related to this concept.

Benner (1984) described five stages of nursing experience: novice, advanced beginner, competent, proficient, and expert. Novice GNs have no clinical experience. Advanced beginners have 1 year of clinical experience and acceptable performance. Competent RNs have 2 to 3 years of clinical experience. Proficient RNs have clinical

experience of more than 3 years and have learned from their experiences. Expert RNs also have more than 3 years of clinical experience and have an intuitive knowledge of every situation. The level of nursing experience builds on each stage, with RNs gaining more knowledge and expertise based upon their clinical experience (Benner, 1984).

Experiential learning is a process that allows learners to construct knowledge and improve skills from direct experiences within their professional environments (Haleem, Manetti, Evanina, & Galleagher, 2011; Hornyak & Page, 2004). The experiences of new GNs postgraduation and during their first year in their professional role of RN speak to the need for the experiential approach, which deals directly with the application of content in a hands-on manner (Foster, Benavides-Vaello, Katz, & Eide, 2012; Wlodkowski, 2008). Experiential learning gives RNs a fuller and deeper understanding as they engage in learning activities and then apply them to real-world environments or situations (Foster et al., 2012; Haleem et al., 2011; Wlodkowski, 2008).

D. Kolb's (1984) experiential learning theory (ELT) is a holistic and interdisciplinary theory of learning that has two components: the ELT model, which has four distinct learning stages, and the learning styles that are interconnected to the ELT model (A. Y. Kolb & Kolb, 2008). Within the four learning stages are two continuums, namely, the vertical and horizontal perception continuum and the vertical and horizontal processing continuum. The concrete experience (CE) and abstract conceptualism (AC) are the two north-south, or perception, continuums. At this level, learners experience emotional responses to learning that describe how they feel or think about the learning process. This characterization supports Benner's (1984) description of novice GNs (as

cited in Poore, Cullen, & Schaar, 2014). Reflective observation (RO) and active experimentation (AE) are the processing continuums, meaning that the learners approach tasks in the learning process in these two stages by watching and doing. This stage also is where new GNs practice (A. Y. Kolb & Kolb, 2008). In addition to these four stages, the ELT model connects each level to one of four distinct learning styles.

Learning Stages

Divergence. Diverging is the first of four learning stages (Manolis, Burns, Assudani, & Chinta, 2013; Poore et al., 2014). This stage involves the learners in two of the four stages: CE and RO. The learners prefer to feel and/or watch or take hold of the learning experiences; novice GNs fall into this stage.

Assimilation. The second learning stage is assimilation, where the learners are in the stages of AC and RO. In these stages, the learners move from feeling and watching to thinking and watching, and are beginning to become reflective while continuing to take in the learning environment through observation; new GNs fall into this stage (Manolis et al., 2013; Poore et al., 2014).

Convergence. The third stage, converging, brings together AC and AE, thinking, and doing. During this stage, the learners become analytical, can begin the hands-on process of doing or participating, are able to think through the process, and can begin to plan; this stage describes proficient RNs (Benner, 1984; Manolis et al., 2013; Poore et al., 2014).

Concrete experience and active experimentation. The final learning stage involves CE and AE. During this stage, the learners have come full circle and not only

can feel, but also can apply what they have learned (Andreou, Papastavrou, & Merkouris, 2014; Manolis et al., 2013; Poore et al., 2014). They have developed an emotional attachment to what they have learned and have gained confidence through the learning process to complete tasks successfully through the acquisition of knowledge and the integration of concepts in all learning stages (Andreou et al., 2014; A. Y. Kolb & Kolb, 2008).

ELT, therefore, is the grasping and transforming of knowledge that takes place during each learning experience (A. Y. Kolb & Kolb, 2008). In line with the ELT model, A. Y. Kolb and Kolb (2008) argued that "practice makes perfect and little of importance is learned in one sitting" (p. 313). Learning is a process that does not occur at a particular rate or speed, or within a defined time frame. Personal and professional growth occurs over time with the ability and opportunity to learn through experiences. According to researchers, moving new GNs during the orientation process requires a systematic approach and an understanding of individualized learning styles, as well as hands-on training through experiential learning (Andreou et al., 2014; Benner, 1984; Haleem et al., 2011; Poore et al., 2014; Roth & Johnson, 2011).

Review of Literature

I developed this review of the literature to synthesize and evaluate the need for the continued educational training of newly licensed GNs after passing the NCLEX and gaining employment at SHMC. This literature review is focused on the conceptual framework of Benner's (1984) model and its kinship to experiential learning and the ongoing education of newly licensed GNs postgraduation and into the employment arena.

Gaining an understanding of experiential learning and the ways in which this concept intertwines with the educational needs of new GNs in reality incorporates the preparation and educational needs of newly licensed GNs as they transform from the role of student to that of safe practitioners in the profession of nursing (Foster et al., 2012; Jones-Bell et al., 2014).

I used various databases from Walden University and SHMC's library to obtain relevant, current, and historical information. The databases included SAGE Premier Full-Text, Nursing Resource Center, Thoreau, EBSCO, Education Research Complete (ERIC), Google Scholar, CINAHL Plus with Full Text, and ProQuest. Historical and current journals that were relevant to the project (see Appendix A) and helped me to obtain information for this study were retrieved from coworkers, nursing educators, and nurses.

This literature review is divided into nine sections. In the first section, I explain the conceptual framework of Benner's (1984) model of the stages of professional growth of GNs and the interconnectedness of experiential learning and nursing education. The second section ties together Benner's work related to the stages of professional development (PD), where GNs work toward becoming proficient RNs. This section begins with an examination of Stage 1 of Benner's model. This section also includes an examination of Stages 2 to 4, detailing Benner's belief in experiential learning from the perspectives of beginner GNs in Stage 2 and moving through each stage to proficient and into Stage 5 of nursing expertise. This section also details the experiences of GNs who have participated in experiential learning and are beginning to grow into strong RNs,

bringing together the interconnectedness of experiential learning and professional growth, as noted in Stage 4 of well-developed and competent RNs.

In the third section, I define the orientation system used for newly licensed GNs. An examination of past and present systems is contrasted with the learning needs of GNs. The fourth section focuses on evidence-based practice through the lens of the TTP. In the fifth section, I consider recommendations from the NCSBN (2011) regarding the orientation of newly licensed GNs across the United States. The sixth section includes a focus on nurse residency program health care models of excellence using a TTP or its components. Also included in this section are the program goals and the systematic schedule as integral components of an orientation program for newly licensed GNs.

The seventh section details the orientation program at SHMC for GNs from a different perspective of the TTP. This program incorporates elements of the TTP from the NCSBN (2011) recommendations that are specific to the needs of this health care organization. Also included is a discussion of precepting teams and formative and summative evaluations as part of research-based orientation programs. The eighth and ninth sections detail the need for orientation programs with consistency, along with educational programs for nursing preceptors and mentors as fundamental and essential components of successful orientation programs. The eighth section contains a description of the benefits of consistency during the orientation process for the organization and newly licensed GNs, and the ninth section emphasizes the need for quality, compassion, and educational guidelines for nursing preceptors.

Nursing Education and Professional Development

From Novice to Expert

Benner's (1984) model addresses the educational and experiential needs of GNs as they advance through the stages of proficiency and transform from novices to experts in professional nursing. Benner used the Dreyfus model of skill acquisition from 1980 and 1981 and applied it to nursing. The Dreyfus model posits that in the development and attainment of skills, students pass through five levels of proficiency that are reflective of the acquisition of skills and the ways in which they are performed (Benner, 1984). Benner's five stages are taken from the Dreyfus model and are applied to nursing at the level of novice, advanced beginner, competent, proficient, and expert. Benner argued that this progression is a movement from RNs' reliance on "knowing that" to the clinical expertise of "knowing how." This belief aligns with the philosophy of experiential learning; the ELT model describes learners as shifting from watching and taking to acting through the acquisition and integration of knowledge and skills (Manolis et al., 2013; Poore et al., 2014).

Stage 1. The first stage is that of novice GN; at this stage, student nurses have no concrete experience or reflective observations to prepare them for future situations during which they will be expected to perform (Benner, 1984). During their years of preparation in an academic setting as students, newly licensed GNs learned to perform skills to meet the objectives of a nursing curriculum. The majority of their learning was task orientated and mandated to meet the standards of the nursing program, as well as state and national nursing educational organizations (Benner, 1984). Novice training programs have very

strict rules because these nurses have limited or no clinical experience. As such, most novice GNs act only if someone with more experience tells them what to do.

Stage 2. Advanced beginner GNs demonstrate minimal acceptable performance. According to Benner (1984), advanced beginner GNs are nurses "who can demonstrate marginally acceptable performance who have coped with enough real situations to note the recurring meaningful situational components that are termed aspects of the situation in the Dreyfus model" (p. 22). These nurses have enough knowledge to enter the professional world of nursing and possess some experience from the academic setting, but they need continued educational experience gained though working with mentors (Benner, 1984). Once students have successfully passed the RN NCLEX®, they are considered professional RNs. A major concern in the past has been the lack of continued education of advanced beginner GNs once they leave the safety of the academic setting, where faculty members nurtured, molded, and provided guidance in an educational environment (Jones-Bell et al., 2014). It has become evident through research that it is important to continue preparing GNs in the academic and affective domains of nursing (Banks & Zionts, 2009).

The perfection of skill sets, the development of critical-thinking abilities, and the ability to provide safe and proficient nursing care are dependent upon GNs having consistent and systematic educational backgrounds upon which they can build and continue to grow in their new role (Benner, 1984; QSEN Institute, 2014; Spector & Echternacht, 2010). The education of nurses should not stop once they graduate from a school of nursing (Banks & Zionts, 2009; Jones-Bell et al., 2014). The ability to think

critically and analytically, in addition to the perfection of skill sets, is a priority for every GN and should be accompanied by experiential learning during the orientation process (Benner, 1984; Foster et al., 2012; Haleem et al., 2011; Jones-Bell et al., 2014).

The manner by which information is disseminated to advanced beginner GNs speaks to the organization's motivation to engage GNs in a process that intrinsically motivates them to continue the learning process beyond the educational walls and into the real world of health care (Donavant, 2009). Benner (1984) argued that the greatest implication for staff education in health care facilities is to remember that advanced beginner GNs require support in the clinical setting and need help setting priorities, educating patients, perceiving recurring patterns, and being provided with consistent preceptors or mentors.

Traditional hospital-based orientation programs implemented without the benefit of program extensions on an individualized basis are no longer a valid method for training advanced beginner GNs and do not lead to movement into Benner's subsequent levels of expertise (Mariani, 2012; Roth & Johnson, 2011). Without experiential learning at this level, the acquisition of knowledge beyond a basic skill set will not increase. The postgraduation education of GNs must be based upon evidence-based research and sound learning theory that leads to experiential learning (Jones-Bell et al., 2014; Mariani, 2012; Roth & Johnson, 2011; Spector & Echternacht, 2010).

Stage 3. Competent RNs have worked in the same or similar jobs uninterrupted and possess 2 to 3 years of experience (Benner, 1984). These nurses can look beyond the short term and can envision their actions in terms of future plans of care. Competent RNs

have learned how to cope in difficult clinical situations, and they have begun to master skill sets, despite still lacking some speed and flexibility. However, their ability to plan for the long term assists them in achieving organization and efficiency (Benner, 1984).

Stage 4. Proficient RNs have shifted from viewing parts of the whole to viewing and perceiving each clinical situation based upon experience. Their understanding of a clinical situation is seen as a whole, that is, they can put all of the pieces of the situation together. Proficient RNs have learned a lot based upon experience.

Stage 5. During Stage 5, expert RNs have moved beyond understanding the rules and guidelines to possessing the ability to analyze different clinical situations. These nurses have a significant background in nursing, and they are intuitive, accurate, flexible, and decisive (Benner, 1984). Expert RNs also are mature enough to realize that even though they will make mistakes, they can use the professional perceptions gained through years of experience to analyze each clinical situation inductively and deductively to avoid patient care errors (Benner, 1984). These types of nurses are able to make decisions without the use of analytical tools or checklists. They also are able to use critical thinking and analytical reasoning in clinical situations.

Benner (1984) laid the foundation for experiential learning for nurses to transition from novice GNs to expert RNs. Educational facilities should develop nurses who possess the ability to think, interpret, understand, and act in the best interest of each patient in their care. To upgrade young nurses from advanced beginner to expert, training or orientation programs should be implemented. Health care educators have to engage GNs purposefully in ways that develop their basic skills, challenge them with hands-on

experience, provide support, and move away from short and unrealistic time frames for effective knowledge acquisition to take place.

Novice-to-Expert Theory

Several researchers have explored the application of Benner's (1984) framework. The novice-to-expert theory has provided a foundation for practice, education, and leadership development in the nursing field. The novice-to-expert theory has been used as a guide to nursing practices and in making changes in the profession (Alligood, 2010). Furthermore, the theory has been used as a rationale for the PD of nurses. Brykcznski (2010) suggested that it "focuses on developing and understanding perceptual acuity, clinical judgment, skilled know-how, ethical comportment, and ongoing experiential learning" (p. 141). Alber et al. (2009) examined the relationships between psychiatric mental health nurse practitioners' (PMHNPs') perceptions of competence, prior basic-level nursing experience, and years of PMHNP practice using a questionnaire designed from Benner's model. Alber et al. supported the conceptual framework of Benner, stating that self-perceptions of competence increased as PMHNPs progressed through years of practice. They also concluded that perceptions of competence occurred between career entry and 3 to 5 years of practice, or during Stage 3 and Stage 4 of Benner's model.

In a similar study, Burger, Parker, Kaetzel, O'Nan, and White (2010) explored the elements that impinge upon the capacity of GNs and RNs to be productive in the leading-edge health care climate. Burger et al. investigated the inequalities and variations among nurses with 1 year, 3 years, and 5 years of nursing experience regarding their ability to formulate and reformulate patient care needs and outcomes. The result supported

Benner's (1984) framework. In addition, Burger et al. found that as the nurses grew in ability, proficiency, and know-how, they improved in their mastery of putting together, mapping out, and processing how to deal productively with disturbances, forecast client exigency, orchestrate numerous professional roles into their practice, and interact persuasively. Gentile (2012) suggested that the novice-to-expert model be examined and contemplated for its groundwork and underpinning as a longstanding and fundamental infrastructure regarding entry into practice for GNs as well as for the significance of the model relevant to nursing practice and nursing needs.

Benner (1984) posited that proficiency, competency, and skillfulness evolve and eventually flourish as nurses' inquiry leads to analysis and evaluation over time. Adept and experienced practitioners can process premises, theorems, and criteria that are fundamental to real, applicable work-related settings. Accordingly, Benner believed that training, know-how, skillfulness, involvement, and doing are all necessary and required in order to move from novice GN to expert professional RN.

Clinical Expertise

Clinical expertise is emphasized in Benner's (1984) model. Clinical nursing expertise also is vital to quality patient care (McHugh & Lake, 2010). Several studies have explored the factors and impact of clinical expertise on the PD of nurses. On the other hand, educational preparation and certification have not been correlated with expertise (Bobay, Gentile, & Hagle, 2009). According to Gillespie and Peterson (2009), with sufficient experience in the clinical setting, GNs can move from dependence on transcendental precepts to the employment of tangible skill and understanding, looking at

clinical situations endogenous to their frames of reference fixed and unabridged. Some clinicians also have expressed their readiness to impart their clinical proficiency and know-how as educators, but they lack preparation for this new role and do not possess the necessary qualifications (Cangelosi, Crocker, & Sorrell, 2009).

Many researchers have stated that Benner's (1984) framework oversimplifies the stages of growth and experience that RNs must go through to reach the expert level. At first, it would seem that the theory truly encapsulates the development of experts. An example would be the assertion that nurses progress from slow and doubtful to fast, instantaneous, and intuitive problem solvers. Benner's framework provides important insights into the complex relationship of nursing theory and nursing practice. Moreover, Benner emphasized the role of emotions in the development of expert nurses.

The complexities of health care and the demands on GNs are high, making training essential to the delivery of safe and effective care within health care facilities. The consensus within the literature is that an evidence-based orientation to the professional role of RN within health care organizations reduces the amount of orienting time that GNs need. The lack of an evidence-based orientation leads to nurse turnover, burnout, and inability to meet the expected demands of the health care system effectively (Anderson et al., 2012; Foster et al., 2012; Haleem et al., 2011; Jones-Bell et al., 2014). Past research and theories have been devoted to studying the ways in which health care facilities develop and train GNs after they leave the setting of a school of nursing and pass the NCLEX (Bratt, 2009; Goode et al., 2009; Welding, 2011).

Nursing Orientation

Past and Experiential Learning

The value of the clinical application of theory is important in providing GNs with a deeper understanding of the profession. Experiential learning prepares GNs to care for a variety of patients. GNs also should have ample opportunities to put their classroom knowledge into practice. Postgraduation orientation programs should provide trained preceptors who have the nursing experience to guide GNs in experiential manners on clinical units that are inclusive of hands-on experience that includes collecting and interpreting data, understanding acute versus chronic conditions, and addressing overall patient care outcomes in the health care system. The advantage of having these on-the-job experiences have been shown to improve patient care and the clinical judgment of newly licensed nurses (M. Johnson, Sonson, & Golden, 2010; Lisko & O'Dell, 2010).

Experiential learning is helpful in developing and improving the skills of analytical reasoning and scientific discernment needed by GNs, both of which are vital to the profession of nursing (Lisko & O'Dell, 2010). Simulation also is associated with experiential learning. In nursing education, this learning takes the form of role-playing, static manikins, CPR manikins, and other techniques. However, some researchers have suggested that simulation is not as effective as experiential learning (Cannon-Diehl, 2009; Kaakinen & Arwood, 2009).

As health care educators attempt to develop new ways to educate and train GNs, historical nursing orientations have shown the previously allotted time that new graduates received prior to 1994 as provisional licensed nurses or GNs was approximately 6

months. During this time, GNs were given the opportunity to work, which provided them with a gradual realignment and metamorphosis from novice to GN, which was primarily related to the length of time that GNs waited to take the NCLEX (Clark & Springer, 2011). In contrast, with present-day computerized testing, the turnaround time for GNs to take the NCLEX is faster and often occurs within weeks of graduation (Clark & Springer, 2011; Jones-Bell et al., 2014; Roth & Johnson, 2011).

GNs experience transition shock when moving from academia and the guidance of educators into the health care arena, where they are expected to perform as well-qualified, polished, experienced, and proficient professionals. Without the intuitive perceptual refinement of experienced RNs, GNs often find themselves socially and emotionally unable to handle the demands of the professional role of RN without consistent mentors and champions (Duchscher, 2009). There should be a smooth transition from the role of new GNs to that of licensed RNs. As such, it highlights the relevance and merit of fusing novice academic educational programs amid expanding organizational outlooks and beliefs.

Researchers have contributed logical affirmation of the presence of a doctrine-praxis gap in nursing (QSEN Institute, 2013; Romyn et al., 2009; Ulrich et al., 2010). Evident distinctions have been validated between and among the preeminent practice concepts and beliefs that are instructed and those genuinely experienced in day-to-day nursing practice. Experiential learning is a specific and definitive way to link the separation between theorem and process in the nursing profession.

The initial year of nursing practice is crucial in shaping new GNs into secure, cautious, and effectual practitioners. Many GNs abandon the profession because of the tremendous pressure and strain in their places of employment, little to no support from the organizations' authority figures, meager nurse-doctor relationships, capricious assignments, and harmful occupational conditions; they also face additional adversity when transforming from academia to practice (Lisko & O'Dell, 2010; Roth & Johnson, 2011). One of the ways to retain new GNs is through orientation programs such as extended transition programs.

Transition Programs

Jones-Bell et al. (2014) examined four transition programs that were an average of 12 to 16 weeks in length that focused on GNs who were not yet employed postgraduation. The expected outcomes of the programs were to develop the serviceability, proficiency, assurance, and determination of the GNs in the programs. Precisely, one of the transition programs concentrated solely on neighborhood and public health environments, with a significant number of GNs completing the program and attaining positions (Jones-Bell et al., 2014). As reported by Jones-Bell et al., this particular public health transition program continues to maintain favorable advantages for GNs and has become an illustrative example for revamping the transition of GNs into practice.

Roth and Johnson (2011) highlighted the importance of TTPs, citing the overall benefit to GNs in the hospital setting. This longitudinal study found that the relationship of the GNs and their assigned preceptors, coupled with an evidence-based TTP, increased

the confidence and competency of GNs. They found that a well-developed and well-administered TTP produced GNs with enhanced skills who were more capable, more aware, and more savvy. Roth and Johnson also found a quantitatively compelling interconnection between preceptors and new GNs that enhanced the GNs' proficiency outcomes, as reported by preceptors. The study results revealed that in this TTP, approximately 84% of the GNs worked only when their assigned preceptors worked; were afforded one specific preceptor each; and were not given individual patient assignments, on average, among the three groups studied before their 31st day during the TTP.

This length of orientation allowed the GNs to spend more time with experienced RNs and gave them the ability to begin to master clinical decision making. This type of orientation also facilitated a smoother integration into the new role of RN and increased the nurses' self-concept as GNs, as suggested by Clark and Springer (2011). During this time, experiential learning took place through the acquisition of knowledge, support, hands-on training, and acculturation to the professional role of RN. According to Clark and Springer, because of present-day computer testing, new graduates take the NCLEX examination in a much shorter time frame and are placed on a 6-week orientation period directly after receiving their nursing license. New GNs would want to have supportive preceptors and nursing staff, and they would want to be perceived as vital members of the health care teams (Clark & Springer, 2011).

This shorter orientation period, although appearing to be financially feasible for organizations on the surface, very often becomes costly as GNs unable to cope with the

complexities of the job perform poorly, make serious and often life-threatening errors, and leave the organizations either to work in other facilities or abandon the profession entirely (Spector & Echternacht, 2010; Welding, 2011). This constant turnover costs the facilities more money in terms of orienting and training fees, as well as the loss of GNs with 6 to 12 months of nursing experience (Friedman, Delaney, Schmidt, Quinn, & Macyk, 2013; Welding, 2011). The NCSBN recommendations for comprehensive transition periods that meet the QSEN competencies should be fluid and evidence based (Bratt, 2009; Spector & Echternacht, 2010).

Winfield, Melo, and Myrick (2009) compared the turnover rates of internship programs and orientation programs, and they reported that an internship program is a design proven to produce affirmative outcomes when promoting GN role development, progression, and transformation. Programs specifically constructed and created as internship programs for nurses decreased their attrition rates 1-year postemployment in comparison to conventional nurse graduate training programs, according to Winfield et al.

Transition-to-Practice Models

According to Benner (2004), a discussion about the orientation of new GNs and TTPs in nursing is not new and has been well documented for more than 70 years. Spector and Echternacht (2010) asserted that the issue is not only a national nursing problem but also an international one. Moreover, research has shown that other countries, including Australia, Ireland, Portugal, and Scotland, have already implemented TTPs. Each of these countries supports a 1-year TTP for GNs that is nationally funded (Spector

& Echternacht, 2010; Xu & He, 2012). Past research also has shown that even though there are several different forms of TTPs, there are similarities in all programs that are essential to the development and transition of new GNs to the professional role of RN (Jones-Bell et al., 2014; Kaddoura, 2010; Romyn et al., 2009; Roth & Johnson, 2011). TTPs might vary according to clinical environments and unit-specific orientations. Researchers have presented information related to successful models with clearly defined program goals that are specific to the needs of GNs, organizations, and all stakeholders involved in providing responsible and collaborative orientation programs for new GNs as an international initiative (Friedman et al., 2013; Jones-Bell et al., 2014; Romyn et al., 2009).

A successful TTP model is important to ensuring the effectiveness of nurses as practitioners regarding the care and outcomes of all patients. Nash, Lemcke, and Sacre (2009) described a fortified TTP blueprint of senior nursing students that was trialed in 2006 at the Queensland University of Technology. The results revealed that students who felt more qualified and ready for the professional role of RN reported a kinship with their mentors and felt an enhanced socialization to the practice arena than before the last semester of training. Nash et al. identified an overall expansion regarding clinical readiness in the students who were aggressive, were eager, and took charge of their time spent in the program. The researchers also discovered that the preeminent gainful facets of participation for students involved their becoming part of a group that expressed and appreciated their educational needs and made every effort advantageously to guide them and include them as members of the group.

