A Phenomenonological Investigation into Mentors' Helping Behaviors in a Nurse Residency Program: An Emerging Model

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and authored by Michelle M. Murphy-Rozanski, is hereby accepted and approved.

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ABSTRACT

The purpose of this study was to evaluate Graduate Nurses' (GN) perceptions of helping behaviors of their preceptors, mentors, or coaches, during their nurse residency program. The nurse residency program correlates with the GNs transition into the nursing profession to become a competent Registered Nurse (RN).

With the ever growing increase in the shortage of nurses nationally there is a need to evaluate and identify themes that will assist in easing the transition, retention, and recruitment of competent new nurses into the nursing profession. These themes are of significance to both the hiring Healthcare facilities and the educational institutions that prepare and train future nurses.

The phenomenon of the perceptions of the graduate nurse's lived experiences of the helping behaviors through the residency programs was studied. A qualitative phenomenological method was used. Data collection included a series of three focus group sessions; with a total of nineteen participants included in this study. In addition to the focus group sessions, audio recordings were used along with the researcher's notes and participant data collection sheets and comments. Participants were Graduate Nurse's attending the Nurse Residency Program at Pennsylvania Hospital in Center City Philadelphia.

Results of the study identified three primary themes. First, Graduate Nurses feel that a facilitative learning environment in the academic and clinical setting would be

beneficial. Second, the participants added the need for more "hands on" interactions in their nursing education programs. And third, nurse's needed a supportive learning environment with the guidance of a mentor who was readily available in the residency program.

The researcher stated five conclusions. First, the new nurses want the ability to be autonomous in their practice setting. Second, there is the need for a supportive and nurturing working environment. Third, there needs to be a mentor is readily available to provide guidance and structure to the novice nurse. Fourth, mentors need to model their behavior to provide realistic guidelines and expectations that will the advanced beginners develop a competent method of practice. And fifth, nursing education programs need to integrate a more facilitative method of teaching this generation of nurses.

This study is significant to both the fields of education and nursing respectively. This research supports and extends various comprehensive research studies. This study specifies that additional research is needed in the areas of mentoring, Nurse Residency Programs, and the retention of competent registered nurses within the profession to combat the issues related to the ever growing nursing shortage.

Chapter I

Introduction

A. The Purpose of the Study

The purpose of this proposed phenomenological research study was to identify the actual lived experiences of new graduate nurses as they transition into the profession; the nurses attended a Nurse Residency Program and the study looked for insight into the perceived helping behaviors described by the individuals in relation to the preceptors, mentors, or coaches. The descriptions and perceptions provided by the individuals in the focus groups provided data regarding helping behaviors by mentors leading to an effective mentoring model to ease the transition of Graduate Nurses into the profession. Additionally, the study explored the benefits of the Nurse Residency Program and most importantly ways to retain competent nurses within the profession.

B. Background of the Study

The Nursing Shortage

Recent national statistical data and comprehensive research have demonstrated evidence of a widespread shortage of registered nurses in the USA which will be approximately 808,400 by the year 2020 (HRSA, July 2002). The American Nurses Association (ANA) referred to this shortage as a public health Crisis (Candela, 2005). It would have the most serious impact in specialty areas, such as critical care; therefore will be devastating for the "sickest patients" (AACCN, 2002; National League for Nursing,

2001; Santucci, 2005).

Another fact adding to the crisis is that the current shortage of nurses comes at a time when approximately 78 million baby boomers will begin to retire and enroll in Medicare (Altier and Kresk, 2006; Buerhaus, Staiger, and Auerbach, 2000).

In an analysis of the national nursing crisis, research indicates discrepancies in the data, specifically in numbers related to the projections for the decrease in the nursing workforce. Reports released in 2002 reflect 126,000 vacant RN positions in the active nursing workforce (Murray, 2002). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (2002) anticipate by the year 2010 the demand of RNs will begin to exceed the supply, and by the year 2020 the demand will grow almost twice as fast as the expected increase in the RN workforce (Altier and Kresk, 2006; JCAHO, 2002). Further, analysis indicate ranges in the shortage of RNs to be from 400,000 to 1.5 million nurses by the year 2020 (Bleich, Hewlett, Santos, Rice, Cox, and Richmeier, 2003). Murray (2002) indicates that the RN job market will peak in the year 2007, and then continually decline through the year 2020. With these predictions, the estimated shortage of RNs will equal up to a 20% decrease in Registered Nurses over the next decade and an estimated 400,000 empty RN positions in the workforce by the year 2020 (Murray, 2002).

The imbalance of the supply and demand of competent nurses continues to fuel the current shortage. Areas that will experience the greatest impact of the ongoing shortage of nurses will be specialty units that require extensive training such as critical care units (ERs-Emergency rooms, ICUs-Intensive Care Units), geriatrics, pediatrics, neonatal, and cardiac (Yoder, 2002; ANA, 2000). Additionally, patients that are

hospitalized in an acute care setting on basic Medical-Surgical floor are considerably "sicker" than patients that would have occupied those units a decade ago. Many of the expectations for nurses, specifically new nurses are often unrealistic in today's acute healthcare setting. Further research details that the aging of the current nursing workforce continues to impact the affects of the nursing shortage. The estimated nursing workforce in 2001 was nearly 2.7 million. The average age of nurses was at 45.2 years old. Nurses under the age of 30 decreased.

The number of new graduate nurses showing turnover (or leaving their place of employment) in employment during the first twelve months following graduation has ranged from 35% to 60%. Studies indicate that approximately one out of every three nurses under the age of thirty in the US will plan to leave their job within one year. Factors on the determinants to leave are many, including high stress, job dissatisfaction, schedule discrepancies, mandatory overtime, and burn-out (Murray, 2002). Additional research on nursing satisfaction shows that over half of the practicing nurses surveyed would not recommend the profession to their children or friends (Murray, 2002; Hopkins, 2001). These statistics are detrimental to the learning process of the transitioning novice RN and are extremely costly to the health care institutions (Halfer and Graf, 2006).

21st Century Challenges for Nurses

Now more than ever, nurses are faced with the escalating demands of promoting and ensuring competency of all nurses to safeguard the nursing profession into the 21st century (Joel, 2002). Coupled with the complexities and projected devastation of the

national nursing shortage, nurses are strained to face progressively more critical demands and expectations in skill requirements, flexibility, critical thinking and problem solving skills to remain current and competent within the profession (Cantrell and Browne, 2005). New nurses must be able to translate theoretical concepts into hands on practicality and learn to adapt to actual clinical based scenarios. As noted previously, the demands and expectations of new graduate nurses are often unrealistic for the professional development and retention of the new nurse, and the overall well being of the patients for which they are caring.

Through the use of mentors and residency based programs, many healthcare facilities have recognized, and are now addressing these issues that impede and affect recruitment and retention of new nurses (AACN, 2002a).

According to the *AACN Task Force on Hallmarks of the Professional Practice Setting* (2002) nursing work in an acute practice setting is said to be the most demanding of all work settings including outside professions. The American Association of Nursing Executives (AONE) (2000) state that nurses provide the largest majority of patient care in hospitals, and other health care settings. Over the past few decades, the ever changing climate of the healthcare setting has brought forth new demands for registered nurses. Healthcare is now faced with rapid advances in technology in the workplace, scientific advances, and improvements in disease prevention and management. These factors present a demand for well-educated, experienced and competent nurses (AACN, 2002). New nurses are expected to be able to translate the theories, principles, and knowledge accumulated in school and be able to generalize and apply that information and in specific clinical settings (Santucci, 2004). Joel (2002) reports that nurses practicing in

today's work environments are challenged with multiple new demands such as cost containment, a growing demand for self care, decreasing usage of inpatient care facilities, and the growing advances and uses of technology in the nursing profession. Goode, Pinkerton, McCausland, Southard, Graham, and Kresk (2001) suggest that the level of education for the Registered Nurse is a factor. They suggest that there is an intense demand for baccalaureate prepared nurses, as the research teams believes that baccalaureate nurses demonstrate competent skills in critical thinking and problem solving, they do patient and family teaching in health promotion, and finally, perform case management skills in addition to the "hands on" applications of nursing practice. In 1998, the President's Advisory Commission on Consumer protection and Quality in the Health Care Industry reported on an increased demand in the need for more culturally competent and diverse nurses on issues of gerontology, as the rapidly changing population demographics is advancing as "Baby-Boomers" reach retirement.

As described by Kramer (1974) the ability for new nurses to transition smoothly is not an easy task; new graduates experience what Kramer described as the reality shock of nursing, of not having the real world nursing experience being what they expected it to be (Bowles and Candela, 2005; ANA, 2003). The estimated cost to the Healthcare institutions on training and orienting new nurses' ranges from $8,000 to $50,000 per year dependent on the institution and region (Beeman, Jernigan, and Hensley, 1999). Weston reports that the cost of recruiting and orienting new graduate nurses may cost institutions more than $40,000 (Weston, 2000). Recruitment, and more importantly, retention of new nurses within the profession is essential at addressing the core of the most recent, and crippling shortage of Registered Nurses that our country has experienced. Additional

factors, including the aging nursing workforce and lack of adequately prepared RNs to work in specialty areas, makes this most recent nursing shortage most difficult to correct (Murray, 2002). Therefore, the financial and psychological implications of the shortage of nurses will have an adverse affect on the overall healthcare systems in this country and the nation in general.

The expectations of new nurses in today's work environment far exceed the responsibilities of nurses over in the past. New nurses are faced with greater responsibilities not only in the hands on acute care work in a hospital environment, but in the technological demands incorporated in the professions, and the social and communicative responsibilities of interacting with Doctors, patients and their families. These demands can be overwhelming and consuming to a new nurse that is trying to learn to adapt to their new role, while dealing with the lives of other individuals. The shortage of nurses is not only crucial for the retention and recruitment of new nurses, but for the welfare of the patients overall in hospital settings. Research by O'Neil and Seago (2002) indicate a 23 % increase in nurse burnout and job satisfaction when *one* additional patient is added to a nurse's workload. More disturbing is the statistical findings that by adding one additional patient to a nurse's workload equivated in 7 % increase in the odds of failure-to-rescue during a crisis (Altier and Kresk, 2006). These frightening statistics bring the reality of the overall impact of the nursing shortage to all individuals and their families, not just the healthcare industry in this country.

<u>Preparation for Nurses Entry into practice in conflict</u>

Joel (2002) states "*An external locus has divided our strength, created internal unrest and kept nursing straddling the fence between expedient educational programs and those that create professionalism*" (p. 2). The nursing profession currently has three separate acceptable levels of entry into practice. Nursing candidates may attend a BSN (Bachelors in Science of Nursing), ADN (Associates Degree in Nursing), or a Diploma in nursing program. Many professions such as medicine, law, engineering, and social work have taken a firm stand at the accepted level of entry into practice, nursing has not (Joel, 2002; Smith and Crawford, 2003). With the shortage of nurses, the debate on the acceptable level of entry into practice has resurfaced and is in the spotlight again. The Pew Health Profession Committee (O'Neill & Coffman, 1998) supports diversity among students and recognizes the value of multiple entry points of professionals in the nursing practice. According to Speakman, 2000, multiple entry points can provide a strength that will graft each level of nursing education. Mengel and Donnelly (1997) metaphorically define grafting as a commitment to live and work in harmony and share space and resources. The ability of nurses collectively to deal with adversity will affect the professions ability to interact with other members of the health care team (Speakman, 2000). The National Council of State Boards of Nursing designates the NCLEX-RN® examination as the nationally accepted method of demonstrating an individual's ability to practice safely, effectively, and competently as a newly licensed, entry-level registered nurse (NCSBN, 2001). However, researchers such as Long (2004) and Joel (2002) argue that the multiple levels of entry into practice are not supportive for positive outcomes in the nursing profession. Long (2004) emphasizes that the baccalaureate level of nursing or higher is not only important for supporting the professionalism of the nursing practice,

but that the enhanced level of education by the nurse providing care for surgical patients also supports a "substantial survival advantage". Long's (2004) article supports Aiken et al 2003 study on the association between education levels of hospital RNs and the mortality rate of surgical patients. The conclusion of this study was that the nurse's education level does relate to safer patient outcomes. The researchers suggested further studies nationwide to support these findings.

Conversely Bargagliotti (2003) suggests that it is not the entry into practice that is the problem with the nursing profession, but the exit from practice. As she emphasized, many Registered Nurses, nursing leaders, and nursing mentors actively working in the nursing profession today would not be *in* the profession if not for associate or diploma based programs, (including this researcher). Further Bargagliotti suggest that many regional sections in our country, such as Bucksnort, TN do not have a university for nurses to attend a baccalaureate program. Therefore she supports recruiting new nurses at an early age, (as research supports the aging of the nursing profession in general) and preparing the nurses both clinically and academically at a younger age to the obtain advanced degrees and be committed and invested in the profession for a longer period of time.

Smith (2002) completed an evaluation of the 1999 RN Practice analysis conducted by Hertz, Yocom, and Gaswel (1999) on a nurse's educational preparation. These findings did not support differences in the frequencies of performance of activities within the entry-level of practice (p. 494). Along with the discrepancies on an acceptable level of entry into practice, the individual State Boards of Nursing conform to the organizational and administrative requirements set forth by the governing State on

curriculum guidelines and standards of practice set forth by that state, however program content and training will vary at all three levels.

Identifying the challenges and demands for nurses now and in the future, the AACN's Hallmarks of Professional Nursing Practice Environments are characteristics to better support professional nurses and allow nurses to practice at their highest potential. It should be noted, the report indicates the hallmarks for baccalaureate or higher degree nurses in practice. The hallmarks are as follows:

1. *Manifest a philosophy of clinical care emphasizing quality, safety, interdisciplinary collaboration, continuity of care, and professional accountability (Nursing staff assumes responsibility and accountability for their own practice).*
2. *Recognize contributions of nurses' knowledge and expertise to clinical care quality and patient outcomes (Advanced practice roles in nursing including nurse practitioners, nurse specialist, scientist, and educators support and enhance nursing care).*
3. *Promote executive level nursing leadership (Nurse Executive is supported by adequate managerial and support staff).*
4. *Empower nurses' participation in clinical decision making and organization of clinical care systems (staff nurses have the authority to develop and execute nursing care orders and actions and to control their practice).*
5. *Maintain clinical advancement programs based on education, certification, and advanced preparation (individuals in nursing*

leadership/management positions have appropriate education and credentials aligned with their role and responsibilities).

6. *Demonstrate professional development support for nurses (APNs (Advanced Practice Nurses), nurse educators, and nurse researchers are employed and utilized in leadership roles to support clinical nursing practice).*

7. *Create collaborative relationships among members of the health care provider team (interdisciplinary peer review process is used, especially to review patient care errors).*

8. *Utilize technological advances in clinical care and information systems (Documentation is supported through appropriate application of technology to the patient care process). (AACN, 2002a, pp. 5-7).*

Murray (2002) affirms that it is imperative for nurses to take an active role in developing and implementing a plan to avert the impact of the projections in the healthcare delivery system before the year 2020. Nursing educators and leaders are challenged to create smooth transitions from the educational to practice setting (Speakman, 2000).

Experiential Learning

A critical issue to examine in nurse preparation programs is how students learn most effectively to apply key nursing concepts and skills in their jobs. The more recent research on learning stresses the importance of "teaching for understanding and application" through experienced-based learning.

Research on experiential learning can be credited to such theorist as John Dewey (1916, 1938, and 1958) and Carl Rogers (1951, 1967, and 1983). Dewey's work on experiential learning was developed in the early 20th century; he was said to have been a leader in the philosophy of science and education (Mowan and Harder, 2005). Dewey postulates that students learn by practicing what they seek to become (Schön, 1987). Dewey's work on experiential learning focused on the use of reflection to promote thinking in discussions. Much of the current research grounded in critical thinking evolved from the work of Dewey (Maudsley and Strivens, 2000). Dewey states:

> *The student cannot be taught what he needs to know, but he can be coached: "He needs to see on his own behalf and in his own way the means and methods employed and results achieved* (Dewey, 1974, p. 151 as cited in Schön, 1987, p. 17).

Rogers work in experiential learning is posits knowledge is gained through relationships. Rogers' work is directed at student centered learning. Rogers emphasizes that experiential knowledge is personal and difficult to be described by another individual (Rogers, 1985; Burnard, 1987).

Sewchuk (2005) describes experiential learning as:

> *a "continuous process in which knowledge is created by transforming experience into existing cognitive frameworks, thus changing the way a person thinks and behaves" (p1311).*

Further, Sewchuk suggests that experiences are grasped through comprehension or apprehension.

Apprehension is when an individual learns through participation in an experience

and comprehension occurs through an abstract conceptualization (Sewchuk, 2005). Kolb's description of experiential learning defines the processes of getting a hold or grasping an experience and developing those experiences into new ways of thinking and behaving. Kolb (1984) acknowledges that this is accomplished through four different learning styles. These styles are accommodating, diverging, converging, and assimilating. Accommodation is learned best through experience (apprehension) or experimenting with a process until you get it right. Second, is diverging, which is also learned by apprehension, but the experience is internalized and the experience is individualized through reflection or thinking. Third are converging learners; these learners learn through abstract concepts that are separate from the lived experience (comprehension). And finally, assimilating learners too learn through comprehension, but learn by intension (Kolb, 1984). The nursing profession is generally listed as divergent learners as nurses typically grasp by apprehension and transform through intention (Sewchuk, 2005).

In the 1980's, the Dreyfus brothers detailed a report from of the University of California, Berkeley. This report detailed a five-stage model of the mental activities of direct skill acquisition. The findings from this unpublished report were supported by the United States Air Force Office of Scientific research. The report suggested the stages of transition that an individual must go through to advance from novice to expert in any skill area. Building on the work of the Dreyfus brothers and research on skills acquisition, Dr Patricia Benner released *From Novice to Expert: Excellence and Power in Clinical Nursing Practice* (1984). Benner's work elaborated on the direct skills acquisition theory in its application to the nursing practice, and she described how an expert nurse develops knowledge and skills in caring for patients through a continued expansion of education

and experience (Benner, 1982). Benner describes the five levels of nursing development as: Novice, Advanced Beginner, Competent, Proficient, and Expert (Dracup, 2004).

Benner's 1982 work describes the transition of nurses in the practice as follows. The first level, Level I, is the *Novice*; they are said to have no experience in the practice of nursing. They have been taught task and given objectives, however they cannot apply their knowledge to any situational experience. They are unable to use as Benner describes "discretionary judgment" in making decisions and applying those decisions to practice. This describes the student nurse. Next is Level II, the *Advanced Beginner*; this is an example of a Graduate nurse starting out in practice. These individuals are said to have the ability to marginally demonstrate safe and acceptable performance. The advanced beginner learns to identify guidelines of actions and attributes of the nursing practice. However, as Benner indicates, the advanced beginner treats all attributes of equal importance and is often unable to differentiate the priority in actual clinical situations. They are still learning what is most important in regards to patient care and safety in clinical practice. The third is Level III, this is the C*ompetent* practitioner. This generally takes approximately two to three years of clinical practice. This level of nursing is defined by the nurse's ability to see their actions in a long-range plan of care.
The nurse will express a feeling of mastery of skills and the ability to cope and manage difficult situations in a clinical setting. The nurse often is still limited in speed or flexibility, but they can make safe and effective decisions and apply them in their practice. Level IV, is the *Proficient* nurse. Nurses at this level hold the ability to look at the "big picture" to see a situation as a whole, rather than in pieces.
As Benner postulates:

"Experience teaches the proficient nurse what typical events to expect in a given situation and how to modify plans in response to these events." (p. 405).

Nurses practicing at this level have the knowledge and experience to allow them to use effective decision making skills in modifying their plans when a situation changes from the expected norm. A proficient nurse has experienced based knowledge and this allows the nurse to make salient decisions on what aspects of a situation are most crucial for the patient. Maxims reflect the subtle differences of problem or situation. These maxims guide the practice or a proficient nurse; however the nurse must have a deep understanding of a situation for a maxim to be effective. Finally, Level V, the *Expert* nurse. This level of nursing allows the nurse to use their intuitive grasp of a situation to make decisions. The practicing nurse no longer has to rely on the analytical principles that previously applied in their transition to expertise status. An expert nurse is able to hone in on a situation without mulling over other differential decisions that a less experienced nurse may need to work through to make a safe and effective decision. This level of nursing is difficult to express, as many individuals will make decisions based on "gut" instinct, or doing something because "it felt right". The "gut feelings" evolve from previous lived experiences of the individual RN and their interpretation and reaction to earlier situations.

Benner, in comparing nursing competencies in relation to the Dreyfus Model of Skill Acquisition, emphasizes that an expert nurse's performance is more holistic and not fractionated as in other levels of the nursing practice. Benner (1982) goes on to say as nurse transitions through the levels of practice, they are building on previous concrete

experiences to make logical and safe decisions in active practice. Benner describes the acquisition of expertise in a nursing model as:

> *"not the mere passage of time or longevity; it is the refinement of reconceived notions and theory by encountering many actual practical situations that add nuances or shades of differences to theory" (p.407).*

Burnard (1991) describes the benefits for nurses to use experiential learning in teaching practical and interpersonal skills. The nursing profession has strong roots in the basis of experiential learning. Weil & McGill (1989) describe experiential learning as "swimming against the mainstream to bring about change" (Maudsley and Strivens, 2000). Kolb's work on experiential learning built on concepts derived from Dewey, Piaget, and Lewin. Kolb's work expresses that knowledge is created through the transformation of an experience (Maudsley and Strivens, 2000). Schön describes similar situations as unique, uncertain, and unstable and emphasizes the need for the use of "professional artistry" (Schön, 1991).

Benner's (1984) work on the transition form Novice to Expert laid the groundwork for nursing theorists interested in experiential learning and the transition of newcomers to the practice. Maudsley and Strivens, (2000) postulate that novice nurses progress in their practice in increments, acquiring skills as they accrue experience. Problem solving and critical thinking skills are imperative to the advanced beginning nurse, but having knowledge does not necessarily mean one can critically think. These are two separate and equally important aspects of practice (Maudsley and Strivens, 2000). Brookfield's approach to critical thinking is that diversity is essential and risk taking is important and one must take advantage of any and all moments to teach (Brookfield,

1987).

Transition into the Nursing Profession

Taber's medical dictionary (2005) defines transition as:

"Passage from state to another or from one part to another; ...Transitions often require adaptations within the person, the group, or the environment" (p. 2223).

Terrill (2007) states:

"a process or period in which something undergoes a change and passes from one state, stage, form or activity to another"(p. 1).

Delaney (2003) emphasizes that transitions are "complex and multidimensional". Upon graduation, the student nurse (SN) becomes a graduate nurse (GN); the first milestone the GN will experience is the transition to registered nurse (RN). The student is required to pass the NCLEX-RN® Examination. This is a monumental accomplishment. This is the pinnacle of their academic achievements from nursing school. Often, the GN will feel accomplished and "on top of the world". However, once the GN moves into the health care system, the support and safety they experienced as a student nurse along with the trusting relationships that were created with the faculty, often do not exist in a work environment. Many GNs feel lost in the transition to their new role of an advanced beginning RN, and feel overwhelmed within the nursing profession.

Role transition for a GN is difficult; as a student the expectations, objectives, and guidelines are generally clearly defined (Yoder-Wise, 2007). The first three months of practice for the GN is considered to be the most difficult and most stressful of their nursing career (Godinez, Schweiger, Gruver, and Ryan, 1999). Role changes can be stressful, painful, or exciting depending on the flexibility and support provided within the

hiring institution (Yoder-Wise, 2007: Ewens, 2003). A large number of GNs leave their first nursing job, and as many as 60% will leave the profession within the first eighteen months of practice (Halfer and Graf, 2006). Over 50% of the nurses that leave nursing profession in general are new graduate nurses (Newhouse, Hoffman, and Hairston, 2007).

Graduate nurses are faced with the challenges of having to problem-solve through situations that may be unknown to them as an advanced beginning practitioner. Yoder-Wise, (2007) defines five strategies to promote role transition.

The strategies are as follows:

> *Strengthen internal resources; Assess the organization's resources, culture, and group dynamics, Negotiate the role, Grow with a mentor, and Develop management knowledge and skills (p.524).*

It is imperative that "seasoned" nurses support the next generation of nurses, as many nurses currently feel that the work environment is professionally unfulfilling and highly stressful (Josiah Macy Foundation, 2000 as reported in AACN, 2002a).

Mentoring

Being mentored is an ongoing learning process (Yoder-Wise, 2007). Mentoring is a vital tool in career development. Mentorship is a developmental process. It is important in training individuals and in professional development (Hunt & Michael, 2001). Dracup and Byran-Brown (2004) indicate that mentors facilitate learning and help he new nurse grow in a professional setting. Additionally, they serve to promote staff retention (Yoder-Wise, 2007). Mentors nurture relationships (Yoder-Wise, 2007). Mentors serve many

roles; minimizing the GNs vulnerability and guiding them in role socialization is key in helping the nurse in their professional development (Thorne, 1996). Finkelman (2006) postulates "all effective leaders have had mentors and are mentors" (p. 390). Mentoring relationships help nurses in personal and professional growth. "Mentoring is a fundamental form of human development where one person invests time, energy and personal knowledge to assist another" (McKinley, 2004). "Mentors awaken our confidence in our capacity and work with us on how we view ourselves" (Klein & Dickenson-Hazard, 2000, p. 20). Mentoring will occur at all levels of the nursing professions, it is not exclusive for new nurses (Gordon, 2000). Mentoring aids in building self-confidence, enhancing job satisfaction, developing stronger decision and problem solving skills (Finkelman, 2006). As noted in Yoder-Wise (2007), the Robert Wood Johnson Nurse Executive Fellows program identified five competencies of leaders and mentors. The competencies are self-knowledge, strategic vision, risk-taking and creativity, inter-personal and communication effectiveness, and managing change (p. 525).

The roles of mentors, preceptors, and coaches are often thought of as interchangeable or synonymous. They describe three very different roles and responsibilities (Finkelman, 2006). Gordon (2000) compared the three different roles as follows. A preceptor is an individual that is assigned by the hiring institution; generally a seasoned experienced nurse is teamed with a new nurse. The preceptor is in the role for a specified period of time, and much of their work is focused on task-oriented goals for the new nurse. Gordon describes a coach as an individual who focuses on a specific topic or event, and is not focused on the development of the new nurses interpersonal skills.

Finkelman (2006) defines coaching as "a performance focused conversation of discovery". Lachman (2000) describes four strategies that are effective in coaching; to help the nurse master challenges, to use experience to model future actions, third to use social persuasion, and finally to promote taking care of oneself to improve self efficacy. In coaching, a mentor will help the mentee to learn both technical and managerial skills that are need to accomplish task (Yoder-Wise, 2007).

Finally, a mentoring relationship is generally one of a mentor-protégé relationship. Finkelman (2006) adds that the mentor-protégé relationship occurs more naturally and does not have a designated beginning and ending time frame. Mentors generally do not focus on task as much as interpersonal skill development. (Finkelman, 2006; Gordon, 2000).

Bower (2000) describes a mentoring relationship as a three-step process. The first step is selection; generally the mentor will select the protégé, however a protégé may approach an individual that they feel would serve as a positive role model for development. The next phase is goal setting; this is where the protégé determines goals that she hopes to accomplish with the mentor. Finally, the third phase is the working phase; this is the ongoing relationship where boundaries are established and the mentor-protégé will define the context of the relationship (Bower, 2000; Finkelman, 2006).

Smith, McAllister, and Crawford (2001) concur that there are a number of mentoring models that have been discussed in nursing research; however none of the models have been accepted universally. Fox, Rothrock, and Skelton (1992) described the mentoring process as having three phases; recognition and development, limited independence, and realignment. Holloran (1993) defined mentoring as having primary

and secondary mentoring roles. The primary mentoring role is a complete commitment to the mentoring whereas the secondary mentor serves more as a role model or preceptor. Finally, Nolinske (1995) described the mentoring model as a multiple mentor experience. The new nurse is said to have support and access to multiple mentors throughout their transition process. As reported by the AACN (2002a) mentoring of new graduate nurses produces beneficial outcomes for both the mentor and mentee, and enhances the professionalism of the nursing profession.

Nursing Residency Programs

As identified by the AACN (2002a) with the ever changing complexity of the healthcare setting, the need to assist new nurses in their transition into the workforce has been made evident. Due to the difficulties in the transition of new nurses into practice, many institutions have implemented specialized programs to assist the nurses in their transition. Programs such as internships, residency, externships or fellowships have been aimed at alleviating some of the difficulties associated with transition into practice. Mills, Jenkins, and Waltz (2000) state that preceptor based programs assist in recruiting new nurses and decreasing turnover rates. In 1983, the NLN described residency programs as formal contracts between the RN and the employer describing and defining the activities to be performed. Further, the new graduate is offered the opportunity to learn and gain experience through this residency program, further aiding the new nurse in professional development (AACN, 2002a).

There are a number of different types of orientation programs utilized in the

nursing profession to prepare the GN for entry into practice. Over the years, programs have varied in length and type. Traditional orientation programs have been said to last anywhere from 8 weeks to 6 months. Due to the financial constraints, many institutions have decreased the length of time allotted to orient new nurses. This decrease comes at a crucial time in the transition process for GNs. As noted, the first 3 months of practice for GNs is crucial in the determination of their willingness and ability to continue in the nursing profession. Research indicates that it may take up to 12 to 18 months to feel competent and comfortable in their roles and responsibility as an RN (Hayes and Scott, 2007; Newhouse, Hoffman, and Hairston, 2007; Tradewell, 1996).

Nursing Residency Programs (NRPs) were first reported in the literature in the 1980's. Research indicates that nurse residency programs are valuable in contributing to the success of the new graduate nurse (Altier and Kresk, 2006). The current shortage of nurses calls for the development of strategies in seizing the decline of competent nurses practicing in the profession. The residency programs serve to promote the mentor-mentee relationship and help to build upon the theoretical and practical implications of the nursing practice.

According to Altier and Kresk (2006), Nurse Residency Programs were designed to allow for additional support, mentoring and guidance for the new GN as they transition into practice. Additionally, the (NRPs) allow the advanced beginning nurse to expand their critical thinking and problem solving skills in a supportive, protective, and nurturing environment (Altier and Kresk, 2006). Further, with the numerous demands and specific knowledge requirements in today's acute care setting, the nurse residency programs provide a positive environment for the GN to grow professionally (Goode and Williams,

2004: Altier and Kresk, 2006).

The United Health System Consortium (UHC) (2007) defined residency curriculum objectives. The objectives entail that at the conclusion of the residency programs the graduate nurse will: Transition from an advanced beginning nurse to competent professional in a clinical setting, to develop effective decision-making skills related to clinical judgment and performance, to provide clinical nursing leadership at the point of care, to incorporate evidence based research related to outcomes in clinical practice, to affirm a commitment to strengthening nursing as a profession, and to develop a individual plan of growth for their new clinical role (UHC, 2007, p. 4).

The residency programs assist in providing guidance through mentoring and experience in sensitive areas of nursing such as end of life decisions, managing difficult and changing patient conditions, failure to rescue, and situational stress issues (UHC, 2007). Nurse residency programs have been shown to enhance the commitment to the nursing profession, to assist in the recruitment of new nurses, and improve the overall retention of nurses within the profession (AACN, 2002a; Currie, Vierke, and Greer, 2000; Hunter, Pollman, and Moore, 1990; Kasprisin and Young, 1985).

At present, the Nurse Residency Programs are seeking accreditation standards for approval. Therefore, a supportive program such as a residency program serves beneficial in the empowerment of the new RN and the retention of nurses within the workforce.

C. The Problem Statement

With the impact of the current shortage of Registered Nurses, new graduate nurses are expected to "hit the ground running" as they complete orientation programs

and begin working independently as a professionally licensed individual. Many of the unrealistic expectations placed on new graduates can be overwhelming and all consuming. Mentoring new nurses during their residency is imperative to assist them in their transition to becoming a competent registered nurse.

Purpose of the Study

The purpose of this proposed phenomenological research study was to identify the actual lived experiences of new graduate nurses as they transition into the profession; the nurses were attending a Nurse Residency Program. The study looked for insight into the perceived helping behaviors described by the individuals in relation to the preceptors, mentors, or coaches. The descriptions and perceptions offered by the individuals provided information regarding helping behaviors by mentors, the ease of the transition into the profession, the benefits of the Nurse Residency Program, and most importantly ways to retain competent nurses within the profession.

D. Research Questions

The research questions that guided this study are:

1. What behaviors by preceptors, mentors, or coaches were the most helpful during the Graduate Nurses' transition into the nursing profession?
2. Do the new graduate nurses feel adequately prepared from their educational program for their transition into the nursing practice?

E. Significance of the Study

Relevance for this phenomenological research study evolved from the continued impact of the national nursing shortage and the ongoing challenges in the healthcare and educational systems in our country. Preparing SNs to be safe and competent practitioners is the goal of all nursing education programs. Retention of new nurse is imperative to build a solid healthcare system in our country. New GNs make up a one of the largest portion of the active RN workforce in acute care settings in the USA.

The significance of this study incorporates multiple key factors. First, the controversy on how to best educate student nurses is continually at debate, and no closer to resolution than it's been over the past few decades. The failure to adequately prepare student nurses for unforeseen events occurring in an acute care setting as they transition from student, to graduate, to registered nurse makes this study of value for the education process of competent registered Nurses. Educational institutions must identify themes on how to prepare students for the transition from SN to GN to RN as a supportive experience that will yield positive outcomes for both the new RN and the institutional hiring facilities.

Secondly implications on improving the transition process will serve as beneficial to the education and economics of the nursing profession. Retention and support of new nurses is crucial in working towards identifying solutions to address the healthcare crisis. Research indicates that nursing job satisfaction is a primary indicator for the retention of new nurses within the profession (Halfer and Graf, 2006). Godfrey and Purdy (2004) report that mentoring programs for new nurses showed a decrease in turnover rates from

47 % to 23 % when used. Thorne (1996) supports mentoring as improving staff retention, fostering a more informed workforce, and assisting in the development of the organizational culture as a whole. Mentoring allows the individual be supportive while learning in a "hands on" environment; hence learning through experience.

Third, hiring healthcare agencies are hesitant to invest time, training, and most of all money into individuals who are unable to make the transition to competent RN efficiently. The ultimate goal for formal orientation program is to incorporate mentoring as a facilitative method to create and achieve a safe and competent environment to practice nursing (Greene and Puetzer, 2002). Nurse Residency Programs provide guidance through precepting and mentoring. These residency programs aid in providing the new nurse with "real life" experience, but they help to build confidence and support by allowing the new nurse to practice competently when faced with delicate issues in nursing such as end of life decisions, managing difficult patient scenarios, failure to rescue, and stress management (UHC, 2007).

F. Methodology of the Study

In this phenomenological research study, focus group interviews were used as methods for data collection. Results of this research study intend to provide useful information in the evaluation of the actual lived experiences by the new graduate nurses and the translation of their perceived helping behaviors will provide an important contribution to both the fields of nursing and educational research respectively.

G. Assumptions, Biases, Experiences Related to the study of the Phenomenon

In any qualitative research study, the researcher serves as the instrument (Marshall and Rossman, 1999). Speakman (2000) states that the relationship of the knower to the known is crucial in a study of lived experiences. Marshall and Rossman (1999) explain that the self-examination or epoche stage of the inquiry is crucial for the researcher to gain clarity on their on preconceptions. van Manen (1990) postulates that the researcher is not to forget their assumptions, just to put them aside and be open to the perceptions of others in relation to the phenomenon. van Manen (1990) elucidates that our common sense or suppositions of a phenomenon predisposes us to interpretation of the said phenomenon before we grasp the significance of the phenomenological question. Husserl (1970) used the term "bracketing" to describe the placing aside of one's own beliefs in a phenomenological study to allow for openness to interpretations without discounted our own experience (van Manen, 1990).

Assumptions of the Researcher

This study is based on the following assumptions:

1. Graduate nurses will have some type of perceptions on the helping behaviors that they experienced during their residency training program.
2. Graduate nurses who participate in focus groups will recall and report information honestly and accurately.
3. Graduate nurses who participate in interviews will recall events and narrate information honestly and accurately.

4. Graduate nurses who have experienced a higher number of perceived helping behaviors will have an easier transition into the nursing practice.
5. Graduate nurses who have experienced a higher number of perceived helping behaviors will have higher levels of job satisfaction and self-confidence during the residency program.
6. Graduate nurses who have experienced a higher number of helping behaviors will be more apt to stay at their place of employment and continue working in the nursing profession.
7. Graduate nurses who participate in residency programs will define similar perceptions of helping behaviors as other members in their cohort.

Biases of the Researcher

The reality of knowing or experiencing a phenomenon will require the researcher to bracket, or set aside what is known of their own individual experience and explore the phenomenon of interest (Marshall and Rossman, 1999; Speakman, 2000). Interest in the perceptions of new graduate nurses on helping behaviors during their transition into the nursing practice evolved from this researcher's experience of working with nursing students over the past seven years. As nursing educators, we strive to make the educational process and transition into clinical practice smooth and attainable for student nurses and graduate nurses.

The student nurse is prepared through both theory and clinical education; however much of the learning experienced by the student nurses can not adequately incorporate

the actual behaviors or lived experiences of a practicing nurse. Many student nurses and new nurses alike have responded to a clinical situation by saying "I've read about that many times before, but I did not understand it until now". The actual lived experience is often much different than a case scenario or simulated laboratory experience. The classroom or laboratory cannot construct every unforeseen event that may occur in a clinical setting, and the social interactions between nurse and patient, and their families will differ for every individual.

I feel as both a nurse educator and a practicing Registered nurse, I have an obligation to better prepare future nurses for transition process and allow them to feel supported during their development into a competent nurse.

It is this researcher's belief that the examination of the perceptions of graduate nurses on the helping behaviors through the residency program will provide invaluable information for both educators and hiring facilities on the recruitment, and more importantly the retention of nurses within the profession.

In February 2007, the United Health System Consortium (UHC) held a conference addressing the issues of retention within the nursing profession. The session titled *Transition of new nurses from education to practice. A Regulatory Perspective* was supported by the American Association of Colleges of Nursing (AACN) and the National Council of State Boards of Nursing (NCSBN). Collaboration of these organizations evolved on a consensual desire to aggressively seek solutions to meet issues relating to the decline in the nursing workforce. A key area of focus in the conference was the need for Nurse Residency programs to address issues of recruitment and retention in the nursing profession.

Implications of a CNO survey conducted in 2001 indicated that 85% of those surveys currently used an extended program to prepare new graduates to become competent practitioners. Residency programs were described s lasting 4 weeks to 2 years in length and incorporating 13 to 376 classroom hours in the programs. Additional information relayed that the programs included a technical component from 0 % to 90 % and a critical thinking component of 20 % to 100 %. The cost of the residency programs was not quantified by the respondents to the survey (UHC/AACN, 2007).

H. Delimitations and Limitations of the Study

In all research studies, there are limitations to the interpretation of the results collected, and other issues that need to be considered when trying to generalize these analyses to broader issues of interest. The following is a discussion of some of these issues.

Delimitations of the Study

As with all research, delimitations intrinsically existed in this study. The first of these will deal with the method of data collection. When conducting focus groups, I may allow personal bias to impact the tone of the questions I ask or instructions given to participants. If so, this may cause participants to answer in a particular way, skewing the data collected.

Another delimitation of this study may involve the sample. A purposeful sample of voluntary respondents will be used to allow me to fully understand the problem and

the research questions. Those who volunteer to participate in the study may have opinions differing from those who chose not to participate. This could alter the findings in the study (Creswell, 2003).

A third delimitation will deal with the method of data collection. In the focus groups, the respondents may not understand the directions given prior to the group, or they may hesitate to report certain types of interactions between preceptors or mentors for fear of repercussions. These factors may influence the results of the study.

This study will be delimited to the conceptualization of subjective perception of perceived helping behaviors of preceptors and mentors for new graduate nurses in residency programs.

The demographic variables will be delimited to gender, age, marital status, nursing education background, ethnicity, and length of time within the residency program at the time of the study.

The sample will be delimited to new graduate nurses attending a Nurse Residency Program at Pennsylvania Hospital in Philadelphia, PA.

The study will be delimited to audio taped focus groups as a primary source of data collection. Personal interviews were not necessary to clarify data.

Limitations of the Study

A possible weakness of this study may come from the phenomenological research process. The representativeness of the sample for all new graduate nurses participating in various residency or orientation programs may vary due to the uniqueness of individual programs. Lack of generalizability, therefore, is recognized as a possible weakness.

Measures on the subjective data collection may not be interpreted correctly by respondents and the researcher.

I. Personal Interest

Through the transitional course of my nursing career, as a Registered Nurse in an acute care setting, to an Advanced Practice Nurse in both an acute care setting and an educational setting, finally to a Nurse Educator, I hold the responsibilities and reverence of the nursing profession dear to my heart.

As a Nurse Educator in a society of great complexity and diversity, we are challenged to find ways to ensure the integrity of nursing and to prepare nurses to serve as safe and competent advocates for patients. The multiple variables contributing to the current nursing shortage demand that as a profession, and a nation as whole, that we identify ways of recruiting and retaining competent individuals to carry the profession into the next century.

As the largest population of healthcare providers, nurses need to be supported and encouraged in their transition into the profession. Not too long ago, the image of nursing was that of "those who ate their young". Nurses are characteristically empathetic and compassionate individuals, therefore, as a nurse, I strive to improve that image of the profession.

The challenges in today's healthcare setting support the need for competent and positive role models for new graduate nurses. Easing the transition of new nurses in the profession has been comprehensive in the research for over thirty years. Additionally,

multiple research studies have identified the benefits of mentors and preceptors in a healthcare setting. Further, the use of residency programs for nurses has been recognized as beneficial in the preparation and training of new graduate nurses since the early 1980's. Finally, the 2007 report by the UHC/AACN Consortium identified the need to support nursing residency programs universally; I believe an evaluation of these programs is important in the contribution of nursing education and nursing staff development.

As a dedicated member of the nursing profession, and in a desire to increase my personal knowledge on ways of improving the preparation of new nurses in the profession, and finally to in an effort to contribute educational constructs in the field of Nursing education prompted me to enter the doctoral program at Drexel University School of Education. I hope my research will enhance my understandings on ways of improving the teaching methods of new nurses.

J. Operational Definitions and Terms

AACN- American Association of College of Nursing.

ACE – Accelerated Baccalaureate Nursing Program.

ADN- Associate Degree of Nursing program; A two-year college degree program of nursing developed under the authority of a regionally accredited university or college.

AHA-American Hospital Association.

ANA- American Nurse's Association.

AONE -American Organization of Nurse Executives.

APN- Advanced Practice Nurse.

ATI- Assessment Technologies Institute.

ATI Comprehensive Predictor Exam- Assessment Technologies Institute.

Baby Boomers- Individuals born between the years 1945 to 1964.

BSN- Bachelors of Science in Nursing; A four-year college degree program of nursing developed under the authority of a regionally accredited university or college.

CAT- Computerized Adaptive Testing.

Competence- A principle of professional practice, identifying the ability of a provider to administer safe and reliable care on a consistent basis.

CNA – Certified Nursing Assistant.

CNOs -Chief Nursing Officers.

Diploma- RN Hospital based diploma program that is approximately a two-year program. This program is developed under the authority of a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations.

ENA-Emergency Nurses Association.

Entry into Practice- The first months of practice; the period during which the newly licensed Registered Nurse must rely on knowledge and skills garnered prior to employment to safely provide patient care.

ER-Emergency Room.

First-Time success rates- All statistical data is based on the individuals first time attempting the NCLEX-RN® Examination.

GAO- The General Accounting Office of the United States

GN- A Graduate Nurse is one who has completed all the theoretical course work and recommended clinical hours as set forth by the National Council of State Boards of Nursing and the National League for Nursing, giving the individual eligibility for sitting for the NCLEX-RN® examination.

GPA- Grade Point Average.

JAMA- Journal of American Medical Association.

JCAHO- Joint Commission of accreditation of Hospital Organizations.

HESI- Health Education System, Incorporated. This is an examination given to predict a student's probability for success on the NCLEX-RN® exam.

ICU-Intensive Care Unit

IHS-Inova Health System.

IRB-Institutional Review Board.

ILN-Inova Learning Network.

IV – Intravenous.

LPN- Licensed Practical Nurse.

MED/SURG – Medical Surgical Unit.

MEDS – Medications.

Mosby Assess Test- This is an examination given to predict a student's probability for success on the NCLEX-RN® exam.

NA – Nursing Assistant.

NCLEX-RN® Examination- National Council Licensure Examination for Registered Nurses-This is the national examination given in our country to determine a graduate's nurse's ability to practice nursing safely and effectively at an entry level of nursing.

NCSBN- National Council State Board of Nursing.

"New Test Plan"- Data and information collected on passing rates on the licensure exam from 1988 to 1994.

NIP- Nurse Internship Program.

NLN- National League of Nursing.

NLNAC- National League of Nursing Accreditation Commission.

NRPs-Nurse Residency Programs- is a joint partnership between academia and practice that is learner focused, postgraduate experience designed to support the development of competency in nursing practice.

"Old Test Plan"- Data and information collected on passing rates on the licensure exam prior to 1988.

PEDS – Pediatrics.

PO – By Mouth.

Q - Every

RN- A Registered Nurse is one who has completed and passed the NCLEX-RN® examination and has been given a license from the State that they applied for licensure from.

SAT-Scholastic Aptitude Test.

SIM – Human patient simulation Lab.

STTI-Sigma Theta Tau International Honor Society of Nursing

SN- A student Nurse is an individual that is actively participating in an accredited Nursing program.

STTI- Sigma Theta Tau International-International Honor Society for Nursing.

UHSC- University Health Systems Consortium.

U.S. - United States.

U.S.A. - United States of America

K. Summary

This chapter describes the purpose of the study and the intent to explore the phenomenon of the perceptions of graduate nurses on the helping behaviors through the residency programs in their transition into the nursing practice. Relevance for this study evolved from the current shortage of competent nurses in the health care system and the ability to retain nurses in the profession. Finally, qualitative research was used as the method to examine the phenomenon of the perception of the graduate nurses as they experienced the Nurse Residency Program.

Chapter II

Review of the Literature

This chapter consists of three sections. The first section is an overview of the historical aspects of nursing and the evolution of the national nursing shortage. The conceptual framework of the phenomenology of transition into the nursing practice is in the second section. Finally, the third section explores mentoring and coaching, and elaborates on the researchers' experience as a mentor of students prior to and during their transition into the nursing profession.

Introduction

Miller-Keane's Encyclopedia & Dictionary of Medicine, Nursing, and Allied Health define a nurse as:

> 1. ***A person who is trained in the scientific basis of nursing and meets certain prescribed standards of education and clinical competence. 2. To provide services that are essential to or helpful in the promotion, maintenance, and restoration of health and well-being***. p. 1040. (Saunders, 1992)

Moss (2005) describes nurses are the people who are actually perceived as caring for the sick; "the public face of the health care system". The ability to maintain the nursing profession with safe and competent practitioners is crucial to the overall healthcare system in our country. A profession is said to be a "Vocation". Cogan (1953) defines a profession as:

"A vocation…founded upon an understanding of a theoretical structure of some department of leaning or science". Professionals hold the responsibility of compiling a knowledge base and having the ability to place their knowledge-in-action in an acute care setting (Smith and Crawford, 2002; Maudsley and Strivens, 2000). Bellinger and McCloskey (1992) define professionalism as "attachment to a particular occupation or profession". The boards of nursing throughout our country promote public safety by regulating the practice of the nurses under the states jurisdiction (Smith and Crawford, 2002).

Registered nurses (RN) make up the largest portion of the health care work force with an estimated 2,558,874 registered nurses in the United States (US), and approximately 83 %, or 2,115,815, are employed in nursing (Cooper, 2003; Peterson, 2001; Berlinger and Ginzberg, 2002;Moses, 1998). Registered nurses comprise the largest individual healthcare occupation, with over 2.3 million jobs (Bureau of Labor Statistics, 2004). Of that group, approximately twenty percent worked part-time and about ten per cent held more than one job. They are a diverse group from every state, county, and territory in the nation.

Background History of Nursing

In general the nursing profession evolved as a result of war and has developed throughout its hierarchical practices (Moss, 2005). Nursing has been referenced in history dating back to ancient times. In Egypt during ancient times, many slaves served to care for the sick and debilitated (Moss, 2005). Many nursing practices established in the

United States (U.S.) evolved as a result of necessity due to war times. Individuals were needed to aid in the care of sick or wounded people. There were not enough medical personnel to care for the sick. Nurses have been referenced historically back to the American revolutionary and the Civil War. During the Civil War, most of the "nurses" had no formal or organized training. Their responsibilities were strictly to care for the sick and wounded soldiers (Brown, 1982).

In 1751, Pennsylvania Hospital became the first formally structured U.S. Hospital. Pennsylvania Hospital was founded by Benjamin Franklin and Dr. Thomas Bond to care for the needs of the "sick-poor" and insane of Philadelphia. (Pennsylvania Hospital Archives).

In 1839, an organized School of Nursing was founded by the Nurse Society of Philadelphia under the direction of Dr. Joseph Warrington. This school awarded its graduates a certificate of completion after a designated period of lectures, demonstrations, and on the job training in a hospital setting. In 1861, the society connected with the Women's Hospital in Philadelphia, and granted a Diploma to their graduates after six months of formal lectures and training.

Florence Nightingale, considered by many as the "Mother of Modern Nursing" founded the first Nightingale School of nursing in London in 1860. Nightingale was well known and respected for her documentation on caring for the sick, the needs in a hospital setting, and for setting the standards for higher, formal education for nurses. Nightingale wrote about her experiences in the Crimean War. Additionally, she worked as a hospital superintendent in Germany, and she documented experiences with both lay and religious nursing orders in her development of a formal nursing educational plan. She was

politically connected to both the Queen and Prime ministers of her time. Nightingale's work became the model for formal nursing education in the United States, and the first American Nursing Schools modeled their programs after her plan. In 1873, three formal Nursing Schools opened almost simultaneously in the U.S.: the Bellevue Hospital in New York, Connecticut Training School in New Haven CT, and Massachusetts General Hospital in Boston. These schools became the influence for the development of all modern Nursing programs in the U.S. (Griffin and Griffin, 1973). In 1873, the first nursing student, Linda Richards graduated from a school of nursing (Bargagliotitti, 2003).

In the later part of the 1800s, nurses were said to "require little teaching…and tend to the patient's wants" (Moss, 2005, p. 168). In the development of modern nursing, 1903 marked the year that the first nursing licensure laws were developed and standards were established for nursing education and practices. In 1893, nursing leaders and educators met at the Chicago World's fair, and formed the first formal nursing organization in the United States, the American Society of Superintendents of Training Schools for nurses. This organization later led to the formation of the National League for Nursing Education and finally to the National League for Nursing (NLN) which is still in operation today (Bargagliotti, 2003). In 1917, the National League for Nursing (NLN) published a Standard curriculum for all schools of nursing. Their book gave guidelines on how to set up classes and improve the standards of the nursing programs (Brown, 1982). In 1923, The Goldmark report was released; this report addressed issues in nursing and nursing education in the United States. The report dealt with nursing education issues in general, and the recommendations of the report were that all nursing education should

take place in an area of Higher learning. As a result, Yale University opened the first formal school of nursing in 1923. (Krampitz, 1987).

The impact of World War II on the health care industry in America and the nursing profession at large was profound. By the 1930s, hospitals began to progress rapidly, nurses were in demand, the responsibilities and requirements for nurses had increased, and the turnover and dropout rates for nurses in the profession was increasing (Moss, 2005). People in our country wanted better health care; this created the need for more trained nurses to care for the sick. (Speakman, 2000).

With the changing responsibilities in the American healthcare system, Dr. Louise McManus, the Director of Nursing at the Teachers College at Columbia University recognized the need to develop a team of experts from various fields to initiate strategies for the future of nursing education (Speakman, 2000; Champagne, 1981). The committee's findings recognized the need for multiple levels of nursing education (Haase, 1990). The multiple levels of training for nurses evolved in response to a shortage of nurses to provide competent health care.

Currently the nursing profession has three separate acceptable levels of entry into practice. Nursing candidates may attend a BSN (Bachelors in Science of Nursing), ADN (Associates Degree in Nursing), or a Diploma in nursing program. In February 2006, the Pennsylvania Department of Health released a state health improvement plan on the status of nursing education programs. This plan is part of the nursing education annual reports of 2004. They defined the basic nursing education programs in accordance with the Pennsylvania Code, Title 49, Professional and Vocational Standards, as follows:

RN Baccalaureate program (RN-BS)-a four-year college degree program of nursing developed under the authority of a regionally accredited university or college.

RN Hospital-based diploma program (RN-DIP)-Approximately a two-year nursing diploma program developed under the authority of a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations.

RN Associate program (RN-AD)-a two-year college degree program of nursing developed under the authority of a regionally accredited university or college. (p.4)

All approved programs in the state of Pennsylvania must meet the organizational and administrative requirements set forth by the State Board of Nursing. The State board sets clear curriculum guidelines and standards of protocol for each type of approved nursing program. Provisions 21.62, 21.63, 21.74, and 21.81 as defined by the State of Pennsylvania define these terms.

Nurses are required to pass a standardized examination to determine competency for entry into the nursing practice. The national licensure examination for registered nurses originated in 1955 as a pen and paper test, and the test was divided into five content sections. At that time, the examination was overseen by the American Nurses Association (ANA). In 1978, the (National Council of State Boards of Nursing (NCSBN) took over the responsibility or developing, administering, and evaluating the national licensure exam. (Schwartz, 2005). The NCLEX-RN® exam that is currently in use was instituted in the United States in 1982 (Jenks, Selekman, Bross, and Paquet, 1998). This exam is an integrated test of the nursing practice. The results were originally

given in numerical scores. In 1988, the examination scores moved to a "pass" or "fail" grading system. The testing standards were revised in 1986 after a registered nurse job analysis was conducted by the NCSBN (Schwartz, 2005).

In 1998 the standards used to determine the passing criteria for nurses were increased (Morrison, Walsh and Newman, 2002), and the exams moved to a computerized licensure exam (CAT exam) format in 1994 (Beeson and Kissling, 2001). Research refers to data prior to 1988 as the "old test plan". Data in the research from the years 1988 through 1994 are considered the "new test plan". Prior to 1988, first time test takers passing rates for the National licensure examination was 91%; in 1989 after the passing standards were increased, the national passing rates dropped to 84%. In 1997 the National passing rates for the NCLEX-RN® exam was 87.7% and fell to 82.2% in 2002 (NCSBN, 2002a). It should be noted that the research suggest that the statistical data found for NCLEX-RN® examination results after the 1988 changes will probably differ from earlier exam results (Beeson and Kissling, 2001; Waterhouse, Carroll, and Beeman, 1993; Wall et al., 1993). Revisions were made in April 2004, where the passing standards were again raised (Schwartz, 2005). Revisions are performed every three years and will take place in 2007 (NCSBN, 2007).

All candidates upon completion of an accredited nursing program (Diploma, AND, or BSN) must pass the NCLEX-RN® exam in order to work as a RN. The National Council Licensure Examination for Registered Nurses (NCLEX-RN®) examination is a standardized test devised through the NCSBN (National Council for State Boards of Nursing). The NCLEX-RN® exam is currently given in a computerized testing format. The examination is at a minimum of 75 questions, up to a maximum of

265 questions; candidates are given a maximum of 6 hours to complete the exam.

The outcome performance on the NCLEX-RN® examination for first time test takers is the defining measurement of success to both the individual nursing graduate and the institutes of learning. Generally, the nationally reported PASS/FAIL rates are based on the individual's first attempt at passing the licensure exam. This examination is a standardized measurement of graduate nursing competence for candidates from all fifty states. There are individual State boards of nursing; however there is only one national licensure exam. The examination is designed to demonstrate the individual's ability to practice safely, effectively, and competently as a newly licensed, entry-level registered nurse (NCSBN, 2001).

Nursing as defined by Lutjens and Horan (1992) is said to be "a science, an art, and a profession". They suggest that theory, practice and research are a cyclical process the define nursing as a science (Wilson-Thomas, 1995). Smith and Crawford (2002) define entry level for new registered nurses as follows:

> *The first months of practice, that period during which the newly licensed nurse must rely on knowledge and skills garnered prior to employment to safely provide patient care.*

New nurses are thought of as competent advanced beginners. Competency for new nurses in a clinical setting as described by Butler and Felts (2006) is

> "*the simultaneous integration of the cognitive, psychomotor, and affective skills required for performance in a particular setting*". "*The competencies of critical thinking, interpersonal skills, and leadership skills*" (p. 212).

Ramritu and Barnard (2001) stress the need to differentiate between competency

and performance. Research supports that competence does not always correlate with performance (Ramritu and Barnard, 2001; Wood and Power, 1987). Newble (1992) discussed the differences between clinical competency and clinical performance. Differentiation is described as clinical competence is "what a student or doctor should be able to do at an expected level of achievement" and clinical performance, as "what a student or doctor actually does in real practice" (p. 504).

Many new nurses at the entry into practice experience what Kramer (1974) termed the "Reality Shock". This is the transitional time when the GN realizes that they have had training in a controlled institutional setting and now are challenged with the complexity of applying the instruction in a real-life practical and often chaotic setting. Kramer describes the experience as "the shock-like reaction that an individual who has been .....Educated in that subculture of nursing.....discovers that nursing as practiced in the world of work is not the same as was learned" (Kramer, 1985, p. 291). The transition process for new nurses is both a technical and social maturation into the role of a professionally licensed practitioner that is accountable for the responsibilities that go with a license. The new graduate nurse is learning how to assimilate into the culture of the real world of nursing, in addition to improving communication skills between colleagues, patients, and families (Cantrell and Browne, 2005; Duchsher, 2001; Heslop, McIntyre, and Ives, 2001; Caroselli, 2001). Furthermore, novice or advanced beginning practitioners will learn their behaviors and actions from experienced practitioners (Maudsley and Strivens, 2000). Benner refers to having experience as "the refinement of preconceived notions and theory by encountering many actual practical situations" (Benner, 1982).

The majority of GNs work in a hospital setting for their first employment as a new nurse. The transition in the work place is demanding and stressful for the GN. GNs need the support of a mentor or preceptor to ease in the transition process (Bowles and Candela, 2005; Bellinger and McCloskey, 1992).

In a seminal study conducted by Jenks, Selekman, Bross, and Paquet, (1998), noted that the nursing shortage has been impacted by a variety of factors including the loss of graduates during their nursing education programs and the delay of graduates entering the profession due to failure on the NCLEX-RN® exam on the first attempt counterproductive in improving the numbers of nurses entering the profession.

In the United States there is a concern for the pattern of decline on the NCLEX-RN® passing rates on the first-time attempt. (NCSBN, 2000). From 1994 to the year 2000, the annual NCLEX-RN® pass rate for first time, US educated individuals dropped from 90.3% in 1994 to 83.8% in the year 2000 (Morrison, Free, and Newman, 2002). The declining national pass rate for the NCLEX-RN® exam has many variables, both academic and non-academic in nature, for various groups of students. This decreasing pass rate has a direct affect on the nursing shortage, as it delays the numbers of nurses entering the profession as a safe and competent practitioner.

Reports indicate that the public image of nursing is that of "helping people" or "caring" individuals. Nursing image is a priority in the times of this nursing shortage. Schroeter (2006) feels that "nursing image" may impact a vast variety of issues in nursing including policymaking decisions, retention and recruitment of nurses, self image and self-esteem for nurses, and nursing job satisfaction. Further, to ensure the professionalism associated within the nursing profession, it is essential for all nurses to "create a shared

vision of their image and then advocate for themselves" (Schroeter, 2006; p. 49). Cohen (2007) discusses results of the 2006 Gallup poll ranking nursing as the most honest and ethical professions in the U.S.; and emphasizes that for eight consecutive years in a row, nursing has been in the top ten, holding the number one spot for the past five years (p. 24-25). She additionally feels the profession has an obligation to redefine the image of nursing. The nursing profession must cultivate a professional image, identify and define unacceptable conditions and behaviors in the workplace, recognize that appearances often reflect the perceptions of nurses, become involved in staff development issues, listen to the patient's, families, and community issues, and finally mentor and guide other nurses to feel empowered in their profession (Cohen, 2007).

Yoder (1997) relays that assessment of nurses' job satisfaction and their intent to stay should continue to be evaluated and issues should be addressed in order to retain nursing personnel within the profession.

Experiential Learning

Sewchuck (2005) describes experiential learning as a continuous process where knowledge is created by transforming an experience into a cognitive framework. Canales (2003) defines experiential learning as

> "*a cyclical process wherein people view heir experiences as opportunities to learn, integrate those experiences into their education, and engage in subsequent action based on the integration*" (p. 1232).

Rogers (1971 and 1982) was a key pioneer that assisted in the evolution of

experiential learning. Weil and McGill's, (1989) unifying definition of experiential learning is:

> *"...the process whereby people individually and in association wit others, engage in direct encounter and then purposefully reflect upon, validate, transform, give personal meaning and seek to integrate their different ways of knowing....it enables the discovery of possibilities that may not be evident from direct e experience alone (p 245-72).*

Kolb (1984) defines experiential learning as a process where knowledge is created through the transformation of life's experiences. Kolb states individuals learn through experience, reflection and experimentation. Kolb's model of experiential learning has four modes, concrete experience, reflective observation, abstract conceptualization and active experimentation. Kolb's Experiential Learning Theory describes two different ways an individual grasps information, apprehension and comprehension.
Prehension refers to the way individuals acquire information through a direct experience or a recreation of experiences. Apprehension is qualities formed through tangible immediate experiences and comprehension is a conceptual interpretation and symbolic representation. Information is transformed via intention and extension. This means that if an individual learns by testing ideas and experiences of real life, this is transformation of information via extension. Whereas if you transform information via intention, you generally reflect on ideas and experiences (Corbett, 2005; Carlson, 1998). Kolb's learning styles further details the different ways that people learn. These styles are accommodating, diverging, converging, and assimilating. An Accommodator is said to grasp an experience through apprehension and transform it through extension. The

Diverger grasps experience through apprehension and transforms it through intention. An Assimilator grasps knowledge through comprehension and transforms it through intention. And finally, the Converger grasps information through comprehension and transforms information through extension (Corbett, 2005; Carlson, 1998). Detailed research concurs that people will learn best when they can cycle through all four forms of learning (Kolb, 1984; Corbett, 2005; Kolb, Boyatzis, and Mainemelis, 2000; Armstrong, 2005). Corbett (2005) and Bolan (2003) stress that learning is individual and people may transform and acquire information differently. Jung (1977) as cited in Corbett (2005) states that due to the complexity of individual interactions and chaos in the environment, there is great variability in the learning processes for different people.