In another case study, Hickey (2010) sought to examine and understand the perceptions of GNs with reference to their educational on-the-ground training to assess their feelings of being ready to enter the health care system as providers. Hickey also noted that hands-on educational training was seen as a crucial and essential chance for students to develop their skills prior to approaching the practice setting. Moreover, Hickey stated that having preceptorships as part of the training proved to be a determinative factor related to the preparation of students for real-world, self-reliant practice.

The NCSBN designed a TTP model that incorporated the QSEN's (2013) IOM core competencies. The five modules in the model were intended to become a standardized national model for transitioning newly licensed GNs into the nursing profession. The model called for a 1-year transition and was broken down into 6-month time frames.

Presently, the orientation process at SHMC (2013) is a 6-week program that does not fit into this model. The first 6 months build on the preceptor-advanced beginner relationship and include the education of the orienting GNs related to the core competencies. The last 6 months are devoted to ongoing institutional support and reinforcement of the core competencies. According to Spector and Echternacht (2010), the model is evidence based, supports the use of one consistent and trained preceptor with each advanced beginner GN, is patient centered, and is based upon experiential learning. Some states and health care organizations are using the NCSBN model to develop their own or are incorporating parts of it into their orientations or nurse residency programs.

Bratt (2009) discussed the Wisconsin Nurse Residency Program (WNRP) as an effective example that provides advanced beginner GNs with the necessary support during their transition from students to RNs. The WNRP offers a continuous support system that can be extended to 15 months after hire, which is in contrast to the mandated 6-week SHMC (2013) orientation. TTPs include learning sessions, clinical coaches, preceptors, professional socialization, and professional support on a continuous basis once enrolled in the nurse residency program (Bratt, 2009).

The aim of achieving low turnover rates of nurses is an important aspect of orientation programs (Bratt, 2009; Friedman et al., 2013; Goode et al., 2009; Welding, 2011). Effective programs should be circular in nature and should include action and reflection, as well as knowledge, skills, and professional behavior training (Bratt, 2009). There are nurse-centered objectives that relate to the successful implementation of orientation programs. The objectives should provide clear definitions of the programs' goals while also providing systematic schedules for new GNs during the orientation programs (Friedman et al., 2013; Mennenga & Smyer, 2010; Romyn et al., 2009; Roth & Johnson, 2011).

Program Goals

The goals of TTPs involve the successful transition of new GNs into the professional role of RNs, that is, from novice to expert. According to the literature, some goals of effective TTPs include the following: improve critical-thinking skills (Bratt, 2009); cultivate a sense of belonging in a team (Nash et al., 2009); improve skills in clinical decision making (Bratt, 2009; Gentile, 2012); enhance the preceptor type of

experience (Hickey, 2010); and develop practical skills (Rush, Adamack, Janke, Gordon, & Ghement, 2013).

Didactic aspects of residency programs include monthly or weekly educational sessions in the classroom and simulation sessions led by educators and clinicians. These sessions are learner directed and are used to discuss content that is applicable to real-world clinical situations. The sessions also involve building clinical judgment skills and increasing the learners' ability to deliver quality care in the clinical setting (Bratt, 2009).

Systematic Schedule

Month-by-month program schedules delineate what will be covered during the first 12 months of residency programs while also providing systematic plans for the GNs in the residency programs (Goode et al., 2009). Having plans during the orientation programs decreases stress, focuses students on the learning experience, and helps to develop competencies during the orientation period (Bashford et al., 2012; Friedman et al., 2013; Jones-Bell et al., 2014; Roth & Johnson, 2011). During the initial months in orientation programs, GNs are focused on building self-related abilities related to critical thinking, stress management, PD, and clinical decision making (Bratt, 2009). As the orientation programs progress, the focus shifts to the GNs learning team building and discussing how to prioritize care, set schedules during their work hours, make appropriate assignments, settle conflicting issues, deal with horizontal violence, and give and receive constructive criticism (Bratt, 2009). At the conclusion of the orientation programs, the GNs are involved with subject matter that deals with evidence-based practice in each specialty area of the acute care setting as well as best practices related to medical surgical

and critical care of patients across the life span (Bratt, 2009). Topics included in the latter days also pinpoint hospital initiatives and outcomes germane to patient safety, satisfaction, and performance improvement (Bratt, 2009). The final weeks focus on building capacity within the profession and discussing the professional journey (Bratt, 2009). An additional aspect of successful orientation programs that use parts of the NCSBN model is the use of the preceptor approach.

Precepting Team

Nurse educators at a hospital implemented a precepting team approach during their orientation of newly licensed GNs (Goodwin-Esola, Deely, & Powell, 2009). The team of educators developed an orientation program based upon Maslow's (1954) hierarchy of needs, Benner's (1984) stages of clinical competency, and Swanson's (1991) middle range theory of caring, thereby ensuring an evidence-based approach to their particular orientation program. The focus of this orientation program was to integrate progress meetings to the established orientation process, thus providing the necessary support and mentoring that the new GNs required. This approach met the needs of the organization and individualized the transition program for each new GN (Cadmus et al., 2008; Goodwin-Esola et al., 2009; Mariani, 2012; Romyn et al., 2009).

When using the precepting team approach, preceptors should be specially trained nurses, clinical educators, and the directors of clinical education departments within the organizations (Goodwin-Esola et al., 2009). The goal of the precepting team approach is to individualize the orientation to the needs of clinical units and GNs (Cubit & Lopez, 2012). Each orienting GN is assigned a preceptor as part of the orientation process.

Progress meetings are a component of this approach and are scheduled by the preceptor and/or the clinical educator during predetermined weeks of the orientation period, according to the needs of the GN (Goodwin-Esola et al., 2009). Ideally, the GN will have one specific preceptor during the complete orientation period who helps the GN in building social relationships, gaining insight through experiential learning, and receiving consistent formative and summative evaluations (Goodwin-Esola et al., 2009; Hilli, Salmu, & Jonsen, 2014; Kelly & McAllister, 2013).

According to Kramer et al. (2012), socialization within the professional role of RN is an important factor in the success of GNs as understanding the expected role performance regarding the skills and competencies of RNs. The role of preceptor is significant to the training program of nurses. Preceptors are an important element to any successful orientation program that brings together each of these aspects to assist GNs in beginning their journey toward becoming proficient RNs. The involuntary drafting of RNs to serve as preceptors who are overloaded at work and in their personal lives has proven to be an ineffective teaching and learning experience for advanced beginner GNs (Swihart, 2012). Preceptors have to share their knowledge and have been given educational classes regarding their roles and responsibilities as preceptors.

Preceptors should have a minimum of 3 to 5 years of nursing experience that is specific to the units or areas within the health care system that the GNs will become staff members of (Kramer, Maguire, Halfer, Brewer, & Schmalenberg, 2011; Swihart, 2007). This professional experience provides preceptees with the advantage of having champions (i.e., mentors) who serve as the key to their individual learning and who can

provide the necessary formative and summative evaluations. Explanations of hospital policies, regulatory requirements, and skill evaluations provided by dedicated preceptors can ensure accountability and reflective practice during the orientation period.

Experienced RNs developed and educated as preceptors who are willing to participate in the development of GNs in an environment that is safe should encourage learning. This type of learning environment ensures that the learning taking place is not task orientated, is free from penalty, and establishes high-quality nursing care for the future of the organization and the profession of nursing. Several organizations do not provide instruction or guidance to develop and strengthen staff members who work as preceptors. Other organizations offer training programs for RNs in preparation for their role as preceptors but allot only limited time to the orientation programs themselves. Some health care facilities provide training programs to prepare RNs for their role as preceptors, but they do not have a standardized or an evidence-based curriculum that ensures that each preceptor is qualified to train and work with GNs in a uniform manner. These preceptor programs also lack consistency and the mandate to complete the preceptor training as a condition of being prepared to train GNs (Mariani, 2012; Price, 2013; Romyn et al., 2009).

Most researchers have concluded that the training programs for preceptors have indicated that working as preceptors of new GNs and working as preceptors of students in clinical practice are not the same. Preceptors' roles and responsibilities vary with the types of learners that they have (Price, 2013). Moreover, because some preceptor training

programs lack structure, many preceptors do not have the readily accessible support, backing, or basic information necessary to guide them in their work (Price, 2013).

Formative and Summative Evaluations

Progress meetings are a crucial element of TTPs and should spotlight the orienting GNs' progress in the areas of evaluation of time management skills, clinical competencies, support, socialization, and patient responsibilities, and they also should follow a systematic plan (Goodwin-Esola et al., 2009; Haggerty, Holloway, & Wilson, 2013; Harrison-White & Simons, 2013). This formative evaluation process helps preceptors and GNs to revisit clinical issues covered according to the plan and add or layer new topics for discussion (Haggerty et al., 2013; Harrison-White & Simons, 2013). The layering of responsibilities during orientation programs provides educators with the necessary information regarding the orientating GNs' mastery of skills, achieved competencies, and individual learning experiences. It also provides GNs with the support and experiential tools necessary to maintain progression during the orientation process, along with assistance in extending the orientation according to the needs of the learners (Goodwin-Esola, et al, 2009; Harrison-White & Simons, 2013; Phillips, Easterman, Smith, & Kenny, 2012). According to past research, traditional orientation programs are not sufficient to train and support new GNs, particularly because they lack the consistency, sustainability, and support of longer orientation programs (Bashford et al., 2012; Dyess & Parker, 2012; Friedman et al., 2013; Haggerty et al., 2013; Phillips et al., 2012).

Consistency

When GNs lack consistency, continuity, and stability during the orientation process, they begin their careers without the tools necessary to make the transition from novice students to advanced beginners (Benner, 1984; Harrison-White & Simons, 2013; Hilli et al., 2014; Welding, 2011). Consistency and continuity when orienting GNs are significant and meaningful components of developing the skills of the GNs essential to their advancing into the professional role of RN. These two aspects during the training of GNs are influential in understanding the complexity of the profession, the autonomy of nurses, the increasing use of technology, and the importance of skill acquisition as new GNs.

Implications

The results of this study allowed me to develop a 6-month TTP and a 3-day preceptor workshop that meet the needs of the stakeholders involved in the orientation process at SHMC. Specifically, I created a design that is viable and sustainable within the SHMC health care system as a model for orientation programs for the parent organization. Implementation of a TTP and a preceptor workshop will include individualized and group training sessions in clinical and classroom settings that promote the development of clinical and critical-thinking skills under the guidance of experienced nurse educators (Beecroft, Hernandez, & Reid, 2008).

The TTP and the preceptor workshop will have a classroom component to reinforce national nursing standards. The topics in the TTP and the preceptor workshop will aid in the development of professional responsibility and ethical behavior, and they

will include nursing policies specific to the regulations of the state, the organization, and hospital policies (Dyess & Sherman, 2009). QSEN competencies will be reinforced and will include evidence-based practice (Gantt & Webb-Corbett, 2010). The economic viability of health care institutions lies in their commitment to the services provided by nursing personnel. The hospital's investment in proper orientation and training programs of their nurses will have long-lasting financial benefits (Fink et al., 2008).

Summary

This section of the study focused on the orientation program provided by the SHMC. The SHMC provides a standard 6-week orientation that does not meet the core competencies of the regulatory bodies in nursing, is fragmented, is not individualized, and lacks formal and summative evaluation processes. These factors have resulted in a cyclical turnover of nursing staff with less than 1 year of nursing experience. Past researchers have contended that providing a well-structured evaluation program designed to meet the specific needs of newly licensed GNs increases patient satisfaction, decreases employer costs, and reduces GN turnover rates.

I used a case study approach to examine the orientation program at SHMC and determine its effectiveness. The methodology that I followed used to examine the orientation program is presented in the next section. Consequent to the successful achievement and implementation of this study, a TTP and a preceptor workshop were developed for SHMC.

Section 2: Methodology

Introduction

I chose a qualitative methodology and case study for the research design and approach for this study to answer the RQs. A qualitative design provides researchers with the opportunity to be descriptive with the data and to practice induction without testing a hypothesis (Lodico, Spaulding, & Voegtle, 2010). Qualitative research focuses on how individuals apply meaning to their experiences rather than relying on numerical outcomes (Bogdan & Biklen, 2007).

Research Design and Approach

I used a case study methodology as the research approach and design. I deemed a qualitative case study method the best way to satisfy the intention, purpose, and RQs. Following a qualitative design allowed me to conduct interviews and collect the participants' perceptions (Yin, 2013). I considered several case study designs but rejected them. I did not use an intrinsic design because the case itself was not of interest to others in the target population. I did not use a collective case study design because this method focuses on one case and one setting only (Creswell, 2012). I used an instrumental study to highlight a local issue in an individual setting and support the RQs and the scope of this study (Creswell, 2012).

Using an instrumental case study allowed me to analyze a subject using one specific setting, which is descriptive of a bounded system (Bogdan & Biklen, 2007; Merriam, 2009). I used a bounded system to focus on one health care institution and its specific practices regarding the orientation of GNs. This focus gave me the ability to

delineate and illustrate the essentials of a bounded system using SHMC's orientation program as the case study (Creswell, 2012; Merriam, 2009). To answer the RQs and facilitate the emergence of data, I used a qualitative methodology. A case study approach was appropriate for this study because this method encouraged the participants to share their feelings about completing the orientation program and assuming their professional role of RN. The use of SHMC as the subject facility provided me with a purposeful sample and met the requirements of a case study.

Access to Participants

To begin the process of conducting this study at SHMC, I sent a letter to the chief nursing officer (CNO) of the medical center to request the cooperation of the research partner. The CNO granted my request. I also sent a letter requesting permission to conduct the study at SHMC to SHMC's Institutional Review Board (IRB). I contacted the IRB at SHMC to gain access to the research site and participants, as well as gather data and conduct the study (Creswell, 2012). I also sought approval from Walden University's IRB to conduct the study. The letter to both IRBs included information about the terms of agreement that I had to follow (Bogdan & Biklen, 2007).

I also prepared a proposal and sent it to both IRBs to ensure the protection of each participant and solicit permission to begin the study (Bogdan & Biklen, 2007). The information in the proposal explained the need for the study and the possible contributions of the research to the hospital's organization, the field of nursing education, and the profession of nursing. I included explanations of the data collection process, the categories of each participant used, and the method of data analysis in the proposal. Once

I received permission from Walden University's IRB to conduct the study (approval #09-18-15-0306892), SHMC's IRB agreed to serve as the IRB of record (approval #15-001).

Participants

I used purposeful sampling in this case study because I selected the participants and the site (Creswell, 2012). Purposeful sampling is a procedure generally used in qualitative research to select participants and the research site to understand the phenomenon (Bogdan & Biklen, 2007; Creswell, 2012; Merriam, 2009). I chose three specific target populations for this case study: GNs, nursing preceptors, and nurse managers. The participants were chosen from GNs who had completed SHMC's orientation program and had been employed at SHMC for less than 18 months. Using participants from this target population helped me to understand the central phenomenon of their experiences during the orientation program, as well as how the orientation program prepared them for their professional role as RNs.

A purposeful sample of six GNs, four nurse preceptors, one nurse educator, and two nurse managers employed by SHMC comprised the sample. Each of these individuals had a defined role in the orientation of GNs (Creswell, 2012). I requested a list of all GNs who had completed the orientation program within the previous 17 months prior to conducting the study. I also requested and received a list of nurse preceptors from the education department at the hospital. I invited all GNs and preceptors on this list via e-mail to participate in the study. I chose six of the participants from the GN group and four of the participants from the nurse preceptor group who expressed an interest in joining the study. I also sent e-mail invitations to the five nurse managers in the

organization. The one nurse educator at the hospital verbally agreed to participate in the study. All participants were required to submit a signed informed consent.

Orientation is an ongoing process throughout the year at SHMC, with six to eight new GNs participating in the orientation program administered approximately every 3 months. Variations among the GN participants included gender, age, and graduation date, as well as the type of nursing school from which each GN graduated (i.e., college, university, diploma, or community college program). No students were involved in this study; all GNs were graduates of schools of nursing, had less than 18 months of nursing experience, and had already completed the orientation program at SHMC.

I sent the initial contact letters to all potential participants according to their individual positions within the hospital organization. The letters explained the purpose of the study, requested their involvement, and explained their role in the research process. I drafted separate contact letters for the GNs, the nurse managers, the nurse preceptors, and the nurse educator.

I selected the number of participants in relationship to saturation and redundancy (Munhall, 2012). The number of participants was based upon Yin's (2013) recommendation that qualitative studies have a minimum of five and a maximum of 12 participants. Saturation was achieved in that unique and unfamiliar knowledge did not become apparent as the categories were refined; at the same time, redundancy was achieved in that no new definitive information emerged from the collected data (Creswell, 2012; Munhall, 2012).

Participants' Rights

All participants in the study were 18 years of age or older. Each participant signed the informed consent, which explained the purpose of the study; participants' rights, including maintenance of confidentiality and the right to withdraw at any time without repercussions; the risks and benefits of participating in the study; the voluntary nature of participation; and participants' right to ask questions (Creswell, 2012). All of my contact information, including my telephone number and e-mail address, was shared with the participants. In a case study, the relationship between the researcher and the informants is ongoing and should evolve over time. As the primary researcher, I did not and do not hold any supervisory position over the participants, thereby avoiding intimidation and possible bias (Creswell, 2012). After receiving site permission, approval from both IRBs, and informed consent from each participant, I begin the data collection process.

I advised the participants that they were not obligated to participate in this study and were free to withdraw at any time without consequence. I explained to the participants that the findings would in no way do them any harm. The participants had nothing to gain by being in this study, and I did not offer them any tangible gifts or rewards to influence their decisions about participation.

As the researcher, I made every effort to ensure the confidentiality of each stakeholder involved in this study (Creswell, 2012). I collected all data and stored them in a locked file cabinet in my home office. I used a password-protected computer to which only I had access (Bogdan & Biklen, 2007; Creswell, 2012; Merriam, 2009; Munhall, 2012). To conform to IRB standards, permission forms were reviewed from each

individual involved in the study. The permission forms explained the intent of the study and the rights of each stakeholder. Each participant had the opportunity and the right to ask me questions prior to beginning the study as well as during the process. To protect the rights of the participants to privacy, I identified each informant using a randomly generated participant number. During the data collection, coding excluded the names of the participants, and I used numbers that were identifiable only by me (Creswell, 2012).

Role of the Researcher

My role as the researcher was to facilitate and contact all stakeholders involved in the study. My involvement was to function as a collector, an analyzer, and an evaluator of the data. At the time of this study, I was the dean of the SHMCSON, which is a separate entity of SHMC. SHMC might employ some of the GNs from the school of nursing after they successfully complete the NCLEX. Postgraduation, I held no direct or indirect supervisory position related to any potential participants who consented to join the study. I held no position within the site chosen for this case study.

I am an RN with more than 27 years of combined nursing and nurse educator experience. My understanding of the health care environment, health care facility policies, national and local health care regulations, and the national regulatory bodies of the nursing profession and nursing education enhanced the outcomes of this study by encouraging best practices related to orienting GNs.

Data Collection

After receiving IRB approvals from Walden University and SHMC, I began to contact participants who met the established criteria approved by each IRB (Creswell,

2012). I sent all participants their respective contact letters via e-mail after I received their e-mail addresses from SHMC's education department. Separate but grouped e-mails were sent to GNs with less than 18 months of nursing experience who met the established criteria, along with all nurse managers, the nurse educator, and all nursing preceptors within the organization.

I chose all of the participants according to established criteria and on a first-response basis until the number of participants in each category was met. As mentioned earlier, each participant had to sign the informed consent before I could begin to collect data from that participant. Prior to signing the consent form and joining the study, a mutually agreed-upon time was set with each participant to meet with me to read the form and ask any questions related to the study (Creswell, 2012; Merriam, 2009). I maintained contact with each participant through e-mails and telephone calls. Using the inductive process for qualitative research, I personally conducted all interviews and reviewed all documents.

I conducted individual face-to-face interviews to gather information related to each participant's experiences during and after the orientation program. To protect the confidentiality and privacy of the participants and their data, I assigned numeric identifiers to them just prior to the interview for identification purposes. Only I knew which numbers had been assigned to which participants.

I also designed the interview questions to address the RQs. I then coded and organized the data to complete a thematic analysis of the testimonies collected (Bogdan & Biklen, 2007; Creswell, 2012). Coding was completed by hand. Data from each

participant group were coded for recurring phrases, words, themes, and concepts. I examined the documents related to the orientation program and the education of preceptors received from the nurse educator at SHMC to understand the principles of the orientation program from its perspective.

Interviews

I collected the data by conducting semistructured interviews with the 12 participants in a private conference room at the school of nursing (Creswell, 2012; Merriam, 2009; Munhall, 2012). This setting was agreeable to all participants. I audio recorded the interviews to capture the interview questions and the participants' responses, and to provide detailed transcriptions (Creswell, 2012). I used an interview protocol form to conduct the interviews and to ensure that I asked all participants the same questions (Creswell, 2012). I asked open-ended questions so that the participants felt free to express their experiences; this protocol also allowed me to ask probing questions as necessary during the interviews and a final question to request additional comments (Creswell, 2012; Merriam, 2009).

Mutually acceptable dates, times, and places for the interviews were scheduled to ensure the best possible outcomes related to participation. The time allotted for each interview was approximately 60 to 90 minutes; this time was sufficient to review the informed consent and allowed the participants to tell their stories (Creswell, 2012). I used an interview demographics (see Appendix B) form as a method to maintain organization related to each participant (Creswell, 2012). I asked the GNs 12 questions (see Appendix C), and I asked the preceptors and managers seven questions (see Appendix D). The

questions for both groups were different and were based upon their positions at SHMC and their respective roles in the orientation program. The nurse educator was not interviewed.

Documents

The second data collection method involved examining and analyzing documents related to the orientation program at SHMC to orient and train GNs, as well as train preceptors (Merriam, 2009). The types of documents that I examined were not available to the public; rather, they were agency records and program documents (Merriam, 2009). To access these documents, I obtained a letter of cooperation from the CNO at SHMC and requested the information related to the orientation of GNs and the training of preceptors from the hospital's nurse educator. Completing this task was the nurse educator's only role in the study. The nurse educator did not participate in the interviews. Examining the orientation program documents helped me to understand SHMC's methods, plans, and goals for the orientation process for newly hired GNs. There were no documents available related to the training of preceptors.

Data Analysis and Validation

I used coding, thematic analysis, and testing alternative interpretations of the data, as recommended by Creswell (2012). First, I collected the data, read and reread the data to obtain a clear understanding of them, organized the data into categories, and coded the responses from the interviews by assigning specific colors to the various themes (Creswell, 2012). The three subsamples of participants described their individual experiences relevant to the orientation program at SHMC. I identified each group as

preceptors (P), graduate nurses (GN), and managers (M). I then assigned randomly selected numbers to each participant (e.g., GN-1, P-1, etc.).

I also reviewed my field notes regularly to ensure the accuracy of the data. I took the field notes during the interviews and recorded them on the interview form with each participant's assigned numeric identifier. Recording the field notes in descriptive and reflective manners helped me to decrease researcher bias (Lodico et al., 2010). At the conclusion of each interview, I used the inductive process to code small amounts of data, which led to a more organized method of data analysis (Lodico et al., 2010).

Analysis of Interviews

The methods that I used were coding, thematic analysis, and testing alternative interpretations of the data, as recommended by Creswell (2012). During the qualitative process, I was cognizant that the following predetermined codes might become apparent and that other codes derived from the data during the analysis would be added using open coding:

1. Length of the orientation program.
2. Assignment of a preceptor.
3. Positive or negative feelings related to support in the role of professional nurse.
4. Consistency of the orientation program.
5. Prepared or underprepared for the role of a nurse.

I completed verbatim transcriptions of the interviews within 48 hours of concluding each one (Bogdan & Biklen, 2007). Through inductive reasoning, I narrowed

the organized data into themes and categories. Coding and categorizing data helped in the analysis portion of the study (Bogdan & Biklen, 2007). After each interview, I examined and then reexamined the data before extracting the resultant codes. As I analyzed the data, I added new and emerging codes and modified existing codes. This process continued as each interview was completed. I then refined all codes discovered at the end of the interview process to prevent duplication and similarity (Bogdan & Biklen, 2007; Creswell, 2012; Lodico et al., 2010). Open coding allowed me to establish parallels, connections, similarities, and relationships in the data collected from which all codes and themes were extracted. The open coding facilitated the addition of three codes during the analysis: curriculum offered during the orientation program, work schedule, and relationship with preceptor.