Sarason (2004) postulates that the teacher can not create and sustain a supportive learning environment for a student if they don't feel that way themselves. A teacher can not be a facilitator of education or a coach or mentor if the environment of learning is not suitable for a climate of learning. Further, Sarason 2004, states:

> *"Individuality is a fact and respect for it carries with it the obligation, the moral and professional obligation, to know and understand a student in a way that allows you to determine how and why a test score takes on meaning when related to the features present in the learning process." (p. 139-140).*

Marlin-Bennett (2002) postulate that hands on experience helps an individual to understand how decisions are made and how politics are handled. Dracup and Bryan-Brown (2004) state that experience is a prerequisite for becoming an expert in a desired field. Further, through experiential learning a person strives to create a link between what is learned in the classroom and how things are handled in practice, therefore integrating

the two.

Benner, Hooper-Kyriakidis, and Stannard, (1999) discuss the process of experiential learning as having a narrative memory that can assist in developing a nurse to act skillfully in a similar situation in the future. In the transition of nurse, the experiential learning requires and individual's "engagement" in a situation and the need to "turn around preconceptions that generates problems" (Benner, Hooper-Kyriakidis, & Stannard, 1999). Experiential learning is useful in research of professions such as nursing as it employees a clinical practical element as well as a theoretical one (Laschinger, 1990).

Baron (2004) states that everything we do, think, or say is affected by how and what we accumulate, transform, and acquire information. Smith, a constructivist humanistic scientist, wrote of alternative research paradigms. In an exert from Smith's 1990 *The paradigm dialogue*, he states that "knowledge is the result of a dialogical process between the self-understanding person and that which is encountered-whether a text, a work of art, or a meaningful expression of another person" (Smith, 1990, p. 177). Other studies found that knowledge retention for adult learners is best conceptualized in "practical" situations (Diachum, Dumbrell, Byrne and Esbaugh, 2006). Vygotsky (1978) felt that learning is a social process where individuals develop understanding of concepts through interaction in the environment. He felt the best outcomes for learning arise from integration in an environment of learning and allowing the individual to explore topics of interest to them, give meaning to their interest through experience, and develop concepts based on learning (Brush and Saye, 2000).

In the 1980's, the Dreyfus brothers detailed a report out of the University of

California, Berkeley. This report was on a five-stage model of the mental activities of direct skills acquisition. The findings from this unpublished report were supported by the United States Air Force Office of Scientific research. The report detailed the transition that an individual must go through to advance from a novice to expert in any skill setting. Dreyfus and Dreyfus (1986) state that recognizing changes in clinical relevance is an experientially learned skill and this allows an individual to distinguish what is important or relevant.

In 1984, Dr Patricia Benner released *From Novice to Expert: Excellence and Power in Clinical Nursing Practice.* Her work described how the skills acquisition model would be applied to the field of nursing. Benner's work describes how an expert nurse develops knowledge and skills in caring for patients through a continued development of education and experience (Benner, 1984). Benner discusses the nurse's stages of development as having five levels. These levels are novice, advanced beginner, competent, proficient, and expert. The first stage "novice" is when the nurse is a student and has no experiential background in a nursing clinical setting; second, is the "advanced beginner" this is the GN, one who has attended nursing school and completed clinical experiences; third is "competent", the nurse has one to two years of practice in the field and posses the ability to function independently and safe; fourth is "Proficiency", or the transitional phase leading up to an expert; and finally an "expert" is where the nurse functions at the highest level (Benner, 1984; Dracup, 2004; Spector, 2007).

Spector and Li (2007) defined the need for support to GNs in their transitional process in order to allow them to proceed proficiently through each of the stages of professional development. Novices will develop clinical decision making skills when

they are able to apply technical knowledge along with the skilled action (Maudsley and Strivens, 2000). Benner, Hooper-Kyriakidis, and Stannard, (1999) state that in order to accomplish expertise in nursing, an individual "requires experiential learning under pressure" and "thinking in action" (p. 2). Benner, Hooper-Kyriakidis, & Stannard, (1999) further elaborate that their work serves as a guide in experiential learning. *The work in the Clinical Wisdom and Interventions in Critical Care. A Thinking-In-Action Approach* articulates the importance of aiding in the description of "taken for granted areas of practical wisdom and skilled know how" (Benner, Hooper-Kyriakidis, and Stannard, 1999).

Benner, et. al (1999) state:

> *"Nursing and medicine, like other practice disciplines such as law, social work, teaching, and psychology, involve a…mix of science, technology, and praxis. Praxis is …the working out of knowledge, inquiry, and relationships in practice".* (Benner, Hooper-Kyriakidis, and Stannard, 1999, p. 19).

The "working through of knowledge" as described by Benner, et. al (1999) for new nurses is acquired in the transition into practice during the orientation or residency period. For years, individuals who have been considered "good nurses" have said to have the ability to use their "gut instinct" in making decisions. This type of "instinct" is developed through acquired knowledge, theoretical research, and lived experiences by nurses. Joel (2002) describes a profession as encompassing a body of knowledge and skills unique to a discipline. She further discusses the "*art of professions is cognitive artfulness. It consists of the ability to manipulate in the mind circumstances that have never been experienced and see relevancy between situations that on the surface have*

little in common" (p. 3). These descriptions by Joel on "cognitive artfulness" are significant in the application of nursing practice. Nurses must be able to take the theoretical knowledge acquired in nursing school and apply that knowledge to the hands on experiences in which they encounter in a practice setting that may be similar, but not exact to what was learned in school, and still be able to interact with appropriate and competent care.

Santucci (2004) identified key concepts that portray the benefits that nurses acquire through experience, these concepts are: role integration, reshaping of values, and interpersonal, social, and clinical skills. Professional growth is gained through mentoring and support from a preceptor or residency based program (Santucci, 2004; Spector and Li, 2007).Starr and Conely (2006) believe that student nurses prior to graduation will benefit from experienced based externship programs that will support professional growth as a new RN. Bolan (2003) emphasized that nurse educators have a responsibility to use a variety of learning styles to ensure a holistic learning experience for the student nurses. Harkins, Schambach, and Brodie (1983) reported that clinical externship programs assist in decreasing stress for new nurses and they support reflections of the new nurse's experience.

Moss (2005) states that advancement of leaders in the health care field can be made by the application and utilization of the emotional component of thinking and decision making that is present in actual health care situations every day. Briers (2005) describe "life learning" or learning through experience without fear of mistakes or ridicule; it involves applying knowledge, not memorizing it. Experiential learning is developed through simulation, role playing, and "doing" (Kidd and Kendall, 2006).

Further, experiential learning techniques allow an individual to learn through psychomotor, cognitive, and affective domains, therefore, this results in deeper learning (Kidd and Kendall, 2006; Zimmerman & Phillips, 2000; Daley, 2001). Nursing schools prepare students through a scientific program of study and through clinical "hands-on" didactics, clearly an experiential learning technique.

Santucci (2004) discusses role integration for new nursing graduates as a time of discovery and a sense of self for nurses. This is a period when the new nurse is developing a personal identity and mounting their own "voice" as a professional nurse. This time of discovery is available based on the lived experience of the new nurse.

Hatcliff (2003) describes how an individual will retain more information when they learn through application, as opposed to being a passive learner. Cooper, Taft, and Thelan, (2005) conducted a qualitative study; this study indicates the importance of promoting reflection during the transition period for new nurses entering the practice.

Benner's extensive research supports the concept of new graduate nurses needing mentoring, coaching, support, constructive feedback, and the opportunity to reflect on the stages of their professional development (Benner, 2004; Spector and Li, 2007). Canales (2003) states that through experiential learning nurses are able to learn the values of the profession and society and to integrate those values into their practice by creating meaningful relationship.

The Nursing Shortage

Wright (2001) as cited in Murray (2002) states "the nursing shortage is an extremely serious and complex healthcare problem that affects all Americans (p. 79). It is

rapidly approaching critical levels. Several factors have contributed to this shortage including decreased nursing school enrollment, an aging workforce, and non competitive salaries (Meyer and Meyer, 2000; Mangan, 1999). Minnick (2000) reports that

> "*although these current shortages are sometimes dismissed by administrators as a mini-event in the cycle of RN shortages that have been documented since WWII, their presence makes it possible to raise some long term policy and employment issues that the "today-oriented" labor market might other wise ignore*" (p. 211).

The Joint Commission on Accreditation of Healthcare Organization (JCAHO) (2002) estimated that the current nursing shortage is at approximately 126,000 open positions (Tanner, 2002). In 2002, the Bureau of Health professions estimated that the shortage of registered nurses in this country was at 6%, or approximately 110,000 nurses, and estimated that if the trend continued, by the year 2020 the registered nursing shortage would increase to 29%.The nursing shortage is projected to reach a crisis state, a 20% deficit by the year 2020. (Nelson, 2002; Seldomridge and DiBartolo, 2004; Tanner, 2002). The current shortage differs from previous ones, as this one exploits a deficit in the absolute numbers of nurses entering the profession (Curran & Minnick, 1989).Cavanaugh and Huse (2004) state that the shortage of hospital based nurses will culminate at a time when the demand is most severe (p. 251).

Bowles and Candela (2005) reported the American Nurses Association (ANA) calling the staffing of nurses in the United States a public health crisis. The U.S. Healthcare system has significantly changed over the past two decades. The changes have come about due to multiple factors including, advances in technology, the changes in the structures of hospitals or healthcare settings, and the shift from hospital to community

based settings (U.S. GAO, 2001).

The demand for nurses has come full circle over the past few decades through absolute demand for knowledgeable and competent caregivers. The U.S. GAO indicated that registered nurses are responsible for the largest portion of health care provided in this country. Nurses can serve as a potent force in shaping public policy in relation to healthcare issues (Reid Ponte, 2004). A collaboration of data and research from U.S. government and nursing and healthcare organizations has shown evidence of a continuing shortage of registered nurses in the United States. There was a nationwide increase of RNs per capita of 44 % during the years of 1980 through 1996. However, the total employment of RNs per capita declined 2 % between 1996 and 2000 (U.S. GAO, 2001).

In the 1990s, the Pew Health Commissions developed a panel to evaluate the future of the nursing profession. In 1995, the shortage of nurses began to become more prevalent in the literature (Winter-Collins and McDaniel, 2000). In 1995, the Pew Commission released suggestions for the future of the nursing profession. The reports indicated that there were too many nurses, and that nursing should reduce the number and size of education programs (Donely, 2005). Many healthcare institutions in the 1990's completed restructuring, reengineering, and downsizing of their healthcare workforce, thus eliminating many RN positions. Many practice environments at this time became less appealing to nurses and the vacancies began. Nursing school enrollments continued to drop and the need for technological advanced nurses began (Ward and Saylor, 2002; Tanner, 2002; Hart, 2006; Murray, 2002; U.S. GAO, 2001; Mee and Robinson, 2003; Reid Ponte, 2004).

In July 2001, the Untied States General Accounting Office (U.S. GAO) reported

findings of an investigation into the emerging nursing shortage and the factors that are related to the shortage. Over the years, the nursing profession has demonstrated a cyclical series of shortages and surplus of nurses. Retention of nurses has become a widespread concern as the turnover rate of hospital staff was at 15% in 1999 up 3 % from 1996. Nationally, turnover rates for RNs had an increase of 14.5 %, from the years 1998 through 2000 equally 26.2 % overall (U.S. GAO, 2001). Turnover as defined by Bellinger and McCloskey (1992) is "the voluntary turnover of organizational membership" (p. 322). Halfer and Graf, (2006) describe turnover as the intent to leave a job, and feel as though this has an inverse relationship to job satisfaction. As satisfaction in a job increases, turnover rates will decrease (Halfer and Graf, 2006).

It is estimated that the population of the U.S. will increase by approximately 1 % annually. Many baby-boomers are retiring, and health needs will continue to increase. The population of persons over the age of 85 will double from 3.5 million people in 1998 to almost 7 million by the year 2020 (Cooper, 2003). Data suggest that by the year 2010 the current registered nursing workforce will be dramatically reduced and the demand for nurses will continue to increase as "Baby boomers", people born between the years 1946-1964 (http://www.babyboomers.com/) reach their 60's and 70's. (U.S. GAO, 2001; Hart, 2006; Cooper, 2003; Murray, 2002).

Minnick (2000) reports that in 1996, 49 % of the RNs holding licensure in the U.S. were baby boomers (those born between 1947 and 1962), making this group of nurses the largest cohort of U.S. RNs. This is significant as that cohort of nurses reached retirement eligibility in 2005, and by 2010 they will all be of prime retirement age. Additionally, in 1996 only 9 % of RNs were younger than 30 years old (Minnick, 2000).

Berlinger and Ginzberg (2002) postulate that the current shortage of nurses is three separate, but highly related problems. The first is a decrease in the numbers of new nurses entering (and being retained) within the workforce. Second, recruiting and retaining nurses to work in an acute care hospital setting and third, combating issues related to retaining nurses from leaving the workforce early or retiring. Furthermore, approximately 500,000 RNs who held nursing licenses in the year 2000 were not working in the profession (Berlinger and Ginzberg, 2002; Bowles and Candela, 2005). Ward and Saylor (2002) believe that the nursing shortage is the result of irregularities in the supply and demand of nurses in the workforce. Sigma Theta Tau International Honor Society of Nursing (STTI) (2000) reports that by the year 2018, approximately half of the nursing workforce will reach retirement age. Buerhaus, Staiger, and Auerbach (2000c) estimate that the actual number of employed RNs will begin to significantly decrease by 2012 and will be at a 20 % deficit by the year 2020.

Buerhaus, Staiger, and Auerbach (2000a) contend on factors contributing to the shortage of registered nurses; the aging of the current population of RNs and the demands of shift work are two areas of interest. Other contributory factors are declining nurses entering the profession (Lake and Friese, 2006).

The average age of nurses actively working in the profession increased by more than four years from the years 1980 through 1996, going from 37 years of age up to 41 (Ward and Saylor, 2002).Predictions suggest by the year 2010, the average age of the nursing population will be greater than 50 (Buerhaus, Staiger, and Auerbach, 2000b; Cooper; 2003; Murray, 2002). Berlinger and Ginzberg (2002) report the average age of nurses as 45.2 years old, and only 9.1 % of nurses in the year 2000 were under the age of

30; in 1980, 25.1 % of the nurses were under the age of 30. Bowles and Candela (2005) report an RN deficit of approximately one million nurses by the year 2010. Cooper (2003) cites that from the years 1983 through 1998, the average age of RNs increase 4 plus years, from 37 to 41.9 years of age. Additionally, the percentage of RNs under the age of 30 decreased at a rate of approximately 41 % (Cooper, 2003). A compilation of data collected by the staff of "*The Nursing Spectrum*" reports in 2004, the average age of an RN was estimated at 46.8 years old, and that the ranks of nurses over the age of 45 is increasing, whereas the rates of nurses younger than that is not (Nursing Spectrum, 2006). Nursing Economics (2003) reports that the percentage of nurses less than 30 in 1980 was 26 % compared to 9 % in the year 2000. JAMA (2002) reported that as the nursing workforce continues to age, by the year 2010, there will be approximately 40 % of the workforce older than 50, and by the year 2020, there will be less than 20 % of available registered nurses to meet the necessary supply to maintain the workforce. Additionally, many nurses are entering the profession in their thirties or forties, as a second career; therefore the "work life" of the average Registered Nurse will decreased due to retirement. Most nurses begin to retire in their fifties due to the ever changing demands of the profession and the fluctuating shift work environment (Berlinger and Ginzberg, 2002). Allen (2001) reports that the gap between the supply and demand of nurses will grow wider throughout the resulting years if measures are not taken to slow down or eradicate this trend.

Data derived from the National Sample Survey of Registered Nurses (March 2000) reported 2.7 million individuals held active nursing licenses in the year 2000. This total was greater than the 1 million reported in 1980, however close to 5000,000 RNs

were not working in nursing in the year 2000 (Berlinger and Ginzberg, 2002). Many researchers feel that the current nursing shortage is far worse than any previous shortage, and therefore previous solutions that have been used will no longer be effective. (Berlinger and Ginsberg, 2002). Unless there is a drastic change occurs, the impact will be profound. Key factors relating to the ongoing shortage of nurses is that nursing is a 24 hour a day/7 days a week/365 days a year profession; the work is physical and demanding, and the workforce continues to age as the recruitment and retention is becoming difficult (Cooper, 2003). The age of the nursing students enrolling in programs is increasing as individuals are now choosing to enter nursing as a second career, or people return to the workforce as their children become grown. Therefore, the profession is starting out "aged". Recruitment and retention of registered nurses is of grave concern to the profession, and must be made a priority at fixing the deficit (Guhde, 2005; Berlinger and McCloskey, 1992; Buerhaus, Staiger, and Auerbach, 2000; Yoder, 1997).

In 2004, a report by the State of PA indicated the total number of students enrolled in professional RN nursing programs increased by 83% from 9,859 to 18,017 between 1999 and 2004 (Commonwealth of PA, 2006). Additionally in PA, there was report of a slight decline in total nursing program enrollment between 1999 and 2000, and then an increase from years 2000 through 2004. Reports indicate Diploma programs produce fewer graduates than the other programs. (Commonwealth of PA, 2006).

The PA Department of Health's 2004 report on Nursing Education programs identified 85 professional nursing programs (RN) in the state. Of these 85 programs, 33 programs were BSN programs, 22 were Diploma programs, and 25 were ADN programs. Reports show that from 1995 through 2002 in the State of PA, the number of RN

programs decreased from 84 to 78 programs, and in 2004, the number then increased to 85 RN programs (Commonwealth of PA, 2006). In PA, the general attrition rates for nursing education programs decreased during the four years between 2000 and 2003. BSN programs maintained the lowest attrition rates between the years 2000 and 2004. A reported 51% of all attrition was due to academic failure for the State of PA (Commonwealth of PA, 2006). The nursing education programs also reported difficulty in finding clinical sites for students. The BSN reported a difficulty of 80% where the ADN programs reported difficulty at 76% and Diploma programs reported a 23% difficulty in clinical placements (Commonwealth of PA, 2006). This difference in difficulty percentage may be related to the Diploma programs affiliation with participating institutions.

Over the past two decades the age of the nursing profession has been increasing steadily (U.S. GAO, 2003; Reid Ponte, 2004). Ward and Saylor, (2002) report that the nursing profession is the most rapidly aging population of any occupation in the nation. The nursing workforce aged over four years from 1980 through 1996; this is double the average age of all other working populations (Ward and Saylor, 2002). The average age of working nurses within the profession ranged from 43.3 to 46 years of age, and projected to be age 50 or older by the year 2010 (Bleich, Hewlett, Santos, Rice, Cox, and Richmeier, 2003; Murray, 2002). Adding to the educational issues associated with the most recent shortage is the aging of nursing professional educators. Cooper (2003) reports the nursing professors average age is between 48.5 and 52.1. Tanner (2002) reports that 38 % of nursing schools reported turning away nursing school applicants due to a shortage of faculty. The AACN (2002) reported from the year 2000 to 2001, close to

6,000 qualified applicants were turned away from attending nursing programs related to a faculty shortage, inadequate numbers of clinical sites, insufficient classroom space, and budgetary constraints. Projections are that 50 % of the nursing school faculty will retire by the year 2010, further complicating the recruitment of new people into the nursing profession and not having enough educators to teach them (Hart, 2006; Inglis, 2004). The struggle to educate new nurses seemingly will continue as statistics indicate that of the nursing workforce, approximately 40 % have associates degrees, 32.3 % have baccalaureate degrees, 7.3 % have master's degrees, and only 0.6 % holds doctorates. 55.4 % of new graduates come from associate degree program. Educators that are doctoral prepared have an average age of 53.3, where master's prepared individuals mean age is 48.8 (Donely, 2005; AACN, 2003; Spratley, 2001, Johnson, Sochalski, Fritz and Spencer, 2001).

Rapid exit from the nursing profession and early retirement of nurse's are other contributing factor to the current nursing shortage. Approximately 1 in 10 nursing jobs in the U.S. are unfilled (Erickson, Holm, Chelminiak, and Ditomassi, 2005). Research indicates that 2 income families with grown children may no longer need to perform the physical burdens and tasks associated with the nursing profession, and often there is a lack of financial incentives for many nurses to continue working (Berlinger and Ginzberg, 2002; Donely, 2005; Lake and Friese, 2006). However, it should be noted that financial issues do not to be at the root of nursing school decreases or dissatisfaction overall (Berlinger and Ginzberg, 2002). Erickson, Holm, Chelminiak, and Ditomassi, (2005) state that when surveying high school students and adult career changers about their interest in the nursing profession, only 5 % of high school students, and 3 % of adult

career changers said they would choose nursing as a career. Donely (2005) describes that the current state of healthcare as "a violent revolution" and adds that the current shortage of nurses will not be quickly resolved.

There has been an increase in dissatisfaction within the workplace (Lake and Friese, 2006; Aiken, Clarke, Sloane, Sochalski, Busse, and Clarke, 2001; Sochalski, 2002; Yoder, 1997). A survey conducted by the Federation of Nurses and Health Professionals in 2001 reported that over half of the nurses employed in a clinical setting had considered leaving the profession for reasons other than retiring. Berlinger and Ginzberg (2002) report that more than 40 % of nurses working in a hospital setting reported being dissatisfied with their job, while only 10 % to 15 % if workers in other profession reported dissatisfaction. Furthermore, nurses in the U.S. reported a greater level of dissatisfaction that nurses in other countries (Berlinger and Ginzberg, 2002). Hayes and Sexton Scott (2007) and Casey, Fink, Krugman, and Propst (2004) support the statistical report of 35 % to 69 % of new graduates leaving their place of employment within the first year and also indicate that there is a nationwide turnover rate of new nurses from 55 % to 61 %.

A seminal study conducted by Aiken, Clarke, Sloane, Sochalski, Busse, Clarke Giovannetti, Hunt, Rafferty and Shamin (2001), on "Nurses' reports on hospital care in five countries" examined reports from 43,329 nurses from 711 hospitals in five countries including the U.S., Canada, England, Scotland, and Germany from 1998-1999. The study evaluated cross national comparisons on job satisfaction in the workplace, the work environments for nurses, management issues, and threats to safe and effective care for patients. A consortium was formed by the University Of Pennsylvania School Of

Nursing's Center for Health Outcomes and Policy research Design and conducted by the International Hospital Outcomes Research Consortium. The survey sample of nurses consisted of 43,329 nurses from: the U.S. (Pennsylvania) (13,471), Canada (17,450), England (5,006), Scotland (4,721), and Germany (2,681) working in an adult acute care setting in a hospital during 1998-1999. The consortium which consisted of seven interdisciplinary research teams located in participating countries developed a core nursing questionnaire. The variety of questions evaluated the nurse's perceptions of the quality of care provided in the hospitals, career plans, job satisfaction, and feeling "burnout". High percentages of nurse's in all countries, excluding Germany were dissatisfied with their jobs. In Pennsylvania (PA), more than 40 % of nurses were dissatisfied with their jobs. These statistics indicate that nurses in PA were three to four times more unhappy with their positions than other average U.S. workers (National Opinion research center, 1999). Two in ten nurses in the U.S. and three in ten nurses in England and Scotland plan on leaving their positions within 12 months of the study.

The climate within the hospital setting is not as problematic as anticipated by many. The managerial receptiveness of working short staffed or dealing with higher patient acuity levels was perceived as a problem with adequacy in staffing. Reports indicate that 60-70 % of nurses in North America (U.S. and Canada) feel their salary is adequate; however working conditions cause higher levels of dissatisfaction. Job dissatisfaction can leave the nurse feeling emotionally drained and exhausted, directly impacting the quality of care delivered to patients (Aiken and Sloane, 1997; Mee and Robinson, 2003). Research indicates that one in five registered nurses plan on leaving the profession within five years. In a 1999 survey conducted by the Nursing Executive

Center reported over half the nurses who responded (51 %) reported being much less satisfied with their jobs than they were in the past. An online survey conducted in 2001 by the ANA reflected that 54.8 % of the RNs and LPNs who responded would not recommend nursing as a career (Bowles and Candela, 2005; Letvak 2002; Berlinger and Ginzberg, 2002; Fetcher, 2001; Uhlman, 2002; GAO, 2001).

Research compiled by AONE (American Organization of Nurse Executives) found in "Perspectives on the nursing shortage: A blueprint for action" (2000) in addition to comprehensive research studies identified factors contributing to the nursing shortage. Factors include: heavy workloads, work stress, lack of autonomy, more physical demands on registered nurses, poor staffing, increased overtime, lack of support staff, and inadequate wages early exits from the profession, aging workforce, low pay, unsafe nurse-to patient ratios, cut in nurse manager positions, higher patient acuity levels, dissatisfied workforce, poor compensation for work, patient workload, working longer shifts, having overtime mandated by employers, and being physically and emotionally drained contributes to the dissatisfaction of new nurses and decrease in people, specifically women entering the nursing profession, and mandatory overtime (Bowles and Candela, 2005; Berlinger and Ginzberg, 2002; Loquist, 2002; Fletcher, 2001; U.S. GAO, 2001: Donely, 2005; Lake and Friese, 2006 Aiken, Clarke, Sloane, Sochalski, Busse, Clarke, Giovannetti, Hunt, Rafferty and Shamin, 2001;Baggot and Dawson, 2005; ANA, 2003; Reid Ponte, 2004; AONE, 2000; Yoder, 1995).

Nurse's working in acute care hospital settings report to "love" their work, but "hate" their jobs (Berlinger and Ginzberg, 2002, p. 2742). Many nurses feel unsatisfied with the quality of care they are able to provide due to a variety of constraints including

time, preparedness, and training (Aiken, Clarke, Sloane, Sochalski, Busse, Clarke, Giovannetti, Hunt, Rafferty and Shamin, 2001; Malugan, 2006). Leifer (1995) postulated that the growing dissatisfaction in the nursing profession along with the falling levels of morale will have long lasting affects on the profession as the seasoned nurses will be expected to train and mentor new RNs (Leifer, 1995). Many nurses expect new graduates to "hit the ground running" and don't want to invest the time and energy necessary to guide new graduates in the transition process (Ellerton and Gregor, 2003). The American Hospital Association (AHA) conducted a survey in 2001 relating to job satisfaction. Results indicate that nurses that responded to the survey indicated not feeling adequately supported by their hospital (AHA and Lewin Group, 2001). New graduates often are disillusioned at the aspect of not being able to provide the type of patient care they were instructed on during nursing school (Bowles and Candela, 2005; ANA, 2003). The disillusionment often leads to new nurses leaving the hospital settings, or the profession. It also contributes to poor morale amongst the staff in the hospital setting (Guhde, 2005; Malugan, 2006).

In 1999 the Nursing Executive Center conducted a survey, and reported that over 28 % of the respondents reported being somewhat or very dissatisfied with their jobs. Mooney, Driver, and Schnackel (1988) surveyed new graduates. Findings indicated that new graduate nurses did not feel as though they "fit in"; they were uncomfortable in their roles and did not feel a sense of belonging (Tradewell, 1996). Many seasoned nurses are experiencing a greater state of uneasiness, and senses of being over worked and over stressed, and therefore are not able to serve as effective positive mentors to new graduates (Domrose, 2004).

Job satisfaction is one of the leading causes of the increase in turnover rates for GNs (Hafer and Graf, 2006; Hinshaw, Smeltzer and Atwood, 1987; Garner, 1992; Bellinger & McCloskey, 1992). Turnover as defined by Bellinger and McCloskey (1992) is "the voluntary turnover of organizational membership" (p. 322). A 2003 study conducted by Larabee et al.'s found job dissatisfaction to be a major predictor of a nurse's intent to leave (Larabee, Janney, Ostrow, Witbrow, Hobbs, and Burant, 2003). Turnover is costly for the hospitals and hiring institutions. It is estimated that the cost for the loss of one RN is estimated between $25,000 up to $49,000 dollars (Woods and Craig, 2005; Winter-Collins and McDaniel, 2000; Beecroft, Kunzman, and Krozek, 2001; Lindsey and Kleiner, 2005). It is estimated that up to 88 % of GNs start in acute care settings, and up to 35-60 % of them will change employment within the first year (Woods and Craig, 2005; Godinez, Schweiger, Gruver, and Ryan, 1999). Butler and Felts (2006) describe turnover among new graduates as caused by unmatched expectations and frustration due to increased demands and limited time to provide the care they would like to give to their patients. Newhouse, Hoffman, and Hairston (2007) and Manias, Aitken, and Dunning (2004) relay that 50 % of total nurse turnover and vacancies in hospital settings is caused by new graduates.

Dissatisfaction with healthcare in general is not exclusive for nurses; it has formed roots in the public opinion also. Many patients and families have resorted to verbal abuse and complaints towards nurses due to the current climate of the overall healthcare system. Statistical findings reveal that adequate staffing for nurses is one of the most important predictors in the variation of patient outcomes in a hospital setting. The ability to recognize or rescue an individual has been of great interest in the research

as the competent nurse must be able to perform in this manner regardless of the multiple demands that have been placed on them. The expectations are often overwhelming for a seasoned nurse, let alone a novice or advanced beginner (Aiken, Clarke, Sloane, Sochalski, Busse, Clarke, Giovannetti, Hunt, Rafferty and Shamin, 2001; Malugan, 2006; Atencio, Cohen, and Gorenberg, 2003).

Safe nurse staffing is an issue being evaluated nationwide (Greene and Peutzer, 2003). Staffing issues are found to have a direct impact on the satisfaction levels of nurses and retention of nurses within the profession, as well as the overall outcomes for patients. No specific solutions have been implemented to serve as the "magic bullet" to fix the impact of the nursing shortage. However, in 1999 the state of California implemented a government mandated nurse-to-patient ratio statewide that went into full effect in July 2003 (Aiken, Clarke, Sloane, Sochalski, and Siber, 2002; Malugan, 2006). The legislate created staffing ratios that are said to reflect the maximum number of patients that may be assigned to one RN in an acute care setting. The ratio will vary according to each unit's acuity and responsibilities for the RNs. In early 2002, the governor of California announced that there must be at least one licensed nurse for every six medical surgical patients by July 2003, and the ratio will go to one to five when the mandates are fully implemented (Aiken, Clarke, Sloane, Sochalski, and Siber, 2002;California, Office of the Governor, 2002). Indications are that the results have been positive, many nurses who had cut back the time they work in nursing, or who had left the profession due to burnout or stress related issues have returned. In California, the president of the states nursing association reports that the working conditions for nurses are becoming safer and the care is better. The members of the ANA caution that

government mandated ratios are not the only issue that should be addressed, that there are many elements in determining safe staffing levels (Malugan, 2006). Further, the president of the ANA stipulate

> *"If you mandate a hard number that people believe is right today, you may find tomorrow or a year from now that there is new technology that may change your unit. If you are hardwired into a number, you've got an uphill battle to change it"* (Malugan, 2006, p. 59).