Analysis of Documents

During the analysis of the documents, I considered their authenticity, credibility, and accuracy, as well their relevance to the RQs (Creswell, 2012; Merriam, 2009). According to Merriam (2009), it is important when analyzing documents to take into account who prepared the documents and where the documents came from. The history of the documents, along with updated revisions of the documents, prior to analysis also played a role in their accuracy and creditability (Merriam, 2009). During the evaluation and analysis of the documents from SHMC, I considered the authors of the documents, their biases, and the original purposes of the documents (Merriam, 2009).

As mentioned previously, SHMC did not have any documents related to a training program for preceptors simply because the organization does not offer a preceptor

training program, according to the hospital's nurse educator (personal communication, November 11, 2015). Therefore, the documents that I received and reviewed were related solely to the orientation program and its implementation at SHMC. I studied the documents for authenticity, credibility, accuracy, and relevance to the RQs and the research project as a whole. I found the documents to be valid and reliable, according to the date of authorship, established as organizational policy, authored by a standing institutional committee. They were complete as originally constructed, and they were given to me by the organization's nurse educator, thus meeting the criteria according to Merriam (2009).

Analysis of the orientation documents identified checklists of skills to be accomplished by all nursing personnel employed by SHMC as a requirement for completion of the orientation program. I also found a standardized method for implementation of the orientation program. The checklists were as follows:

1. Intravenous (IV) proficiency for certification course.
2. Skills competency self-assessment.
3. RN team coordinator general summary competency checklist.
4. RN team coordinator medication administration competency checklist.
5. RN team coordinator IV therapy/central venous access/blood component therapy competency checklist.

I received no other documents related to the orientation program from the nurse educator. The documents did not include a daily or weekly schedule for educational classes for new GNs. The documents did not include forms related to the orientation

program or individual formative or summative evaluations, with the exception of the aforementioned skills checklists.

I examined the documents for common and recurring themes, as previously listed. It is notable that the examined documents did not include a work schedule, evaluation forms, length of time to be spent in orientation program is 6 weeks, a list of designated preceptors on a unit basis, a preceptor training program, an orientation curriculum, and the process or plan how to transition new GNs into the professional role of RN. Lastly, a 1-week classroom experience was indicated as a routine part of the orientation program.

Validity

Validity, credibility, and accuracy are important aspects of any study (Lodico et al., 2010). To ensure validity during the study, I used member checking and triangulation. Because there was more than one data collection method, I used triangulation to compare one data source to another for accuracy (see Appendix E; Creswell, 2012). Transcriptions of all interviews were completed within 48 hours, and the first round of member checking was completed within 72 hours with a time frame of 1 to 2 hours for each participant. During this time, each participant received a copy of the individual verbatim transcription to read and verify.

Member Checking

I shared the preliminary analysis and interpretation of the data with the participants to ensure accuracy, validity, stability, and reproducibility (Creswell, 2012). Member checking provided a safeguard ensuring that the findings were reliable. Member checking allowed the participants to review their own transcriptions and my

interpretations of the data to determine whether I objectively and impartially represented their individual experiences (Creswell, 2012). The use of member checking helped me to maintain credibility and validity during the research process (Merriam, 2009). Member checking also helped me to decrease personal bias or any misinterpretations, such as changing or adding to the perspectives of the participants' data. I shared my interpretations of the codes and themes with them after I had analyzed the data.

During the process of member checking, I asked the participants to verify their answers to the interview questions, ensure that the data were credible, and confirm that I had transcribed their responses correctly. I gave the participants copies of the emerging codes and themes derived from the data analysis. I also asked all participants whether they wanted to make any changes, deletions, or additions to the transcription or to the emergent themes.

Triangulation

Ensuring that the data are accurate and consistent occurs during triangulation, which is the testing of more than one source of data. Contrasting and analyzing each data source against another result in a reliable and valid study (Creswell, 2012; Merriam, 2009). Accuracy and credibility of a study are ensured when each source of information is found to be trustworthy through the examination of all data using triangulation (Creswell, 2012). Triangulating data from multiple sources ensures that the emerging themes are authentic, valid, and credible (Creswell, 2012; Merriam, 2009). Using the different of types of data collected, I drew from distinctive viewpoints to answer the RQs.

Triangulation of the data gave me the information needed to answer the RQs regarding the best practice of a formal standardized orientation program and preceptor training at SHMC. Using different methods offered balance, validity, and credibility to the data collected. Triangulation of the data helped me to draw out each theme and identify any evidence of bias, if such bias had existed. As I analyzed and compared the data, the strengths and weaknesses of each method of collection became evident.

Discrepant Cases

I considered any discrepancies that might have arisen during member checking and/or data analysis and would have reported them in the study if they had existed. However, I found no discrepant cases; the data were valid and accurate. The participants and I discussed the collected data, and no discrepancies were discovered during the study (Yanow & Schwartz-Shea, 2006).

Assumptions

Orientations of GNs into the health care system are intended to provide new GNs with the critical and analytical skills necessary to perform in the professional role of RN (Jones-Bell et al., 2014; Spector & Echternacht, 2010; Ulrich et al., 2010). The most pressing assumption that I made was that the orientation program at SHMC was not sufficient to train GNs with less than 18 months of nursing experience to assume the professional role of RN. I assumed that following completion of the orientation program, these GNs would be able to manage the comprehensive care that patients require. I also assumed that the preceptors who were responsible for training the GNs had been chosen purposefully and had been given a training course. I assumed that the preceptor course

provided information related to formative and summative evaluations of the orientation program, preceptor role and responsibilities, and the progress of GNs. This was a mistaken assumption because there was no training program for preceptors.

Delimitations

I conducted all 12 interviews in a designated conference room in Crean Hall, a building adjacent to SHMC. I conducted each interview, which lasted approximately 60 to 90 minutes; one interview that lasted approximately 52 minutes. Each participant met the criteria to be in the study. All participants (i.e., GNs, managers, and preceptors) were asked the same questions related to their specific roles at SHMC.

Limitations

There were some limitations to using the case study approach in the study. First, SHMC was the only designated site for this study. Although the problem was local as well as national, the case study methodology made it difficult to generalize to a larger target population. The SHMCSON is an entity of SHMC, I am employed indirectly by SHMC and directly by the SHMCSON., and many of the newly hired GNs are graduates of the SHMCSON. It is possible that many, but not all, of the participants were graduates of the SHMCSON. This situation could have created unintended bias based upon my position as a former instructor to potential participants. To ensure that researcher bias did not influence this study, I used member checking and triangulation to establish accuracy, stability, reproducibility, and validity. In addition, I chose the participants on a first-agreement/first-commitment basis to participate in the study in an effort to eliminate the

potential bias of choosing SHMCSON graduates only. I also reported the data as I received them, that is, without the inclusion of personal opinions and perceptions.

The limitation that played a major role in the collection of data was time. Many participants worked 12-hour shifts, so scheduling times for the interviews became an issue. The interviews and member checking were scheduled at mutually agreeable times to give the participants the time necessary to tell their stories and review the data. Completing the interviews, along with hand coding, transcribing, and analyzing the data were time-consuming tasks. With this in mind, the ability of the participants to complete the study was viewed as a limitation.

Organization and Participants

The design of the RQs concentrated on the orientation program at SHMC and how the organization prepared newly licensed GNs with less than 18 months of nursing experience for the professional role of RN. I prepared and asked interview questions to gain insight into the experiences of all participants (i.e., GNs, nurse preceptors, and nurse managers) while working as staff members at SHMC during and after the completion of the orientation program. The participants' individual perceptions, insights, work-related experiences, and beliefs were central to the emergence of seven themes that were fundamental to their individual roles and responsibilities in relation to the orientation program at SHMC and the preparation of GNs to perform in the professional role of RN.

Findings

The seven themes that emerged from the analysis of the interview responses and the documents were (a) length of orientation program, (b) being left alone, (c) critical

decision making and time spent with preceptors, (d) number of preceptors, (e) training of preceptors, (f) training and attrition, and (g) evaluation by preceptors during and at completion of orientation process. A discussion of the findings related to each theme follows.

Discussion of Findings

Theme 1: Length of Orientation Program

According to all of the participants, the length of the orientation program at SHMC lacked structure and organization, and was incongruent with the orientation policies and the realities of daily practice. All participants reported differences in the policies of the orientation program related to the length of the program and the daily reality of the time spent in the orientation by GNs. All participants reported their individual understanding of a range of 6 weeks to 3 months as the designated time frames established by the education department. It was interesting to note that M1 and M2 reported that their understanding of the length time of the orientation was 6 to 8 weeks. Both managers also felt that 6 to 8 weeks was not enough time to orient the GNs.

M1 stated:

> Six to 8 weeks of training is just not enough, absolutely not, when they're done in 6 to 8 weeks, they're not even sure how to do the everyday practical things every nurse should be able to do, let alone begin the process of critically analyzing information.

P1 and P4 understood that according to SHMC policy, the orientation was approximately 3 months. The time frames mentioned by the nurse managers and the

nurse preceptors were starkly different from of the time frame mentioned by the GNs. GN2, GN6, P2, and GN3 believed that they were to have a minimum of 6 and a maximum of 9 weeks of orientation.

P2 stated, "New grads need more orientation; 4 to 6 weeks is not enough. Three or 4 months, I think may be okay, but some may even need more and we need to be aware of that."

GN1 believed that the orientation should be 8 weeks. Conversely, GN4 reported that she had received 6 weeks of orientation and believed that 6 weeks was enough time. P3 and GN5 stated that the orientation was 6 weeks but could be extended if any GNs requested more time.

There were different opinions among the members of each group in the sample as to the actual length of the orientation program; however, the documents revealed 6 weeks as the established length of time offered by SHMC for the orientation of each GN. The participants felt that the orientation process was fragmented related to time inconsistencies. Each participant reported different understandings of the exact number of weeks as stated in the orientation policy. The participants also believed that in addition to the orientation not being long enough, the orientation time decreased as GNs were "pulled off early" or were "pulled" to other units or "other shifts" during their orientation.

GN6 explained, "In between my full orientation time, they pulled me off early. They do that a lot here. They might say you're okay to have patients on your own." The policies, as referenced in the documents, did not support the practice of moving GNs on orientation to other units or different shifts, or taking them off orientation early. M1, P1,

P3, and P4 agreed that this practice had become the norm within the facility, especially when nursing units were short of nursing personnel.

M1 stated, “That is what we do here. I know we should not to this but this has been the practice when we are short staffed and other units have what are considered extra nurses when they are orientating.”

The preceptors had different perspectives from what M1 stated. They reported themselves or their orientees being pulled during the orientation period. According to P4, “They believe that because I am orientating a new nurse, it is okay to pull me and leave the new nurse with another nurse who is very often not qualified to be a preceptor.”

Moreover, all of the participants equally reported that new GNs were “pulled” to other units and given patient assignments that they were not ready to handle and did not have sufficient time to train for within the subjective time frame. Likewise, M1, M2, P3, P4, and P5 expressed concern that the orientation program should be evaluated to assist in the training of new GNs regarding critical decision making and mastery of skills before putting new GNs in charge of critical patients. GN6 and GN4 recounted instances during orientation when they were pulled to the critical care unit (CCU) early during their orientation. GN6 said that “I was horrified when I was told I had to go to CCU, I was not ready. I had only been out of school for a little more than a month and had only been on orientation 2 weeks.”

GN4 explained:

> Early in orientation, I felt very unsure of my ability to make good decisions and then they pulled me to CCU and gave me patients, I still can’t believe they gave

me critical patients. For sure, I learned, but under pressure, that was unsafe, but thank God everything turned out okay.

Summary. Time spent in the orientation gave the GNs the opportunity to be mentored, perfect their skill sets, and develop their critical decision-making skills (Benner, 1984; Harrison-White & Simons, 2013; Hilli et al., 2014; Mariani, 2012). The orientation of GNs, as implemented by the organization, should be encouraged as a policy that is important for patient safety and good patient outcomes. Having the support of the educational and administrative stakeholders has been identified as significant and consequential to an effective orientation process that will train GNs using evidence-based practice (Spector & Echternacht, 2010). Such support will affirm that the practices used will provide the necessary collective and individual training in consistent, accurate, and comprehensive manners.

Theme 2: Being Left Alone

The GN orientees expressed their perceptions that they often were left alone or on their own during their orientation. The GNs spoke of this as an aspect of the orientation that they had not expected. From the perspectives of GN1, GN2, and GN4, there were days when they were assigned patients with some, albeit minimal, oversight from their designated preceptors. During these times, GN1, GN2, and GN4 claimed that they were left alone to make independent decisions related to the care of their assigned patients because their preceptors had patient assignments of their own and were too busy to help them. GN5 and GN6 recalled being pulled to other nursing units, being given patient assignments, and having preceptors to guide them.

GN6 stated:

> When I was pulled to CCU, I felt like the preceptor and nurses there did their best to help me; I felt guided, and everything was explained. I felt that the preceptor there cared about me doing things the right way, but after I went back downstairs to med-surg, I felt as if I was on my own. I was left alone to figure out a lot of things by myself.

M1, M2, and P3 reported that in their view as experienced nurses, putting inexperienced GNs into clinical situations for which they were not prepared and for which they did not have the guidance of preceptors left their clinical judgments up to subjectivity. P1 added that allowing GNs to work on their own before they were ready to assume those responsibilities as advanced beginner nurses without the knowledge base or experiential learning needed put all stakeholders (i.e., other nursing personnel, medical personnel, and patients) at risk. The preceptors explained this from their general perspective as something that had been happening for a great deal of time. P1, P2, and P4 claimed that this situation was a usual occurrence when nursing units were understaffed.

GN6 told of a time when her preceptor was pulled and she was on her own:

> I was scared and nervous because I was left alone many times during orientation because my preceptor was pulled, or she had a set of patients she had to worry about. I had to try to figure things out by myself a lot during the orientation.

The reviewed documents did not support letting GNs practice without the supervision of preceptors during the orientation. Researchers have asserted that paying attention to the safety issues surrounding patient care outcomes and the safe practice of

GNs during the orientation period should be fundamental when training nurses to care for patients with acute and chronic illnesses (Haleem et al., 2011; Harrison-White & Simons, 2013; Mariani, 2012; Romyn et al., 2009).

Summary. The preceptor and GN participants agreed that not having the supervision of experienced nurses during the orientation when critical decisions had to be made was not clinically safe. In addition, transferring GNs from one unit to another did not provide the GNs with a structured orientation; instead, they found themselves constantly transitioning between new preceptors and new nursing units, and lacking the understanding and confidence to practice at a level for which they were not yet prepared. Practicing independently as RNs requires a background and an understanding of the different categories, classifications, and subdivisions of nursing within the acute care setting.

M1 and M2 discussed the GNs being on their own during orientation from a managerial perspective. They argued that according to the orientation policy, the GNs should never be left on their own for one major reason: patient safety. When assigning preceptors to GNs, it was the organization's responsibility to ensure no deviation from the safety measures that were in place during the orientation, even if there were a lack of nursing personnel in the hospital. It was important to adhere to the orientation policy to ensure that no inexperienced orientees were substituted for expert staff RNs.

The provision of expert nursing support by qualified RNs was the responsibility of the organization. In addition, the facility had to ensure the safe practice of GNs by upholding the practice as established by policy that the orientees had to remain with the

preceptors during the orientation period. Using GNs as staff nurses and putting them in positions to make decisions for which they were not ready did not ensure the best possible outcomes for patients, the community, the hospital, and the orienting GNs, as expressed by all participants.

All of the participants also agreed that it was the responsibility of SHMC to ensure that the GNs were not alone to provide care to acutely and critically ill patients without the benefit of having more experienced nurses with them to guide, train, monitor, and confidently ensure that the inexperienced GNs were working within their scope of practice. Moving preceptors to other units and leaving GNs without preceptors or with RNs who might or might not have had precepting experience or who lacked confidence in this area did not safeguard or support the policies of SHMC and the patients.

Theme 3: Critical Decision Making and Time Spent With Preceptors

Critical decision making. Critical decision making in nursing is a skill set that can be taught and learned over time. GN6 recalled a preceptor with whom she was able to spend consistent time. She stated, "I was there for a couple of weeks, so I really got to learn from her. You know, timing of your day, setting priorities, when to pull labs, making tough decisions you know everyday nursing routines."

Having time for preceptors and GNs to collaborate to reinforce the GNs' critical decision-making skills is absolutely fundamental to saving patients' lives. To remove this element from nursing orientation in the way of removing GNs from their preceptors and putting them into situations to make decisions that they are not prepared to make creates

long-lasting effects regarding the ways in which GNs will handle emergent or critical situations as they move forward in their professional role of RNs.

From a manager's perspective, M1 agreed that GNs are very young nurses and that learning how to think critically is a skill set that they will need as RNs. However, M1 explained that in order to meet the needs of the nursing unit, pulling the preceptors and GNs, although not the best alternative, was required to care for the patients at that particular time. Policies related to the day-to-day expectations and routines of each orientation were not expressed during the interviews or in the reviewed documents, which lacked organizational standards regarding a consistent and planned orientation program for new GNs.

Time spent with preceptors. The GN and preceptor participants reported that a kinship developed during the time that the orientees spent with their individual preceptors and when they began to learn how to think critically and make critical decisions in the professional role of RN. Time spent with preceptors, as reported by the GNs, often equated to either increased or decreased ability of the GNs to think through critical and demanding situations. The time spent with preceptors represented the opportunity for one-on-one training and teaching. Preceptor and GN participants reported without this time, confusion and frustration ensued. The GNs needed time to develop the critical reasoning skills and critical decision-making skills that they did not yet possess as GNs.

Preceptors and GNs noted that the learning needs of the GNs in regard to critical decision making were not factored into the orientation plan and that from their perspective, the orientation program did not provide for individualization. These critical

decision-making skills come with direction, time, and guidance. P2 recognized that although the GNs lacked critical decision-making skills, they could gain these skills through experiential learning and guidance. P1 and P4 discussed their role as preceptors being difficult to manage when it was related to evaluating progress when they were not able to work with their assigned GNs consistently. The benefit that organizations provide for experiential learning in health care for nursing personnel requires a format during orientation that is supportive not only of new colleagues but also of colleagues who are willing to share their years of experience and expertise.

M1 shared her belief as a manager that GNs should not be pulled to CCUs and should not be pulled at all for 6 months to 1 year. M1 added, "We very often pull them anyway because of staffing or the only preceptor available works in the ICU or CCU, this is dangerous as these units require special training that they do not have."

The interviewed GNs reported being pulled or having more than one preceptor during their orientation. The GNs also felt that as new graduates, they did not benefit from learning when they were being placed with different preceptors. The GN participants felt that there were many different practices related to nursing procedures, including how to set priorities and how to schedule the workday. They stated that they had to find coping strategies that worked for them to decrease their frustration and confusion and manage the care of patients during their assigned shifts. P3 expressed this concern in the comment, "When they are spread out all over the place with so many different people and so many different ideas and they work with nurses who should not be precepting, how do they learn to make the right decisions?"

P1 acknowledged that it was difficult to begin the science of critical decision making when the GNs learned so many different personal work-related styles during the orientation because they had several preceptors while in the orientation program. P1 stated, “I think it’s difficult for us to give them that foundation in making critical decisions when they have been taught different ways from different nurses on how to solve problems.”

The science of critical decision making in nursing is not an easy skill set to teach or to master. All of the participants (i.e., GNs, preceptors, and managers) agreed that this skill set should be taught by experienced preceptors in a consistent manner. P4 supported this assertion by noting, “This is not an easy thing to teach, or to judge, it’s even more difficult when you’re not with them all the time.”

Time spent with many different preceptors who had no standard protocol regarding education and training seemed to reflect the misguided value of quantity over quality. This happened when nurse preceptors were pulled or the GNs were pulled to other units, leaving GNs with new preceptors during their shifts.

GN6 stated:

> I had five different preceptors and one was in CCU, I was pulled to CCU, so the amount of time I had with each one, it’s hard to tell exactly. They all did things differently and they all taught differently.

Summary. The preceptors and the nurse managers felt that pulling GNs into critical care areas at SHMC posed an increased risk of harm to patients and additional risks of sentinel events happening within the health care facility itself. Recent GNs who

possess entry-level knowledge want to continue their education beyond the classroom to obtain experiential learning based on current skill sets, not staffing needs. SHMC is responsible for ensuring that the communities being served receive the safest care possible. Staff nurses with little experiential learning related to acute care and a lack of specialty training for critical nursing care are not prepared to care for patients with life-threatening problems. These patients require complex care, and nurses must have the ability to make immediate critical decisions. GNs are not prepared to provide this level of care to patients without the training needed. Putting GNs in this position is a patient safety issue.

Theme 4: Number of Preceptors

The number of preceptors, as reported by all of the participants, was discussed in terms of the GNs not having steady, unchanging, reliable, and experienced nurses as preceptors on a consistent basis during the orientation program. All participants reported this as a preeminent element that prevented GNs from obtaining the skills that they needed on a daily basis to advance into the professional role of RN.

M2 felt that having one designated skillful and adept preceptor during the orientation led to stability of training and provided the correct information regarding policy-driven procedures. M2 reported that in his department, a change had been implemented to ensure that each hired GN would receive one-on-one consistent training that he felt was needed for success. M2 conceded that according to the hospital's orientation, this type of training was not being done on the medical surgical units of the hospital. All participants believed that assigning one preceptor to one GN would generate

better outcomes for each patient under the care of GNs during the orientation and into the future.

M2 believed, “I think they need the consistency to build relationships, learn how to critically think and set priorities so they keep the same preceptor here. I tend not to change preceptors in my department.” The present assignment, as reported by the all participants, of three; four; and, on one occasion, five different preceptors left GNs confused about the most accurate and standardized methods of performing procedures, understanding organizational policies, and caring for patients.

GN6 said, “I had one preceptor in the ER, one in CCU, and three different preceptors in med-surg, and one was a charge nurse who did not have time to help me. That was scary.”

The preceptors commented that when the GNs had to work with several different preceptors, the GNs were left with different opinions about the methods used to interpret, apply, and comprehend the hospital’s policies during the orientation program.

P2 claimed, “It’s not done like the orientation paper works says. On any given day the person I am orientating could be on the monitor with the telemetry (tele) technician (tech), with me, or with the unit secretary without advanced notice.” GN2 reported having four preceptors, GN3 had three preceptors, GN4 claimed to have had three preceptors, GN1 reported four preceptors, and GN5 reported four preceptors.

Summary. Competency of GNs begins during the formal introductory period into professional practice. The orientation to the health care organization serves as this introductory process. Having a standardized and evidence-based process is crucial to the

quality and merit of the program itself. The participants felt that to establish the expectation of one preceptor to one orientee during the time in the orientation program and then not follow through was substandard. They believed that the organization had a responsibility to the GN, the nurse preceptor, and the patients to execute the policy as written. The understanding of each of the groups interviewed was that the policy had written provisions for one preceptor for each GN during the orientation. The SHMC documents supported this understanding and provided for one assigned preceptor for each GN during the orientation. I did not find any statements in the documents regarding the number of preceptors to be assigned. Safety is an issue when GNs with entry-level knowledge are assigned to units in the hospital that take them away from the watchful eye of preceptors tasked with the responsibility of training and helping the GNs to transition into the professional role of RN. Without a policy-driven and standardized format for this process, the participants felt that the GNs did not have the opportunity to identify and improve upon their weaknesses and build their strengths.

Theme 5: Training of Preceptors

This theme was representative of preceptors not having the training that all of the participants believed was needed to serve as preceptors within the organization. Lacking a systematic educational framework from which they could base the policy-driven orientation, all of the participants reported seeing the need for an evidence-based process for preceptor training.

P4, the only preceptor who recalled attending a preceptor training class, stated, "I remember going through a preceptor course here. It was a long time ago, but they have not offered that in a very, very long time. I think it would be helpful to have that again."

The participants felt that this course was needed for various reasons, including, but not limited to, teaching concepts, training related to evaluating GNs' progress, having one format that all preceptors could follow, understanding what was expected of preceptors, and having a cognitive mastery of what was involved in the orientation policy and process as a whole. M1 and M2 agreed that a formal training process for preceptors within their departments would be welcome. When discussing how preceptors were identified, M1 and M2 looked to the more experienced and competent nurses in their respective departments. They stated that they would welcome formalized training for the nurses whom they had identified as preceptors and believed that this training should rest with the education department.

In regard to how the preceptors understood the present orientation program and the perceived inconsistencies in the orientation process, the manager and preceptor participants discussed staffing issues versus helping new GNs and how the information was interpreted differently by each preceptor. All of the preceptors agreed that the orientation was fragmented and that hospital policies often were interpreted differently and subsequently taught to GNs in ways that were not congruent with SHMC's policies. P1, P3, and P4 believed that the incongruencies regarding GN training were found in the orientation policies as written, the daily realities of orientation, the movement of GNs and

preceptors to other units, and the assignment of inexperienced nurses to the role of preceptor.

P5 claimed that when she or her orientees were pulled to other units, the orientees did not go with her and were assigned to other nurses who might not have precepted before. P3 and P5 also mentioned that after GNs were moved to other units for several days and then returned to them as the original preceptors, they did not receive reports or updates on the GNs' progress or problems when they were on the other nursing units. The preceptors believed that training would help to solve many of the issues and increase communication between the education department and the managers, preceptors, and GNs. The participants also believed that a training program for preceptors would lead to the development of a manual or some form of documentation outlining the role and responsibilities of preceptors.

The preceptors believed that it is crucial that nursing leadership and educational leadership support the educational needs of nurses who are responsible for training newly hired GNs. The preceptors discussed the evaluation process of each GN as completing the checklist provided by the education department. The participants did not discuss a formative or summative evaluation of GNs. M1 claimed that the evaluation consisted of the checklist and a weekly meeting with the manager, the nurse educator, the GN, and the preceptor; however, the GN and preceptor participants claimed that they were not involved in the weekly meetings described by M1.

Summary. Everyone involved in the training process is obliged professionally to be familiar with and understand it. Training regarding the expectations of the

organization and the methods used in the existing program is necessary for all individuals responsible for delivering the orientation program. Each individual involved in the step-by-step delivery of the orientation program is expected to understand the expectations and have a voice in the process. Those responsible for disseminating the program goals are expected to have a baseline education related to the group and individual expectations and how to present the information that they are expected to share. Training for the preceptors would benefit from a standardized format with specific time frames, an orientation plan, and a specified formalized evaluation plan of GNs.

Theme 6: Training and Attrition

The participants expressed concern about the training provided by SHMC to GNs and the attrition of GNs after they had completed the orientation. The participants discussed the types of additional training that they believed would be helpful to the GNs during the orientation. Obtaining unit-specific certifications, more classroom time, and disease-specific simulations were some of the topics discussed by all participants. The managers and preceptors discussed the attrition of GNs from the perspectives of expending time, effort, and money to train GNs and then seeing them leave the facility.

Managers and preceptors claimed that GNs were leaving SHMC within 6 months to 1 year of hire. They also claimed that there was no effort to understand why they were leaving and what could be done to retain them after orientation.

M1 stated, “We spend so much money training them, and then a few months later they’re gone. So where are our studies on attrition and recruitment? Do we actually find out why people are leaving”?

Managers and preceptors also claimed that the GNs often needed more time during the orientation but were afraid to ask for more than 6 weeks. Eventually, they left SHMC for organizations that provided longer orientations.

P1 stated, "There are many reasons they tell me they're leaving after staying for maybe 6 months, the biggest they don't feel supported. They leave for other places that have longer training programs, and some leave for money."

The participants expressed frustration and sadness when discussing the attrition of GNs whom they had mentored. P2, P3, and M1 stated that mentoring GNs and working with them as colleagues over several months and then learning that they were leaving the organization was difficult, especially when the cycle repeated itself continuously. The participants mentioned the need for change regarding orienting that would help to keep GNs at SHMC.

P3 and P4 expressed the need for support from nursing managers and nursing administration to dialogue with nursing preceptors about the orientation process and unit-specific training that they believed was needed for GNs in the clinical setting. The participants claimed that there was a lack of communication between the education department and the nurses involved in the day-to-day orientation process regarding training, unit-specific training, and what the GNs needed to be taught. P1 and P3 asserted that when GNs are hired to work on specific nursing units, they should be provided with unit training. The participants agreed that GNs receive computer, medication cart, glucose monitoring, and other training required to accomplish their tasks on a day-to-day basis.

There was a difference of opinion between M1 and the preceptors regarding training for advanced cardiac life support and telemetry certifications. M1 believed that these course were offered to all GNs, but the preceptors believed that they were offered only to GNs who worked in critical areas such as CCU and the emergency room (ER).

M2 had a different perspective. He believed that the training that he offered to GNs should extend beyond the hospital setting. M2 described sending GNs to classes and seminars for unit-specific training that was not otherwise offered at SHMC:

> I think there should be more opportunity for off the clinical floor orientation throughout their orientation. For example, in our department right now, I have about five or six new hires who are new graduates and each of them are being sent out to unit specific courses. When they come back, they're going to be doing some pediatric certification classes. I think that there should be more of that here. I think this is lacking when it comes to the floors and training nurses. I think people can fall through the cracks because there's no standardization across the units. We need to provide them the education they need to be successful, and maybe if we show them we want them to be successful they will stay.

Summary. The orientation used many nursing resources on a day-to-day basis, and the participants wanted to be included in the planning process of the orientation as the individuals responsible for delivering the program. Hospital resources used to provide training for the newly licensed GNs were costly and time-consuming components. The participants believed that unless this training was provided, the organization would continue to see ongoing and cyclical attrition.

Theme 7: Evaluation by Preceptors During and at Completion of the Orientation Process

The participants discussed the evaluation process used in the orientation program. The evaluation of nurses during and after the orientation centered around a skills checklist. The participants believed that the lack of a formalized evaluation process resulted in a great deal of subjectivity related to how the GNs were progressing and what their present and future educational needs were.

According to the GNs, the evaluation process consisted of a checklist; however, depending on the preceptors to whom they were assigned, their evaluations during the orientation were subjective. Very few participants spoke of a summative evaluation process. In addition, some self-directed participants who requested feedback on a daily or shift-by-shift basis noted that this was not standard practice. The GNs described asking how they were doing so that they could determine their own progress during the orientation. The subjectivity of the evaluation process left them feeling either confident or unsure of themselves. GN1, GN2, and GN6 reported doing extra studying on their own using the hospital policies, their textbooks, or other resources within or outside of the facility. M2 believed that evaluations following an organized and uniform format should be ongoing during the orientation, unbiased, and overseen by managers and nursing education.

Summary. The preceptors and the GNs claimed that weekly meetings were supposed to be part of the evaluation process, but they were not taking place. The participants also believed that evaluating GNs' progress during the orientation was a

priority only if the GNs were making mistakes. Without the benefit of a formative and summative evaluation process as well as evaluations routinely by the nursing preceptors, nurse educators, and managers, the GNs lacked an understanding of what they needed to advance in their professional role of RN. The preceptors and GNs also agreed that without routine evaluations, the orientation program will not improve and changes will not be made.

Interpretation of Findings

Based upon the data analysis, emergent themes, participants' stories, the three RQs posed, and a detailed examination of the orientation program's documents, following is a discussion of the findings of the study. During the data analysis, I found that each participant group (i.e., GNs, preceptors, and managers) reported working under time frame assumptions that were not congruent with SHMC's orientation documents delineating a specific time frame of 6 weeks for all nurses to complete the orientation. In addition, all participants agreed that the orientation should be longer, with the majority of participants agreeing that it should be 3 to 6 months. This response answered RQ1 (What are the perceptions of newly licensed nurses after completion of the orientation process related to their ability to make critical decisions in the professional role of RN?). This finding agrees with previous findings that a systematic and longer orientation of 6 to 12 months is beneficial to new GNs and will improve patient care outcomes and the GNs' critical decision-making skills more than an orientation of less than 6 to 12 months would (Romyn et al., 2009; Roth & Johnson, 2011; Rush et al., 2013; Spector & Echternacht, 2010; Ulrich et al., 2010; Welding, 2011).

All three groups of participants (i.e., GNs, preceptors, and managers) reported inconsistencies such as time frame for completion, one-on-one GN-to -preceptor training, documentation of checklist completion, GN patient care assignments, and "pulling" of GNs and preceptors during the orientation period in the orientation program. According to the longitudinal study by Roth and Johnson (2011), consistency plays a major role in the success of an orientation program and improved patient care outcomes. Bratt (2009) reported that GNs enrolled in longer orientation programs that provided consistency and experiential learning opportunities helped to improve the GNs' critical decision-making skills.

Each group of participants reported GNs being pulled off the orientation before completing the program, and the GNs recalled being left alone during the orientation without the direction of preceptors. These responses provided insight into RQ1 and RQ3. Research has shown that consistent training by experienced nurses during the orientation period and the benefits of nursing mentors following completion of the orientation are essential to the professional and emotional growth of GNs (Roth & Johnson, 2011; Ulrich et al., 2010; Welding, 2009).

Likewise, in regard to RQ2 (How does the preceptor educational training program prepare staff nurses for the role of preceptor?), the interview responses of the preceptors and managers, along with the analysis of the orientation documents provided by SHMC, indicated that no educational training program for the role of preceptor was in place or was being offered by SHMC at the time of this study. Results indicated that all of the interviewed preceptors and nurse managers believed that a training program for potential

preceptors would be beneficial to nurses serving in this role and that they would welcome the opportunity to participate in a specific training program.

Swihart (2012) discussed the importance of providing training to nurses serving as preceptors and saw this training as a significant aspect of an orientation program. Providing education to GNs participating in an orientation at a health care facility relevant to the professional role of RN and the development of critical decision-making skills also should involve training the nurses who act as their preceptors (Romyn et al., 2009; Roth & Johnson, 2011; Spector & Echternacht, 2010; Welding, 2009). The responses of the nurse preceptors indicated that they perceived the need for preceptor training that would be uniform and meet the expectations of SHMC. I also found that all of the nurse managers and nurse preceptors in the sample expressed the need for educational training regarding the process of evaluating GNs. Their responses provided insight into RQ1 and RQ2.

In regard to answering RQ1, no formative or summative evaluations of GNs during and after completion of the orientation were found. Orientations that do not have formal methods for objective feedback regarding the progress and safety of GNs to practice within their chosen health care facilities cannot determine whether the GNs can think critically related to patient safety and patient outcomes (Spector & Echternacht, 2010; Romyn et al., 2009; Roth & Johnson, 2011). All of the participants (i.e., GNs, preceptors, and managers) agreed that a formalized educational program for preceptors would be beneficial to SHMC and to all nurses serving in the preceptor role.

Pertaining to RQ3 (What are the beliefs of newly licensed nurses and nurse managers regarding the role of the nurse mentor?), one nurse manager believed that the GNs were always working with nurse preceptors to guide and assist them when they had to make critical decisions about patient care during the orientation. All of the other participants (i.e., GNs, preceptors, and other managers) believed that the GNs had to make critical patient care decisions during the orientation because they often were left alone (i.e., without preceptors). Roth and Johnson (2011) as well as Spector and Echternacht (2010) asserted that preceptors are an integral part of the orientation process and should be present with and invested in the GNs whom they are training. In their longitudinal study, Roth and Johnson discussed the benefit of designated and long-term preceptors serving as experienced guides and mentors during and following completion of an orientation program. They asserted that the guidance and mentoring provided by preceptors was essential to the ability of GNs to deliver safe patient care during and after participation in an orientation program. Spector and Echternacht (2010) noted that preceptors are essential to the development of GNs and that when preceptors are trained in their role, they can provide the guidance that GNs need in the short term and the long term to assimilate to the professional role of RN.

In addition, the preceptors and the GNs believed that assigning GNs to other nurses on different nursing units who might or might not have served in the role of preceptor before, and who might have less than 1 to 2 years of nursing experience, was an unsafe protocol that was not beneficial to either patients or GNs. These beliefs reflected what was asked in RQ2 and RQ3. When there is consistency in the orientation process

and experienced nurses serving in the role as preceptors who have completed a preceptor training program, the practice readiness of GNs increases (Romyn et al., 2009; Swihart, 2012).

Developing the findings into themes allowed me to understand the difficulties and challenges related to the orientation program at SHMC. The themes also helped me to see how and how much the orientation program affected the outcomes of daily patient management. Through the data collection process, the GNs, managers, and preceptors provided clear narratives of the orientation program and what they experienced as participants in the program.

The findings suggest that in its present state of implementation, the orientation program deviates from the original standards and guidelines of the policy. The findings also suggest that staff (i.e., preceptors and nurse managers) involved in the nursing orientation need additional educational training. The preceptors and the managers reported having different understandings and interpretations of the orientation policy provisions and limitations. In addition, I found no formal method for educating and training preceptors in the orientation documents provided by SHMC. According to my analysis of the data, the findings suggest two areas of need, namely, a longer and more organized orientation program of at least 6 to 12 months for GNs and a comprehensive training program for nurses acting in the role of preceptor in the orientation program.

Conclusion

I designed the RQs to understand how the SHMC orientation program prepared GNs for the professional role of RN. In the literature review in Section 1, I explained the

need for experiential learning and the stages of nursing expertise according to Benner (1984). These stages were spotlighted during the case study and were found to be absent from the orientation process. I explained the problem and the rationale for the study as possible areas of improvement related to the orientation program provided by SHMC. In Section 2, I explained the methodology for the SHMC case study design to determine whether the orientation program met the standards of best practices regarding the continued training of GNs postgraduation. I designed the case study and explained the methodology to obtain the perceptions of beginner GNs who had completed the orientation program, preceptors, and managers to understand their experiences during and after the completion of the orientation program.

I collected data by conducting interviews and reviewing documents. I then analyzed the data and extracted the themes. The concerns shared by all participants (i.e., GNs, preceptors, and managers) about the orientation program and the day-to-day realities of caring for patients in an acute care setting were centered around patient outcomes and patient safety. I conducted individual interviews with the 12 participants so that they could tell their stories. All interview responses were recorded and transcribed verbatim. Member checking was completed with each participant, and the data were analyzed. Based upon the results of the data, I designed a TTP and a preceptor training program for SHMC in an effort to effect social change.

Section 3: The Project

Introduction

As previously discussed, the purpose of this qualitative study was to determine how the orientation program at SHMC helped GNs to transition into the professional role of RN. In Section 3, I discuss the goals and rationale of the project, proposed project implementation, the time line, and a final literature review. I designed a two-part project for SHMC comprising a 3-day preceptor workshop and a 6-month TTP. Educating the preceptors and managers who are responsible for administering and delivering the program is essential to implementing an evidence-based orientation program.

Description and Goals

The goals of the study were to determine whether SHMC's orientation program was preparing newly licensed GNs for the professional role of RN and to understand the educational preparation of nurse preceptors assigned to train and educate these GNs. Another objective was to determine what could be done to help SHMC to design and implement an evidence-based orientation program for new GNs as well as a preceptor training workshop.

I chose to develop the TTP and the preceptor training workshop based upon interview responses from the participants indicating that the orientation program needed to be improved and that the preceptors required formal training. Helping GNs transition from the role of student to that of RN requires that their education continue in the health care setting. Experiential learning under the supervised guidance of experienced RNs (i.e., nurse preceptors) fosters ongoing education in a safe and supportive environment.

The participants agreed that the orientation program did not provide sufficient time and education for GNs to learn and grow professionally and did not offer training to nurses serving as preceptors at SHMC. Changing and redesigning the orientation program and adding a preceptor training workshop can give SHMC an evidence-based approach to meeting both challenges. The results of the study can be used by the education department at SHMC to help to prepare GNs to assume the responsibilities of the professional role of RN.

Rationale

Prior to considering and undertaking this project study, I considered several areas that would effect social change at SHMC. I chose to conduct a qualitative case study to examine how GNs were trained and prepared for the professional role of RN following graduation from a school or college of nursing. The results identified the need for revisions to the orientation program at SHMC that would offer consistency and would be relevant to the daily needs of all stakeholders in the program. The need for both parts of the project was revealed in the data.

The participants discussed the length of the orientation program and the time spent in the program as inconsistent, stopped, interrupted, and too short. All participants agreed that the orientation could or should be longer than the 6 weeks mandated in SHMC's policy. I analyzed the data and determined that development of a longer TTP should be the focus of the project study. The data also revealed a lack of training for nurse preceptors. The preceptors agreed that there was no training program that they had to complete to serve in the role of preceptor. There was no mention of a preceptor

training program in the orientation documents for preceptors, and the hospital's educator confirmed that a training program for nurse preceptors did not exist within the facility. Subsequently, I decided that to facilitate an evidence-based change in the orientation program, I would develop the preceptor workshop and the TTP as the two parts of my project.

As mentioned previously, I decided that the two parts of this project would be a 6-month structured TTP and a 3-day preceptor workshop. In preparation for the development of the project, I was aware of the three domains of learning (cognitive, affective, and psychomotor), and I understood that all learners do not learn in the same fashion. I also was aware of the difference between the paradigms of pedagogy and andragogy and was cognizant that the participants in the two parts of the project would be adult learners. Therefore, I selected various instructional strategies to present both parts of the project, including slide presentation, role-play, journaling, unit-based education, hospital-based education, clinical skills exercises and education, interactive learning, medium- and low-fidelity simulation, online patient simulation, small- and large-group discussions, and formative and summative evaluations.

On Day 1 of the workshop and the TTP, participants will receive an information packet outlining the activities for each day of the workshop and the weekly activities for the TTP. I will organize the 6-month TTP on a monthly basis and break it down into weekly topics. The information will be provided to all participants as well as the designated preceptors assigned to the GNs. It will be important to group the information on a week-by-week basis for ease of understanding and implementation for all

stakeholders involved, given that the TTP will be implemented over 6 months. Following completion of the 3-day workshop, I will schedule a date and time as a planning day for nurse preceptors, hospital educators, and nursing administration to collaborate in redesigning the orientation policy. The goal of this collaboration will be to bring personnel in the administrative and staffing areas of nursing together to work toward designing a policy that will benefit all stakeholders.

Review of the Literature

The literature review helped me to gain a fuller understanding of staff development, experiential learning, and continuing education for adult learners. I searched scholarly journals for peer-reviewed articles related to program evaluation and health care, nursing practice education, and preceptorships. The databases used to conduct the literature review were CINAHL Plus with Full Text, Thoreau, EBSCO, ProQuest, ERIC, SAGE Premier Full-Text, Google Scholar, Nursing Resource Center, and Dissertations and Theses at Walden University. Key words used to conduct the search were *preceptorships*, *staff development*, *continuing education in health care*, *adult learning theory*, *graduate nurses*, *nursing orientation*, *simulation*, *learning management systems*, *workshops*, *nursing education*, and *experiential learning*. Researching the peer-reviewed articles and specific textbooks gave me a better understanding of PD and helped with the development of this project study.

Staff Development

Changing the culture in the acute care setting requires ongoing training and staff development that are sustainable and support the personal growth and skill set attainment

of all nursing staff (Seibold & Gamble, 2015). Hospital nurse educators are responsible for staff development, or they might even comprise the education department, in the health care setting, and they can play a major role in providing the training and education of staff members, GNs, and experienced RNs (Chunta & Katrancha, 2010). The development of staff competence has historically been limited to in-services that are provided by outside product vendors and address nursing unit-specific problems as they arise in the clinical setting. Staff development in the complex and evolving health care environment should meet the needs of nursing staff to promote positive patient outcomes and relieve unit-specific problems (Lima, Jordan, Kinney, Hamilton, & Newell, 2015).

Staff development should be about nursing competence, professional practice, training, and the development of knowledge and skills using findings, data analysis, and outcomes evaluations (Boyer, 2008; Okougha, 2013; Romp & Kiehl, 2009). To promote better patient outcomes, nursing training should continue postgraduation for GNs and during experienced RNs' careers in the health care setting (Chunta & Katrancha, 2010). Progressive nursing education departments are moving away from vendor-sponsored and unit-specific, problem-based education toward the provision of educational opportunities that stress critical thinking, skills improvement, competency, decision making, application, reflection, supervision, and experiential learning (Fitzgerald, Moores, Coleman, & Fleming, 2015). Staff education should continue long after the novice educational experience is complete in order for GNs to reach the expert level in nursing to become proficient and competent RNs (Benner, 1984). Nurse educators in the hospital setting should focus on the PD of nurses at all levels of experience.

Understanding that nurses are not equal in their nursing knowledge or skills, nurse educators should provide different learning opportunities for nursing staff. Staff developers who use different teaching modalities to deliver the education needed by nursing staff consider the different learning styles of staff members (Cubit & Lopez, 2012). Efforts to present information to nursing professionals should target the educational needs of new GNs as well as experienced RNs in order to achieve effective and long-term success regarding professional competency (Chunta & Katrancha, 2010; Lee, Kim, & Kim, 2014; Lima et al., 2015). Relying less on vendor presentations and unit-specific, problem-based education, and replacing them with learning management systems (LMSs), workshops, and simulation gives educators and learners a balanced approach to staff development in the health care setting.

Online Training

LMSs in the hospital setting to advance staff development have become increasingly popular in delivering traditional classroom concepts to working nursing professionals (Ma & Harmon, 2006). LMSs are used in the health care setting to provide online educational experiences that were once completed in the classroom setting (Macnaughton & Medinsky, 2015). Annual nurse competencies and hospitals' mandatory education are typically delivered using this educational method. The educational modalities delivered through a hospital LMS can be used for staff development as a self-directed learning experience (Ma & Harmon, 2006). Educational modules can be offered through LMSs, allowing staff to register for short online classes that might be completed in the health care or the home setting (Yoon, Song, & Lim, 2009).

The benefits of a hospital LMS as a method of staff development are the convenience, the numerous educational offerings, and the various nursing and health care topics found in the LMS. Learners can complete a module at their own pace, or they might be assigned specific modules with deadlines for completion (See & Teetor, 2014). After completing a module, learners might complete an online assessment, which is generally scored and graded once the course is complete. Learners can receive their individual assessment scores and rationales for any incorrect answers. Learners also can print out a certificate after completing a module that might offer continuing education units. The drawbacks for learners of an LMS are individual learning styles, lack of computer access, and a lack of technological proficiency or comfort using an LMS (See & Teetor, 2014).

Workshops

Research has shown that education has a positive effect on nurses' attitudes related to patient care and patient care outcomes (Bailey & Hewison, 2014; Banks & Zionts, 2009; Benner, 2004; Bobay et al., 2009; Hilli et al., 2014; Ulrich et al., 2010). Workshops are intensive, structured educational programs that focus on techniques and skills in particular fields. Workshops can be general sessions that are open to everyone, or they can be closed training sessions related to specific topics within professional fields of study (Bellolio & Stead, 2009; Drey, Gould, & Allan, 2009). Workshops for the purpose of PD in the health care setting should provide opportunities for training that are interactive, informative, and goal specific to meet the specific needs of the learners. Staff

development nurse educators play a principal role in the dissemination of information, choice of venue, and selection of educational materials.

Staff educators must keep in mind the audience for which workshops are prepared and the time frames needed to present the content. When planning a workshop for experienced RNs, one should ensure that the depth and breadth of information meet the educational needs of the participants (Nicol & Dosser, 2016). GNs required to attend staff development workshops should not feel intimidated about the information being taught. The purposes of workshops for adult learners should be clearly understood and should relate directly to the learners' abilities and daily responsibilities in the workplace.

The challenge for staff developers is to ensure that educational offerings achieve the goals and outcomes required to provide long-term benefits to the organization and the learners (K. Johnson, Vaughan, & Lynall, 2014). Workshops for new GNs and experienced RNs should begin to build a foundation related to the specific material being offered that will be applicable to participants' responsibilities.

Workshops that are successful and meet the learning needs of nurses decrease turnover and lead to more positive work behaviors (Corcoran, 2016). Ongoing and structured education provided by health care organizations provide an opportunity for new GNs and experienced RNs to reflect on their individual professional practice. The opportunity to explore work-related concerns in an educational environment can help to bridge the gap between health care theory and nursing practice (Miltner, Jukkala, Dawson, & Patrician, 2015). A key component of any workshop is validation of its success through formative and or summative evaluations.

Simulation

The use of simulation as an instructional strategy for staff development provides nurse educators with another approach to the training of staff with different levels of competency with respect to the clinical judgment of GNs as they advance toward the professional role of RN. The objective of clinical simulations involving nurses should be the long-term improvement of clinical skills as well as the daily performance of nurses in the real-world clinical setting. Staff developers might use the educational modality of simulation as an opportunity to teach leadership skills and facilitate collaboration and teamwork between nursing and medical personnel. Simulation should be used with GNs during the orientation program so that staff development educators can judge their clinical knowledge and competency in a safe educational environment (Roche, Schoen, & Kruzel, 2013).