Many physicians have cited poor nursing staffing levels as a primary impediment to safe and effective patient care (Aiken, Clarke, Sloane, Sochalski, and Siber, 2002). Job dissatisfaction for the different ages of new RNs varies. New RNs under the age of 32 found the most dissatisfaction with balance between their professional/personal lives, insufficient development opportunities (Halfer and Graf, 2006). Bowles and Candela (2005) emphasize retention of new graduates is key to combating the current nursing shortage. The Bureau of Health Professions (2002) report unsatisfactory working conditions as contributing factors to nurses leaving the profession (Tanner, 2002).

Aiken, Clarke, Sloane, Sochalski, and Siber (2002) conducted a influential study in 1999. Data was collected on 210 adult general hospitals in Pennsylvania, 168 of the hospitals met the requirements for study. Data for the study was collected and evaluated from the 1999 AHA annual survey and the 1999 PA Department of Health and Hospitals Survey. Surveys were mailed to a random sample of RNs in PA. Statistics indicate 52 % of the nurses surveyed responded, equaling 10,184 nurses in the sample. Results from this study indicate higher levels of job dissatisfaction and emotional exhaustion and burnout were significantly associated with nurse-to-patient ratios. Additionally, there was a

significant relationship between mortality rates and failure-to-rescue (mortality following a complication) direct relation to inadequate staffing or higher nurse-to-patient ratios. Finally, results indicated that nurses with the highest nurse-to-patient ratios were twice as likely to experience job related burnout and to be dissatisfied with their jobs in comparison to nurses with lowest patient-to-nurse ratios.

Allen (2001) and Bednash (2000) suggested reforming the education and credentialing for nursing, restructuring the nursing work environments, and developing systems that aide in empowering RNs in their profession. Finally, women's career choices are now unlimited. Approximately 30 to 40 years ago, women's professions were said to be limited to nursing or teaching. (Berlinger and Ginzberg, 2002; Mee and Robinson, 2003). Women are said to be 35 % to 40 % less likely at choosing nursing as a profession from 1973 through 2003 (Cooper, 2003; Buerhaus, Staiger, and Auerbach, 2000).Women make up the vast majority of the nursing profession, however data collected from the National Sample Survey of Registered Nurses compiled in March 2000 indicates that men represented 5.4 % of all nursing positions, this total doubling numbers from 1980, but still very low overall in the profession (Berlinger and Ginzberg, 2002).

Malugan (2006) postulates that hospitals have a responsibility to provide safe and effective care and efforts should focus on recruiting and retaining new nurses within the profession. By improving nurse-to-patient ratios this will allow nurses more time to provide quality care to patients, and further improve satisfaction within their job, serving as a cost effective way to address issues of retention (Malugan, 2006). Additionally, improving the nurse-to-patient ratios and ensuring sufficient staffing for nurses on their

respective units can help to reduce the cost to hospitals by improving the retention of nurses, by decreasing turnover rates, by decreasing job dissatisfaction and burnout within the profession, and most importantly by avoiding preventable patient deaths. Patient safety should serve as a motivational force in improving safe staffing levels for nurse. Significant data supports that nurses' staffing levels contribute to the "surveillance, early detection, and timely interventions that save lives" (Aiken, Clarke, Sloane, Sochalski, and Siber, 2002; Yoder, 1997).

Transition into the Nursing Profession

Delaney (2003) postulates that transitions in general are stressful, and many new graduates are anxious about this time in their lives as they don't feel adequately prepared to assume their role as a professional competent nurse. Often experienced nurses are not supportive in assisting new graduates during their transition. Graduate nurses are said to be the primary source for staffing in an acute care setting (Beecroft, Kunzman, Taylor, Devenis, and Guzek, 2004). Delaney (2003) describes transitions as complex and multidimensional; she feels theses are a result in changes in life, health, environments and relationships (p. 437). Extensive research has recognized the first three months of nursing practice for newly licensed RNs as the most stressful and difficult of their career (Godinez, Schweiger, Gruver, & Ryan, 1999; Dobbs, 1988; Fisher & Connelly, 1989; Delaney, 2003; Halfer and Graf, 2006; Bowles and Candela, 2005; Uhlman, 2002). Kelly (1996) describes the first year of hospital nursing to an "obstacle course" and says that many new nurses feel that have to "prove themselves" worthy to do the job in which they've trained for. This time of transition is very traumatic and disillusioning for new

nurses trying to accommodate to a difficult and chaotic workplace setting. Almada, Carafoli, Flattery, French, and McNamara (2004) indicate that new nurses experience stress during their transition into practice, which can be a detriment to learning their new role and responsibilities. Newhouse, Hoffman, Suflita, and Hairston (2007) and Hayes and Sexton Scott (2007) report that between 35 % and 60% of new graduates will change their place of employment within the first year, and as many as 57 % will leave their first job within two years of employment.

According to Yoder-Wise (2007), role transition involves transforming a person's professional identity. Newhouse, Hoffman, Suflita, and Hairston (2007) describe the transition into the profession as "a rite of passage that influences both short and long term outcomes" (pp. 50, 51). Nurse's make a number of role transitions throughout their career. Student Nurses (SN) transform to Graduate Nurses (GN) and then to Registered nurses (RN). This transition is said to be the most difficult time in the professional nurse's career. Whitehead (2001) emphasizes that SNs should be prepared for the "real" rather than the "ideal" situations in clinical practice. Uhlman (2002) reported that within 4 years of graduation, 4.1 % of female nurses and 7.5 % of male nurses left the profession. The transition from a student nurse to a professional nurse is very stressful and challenging. It includes learning and refining of technical skills as well as professional growth and maturing in the roles and responsibilities of a registered nurse. Socialization and communication are necessary for interactions with colleagues, patients, families, and other healthcare professionals (Cantrell and Browne, 2005; Duchsher, 2001; Caroselli, 2001; Heslop, McIntyre, and Ives, 2001). New nursing graduates struggle to incorporate the translation of theoretical knowledge into practice, to apply technical skills

in a formal clinical setting, to apply effective and appropriate communication skills and techniques when speaking to colleagues, patients, and families, and to fostering appropriate coping skills in relation to their nursing practice (Santucci, 2004).

Recognizing transitions in clinical situations are aspects of clinical judgment (Benner, Hooper-Kyriakidis, and Stannard, 1999). Mentoring programs are supportive in facilitating an individual's adjustment or transition into practice (Veith, Yasuri, Sherman, and Pellino, 2006). New nurses are responsible to use critical thinking and problem solving skills and to work effectively in a multidisciplinary team setting (Utley-Smith, 2004; Cavanaugh and Huse, 2004). A SN has clearly defined objectives and expectations that must be met in order to transition to the novice registered nurse. The advanced beginning RNs often do not have as clear expectations and their transition is more difficult. Meissner (1999) reports that "novice nurses today still seem most frustrated by the lack of care and concern that they're shown by staff nurses-their peers and colleagues" (p. 43). The frustration felt by new nurses is a result of how they are received by others during the transition process (Guhde, 2005; Roman, 2001). Beecroft, Kunzman, Taylor, Devenis, and Guzek, (2004) postulate that it is unrealistic to think that academics alone can prepare an individual for real-world application in practice. Chesla (1996) state that learners will perform better once they have mastered the "task world" so their concerns can be refocused in other aspects of taking care of the patient. Many new nurses are consumed with mastering the technical skill associated with nursing, whereas an expert nurse will have an immediate understanding of a rapidly changing situation and be able to direct their interventions quickly and appropriately (Benner, Stannard, and Hooper, 1996; Cavanaugh and Huse, 2004). Utley-Smith (2004) indicates that

competence is not static; it evolves within the system of professional practice (p. 166).The responsibility charged to the nursing profession is to "focus on preventing vacancies" in RN positions (Bellinger and McCloskey, 1992; Curran and Minnick, 1989).

Kramer (1974) found that role transition for new graduates was said to be the major contributing factor to stress and dissatisfaction in the first 18 months of practice. During nursing school, students are taught specific skills and techniques in a controlled lab setting. Many of the skills are then performed by the SN and observed by nursing faculty throughout the course of the educational program. However, many of the skills are not able to be mastered at a student level and therefore will have to be developed over time by the novice RN in the practical setting. Research has emphasized the challenge for healthcare professionals implying that the practitioner is responsible not only for developing and understanding of the commonalities of the disease processes and its implications to specific patients, but the individuality of the situation and patient (Maudsley and Strivens, 2000; Leggett, 1997). Upon the development of clinical reasoning skills or "reasoning about the change in a situation" the practitioner goes through a process of reasoning in transition. A good clinician holds the ability to look at the big picture (Benner, Hooper-Kyriakidis, and Stannard, 1999).

The hospital organizations will play a major role in the training and retention of novice RNs (Yoder-Wise, 2007). Recruiting and orienting one new GN can cost a hospital more than $40,000 (Weston, 2000; Almada, Carafoli, Flattery, French, and McNamara, 2004). The institutions must create a learning environment that will facilitate the transition process for new RNs. Role stress can occur if the working environment is not supportive. Studies indicate that supportive training programs improve retention for

GNs. (Spector, 2007; Krugman, Bretschneider, Horn, Krsek, Moutafis, and Smith, 2006; Beauregard, Davis, and Kutash, 2007). Nurses who experience such stress may leave the organization or the profession (Ewens, 2003). Research indicates that as many as 35-60% of new nurses will change employment in their first year of practice (Gonzalez, 1996; Godinez, et al 1999; Halfer and Graf, 2006; Beecroft, Kunzman, and Krozek, 2001; Matthews and Nunley, 1992; Hayes and Sexton Scott, 2007). A study by Hamilton, Murray, Lindholm, and Myers completed in 1989 showed that the attrition rate of RNs ranged from 55-61% in the first year of employment following graduation (Winter-Collins and McDaniels, 2007).

The reality shock occurs when the pressures and priorities from the educational setting transition into a real life acute care setting. Many student nurses feel that you don't get all the information on the reality of nursing in nursing school (Halfer and Graf, 2006; Steinmiller, Levonian, and Lengetti, 2003). Changes in the role of the RN can be both exciting and frightening; the results are based on the support that the individual feels while going through this process (Yoder-Wise, 2007). The high turnover rate holds ill effects for the advanced beginner RN in training and the employers that have hired them. The effects have been researched extensively both nationally and internationally (Godinez, Schweiger, Gruver, and Ryan, 1999; Bygrave, 1985; Horsburgh, 1989).

Kramer's classic 1974 study of the "reality shock" of graduate nurses on their initial work experience in the nursing profession introduced the importance of the transition into practice (Godinez, Schweiger, Gruver, and Ryan, 1999; Spector and Li, 2007). Kramer's Reality shock for new nurses has four phases. Phase one is the *Honeymoon phase*; during this phase the GN feels excitement and euphoria about

working and getting paid to be a real nurse. The second phase is the *Shock phase*; this is where the GN starts to recognize their individual limitations within the place of employment and realize their goals and expectations of the job may not be met. The third phase is the *Recovery phase*; this is when the GN starts to gain a sense of perspective on their work and responsibility. The final phase is the *Resolution phase*; this when the GN is able to find their self-identity in the nursing profession (Kramer, 1974; Winter-Collins and McDaniels, 2007). In Kramer's studies, she identified the need for changes; that the profession needs to be made to be more supportive of GNs in their transition into practice (Spector, 2007). The GN has to learn balance within the institutional setting. Some of the many stressors reported by new GNs are lack of experience, lack of organization, communications and interactions with physicians and other nursing staff, managing multiple difficult patients, inadequate orientation, and interruptions in daily plan, administering medications, and having to rely on others to manage the day (Halfer and Graf, 2006; Oermann and Moffitt-Wolf, 1997). Many new nurses find it difficult to adjust to readjusting their ideations of the nursing professions and are faced with feelings of disillusionment with their interactions with patients (Malugan, 2006). Winter-Collins and McDaniel (2000) report that job conflict; stress and decreased satisfaction will directly affect retention of new nurses. It may cost as much as $30,000 to replace one nurse after recruitment and training, and it will take approximately 60 to 90 days, on average to recruit a new nurse (Winter-Collins and McDaniel, 2000)

Job dissatisfaction for the different ages of new RNs varies. The current nursing workforce is said to be made up of the "baby boomers" (those born between 1946 -1964) and the "Generation Xers (those born between 1965 through the late 1970's)

(Thorgrimson and Robinson, 2005). New RNs under the age of 32 found the most dissatisfaction with balance between their professional/personal lives, insufficient development opportunities. Additionally, findings suggest that novice nurse's adjustment extends the mastering of clinical skills it includes a personal commitment to their profession (Halfer and Graf, 2006; Green, 2005). The GN has conflicting expectations of the reality of nursing, and this leads to the stress experienced with "reality shock" (Godinez, Schweiger, Gruver, and Ryan, 1999). There are multiple factors that are related to these recruitment and retention. Nursing educators and administrators alike feel that one key to improving retention within the institutions is to focus on new nurses entering the profession. Fewer nurses are going into the profession, many nurses are working in a non-clinical setting, and others are retiring or leaving nursing (Bowles and Candela, 2005; Loquist, 2002).

The nursing profession has recognized the need to develop a best practice model for easing the transition of new nurses into a competent beginning practitioner. The use of residency programs and preceptors are areas key in the transition process. According to Li (2007) new nurses who were precepted during their first three months of practice performed at higher competency levels than new nurses without preceptors. Additionally, new nurses who participated in internship programs were less likely to leave their positions within the following six months of their practice. Finally, nurses who were supported in the transition process made less errors and were less stressed (Li, 2007).

Mentoring

Mentoring has roots of Greek origin (Bensing, 2007; McKinley, 2004; Gordon, 2000; Dracup and Bryan-Brown, 2004; Kirk and Reichert, 1992; Roman, 2003; Goran, 2001). When Odysseus, King of Ithaca was going off to fight the Trojan War, he selected his friend Mentor to protect, support, affirm, nurture, and serve as a caretaker for his son Telmachus. Hence, the term mentor was adapted to describe a person who guides and cares for another individual (Bensing, 2007; Yoder-Wise, 2007; Moss, 2005; Haack and Smith, 2000; McKinley, 2004; Smith, McAllister, and Crawford, 2001; Hunt and Michael, 1983; Wood, 1997; Kirk and Reichert, 1992; Roman, 2003). Mentors support, sponsor, inspire, build confidence, challenge, protect, and advise a mentee. Mentors will often have a positive influence on the career of others, and will assist in professional growth through skills development, advising, and personal growth (Hayes, 2005; Moulton, 2005; McMahon, 2005; Tracey and Nicholl, 2006). McMahon (2005) states of mentoring that "*Mentoring is a gift that is never truly owned, but it is passed from one person to the next*" (p. 195).

Webster's defines a mentor as:

An advisor, tutor, sponsor, guru, teacher, counselor, master and coach. (p. 286).

Gordon (2000) defines a mentor as a person who takes a special interest in helping another individual in professional development. Mentors help nurses to facilitate learning in a professional milieu and network with individuals who can help to provide a supportive environment. Mentors assist in career guidance and coping with interpersonal challenges. It allows individuals to learn to lead through guidance of another. Mentoring is said to demonstrate a positive correlation with professional and academic success (Yoder-Wise, 2007; Dracup and Bryan-Brown, 2004; Scott, 2005; Gudyk, 2005;

Lewellen-Williams, Johnson, Deloney, Thomas, Goyol, and Henry-Tillman, 2006; Gibson, 2004). Successful mentoring interactions promote professional growth, productivity, and competency (Barker, 2006). Mentors serve to promote confidence building in new graduate nurses, especially those going into specialty units like an ICU (Intensive Care Unit) (Ihlenfeld, 2005).

Yoder (1990) proposed a dual dimension mentoring model incorporating instrumental or career functions which are coaching, challenging, sponsorship, and visibility and psychosocial functions including counseling, role modeling, and acceptance (Yoder, 1990; Byrne and Keefe, 2002).

Mentoring has been used in multiple professions as a means of professional development; fields such as physicians, master-apprentice, and teacher-student (Hunt and Michael, 1983). Mentoring became common in the nursing practice in the 1970's (Vance, 2002). Florence Nightingale, the mother of modern nursing, was known to have had multiple mentors that were instrumental in her development as a professional RN (Hurst and Koplin-Baucman, 2003). The goal of mentoring in nurses is to support and retain nurses in the practice, to increase professional development, and facilitate recruitment. Mentoring is important within the profession as it "regenerates nurses from within" and aides in uniting nurses within the profession. Research indicates that a nurse that has been mentored is more likely to mentor another, therefore strengthening the profession (Anderson, Kroll, Luoma, Nelson, Shemon, and Surdo, 2002). Blakeney (2005) states that nurses by nature are teachers; teachers are often thought of as mentors. Gibson (2004) describes mentoring as a time when a mentor opens door for and shows a protégé the ropes. Ansbacher (2006) states that a mentor provides a supportive and nurturing

environment for a mentee, and creates a trust that will promote a positive interaction. Greene and Puetzer (2002) support mentoring in nursing as staff attrition adds to the operational cost for hospitals ant it is costly to recruit and orient new nurses to fill staffing vacancies.

The concept of mentoring is not new in the fields of business, politics, education, and the medicine; however it is relatively new in nursing. (McKinley, 2004). Smith (1997) describes mentoring as helping a peer or subordinate develop skills and attitudes to become more productive and promotable within an organization. Peddy (1998) defined mentorship as a three step process. Her three steps are lead, follow, and get out of the way. Her description of leading includes teaching, coaching, and training. The next step is follow up and being available for the individual being mentored. The third and final step in Peddy's mentorship process is getting out of the way and allowing the individual to grow; the mentor is then available in a collegial relationship (Peddy, 1998).

Stewart and Krueger (1996) conducted research in mentoring. The pair compiled essential attributes of mentoring from 82 research abstracts and journal articles. The key attributes are: teaching-learning process, knowledge differential between participants, duration of several years, and resonance (Byrne and Keefe, 2002, p. 391). Smith, McAllister, and Crawford (2001) and Kirk and Reichert (1992) describe benefits of mentoring programs for nursing as promoting growth and development within the profession. Madison's (1994) descriptive study of 367 nurse managers and outcomes related to mentoring, these positive benefits include enhanced thinking and risk taking, job enrichment, political awareness, improved performance, and enhanced self esteem.

The research compiled on mentoring in the nursing profession has been shown to

have significant value (Andrews and Wallace, 1999). Snell (1999) describes a mentor as a problem solver, a coach, a devil's advocate, a networker, and a sounding board. Gordon (2000) states that mentoring is currently used primarily as a career development tool. Mentoring relationships in nursing have traditionally taken place at the master's level or above; and the conditions essential for effective mentoring relationships are similar to other professions that utilize mentoring consistently (Moss, 2005; Byrne and Keefe, 2002; Owens and Patton, 2003). Dracup and Bryan-Brown (2004) emphasize that mentors do more than teach skills to new nurses, they enhance learning through experience, they provide networking opportunities for colleagues, and serve as a sounding board that assist in clinical decision skills. Mentoring is crucial in promoting career success for both males and females (Hunt and Michael, 1983; Roche, 1979)

Byrne and Keefe (2002) state that mentoring is a "*special way to transfer knowledge, and it can occur in all the settings in which scientific inquiry is being deliberately pursued*" (p. 392). Thorne (1996) supports mentoring as improving staff retention, fostering a more informed workforce, and assisting in the development of the organizational culture as a whole. Walsh and Clements (1995) report that 83 % of the most influential nurses in the U.S. were mentored at some point in their career. Advanced Practice Nurses (APNs) often assume the role of a mentor to new nurses (Gordon, 2000; Yoder, 1995; Angelini, 1995; Madison, 1994; Walsh and Clements, 1995). Beecroft, Santner, Lacy, Kunzman, and Dorey (2006) emphasize that the timing of mentoring relationships are key, and building the mentoring relationship early on in the new nurses career is important to decrease anxiety and feeling overwhelmed. Mentors should be committed to the position and have formal training on the specific details of their role in

the mentoring process.

Girves, Zepeda, and Gwathmey (2005) suggest that mentors are key in integrating academic principles into practice and can provide a positive impact for students. Jacobi (1991) described effective mentoring as possessing five key concepts: The relationship is focused on the achievement of acquiring knowledge, it supports role modeling behaviors, it provides reciprocal benefits for the mentor and mentee, it provides a personal interaction, and the mentors provide great experiential guidance in a clinical setting. Johnson (2002) states that those who lead in health are must do so through their actions, by leading through example. Anderson (2000) emphasizes that "practicing nurses need to "step back from the difficulties of their current situation and recall...the intrinsic rewards that accrue from doing valuable work in service to others" (p. 149). Mentoring advances the nursing profession, as well as the development of the individuals. Goran (2001) states that "mentors teaching in the workplace often focus on building competence and career rather than on developing awareness". Goran emphasizes that competence, particularly in nursing is important; however other types of learning are necessary for professional growth.

Darling (1984) as cited in Thorne (1996) conducted a seminal study on mentoring. The sample included interviews of 150 people, 50 of which were nurses, 20 physicians, and the remaining individuals worked in healthcare positions including executives. The study evaluated the key aspects of mentoring that individuals found essential. Findings were that a mentor must be an inspirer (attraction), be an investor (action), and finally a supporter (affect). Mentoring utilizes a supportive and interactive environment to meet the goals of the mentee. It's a process of teaching and learning

(Moss, 2005; McKinley, 2004; Smith, McAllister, and Crawford, 2001; Bensing, 2007; Roman, 2003). Research indicates that the type of orientation a new nurse receives is related to their levels of job satisfaction. Preceptorship is said to improve a new nurses perceptions of job satisfaction (Bellinger and McCloskey, 1992; McKinley, 2004; Beecroft, Santner, Lacy, Kunzman, and Dorey, 2006).

In 2003, Pinkerton wrote of retention and recruitment issues in nursing for the Journal of Nursing Economics. In this report, she described Presholdt's 1990's work on functions and phases for mentoring. Presholdt described mentoring as having a dual function with career components including coaching, challenging, protection, and a firm belief in the individual mentee's ability to succeed. The second component of mentoring is a psychological function, which promotes role modeling, confirmation of skills, acceptance, clarity of identity, taking on a new role, and self-competence. (Pinkerton, 2003).

Precepting is said to be more of an assigned position within the work environment. Many times the terms of mentors and preceptors are used interchangeably. Generally, preceptors are selected as they may serve as a good role model for the new nurse. Bellinger & McCloskey, (1992) define a preceptor as: "*a peer nurse who is responsible for the orientation of a new nurse to a particular unit for a limited time period*" (p. 322). Bensing (2007) indicates that as preceptors are assigned, the goals for their relationship have been set and the relationship is generally temporary. Communication between the GN and preceptor is essential to the transition process (Godinez, Schweiger, Gruver, and Ryan, 1999; Ardoin, and Pryor, 2006). Myrick and Yonge, (2002) describe preceptors serve as powerful and motivating influences by role

modeling for students. A preceptor is said to provide a "one-to-one" relationship for the new nurse and this will then allow the GN to have continuity and consistency which will assist in developing knowledge and skills and therefore promoting professional growth for new nurses (Bellinger and McCloskey, 1992). Preceptors in a clinical setting have contributed to the building of competence in new nurses. It is said to be instrumental in socializing nurses to a clinical practical setting. Mentoring and preceptoring assist in guiding the novice nurse to recognize "what they don't know" and helping them to figure out the answers to the questions they are unsure of (Butler and Felts, 2006). Preceptors are said to exhibit behaviors that demonstrate confidence, they possess a positive attitude and interpersonal skills, they have a willingness to serve in the role to new nurses, they serve as role models for professionalism, they provide stability and security for nurses, and they possess experience in a specific clinical area (Myrick and Yonge, 2002; Modic and Schloesser, 2004). Selecting the correct preceptor for the new nurses is essential in the success of a precepting program (Modic and Schloesser, 2006 Ardoin, and Pryor, 2006). Many institutions have recognized the need to prepare and compensate preceptors for their roles in preparing new nurses for the transition into practice. Mooney, Driver, and Schnackel (1988) report that financial compensation was recommended for preceptors, in addition to proper training for preceptors to adequately perform their roles. Beeman, Jernigan, and Hensley (1999) refer to a preceptor as a guide, and describe this role as orienting a new graduate to meet individual workload demands, complete extensive paperwork, and meet conflicting demands of new graduates to decrease their feelings of being unprepared and overwhelmed.

Coaching is different in the mentoring process; in as that there is a responsibility

on the part of the mentee to accept feedback on their performance (Yoder-Wise, 2007 Smith, McAllister, and Crawford, 200 Ardoin, and Pryor, 2006). Mentees need to have a commitment to learning, be honest and empathetic, and respect the guidance that is provided by the mentor (Smith, McAllister, and Crawford, 2001). Coaching is often done in a generalized sense, not the one to one relationship found with precepting and mentoring. A coach may serve as a mentor, but the coaching aspect is said to have "a tightly focused goal". Mentors can use coaching to encourage a mentee to seek direction with people who can assist them in improving their transition into nursing (McKinley, 2004). Mentors and preceptors roles differ and the roles need to be clearly identified at the commencement of a nurturing professional relationship (Gordon, 2000). Mentor/mentee relationships may not always be effective, however for most it aides in promoting professional growth and helps to ease the transition of novice nurse into the real world of nursing (Kirk and Reichert, 1992; Ardoin, and Pryor, 2006).

The Robert Wood Johnson Nurse Executive Fellows have identified five competencies of leaders and mentors. They are as follows: Self-Knowledge, Strategic Vision, Risk-taking and Creativity, Interpersonal and Communication effectiveness, & managing change. (Yoder-Wise, 2007). Mentors generally are "role models" for nurses throughout the course of their career. As nursing educators, it is the responsibility of the group collectively to serve as mentors to the GN or novice RN. Many educational facilities as well as staff developments programs within the health care facility have varying levels of mentoring, tutoring, counseling, precepting, and coaching. Kuhl (2005) suggest that mentors provide a network to allow for the development of organizational skills and allow the mentee to see modeling behaviors that work to motivate the new

nurse through knowledge, skills, and "life experiences".

Eddy and Schermer (1999) describe modeling as a process where an individual conveys beliefs, values, and behaviors to influence another. Whereas a role model is perceived by others as being successful, credible, and possess competence in practice (p. 365). Effective mentoring can decrease an individual's risk of burn-out and enhance job satisfaction. Additionally, mentoring helps a person realize their own dream (Pololi and Knight, 2005).

Butler and Felts (2006) also referred to mentors as "keystoners". These individual's are describes as people who make a positive difference in the adaptation of the new nurse into the profession, allowing for nurturing of new graduates in the clinical milieu. A keystoner will encourage, teach, and guide the new nurse; leading by example serving as a role model by providing honest feedback and allowing the new nurse to grow within their profession (Butler and Felts, 2006).

Nursing mentors are experts in their field that support, advise, listen, and encourage student or new nursing graduates develop professionally. Mentors are thought people who support another in the progression of the career and help them to meet their life goals. They are thought of as being generous, competent, self-confident, and committed to practice (MacDonald and Gallant, 2007; Gray and Smith, 2000; Shaffer, Tallarica, and Walsh, 2000; Wink, 2007; Smith and Zsohar, 2007).

In 2007, the NCSBN appointed the responsibility of practice on developing a regulatory model for the transition of nurses from the educational realm into nursing practice (Spector and Li, 2007). Spector and Li, (2007) highlight the mission of the State Boards of nursing are to serve and protect the public and ensure the competency and

ability to practice safely for new nurses entering the profession. The NCSBN requested the committee to develop an evidence-based model for transition that could be adapted by individual state boards of nursing to serve as a regulatory model. Recommendations from the NCSBNs Practice, Regulation, and Education Committee development include the following:

> **Having the same mentor and following that mentor's schedule is the most significant factor in designing a transition program.*
>
> **Designing the transition program with core/general knowledge while including specialty knowledge produced even more significant t outcomes.*
>
> **Timing of the transition program is an important consideration. Post-graduation transition programs were associated with better outcomes than were pre-licensure transition programs.* (Spector and Li, 2007, p 22).

Educational facilities and hiring institutions alike have realized the need to build stronger recruitment and retention techniques to assist in filling the void of nurses. Mentoring is essential to ease the transition of student nurses more easily into competent nursing professionals (Beecroft, Santner, Lacy, Kunzman, and Dorey, 2006). Turnover rates in hospitals have become "excessive & unacceptable" (Beeman, Jernigan and Hensley, 1999, p. 91). Nursing economist recognize that a nurse with less than one year of tenure will represent a loss of approximately $40,000 in orientation expenses (Halfer and Graf, 2006). McKinley (2004) estimates in a critical care unit, the annual salary for a full time nurse is approximately $64,000, with a vacancy rate of 20 %, the replacement cost in a specialty unit is nearly $900,000 per year. Aiken, Clarke, Sloane, Sochalski, and Siber (2002) concur with the $64,000 cost for a specialty unit such as critical care, and

report on a cost of $42,000 for replacing a nurse on a general medical surgical unit. Implications that have emerged over the past decade are that formal training programs to assist the transition from GN to RN. These programs are generally individualized to the needs of the hiring facilities; however the premises for these programs are to develop competent RNs to be retained within the health care system. Formal training programs designed for new graduates serve to promote increased retention and decreased turnover rates (Beeman, Jernigan and Hensley, 1999; Almada, Carafoli, Flattery, French, and McNamarra, 2004). Preceptor programs vary intuitionally, and may range from eight weeks to one year. Many new graduate nurses do not feel that the preceptoring program they attended was long enough for them to feel comfortable (Almada, Carafoli, Flattery, French, and McNamarra, 2004).

A number of healthcare facilities use formal orientation programs. Orientation as described in Ardoin and Pryor (2006) as the adaptation in a new environment, and the orientation programs shape the behavior of the individual to meet the needs of the organization. Nursing orientation is designed to advise the new nurse on the specific responsibilities and the policies of their institution. Orientation programs vary in length and content. Orientation programs help to support the GN in unit specific are techniques and identification of hospital policies and procedures. In order for an orientation program to be effective, all levels of nursing and hospital management must be involved and committed to the success of the new hires (Winter-Collins and McDaniels, 2007; Ardoin, and Pryor, 2006). The cost for the orientation of a new nurse will vary from institution, however the costs of the orientation may range from $8000-$51,000 (Guhde, 2005; Beeman, Jernigan, and Hensley, 1999; Contino, 2002; Mundie, Eishna, and DeLima,

2002; Messmer, Abelleria and Erb, 1995; Lindsey and Kleiner, 2005). Benner, Hooper-Kyriakidis, and Stannard, (1999) postulate that gaining a good grasp on a clinical situation is an "orienting activity". They describe this as the way the nurse will develop their actions and plans when a patient's condition has changed. The group further charges that gaining this "clinical grasp" requires experiential learning, a strong theoretical background, and the development of perceptual acuity in clinical situations.