Experienced RNs could benefit from working collaboratively with nurse educators to reinforce and refresh their nursing competencies and nursing skills and to identify personal areas of strength and weakness. RNs could use simulation related to daily tasks such as communicating with patients, assessing vital signs, correctly interpreting laboratory tests, and administering medication correctly. High-risk simulations might include such scenarios as cardiac and respiratory arrest and intracranial bleeding. The responsibility of preparing and planning simulations requires a staff development team whose members understand and can differentiate between the learning needs of nurses on the novice-to-expert continuum. According to Josephsen (2015),

critical decision making and gains in knowledge through simulation are related to positive patient outcomes.

Educators play a defining role when implementing simulation experiences. Simulations can have long-lasting positive effects as well as result in situations where learning is inhibited (Josephsen, 2015). Simulations are guided clinical exercises that require a team approach. The educational team members are responsible for planning, providing a script or focused scenario, assigning roles for each nurse and physician, managing time, ensuring that the equipment is working, and debriefing (Zekonis & Gantt, 2007).

Although simulation has proven to be a safe learning environment for GNs as well as experienced RNs, the cost-benefit ratio of high-fidelity (HF) to low-fidelity (LF) simulations has not shown a significant difference (Chen, Grierson, & Norman, 2015; DeStephano, Chou, Patel, Slattery, & Hueppchen, 2015; Nimbalkar et al., 2015; Norman, Dore, & Grierson, 2012). In a randomized study of advanced-level nursing students regarding skills acquisition (Chen et al., 2015), HF simulation did not prove to be more beneficial than LF simulation. In this same study, the LF simulation participants demonstrated skills performance that was comparable or superior to that of the HF simulation group. Results showed that GNs would have equal or better learning outcomes in a simulation environment that is less complex but meets their educational needs.

A simulation learning environment that is too complex does not lead to long-term learning and does not benefit the learners or improve patient outcomes (Josephsen, 2015). Norman et al. (2012) found a minimal correlation between the use of costly HF

simulators and LF simulators and clinical performance in a review of 18 studies related to the simulation of auscultation skills and the complex management of cardiac resuscitation. Another barrier to HF simulation, as opposed to LF simulation, is not the cost to some organizations, but the training and use of HF simulators (Al-Ghareeb & Cooper, 2015). If educators do not have adequate training and education on the use and integration of HF simulation, usage does not occur, leaving organizations with costly HF manikins without the personnel to implement and integrate complex simulations into the curricula or staff development (Al-Ghareeb & Cooper, 2015).

Nursing is a profession that requires rehearsal (Al-Ghareeb & Cooper, 2015). Experiential learning is an important aspect of providing competent nursing care in a real-world setting; simulation gives nursing staff the opportunity to learn in a safe and guided instructional environment that supports long-term learning and offers a place to make errors without causing patients harm (Basak, Unver, Moss, Watts, & Gaioso, 2016; Benner, 2004; Josephsen, 2015). Having GNs and experienced RNs learn in a real-world setting and make real-world mistakes that are critical to patient outcomes is not in the best interests of health care facilities, patients, or nurses (Bricker & Pardee, 2011). Simulation has the potential to be beneficial to new GNs and experienced RNs when it is well planned. The cost-benefit ratios of HF and LF simulators in relation to the outcomes and objectives of training to increase staff competency levels should be considered.

Theoretical Framework

Based upon the findings of the study, it is important to focus on adult learning theory related to the PD of nurses, experiential learning, and the ways in which nurses

transition from novice GNs to expert RNs. Adult learning theory, experiential learning, and the development of nurses were the foundations of the project as I was developing it. The two frameworks focused on Knowles's (1975) adult learning theory and D. Kolb's (1984) ELT.

Andragogy

When developing the preceptor workshop and the TTP, I kept in mind the needs of adult learners and the importance of differentiating pedagogy from andragogy. Both the preceptor workshop and the TTP had to satisfy the needs of both groups of adult learners and be matched and equipped with the specific information that they required. I used Knowles's (1975) theory of andragogy to prepare the workshop and the TTP.

Knowles's (1975) theory of adult learning, or andragogy, describes six assumptions or methods regarding why and how adults learn. Knowles believed that adults need to know why they are learning, they are motivated to be self-directed, they come to education ready to learn, they are problem resolution focused, they bring past learning experiences into their educational experiences, and they are motivated by internal forces related to personal goals (Knowles, 1975; Knowles & Bradford, 1952). As discovered during the interviews, the GNs and the nurse preceptors were expecting and ready for learning to take place. All participants recognized that if the education needed to do their jobs competently was lacking, the outcomes would be poor for all stakeholders.

The participants' requests for preceptor training and improvements to the orientation program spoke directly to Knowles's assumptions that adult learners must be

active participants in their own education (Knowles & Bradford, 1952). Adult learners want educational opportunities to practice effectively as health care providers, yet they must see the benefit of the educational offerings to find reasons for their personal and professional goals (Henschke, 2008). According to Harper and Ross (2011), the organizations that adults work for must be instrumental in helping them to meet their professional and personal potential. Using andragogy as a foundation to understand how adults learn encourages positive social change become long lasting. Staff developers who understand the collective and individual needs of adult learners and their desire to be involved in the learning process will create a positive and long-lasting learning environment (Chang, 2010).

Experiential Learning

D. Kolb's (1984) ELT has four phases: abstract conceptualization, active experimentation, concrete experience, and reflective observation. These elements were discussed in detail in Section 1 of this project study (A. Y. Kolb & Kolb, 2008). Learning by doing is the infrastructure for providing competency-based nursing education and training to develop clinical judgment (Chmil, Turk, Adamson, & Larew, 2015). Specific to my study, preceptors and GNs will complete hands-on activities based on clinical scenarios.

The experiential learning activities will center around abstract conceptualization and reflective observation. Abstract conceptualization allows learners to form conclusions about their learning experiences based on individual observations and reflection. Reflective observation gives learners the opportunity to observe and learn

from others (Hunt, Curtis, & Gore, 2015). Interactive and hands-on activities should be included in the training of adult learners.

Using abstract conceptualization and reflective observation invites past and present knowledge and logic from the experiences of the learners (Chmil et al., 2015). Adult educational programs should use each of the four elements of experiential learning and lean toward activities rooted in concrete experience and require the learners to engage in observable and measurable activities (Chmil et al., 2015). It is important for learners to be consciously aware of the learning and their individual ability to use clinical judgment and evaluate their own learning. The goal when educating RNs and training newly licensed GNs is to provide training and education that finds a balance between clinical preparation and practice readiness (Bleich, 2015). Using the experiential learning cycle will help the educators to translate the concepts and create a learning experience that is transformative for each individual learner, moving abstract ideas into active and reflective educational experiences (Hunt et al., 2015).

Implementation

Using the data collected and analyzed, I found that the nurses at SHMC who were serving as preceptors felt that they were unprepared for their role and were looking for an educational avenue to receive the training and education to become proficient when training GNs. Most of the participants wanted a new and longer orientation program that was organized, structured, and evidence based to ensure the competent transition of GNs into their professional role of RN.

The purpose of the 3-day workshop is to provide the nurse preceptors with the training needed to function competently as the preceptors of GNs at SHMC. The TTP will not be a standard orientation program; rather, it will be an evidence-based and research-focused 6-month program to train GNs to transition into the professional role of RN. The TTP will set the foundation for this ongoing professional growth and development. Implementation of the program will take place only with the support of all stakeholders. I am aware that barriers will have to be overcome to bring the project to fruition. Following is a discussion of these barriers, the resources needed, a time line for implementation, existing support for the project, and the roles and responsibilities of everyone involved in the project.

Potential Resources and Existing Supports

Following data collection, I was able to identify potential resources and existing supports. The CNO, SHMC's director of nursing care, the hospital's IRB committee, and various nurse educators at SHMC expressed an interest in the outcomes. These individuals are stakeholders at SHMC and are supportive of an evidence-based and research-focused project that will effect social change within the organization. The CNO and the director of nursing care each requested more information about the project, the outcomes of the project, and the two parts of the themselves. I am aware that resistance to change regarding implementation of the project and movement away from the past and present program might happen.

Potential Barriers

I am optimistic about the actualization of the project; however, the reality of achieving social change often is met with barriers and obstacles. The cost of the project might be one barrier to its implementation. In addition, providing enough nurse educators for the project will be challenging; presently, SHMC employs just one part-time nurse educator. Another barrier is change: Moving away from the present orientation program, which is embedded in the organizational structure, might be challenging.

I do not anticipate that finding meeting space will be a potential barrier because there are meeting spaces, laboratories, and classrooms available on the SHMC campus. Time, however, does present itself as a barrier and an additional cost to the organization. The preceptor workshop will be free to present and prospective preceptors. This requires paid time for nonclinical hours and means that all nurse preceptors attending the workshop must have nurse replacements for their regular working shifts, which will be an additional cost to the organization.

Moreover, in the present orientation period, GNs serve a dual role: They are participating in the orientation program while also serving as regular staff when particular nursing units do not have enough nurses to care for their patients. The TTP would require that this practice cease, meaning that SHMC would not be able to depend on GNs to fill any staffing role during the entire 6-month TTP. I am confident that each barrier has the potential to be worked through, especially once the long-term effects of each part of the project are measured against the current lack of a preceptor training program and an evidence-based, and structured TTP.

Dissemination of the Findings

I will present the findings and the project to nursing administration and the hospital's IRB. I will give an oral presentation of the findings and recommendations to the organization's administrative leadership during a face-to-face meeting using a slide presentation and a question-and-answer session. I anticipate that discussing the outcomes and recommendations will help SHMC to redesign and implement an evidence-based orientation program for newly licensed GNs and an educational workshop for nursing preceptors. The implications for social change on a local and larger spectrum are discussed and included in this section.

Presenting the findings to the hospital's IRB and nursing administration in the form of a completed study is the delivery method requested by SHMC. This delivery method is the most appropriate for the IRB committee, which keeps copies of all research and reviews these studies with the committee at their request. Nursing administration will receive a copy of my completed study as a reference for the nursing research committee. I will review the results of the study with the nursing research committee to look for potential opportunities for future research within the organization. The best way to share the findings with the administrative leaders at SHMC is through a face-to-face PowerPoint presentation that will allow me to explain the recommendations and program evaluations, and summarize the conclusions of the study. The presentation also will allow time for questions and answers related to the study and the proposed implementation of the project.

Proposal for Implementation and Time Line

After dissemination of the findings, planning of the two parts of the project will begin in the fall of 2016. Planning of the preceptor workshop and the TTP will begin at the same time, but because it will be the less costly of the two parts of the project, the workshop will begin in late spring or early summer of 2017, but the TTP will start in the fall of 2017. It is my goal to begin implementing the project after disseminating the findings to all stakeholders. Completion of the doctoral program is a prerequisite before I can move forward with the two parts of the project.

The preceptor workshop will be the first part of the project to be discussed and planned. It is important to train the nurses now serving as preceptors in an effort to educate them about their roles and responsibilities. I see this first effort as interventional and movement toward the implementation of the TTP. As the data revealed, the preceptors wanted specific training that they felt that they needed to be competent in their present role. Training the preceptors as they continue carrying out these duties will begin the process of implementing a research-based orientation program at SHMC.

Implementation of the TTP will require planning and a financial commitment at the administrative level. I do not foresee a problem because the administrative stakeholders continue to express their interest related to the outcomes of this project study and have voiced their understanding of the need for a transition program that will bring about a research-focused change to the organization. I anticipate that the project will be implemented in stages and will begin with planning. The first class to complete the TTP will be in the spring of 2018.

Roles and Responsibilities of Students and Project Developer

My role will be to act as the facilitator during the planning sessions for the project. In conjunction with the CNO, I will select a program planning committee for the project. The responsibility falls to me to disseminate the finding of the study and present the rationale for the two parts of the project, the workshop and TTP, and the proposed time line to the committee assembled. After presenting the findings to the committee and administration, I will work to secure the funding for both parts of the project.

I will look for educators who are experts in adult education in general and the adult education of nursing professionals to possibly teach both parts of the project. I will teach the preceptor workshop along with the assistance of any other nurse educators who might be required, and the TTP will require a minimum of three educators. All educators will be employees of SHMC.

I will choose the accommodations for the preceptor workshop and the TTP. The planning committee will supply all resources for the learners, including handouts, manuals, and schedules. The committee will designate who will contact and how contact will be made with the potential learners. Most participants for the preceptor workshop will be chosen from the list of preceptors at SHMC.

GNs will be identified upon hire and will automatically be enrolled in the TTP. For GNs presently working with less than 18 months of nursing experience, they also will be identified and enrolled in the TTP. Identification of potential GN learners will be the responsibility of the hospital's educator. It will be my responsibility to facilitate all activities previously described. I will ensure that the educators feel comfortable in their

roles and have received the training needed to be nurse educators. I will facilitate learning environments that are respectful of their time, are comfortable, and are conducive to learning.

The responsibilities of the learners (i.e., preceptors and GNs) are to be on time and be ready to learn. They will attend preclass or presimulation in-services as scheduled. Learners are expected to be active and collaborative participants of either the preceptor workshop or the TTP part of the project. Learners will be required to complete homework and daily assignments as required by the workshop of the TTP. Learners will be expected to evaluate the designated learning experiences as an individual learners or as members of a group.

Project Evaluation

Evaluations have long been understood as a process undertaken to improve or change a program in a formative manner when looking for best outcomes (Caffarella & Vella, 2010). The project and its value to all stakeholders is dependent upon the evaluation criteria presented in formative and summative assessments. The focus of the evaluation will center on the educational outcomes and whether the project objectives have been met. Fashioning the evaluation process as a method of accountability, that is, determining the delivery and design of each part of the project, will be the central purpose that will drive future decisions about the project (Caffarella & Vella, 2010). Each part of the project (i.e., preceptor workshop and TTP) will use evaluation forms that include a Likert scale and areas for narrative feedback. Opportunities for feedback during and after each part of the project are crucial to improve the project and keep the project

director apprised of any concerns. Therefore, formative and summative evaluations are an important aspect of the preceptor workshop and the TTP.

I will use formative evaluations during Day 1 of the preceptor workshop to improve, change, or refocus the activities as the workshop progresses. A formative evaluation will provide ongoing feedback from the participants and enable the educators to gage whether the program is providing the information needed by the participants and the information is meeting the objectives and the expected outcomes of both the program and the adult learners. Formative evaluations also will be conducted during the TTP.

Because the TTP is scheduled to be a 6-month program, the GNs will complete biweekly formative evaluations that will be used in same manner as the formative evaluations for the preceptor workshop. However, I understand that even though the learning objectives and outcomes for both parts of the project and the learners will be different, the fundamental purpose of the formative evaluations will remain the same (Caffarella & Vella, 2010). An extra formative evaluation will be conducted at the end of Month 3 of the TTP.

Summative evaluations will likewise be used for each part of the project. The TTP will have two summative evaluations, one at 3 months and the other at 6 months. The formative evaluation described earlier for the end of Month 3 of the TTP will be both formative and summative in nature for the 3-month time frame. I acknowledge that summative evaluations focus on the results and outcomes of programs and often are used at the completion of programs, but the predominant driving purposes of evaluations are analysis of data, decision making, and accountability (Caffarella & Vella, 2010).

Therefore, I deemed it necessary to complete a summative 3-month evaluation to engage all stakeholders regarding the outcomes of previously collected formative evaluations at the midpoint of the project to report results and gather feedback as all participants move forward in the remaining 3 months of the project. I understand that good evaluations will provide useful information during the life of the project (Caffarella & Vella, 2010). A summative evaluation of the workshop will be completed at the end of Day 3. The results of the project will be reported to all stakeholders, and decisions related to project changes will be implemented prior to future workshops and TTPs.

Implications, Including Social Change

In order for social change to become a reality, all stakeholders should collaborate to participate in and coproduce the project. This working relationship can have long-term benefits to SHMC, colleagues, and the surrounding communities. Nurses serving as preceptors with long service histories at SHMC reported needing the education to train and mentor GNs more efficaciously. All participants reported deficiencies in the present orientation program. Making positive long-term changes to the present orientation program and implementing a preceptor training workshop will benefit the communities and SHMC by improving clinical practice and patient outcomes.

Local Community Implications

Providing ongoing PD to health care providers sends a clear message to the community about the importance of investing in the educational needs of health care practitioners at SHMC. As a teaching hospital, is imperative that SHMC have well-educated, front-line practitioners at the immediate point of care who are competent and

possess the tools needed to care for members of the community. Analysis of the data revealed the need for this two-part project. Implementation of the workshop and the TTP will provide the community with the benefit of having nurses at all levels who can deliver care in consistent, evidence-based ways.

Provision of the resources for the workshop and the TTP needed for preceptors and GNs, respectively, to become successful and competent is the responsibility of the administrative and nursing leadership at SHMC. The workshop and the TTP have the potential to increase the clinical competencies of nursing staff within the organization. Implementation of the two parts of the project can facilitate change internally and externally through collaboration, education, support, and the understanding of the needs described by the participants themselves.

Far-Reaching Implications

The preceptor workshop and the TTP have both been proposed as national programs for mandatory implementation by the NCSBN (2011). Implementation of both parts of the project will have local and broad implications for preceptors and GNs. Several hospitals have implemented preceptor workshops and TTPs with long-term success (NCSBN, 2011). However, no hospitals with the same region as SHMC have implemented either a research-based workshop or a TTP. This type of educational offering puts SHMC in the vanguard of setting the standard of training preceptors and GNs. Looking to the future, new employees will be looking for health care organizations that are willing to provide these types of learning opportunities (Gillespie & Peterson, 2009).

Conclusion

I developed this project to obtain firsthand knowledge from newly licensed GNs, preceptors, and nurse managers about the orientation program currently being offered at SHMC. During the collection and analysis of the data, I extracted key themes that became central to the project study. The present orientation program at SHMC is not consistent, lacks a research focus, is not evidence based, and is not administered systematically by all parties involved in the orientation process. In addition, there is no formal or informal method of training the nurses who serve as preceptors and are charged with training GNs and implementing the present orientation program. I decided to develop two parts of the project to meet the needs of the organization.

The TTP is fundamentally based upon having preceptors who are educationally trained in the evidence-based methods of precepting GNs (Anderson et al., 2012; Beecroft et al., 2008; Benner, 2004; Gillespie & Peterson, 2009; NCSBN, 2011). Providing the two parts of the project will facilitate social change at SHMC and will have long-term effects on the communities to which the health care professionals at SHMC provide care. Through the collection and analysis of the data, I can share with key stakeholders the next steps to develop research-based projects that will meet the needs of all stakeholders and have the potential for positive long-term effects in terms of training and more competent care.

Section 4: Reflections and Conclusions

Introduction

The purpose of this study was to investigate the experiences of newly licensed GNs, preceptors, and nurse managers regarding GNs' movement into the professional role of RNs following completion of a hospital-based orientation program. I determined that development of a two-part project would help to focus on the PD of nurses serving as preceptors and new GNs with less than 18 months of nursing experience. In this section, I review the strengths of the project and my recommendations to reduce the limitations. Also included in this section are my self-appraisal as a scholar, practitioner, and project developer, and a discussion of the project's impact on social change.

Project Strengths

Exploring the perceptions of new GNs after they had completed a hospital-based orientation program was the focus of this study. Following data collection and analysis, I could identify two organizational problems, namely, the need for a research-focused TTP and the need for a preceptor training workshop. The project blueprint will provide plans for possible implementation of each part of the project designed for SHMC. The project will offer two evidence-based and research-focused parts for implementation at SHMC, the organization that was the focus of this study.

One of the primary strengths of this project is that its development was data driven, meaning that the information that I collected led me to determine that there were two organizational needs. I developed this two-part project to meet the needs of all stakeholders according to the outcomes of the data analysis. A second strength of the

project is that all of the stakeholders had a clear understanding of the educational needs of the new GNs and experienced nurses serving as preceptors. A third strength is that development of the two parts of the project was based upon research and the nationally recognized TTP of the NCSBN. Another strength of the project is that it will provide an organized and standardized TTP and preceptor workshop that will speak to the needs of all stakeholders involved in the orientation of new GNs.

Implementation of the TTP will help SHMC to decrease many of the nursing problems common to health care organizations that do not provide GNs with TTP postgraduation—that is, high turnover rates and poor patient outcomes (Spector & Echternacht, 2010). The TTP will be an excellent method of providing a research-focused method of delivering to GNs within the organization a standardized program that focuses on their educational needs, not the staffing needs of the organization. The preceptor workshop will improve participants' understanding of their role in the orientation process. Each part of the project will provide answers to frequently asked questions by stakeholders who participate in the orientation of new GNs and will encourage discussion about implementation.

Recommendations for Remediation of Limitations

Although this study and both parts of the project have been grounded in research, there are limitations to each part. Although the intentions of the project are fundamentally and educationally sound to meet the needs of the organization, according to the data collected and analyzed, each part of the project will also require a financial investment from SHMC. The commitment will require the support not only of nursing

administration, but also of executive leadership and nursing education. It also will require the participation of nursing personnel (i.e., preceptors and the nurse educator). The nurse educator will be heavily involved in the planning and implementation of each part of the project. Individual and collective input and endorsement, as well as willingness by all stakeholders to champion each part of the project, will ensure its success.

Participation will be mandatory for preceptors or newly hired GNs at SHMC. Providing GNs and preceptors with the time needed to participate in each part of the project might be a scheduling challenge for the organization. Nurses at SHMC work regularly scheduled 12-hour shifts; the TTP and the workshop will follow 8-hour daily schedules. Participants might lose part of their regular salaries when attending the TTP or the workshop unless SHMC contributes financial support to compensate the participants for their regular hourly scheduled rates of pay.

Finally, the timing and planning for each part of the project are other limitations. The work hours of the stakeholders who will be involved in planning the implementation of the project will require consensus related to meeting times for all participants. Scheduling for a committee of planners will be difficult because the majority of stakeholders work different shifts and are full-time, part-time, or per diem employees. The needs of committee members regarding family commitments, transportation issues, and diverse schedules are real-world factors that could be initial threats to the implementation of each part of the project.

At the onset of this study, the purpose was to examine the experiences of each participant after completion of a hospital-based orientation program. I chose to follow a

qualitative case study methodology. The data collected for analysis included interviews and documents. Analysis of the data identified an organizational need for a TTP and a preceptor training workshop. Providing nursing administrators, executive leaders, and nursing educators with the information gathered in this study regarding the long-term benefits of each part of the project may support the decision to invest in the ongoing education of nursing staff at SHMC.

SHMC is a teaching and research-focused hospital, so implementation of an educational two-part project that has the potential to decrease sentinel events and improve patient outcomes will be seen as beneficial to the patients, the community, and the organization (Spector & Echternacht, 2010). When there is support from administrative leaders, there also will be support from other parts of the organization.

Scholarship

Being on the last leg of this doctoral journey was an overwhelming and personally treacherous adventure because the terrain was not always easy to navigate. I often wondered whether I fit into this group of accomplished scholars. I came to learn that there is always more to learn and that scholars are not reticent about acknowledging what they do not know or understand. This project and the entire research process taught me that no matter what I believe that I know about nursing and educating nurses, there is always more to learn. By searching the literature, I discovered that other scholars have a wealth of knowledge to offer on the education of GNs. This discovery helped me as a scholar to look beyond my local area and toward national and international researchers to inform my beliefs about the continuing education of newly licensed GNs. Having a

foundation upon which to build the framework of a study helped me to understand theories and their value in the research process.

I have shared this journey with other doctoral students and my chair, to whom I owe a great deal; these relationships will endure. Scholarship is much more than completing a study or conducting research to find answers; rather, it is about collaborating, being open to different points of view, finding solutions to problems, pushing oneself beyond personal expectations, and finding one's own path along the way. Although the terrain was fraught with obstacles, tears, doubt, illness, and even tears of joy, the journey was worth it.

Project Development and Evaluation

My selection of a type of project stemmed from the data collection and analysis. Although the data collection and analysis consumed more time than I expected, they were crucial steps in this qualitative study that helped me to understand and make sense of the information that I obtained. I found through the analysis of the data that two parts of the project were needed for social change to occur within the institution. The data collection process began with the examination of documents; later, interviews were scheduled and completed.

Meeting the scheduling needs of the GNs, preceptors, and nurse managers, all of whom worked different shifts, along with managing my own time and responsibilities as the dean of nursing, presented a challenge. I worked with each participant to meet individual needs and schedule each private interview. I completed each interview individually and transcribed the recorded interview responses verbatim. Member

checking proved to be challenging when I was trying to work within the participants' schedules to ensure that the process was completed in a timely manner.