In the times of cost containment and down-sizing, many institutions have shortened their training, precepting, and orientation programs (Meissner, 1999). Research by Messmer, Abelleria, and Erb (1995) indicated that the cost of orienting a new GN employee is estimated at $20,000 to $50,000 per hire. With an estimate of orientation at $33,841 (Beauregard, Davis, and Kutash, 2007; Casey, Fink, Krugman, Propst, 2004; Hayes and Sexton Scott, 2007). Winter-Collins and McDaniels, (2007) indicate that between the mentoring, educating, and training that goes on with new GN, the individual may have lost the orientation content, therefore leading to a lack of confidence for the GN.

Nash (2001) as cited in Pickens and Fargotstein, (2006) defined preceptorship as "a structured educational program in which nurses are prepared to facilitate the transition to new nurses in clinical roles" (p. 32). As reported by Pickens and Fargotstein, (2006) the administrative nursing team reported a 70 % retention rate for nurses who were precepted during a two year period of time. Almada, Carofoli, Flattery, French, and McNamara (2004) stipulate that preceptor programs increase the competence, confidence, acceptance, and retention of GNs.

McKinley (2004) states that mentoring in nursing is effective. Seminal studies compiled data from Banner Good Samaritan Hospital indicated that the hospital showed a 3.1 % decrease in nursing turnover following a formal one year mentoring program. Additionally, New Hanover Regional Medical Center reduced turnover rates from 34 % to 8 % by initiating a formal mentorship program (McKinley, 2004; Hurst and Koplin-Baucum, 2003; Verdejo, 2002).

Leners, Wilson, Connor, and Fenton (2006) postulate that the benefits of mentoring programs include developing a safe learning environment, a place to provide professional encouragement, modeling behaviors for new graduates, fostering professional and personal relationships, easing the transition into practice, and creating a support system for new or first time nursing employees (p. 653). Additionally, mentoring programs support continued quality improvement in the workplace.

Messmer, Jones, and Taylor (2004) report that mentoring by experienced nurses enhances professional development and improves critical thinking abilities. Nelson, Godfrey, and Purdy (2004) report that new nurses need support through mentoring, they report on a decrease in new graduate turnover rates from 47 % to 23 % when mentoring programs were used. Mentors in general are considered to be older than the mentee, a role model, teacher, coach, sponsor, guide, advisor, wiser, powerful, and more experienced (Beecroft, Santner, Lacy, Kunzman, and Dorey, 2006; Goran, 2001; Neary, 2000).

Casey, Fink, Krugman, and Propst (2004) elucidate that new graduates require at least one full year of support in order to gain confidence and feel comfortable in their professional role. Moss (2005) postulated that "Leaders should be the visionaries of their

organizations and should understand what is needed to make them successful" (p.7). The goal of a mentoring program is to achieve safety and competency in nursing practice. Mentors serve as role models and a resource for new nurses. Mentoring enables a supportive environment for learning and integration of needs for new nurses (Greene and Puetzer, 2002). Nurses are now called to recognize the importance of developing new nurses for the strength and retention of the profession. Preceptor based programs aid in alleviating the stress that new nurses experience during their transition into practice (Pickens and Fargotstein, 2006). Successful mentoring can serve to promote higher retention rates for new nurses, and greater work place satisfaction. Mentoring requires specific skills in order to be an effective tool for retention of new graduates. Mentors need to be clinically competent, self-assured, and confident. Further, they should posses' traits such as sensitive, caring, supportive, sensitive and accepting. Mentors need to embrace the ability to foster networking experiences for the mentee (Butler and Felts, 2006; Smith, McAllister, and Crawford, 2001; Hayes, 2005).

Blanzola, Linderman, and King (2004) conducted a study to evaluate the Nurse Internship Program (NIP) at a U.S. Naval hospital. The program was initiated to increase the new nurses' clinical competence, comfort and confidence in practice. The internship was designed to strengthen the nursing workforce and allow the new nurses to develop confidence and comfort while learning to be competent in practice. The NIP program was 16 weeks long, it was designed as a competency based and performance based program. The conclusion of the pilot program indicated that nurses that participated in NIP programs had significantly higher mean scores on core competencies than a control group of nurses. Other findings show that the national average for first time NCLEX-RN®

failures is 25 % whereas nurse interns first time NCLEX-RN® failure rates are only 14 %. Nurse interns had higher levels of self confidence, with higher acuity level patients, they had a broader base of knowledge and skills in specialty areas, they were more likely to volunteer to support other staff, they were more active in seeking out new learning experiences, complex clinical situations, and higher acuity patients, they were more proactive than reactive in practice, They demonstrated more self-confidence and self-direction, and finally the nurse interns made their transition into practice easier than their peers who did not participate in internship programs (p. 35).

Owens, Turjanica, Scanion, Sandhusen, Williamson, Hebert, and Facteau, (2001) conducted a seminal study on evaluating internship programs for a system-wide integration. The IHS (Inova Health System) which is a comprehensive network of several acute care hospitals, assisted living facilities, and long term care facilities paired up with the ILN (Inova Learning Network) which is the educational branch of the IHS combined efforts to develop a program to retain new graduate nurses and assist in building up the professional workforce. The curriculum development for the program was geared at assisting the new graduate in implementing curricular content into practice and being able to pull it all together. The program was 8 weeks long, consisting of classroom and clinical concepts. Results of the program evaluation from 49 graduates in June 1998 identified a higher retention rate of 74 %, as compared to 35 % to 60 % identified in the literature. Findings form additional years supported the benefits of internship programs. Findings of this study suggest that the internship programs are an effective tool in the recruitment and retention of new graduates during their transition into practice.

As identified by Spector and Li (2007) the key components of any preceptor based or internship program should include clearly identified roles and responsibilities for both the mentor and mentee, including a delineation of the time line for the precepting. There should be a clinical coaching plan that includes measurable outcomes, specific activities and goals, and core competency requirements. There should be a specific plan for the development of critical thinking and socialization integration for documentation, case studies, meetings, and problem solving sessions. And finally, there must be reliable tools to evaluate competency and include measurable criteria for assessment (Spector and Li, 2007, p. 21).

Residency Programs

The Joint Commission on Accreditation of Healthcare Organizations, the Nursing Executive Watch and the Robert Wood Johnson Foundation among others identified nurse residency programs (NRPs) as a key strategy in the recruitment and retention of graduate nurses (Herdrich and Lindsay, 2006). According to the Healthcare Advisory Board, (2001) to goal of the NRPs is to address the numbers of nurses leaving their jobs within the first three years of practice. A NRP as defined by Herdrich and Lindsay (2006)

> "*is a joint partnership between academia and practice that is learner focused, postgraduate experience designed to support the development of competency in nursing practice. The role of the academic partner is to aid in the development of the theoretical framework and conduct the research based program evaluation, whereas the role of the practice partner is to actualize and guide the program itself*" (p. 55).

Further, Herdrich and Lindsay (2006) stipulate that the partnership formed in the residency programs is essential for the transition from academia to practice, and by extending the orientation time in a residency program, it promotes a mentoring relationship and enhances the learning experience for new graduates.

The United Health System Consortium (UHC) and the American Association of Colleges of Nursing (AACN) (2007) described the benefits and objectives of residency programs. The RN at the completion of a residency programs will be able to safely transition from an advanced beginning nurse to competent professional in a clinical setting, they will have developed valuable clinical decision-making skills related to clinical judgment and performance, the RN will be able to demonstrate competent clinical nursing leadership at the point of care, the nurse will be able to integrate evidence based research related to outcomes in clinical practice, the nurse will possess a commitment to strengthening nursing as a profession, and finally, the nurse will develop a individual plan of growth for their new clinical role. The residency programs assist in providing guidance through precepting and mentoring guiding the new nurse in experience and competency through sensitive areas of nursing such as end of life decisions, managing difficult and changing patient conditions, failure to rescue, and situational stress management and self care issues (UHC, 2007, p. 4).

Krugman, Bretschneider, Horn, Krsek, Moutafis, and Smith (2006) reported on a partnership between the CNOs (Chief Nursing Officers) of the UHC (University HealthSystems Consortium) and the AACN (American Association of Colleges of Nursing) to evaluate the effectiveness of a Graduate Nurse Residency program. The partnership evolved in a desire to ease the transition into practice for new graduate

nurses. Additionally, the program outcomes were looking to provide the graduate nurses with a uniform and more consistent transition into practice. The initial curriculum structure and the outcomes of the program structure grew from six pilot sites to 34 academic hospitals. The curriculum included leadership based modules addressing organization and prioritization of activities, evidence-based patient outcomes including safety, assessment, and emergency related issues, and finally the professional role of a nurse including end of life decisions, communication between patient and families and peers, and self-care/stress management issues. Outcomes from the first year program evaluations for the six hospitals indicated that nurse who participated in the residency programs had decreased stress rates, higher retention rates in their positions, had better organizational and prioritization skills, and increased satisfaction levels than nurses who did not participate in residency based programs.

Williams, Sims, Burkhead, and Ward, (2002) discussed the needs to develop a residency program for the ICU (Intensive Care Unit). The program evolved following an evaluation of exit interviews at a 404-bed, level-one trauma center where 60 % of the beds are designated for critical care patients. In June of 1999, the institution had 93 nurses attend a critical care orientation, by June of 2000, only 8 nurses remained. The indications from the exit interviews were that dissatisfaction in the job were the primary reason for nurses who exited the job. The residency program was developed to incorporate aspects of leadership and mentoring. The program length was six months. Preceptors were selected and educated on their responsibilities and role for serving as mentors for new nurses. The staff was oriented to the goals of the program. Educational evidence based research was incorporated into the program. At the conclusion of the

program, the researches indicated a need for further evaluation of unit specific residency based programs, they emphasized the need to promote relationship building for new nurses and mentors, and finally the curriculum needs continual updating and evaluation.

The UHC/AACN (2007) consortium developed a Residency work group task force to evaluate current programs that are operational. Findings suggest that current programs make recommendations of admission criteria, expectations for RN residents, and format guideline. Most of the outcome measures suggest methods for recruitment and retention of new nurses, areas of need for continued education, core and clinical competencies, issues of job satisfaction, and socialization through collaboration and teamwork. Recommendations for preceptors suggest training for preceptors, standardized curriculum content, and role delineation for preceptors. The consortium used the Dreyfus' model of Skill Acquisition and Benner's From Novice to Expert in Clinical Nursing practice as the theoretical framework for evaluation. The key threads identified were patient safety, critical thinking, communication and leadership, professional development and research evidence based practice. Findings form the work group identified the need for Nurse Residency programs to obtain accreditation approval in the near future. The residency programs address key conflicts in nursing such as job satisfaction, turnover rates for new nurses, and competency in practice. The goal will be to retain nurses within the profession and to alleviate the concerns of the progressing nursing shortage.

Alban, Coburn, and May, (1999) evaluated the need to implement an internship program at a Washington, DC faith based hospital program to address the 30 % vacancy rates of RNs in the emergency department. The program was implemented to assist in

retaining new nurses and "grow their own" professionals. The program included weekly classes based on the ENA (Emergency Nurses Association) program entitled Diversity in Practice, and 3 month clinical orientation with designated preceptors. The internship included approximately 170 hours in a classroom, 85 hours of structured observation, 80 hours of independent study (this time was designated for completing self-study modules form the ENA orientation package) and 600 hours in the emergency department (p. 511). Indications from this study were that the internship program is an effective recruiting tool for RNs and the RN vacancy rate decreased from 30 % to 6 % respectively. Finally the cost of using outside hiring agencies to fill vacant RN positions has decreased 40 %. The agencies conducted the study feel that positive outcomes were not only the cost effectiveness of the program, but the RNs following completion of the internship program displayed stronger clinical abilities in their performances and required less time to adapt to the transition into practice (Alban, Coburn, and May, 1999).

Residency programs have been developed for a variety of reasons. Supporting the retention of current nurses in the profession, and most importantly new recruits in the field is imperative. Herdrich and Lindsay (2006) report that analyzing and comparing existing NRPs is difficult due to the highly variable structures and individuality of programs. Other professions, such as physicians, have recognized and utilized this form of orienting new members to their profession to assure competency and safety in caring for patients. The residency period for physicians occurs in the postgraduate years of clinical training after the internship, or first year of training. The length and time, and specifics of physician's residency programs vary with individual specialties (Mosby Medical Dictionary, 2002). Special orientation programs such as residency based

programs emerged from issues involved with precepting and mentoring of new graduate nurses. Residency programs have significant impact on the hospital settings; with the influx of inexperienced nurses, there becomes a need for experienced preceptors, this then has significance in relation to staffing and scheduling issues for the hospital (Santucci, 2004).

Connelly and Hoffart (1998) defined nursing orientation as "a formal organizational program designed to inform the new employee of specific responsibilities of a particular nursing role" (p.31). Further, they describe the orientation period as a time where the new nurse develops a "first impression" of a facility (Connelly and Hoffart, 1998). Conventional orientation programs overall have lacked the clinical support and follow up necessary to adequately prepare new nurses for their transition into practice (Mooney, Driver, and Schnackel, 1988). Internships are similar to residency programs in that they are transition programs that include didactic material as well as clinical rotations with an assigned preceptor for support and guidance (Connelly and Hoffart, 1998). Orientation to acute care nursing settings is more difficult today then in years past, as the documentation is more detailed, there are more medications, higher patient acuity, minimal accrediting body compliance, and the technology is more advanced (Contino, 2002). Orienting a new nurse to a clinical setting is essential is facilitating the transition process. Tradewell (1996) describes the first few weeks of orienting new graduates as a time for new nurses to improve socialization and interaction amongst others, finding ways to "fit in" in the hospital setting (p. 184). Myrick and Yonge (2002) describe a preceptorship experience a time to identify the learning needs and the establishment of individual goals. The residency programs serve to facilitate, or "make easy" the transition

of new nurses into the profession.

Beecroft, Kunzman, Taylor, Devenis, and Guzek, (2004) describe an pediatric RN residency program in Los Angeles, CA. the program was designed to bridge the gap between the academic preparation and the clinical responsibilities for new graduate nurses from a novice level to an advanced beginner in a pediatric nursing setting. The residency programs address issues of organizational skills, acquisition and transformation of knowledge in an evidence-based clinical setting. Evaluation of the program supports residency programs as allowing for a safer and more effective transition into practice for new nurses, in a specific clinical setting of pediatrics. These findings encourage other hospitals to initiate residency programs to improve the preparation of new graduate nurses in a clinical setting.

Benefits of residency programs are to improve job performance, patient safety, and employee satisfaction with their place of employment. These well organized transition based programs are effective as they not only address educational outcomes, but have an extended benefit of improving the retention rates for new nurses. The objectives of the residency program are to have the GN transition from advanced beginner moving toward competent RN in a clinical setting. Next, the GN will demonstrate evidence bases in their practice and finally the GN will develop affective clinical decision making skills in a clinical setting (Spector and Li, 2007; Li, 2007).

Beecroft, Santner, Lacy, Kunzman, and Dorey (2006) conducted a six-year study on the perceptions of mentoring for new graduate nurses. The study was conducted from 1999 through 2005; data were generated through survey responses on mentoring. Responses were compiled and summarized with descriptive statistics, and logistical

regression performed to see if demographic variables predicted successful program outcomes. The evaluation was undertaken as part of a larger national evaluation of the RN residency programs. The larger evaluation utilized a 35 item survey which was completed by the RN residents at the completion of the program. This study included an 8 question survey, designed to provide both qualitative and quantitative evaluation on mentoring in a formative method of evaluation. Results of the study suggested that for mentees who met with their mentors on a regular basis (54 %) the mentor provided support and guidance for more than 90 % of the participants and the interaction supported stress reduction for the majority of the respondents. In general, 58 % of all comments were positively coded with a 44 % satisfaction rating. This study was important as it identified potential obstacles that occurred with mentors and mentees, specifically time constraints and a lack of commitment by one of the parties. Mentors new clear guidance on the role they are expected to perform and finally diversity of new nurses, including educational levels, age, type of nursing units, may all increase or decrease stress and have an effect on the mentoring relationship. Formal residency programs need to allow for diversity amongst the mentors and mentees, and the mentoring relationship needs to have adequate time for the mentor-mentee to interact effectively to meet the mutual satisfactory needs of both participants (Beecroft, Santner, Lacy, Kunzman, and Dorey, 2006).

Tradewell (1996) postulates that it takes approximately one full year to master the transition from advanced beginner to competent RN. Kramer states that a supportive environment is imperative to the success of the new GN as it helps to empower the individual and give them a sense of belonging within the healthcare system.

Job satisfaction is said to be directly related to the retention of new nurses within the profession (Contino, 2002; Meissner, 1999; Bellinger and McCloskey, 1992; Curran and Minnick, 1989; McKinley, 2004; Santucci, 2004). Units that are continually understaffed provide greater stress levels, increased burnout, lower morale, and significant quality care issues (Leners, Wilson, Connor, and Fenton, 2006). Achieving goals set forth in the orientation period, allows the new nurse to feel satisfied and improves morale, therefore leading to greater retention and commitment of the new nurse in a specific hospital setting. The new nurses perceptions of being accepted by fellow staff members and peers work in developing a desire to remain and stay vested in an institution (Beeman, Jerningan, and Hensley, 1999; Dunnette and Hough, 1990). The mentoring relationships that are fostered in residency programs serve to promote retention in this way. Verdejo (2002) describes a decrease in nursing turnover rates at a North Carolina Hospital from 34 % to 8 % following a formal mentorship program. Multiple research studies support a preceptor based program to support and retain the new graduate during the orientation process (Gudhe, 2005; Bartz, 1999; Bumgarner and Biggerstaff, 2000; Bellinger and McCloskey, 1992; Beeman, Jernigan, and Hensley, 1999; Newhouse, Hoffman, Suflita, and Hairston, 2007; Leners, Wilson, Connor, and Fenton, 2006).

Leners, Wilson, Connor, and Fenton (2006) report benefits related to retention of new nurses in relation to mentoring programs as: Increased awareness of hospital culture and values, and increased professional development that support job satisfaction.
It should be noted that the effectiveness of the NRPs will be dependent on the ability to develop a learning environment that enables the development of critical thinking and

clinical judgment skills, enhances job satisfaction, supports an organizational commitment to the new nursing individual (Herdrich and Lindsay, 2006). Effective internship programs support the retention, socialization, and organizational commitment to nursing (Newhouse, Hoffman, Suflita, and Hairston, 2007).

Additionally, nurses not only strive for autonomy in practice, but are looking for safer setting in which to practice that will assist in improving better patient outcomes (MacPhee, McLean, and Woo, 2005;Aiken, Clarke, Sloan, Sochalski and Sibler, 2002; Schroeter, 2006; Malugan, 2006). Studies now emphasize that safe nurse staffing is not only related to nursing job satisfaction levels, but with saving patient lives too (Malugan, 2006; Leners, Wilson, Connor, and Fenton, 2006). Malugan (2006) reported on a study in the Journal of Health Affairs conducted in January 2006 revealed that if hospitals in the U.S. improved on nursing staffing hours and improved the nurse to patient ratios, that more than 6,700 deaths and over four million days of care in hospitals could be avoided each year (Malugan, 2006;).

Relevance to Nursing

Cooper (2003) states that the obvious imbalance of supply and demand of nurses should make the health care fields and the public at large "wake up and take notice" to the severity of the situation. Multiple research studies indicate that many professional national groups have expressed the need for improving nursing work environments to ease the problems related with the current nursing shortage (Lake and Friese, 2006; AHA, 2002; ANA, 2002; JCOAHO, 2002; Kimball and O'Neil, 2002; U.S. GAO, 2001). Nurses need a work environment that promotes strong models of professional practice, and allow for a supportive and nurturing learning environment (Mee and Robinson,

2003). It is the basic assumption of this researcher that the Graduate nurse (GN) will develop a positive self concept as a result of working with a mentor, coach, preceptor, or role-model in a residency based program and this will have a significant impact on their ease of transition into the nursing practice, as well as long term retention within the profession.

The ultimate goal for formal orientation programs that incorporate mentoring as a facilitative method to create and achieve a safe and competent environment to practice nursing (Greene and Puetzer, 2002). Ewens (2003) and Gough (2001) emphasize that the professional roles for nurses will continue to evolve, and it is now time to reassess the identity of nurses to modernize the profession.

Summary

This chapter addressed four key topics: The nursing shortage, experiential learning, mentoring, and Nurse Residency Programs.

Registered nurses comprise the largest individual healthcare occupation, with over 2.3 million jobs (Bureau of Labor Statistics, 2004). The nursing shortage is projected to reach a crisis state, a 20% deficit by the year 2020. The U.S. nursing shortage is serious and complex, and the diminished staffing situations throughout the country have been described as a public health crisis (Nelson, 2002; Seldomridge and DiBartolo, 2004; Tanner, 2002; Bowles and Candela, 2005; Murray, 2002). Multiple factors were identified as contributing to the nursing shortage. These factors include: heavy workloads, work stress, more physical demands on registered nurses, poor staffing, increased mandated overtime, lack of support staff, early exits/retirement from the profession, an aging workforce, unsafe nurse-to patient ratios, higher patient acuity

levels, a dissatisfied workforce, poor compensation for patient workload, a decrease in new nurses being retained within the workforce, inability to recruit nurses to work in an acute care hospital setting, and being physically and emotionally drained contributes to the dissatisfaction of new nurses (Bowles and Candela, 2005; Berlinger and Ginzberg, 2002; Loquist, 2002; Fletcher, 2001; U.S. GAO, 2001: Donely, 2005; Lake and Friese, 2006 Aiken, Clarke, Sloane, Sochalski, Busse, Clarke, Giovannetti, Hunt, Rafferty and Shamin, 2001;Baggot and Dawson, 2005; ANA, 2003; Reid Ponte, 2004; AONE, 2000; Yoder, 1995; Meyer and Meyer, 2000; Mangan, 1999; Erickson, Holm, Chelminiak, and Ditomassi, 2005; Berlinger and Ginzberg, 2002). Up to 88 % of GNs will begin their career in an acute care hospital settings; research indicates that 35-60 % of those individuals will change employment within the first year of practice (Woods and Craig, 2005; Godinez, Schweiger, Gruver, and Ryan, 1999). Newhouse, Hoffman, and Hairston (2007) and Manias, Aiken, and Dunning (2004) express that 50 % of the total nursing turnover and vacancies in a hospital settings are caused by new graduates. Data supports that nursing staff ratios contribute to the "surveillance, early detection, and timely interventions that save lives" (Malugan, 2006; Aiken, Clarke, Sloane, Sochalski, and Siber, 2002; Yoder, 1997).

Kramer (1974) described the experience of new nurses as a "Reality Shock", or the shock-like reaction of a real world chaotic experience. Further research supports that the first three months practice for newly licensed RNs as an obstacle course, and are said to be the most stressful and difficult of their career (Kelly, 1996; Godinez, Schweiger, Gruver, & Ryan, 1999; Dobbs, 1988; Fisher & Connelly, 1989; Delaney, 2003; Halfer and Graf, 2006; Bowles and Candela, 2005; Uhlman, 2002; Yoder-Wise, 2007).

Experiential learning as a process where knowledge is created through the transformation of life's experiences (Kolb, 1984). Experiential Learning has been described as a continuous process and cyclical process (Sewchuck, 2005; Canales, 2003). Weil and McGill (1989) describe experiential learning as a process where people engage in a direct encounter and purposefully reflect upon it to transform it into personal meaning.

In 1984, Dr Patricia Benner published *From Novice to Expert: Excellence and Power in Clinical Nursing Practice.* Benner's work built on work developed by the Dreyfus' brothers describing a model of the mental activities of direct skills acquisition one must go through to advance from a novice to expert. Benner's description of the nurse's stages of development as novice, advanced beginner, competent, proficient, and expert. These stages of experiential learning provide a framework for the nurses' transition into the nursing profession. Research has emphasized the need to support Graduate nurses in their transitional process, allowing the individual to learn the values of the profession and to integrate those values into their practice by creating meaningful relationships (Benner, 1984; Benner, Hooper-Kyriakidis, and Stannard, 1999; Spector and Li, 2007; Canales, 2003).

A mentor is said to support, sponsor, inspire, build confidence, challenge, protect, and advise a mentee. Mentoring is said to promote professional growth, productivity, and competency. (Yoder-Wise, 2007; Dracup and Bryan-Brown, 2004; Scott, 2005; Gudyk, 2005; Lewellen-Williams, Johnson, Deloney, Thomas, Goyol, and Henry-Tillman, 2006; Gibson, 2004; Hayes, 2005; Moulton, 2005; McMahon, 2005; Tracey and Nicholl, 2006; Barker, 2006). Mentoring and preceptoring assist in guiding the novice nurse to recognize

"what they don't know" and they enhance the learning experience (Butler and Felts, 2006 Bryan-Brown, 2004). Effective mentoring can decrease an individual's risk of burn-out, enhance job satisfaction, and ease in the transition process (Pololi and Knight, 2005; Beecroft, Santner, Lacy, Kunzman, and Dorey, 2006).

Finally, Nurse Residency Programs were addressed. Conventional orientation programs overall have lacked the clinical support and follow up necessary to adequately prepare new nurses for their transition into practice (Mooney, Driver, and Schnackel, 1988). Nurse Residency Programs (NRPs) have been identified as a key strategy in the recruitment and retention of graduate nurses. The NRPs provides a joint partnership between academia and practice. The NRPs improve job performance, patient safety, and employee satisfaction with their place of employment, therefore supporting the retention of competent nurses within the profession. The NRPs provide guidance through precepting and mentoring. The ultimate goal of the NRPs is to retain nurses within the profession and to alleviate the concerns of the progressing nursing shortage (Santucci, 2004; UHC/AACN, 2007; Spector and Li, 2007; Herdrich and Lindsay, 2006).

Four key components related to the national nursing shortage were presented.

Implications

1. Conventional orientation programs overall have lacked the clinical support and follow up necessary to adequately prepare new nurses for their transition into practice (Mooney, Driver, and Schnackel, 1988). Healthcare organizations and nursing educators may consider implementing the Nurse Residency Programs as the standard of practice to safely allow Graduate Nurses to transition from an advanced beginning nurse to competent professional in a clinical setting.

2. Healthcare Organizations that have not implemented Preceptor based Nurse Residency Programs as a form of formal orientation might consider doing so as the benefits are many. Mentoring and preceptoring assist in guiding the novice nurse to recognize "what they don't know" and they enhance the learning experience (Butler and Felts, 2006 Bryan-Brown, 2004).
3. Continued research, such as this proposed research study, should be implemented to determine what mentoring behaviors are found to be beneficial for new graduate nurses participating in a Nurse Residency Program.
4. The research compiled in this proposed study and combined with other researchers on the topic of perceived helping behaviors by mentors during a Nurse Residency Program may be placed into a model and/or a set of strategies for healthcare institutions and educational facilities to incorporate to better prepare and retain competent nurses within the profession, so as to encourage its use.

Chapter III

METHODOLOGY

Overall Approach and Rationale

This qualitative study focused on the actual lived experiences of new graduate nurses as they transitioned into the nursing profession. The nurses attended a Nurse Residency Program and the study looked for insight into the perceived helping behaviors described by the individuals in relation to the preceptors, mentors, or coaches. The descriptions and perceptions provided by the individuals granted information regarding helping behaviors by mentors, the ease of the transition into the profession, the benefits of the Nurse Residency Program, and most importantly ways to retain competent nurses within the profession.

Thomas (2003) describes qualitative research as attempting to make sense of or interpret things in a natural setting as determined by the meanings set forth by individuals in those settings (p. 1). Maxwell (2005) suggests that the selection of the method of research is prepared by discovering the "best match or best fit" approach for the study to be conducted. The choice of the method of research will guide the researcher in decisions on the research design, the collection of data, and the documentation and reporting of data findings based on the research questions (Maxwell, 2005). The researcher is challenged with the complexity of identifying social interactions and their meanings of individuals as the participate in their daily experiences (Thomas, 2003; Marshall and Rossman, 1999). As suggested by Fielden (2003), qualitative research is bound to the context in which the research study takes place. Data colleted and the interpretation of the

themes and clusters of information by the researcher may not be generalized overall; however the identified themes brought forth in a qualitative research study will contributes to the overall pool of knowledge on a desired subject of study (Fielden, 2003).

Lincoln (1992) described research in the healthcare setting, postulating that health related studies should be open to inquiry and therefore the qualitative model for research reaps more benefits than other types of studies. Thorne (1997) suggest that qualitative research in a health care setting can evoke passion, awaken understanding, and shape practice. It allows the researcher to generate meaningful knowledge about humans' health and illness experiences (p. 292). Cheek (1996) stresses the prominence of qualitative approaches on research in health-related disciplines. Lawler (1995) cautions of non clinical researchers reporting on nursing issues, as the non clinical individuals will conduct the research form a qualitatively different base of knowledge and parameters.

Qualitative research is guided by an underlying set of assumptions or epistemology (Ruffin, 2007; Polit and Beck, 2004: Thomas, 2003; Wiersma, 2000; Rossman and Rallis, 1998). Janesick (2000) identified twelve assumption characteristics of qualitative research. Additionally, Janescik acknowledged three rules that researchers should consider when conducting qualitative research. First, identify the meaning and perspectives of the participants in the study. Second, find the relationships in the structure and occurrences, and third, recognize and acknowledge areas of tension or conflict that may not fit the scenario (Janesick, 2000, p. 387-388; Ruffin, 2007). Fielden (2003) suggest that in order to conduct a good quality qualitative research study, the researcher must "ask the right questions, gather the right data, measure the data collected, analyze

the measurements, interpret the analysis to reach conclusions, set clear boundaries for the study, obtain informed consent and ethical approval, and apply the appropriate research methodology" (p. 129).

Selection of a qualitative research method for this study was guided by several factors. In chapter two, the review of literature found limited studies identifying factors related to recruitment and retention of nurses within the profession, as well as characteristics identified as helpful on the parts of mentors, preceptors, or coaches. I was unable to find any phenomenological studies specifically identifying the perceptions of new graduate nurses on the helping behaviors of preceptors, mentors, or coaches during their nursing residency program on their transition into professional nursing practice as a competent Registered Nurse. I am interested in identifying individual perspectives on helping behaviors of mentors, preceptors, and coaches for new graduate nurses during the critical transition period into the nursing profession. I was further guided by the topic of research, the significance of the study, and the research questions to select a qualitative approach as a best fit for this proposed research study.