After data collection and analysis, I determined that a two-part project was needed to meet the needs of the organization and effect long-term clinical and educational change. I developed a 3-day workshop for nurse preceptors and an evidence-based TTP using the research-based TTP developed by the NCSBN (2011) as the model. The workshop will focus on four specific areas: role of the nursing preceptor, nurse as educator, nurse as facilitator, and preceptor as evaluator. The TTP will comprise five transition modules as delineated in the TTP of the NCSBN (2011): communication and teamwork, patient-centered care, evidence-based practice, quality improvement, and informatics.

Formative and summative evaluations will play an integral role during each part of the project; these methods of evaluation are not part of the present orientation format. Evaluations will help all stakeholders to understand what the immediate and long-term needs of each part of the project are and will be. Meeting the needs of the participants is an important aspect of adult learning. Each part of the project must be engaging, participative, informative, and related experientially to the work of the participants.

At the onset of data collection, I thought that I had a clear understanding of the needs of the organization. As the data unfolded, I found that what I believed was only partially true. The data revealed the need for a TTP and a preceptor workshop to train the experienced nurses responsible for mentoring and training GNs. I did not anticipate this need for the preceptor workshop. This was an assumption that I should not have made.

After completing this study, I am more confident in my skills as a researcher and project developer and look forward to the future development of more projects.

Leadership and Change

To be a great leader, I believe that it is important to be a good follower. During this doctoral journey, I learned to follow and then to lead in this arena of research, evidence-based practice, and doctoral studies. Change was a driving force in the development of both parts of the project. Understanding a need that is rooted in evidence and moving forward to develop methods to meet that need requires solid leadership. Leadership must have determination and persistence in a belief in whatever the leader is committed to doing. I believe that to implement effective change, leaders should possess humility and the ability to work with others at all levels. Now that I have completed this doctoral study, I consider myself a leader academically, professionally, and personally.

As a leader, I understand that effective change takes a coordinated effort. Listening to others and considering different points of view will be of paramount importance to the success of each part of the project. Garnering support from stakeholders and moving forward will require an investment of time; leaders must be willing to make this investment. As a leader, I must value the input of others and see it as important to the process of planning and implementing each part of the project. I believe as a leader that every voice involved in the process should be respected and that the decisions made should be in the best interests of all stakeholders.

As a leader, I found that this project helped me to understand the importance of listening, educating professionals, and being present and in the moment with the

individuals being led. I believe that in order for long-lasting change to happen, leaders must be visionaries, have direction, prepare plans, and understand how to navigate and move from vision to reality by bringing others along in a productive manner.

Analysis of Self as Scholar

This process helped me to learn a great deal about myself as an educator, a nurse, a professional, a person, and a scholar. Writing and researching take time, and neither of them should be rushed. I learned to be patient with the process of scholarly writing and with myself. I learned that persistence and dedication will eventually get the work done. Learning to be scholarly involved such diverse activities as reading and rereading, collaborating, asking for assistance, gathering information, and ensuring that sources of information were correct. Reasoning, understanding, and making sense of what others or I wrote or collected were important aspects of this journey for me.

This has been an amazing and prayerful journey. I consider myself fortunate and blessed beyond measure. Being here and writing these words in this moment, I find myself amazingly humbled, grateful, and thankful.

Analysis of Self as Practitioner

As an RN, a nurse educator, and dean of a nursing program, I understand the need for research and evidence-based practice to become a living and breathing reality within nursing practice and health care organizations. Throughout this process, I came to understand how research related to the many issues in the nursing profession can facilitate change with the profession itself, within myself as an RN and a nursing administrator, within health care organizations, and within the communities being served.

To answer questions, find solutions to problems, and effect positive change in the profession and in health care organizations, practice professionals need to be involved in the research process.

Analysis of Self as Project Developer

As the project developer, I became energized and concerned as the data unfolded. I was excited about the opportunity to implement the much-needed project. I became concerned when I understood that two parts of the project were needed. I was unsure how this information would be received, and I was concerned that I was taking on more than I could handle. After completing my research and literature review, I came to understand that my concerns were groundless.

Potential Impact of the Project on Social Change

I conducted this qualitative case study at SHMC. The collected and analyzed data revealed that SHMC presently does not provide a research-based orientation program or nurse preceptor training. TTP are being used with long-term success in health care organizations across the United States as well as internationally (NCSBN, 2011; Spector & Echternacht, 2010). Providing a research-based TTP for GNs and training for the nurses responsible for mentoring and precepting GNs will benefit the organization and improve patient outcomes.

Supporting the TTP and the workshop has the potential to save the organization money related to reducing the rate of nursing staff turnover and increasing the recruitment of nurses. Research has shown that GNs gravitate toward other acute care facilities that offer longer and better organized TTPs (Spector & Echternacht, 2010;

Welding, 2011). The TTP can help GNs to focus on the fundamentals of nursing care and move to more complex issues related to patient outcomes, and it might aid GNs in understanding the prevention of sentinel events within the organization. The preceptor workshop can provide these nurses with an understanding of their role as preceptors and the purpose of formative and summative evaluations when training GNs.

As the project developer, I collected, analyzed, and read the transcriptions of the participants' stories. I assessed the needs of the organization and all stakeholders, and I decided to develop a two-part project as the best means to meet these collective needs. Implementation of the project will take time. An informed and educated workforce can become a reality with the input and collaboration of nursing administration and nursing education. Implementation should bring about positive clinical change at SHMC if the issues are addressed in a collaborative manner to provide the nurses at the facility with the ongoing education that they need to care for patients more efficaciously.

Implications, Applications, and Directions for Future Research

This journey gave me great opportunities for personal and professional growth. I have grown as a person, an educator, a nurse, a professional, and a scholar. I learned how to bring about potentially lasting change through the research process. Working on this project taught me that I can make effective change within my profession and the organization if I ensure that the product is credible, unbiased, truthful, and based upon established research processes.

Taking into consideration the evaluations of each part of the project, I would explore the relationship between nurse preceptors and GNs during the course of the TTP

or orientation period. Exploring a correlational study related to the implementation of a preceptor training workshop would not be limited to the mentoring of the GNs, generational differences, and years of nursing experience. In addition, for future research and social change within the parent organization, I would explore a multiple case study using a qualitative design to include the other two hospitals to examine their respective orientation programs.

Conclusion

The training of GNs postgraduation varies nationally and internationally. Establishing a research-based orientation that focuses on the needs of GNs and the organization has been shown to yield better outcomes for nurses, patients, and employing organizations (Spector & Echternacht, 2010; Welding, 2011). I identified the need for not only a TTP, but also a preceptor training workshop. The project is developed in two parts to train nurses serving as preceptors and to train GNs enrolled in the TTP to the role of professional nurse. Implementation of each part will require support from all stakeholders at SHMC. Effective change does not happen without collaboration and a strong commitment from all parties involved to achieve improved patient and community outcomes. It is my hope that SHMC will make a long-term investment in the future of nursing, in newly licensed GNs, and in the PD of these frontline caregivers to support the ongoing growth of the organization.

References

Alber, L., Augustus, L., Hahn, S., Penkert, J., Sauer, R., & DeSocio, J. (2009). Applying Benner's model to psychiatric mental health nurse practitioner self-ratings of role competence. *Journal of the American Psychiatric Nurses Association, 15*(2), 126-137. doi:10.1177/1078390309333181

Al-Ghareeb, A., & Cooper, S. J. (2015). Barriers and enablers to the use of high fidelity patient simulation manikins in nursing education: An integrative review. *Nurse Education Today, 36,* 281-286. doi:10.1016/j.nedt.2015.08.005

Alligood, M. R. (2010). *Philosophies, models, and theories: Critical thinking structures.* Heights, MO: Mosby Elsevier.

American Nurses Credentialing Center. (2014). About ANCC. Retrieved from http://www.nursecredentialing.org/

Anderson, G., Hair, C., & Todero, C. (2012). Nurse residency programs: An evidence-based review of theory, process, and outcomes. *Journal of Professional Nursing, 28*(4), 203-212. doi:10.1016/j.profnurs.2011.11.020

Andreou, C., Papastavrou, E., & Merkouris, A. (2014). Learning styles and critical thinking relationship in baccalaureate nursing education: A systemic review. *Nurse Education Today, 34,* 362-371. doi:10.1016/j.nedt.3013.06.004

Bailey, C., & Hewison, A. (2014). The impact of a critical moments workshop on undergraduate nursing students' attitudes to caring for patients at the end of life: An evaluation. *Journal of Clinical Practice, 23,* 3555-3563. doi:10.111/jocn .12642

Banks, T., & Zionts, P. (2009). Teaching a cognitive behavioral strategy to manage emotions rational emotive behavior therapy in an educational setting. *Intervention in School and Clinic, 44,* 307-313. doi:10.1177/1053451208330893

Basak, T., Unver, V., Moss, J., Watts, P., & Gaioso, V. (2016). Beginning and advanced students' perceptions of the use of low- and high-fidelity mannequins in nursing simulation. *Nurse Education Today, 36,* 37-43. doi:10.1016/j.nedt.2015.07.020

Bashford, C. W., Shaffer, B. J., & Young, C. M. (2012). Assessment of clinical judgment in nursing orientation: Time well vested. *Journal for Nurses in Staff Development, 28,* 62-65. doi:10.1097/NND.0B013e31824b4155

Beecroft, P., Hernandez, A., & Reid, D. (2008). Team preceptorships. *Journal for Nurses in Staff Development, 24*(4), 143-148.

Bellolio, M. F., & Stead, L. G. (2009). Continuing education meetings and workshops: Effects on professional practice and health care outcomes. *Annals of Emergency Medicine, 53*(5), 685-687. doi:10.1016/j.annemergmed.2008.05.034

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice.* Menlo Park, CA: Addison-Wesley.

Benner, P. (2004). Using the Dreyfus Model of Skill Acquisition to describe and interpret skill acquisition and clinical judgment. *Nursing Practice and Education Bulletin of Science, Technology & Society, 24*(3), 188-199. doi:10.1177/02704676042650 61

Berkow, S., Virkstis, K., Stewart, J., & Conway, L. (2009). Assessing new graduate performance. *Nurse Educator, 38*(11), 17-22. doi:10.1097/01.NNA.0000339477.50219.06

Bleich, M. R. (2015). Defining moments in leadership character development. *Journal of Continuing Education in Nursing, 46*(6), 247-249.

Bobay, K., Gentile, D. L., & Hagle, M. E. (2009). The relationship of nurses' professional characteristics to levels of clinical nursing expertise. *Applied Nursing Research, 22*(1), 48-53. doi:10.1016/j.apnr.2007.03.005

Bogdan, R. C., & Biklen, S. K. (2007). *Qualitative research for education: An introduction to theories and methods* (5th ed.). Boston, MA: Allyn & Bacon.

Boyer, S. (2008). Competence and innovation in preceptor development: Updating our programs. *Journal for Nurses in Staff Development, 24*(2), E1-E6.

Bratt, M. M. (2009). Retaining the next generation of nurses: The Wisconsin Nurse Residency Program provides a continuum of support. *Journal of Continuing Education in Nursing, 40,* 416-425. doi:10.3928/00220124-20090824-05

Bricker, D. J., & Pardee, C. J. (2011). Nurse experts jump-start clinical simulation in rehabilitation nursing: Supporting new graduate transition to competence. *Nursing Education Perspectives, 32*(1), 34-36. doi:10.5480/1536-5026-32.1.34

Brykcznski, K. A. (2010). Benner's philosophy in nursing practice. In M. R. Alligood (Ed.), *Nursing theory: Utilization and application* (pp. 137-159). Heights, MO: Mosby Elsevier.

Burger, J. L., Parker, K., Kaetzel, D., O'Nan, C., & White, A. (2010). Responses to work complexity: The novice to expert effect. *Western Journal of Nursing Research, 32*(4), 497-510. doi:10.1177/0193945909355149

Cadmus, E., Van Wynen, E. A., Chamberlain, B., Steingall, P., Kilgallen, M. E., Holly, C., & Gallager-Ford, L. (2008). Nurses' skill level and access to evidence based practice. *Journal of Nursing Administration, 38*(11), 494-503.

Caffarella, R., S., & Vella, J. (2010). *Designing and assessing learning experiences* (2nd ed.). San Francisco, CA: Jossey-Bass.

Cangelosi, P., Crocker, S., & Sorrell, J. (2009). Expert to novice: Clinicians learning new roles as clinical nurse educators. *Nursing Education Perspectives, 30*(6), 367-371. doi:10.1043/1536-5026-30.6.367

Cannon-Diehl, M. (2009). Simulation in healthcare and nursing: State of the science. *Critical Care Nursing Quarterly, 32*(2), 128-136. doi:10.1097/CNQ.0b013e3181a27e0f

Chang, S. (2010). Applications of andragogy in multi-disciplined teaching and learning. *Journal of Adult Education, 39*(2), 25-35.

Chen, R., Grierson, L. E., & Norman, G. R. (2015). Evaluating the impact of high- and low-fidelity instruction in the development of auscultation skills. *Medical Education, 49*(3), 276-285. doi:10.1111/medu.12653

Chmil, J. V., Turk, M., Adamson, K., & Larew, C. (2015). Effects of an experiential learning simulation design on clinical nursing judgment development. *Nurse Educator, 40*(5), 228-232.

Chunta, K. S., & Katrancha, E. D. (2010). Using problem-based learning in staff development: Strategies for teaching registered nurses and new graduate nurses. *Journal of Continuing Education, 41*(12), 557-564. doi:10.3928/00220124-20100701-06

Clark, M., & Springer, P. J. (2011). Nurse residents' first-hand accounts on transition to practice. *Nursing Outlook, 60*(4), 2-8. doi:10.1016/j.outlook.2011.08.003

Corcoran, K. (2016). Evaluation of an educational workshop to increase comfort levels of professional caregivers with end of life care. *MEDSURG Nursing, 25*(2), 103-109.

Creswell, J. W. (2012). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (4th ed.). Boston, MA: Pearson Education.

Cubit, K., & Lopez, V. (2012). Qualitative study of enrolled nurses' transition to registered nurses. *Journal of Advanced Nursing, 68,* 206-211. doi:10.1111/j.1365-2648.2011.05729.x

DeStephano, C. C., Chou, B., Patel, S., Slattery, R., & Hueppchen, N. (2015). Research: A randomized controlled trial of birth simulation for medical students. *American Journal of Obstetrics and Gynecology, 21*(391), 1-91. doi:10.1016/j.ajog.2105.03.024

Donavant, B. W. (2009). The new, modern practice of adult education: Online instruction in a continuing professional education setting. *Adult Education Quarterly, 59,* 227-245. doi:10.1177/0741713609331546

Drey, N., Gould, D., & Allan, T. (2009). The relationship between continuing professional educational education and commitment to nursing. *Nurse Education Today, 29,* 740-745. doi:10.1016/j.nedt.2009.03.008

Duchscher, J. E. B. (2009). Transition shock: The initial stage of role adaptation for newly graduated registered nurses. *Journal of Advanced Nursing, 35,* 1103-1113. doi:10.1111/j.1365-2648.2008.04898.x

Dyess, S., & Parker, C. G. (2012). Transition support for the newly licensed nurse: A programme that made a difference. *Journal of Nursing Management, 20,* 615-623. doi:10.1111/j.1365-2834.2012.01330.x

Dyess, S., & Sherman, R. O. (2009). The first year of practice: New graduate nurses' transition and learning needs. *Journal of Continuing Education in Nursing, 40*(9), 403-410. doi:10.3928/00220124-20090824-03

Ellenbecker, C. H. (2010). Preparing the nursing workforce of the future. *Policy, Politics, & Nursing Practice, 11,* 115-125. doi:10.1177/15277154410380142

Fink, R., Krugman, M., Casey, K., & Goode, C. (2008). The graduate nurse experience. *Journal of Nursing Administration, 34*(6), 341-348. Retrieved from http://journals.lww.com/

Fitzgerald, C., Moores, A., Coleman, A., & Fleming, J. (2015). Supporting new graduate professional development: A clinical learning framework. *Australian Occupational Journal, 62,* 13-20. doi:10.111/1440-1630.12165

Foster, K. I., Benavides-Vaello, S., Katz, J. R., & Eide, P. (2012). Using the generative nursing model to reframe nursing student transition to practice. *Nurse Educator, 37,* 252-257. doi:10.1097/NNE.0b013e31826f27c1

Friedman, M. I., Delaney, M. M., Schmidt, K., Quinn, C., & Macyk, I. (2013). Specialized new graduate RN pediatric orientation: A strategy for nursing retention and its financial impact. *Nursing Economics, 31,* 162-170. Retrieved from https://www.nursingeconomics.net/ce/2015/article3104162170.pdf

Gaberson, K. B., & Oermann, M. H. (2007). *Clinical teaching strategies in nursing* (2nd ed.). New York, NY: Springer.

Gantt, L. T., & Webb-Corbett, R. (2010). Using simulation to teach patient safety behaviors in undergraduate nursing education. *Journal of Nursing Education, 49,* 48-51. doi:10.3928/01484834-20090918-10

Gentile, D. L. (2012). Applying the novice to expert model to infusion nursing. *Journal of Infusion Nursing, 35*(2), 101-107. doi:10.1097/NAN.0b013e3182424336

Gillespie, M., & Peterson, B., L. (2009). Helping novice nurses make effective clinical decisions: The situated clinical decision making framework. *Nursing Education Perspectives, 30*(3), 164-170. doi:10.1043/1536-5026-030.003.0164

Goode, C. J., Lynn, M. R., Krsek, C., & Bednash, G. D. (2009). Nurse residency programs: An essential requirement for nursing. *Nursing Economics, 27,* 142-148. Retrieved from https://nursingeconomics.net/ce/2011/article27142159.pdf

Goodwin-Esola, M., Deely, M., & Powell, N. (2009). Progress meetings: Facilitating role transition of the new graduate. *Journal of Continuing Education in Nursing, 40,* 411-415. doi:10.3928/00220124-20090824-04

Haggerty, C., Holloway, K., & Wilson, D. (2013). How to grow our own: An evaluation of preceptorship in New Zealand graduate nurse programme. *Contemporary Nurse, 43*(2), 162-171. doi:10.5172/conu.2013.43.2.162

Haleem, D. M., Manetti, W., Evanina, K., & Gallagher, R. (2011). A senior internship: Facilitating the transition to nursing practice. *Nurse Educator, 36,* 208-213. doi:10.1097/NNE.0b013e3182297cfc

Harper, L., & Ross, J. (2011). An application of Knowles' theories of adult education to an undergraduate interdisciplinary studies degree program. *Journal of Continuing Higher Education, 59,* 161-166.

Harrison-White, K., & Simons, J. (2013). Preceptorship: Ensuring the best possible start for new nurses. *Nursing Children and Young People, 25*(1), 24-27. Retrieved from http://rcnpublishing.com/

Henschke, J. A. (2008). Reflections on the experiences of learning with Dr. Malcolm Shepherd Knowles. *New Horizons in Adult Education & Human Resource Development, 22*(3-4), 44-52.

Hickey, M. T. (2010). Baccalaureate nursing graduates' perceptions of their clinical instructional experiences and preparation for practice. *Journal of Professional Nursing, 26*(1), 35-41. doi:10.1016/j.profnurs.2009.03.001

Hilli, Y., Salmu, M., & Jonsen, E. (2014). Perspectives on good preceptorship: A matter of ethics. *Nursing Ethics, 21,* 565-575. doi:10.1177/0969733013511361

Hornyak, M. J., & Page, D. (2004). Experiential learning: Introducing faculty and staff to a university leadership development program. *Simulation & Gaming, 35,* 461-475. doi:10.1177/1046878104263974

Hunt, C. W., Curtis, A. M., & Gore, T. (2015). Using simulation to promote professional development of clinical instructors. *Journal of Nursing Education, 54*(8), 468-471.

Johnson, K., Vaughan, P., & Lynall, A. (2014). Recognizing the value of learning: A pilot project. *Practice Nursing, 25*(10), 510-514.

Johnson, M., Sonson, R., & Golden, T. (2010). Developing charge nurse leaders with experiential learning. *Nurse Leader, 8*(6), 40-45. doi:10.1016/j.mnl.2010.04.003

Jones-Bell, J., Karshmer, J., Berman, A., Prior, S., Van, P., Wallace, J., & West, N. (2014). Collaborative academic practice transition program for new graduate RNs in community settings: Lessons learned. *Journal of Continuing Education in Nursing, 45,* 259-264. doi:10.3928/00220124-20140402-01

Josephsen, J. (2015). Cognitive load therapy and nursing simulation: An integrative approach. *Clinical Simulation in Nursing, 11*(5), 259-267. doi:10.1016/j.ecns.2015.02.004

Kaakinen, J., & Arwood, E. (2009). Systematic review of nursing simulation literature for use of learning theory. *International Journal of Nursing Education Scholarship, 6*(1), 1. doi:10.2202/1548-923X.1688

Kaddoura, M. A. (2010). Effect of the Essentials of Critical Care Orientation (ECCO) program on the development of nurses' critical thinking skills. *Journal of Continuing Education in Nursing, 41,* 424-432. doi:10.3928/00220124-20100503-05

Kelly, J., & McAllister, M. (2013). Lessons students and new graduates could teach: A phenomenological study that reveals insights on the essence of building a supportive learning culture through preceptorship. *Contemporary Nurse, 44*(2), 170-177. doi:10.5172/conu.2013.44.2.170

Knowles, M. S. (1975). Adult education: New dimensions. *Educational Leadership, 33*(2), 85-88.

Knowles, M. S., & Bradford, L. P. (1952). Group methods in adult education. *Journal of Social Issues, 8*(2), 11-22.

Kolb, A. Y., & Kolb, D. A. (2008). The learning way: Meta-cognitive aspects of experiential learning. *Simulation & Gaming, 40,* 297-327. doi:10.1177/1046878108325713

Kolb, D. (1984). *Experiential learning: Experience as the source of learning and development.* Englewood Cliffs, NJ: Prentice Hall.

Kramer, M., Maguire, P., Halfer, D., Brewer, B., & Schmalenberg, C. (2011). Impact of residency programs on professional socialization of newly licensed registered nurses. *Western Journal of Nursing Research, 35,* 459-496. doi:10.1177/0193945911415555

Kramer, M., Maguire, P., Schmalenberg, C., Halfer, D., Budin, W. C., Hall, D. S., … Lemke, J. (2012). Components and strategies of nurse residency programs effective in new graduate socialization. *Western Journal of Nursing Research, 35,* 566-589. doi:10.1177/01939459809

Lee, E. J., Kim, H. S., & Kim, H. Y. (2014). Relationships between core factors of knowledge in hospital organizations and outcomes of nursing performance. *Journal of Clinical Nursing, 23,* 3513-3524. doi:10.111/joen.12603

Lima, S., Jordan, H. L., Kinney, S., Hamilton, B., & Newell, F. (2015). Empirical evolution of a framework that supports the development of nursing competence. *Journal of Advanced Nursing, 72*(4), 889-899. doi:10.111/jan.12872

Lisko, S., & O'Dell, V. (2010). Integration of theory and practice: Experiential learning theory and nursing education. *Nursing Education Perspectives, 31*(2), 106-108. doi:10.1043/1536-5026-31.2.106

Lodico, M. G., Spaulding, D. T., & Voegtle, K. H. (2010). *Methods in educational research: From theory to practice.* San Francisco, CA: Jossey-Bass.

Ma, Y., & Harmon, S. W. (2006). Integrating knowledge management systems, electronic performance support systems, and learning technologies. *Performance Improvement Quarterly, 19*(3), 107-120.

Macnaughton, S., & Medinsky, M. (2015). Staff training, onboarding, and professional development using a learning management system. *Canadian Journal of Library & Information Practice & Research, 10*(2), 1-8.

Manolis, C., Burns, D. J., Assudani, R., & Chinta, R. (2013). Assessing experiential learning styles: A methodological reconstruction and validation of the Kolb learning style inventory. *Learning and Individual Differences, 23,* 44-52. doi:10.1016/j.lindif.2012.10.009

Mariani, B. (2012). Our ethical responsibility in the transition to practice for new RNs. *Pennsylvania Nurse*, *67*(2), 4-7. Retrieved from http://www.panurses.org/

Mark, B. A., Lindley, L., & Jones, C. B. (2009). Nurse working conditions and nursing unit costs. *Policy, Politics, & Nursing Practice, 10,* 120-128. doi:10.1177/1527154409336200

Maslow, A. H. (1954). *Motivation and personality.* New York, NY: Harper and Row.

McHugh, M. D., & Lake, E. T. (2010). Understanding clinical expertise: Nurse education, experience, and the hospital context. *Research in Nursing and Health*, *33*(4), 276-287. doi:10.1002/nur.20388

Mennenga, H. A., & Smyer, T. (2010). A model for easily incorporating team-based learning into nursing education. *International Journal of Nursing Education Scholarship, 7,* 1-14. doi:10.2202/1548-923X.1984

Mentor. (2013). In *Taber's cyclopedic medical dictionary* (22nd ed.). Philadelphia, PA: F. A. Davis.

Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation* (2nd ed.). San Francisco, CA: Jossey-Bass.

Miltner, R. S., Jukkala, A., Dawson, M. A., & Patrician, P. A. (2015). Professional development needs of nurse managers. *Journal of Continuing Education in Nursing, 46*(6), 252-258. doi:10.3928/00220124-20150518-01

Munhall, P. (2012). *Nursing research: A qualitative perspective* (5th ed.). Sudbury, MA: Jones & Bartlett.

Nash, R., Lemcke, P., & Sacre, S. (2009). Enhancing transition: An enhanced model of clinical placement for final year nursing students. *Nurse Education Today, 29*(1), 48-56. doi:10.1016/j.nedt.2008.06.004

National Council of State Boards of Nursing. (2011). *Description of NCSBN's Transition to Practice® (TTP) model.* Retrieved from https://www.ncsbn.org/13_TransitiontoPractice_modeldescription.pdf

National Council of State Boards of Nursing. (2014). About NCLEX. Retrieved from https://www.ncsbn.org/

National League for Nursing. (2012). *Core competencies of nurse educators with task statements.* Retrieved from www.nln.org/aboutnln/PositionStatements/preparation051802.pdf

Nicol, J., & Dosser, I. (2016). Continuing professional development: Understanding reflective practice. *Nursing Standard, 30*(36), 34-42. http://dx.doi.org/10.7748/ns.30.36.34.s44

Nimbalkar, A., Patel, D., Kungwani, A., Phatak, A., Vasa, R., & Nimbalkar, S. (2015). Randomized control trial of high fidelity vs low fidelity simulation for training

undergraduate students in neonatal resuscitation. *BMC Research Notes, 8*(636). doi:10.1186/s13104-015-1623-9

Norman, G., Dore, K., & Grierson, L. (2012). The minimal relationship between simulation fidelity and transfer of learning. *Medical Education, 46*(7), 636-647. doi:10.1111/j.1365-2923.2012.04243.x

Okougha, M. (2013). Promoting patient-centered care through staff development. *Art & Science Professional Development, 27*(34), 42-46.

Phillips, C., Easterman, A., Smith, C., & Kenny, A. (2012). Predictors of successful transition to registered nurse. *Journal of Advanced Nursing, 69,* 1314-1322. doi:10.111/j.1365-2648.2012.06123.x

Poore, J. A., Cullen, D. L., & Schaar, G. L. (2014). Simulation based interprofessional education guided by Kolb's experiential learning theory. *Clinical Simulation in Nursing, 10,* 241-247. doi:10.1016/j.ecns.2014.01.004

Price, B. (2013). Successful preceptorship of newly qualified nurses. *Continuing Professional Development, 28*(14), 51-56. doi:10.7748/ns2013.12.28.14.51.e7944

QSEN Institute. (2013). Institute of Medicine competencies for nursing. Retrieved from http://qsen.org/

QSEN Institute. (2014). About QSEN. Retrieved from http://qsen.org/competencies/

Reid, J., & Catchpole, K. (2011). Patient safety: A core value of nursing so why is achieving it so difficult? *Journal of Research in Nursing, 16,* 209-223. doi:10.1177/1744987110393454

Roche, J., Schoen, D., & Kruzel, A. (2013). Human simulation versus written case studies for new graduate nurses in orientation: A pilot study. *Clinical Simulation in Nursing, 9*(6), 199-205. doi:10.1016/j.ecns.2012.01.004

Romp, C. R., & Kiehl, E. (2009). Applying the Stetler Model of research utilization in staff development. *Journal for Nurses in Staff Development, 25*(6), 278-284.

Romyn, D. M., Linton, N., Giblin, C., Hendrickson, B., Limacher, L. H., Murray, C., … Nordstrom, B. (2009). Successful transition of the new graduate nurse. *International Journal of Nursing Education Scholarship, 6*(1), 1-17. doi:10.2202/1548-923X.1802

Roth, J. W., & Johnson, M. P. (2011). Transition to practice: The North Carolina initiative. *Journal of Nursing Regulation, 2,* 56-60. Retrieved from http://jnr.metapress.com/

Rush, K. L., Adamack, M., Janke, R., Gordon, J., & Ghement, I. R. (2013). The helpfulness and timing of transition program education. *Journal of Nurses in Professional Development, 29,* 191-196. doi:10.1097/NND.0b013e31829aec43

See, A., & Teetor, T. S. (2014). Effective e-training: Using a course management system and e-learning tools to train library employees. *Journal of Access Services, 11*(2), 66-90. doi:10.1080/15367967.2014.896217

Seibold, M., & Gamble, K. (2015). Capacity, commitment, and culture: The 3 Cs of staff development in a learning organization. *Psychiatric Rehabilitation Journal, 38*(3), 286-287. doi:org/10.1037/prj0000157

Spector, N., & Echternacht, M. (2010). A regulatory model for transitioning newly licensed nurses to practice. *Journal of Nursing Regulation, 1,* 18-25. Retrieved from https://www.ncsbn.org/Final_08_reg_model.pdf

St. Holmes Medical Center. (2011). Title. [Retrieval information redacted].

St. Holmes Medical Center. (2013). *Registered nurse clinical orientation program format: Medical surgical orientation.* [Retrieval information redacted].

Swanson, K. M. (1991). Empirical development of a middle range theory of caring. *Nursing Research*, *40*(3), 161-166.

Swihart, D. (2007). *The effective nurse preceptor handbook* (2nd ed.). Danvers, MA: HCPro.

Swihart, D. (2012). *Nurse preceptor program builder: Tools for a successful preceptor program* (2nd ed.). Danvers, MA: HCPro.

Ulrich, B., Kozek, C., Early, S., Ashlock, C. H., Africa, L. M., & Carman, M. L. (2010). Improving retention, confidence, and competence of new graduate nurses: Results from a 10-year longitudinal database. *Nursing Economics, 28,* 363-375. Retrieved from https://www.nursingeconomics.net/ce/2012/article28363375.pdf

VHA registered nurses (RN) transition to practice program. (2011). Retrieved from http://www.va.gov/

Welding, N. M. (2011). Creating a nursing residency: Decrease turnover and increase clinical competence. *Medical Surgical Nursing, 20,* 37-40. Retrieved from https://www.amsn.org/sites/default/files/documents/practice-resources/healthy-work-environment/resources/MSNJ_Welding_20_01.pdf

Winfield, C., Melo, K., & Myrick, F. (2009). Meeting the challenge of new graduate role transition: Clinical nurse educators leading the change. *Journal for Nurses in Staff Development, 25*(2), E7-E13. doi:10.1097/NND.0b013e31819c76a3

Wlodkowski, R. J. (2008). *Enhancing adult motivation to learn: A comprehensive guide for teaching all adults* (3rd ed.). San Francisco, CA: Jossey-Bass.

Xu, Y., & He, F. (2012). Transition programs for internationally educated nurses: What can the United States learn from the United Kingdom, Australia, and Canada? *Nursing Economics, 30,* 215-239. Retrieved from http://www.nursingeconomics.net/

Yanow, D., & Schwartz-Shea, P. (2006). *Interpretation and method: Empirical research methods and the interpretive turn.* New York, NY: M.E. Sharpe.

Yin, R. K. (2013). *Case study research: Design and methods: Applied social research methods* (5th ed.). Los Angeles, CA: Sage

Yoon, S. W., Song, J. H., & Lim, D. H. (2009). Beyond the learning process and toward the knowledge creation process: Linking learning and knowledge in the supportive learning culture. *Performance Improvement Quarterly, 22*(3), 49-69. doi:10.1002/piq.20060

Zekonis, D., & Gantt, L. (2007). New graduate nurse orientation in the emergency department: Use of a simulation scenario for teaching and learning. *Journal of Emergency Nursing, 33,* 283-285.

Appendix A: The Project

Part A: A 6-Month TTP

Purpose of the TTP

At the completion of a study completed by a colleague of the SHMCSON related to the orientation program of newly licensed and their professional role it was determined that a research based TTP was needed to meet the educational and experiential needs of newly licensed nurses as employees of SHMC. The data collected revealed the need for a longer research based structured orientation for newly licensed nurses. The purpose of this program is to provide newly licensed nurses employed by SHMC the continued education and support needed to become successful health care practitioners moving from a graduate nurse to an expert nurse as outlined in Benner's Novice to Expert Theory (1984). To ensure an evidenced approached this program will focus on the TTP as outlined and recommended by the NCSBN (2011). In order to affect social change within SHMC this program will be tailored to meet the special challenges and needs of the SHMC and continue to hold to the fundamental basics of the NCSBN TTP.

General information

The safe and competent practice of new nurses is at the forefront of the SHMC organization. Providing an educational program post-graduation provides needed ongoing education for new nurses at the bedside. Nursing education with nursing administration will work together toward best outcomes for our patients and for nurses.

Workshop Details

The SHMC does not have a TTP. Over the next six months, each new nurse will be automatically enrolled in the program. Successful completion of this program is a requirement of continued employment with the SHMC organization. The modular curriculum will consist of policy and procedure for SHMC and patient care combined, communication and teamwork, quality improvement, and informatics. The program is designed to aid each new nurse with the development of decision-making and hands on

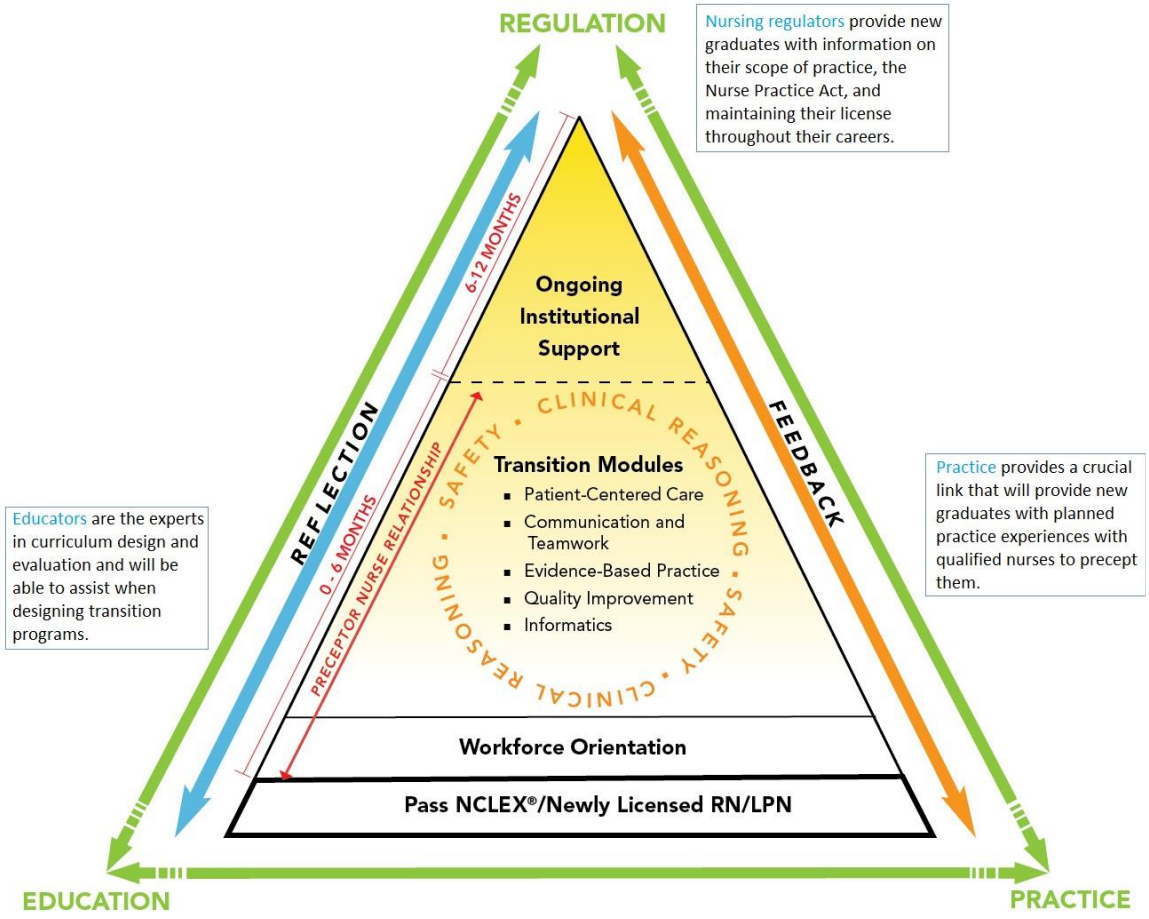
skills to increase nursing safety, judgment, and performance. A program booklet outlining the TTP on a weekly basis will be provided to each nurse enrolled in the program. A one-day orientation session will be held to complete the enrollment into the program and provide an opportunity for questions and answers from the nurses enrolled in the program. Additionally, the orientation day will provide an opportunity for new nurses to meet their unit managers and their nurse preceptors. A tour of the assigned nursing unit, the hospital campus, the TTP site of instruction, and simulation facilities will be included. Classroom, simulation, and clinical schedules will be provided to each participant. A nurse preceptor who has completed the preceptor training program will be assigned to each nurse. This experienced nurse will be mentor and guide the newly licensed nurse into their new profession and to the SHMC organization and community. Each month the new nurse will complete a new educational module designed to help them transition for the educational arena to professional practice. Explanations of the evaluation process will be explained by the nurse educators and reinforced by the assigned nurse preceptors. In class and homework assignments for month one will be reviewed. Organizational expectations and educational opportunities will be included in this introductory day. The TTP practice model will be reviewed and its relevance to beginning nursing practice explained. An introduction of nursing and administrative leadership will take place. Finally, a complete program review will be conducted and a period to provide answers to questions will be included in the orientation day. Contact hours will be provided during the entire program.

TTP Definition

A formal program of active learning implemented across all settings, for newly licensed nurses designed to support their progression from education to practice NCSBN (2011). The RN Transition-to-Practice Program is a comprehensive 6-month standardized curriculum designed to assist the post-graduate nurse in the transition from entry-level, advanced beginner nurse to competent professional RN. This program is a comprehensive developmental training program that has both didactic and clinical components designed

to afford the post-graduate RN the opportunity to perform the role, duties, patient care activities and procedures that are carried out by RNs ("VHA Registered Nurses [RN] Transition to Practice Program," 2011).

Figure 1



Transition to Practice Model

The NCSBN Transition to Practice Model

NCSBN (2011)

Six-Month TTP Program Objectives

At the end of the 6-month TTP, each new nurse will (NCSBN, 2011):

1. Explain the skills to move from a graduate nurse to a competent nurse using Benner's (1984) novice-to-expert theory (1984)
2. Provide an explanation related to clinical policies and procedures
3. Complete each simulation with a satisfactory outcome
4. Define horizontal and lateral violence
5. Explain the importance of integrating evidence-based information into practice
6. Define patient-centered care
7. Make decisions based on the established policies and procedures of SHMC
8. Give an example of an ethical patient care
9. Explain what a patient advocate is in health care
10. Define the role the nurse plays in patient advocacy
11. Identify regularly used medications, common diagnosis, and procedures
12. Evaluate and collect relevant patient data
13. Define sentinel events
14. Explain positive and negative patient outcomes
15. Demonstrate prioritization in the clinical setting
16. Make the transition from novice to competent nurse
17. Define roles of the interdisciplinary health care team
18. Demonstrate the use of SBAR in the health care and classroom setting
19. Accurately demonstrate the use of SHMC documentation system
20. Define the delegation
21. Define communication, accountability, assignment, delegation, and supervision as understood by the New Jersey Nurse Practice Act
22. Participate in conflict resolution exercises in the classroom
23. Give an example of integrating best practice in the clinical setting

24. Complete an assigned research paper related to evidence based practice, using the three of the following databases- Cochrane Database of Systematic Review, CINAHL, ERIC, OVID, Google Scholar, and MEDLINE
25. Define a root cause analysis
26. Complete a utilization review with the assistance of the unit manager
27. Complete a 24-hour chart review and report the findings
28. Work with a group of peers to complete a presentation related to the national patient safety goals
29. Define never events
30. Explain the significance of Six Sigma within the SHMC organization
31. Define Leapfrog and how it is used within the SHMC organization
32. Explain SHMC discharge procedures
33. Complete an incident report in the classroom setting
34. Explain the electronic information available at SHMC
35. Demonstrate the use SORIAN in the collection of patient data, patient documentation, progress notes, ER reports, medication information, physician/patient orders, patient history and physical
36. Demonstrate the use of a MAK for patient medication administration and education in the classroom and clinical setting
37. Define HER, telehealth, HIPPA, and PHI
38. Identify support systems for newly licensed nurse within the SHMC
39. Demonstrate the use of the LAWSON system
40. What is the mission of the New Jersey Board of Nursing?
41. Explain the scope of practice for an RN in New Jersey
42. Complete, analyze, and discuss the Myers-Briggs results
43. Discuss the resources available to a new nurse when there is a conflict with the assigned preceptor
44. Complete all assigned modules with the TTP

TTP Orientation Day Objectives

1. Explain the importance of integrating evidence-based information into practice
2. Define TTP
3. Explain the importance of the TTP
4. Recall the 5 modules of the TTP
5. Discuss the importance of making decisions based on the established policies and procedures of SHMC
6. Define the role of the preceptor
7. Be able to use the TTP manual
8. Explain the TTP calendar and schedule
9. Locate assigned nursing unit, meet preceptor, and unit manager

TTP Orientation Slide Presentation

TTP ORIENTATION DAY

Shirley Richardson MSN, RN
Doctoral Candidate –Walden University

1

TTP ORIENTATION OBJECTIVES

- Explain the importance of integrating evidence-based information into practice
- Define TTP
- Explain the importance of the TTP
- Recall the 5 modules of the TTP
- Discuss the importance of making decisions based on the established policies and procedures of SHMC
- Define the role of the preceptor
- Be able to use the TTP manual
- Explain the TTP calendar and schedule
- Locate assigned nursing unit, meet preceptor, and unit manager

INTEGRATING EVIDENCE-BASED PRACTICE INTO THE CLINICAL SETTING

- WHAT IS EVIDENCED BASED PRACTICE
- WHAT DOES EBP MEAN TO ME AS A PRACTIONTIONER
- HOW IS EBP INTEGRATED INTO PRACTICE AT ST. HOLMES
- WHERE DO I FIND UPDATED PRACTICE INFORMATION AT ST. HOLMES
- WHAT ARE THE BENEFITS OF USING EBP
- WILL THE USE OF EBP IMPROVE PATIENT OUTCOMES

WHAT IS A TTP

- TTP DEFINITION
- THE PURPOSE OF THE ST. HOLMES TTP
- IS THE TTP MODEL USED BY ST. HOLMES EBP
- WHY USE THE NCSBN TTP MODEL
- WHY SIX MONTHS IN LENGTH
- WHAT ARE THE BENEFITS OF IMPLEMENTING THE TTP

THE 6 MODULES OF THE TTP

- Workforce Orientation
- Patient-Centered Care
- Communication and Teamwork
- Evidenced-Based Practice
- Quality Improvement
- Informatics

POLICIES AND PROCEDURES OF SHMC

- OVERVIEW OF ST. HOLMES POLICIES AND PROCEDURES
- OVERVIEW OF NURSING POLICIES AND PROCEDURES
- LEGAL PERSPECTIVE OF POLICIES AND PRODEDURES
- THE NURSES'S ROLE RELATED TO SHMC POLICIES AND PROCEDURES
- PATIENT OUTCOMES AND POLICIES AND PROCEDURES

THE ROLE OF THE PRECEPTOR

- WHAT IS A PRECEPTOR
- WHO QUALIFIES AS A PRECEPTOR
- DEFINITION OF AN EXPERT NURSE
- THE ROLE OF THE PRECEPTOR: DURING ORIENTATION, THE TTP, AS MENTOR
- THE BENEFITS OF AN ASSIGNED PRECEPTOR
- GETTING THE MOST OUT OF THE PRECEPTORSHIP

THE TTP MANUAL

- HOW TO USE THE TTP MANUAL
- REVIEW OF THE TTP MANUAL
- REVIEW OF THE TOC
- QUESTIONS RELATED TO THE TTP MANUAL

MEET ASSIGNED PRECEPTOR, AND UNIT MANAGER

- PROVIDE UNIT ASSIGMENTS
- PROVIDE CLINICAL SCHEDULES
- MEET PRECEPTOR AND UNIT MANAGERS
- TOUR OF FACILITIES

THE TTP CALENDAR AND SCHEDULE

- REVIEW OF THE TTP CALENDAR
- REVIEW OF THE MONTHLY SCHEDULE
- REVIEW OF THE FIRST TWO WEEKS OF THE CALENDAR AND SCHEDULE
- REVIEW OF THE FIRST TWO WEEKS OF THE CLINICAL SCHEDULE
- TIME MANAGEMENT AND THE TTP CALENDAR

REFERENCES

- National Council of State Boards of Nursing. (2011). *Description of NCSBN's Transition to Practice® (TTP) model*. Retrieved from https://www.ncsbn.org/13_Transition toPractice_modeldescription.pdf
- Romyn, D. M., Linton, N., Giblin, C., Hendrickson, B., Limacher, L. H., Murray, C., … & Nordstrom, B. (2009). Successful transition of the new graduate nurse. *International Journal of Nursing Education Scholarship, 6*(1), 1-17. doi:10.2202/ 1548-923X.1802
- Roth, J. W., & Johnson, M. P. (2011). Transition to practice: The North Carolina initiative. *Journal of Nursing Regulation, 2,* 56-60. Retrieved from http://jnr.metapress.com/
- Spector, N., & Echternacht, M. (2010). A regulatory model for transitioning newly licensed nurses to practice. *Journal of Nursing Regulation, 1,* 18-25. Retrieved from https://www.ncsbn.org/Final_08_reg_model.pdf
- Welding, N. M. (2011). Creating a nursing residency: Decrease turnover and increase clinical competence. *Medical Surgical Nursing, 20,* 37-40. Retrieved from https://www.amsn.org/sites/default/files/documents/practice-resources/healthy-work-environment/resources/MSNJ_Welding_20_01.pdf

Orientation Day Schedule for TTP

Scheduled time	Activity
7:30 AM-8:00 AM	Sign In and continental breakfast
8:00 AM-8:30 AM	Introductions of TTP faculty educators and introductions and well wishes from nursing and executive leadership of SHMC
8:30 AM-8:50 AM	Handout of TTP manual and additional materials, review of TTP manual
8:50 AM-9:30 AM	Purpose of 6-month TTP and review of 6-month TTP calendar
9:30 AM-10:00 AM	Overview and expectations of the TTP and Review of TTP Objectives
10:00 AM-10:15 AM	Break
10:15 AM-11:00 AM	Explanation of the five TTP modules
11:00 AM-12:00 AM	Meet your peers/small-group activity
12:00 PM-1:00 PM	Lunch
1:00 AM-1:20 PM	Question and Answer
1:20 PM-3:00 PM	Meet assigned nursing preceptor and unit manager, Tour of TTP classroom, simulation lab, skills laboratory, assigned working unit, and SHMC campus
3:00 PM-3:45 PM	Clarifying program expectations, review of participant questions, review of schedule, review of clinical schedule, reminder of TTP start date and time
3:45 PM-4:00 PM	Evaluation and dismissal

Orientation Day Evaluation

After completing the introductory day of the TTP, please answer the questions using the scale below. Your reflections and feedback regarding this program is appreciated and will help us to improve this educational program for the future. Please check the appropriate box corresponding to your selected answer.