The qualitative method of research is appropriate for this study as I conducted this study in a naturalistic setting and my interest is in identifying and understanding the perceptions of new graduate nurses on the helping behaviors of preceptors, mentors, or coaches during their nursing residency program on their transition into professional nursing practice as a competent Registered Nurse. Support for use of a naturalistic paradigm is offered by Polit and Beck (2004) stating studies conducted in a "naturalistic setting, such as people's homes or offices" allows the researcher to witness the lived experiences of the individuals and give meaning to the uniqueness of the experiences.

Further, the qualitative method of research also allows the researcher to derive meaning on a "case-by-case" basis and focus on specific situations and/or people, rather than focusing on numbers (Maxwell, 2005; Ruffin, 2007). The data collection methods will include focus groups and individual face-to face interviews of selected participants if deemed necessary. Focus groups can provide valuable, credible information when individuals are reporting experiences, thoughts, and feelings with minimal cost to the researcher and the participants (Morrison-Beedy, Côté-Arsenault, Fishbeck Feinstien, 2001; Carey, 1995; Fielden, 2003). Data will be collected and documented in the form of words.

Rationale for Method Selection

It is my intent to study the phenomenon of the perceived helping behaviors of preceptors, mentors, or coaches for new graduate nurses attending a nurse residency program during their transition into the nursing practice to become a competent Registered Nurse.

As indicated in the review of literature, educational facilities and healthcare hiring institutions alike have realized the need to build stronger recruitment and retention techniques to assist in filling the mass void of competent nurses within the profession. Turnover rates within the acute care hospital setting have become "excessive and unacceptable" (Beeman, Jernigan and Hensley, 1999). Nursing economist recognize that a nurse with less than one year of tenure will represent a loss of approximately $40,000 in orientation expenses (Halfer and Graf, 2006). Aiken, Clarke, Sloane, Sochalski, and Siber (2002) report an annual cost of $42,000 for replacing a nurse on a general medical surgical unit.

Formal training programs designed for new graduates serve to promote increased retention and decreased turnover rates (Beeman, Jernigan and Hensley, 1999; Almada, Carafoli, Flattery, French, and McNamara, 2004). The cost for the orientation of a new nurse will vary from individual institutions; costs may range from $8000-$51,000, with an estimate of orientation at $33,841 (Guhde, 2005; Beeman, Jernigan, and Hensley, 1999; Contino, 2002; Mundie, Eishna, and DeLima, 2002; Messmer, Abelleria and Erb, 1995; Lindsey and Kleiner, 2005; Beauregard, Davis, and Kutash, 2007; Casey, Fink, Krugman, Propst, 2004; Hayes and Sexton Scott, 2007).

The nursing profession has recognized the need to develop a best practice model for easing the transition of new nurses into a competent beginning practitioner. The use of Nurse Residency Programs and preceptors has been identified as key areas in easing transition process. According to Li (2007) new nurses who were precepted during their first three months of practice performed at higher competency levels, were less likely to leave their positions, made less errors and were less stressed (Li, 2007). In conclusion, the partnership formed in Nurse Residency programs is essential for the transition from academia to practice, and by extending the orientation time in a residency program, it promotes a mentoring relationship and enhances the learning experience for new graduates (Herdrich and Lindsay, 2006).

The Research Design

The study is further approached as a phenomenological study.
van Manen's work on phenomenology iterates that it is not enough to recall an experience, one must give meaning to the experience as it has been lived and bring back the description of the experience to allow for a possible interpretation of the experience

(van Manen, 1990). van Manen described phenomenology as thinking that will guide you back from the theory into the reality of the lived experience (van Manen, 1997). Oiler (1982) postulates that a self report by a participant will yield a more personal report of the perceptions of their own reality. Spiegelberg (1972) believed that phenomenology grew out of an attempt to have a better understanding of an experience. Much of the original work that was done in the phenomenological setting took place in European universities, and was generalized in areas of psychology or philosophy (Speakman, 2000). Nursing research has found value in the use of phenomenological methods of the exploration of phenomena (Speakman, 2000; Omery, 1983; Oiler, 1982). Phenomenology provides more accurate descriptions of an experience than data that has been transcribed into mechanical values (Polit and Beck, 2004; Omery, 1983). Qualitative research in nursing has the ability to create meaning out of the reality of individual lived experiences and allows subjectivity in the relationship to the phenomena at hand (Speakman, 2000; Streubert and Rinaldi-Carpenter, 1995). In the early 1960s, Max van Manen described phenomenology as world experiences as they are lived, rather than conceptualized, categorized, or theorized (Speakman, 2000; Munhall and Oiler-Boyd, 1993). van Manen coined the term "life-world".

Phenomenology differs from other research methods as it begins with the phenomenon and uses a reflective method to define the human experience. van Manen (1990) states that in the field of human sciences, an individual does not do research without a prior interest in the subject. Phenomenology offers us the plausibility of insights that will bring us into a more direct contact with the world lived experience. It is an internal attempt to describe a phenomenon and internalize the meaning of the lived

experience (van Manen, 1990). Merleau-Ponty (1964) discusses a phenomenon of lived experience as re-looking at the world and re-awakening the experience of the world. van Manen goes on to say that no one interpretation of a human experience will ever exhaust the possibilities of another richer or deeper description (van Manen, 1990). Phenomenology is a *human science*, not a natural science; it speaks of the meaning of the lived experiences of the humans, not the humans themselves. As an individual gives memory to a lived experience, their reflection will hold significance (van Manen, 1990). The uniqueness of this method of evaluation is that the researcher works backward form the meaning to the method (Speakman, 2000). van Manen describes human science as rationalistic; in as that it is based on the assumptions that human life can be made understandable in a broad sense. Further he emphasizes that phenomenology is not an analytical science of empirical facts and scientific generalizations. Phenomenology does not problem solve, as van Manen elucidates that problems seek solutions and ask for meaning, whereas phenomenology provides significance of meaning. van Manen (1990) proposes that phenomenology describes how one interprets the reflections on lived experiences and actions of everyday life.

The phenomenological research method was appropriate for this study, as I am a Registered Nurse, as well as a Nurse Practitioner and Nursing Educator with lived experiences and perceptions of helping behaviors of preceptors, mentors, or coaches during a transition into all levels of my professional nursing practice as a competent practitioner.

In addition to the guiding assumptions associated with qualitative research, additional assumptions support how a phenomenological research study should be

conducted. As noted in Ruffin (2007, p. 62), Wiersma (2000, p. 238-239) identified a list as follows: priori assumptions regarding the phenomenon of interest should be avoided; reality is holistically viewed; The method of data collection and the instruments used during research should have minimal influence on the study; The researcher should be open to explanations of the phenomenon of interest, and finally the theory, as applicable, should be derived from grounded rather that preconceived theories of study. Janesick (2000) postulates that bias in qualitative research is inevitable but desirable. Further, Janesick (2000) suggest that the researcher in a qualitative study, serving as the primary instrument for the study, brings forth personal opinions, thoughts, skills, and their knowledge base. Fielden (2003) suggest that the qualitative researcher possesses a necessary bias, as she/he "takes a stand", (whether aware or unaware), on the results and the individual interpretations of the study (p. 128).

I have no priori assumptions regarding the perceptions of new graduate nurses on the helping behaviors of preceptors, mentors, or coaches during their nursing residency program on their transition into professional nursing practice as a competent Registered Nurse. Rather, I seek to understand the perceptions of new graduate nurses on the helping behaviors of preceptors, mentors, or coaches during their nursing residency programs on their transition into professional nursing practice as a competent Registered Nurse as described by the individuals as their lived experiences.

The study was conducted in a naturalistic setting, and the data collection was completed using self-contained focus groups as a method of generating research. The focus groups were audio taped and transcribed. As recommended in a review of the literature, the researcher did not allow analysis and transcription of information to pile

up, but began the transcription immediately following the initial focus group session (Carey, 1995; Morrison-Beedy, Côté -Arsenault, and Feinstein, 2001; Maxwell, 2005). Additional data, if required was to be collected through individual interviews, and all information was to be analyzed, interpreted, and transcribed. The data will be considered saturated when no new descriptions of helping perceptions are identified. No personal interviews were deemed necessary to enrich the data collected in this study.

I consulted the literature and conducted a thematic and hermeneutic analysis as a method of determining themes associated with perceptions of new graduate nurses on the helping behaviors of mentors, coaches, or preceptors during the residency program in their transition into professional nursing practice as a competent Registered Nurse. I clustered the data around the themes derived from the data collection; this describes the "textures of the experience" (Creswell, 1998; Carey, 1995; Morrison-Beedy, Côté - Arsenault, and Feinstein, 2001; Fielden, 2003). The aforementioned steps will be discussed fully in the next two chapters.

Role of the Researcher

In conducting this qualitative research study, the researcher served as the instrument for the study (Patton, 2002; Fielden, 2003). Using self-as instrument, this researcher acted as the instrument by which data was collected. Ruffin (2007) describes the interpersonal skills of a researcher as key in conducting a valuable research study. She describes theses skills as the ability to observe, respect, listen and communicate clearly and concisely, and build a positive and trusting relationship with the participants while conducting an ethical and successful study (p. 63).

As a Nurse Educator and as a Registered Nurse/Certified Registered Nurse Practitioner, I've had experience in mentoring others as well as being mentored. These experiences have offered me the opportunity to have a sense of what I found to be beneficial in a transitional environment. Coupling my own personal experiences in the nursing profession with an extensive awareness of what processes are supported in mentoring theory through an extensive review of the literature, this allowed me to gain entry to the participants in the study, to gather detailed, honest, and meaningful data, and to document and report the perceptions of the participants clearly. As an instrument, I was provided the opportunity to document the reflections on the phenomenon of the perceived helping behaviors by preceptors, mentors, or coaches for new graduate nurses during the Nurse Residency Program in their transition into the nursing profession.

By interacting with the participants, I was responsible to gather, analyze, interpret, and report the data findings, and conclusions of this proposed study. Rew, Bechtel, and Sapp (1993) addressed the researcher as "self-as- instrument in a qualitative study. This study expressed seven areas of significance for qualitative researchers to address while conducting a study. These areas are: *Appropriateness*-the researcher is clear on the purpose of the study and using self as an instrument, *Authenticity*-the researcher acknowledges their bias in the study, *Credibility*- the researcher's presentation of self is true, *Intuitiveness*-the researchers ability to synthesize the experience and reflect on it as a whole, *Receptivity*-the researcher is open and receptive to the experiences of others, R*eciprocity*-the researcher is receptive to the data and participants and is on par with the participants, and finally *Sensitivity*-the researcher is able to see and document the

data appropriately, being able to transcribe experiences and feelings clearly without bias (Rew, Bechtel, and Sapp, 1993, pp. 300-301).

Fielden (2003) states that in a qualitative research study, the researcher is the primary stakeholder in the study; hence biases will be present. Further, Fielden (2003) cautions the researcher on identifying these biases' as they may become present throughout the proposed study. These biases include: The researcher's mindset, Discarding emergent information, and through Skill level in handling multiple datasets (p. 131). Actual data collection and analysis procedures will be addressed in detail later in the proposal.

As a Registered Nurse, a Nurse Practitioner, and as a Nursing Educator, I have performed a variety of roles as a novice, an expert, a mentee, a preceptor, a mentor, a coach, and/or a counselor to mention a few. These individual experiences have allowed me to interpret meaning from my own lived experiences, and establish value and meaning to these interactions. My own perceptions of helping behaviors do exist. By bracketing my personal opinions and beliefs regarding helping perceptions of preceptors, mentors, or coaches, during the transition period of a new graduate nurse, it allows me to remain neutral and objective (Patton, 2002). Bracketing this information identifies my preconceived beliefs and biases, alleviating my presuppositions, to the extent possible, to allow the data collected to serve as pure (Polit and Beck, 2004, p. 253) I will set aside all biases and assumptions in order to avoid making interpretations of the phenomenon prior to investigating it (Speakman, 2000). As a researcher, I have acknowledged my understanding of these interactions and perceptions allows me to set aside my opinions and to remain open and objective for the design of this study. The purpose of this study

was to evaluate the perceptions of new graduate nurses on the helping behaviors of preceptors, mentors, and coaches during their residency program in their transition into the nursing profession as a competent registered nurse.

I hope that my experiences in both the traditional nursing setting and in the academic setting will aid in bringing out the perceptions of new nursing graduates in regard to their own meaning of helping behaviors by preceptors, mentors, and coaches in making the transitional experience more positive and assisting in the retention of nurses within the profession.

Participant Selection

This study was conducted to establish perceptions and meaning from new nursing graduates in a Nurse Residency Program regarding helping behaviors by preceptors, mentors, and coaches during their initial transition into the nursing practice. Therefore, purposive sampling was used. Wiersma (2000) states "the logic of purposive sampling based on a sample of information-rich cases that is studied in depth" (p. 285). Polit and Beck (2004) describe purposive sampling as "nonprobability sampling method in which the researcher selects participants based on personal judgment about which ones will be most representative or informative" (p. 729). Streubert and Rinaldi-Carpenter (1995) describe purposive sampling as a method of selecting individuals to participate in a study due to their experience or understanding of a specific phenomenon of interest. The use of the purposive sampling allows the participants to focus their discussions on the phenomenon at hand and not have to spend as much time explaining themselves to each other (Speakman, 2000; Morgan, 1998).

All participants were new graduate nurses experiencing their first formal transition into the nursing practice. Using a purposive sampling method, focus group interviews were conducted with recent graduate nurses participating in a nurse residency program. The population for the study were new graduate nurses attending a Nurse Residency orientation program at Pennsylvania Hospital, in Philadelphia, PA. The participants were voluntary; and were able to withdraw from the study at any time. The United Health System Consortium (UHC) and the American Association of Colleges of Nursing (AACN) (2007) defined the model for Nurse Residency Programs in addition to the benefits of the program. At the completion of a residency program, the RN will be able to safely transition from an advanced beginning nurse to competent professional in a clinical setting. The nurse will have developed valuable clinical decision-making skills related to clinical judgment and performance in a socialized hospital setting. The RN will demonstrate nursing leadership at the point of care with the patients and families and a collegiality with peers. The RN will integrate evidence based research in clinical practice skills. The RN will demonstrate a commitment to strengthening the professionalism of nursing, and will develop a plan of growth for their new clinical role as a nursing professional. The residency programs assist in providing leadership through precepting and mentoring the new nurse in clinical experience, socialization and communicative interactions, and competency throughout sensitive areas of nursing such as end of life decisions, managing difficult and changing patient conditions, failure to rescue, and situational stress management and self care issues (UHC, 2007, p. 4).

An informal pilot study was conducted with new nurse graduates attending an orientation program during their initial transition into the nursing practice.

Site Selection

The primary focus of this phenomenological study is the perceptions and meaning constructed by the participants. Therefore conducting the study in a naturalistic setting is appropriate. As discussed earlier, the study took place at Pennsylvania Hospital in center city Philadelphia, PA, where the Nurse Residency Program of study was taking place. The focus group sessions took place within the Nursing Education Department at the hospital to provide convenience for participants in the study. Refreshments were provided for all participants by the Nurse Residency Coordinator.

Data Collection

The primary data collection method for this study was focus group sessions. Personal interviews were not deemed necessary for enrichment of this study. The self-contained focus groups served as the primary source for data collection. Morgan (1997) asserted that focus group size should be six to ten participants, less than six is too difficult to maintain a conversation with meaning, and more than ten is too difficult to keep under control. Morgan (1998) suggests the use of food during focus groups to help promote conversation and communication within a group. Carey (1995) emphasizes that a guideline of questions should be formulated prior to the group session and guidelines should be refined to enhance the participants understanding of the topic of study. She cautions not to exceed 4 to 5 questions, as too many questions will not allow for depth of enriched data. Carey also suggests the use of recording devices to collect data and advises the researcher or an observer to perform the transcription of data to ensure purity of details (Carey, 1995). The minimum number of focus groups should be three or four

groups of six participants in each group. Morgan (1997) and Kreuger (1988) suggest that it usually takes at least three to four groups to gain perspective on the data to be collected. Additionally, group size generally is considered moderate between six to ten individuals (Morgan, 1997). Maxwell (2005) states that using a small number of participants in a qualitative research study helps preserve the individuality of the analyses of the phenomenon of interest. Focus groups serve as an inexpensive, flexible way of collecting enriched elaborate data on a group of individuals experiencing a common lived experience (Marshall & Rossman, 1999; Carey, 1995; Morrison-Beedy, Côté -Arsenault, and Feinstein, 2001). Focus groups provide the researcher with similarities and differences of each participant from their own accounts of the phenomenon at hand. (Speakman, 2000; Morrison-Beedy, Côté -Arsenault, and Feinstein, 2001). One disadvantage of a focus group, as described by Streubert and Carpenter (1999) is a process referred to as *group think*. This is described as a process that occurs when a stronger member of a group may influence others in the group with their opinions. This tendency may be minimized by an effective group leader (Streubert and Carpenter, 1999). Marshall and Rossman, (1999) concur that focus groups provide a researcher with less control over a group interview than an individual interview. Morrison-Beedy, Cote-Arsenault, and Feinstein (2001) stress the importance of extensive preparation prior to the groups, the researcher should be attentive to engage all participants in the discussions, Interview guidelines must be established on the topic of interest, scientific rigor is critical as well as detailed collection and writing of data findings. Questions should be carefully planned by the moderator, but appear to be spontaneous during the group session. For optimal results, a focus group session should include at least five or six questions, and

should not be more than ten questions (Morgan, 1988; Kreuger, 1988; Morrison-Beedy, Côté -Arsenault, and Feinstein, 2001; Fielden, 2003). Additional evaluation may be completed with the preceptors, mentors, or coaches if available.

The maximum number of groups will be decided as data becomes saturated. Purposive sampling focus groups were used. I accepted Morgan's (1998) position that random sampling is not appropriate for focus groups. Individual interviews of participants were to be conducted if more detailed data collection on the experiences of new nurses was deemed necessary. After an extensive review of the literature, and various professional experiences at different levels of nursing, it was my belief that the use of focus group sessions would provide the research study with more enriched and comprehensive data on the new graduate nurses' perceived helping behaviors by mentors, preceptors, or coaches during their Nurse residency Program than from data collected exclusively through a personal interview. I believe that the collaboration that is experienced by the new graduate nurses in a cohort residency setting offers the individual nurses the opportunity to think in a more global manner. It has been my experience working with student nurses in a clinical setting that they are more apt to discuss experiences, both positive and negative, in a group setting, rather than on an individual basis. Often the student nurses are more open to discussing situations or experiences when surrounded by peers who are going through a comparable occurrence. I believe the unity of the experiences in a nurse residency program can be best divulged through a focus group session as opposed to individual interviews exclusively.

I served as the facilitator and moderator for the focus group discussions. As the moderator, my role was to guide the discussions and assure that the topic remains focused and that no personal conflict ensues (Marshall and Rossman, 1999; Rew, Bechtel, and Sapp, 1993). I served to clarify discrepancies, however avoiding interaction with members of the group that may serve to debate or convince the topic of discussion.

After the data collection was completed following the three series of focus group sessions, no personal interviews were deemed necessary to enrich the data collection. Marshall and Rossman (1999) describe this type of interviewing as "phenomenological interviewing". Ruffin (2007) discusses qualitative interviewing as listening carefully to what the individual is saying "so as to hear the meaning of what is being conveyed" (p. 68). Each interview was to take place after the initial focus group session and was to be scheduled for 45 minutes. The interview was to be guided around themes derived from prior focus group sessions in which the individuals participated. The purposes of the questions were to gain a greater understanding of the perceptions of the participant. To maintain a flow during the interview, prepared questions were derived from the themes of the focus group sessions; I was prepared to have the participant elaborate on attributes of the designated thoughts or perceptions of the participants of the prior focus group. The interview was to be conducted in a private designated area of the hospital, at a location convenient for the participant in the study. Prior to beginning the interview, I would have reviewed the purpose and design of the study, highlight key areas of interest from the focus group session, and ascertain that the *Participant Data Sheet* , (as adapted from Ruffin, 2007) (see Appendix D) was completed. I utilized the data sheets to collect all pertinent information regarding the participant's length of time in the Nurse Residency

Program, the date of the initial focus group, and the individual demographic data. I planned to answer questions related to the study, discuss follow up from the focus group session, or specifics of the interview process. A tape recorded device was to record the interview. Additionally, notes were to be taken during the interview session for clarity of information. Following the interview, I would review the purpose and design of the study, and thank the individual for his or her participation in the study. Demographic data collected from participants will be included as an Appendix (C). As stated, no personal interviews were deemed necessary for the enrichment of data collected in this study.

Recording Data

Data collection during the focus group sessions was recorded with an audio recorder to assure accuracy in transcribing and documentation of information. Precaution should be taken when recording focus group sessions or individual interviews to preserve the confidentiality of each participant (Haslam, 1987). Transcription of data should be performed as soon as possible after the data is collected (Carey, 1995; Morrison-Beedy, Côté -Arsenault, and Feinstein, 2001; Maxwell, 2005). Additionally, a journal will be kept by both the participants and the researcher. This will serve as a supporting method of recording information accurately. Each participant was provided with note sheets and asked to document any topics, ideas, or themes they felt were important during the course of the focus group discussions. At the end of the focus group sessions, participants anonymously turned in their notes to the researcher to allow the opportunity to compare and contrast and develop common themes. At the completion of the focus group sessions the researcher reiterated statements made by the group to insure accuracy of the entry in

my journal. If discrepancies were noted, they were corrected and then reiterated to the group prior to entry in the journal. During the course of the data collection process, a series of multi level note taking was utilized. Haslam (1987) described varying levels of note taking as follows:

> *Level 1-Condensed account-Direct account; taken quickly during the actual event; includes quotes and immediate impressions.*
>
> *Level 2-Expanded Account-Enhancements to level one accounts; additional details and key words not recorded during the actual event.*
>
> *Level 3-Daily Log-Record of questions that arise for the researcher; researchers view of things at that point.*
>
> *Level 4-Ongoing analysis of interpretations-Notes on connections between interpretations and insights with underlying theories and notes from the first three levels. (Haslam, 1987, p. 85).*

Once all data was collected and no new themes emerged, data was then considered saturated. The audio files, transcriptions, journals, and other documents related to this study will be reviewed as needed during the interpretation and analysis phases of the study, and data will then be destroyed at the conclusion of the study.

Data Analysis and Interpretation Procedures

Data analysis collectively can be described as a process of categorizing data, and making sense out of a description of the text (Creswell, 2003; Wiersma, 2000). Marshall and Rossman (1999) describe data analysis as "the process of bringing order, structure, and interpretation to mass of collected data" (p. 150). Further, these researchers explain

in qualitative research studies data collection and analysis goes hand in hand to build a comprehensive interpretation of the data (p. 151). During the analysis phase, the researcher looks to identify emerging themes from the data collected. Themes may be the "structures of the experience" (van Manen, 1990). These emerging themes are the core of the qualitative research study.

Marshall and Rossman (1999) defined six phases for analysis of qualitative research. The phases are: organizing the data; generating categories, themes, and patterns; coding the data; testing the emergent understanding; searching for alternative explanations; and writing the report (p. 152). These phases will be used to guide the interpretation and data analysis in the proposed research study.

I compiled and categorized all data collected, I interpreted the patterns and perceptions of the participants, and collective data was used as the basis for findings and conclusions of this study.

Reliability and Validity Considerations

Reliability

Struebert and Carpenter (1999) define reliability as "the consistency of an instrument to measure an attribute or concept that it was designed to measure" (p. 332). Merriam (2002) defines reliability as the "extent to which the research findings can be replicated" (p. 27). Speakman (2000) concludes that reliability in a phenomenological qualitative research study is based on the trustworthiness of the researcher reporting the data, not so much to the data itself. Sandelowski (1993) defines trustworthiness as not a matter of being right about a phenomenon, rather that the individual has practiced good

science in doing so. When testing reliability researchers look at three areas, stability, equivalence and homogeneity, (Burns and Grove, 2003, pg. 270-271). Ruffin (2007) asserts that replication of a qualitative study will probably not produce the same results (p. 75). Merriam (2002) as cited in Ruffin (2007) describes reliability in qualitative research as the need for the concurrence of others on the results of the data collected to allow the information to "make sense" (p. 76). Fielden (2003) postulates that validity in a qualitative research study has multiple meanings, and that at each stage of the research process, from "inception to published" the biases will affect the research (p. 129).

I investigated the phenomenon of interest through a series of focus group interviews until no new themes were found. It is the process of discovering themes that evolve in the meaning of the research. At that time of the study, the data was considered saturated and reliability was established.

Validity

Validity refers to the instrument being used and its ability to replicate the concept being examined (Burns and Grove, 2003). Polit and Beck (2004) define validity as "the degree to which an instrument measures what it is intended to measure" (p. 735). Creswell (2003) asserts that in qualitative research studies "validity does not carry the same connotations as it does in quantitative research" (p. 195). The accounts of an event are considered valid or true if it accurately represents features of the phenomena it is intended to describe, explain or theorize (Hammersley, 1987). Wiersma (2000) states that "absolute reliability and validity are impossible to attain in any research study, regardless of the type" (p. 263). Lincoln and Guba (1985) define four criteria for establishing trustworthiness of the data collected: credibility, transferability, dependability, and

confirmability. Using this criterion allows the researcher to present data that is meaningful and believable (Morrison-Beedy, Côté -Arsenault, and Feinstein, 2001; Koch, 2006).

A key threat to the validity of a phenomenological study is that the assumption of the validity relies on the reliability of the subject. Validation has no standard procedures assigned to it; therefore it is less technical in qualitative research (Speakman, 2000). A researcher's responsibility in a phenomenological study is to consider all interpretations and to examine all discrepancies of the phenomenon (Sandelowski, 1993).

In this study, data regarding the perceptions of helping behaviors of preceptors, mentors, or coaches by new graduate nurses in the transitional phase of their nursing residency program was collected through focus group sessions. The focus group sessions, were audio taped and each tape was transcribed. Additional information elicited from notes and journals pertaining to the focus groups sessions were transcribed. In this way, the researcher collaborated several types of data to analyze and interpret.

Triangulation

Triangulation is a method of data analysis that synthesizes data from multiple sources (Denzkin, 1978). Halcomb (2005) states that triangulation offers a "rigorous methodological framework" to assist in the investigation of a complex phenomena in nursing research. Triangulation may be used to explain the arrangement of different data collection methods in dealing with a particular topic of interest (Cresswell, 2003; Patton, 2004). The use of triangulation of multiple data sources assist in the confirmation and completeness of data (Breitmayer, Ayers, and Knafl, 1993; Adami and Kiger, 2005). By evaluating data collected by different methods, findings can be corroborated across data

sets, therefore reducing the impact of potential biases that may exist in a research study (Golafshani, 2003). Additionally, Golafshani (2003) describes triangulation as a strategy for improving the validity and reliability of research findings. Wilson (2006) defined triangulation as "an approach to data collection and analysis that uses multiple methods, measures, or approaches to look for convergence on product requirements or problem areas" (p. 46). Triangulation is the utilization of different dimensions and strategies for assessing and strengthening the data on the same phenomena (Jack and Raturi, 2006; Patton, 2001). Additionally, triangulation will transcend inadequacies in each methodological approach to research (Graham, 2005; Monti and Tingen, 1999). Golafshani (2003) stresses that the methods chosen in triangulation to test the reliability and validity of a study will vary, and depend on the specific criterion of the research study. Finally, Thurmond (2001) emphasizes that triangulation will assist in strengthening a studies overall design and enhance the researcher's ability to analyze data findings (Halcomb, 2005).

A triangulation matrix for data collection table, as adapted from Sagor (1993) as referenced in Sagor (2000) is included as *Appendix I* in this research proposal.

Triangulation Matrix

Research Questions	Focus Group Questions	Audio Recording & Transcription of Focus Groups	Focus Group # 1	Focus Group # 2
What behaviors by preceptors, mentors, or coaches have been identified by new graduate nurses as most helpful during their transition period into the nursing profession?				

Ethical Considerations

In a phenomenological qualitative research study, the researcher was challenged with several ethical considerations. Qualitative studies are difficult to structure, as the researcher can not know prior to asking a question what information will transpire. This task makes issues of informed consent more difficult than in a quantitative study (Struebert and Carpenter, 1999). Munhall (1988) stresses that in qualitative research; informed consent should be an ongoing process and should be renegotiated over time (p. 156). Further, the researcher is challenged with ensuring privacy; therefore while compiling the transcribed data, the researcher has to protect the identities of the participants in the study (Struebert and Carpenter, 1999).

The researcher must be careful to avoid using deception in generating data (Struebert and Carpenter, 1999). Creswell (2003) states "the researcher has an obligation to respect the rights, needs, values, and desires of the informants" (p. 201).

As the researcher performing the research study, I took precautionary measures to address the ethical issues that are common while conducting a qualitative research study. First, this study was designed to disclose the purpose of the study at the onset, voluntary participants were sought, and I provided confidentiality and anonymity of all participants. Written permission to conduct the study was obtained from the Drexel University Institutional Review Board (IRB). Collaboration was established with the Nurse Residency Program coordinator Pennsylvania Hospital, and all participants provided verbal consent to participate in this study; written consent was not necessary for this research study. As directed under instruction of the IRB, participants did not fill out a written consent form for this study to ensure anonymity.

After IRB (Institutional Review Board) approval to conduct the study was granted, initial contact with the participants in the Nurse Residency Program was made through the Nurse Residency Coordinator in order to establish a time frame to conduct the study at the convenience of the residency participants. On the day of the focus group sessions, the participants were introduced to me by the coordinator and I identified the goals of conducting this study as partial fulfillment in obtaining my doctoral degree. Also, the participants were provided with a *Participant letter* (See Appendix E) giving a brief description of the purpose, design, and significance of the study and a request for the individual's to participate in the study. The identification of the participants was not disclosed. Group numbers were assigned to the collected data respectively with Focus Group one, two, and three. The Nurse Residency Coordinator has a record of attendance from the residency session if participants were needed to be contacted. This researcher has no identifying information on any individuals.

All written documentation, audio recordings, and data collected during the study were labeled only with Focus Group number instead of participant names. I had no supervisory responsibility over any of the participants in the study. I am aware of my own perceptions and experiences regarding helping mentoring behaviors, however I was open minded and receptive in listening to the opinions and perceptions of participants in the study. As described by Ruffin (2007), I was mindful not to disclose my own perceptions on helping behaviors; I explored and sought understanding of the participant's perceptions.

Protection of Human Subjects

Participants were guaranteed that all information will be confidential. Under the direction of IRB consultant, no written consent was need for this phenomenological research study. Participants were informed of their right to withdraw from the study at any time and all Human Subject considerations were made. All participants were furnished with the address and phone number of the researcher and Drexel's Institutional Review Board.

Chapter Summary

Chapter three begins with description of the methodology and rationale for the research design of this phenomenological study on perceived helping behaviors by preceptors, mentors, and coaches. The choice of a qualitative research method was discussed as appropriate as the study seeks the actual lived experiences of the participants on the perceived helping behaviors. The research questions are:

1. What behaviors by preceptors, mentors, or coaches have been identified by new graduate nurses as most helpful during their transition period into the nursing profession?
2. Do the new graduate nurses feel adequately prepared from their educational program for their transition into the nursing practice?

The research question grew from a gaps identified in the literature that first examine how to best educate and prepare student nurses. The debates on the acceptable entry-level of education into the nursing profession and the failure to adequately prepare student nurses for unforeseen events occurring in an acute care setting as they transition from student, to graduate, to registered nurse. Secondly, identifying factors on improving

the transition process into the nursing profession, as identified by new members of the professions, will serve beneficial to nurse educators and to economics of the nursing profession. Retention and support of new nurses is crucial in working to identifying solutions to address the healthcare crisis. Finally, the evaluation of the benefits of mentoring through the Nurse Residency programs is prudent. The residency programs are promoted to provide the new nurse with "real life, hands-on" experience in a safe and conducive working environment. Many of the expectations that are place on new graduate nurses are unrealistic in the acute care setting. Residency programs are said to help build confidence for the new nurse through mentoring and support of the new nurse to practice competently when faced with delicate issues in nursing such as end of life decisions, managing difficult patient scenarios, failure to rescue, and stress management (UHC, 2007).

As described earlier, a purposive sample of participants from a nursing residency program was utilized in the study. The researcher served as an instrument for data collection. The value of self contained focus groups was discussed as the primary method of data collection. Individual interviews were not deemed necessary to seek enriched perceptions of participants. Following data collection, the data was transcribed, interpreted, analyzed, and documented. Finally, the chapter concludes with a description of reliability and validity, and the ethical issues that are associated with a qualitative research study.

It was the desire of the researcher that the participant's descriptions of their lived experiences with mentors, preceptors, and coaches, as they transition into the nursing profession will elicit enhanced descriptions, whereas themes and patterns will emerge to

contribute new knowledge to both the field of nursing practice as well as nursing education and staff development programs.

Chapter IV will present the findings of the study and describe the relation to thematic analysis from group discussions.

Chapter IV

Results

Introduction

In this chapter the results of the perceptions given by the new nurse graduates on their perceptions relating to the helping behaviors of their mentors are discussed. A description of the data collected and interactions in the focus group will be presented. The chapter summary addresses the varying themes that emerged from the focus group sessions, the data collected, and a collaboration of data.

Purpose of the Study

The objective of the phenomenological study was to identify the perceived helping behaviors demonstrated by the preceptors, mentors, or coaches for new nurse graduates in a nurse residency program. The implications for the study is to provide guidance for the nursing education programs preparing student nurses as well as the healthcare hiring facilities looking to recruit and retain competent registered nurses. Additional implications suggested for further research is instituting the Nurse Residency Programs as the standard of practice to safely allow Graduate Nurses to transition from an advanced beginner to competent Registered Nurse in a clinical setting. Also, encouraging the use of trained and enthusiastic mentors and/or preceptors to assist guiding the novice nurse to recognize "what they don't know" and help to enhance the learning experience. Finally, it is the desire of the researcher to collaborate the results of this study to be placed into a model and/or a set of strategies for healthcare institutions and educational facilities to incorporate to better prepare and retain competent nurses within the profession.

Research Question

The research questions that guided this study were:

1. What behaviors by preceptors, mentors, or coaches have been identified by new graduate nurses as most helpful during their transition period into the nursing profession?

2. Do the new graduate nurses feel adequately prepared from their educational program for their transition into the nursing practice?

Research Design

The study was conducted using a qualitative phenomenological research method. Data was collected through a series of focus group sessions. Data collection took place in a naturalistic setting in the Nursing Education building at Pennsylvania Hospital in center city Philadelphia. The data was collected though three separate focus group sessions while the participants were attending a designated Nurse Residency program session.

Participants

The participants for this study were a sample of graduate nurses attending the Nurse Residency Program at Pennsylvania Hospital in center city Philadelphia. The individuals in groups one and two were scheduled to attend the Nurse Residency Program for an orientation based session. These individuals had been on the clinical floor working with a preceptor prior to this session, but were at the beginning of the Nurse Residency Program meeting with their cohort. The participants from the third group were individual's that have been in the Nurse Residency Program for at least one year and are approaching the end of their residency program. The current residency programs at

Pennsylvania hospital are twelve months in length; further research is ongoing to evaluate extending the program to eighteen months in length.

The volunteers attending the Nurse Residency Program were moved from the conference room to a private sitting area located in the Nursing Education department at Pennsylvania Hospital. The participant's were all provided refreshments from the residency coordinator during the preliminary portion of their day prior to entering the focus group sessions. All participants were given a *Participant's Letter* (see Appendix E) describing the purpose of the proposed study and the researcher's contact information if they had any questions regarding the study. Additionally, they were given a *Demographic Sheet* (see Appendix C) to fill out and turn in at the end of the session. The participants were all instructed to make notes on a distributed sheet of paper and turn it in at the conclusion of the session with any additional information they wanted to share regarding the questions. The first group consisted of six volunteers, the second group also had six volunteers, and the third and final group consisted of seven participants. A total of 19 participants were included in the study.

Data Collection

Data collection during each of the three focus group sessions was recorded with an audio recorder to assure correctness in transcribing and documenting all information. Precaution was taken during the focus group sessions to preserve the confidentiality of each participant. The transcription of data was started within a day after the final focus group data was collected. A journal was kept by the researcher, and each participant was provided blank notes and asked to document any topics, ideas, or themes they felt were important during the course of the focus group sessions. At the end of the focus group

sessions, the participants were asked to anonymously turn in their notes to the researcher to allow the opportunity to compare and contrast the data and develop common themes that evolved from each of the sessions. At the completion of each individual focus group session the researcher reiterated statements out loud made by the group to insure accuracy of the information entered in the researcher's journal. Any discrepancies or information requiring further clarity was corrected and then reiterated to the group prior to entry in the journal. All data collected served to support the researcher in recording information accurately. As described in Chapter three, during the course of the data collection process, Haslam's (1987) multi level note taking guidelines were utilized.

Each of the individual focus group sessions lasted approximately thirty five to fifty five minutes in length. The researcher served as the facilitator for the sessions and led the sessions using the *Revised Generalized Focus Group Questions* (see Appendix B). For clarification purposes when requested by the participants, some questions were paraphrased by the researcher to provide a better understanding for the group on what the question was asking. At the conclusion of each focus group sessions, the information collected by the researcher was reiterated to the group and participants were asked if they would like to contribute any further information to the session. Information gathered was noted in the researcher's journal and included in the data collection and collaboration phase of the research study.

Each focus group session was recorded separately. The researcher stated at the beginning of the tape recorded session the date and time and the name of the focus group (Focus group one, two, and three). Each of the journal notes were transcribed in the same manner. No identifying indicators were used during any of the audio recordings, journal

recordings, or the individual note taking. If deemed necessary for further clarification purposes, the Residency Coordinator has an attendance sheet with the names and contact information of each of the participants in their respective groups. To ensure the privacy of the participants, the researcher holds no personal identifying information on any of the individuals.

Once approval for the proposed study was granted, the Residency Coordinator was contacted. An ongoing communication with the coordinator offered the calendar of events for the upcoming focus group sessions. The date was discussed by the researcher and the coordinator. The pair mutually agreed upon a date for the researcher to meet the Nurse Residency group, explain the purpose of the study, and ask for any volunteers interested in participating in the sessions. Interested participants were then distributed the *Participant's Letter* (see Appendix E).

On the first day of data collection, twelve volunteers evolved from the group. The individual's then, in no particular order were split into two groups of six; one group staying with the Residency Coordinator and completing their residency course requirements, and then the other individuals went with the researcher and completed the focus group session. At the conclusion of the first session, the two groups then switched rooms and the second focus group session took place. At no time did the individual's from the two groups discuss the research questions prior to our session. Focus group session number three took place four days after focus groups one and two were completed. No participant's from the previous groups one and two discussed the study with volunteers from group number three.

Organization of Data and Analysis Procedures

At the beginning of each of the three focus group sessions, the researcher introduced herself, distributed the *Participant's Letter* (see Appendix E) which briefly described the study, distributed the *Demographic Data Sheet* (see Appendix C), and provided the participant's blank notes for note taking. The researcher described her role as a moderator of the session, not an active participant, and then asked if there were any questions prior to turning on the audio recorded device. In all three sessions, questions were answered and the sessions began.

Demographic Data Results

As indicated early in this chapter, all participants were asked to complete a *Demographic Data Sheet* (*see Appendix C*). All information collected from the participants was compiled into a single table shown as Table 1 (*see Appendix J*). There were a total of eight separate questions on this sheet. An analysis of this information will be summarized here.

As stated, there were a total of nineteen participants represented in three separate groups. Question one asked for their age, the ages of the participants ranged from twenty three years old up to age forty-seven, with a mean age of twenty seven point two six (27.26). Question two addressed gender, there were a total of fifteen females and four males represented throughout the groups. Question three asked ethnicity, participants identified themselves as follows: one African American, two Asian, one Hispanic, one Korean, one Native American, and thirteen as White/Caucasian. Question four asked the Type of Nursing Program attended in school, fifteen students attended baccalaureate (BSN) programs, two of which were accelerated BSN programs, three attended Associates (ADN) programs, and one attended a Diploma program. Question five asked

at what stage they at are in the Nurse Residency Program. Twelve participants were at the beginning of the Nurse Residency Program, with less than six months experience on the floor, and seven participants had between twelve and fifteen months experience. Question six asked if they were employed in any capacity at Pennsylvania Hospital prior to the Nurse residency Program. Participants responded as follows: sixteen were not employed in any capacity at Pennsylvania Hospital; one was a nurse extern, one as a patient care tech, and one as a nurse tech. Question seven asked if the participants had a designated preceptor or mentor. Eighteen participants did have a designated preceptor; one person had no designated preceptor. Twelve of the eighteen participants had multiple preceptors; participants responded that they had between two and eight preceptors over the course of the orientation process. And finally, question number eight asked if the participants had the ability to change any part of their nursing education program, what aspect would you change. The responses to this question were less direct. Participant responses include: management of realistic expectations for new graduates, teaching aspects of teamwork, improving the nurse to patient ratio, instructions on what to expect during the GN orientation period, interactive classroom scenarios, detailed instruction on nurse to physician interactions, and finally using a facilitative learning environment for teaching purposes.

It should be noted that most participants completed the *Demographic Data Sheet* (see Appendix C) prior to the focus group sessions. Information that participants included on these written forms were discussed in greater detail during the focus group sessions, primarily responses to number eight on the demographic data sheet.

Table 1
Demographic Information

Demographic Information	Focus Group # 1	Focus Group # 2	Focus Group # 3
Age	25, 24, 24, 33, 33, 24,	35, 34, 27, 23, 44, 47,	39, 25, 32, 28, 23, 28, 23
Gender	6 females	5 females, 1 Male	4 females, 3 Males,
Ethnicity	Korean-American, White, Caucasian, White, Caucasian-Hispanic, Asian Indian	Native American, 4 Caucasian, African American,	Asian, White, 5 Caucasian,
Type of RN Program (Diploma, ADN, BSN)	2 BSN (ACE), 3 BSN, 1 ADN	5 BSN, 1 ADN	5 BSN, 1 ADN, 1 Diploma
At what stage (Weeks/Months) of your residency program are you currently at?	All on Day one of NRP December 2007, 3 May 2008, 2 June 2008,	All on Day one of NRP 5 June 2008, 1 February 2008	14 months, 11 months, 5 @ 12 months,
Were you previously employed in any capacity at Pennsylvania Hospital? If yes, please explain your role.	4 were not previously employed, 1 Nurse Extern, 1 Nurse Tech	None of the 6 were previously employed at PA Hospital	6 were not previously employed at PA Hospital, 1 was a PT Care Tech,
Do you have a designated preceptor or mentor?	4 Have one designated preceptor, 2 have multiple preceptors	6 had designated preceptors, 4 had more than one, some up to 3 to 6	1 had no assigned preceptor, 2 had 1 preceptor, 2 had 2 preceptors, 2 had 4-8 preceptors
If you had the ability to make any type of change, what aspect of the nursing profession would you adjust?	↑Staffing issues with administration & hospital staff, 5 left blank	↑Nurse-Nurse communication & help, Teaching aspects of teamwork, Addressing nurse to nurse interactions, Nurse patient ratios, 2 blank	3 Ratio of Pt to nurse, Management of realistic expectations of interactions with the staff, what to expect during the orientation period, and 4 addressed nurse to patient ratios in clinical settings, different pt satisfaction surveys, classrooms with actual hospital education and how to interact with management, Have instructors teach in a facilitative manner as opposed to a parochial manner, teach on Doctor-nurse interactions,

Results of the Focus Group Sessions

The first focus group session began. The researcher then began to ask the questions from the *Revised Generalized Focus Group Questions* (see Appendix B). The questions are as follows:

1. Describe how your transition from a SN to RN compared to your preconceived expectations of an autonomous nurse.
2. What aspects of the transition process to an autonomous RN do you feel is the most difficult?
3. What were the behaviors exhibited by your preceptors or mentors that were most helpful during your transition period?
4. Describe the behaviors exhibited by your preceptors or mentors that you found the least helpful?
5. What changes in your nursing education and training preparation do you feel would have helped you to feel better prepared as an independent autonomous RN?

The same questions were asked of all three focus group participants. The perceptions of the Graduate Nurses in this Nurse Residency Program were evaluated. Responses to all focus group session questions have been included in a matrix format included as Appendix K through Appendix O. A summarization of responses will be discussed and emerging themes were identified.

Q 1- *Describe how your transition from a SN to RN compared to your preconceived expectations of an autonomous nurse (See Appendix K).*

In correlating the data collected from the focus group sessions, themes began to emerge immediately. In each of the groups, multiple respondents felt inadequately prepared in their training in general. When asked by the researcher to clarify which part of their training they were speaking of, a large majority of the participants emphasized the "hands on" skills training in general, with IV phlebotomy skills being the priority amongst the three groups. Additionally, vast emphasis was stressed on the overwhelming feeling of inadequacy (by the GN) particularly with time management skills and the ability to prioritize and plan for the patient's daily care.

Responses from *Focus Group # 1* included: "I didn't feel as prepared as I would have liked to", and "I would plan out my day and then something always seems to throw me off".

"Working as a nurse extern helped me get experience to make me feel like a RN, not nursing school", "I felt like I had zero skills when I got out, I had no phlebotomy skills and that is a huge part of what you do each day as an RN". "A good preceptor is a necessity, they are your go to person, there's never a day that I don't need their help…I feel like how will I do this myself when I have to go on my own". "Hands on skills were not what you thought as a SN, my time management, documentation, and the legal responsibilities were a reality check when I became an RN". "The difference between Q 1 (Every hour) hour vitals and Q shift (every shift) is a big deal, …the stuff you do in the skills lab is a one time pass off and then you are done and supposed to be able to do this".

In addition to responses on a lack of skills training and strong feelings of inadequacy in general, responses from *Focus Group # 2* included: "I'm constantly running", "Some days I feel like if I don't laugh, I will cry", "I feel like its hard to keep

your sanity some days", and "The work can push you to your breaking point". In addition to these reflections, this group too felt unappreciated, or under-appreciated from their patients. Many comments were referenced regarding the nurse-patient interactions including "the patients are more demanding than I thought, they don't seem to appreciate anything you do for them", "I am often mentally and physically exhausted, and a lot of the patients think you don't do anything for them". "Some aspects do meet my expectations in the care I'm expected to give; there is a large lack of gratitude that wears away faster than I expected it to…some days I feel like an old nurse". "Every time I get to that breaking point, I get a patient that is great and makes me feel like I did a good job". "I hated nursing school, but I love to be a nurse…I don't feel like school prepared me to be a real nurse". "Nursing school does not prepare you for the real world; nursing school prepares you for the book world and not the real world". "In ICU and labor and delivery you are constantly running…I'm constantly running". "In school they don't prepare you for not getting to go to the bathroom for 12 hours and not getting to eat a meal" "I like the responsibility of being independent and autonomous". "This experience has been a real reality shock…I have so much invested in this career, and this job, and what have I done…I'm only six months into this and some days I hate it!". "A lot of times the patients have exhausted my resources…people may think we as nurses are insensitive to patients and don't care, it's really a matter of laughing to keep from crying, it's never laughing at the patients, it's trying to keep your sanity to not feel so overwhelmed and stressed out".

Finally, *Focus Group # 3* also emphasized the lack of skills training, and the feelings of inadequacy, and also added: "Nursing school is all theory, and most of what is

taught is not the reality of nursing". "You go through school with blinders on, and get out in to the field and have all of these unrealistic expectations put on you", "I felt very awkward in my ability to do everything, the skills, my plan of care, and my communication skills…school is not like the real world". "In School, it's all about theory; it's very different from how it is really done in a hospital". "Nursing is a lot harder than what I thought it was going to be".

In moderating the focus group, it was interesting to see how the participants interacted with each other. A few individuals seemed hesitant to admit feeling awkward, overwhelmed, or stressed out, but were able to relay their concerns easier once revealed by another participant. Each of the three focus groups seemed to take on its own tone and pace based on the responses of participants within the group.

In summary, the major themes that emerged from the groups in response to question number one were: 1) most respondents felt inadequately prepared in their skills training and "hands on" techniques and 2) almost all respondents emphasized an overwhelming feeling of inadequacy particularly in time management and the ability to prioritize responsibilities.

Q 2- *What aspects of the transition process to an autonomous RN do you feel is the most difficult? (See Appendix L).*

Many respondents felt question two was very similar to question one. Many participants elaborated on information discussed in question one. The principle theme that emerged from the respondents for question two was inadequate time management skills and understanding of what to do with multiple "difficult" patients in a variety of

scenarios. Additionally, a constant feeling of being overwhelmed by the multiple critical tasks and responsibilities involved as an autonomous RN. Multiple respondents also felt they lacked the feeling of self-confidence that they felt upon graduation. Many individuals stated that they struggled with the task of consistently being able to prioritize multiple tasks, for multiple patients; then having to deal with all of the external factors including physicians, staff, families, collaboration of other departments, legal responsibilities, and the patients in general.

Responses from *Focus Group # 1* included: "Time management and knowing all of the available resources like where things are and who to contact for what…knowing the departmental communication chain of command". "Working in a critical care unit and knowing all of the protocols and what to do in specific emergencies… putting things in perspective whatever your specialty is is a lot harder that I thought it would be". "Figuring out time management on what you have to do first when you have multiple difficult patients". "Figuring out what to do when I come off orientation and trying to figure out what to do next". "Not knowing where to go and who to contact in certain situations". "My preceptor went to get a cup of coffee, and I had a guy that needed to go to the bathroom and he needed a portable oxygen tank…I thought I don't even know where the tanks are, or even how to operate the oxygen tanks either". "All of these stressful issues come up when you have ten other things to do and it's really hard to put in order which one to do first when all three patients have serious issues".

Responses from *Focus Group # 2* were similar to the first group and included the following: "Some days I try to not get impatient with the Moms, but when you are trying to get your morning assessments done and they say *I'm feeding the baby, can you come*

back it throws my day off, I have to get all my AM stuff done for all of the other patients so I can keep up with my afternoon stuff". " I have a large patient load...I had a good preceptor that really taught me time management well but I had three bad patients and I do the A-B-Cs and all three have priority issues...one or two may crash, so who do I see first?". "Compared to nursing school I can see now why students were a burden to the RNs...students don't help you they drag you down". "In the ACE programs, you don't get enough clinical practice; you do more work as an aide and not so much of what the RNs do". "In the diploma and associates program you get more"hands on" preparation than in the BSN program". "On a day where you have multiple patients and then have to give nine or ten meds to each of them, and legally you only have an hour time frame to get everything done, it's almost impossible".

Finally *Focus Group # 3* responses included: "Time management and dealing with multiple patients in very difficult" "trying to figure out what to do next and then to get everything done that needs to be done is hard". "you think you are O.K., you plan out your day and then the constant distractions from the physicians, the patients and their families, the transport coming to take the person to physical therapy....trying to get it all done in time is almost impossible". , "My prioritization skills and my technical skills are not as good as I thought they were". "There are too many distractions in your day".

In summary, the four essential themes that emerged in response to question number two were: 1) inadequate time management skills and understanding what to do with multiple complicated patients and scenarios 2) a constant feeling of being overwhelmed by the multiple critical tasks and responsibilities 3) lack of self-confidence and 4) the inability to prioritize multiple tasks, for multiple patients.

Q 3- *What were the behaviors exhibited by your preceptors or mentors that were most helpful during your transition period? (See Appendix M).*

The principle themes that emerged from the three focus groups in response to question three was providing an autonomous setting with structure and support and being approachable and supportive providing for a nurturing learning environment.

Responses from *Focus Group # 1* included: "I liked the structure my preceptor gave me, but she gave me the autonomy to do what needs to be done; I also knew she was there if I needed her". 'All preceptors are very different; I loved having the trust and the ability to be autonomous by mine [the preceptor], but not having her do it for you". "He was very calm, not anxious, he would tell me who to contact in which situation so the next time I can do it myself". "Multiple preceptors were helpful". My Preceptor parallels what I do, giving me the autonomy to see what I need to do was the most helpful".

Responses from *Focus Group # 2* included: My preceptor said "*see one, do one*" I was so scared when I would have to do it, but it was really helpful for me to see it first and then do it myself the next time". "Mine would say I'll do it now, but you have to do it next time". "AT the time her (the preceptor) pushing me was overwhelming but now it is so helpful that I was allowed to figure it out on my own". "My preceptor taught me how to talk to them (the patients and families) and not get caught up in the room when they keep talking to me". "I found it helpful to have a few different preceptors…I got to see a few different ways of doing things and then find a way to make it my own and work for me". "I liked doing things on my own and knowing it's O.K. …I don't like being told my way was wrong for differing with the preceptor". "My preceptor works fast…she pushed

me I didn't like it at the time, but now I'm thankful for her pushing, I liked the autonomy". "My preceptor was a phenomenal nurse, he knew all policies and procedures; he taught me how to look things up when I'm by myself…he showed me how to continue to educate myself and to find out the information that I needed to know". "Mine taught me how to deal with the other co-workers on the unit…how to communicate with all the back talking, gossiping and cattiness…she taught me how to deal with all of it in a healthy manner". "My preceptor taught me to go through the med (medication) cart and pull out any meds not assigned to my patient so to prevent a later error…she taught me to go over the meds more diligently than the others did".

Finally, responses from *Focus Group # 3* were: "She didn't expect too much from me, in the beginning, she would show me how to do something and then explain to me what she was doing and why…she didn't have unrealistic expectations for me". "Mine was very laid back, so it didn't make me feel afraid to approach her or ask a question". "I had almost everyone (all the RNs) on the floor precepting me and it really helped me to see a lot of different ways to doing things and getting things done…it helped me to find my own way of doing things". "I liked that my preceptor was there for reinforcement, but not in my face every five minutes". "Mine would let me go on my own to do things but she would be available for back-up in case I needed her".

In summary, the most essential theme that emerged in response to question number three was for the Graduate Nurses to have the autonomy to complete their tasks and organize their daily plan of care with the knowledge of the support of the preceptor when needed. Other essential themes include 1) providing a supportive and nurturing environment where it is safe to ask questions, and 2) providing the new nurse with

organizational structure and guidelines for a safe and effective plan of care for the graduate Nurse to follow with mentoring support.

Q 4- *Describe the behaviors exhibited by your preceptors or mentors that you found the least helpful? (See Appendix N).*

The two essential themes that emerged from the focus groups in response to question four was for preceptors to perform the daily skills or tasks for the GN without letting them do it on their own and having unrealistic expectations of the new GNs abilities in all aspects early on during the orientation and residency period.

Responses from *Focus Group # 1* included: "Doing things for me and not letting me do it for myself was terrible…she would say "*I'll take care of it*" and by the end of the day, I didn't know what was or wasn't done because she was doing so much for me and not letting me get organized". "I wasn't able to get into a flow, she was doing so much for me and it would mess up my plan for the day". "They had a lot of unrealistic expectations…like with the different computer systems, I was told to go document on the flow sheets and I wasn't trained on that part of the computer yet and he seemed annoyed to have to show me…I only had a one day training on the computers and I felt legally I wasn't sure of how to do it or what exactly I was responsible for!". "Expecting us to know more, or be more aware of everything…I don't even know what it is I need to know at this point yet".

Responses from *Focus Group # 2* included: "Really overwhelmed initially…it seemed like after the second week on the unit I was expected to do everything on the patients myself…I really had no idea of what "everything" for that patient included". "I

had multiple preceptors and they all had different ways of doing things, so some of them would tell me "*that wasn't right, do it this way*", it was very confusing for me". "trying to figure out how to do all of the skills like IV's and things and then how to do all the documentation in the charts and on the computers…then we have to figure out our time management skills, it's very overwhelming".

Responses from *Focus Group #3* included: "Her being laid back didn't offer me a lot of direction or structure on how or why to do something". "Some (preceptors) want you only to do things their way and if you don't they'll tell you your not doing something right…it makes it really tough to try to develop your own style". "I didn't like the ones that did stuff for me instead of showing me how to do it for myself". "I had a reluctant preceptor that told me she didn't want to precept me…she told me I put a "damper" on her day…she said she had to get her things done and I'm in her way…it was my patient?". "My preceptor would ask you a question and if you didn't know it she would look at me like was an idiot". "She was abrasive and often demeaning…she even humiliated me in front of the other staff…one day she pulled out and (infusion) pump and put it in front of me (at the nurses' station), all the staff were there, and then told me to show her how to work it…I told her I wasn't sure how to use it but she put me in front of her little clique and made me feel stupid". "I didn't feel like I was part of a Nurse Residency Program". "The clinical educator on the floor was often a negative…she was really pushing unrealistic expectations for us so we had to tell her what she wanted to hear to get out of there and let us do what we needed to do…she was out of touch with reality…she would ask if we had six patients yet (by week three) and really we only had

two at that point". It should be noted that all participants in this group were in a Medical-Surgical setting, and only one received additional training in oncology.

In summary, the crucial themes that emerged in response to question number four were: 1) preceptors performing the skills or tasks for the GN without letting them do it on their own, 2) unrealistic expectations of the new GNs abilities in all aspects early on during the orientation and residency period, 3) a non supportive learning environment with fear of humiliation when asking for assistance, and finally 4) not providing the GN with the opportunity to develop a style of their own without criticism.

Q 5- *What changes in your nursing education and training preparation do you feel would have helped you to feel better prepared as an independent autonomous RN? (See Appendix O).*

The critical themes that emerged from the groups in response to question five was more hands on training with case scenarios to enhance critical thinking abilities, more technical skills (like intravenous and phlebotomy in particular), and finally more communication skills in a facilitative environment.

Responses from *Focus Group # 1* included: "we need more IV skills and phlebotomy training…we have to do that every day and never got to do it in school". "Having a full shift of clinical, not just four hours, with breaks". "We need more hands on IV meds…doing IV flow rates…we do too many bed baths". "They have us doing more CNA or tech work than what an RN really does". "We don't come out with a large ability of skills…we never got to actually prime the IV line…I gave injections and P.O. meds". "My instructor was awesome in my maternity rotation…she was always available

and it was helpful…a lot of the others were not organized and never seemed to have a set plan for the day". "the organizational aspect of the day didn't flow…in my ACE (Accelerated) program I didn't get enough clinical experiences". "We don't have as much clinical time at our program…I hear (another hospital based program) does do more in their ACE program". "Research and theory classes didn't help me at all for what I need to do on the unit…I think spending an entire semester on "communities at risk" was a waste…I think it would have been better to do a more rigorous lab or Sim (Simulation) course. "We had a leadership delegation course that helped a little". "they need to put more pharmacology into every course…you should get more application of pharmacology and how it is specific in each course". "Nursing school can't really prepare you how to talk to doctors or families in different situations…I think you can only really find that out when you start working…I didn't know there is a an intern, resident, a fellow…in school they say contact the physician…I didn't know the order of who to contact". "I didn't know until now that we were in a nurse residency program?".

Responses from *Focus Group # 2* included: "Writing APA papers don't help me to take care of my patients…the BSN programs are all about thinking and writing but not about reality". "It would be better to go the lab and have a few fake patients to take care of and have to critically think through the situation then to go on the floor and work as an nurses aide". "Do more patient assessments and overall care than to do bed baths". "we need more critical thinking exercises and more case studies where we can talk through a situation and learn to develop a plan of care". "Many times we had a lecture and they never had time for the case study…it really would have helped us to do the case studies together and learn to work through the process together…not making beds and doing

baths". "When we were in school our instructors took us to the lab and they had us work through scenarios, it was a great critical thinking exercise". "I think we should have had more maternity and Peds (pediatrics) in our program...not having twelve weeks of Med/Surg (medical-Surgical)...I hated Med/Surg...now I'm in post partum I wish we had more time in the area I like". "I know you're in school to learn but a lot of instructors would say "*did you read? If you did you shouldn't have any questions"*...they would tell you go back and read it again and not explain the answer". "One-on-one was better for clinical skills and working on my critical thinking skills". "My program did prepare us to let us know we are novices...they were very good at that". "My orientation here helped address how to communicate with the patients, it was addressed in orientation, not really at school".

Responses from *Focus Group # 3* included: "Skills like IV and phlebotomy...I wish we were allowed to practice on a manikin instead of real person". "You get out of school and a lot of nurses expect you to graduate and be ready to be up and running on your own...it's really not realistic". "Independent practicum's would be more helpful instead of being in a clinical group and not having your friend to lean on...you have to then trust and rely on yourself". "More skills training like IVs, more application based questions and actual case scenarios really help". "We need more hands on and basic skills training...that would help you to feel less stupid on the unit". "My school gave us six patients with total care and meds...the instructor didn't help us at all...now that seems helpful but not at the time". "I would change the culture of nursing schools...the instructors still are "eating their young"...the attitudes of the instructors toward the students seems very parental and non conducive to learning". "There needs to be more

collaboration of the faculty to student…less parochial ways of communicating…a lot of faculty need to stop talking down to the students…as an adult learner I don't think a student should be treated that way". "There should be a more facilitative and supportive environment for adult students". "We need more contact with advanced practice nurses…we never had any contact with them in school or learned how to communicate with them". "In school we were told if there's a problem call the doctor, but they didn't tell you the chain of command with the physicians".

And finally in summary, the essential themes that emerged in response to question number five were: 1) more hands on training, 2) training by means of case scenarios and Simulation lab to enhance critical thinking abilities, 3) more technical skills (like intravenous and phlebotomy in particular), and finally 4) more communication skills in a facilitative environment.

Chapter Summary

Data collection was directed at answering two research questions. The research questions that guided this study were:

1. What behaviors by preceptors, mentors, or coaches have been identified by new graduate nurses as most helpful during their transition period into the nursing profession?

2. Do the new graduate nurses feel adequately prepared from their educational program for their transition into the nursing practice?

Data was collected during three focus group sessions and included a total of nineteen participants.