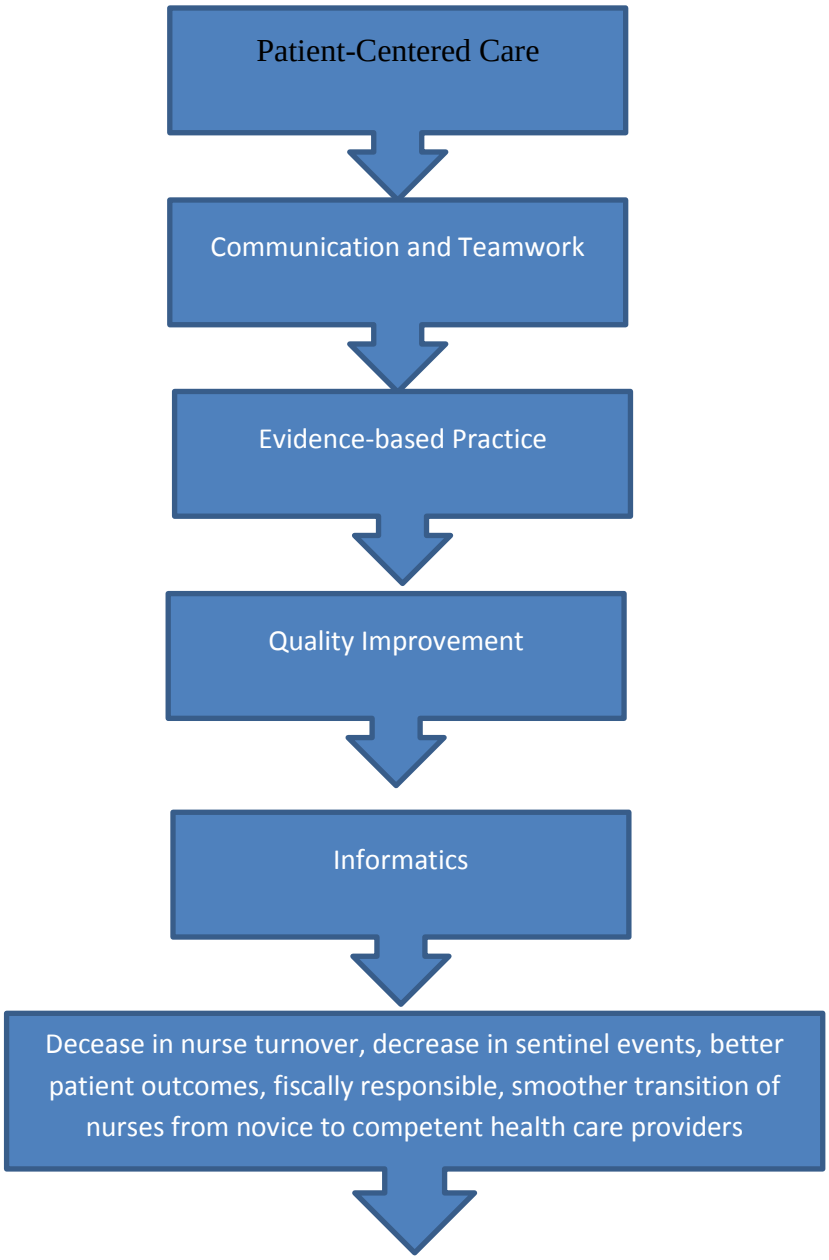
1 - Strongly Disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly Agree

At the conclusion of this program, I feel that:	5	4	3	2	1
The objectives of the TTP were clearly explained and related to topic of the program					
I understand the purpose of the TTP and the program reflects evidenced-based practice					
This program has the support of nursing and executive leadership members					
My role regarding the completion of the TTP was clearly explained					
The five modules of the TTP were identified					
I had an opportunity to ask questions related to the first month scheduling of the TTP					
I have good understanding of how to use the TTP manual					
The nurse educators were knowledgeable about the TTP					
I have a better understanding of the TTP after completing this program					
The nurse educators presented the information in a clear and understandable manner					
The facilities were comfortable					

Below please add any comments that you wish to make regarding the facilities, this program, the educators, the TTP or the overall satisfaction of this orientation program are welcome and appreciated. Please use the space below for your comments. Thank you and we look forward to seeing you on Day 1 of Month 1 of the TTP.

Comments:

6-Month TTP Content Schedule



(NCSBN, 2011; Spector & Echternacht, 2010; Welding, 2011).

Part B: A 3-Day Workshop for Nursing Preceptors

Purpose of the TTP

At the completion of a study completed by a colleague of the SHMCSON related to the orientation program of newly licensed and their professional role it was determined that a research based preceptor program was needed to meet the educational needs of nurses who serve as preceptors within the SHMC organization. The data collected revealed that preceptor is not offered within the facility and expert nurses desired to acquire the education regarding their role as preceptors. The purpose of this program is to provide nurse preceptors the continued education and support needed to train newly licensed nurses employed by SHMC. To ensure an evidenced approached this program will focus on the research conducted by leading nurse educators, nursing authorities, and nursing organizations regarding the education and role of the nurse preceptor. In order to affect social change within SHMC this program will be tailored to meet the special challenges and needs of all stakeholders internally and externally involved with the SHMC regarding this professional development program.

General information

The safe and competent practice of new nurses is at the forefront of the SHMC organization. Providing an educational program that provides training to nurses responsible for training and mentoring new nurses' aids to ensure the correct training and oversight of post graduate nurses practicing within the SHMC. Nursing education and nursing administration will work together toward best outcomes for our patients and for nurses.

Workshop Details

The SHMC does not have a preceptor training program. Over the next two days, each nurse preceptor be provided an opportunity to enroll in the program. The two-day workshop will consist of a review of general nursing policies and procedures for SHMC. Additionally, the concepts of patient care, communication and teamwork, quality

improvement, and informatics will be covered from a teaching perspective for nurse preceptors. The program will also cover the evaluation process, how to evaluate, the forms used to evaluate new nurses, and the formative and summative evaluation processes. The program is designed to assist the nurse preceptor with understanding the role and responsibilities of a nurse preceptor within the SHMC organization. A program folder containing the schedule of activities, program objectives, policies for review, and responsibilities of the nurse preceptor are included in the program folder. Organizational expectations regarding the role of the nurse preceptor in and out of the clinical setting will be reviewed during the workshop. The TTP practice model will be briefly covered in addition to its relevance to graduate nurses and nursing preceptors. Finally, a complete program review will be conducted and a period to provide answers to questions will be included in both workshop days. Contact hours will be provided for this two day workshop.

Nurse Preceptor Definition

According to Swihart (2012), a preceptor is a nurse who is experienced and is considered a competent nurse. This competent and experienced has received formal preceptor training to serve in the role of preceptor. These nurses function in the capacity of role models, and resource personnel to a variety of health care practitioners.

Responsibilities of Nurse Preceptors - Swihart (2012)

1. Introduce preceptees to their new roles and responsibilities
2. Coach preceptees on the basics-- where to park; when to report; where to find supplies and resources; how to fine and use unit areas specific equipment
3. Unit area rules and guidelines
4. The organizations strategic plan and where it can be found
5. Support initiate critical-thinking skills
6. Evaluate performance and give feedback for improvement
7. Introduce the nurse to a wider network of nurses
8. Recommend preceptees for projects, committees, advancements, an honors within

the professional practice environment and community

9. Understand that precepting is time-limited Preset Orient
10. Help preceptees verify their initial service specific and any unit specific competencies when they first arrive on the unit on work area
11. Provide ongoing support and encouragement
12. Assist preceptees transition into their new roles
13. Understand that eventually the preceptorship may evolve into a mentorship as the preceptee matures into his or her new role and responsibilities.

Swihart (2012).

Preceptor Workshop Objectives

At the conclusion of Day 1 of workshop, nurse preceptors will:

1. Provide the definition of a nursing preceptor
2. Explain the role of the nurse preceptor
3. Explain the connection between SHMC policies and procedures and clinical practice
4. Give examples of reality shock
5. Explain the five different strategies of providing constructive feedback

At the conclusion of Day 2 of workshop, nurse preceptors will:

1. Develop an orientation outline
2. Describe the advantages of the learning style inventory test
3. Describe the importance of SHMC nursing policies and procedures
4. Discuss the differences between a visual, tactile, and auditory learner
5. Preceptors will list one characteristic that differentiates each phase of team development
6. Development an action plan for an orientee that fits into one of the three domains of learning

At the conclusion of Day 3 of workshop, nurse preceptors will:

1. Define a TTP
2. Complete an evaluation form used to evaluate new nurses
3. Compare and contrast formative and summative evaluations
4. Define the role of the preceptor in the evaluation process of a new nurse
5. Explain the purpose of the facility's orientation policy

Preceptor Workshop Slide Presentation

Preceptor Workshop

ST. Holmes Medical Center

Day One Schedule

• 7:30 AM-8:00 AM	Sign In and Continental breakfast
• 8:00 AM-8:30AM	Introductions of workshop faculty facilitators and Purpose of the three-day workshop and Review of workshop schedule
• 8:30 AM- 8:50 AM	Handout of preceptor workshop folders and additional materials and Overview and expectations of the preceptor workshop and Review of workshop objectives
• 8:50 AM- 9:30 AM	Large and Small group discussion Defining the preceptors role
• 9:30 AM-10:00 AM	SHMC policies and procedures and clinical practice
• 10:00 AM-10:15 AM	Break
• 10:15 AM-12:00 PM	Reality shock and the preceptors' role
• 12:00 PM-1:00 PM	Lunch
• 1:00 AM- 1:20 PM	Question and Answer
• 1:20 PM- 3:00 PM	5 strategies for providing constructive feedback
• 3:00 PM- 3:45	Clarifying program expectations, review of participant questions, review of schedule for day two of workshop
3:45 PM- 4:00 PM	Evaluation and dismissal

Workshop Objectives- Day 1

At the end of day one of the workshop, the preceptor should be able to implement the following objectives:

- Provide the definition of a nursing preceptor
- Explain the role of the nurse preceptor
- Explain the connection between SHMC policies and procedures and clinical practice
- Give examples of reality shock
- Explain the five different strategies of providing constructive feedback

Day One

- Faculty introductions
- Handout of workshop materials
- Facility overview
- Workshop overview
- Review of schedule for workshop days
- Questions/Answers

What is a Nurse Preceptor

- Definition
- General qualifications
- St. Holmes Standards for nurse preceptors
- Who is an expert nurse
- How do we mentor
- Are you a role model
- Expectations of a St. Holmes preceptor

The Role of the Nurse Preceptor

- The day-to day role of the nurse preceptor
- Socialization
- Lead by example
- Speaking with authority
- Modeling behavior
- Professionalism
- Communication

SHMC Policies and Procedures and Clinical Practice

- Nursing policies
- Clinical practice and nursing policies
- Teaching the organizational policies
- Obtaining clarification of policies
- Where can policies be found?

Give examples of reality shock

- What is reality shock
- What does reality shock look like
- How to assist the new nurse experiencing reality shock
- Mentoring the new nurse through reality shock successfully
- Communicating with a new nurse experiencing reality shock

Five Different Strategies of Providing Constructive Feedback

- Create a safe atmosphere
- Be positive during the interaction
- Be specific when providing feedback
- Be immediate, provide feedback as soon as you are able in in a safe manner
- Be firm but not overly aggressive

Day Two Schedule

• 7:30 AM-8:00 AM	Sign In and Continental breakfast
• 8:00 AM-9:00AM	Review of day one activities, review evaluations received on day one, question and answer period, clarifications
• 9:00 AM- 9:15 AM	Review of workshop folder and materials to be used today
• 9:15 AM- 10:00 AM	Breakout into Small groups and review of SHMC general nursing policies and procedures.
• 10:00 AM-10:25 AM	Break
• 10:25 AM-11:45 AM	How to develop an orientation outline
• 11:45 AM-12:00 PM	Question and Answer
• 12:00 PM- 1:00 PM	Lunch
• 1:00 PM- 2:00 PM	Learning styles
• 2:00 PM- 3:00 PM	Phases of Team Development
• 3:00 PM- 3:15 PM	Break
3:15 PM- 3:45 PM	The three domains of learning
3:45 PM-4:00 PM	Evaluations and dismissal

Workshop Objectives- Day 2

At the end of day two of the workshop, the preceptor should be able to implement the following objectives:

- Develop an orientation outline
- Describe the advantages of the learning style inventory test
- Describe the importance of SHMC nursing policies and procedures
- Discuss the differences between a visual, tactile, and auditory learner
- List one characteristic that differentiates each phase of team development
- Develop an action plan for an orientee that fits into one of the three domains of learning

Developing an Orientation Outline

- What is an orientation line
- The purpose of the orientation outline
- Heading to be placed in the outline
- Ensuring the outline is unit specific
- What to accomplish in first two days, first week, first two weeks, first month
- Tour unit
- Set meeting times
- Set evaluation times

Describe the importance of SHMC nursing policies and procedures

- Adhering to nursing policies
- Violation of nursing policies
- Why are policies necessary?
- Reviewing facility policies

The Learning Style Inventory Test

- What are learning styles
- How interpret the learning style inventory test
- Visual learners
- Auditory learners
- Kinesthetic learners
- Verbal/linguistic
- Completing a learning style inventory test

Differences between a visual, auditory, kinesthetic, and verbal learner

- Visual learners
- Auditory learners
- Kinesthetic learners
- Verbal/linguistic

Characteristics of Team Development

- Forming
- Storming
- Norming
- Performing

Developing an action plan using the Three Domains of Learning

- What is an action plan
- How to develop an action plan
- **Cognitive**
- **Affective**
- **Psychomotor**

Day Three Schedule

• 7:30 AM-8:00 AM	Sign In and Continental breakfast
• 8:00 AM-8:30AM	Handout of preceptor workshop folders and additional materials and review of workshop objectives
• 8:30 AM- 8:50 AM	Purpose of day three workshop and Review of today's schedule
• 8:50 AM- 9:30 AM	Understanding the evaluation process, Review of the formative and summative evaluation forms
• 9:30 AM-10:00 AM	Understanding the preceptors' role in the evaluation process
• 10:00 AM-10:15 AM	Break
• 10:15 AM-12:00 PM	Understanding the TTP, Review of the monthly NCSBN TTP model and the curriculum
• 12:00 PM-1:00 PM	Lunch
• 1:00 AM- 1:20 PM	Question and Answer
• 1:20 PM- 2:30 PM	Understanding the SHMC orientation policy
• 2:30 PM- 3:00	Clarifying program expectations, review of participant questions
• 3:00-3:45	Workshop Quiz
3:45 PM- 4:00 PM	Evaluation and dismissal

Workshop Objectives- Day 3

- Define a TTP
- Complete an evaluation form used to evaluate new nurses
- Compare and contrast formative and summative evaluations
- Define the role of the preceptor in the evaluation process of a new nurse
- Explain the purpose of the facility's orientation policy

Understanding the TTP

- What is a TTP
- What is the purpose of a TTP
- Why is St. Holmes implementing a TTP
- What is my role as a preceptor related to the TTP
- What are the goals of the TTP
- Understanding the Six-month program:
    1. Workforce Orientation
    2. Patient-Centered Care
    3. Communication and Teamwork
    4. Evidenced-Based Practice
    5. Quality Improvement
    6. Informatics

Understanding the Evaluation Form

- The importance of the evaluation process
- Keeping evaluation documentation
- Review of the evaluation form
- Why a new evaluation form
- How to use the evaluation form during the evaluation process
- Completing the evaluation form- Who is responsible?
- Maintaining evaluation confidentiality

Formative and Summative Evaluations

- Formative evaluations
- Summative evaluations
- The purpose of formative and summative evaluations
- Using formative and summative evaluations during the TTP
- Why use each evaluation method
- The role of the preceptor in the evaluation process

The Purpose of the Facility's Orientation Policy

- Why is an orientation policy is needed?
- Where to locate the orientation policy
- The purpose of the orientation policy
- Understanding the orientation policy
- How to use the orientation policy
- Questions related to the orientation policy

Schedule Preceptor Workshop Day 1

Scheduled time	Activity
7:30 AM-8:00 AM	Sign in and continental breakfast
8:00 AM-8:30 AM	Introductions of workshop faculty facilitators and purpose of the 3-day workshop and review of workshop schedule
8:30 AM-8:50 AM	Handout of preceptor workshop folders and additional materials and overview and expectations of the preceptor workshop and review of workshop objectives
8:50 AM-9:30 AM	Large- and small-group discussion Defining the preceptor's role
9:30 AM-10:00 AM	SHMC policies and procedures and clinical practice
10:00 AM-10:15 AM	Break
10:15 AM-12:00 PM	Reality shock and the preceptors' role
12:00 PM-1:00 PM	Lunch
1:00 AM-1:20 PM	Question and Answer
1:20 PM-3:00 PM	5 strategies for providing constructive feedback
3:00 PM-3:45 PM	Clarifying program expectations, review of participant questions, review of schedule for Day 2 of workshop
3:45 PM-4:00 PM	Evaluation and dismissal

Workshop Day 1 Evaluation

After completing the first workshop day of the preceptor program, please answer the questions using the scale below. Your reflections and feedback regarding this program is appreciated and will help us to improve this educational program for the future. Please check the appropriate box corresponding to your selected answer.

1 - Strongly Disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly Agree

At the conclusion of this program, I feel that:	5	4	3	2	1
The objectives of the preceptor program were clearly explained and related to topic of the program					
I understand the purpose of the preceptor program					
The preceptor program reflects evidenced-based practice					
I have better understanding of what it means to be a preceptor					
My role as preceptor within this organization was clearly defined					
I had an opportunity to ask questions about the preceptor program					
I have a better understanding of reality shock					
The faculty facilitators were knowledgeable about the preceptor program					
After today I have better understanding of how to provide constructive feedback					
The faculty facilitators presented the information in a clear and understandable manner					
The facilities were comfortable					

Below please add any comments that you wish to make regarding the facilities, this program, the facilitators, and the preceptor program. All comments are welcome, encouraged, and appreciated. Please comment on any item or items you would like to see covered on Day 2 of the workshop. Please use the space below for your comments.

Thank you and we look forward to seeing you on Day 2 of the workshop.

Comments:

Schedule Preceptor Workshop Day 2

Scheduled time	Activity
7:30 AM-8:00 AM	Sign in and continental breakfast
8:00 AM-9:00 AM	Review of Day 1 activities, review evaluations received on Day 1, question and answer period, clarifications
9:00 AM-9:15 AM	Review of workshop folder and materials to be used today
9:15 AM-10:00 AM	Breakout into small groups and review of SHMC general nursing policies and procedures.
10:00 AM-10:25 AM	Break
10:25 AM-11:45 AM	How to develop an orientation outline
11:45 AM-12:00 PM	Question and answer
12:00 PM-1:00 PM	Lunch
1:00 PM-2:00 PM	Learning styles
2:00 PM-3:00 PM	Phases of team development
3:00 PM-3:15 PM	Break
3:15 PM-3:45 PM	The three domains of learning
3:45 PM-4:00 PM	Evaluations and dismissal

Workshop Day 2 Evaluation

After completing Day 2 of the preceptor program workshop, please answer the questions using the scale below. Your reflections and feedback regarding this program is appreciated and will help us to improve this educational program for the future. Please check the appropriate box corresponding to your selected answer.

1 - Strongly Disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly Agree

At the conclusion of this program, I feel that:	5	4	3	2	1
The objectives of the preceptor program were clearly explained and related to topic of the program					
I am able to develop an orientation outline					
I have a better understanding of the advantages of the learning style inventory test					
I have better understanding of the general nursing policies and procedures within my organization					
I understand how to connect the policies and procedures to clinical practice					
I had an opportunity to ask questions about the policies and procedures of SHMC					
I am more comfortable with developing an action plan based on the three domains of learning					
The faculty facilitators were knowledgeable about the policies and procedures of SHMC					
I have good understanding of the phases of team development					
The faculty facilitators presented the information in a clear and understandable manner					
The facilities were comfortable					

Below please add any comments that you wish to make regarding the facilities, this program, the facilitators, and the preceptor program. All comments are welcome, encouraged, and appreciated. Please comment on any item or items you would like to see covered in future workshops. Please use the space below for your comments. Thank you for attending the workshop.

Comments:

Schedule Preceptor Workshop Day 3

Scheduled time	Activity
7:30 AM-8:00 AM	Sign in and continental breakfast
8:00 AM-8:30 AM	Handout of preceptor workshop folders and additional materials and review of workshop objectives
8:30 AM-8:50 AM	Purpose of Day 3 workshop and review of today's schedule
8:50 AM-9:30 AM	Understanding the evaluation process; review of the formative and summative evaluation forms
9:30 AM-10:00 AM	Understanding the preceptors' role in the evaluation process
10:00 AM-10:15 AM	Break
10:15 AM-12:00 PM	Understanding the TTP; review of the monthly NCSBN TTP model and the curriculum
12:00 PM-1:00 PM	Lunch
1:00 AM- 1:20 PM	Question and Answer
1:20 PM- 2:30 PM	Understanding the SHMC orientation policy
2:30 PM- 3:00 PM	Clarifying program expectations, review of participant questions
3:00-3:45 PM	Workshop quiz
3:45 PM-4:00 PM	Evaluation and dismissal

Content Reviewed Each Month

Workshop Day 3 Evaluation

After completing the third and final day of the preceptor program workshop, please answer the questions using the scale below. Your reflections and feedback regarding this program is appreciated and will help us to improve this educational program for the future. Please check the appropriate box corresponding to your selected answer.

1 - Strongly Disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly Agree

At the conclusion of this program, I feel that:	5	4	3	2	1
The objectives of the preceptor program were clearly explained and related to topic of the program					
I understand the purpose of the SHMC orientation policy					
The preceptor program reflects evidenced-based practice					
I have good understanding of how to use the evaluation forms when evaluating my preceptee					
I understand the difference between a formative and a summative evaluation					
I had an opportunity to ask questions about the preceptor program					
I have a better understanding of the TTP model and the TTP curriculum					
The faculty facilitators were knowledgeable about the preceptor program					
After today I have better understanding of the purpose of the SHMC orientation policy					
The faculty facilitators presented the information in a clear and understandable manner					
The facilities were comfortable					

Below please add any comments that you wish to make regarding the facilities, this program, the facilitators, and the preceptor program. All comments are welcome, encouraged, and appreciated. Please comment on any item or items you would like to see covered in future workshops. Please use the space below for your comments. Thank you for attending the workshop.

Comments:

Appendix B: Interview Demographics

Demographics	GN1	GN2	GN3	GN4	GN5	GN6	P1	P2	P3	P4	M1	M2
Age												
Ethnicity												
Type of nursing program attended												
Gender												
Did you have one designated preceptor during your orientation?												
How many weeks/months was your orientation?												
Did you ask for an extended orientation? Why? Why not?												

Appendix C: Interview Questions for Graduate Nurses

1. Describe your experiences during the first week of your nursing orientation.
2. Describe your evaluation experiences with your preceptor.
3. What was your perception of the role of the preceptor?
4. Did you follow your preceptor's work schedule during your orientation period? Why, or why not?
5. What specific nursing unit/units were you assigned to during your orientation?
6. What educational experiences have you had during the orientation that prepared you for your role as professional nurse?
7. What is your perspective of the time frame for the length of your orientation?
8. Did you attend any classes during your orientation? What were the classes? How did they benefit your transition from student or novice nurse to beginner or graduate nurse?
9. What specific instructional strategies helped you to assimilate into your professional role of a nurse?
10. What additional trainings, workshops, or support would you like to see SHMC offer newly licensed nurses?
11. What are your perceptions of your ability to practice safely and make sound professional decisions after the completion of the orientation process?
12. Do you have any additional comments?

Appendix D: Interview Questions for Preceptors and Managers

1. What are your perceptions of newly licensed nurses during and after completion of the orientation program related to critical decision-making practices?
2. How are staff nurses prepared for the role of preceptor?
3. How effective do you think the SHMC orientation program is?
4. What specific instructional and clinical strategies do you see as important to graduate nurses in their professional role of a nurse?
5. What unit-specific trainings, workshops, or support does SHMC offer newly licensed nurses?
6. What additional trainings, workshops, or support would you like to see SHMC offer newly licensed nurses?
7. Do you have any additional comments?

Appendix E: Triangulation Matrix

RQ	Interview question GNs	Interview questions preceptors	Interview questions managers	Verbatim transcription of audio recording and coding	Documents
What are the perceptions of newly licensed nurses after completion of the orientation process related to their ability to make critical decisions in the professional role of RN? How does the preceptor educational training program prepare staff nurses for the role of preceptor? What are the beliefs of newly licensed nurses and nurse managers regarding the managers' role of nurse mentor?					