With regard to research question number one, the participants collectively described having the autonomy to do things on their own with the support of the preceptor when needed as the most helpful behavior from their preceptors or mentors. No participants used the terminology of coach. The second most emphasized point was for the preceptors or mentors to have realistic plans and expectations for the new nurse. Other key mentoring behaviors included identified was providing a supportive and nurturing environment where it is safe to ask questions without fear of repercussions or humiliation, providing the new nurse with structure and guidelines for their day in order to get better time at their management skills, allowing the GN to develop their own working style without fear of criticism, and finally providing a mentoring relationship whereas the new nurse learns in a facilitative and "hands on" manner .

The critical themes that emerged were: 1) having the autonomy to perform tasks and skills on their own with mentoring support of the preceptor when needed, 2) providing a supportive and nurturing environment where it is safe to ask questions without fear of humiliation, 3) providing the new nurse with organizational structure and guidelines for a daily plan of care for the GN to follow in order to improve time management skills 4) having realistic expectations of new graduate nurses, 5) allowing the GN to develop their own working style without fear of criticism, and finally 6) providing a mentoring relationship whereas the new nurse learns in a facilitative manner .

In response to the second research question, as to whether the graduate nurses feel adequately prepared from their educational program for their transition into the nursing practice, most participants did not feel adequately prepared for this transition. The most critical themes identified included unrealistic expectations for the new graduate, the need

for more "hands on" training, more detailed training by way of case scenarios and lab simulation to enhance critical thinking abilities, more technical skills, specifically in areas of IV insertion and phlebotomy skills, more communication skills in a facilitative environment, and finally learning better time management and prioritization skills.

The critical themes here include: 1) more hands on training, 2) training by means of case scenarios and Simulation lab to enhance critical thinking abilities, 3) more technical skills (like intravenous and phlebotomy in particular), 4) more communication skills in a facilitative environment, 5) and learning better time management and prioritization skills.

After data collection and correlation was completed for the three focus group sessions and no new themes emerged, data was then considered saturated. The audio files, transcriptions, journals, and other documents related to this study will be reviewed as needed during the interpretation, analysis, and defense phases of the study, and the data will then be destroyed at the conclusion of the study.

Chapter five will provide a summary of the results and a discussion about future implications for the continued investigation into helping behaviors by preceptors or mentors as identified by new Graduate Nurses during the Nurse Residency Program.

Chapter V

Summary and Discussion

This fifth and final chapter of the study will present a summary of the research questions and problems; it will discuss the conclusions made by the researcher, and lastly discuss the significance for the study with implications for further research.

The purpose of this phenomenological study was to identify the perceived helping behaviors demonstrated by the preceptors, mentors, or coaches for new nurse graduates in a Nurse Residency Program. Relevance for this study evolved from the continued impact of the national nursing shortage and the ongoing challenges in the healthcare and educational systems in our country. Registered nurses comprise the largest individual healthcare occupation, with over 2.3 million jobs (Bureau of Labor Statistics, 2004).The study is directed at providing guidance for nursing education programs preparing student nurses for their transition into the nursing profession and for the hospital healthcare hiring facilities for purposes of recruitment and retention of competent new Registered Nurses. Spector and Li (2007) described the need for support to GNs to transition effectively through each of the stages of professional development.

Retention of new nurse is imperative to build a solid healthcare system in our country. Up to 88 % of GNs will begin their career in an acute care hospital settings; research indicates that 35-60 % of those individuals will change employment within the first year of practice (Woods and Craig, 2005; Godinez, Schweiger, Gruver, and Ryan, 1999). As much as fifty percent of the total nursing turnover and vacancies in a hospital

settings throughout the U.S.A. are caused by new graduates (Newhouse, Hoffman, and Hairston, 2007; Manias, Aiken, and Dunning, 2004).

Further implications suggest implementing Nurse Residency Programs (which foster mentoring of new graduate nurses) as the standard of practice to safely allow Graduate Nurses to transition from an advanced beginner to competent Registered Nurse in a clinical setting. Research has stressed the need to support GNs in the transition process (Benner, 1984; Benner, Hooper-Kyriakidis, and Stannard, 1999; Spector and Li, 2007; Canales, 2003). Retention and support of new nurses is a key element in working towards solutions to address the healthcare crisis. Mentoring programs for new nurses showed a decrease in turnover rates from 47 % to 23 % when used (Godfrey and Purdy, 2004). Mentoring improves staff retention, promotes a more informed workforce, and allows the individual be supportive while learning in a "hands on" environment; hence learning through experience (Thorne, 1996). Using trained and enthusiastic mentors and/or preceptors to assist guiding the novice nurse to recognize "what they don't know" will help to boost the learning experience. Formal orientation or residency programs incorporate mentoring as a facilitative method to create and achieve a safe and competent environment to practice nursing (Greene and Puetzer, 2002). Nurse Residency Programs provide the new nurse with "real life" experience; they assist in building self-confidence, and support the new nurse to practice competently when managing difficult patient scenarios and stress management (UHC, 2007).

Finally, this researcher has gathered themes identified in this study. These themes will be placed into a mentoring model or a set of strategies for healthcare institutions and educational facilities to incorporate in their training and orientation process to enhance

the preparation and retention of competent Registered Nurses within the profession. The research questions that guided this study were:

1. What behaviors by preceptors, mentors, or coaches have been identified by new graduate nurses as most helpful during their transition period into the nursing profession?

2. Do the new graduate nurses feel adequately prepared from their educational program for their transition into the nursing practice?

A qualitative design was used to conduct this phenomenological research study. The phenomenological research method was utilized to determine the actual lived experiences of the perceived helpful mentoring behaviors identified by new graduate nurses attending a Nurse Residency Program. Data was collected through a series of focus group sessions. A total of three focus groups sessions were completed; two were completed in the same day and the third was conducted three days later. A total of nineteen participants were included in this study. The participants included in this study were a convenient sample of voluntary new Graduate Nurses attending the Nurse Residency Program at Pennsylvania Hospital in center city Philadelphia. On the days of the focus group sessions, the participants reported to their Residency classes and were given a brief description and a letter (*see Appendix E)* describing the purpose of the study. The forty-five minute focus group sessions were then scheduled later that day for the convenience of the participant's schedules.

The data collected for this research study was directed at answering the two research questions which guided this study. As noted in chapter three, there were five focus group questions (*see Appendix B*) used during these sessions. Questions one

through four were designed to answer the first research question: What behaviors by preceptors, mentors, or coaches have been identified by new graduate nurses as most helpful during their transition period into the nursing profession? The primary themes that emerged from these four questions are: 1) having the autonomy to perform skills and tasks on their own with the support of the preceptor when needed, 2) providing a supportive and nurturing environment where it is safe to ask questions without fear of humiliation, 3) providing the new nurse with organizational structure and guidelines to follow in order to improve critical thinking and time management skills 4) having realistic expectations of new graduate nurses in their abilities, 5) allowing the GN to develop their own working style without fear of criticism, and 6) providing a mentoring relationship whereas the new nurse learns in a facilitative manner .

Question number five was designed to answer the second research question: Do the new graduate nurses feel adequately prepared from their educational program for their transition into the nursing practice? Responses to this question, in addition to collaborative responses from questions one through four, the primary themes that emerged are: 1) more hands on training, 2) training by means of case scenarios and Simulation lab to enhance critical thinking abilities, 3) more technical skills (like intravenous and phlebotomy in particular), 4) more communication skills in a facilitative environment, 5) and learning better time management and prioritization skills.

Discussion: Conclusions of the Study

After careful collaboration and interpretation of the data collected, this researcher devised the following five conclusions from this research study: They are as follows:

Conclusion 1: Graduate Nurses desire to be autonomous in the practice setting; they want to learn to develop an independent style of nursing that is both safe and efficient.

Conclusion 2: Graduate Nurses emphasized the need for a supportive and nurturing work environment where a mentor is readily available to provide guidance and structure to the novice nurse transitioning into an advanced beginner.

Conclusion 3: Graduate Nurses desire organizational structure in the Nurse Residency Program with realistic expectations clarified in order to provide safe and competent care.

Conclusion 4: New Graduate Nurses do not feel adequately prepared upon entry into practice.

Conclusion 5: Nursing education programs need to incorporate a more facilitative learning environment for students. Graduate Nurses emphasize the need of more simulation labs, case scenarios, dialoguing, and hands on and technical training.

The first conclusion for this study is that Graduate Nurses desire to be autonomous in the practice setting; they want to learn to develop an independent style of nursing that is both safe and efficient. Results of the three focus group sessions emphasized that although the Graduate Nurses are often anxious or unsure of their abilities, they still desire to be autonomous in the acute care setting in order to evolve through the stages of a nursing professional. Autonomy by definition is:

The freedom to make independent decisions exceeding the standard nursing

practice and that are in the best interest of the patient (Kramer and Schmalenberg, 2004, p. 374).

Graduate Nurses strive for the independence to learn while they are working in the clinical practice. All participants in this study emphasized the dislike for having the experienced Registered Nurse who was the preceptor "doing things for them". Yoder-Wise (2003) states that autonomy in nursing practice encourages new innovation and improves productivity. The goal for nursing educators as well as healthcare hiring agencies is to identify ways to improve retention of competent nurses within the profession. Researchers acknowledged that autonomous nurses have a more positive work environment, a greater satisfaction within the workplace, and they improve patient satisfaction; this leads to retention of nurses at a higher rate (Kramer and Schmalenberg; Kennerly, 2000). The Graduate Nurses who participated in the research study understand the magnitude of their responsibilities as a licensed professional care giver; all respondents stressed the desire to have the autonomy to perform tasks and make critical decisions, but under the surveillance and mentoring of an expert nurse. It is also critical to emphasize to new nurses that they must utilize autonomy only within their scope of professional practice as an advanced beginning Registered Nurse (Yoder-Wise, 2003).

Additionally, a comprehensive review of the literature emphasizes the need to support Graduate Nurses in their transitional process. The individuals must learn the values of the profession and begin to integrate those values into their daily practice and the development of their personal style (Benner, 1984; Benner, Hooper-Kyriakidis, and Stannard, 1999; Spector and Li, 2007; Canales, 2003). Quite often Graduate Nurses are overwrought facing the extensive critical expectations in skill requirements, flexibility,

critical thinking and problem solving skills to remain current and competent within the profession (Cantrell and Browne, 2005). The participants in this study understood the vital importance of being prepared for the unexpected in the daily care of their patients. These individuals recognized the need to identify their own strengths and weaknesses in their plan of care to safely monitor their patients.

The second conclusion is the Graduate Nurses emphasized the need for a supportive and nurturing work environment where a mentor is readily available to provide guidance and structure to the novice nurse transitioning into an advanced beginner.

Nursing research supports that the first three months practice for newly licensed RNs are like an obstacle course, and are said to be the most stressful and difficult of their career (Kelly, 1996; Godinez, Schweiger, Gruver, & Ryan, 1999; Dobbs, 1988; Fisher & Connelly, 1989; Delaney, 2003; Halfer and Graf, 2006; Bowles and Candela, 2005; Uhlman, 2002; Yoder-Wise, 2007). Therefore as a nurse mentor, we are obligated to ease this process to ensure a successful transition period. Findings indicated that new Graduate Nurses don't feel as though they "fit in"; they were uncomfortable in their roles and did not feel a sense of belonging (Tradewell, 1996). We are obligated as professionals to provide the future generation of nurses with a strong sense of belonging and self worth to promote a competent future in nursing, in addition to a safe and effective working environment for the patients. Through mentoring, we are able to assist the advanced beginning nurse to recognize "what they don't know" and they enhance the learning experience. It is often not enough to encourage Graduate Nurses to ask a lot of questions, because quite often they are not readily prepared to anticipate which questions to ask or

what expectations they should have for the people that they are caring for. As described by Benner (1984) in the review of literature sections of this study, nurse's transition through the five stages of nursing (novice, advanced beginner, competent, proficient, and expert). It is through a continuous process and transitioning that nurses learn what to anticipate and how to care for the patient in a complete and holistic manner.

As reported by the AACN (2002a) mentoring of new graduate nurses produces beneficial outcomes for both the mentor and mentee, and enhances the professionalism of the nursing profession. The participants who had negative experiences with the preceptors or mentors were fearful to ask questions. One respondent described a situation where she asked her preceptor how to use an IV infusion pump, she was unfamiliar with the particular model on the unit. The preceptor brought the monitor to the nurses station and then asked the Graduate Nurse to "show her how to run it" in front of the other nursing staff. The Graduate Nurse stated that she felt "like an idiot" and followed by saying "I don't want to ask her anything now". These behaviors are not only unsupportive for the Graduate Nurse, but unsafe for the patients they care for. The purpose of the Nurse Residency Programs is to provide additional mentoring support to the newly licensed RN without the fear of degradation or mortification.

The disillusionment often leads to new nurses leaving the hospital settings, or the profession. It also contributes to poor morale amongst the staff in the hospital setting (Guhde, 2005; Malugan, 2006). The ultimate goal for the nursing profession is to retain competent nurses within the profession. We need to provide an environment that builds up the developing nursing professional and not to break down their hopes and desires to become more efficient at their craft.

The third conclusion for this study is that Graduate Nurses desire organizational structure in the Nurse Residency Program with realistic expectations clarified in order to provide safe and competent care.

Role transition for a Graduate Nurse is often very difficult. As a Student Nurse the daily expectations, role objectives, and patient care guidelines are generally clearly defined. As a newly licensed Registered Nurse, these expectations and guidelines aren't as clear (Yoder-Wise, 2007). It is essential for the expert nurse or mentor to support the next generation of nurses, as many nurses currently feel that the work environment is professionally unfulfilling and highly stressful (Josiah Macy Foundation, 2000 as reported in AACN, 2002a). Various objectives of a Nurse Residency Program are to allow the advanced beginning nurse to become competent in a clinical setting, to aide in the development of effective decision-making skills, and to develop a individual plan of growth for their new clinical role (UHC, 2007, p. 4).

The fourth conclusion of this study is that New Graduate Nurses do not feel adequately prepared upon entry into practice.

Delaney (2003) postulates that t many graduate nurses are anxious about this time in their lives as they don't feel adequately prepared to assume their role as a professional competent nurse. New graduates often are disillusioned at the aspect of not being able to provide the type of patient care they were instructed on during nursing school (Bowles and Candela, 2005; ANA, 2003). Research indicates that it may take up to 12 to 18 months to feel competent and comfortable in their roles and responsibility as an RN (Hayes and Scott, 2007; Newhouse, Hoffman, and Hairston, 2007; Tradewell, 1996). As

a Student Nurse, there are clearly defined objectives and expectations that must be met each day. As the Student or novice nurse transitions to an advanced beginner Registered Nurse, the objectives and expectations aren't as clear. Graduate Nurses are frustrated as a result of how they are received by others during the transition process (Guhde, 2005; Roman, 2001). Multiple responses throughout the course of the focus groups sessions echoed the sense of being overwhelmed, frustrated, and feeling inadequate in their abilities. Participants described "trying to laugh to keep from crying", or "I can't get everything done…what's wrong with me". Most if not all responded that upon graduation they felt prepared; when they began working on the unit, they realized they were not. Many times the new graduate has unrealistic expectations for themselves, and don't realize the need to learn as they grow or transition into the profession. Nursing is both an art and a science, therefore constant variables will exist. y

Beecroft, Kunzman, Taylor, Devenis, and Guzek, (2004) postulate that it is unrealistic to think that academics alone can prepare an individual for real-world application in practice. Some of the greatest concerns that the Graduate nurses emphasized as "not being able to start an IV or draw blood". They placed the largest emphasis on the task, as opposed to the overall care and preparation of the patient. Chesla (1996) believed that the Graduate Nurses who are learning new things everyday will perform better once they have mastered the "task world"; this allows them to focus their concerns in other areas of caring for the patient. Often, the Graduate Nurses will be able to master a task in a much faster sense, giving them a feeling of accomplishment. The other nursing skills or what is referred to as a "gut instinct" is more ambiguous, in a sense of the multiple variables that play into each event. Every patient scenario and outcomes

are different, whereas tasks are a repetitive behavior that is learned. New nurses are consumed with mastering these technical skill associated with nursing, while an expert nurse will have an immediate understanding of a rapidly changing situation and be able to direct their priorities and interventions quickly and appropriately (Benner, Stannard, and Hooper, 1996; Cavanaugh and Huse, 2004).

The fifth and final conclusion is that Nursing education programs need to incorporate a more facilitative learning environment for students. Graduate Nurses emphasize the need of more simulation labs, case scenarios, dialoguing, and hands on and technical training. There has been a rapidly changing climate in the acute healthcare setting that has brought forth multiple new demands for Registered Nurses. In addition to the competent care of the patient, Healthcare is now faced with rapid advances in science and technology in the workplace, cost containment, a growing demand for self care, decreasing usage of inpatient care facilities, and improvements in disease prevention and management. New Graduate Nurses are expected to be able to translate the theories, principles, and knowledge accumulated in school and be able to generalize and apply that information and in specific clinical settings. These factors present a demand for well-educated, experienced and competent nurses (Santucci, 2004; Joel, 2002; AACN, 2002).

Experiential or facilitative learning as a process where knowledge is created through the transformation of life's experiences. It has been described as a continuous and cyclical process; it is a process where people engage in a direct encounter and purposefully reflect upon it to transform it into personal meaning. (Kolb, 1984; Sewchuck, 2005; Canales, 2003; Weil and McGill, 1989).

Over the last decade, many nursing education programs have incorporated the use human patient simulation training models into the curriculum. The patient simulators allow the educators to create any desired case scenario and allow the nurse to critically think through the scenario and develop a safe and effective plan of care without the risk of harm to a human. Multiple scenarios and studies can be applied to the simulated patient with a controlled response to the desired learning outcome. Desired outcomes can not always be replicated with actual patients due to unpredicted variables, such as past medical history or multiple pharmacologic interactions. Human simulators have been used in other professions as a safe and useful training module (Peterson and Becktel, 2000; Rauen, 2001; Vandrey and Whitman, 2001; Cioffi, Purcal, and Arundell, 2005). Most of the respondent that had experience in their nursing education programs with human simulators expressed their openness of learning and making clearer decisions when there is not a threat of harm to a patient. The new graduates felt a great deal of apprehension with making rapid and clear decisions when an actual patient was present.

Caputi (2005) stated that the use of case studies helps to increase the individual's self confidence and aides in their success in working with others.

Case scenarios allow for a road map of sorts in the course you would take in the care of an individual with a designated pathology or disease process. Additionally, by creating case scenarios with predicted outcomes designated by the nursing educator, the student or graduate nurse can express the verbal communication they would use is designated situations. This may assist in enhancing the new graduate's ability to communicate with the physicians, colleagues, and patients and families. The use of case studies as a pedagogical methodology is beneficial in teaching the science of nursing to novice and

advanced beginners. Case studies allow the individual to humanize the science and to illustrate methodology and values. It will enhance the individual's critical thinking and team learning collaboration. Case based learning allows the nurse to integrate the theoretical knowledge base and offers the ability to enhance the problem solving and critical thinking skills (Ertmer and Russell, 1995).

An Emerging Model

The desire at the onset of this research project was to develop a model of perceived helping behaviors by mentors for the new Graduate Nurses participating in a Nurse Residency Program. During the data analysis and interpretation of results at the completion of the focus group sessions, it was noted that the participants did not directly answer the research questions as they were asked. Many participants did not directly identify the specific helping behaviors they desire, rather the replies were answered in a "negative" connotations. In many instances, the participants described behaviors that were undesirable rather than stating the behaviors that were desired. As to avoid any bias, this researcher served merely as the moderator of the focus groups to clarify any confusion or discrepancies in the questions, not to redefine the questions to meet my desired outcomes. Further, the analysis of the data was conducted holistically using Creswell's model of interpretation for a phenomenological study. Applying this approach in addition to utilizing an extensive review of the literature, the implied statements made by the participants served to bridge the evaluation of the responses into a Model of Helping Behaviors.

This study asked two research questions:

1. What behaviors by preceptors, mentors, or coaches have been identified by new graduate nurses as most helpful during their transition period in the nursing professions?

2. Do the new graduate nurses feel adequately prepared from their educational program for their transition into the nursing practice?

My study identified five conclusions based on the research questions.

1. GNs desire to be autonomous in the practice setting; they want to learn to develop an independent style of nursing that is both safe and efficient.

2. GNs emphasized the need for a supportive and nurturing work environment where a mentor is readily available to provide guidance and structure to the novice nurse transitioning into an advanced beginner.

3. GNs desire organizational structure in the Nurse Residency Program with realistic expectations clarified in order to provide safe and competent care.

4. GNs do not feel adequately prepared upon entry into practice.

Nursing education programs need to incorporate a more facilitative learning environment for students.

5. GNs emphasize the need of more simulation labs, case scenarios, dialoguing, and hands on and technical training.

With the development of a model of helping behaviors in mind, the conclusions of this study were analyzed in detail and a group of implied helping behaviors were derived. The five implied helping behaviors are:

1. A plan for continuous monitoring. This includes monitoring the GN as they develop an independent style and working techniques.

2. Mentors role model desired outcomes. Mentors role modeling desired behavioral outcomes for GNs. And mentors emphasizing a continued support in the transition process.
3. Clear expectations at all levels of transition. Stating clear and specific expectations at each level of transition. Providing the transitioning GN with specific benchmarks at each level of the transition process.
4. Individual profile on strengths/needs of the GN with continuous developmental feedback. Mentors encourage and discuss the GNs strengths to focus on positive attributes during the transition period.
5. Program uses simulation labs and case study training. Educational programs using simulation labs and case study training to enhance the GNs learning experience.

The use of concept maps or graphic charts in nursing education have been supported to provide a visual guide to individuals in the analysis of critical information (All, Huycke, and Fisher, 2003). Graphic charts are a form of problem based learning that express an the interpretation of data visual detailed presentation to delineate desired areas of critical thinking. The ideals and concepts that have been derived from this study in part of working toward the full development and implementation of the Model of Mentoring helping behaviors has been described in a graphic explanation of both the conclusions and the Implied helping behaviors of this study. The graphic interpretation of these concepts has been identified below, in addition to *Appendix P* of this study.

Appendix P

Of the Research Questions	
What behaviors by preceptors, mentors, or coaches have been identified by new graduate nurses as most helpful during their transition period into the nursing profession?	
Do the new graduate nurses feel adequately prepared from their educational program for their transition into the nursing practice?	
Conclusions	***Implied Helping Behaviors***
GNs desire to be autonomous in the practice setting; they want to learn to develop an independent style of nursing that is both safe and efficient. GNs are often anxious or unsure of their abilities, they still desire autonomy.	**A Plan for Continuous Monitoring** Monitoring the new GN as they develop an independent style and working techniques.
GNs emphasized the need for a supportive and nurturing work environment where a mentor is readily available to provide guidance and structure to the novice nurse transitioning into an advanced beginner.	**Mentors Role Model desired outcomes** Mentors role modeling desired behavioral outcomes. Emphasizing continued support in the transition process.
GNs desire organizational structure in the NRP with realistic expectations clarified in order to provide safe and competent care.	**Clear expectations at all levels of transition** Stating clear and specific expectations at each level of transition.
GNs do not feel adequately prepared upon entry into practice.	**Individual Profile on Strengths/Needs with continuous developmental feedback** Encourage and discuss the GNs strengths to focus on positive attributes during the transition period.
Nursing education programs need to incorporate a more facilitative learning environment for students. GNs emphasize the need of more simulation labs, case scenarios, dialoguing, and hands on and technical training.	**Program uses simulation labs and Case Study Training** Using simulation labs and case study training sessions to enhance the GNs learning.

As identified in *Appendix P*, this study derived five conclusions based upon the results of the multiple focus group sessions. Further, the analysis of data suggested five implied helping behaviors of the mentors in relation to the Graduate Nurses. The development and implementation of a model for helping behaviors was the desire of this researcher at the onset of this study. After a detailed analysis of the data and a careful collaboration of results, this researcher identified key objectives to the implementation of a mentoring model. The graphic interpretation of *Mentors' helping behaviors in a Nurse Residency Program* is identified below in this chapter; and additionally referred to as *Appendix Q* in this study. This graphic analysis identifies three sets of objectives to be met to carry out the implementation of this model. The first sets of objectives are the program objectives. The **Program Objectives** (A plan for continuous monitoring and Clear expectations at all levels of transition) would be addressed during the initial phases of the Nurse Residency Program and integrated throughout the residency course work and evaluation. Secondly, would be the **Instructional Objectives** (Mentors role model desired outcomes and Program uses simulation labs and case study training). These objectives would be addressed early on in the Nurse residency program and continue throughout the course of the residency program. Finally the **Student Learning Objectives** (Individual profile on the strengths/needs of the GN with continuous developmental feedback and Program uses simulation labs and case study training). These objectives would be addressed in the nursing education programs to assist in the development of more confident and competent Graduate Nurses. It should be noted that the program uses of simulation labs and case study training could and should be

implemented in both the Instructional and Student learning objectives with an integrated transition of scenarios.

Appendix Q

Mentor's Helping Behaviors in a Nurse Residency Program

Conclusions	Implied Helping Behaviors	Nurse Residency Program Objectives
GNs desire to be autonomous in the practice setting; they want to learn to develop an independent style of nursing that is both safe and efficient.	A plan for continuous monitoring. ⇒	**Program Objectives**
GNs emphasized the need for a supportive and nurturing work environment where a mentor is readily available to provide guidance and structure to the novice nurse transitioning into an advanced beginner.	Mentors role model desired outcomes. ⇒	**Instructional Objectives**
GNs desire organizational structure in the Nurse Residency Program with realistic expectations clarified in order to provide safe and competent care.	Clear expectations at all levels of transition. ⇒	**Program Objectives**
GNs do not feel adequately prepared upon entry into practice. Nursing education programs need to incorporate a more facilitative learning environment for students.	Individual profile on strengths/needs of the GN with continuous developmental feedback. ⇒	**Student Learning Objective**
GNs emphasize the need of more simulation labs, case scenarios, dialoguing, and hands on and technical training.	Program uses simulation labs and case study training. ⇒	**Student Learning Objective** **Instructional Objectives**

Significance and Implications for Further Research

The conclusions that were derived from the data collected in this research study amplify a consistent theme. The study investigated the lived experiences of new Graduate Nurses transitioning into the profession and attempted to identify themes in relation to helpful mentoring behaviors and how these behaviors affect this population of nurses. The overwhelming theme that echoed throughout this study is that new nurses want the ability to be autonomous in their practice setting; they want to learn to develop an independent style of nursing that is both safe and efficient in the care of their patients. The new nurses emphasized the need for a supportive and nurturing working environment where a mentor is readily available to provide guidance and structure to the novice nurse transitioning into an advanced beginner. Graduate Nurses strive for the mentors to provide realistic guidelines and expectations that will allow for the individual to develop a safe and competent method of practice. And finally, the Graduate nurses postulates that there is a greater need of more hands on training by means of human simulations and case scenarios to enhance their critical thinking abilities, in addition to more technical skills (like intravenous and phlebotomy in particular).

This study builds on previous research studies indicating that the new nurses experience a reality shock when they transition from a student to a graduate registered nurse. The new graduate Nurses do not feel adequately prepared in their training; many emphasize that the "real world" of nursing is nothing like what they've learned in nursing school. The underlying theme is that Graduate Nurses feel that a facilitative learning environment is what in the academic and clinical setting would be beneficial. Most participants indicated some exposure to a facilitative environment (by means of the

human simulation labs and the use of problem based learning with case scenarios). Most, if not all stressed the need for more exposure at the student level. The participants added the need for more "hands on" interactions in their nursing education programs. The individuals wanted more dialoguing in a simulated or lab setting to improve their communication skills.

Support and Extensions of the Study

This phenomenological research study was limited to one Nurse Residency Program in center city Philadelphia. For further validation of this research study additional data should be investigated and collected for other Nurse Residency Programs throughout the United States of America. The Nurse Residency Program investigated for the purpose of this research study was a generalized program including new Graduate Nurses from all areas of the hospital. Other Nurse Residency programs throughout the country have Nurse Residency Programs designated to specialty areas in nursing such as critical care or pediatrics; further research may investigate the perceptions of new nurses in a Nurse Residency Program that is designated to a specialty area of nursing and evaluate perceived mentoring behaviors with this specific cohort.

Additional research should be directed at the effectiveness of the mentoring that is incorporated into the Nurse Residency Programs as a standard of practice for general nursing orientation programs. Mentoring is an absolute necessity for the success of the Graduate Nurse. Additionally, the residency programs generally provide a safe and nurturing environment for learning.

Finally, for the preparation of student nurses, graduates emphasized the value of integrating a more facilitative learning environment encompassing the use of human

simulators and case study problem based learning.

Limitations

This Qualitative phenomenological research study investigated the perceived helping behaviors by preceptors or mentors as identified by new Graduate Nurses during their Nurse Residency Program. The study was limited to three separate focus groups, with a total of nineteen individuals participating in the study. The interpretations of the results along with the identified themes have been discussed in detail in Chapter Four of this study. The results of this study cannot be generalized as it was limited to one Nurse Residency Program, therefore analysis and conclusions may be open to alternative understanding of the data.

Suggestions of the Study

It is the desire of the researcher to validate the model of *Mentors' Helping Behaviors in a Nurse Residency Program (Appendix Q).* The implementation of this model should be completed through Program, Instructional, and Student Learning objectives as mentioned formerly in this chapter. Validation for this *Model of Mentors' Helping Behaviors in a Nurse Residency Program* could be implemented at additional NRPs throughout the country. Additionally, it is my desire for this Model to assist in guiding healthcare hiring institutions and educational training facilities for better preparation and retention of competent and confident RNs within the profession. And finally, validation of this Model should be completed respectively in both the educational and healthcare settings.

Summary

Graduate Nurses attending the Nurse Residency Program at Pennsylvania Hospital in center city Philadelphia have identified their perceptions of helping behaviors by their preceptors or mentors during the course of this program. The new nurses want the ability to be autonomous in their practice setting; they want to learn to develop an independent and autonomous style of nursing that is both safe and efficient in the management of care for their patients. There is the need for a supportive and nurturing working environment where a mentor is readily available to provide guidance and structure to the novice nurse transitioning into an advanced beginner. Mentors need to model their behavior to provide realistic guidelines and expectations that will allow the advanced beginners to develop a competent method of practice. And finally, nursing education programs need to integrate a more facilitative method of teaching this generation of nurses by means of human simulation labs and case scenario studies. These tools will aide in the enhancement of the graduate Nurses' critical thinking abilities and provide them the opportunity to practice technical skills like IV insertion or phlebotomy..

This study builds on previous research studies indicating that the new nurses experience a reality shock when they transition from a student to a graduate registered nurse. The new graduate Nurses do not feel adequately prepared in their training. The underlying theme is that Graduate Nurses believe that a facilitative learning environment in the academic and clinical setting would be beneficial for novice nurses. Most participants indicated some exposure to a facilitative environment by means of the human simulation labs and the use of problem based learning with case scenarios, however most, if not all stressed the need for more exposure at the student level. The participants added

the need for more "hands on" interactions in their nursing education programs. The individuals wanted more dialoguing in a simulated or lab setting to improve their communication skills.

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APPENDIX A: IRB APPROVAL

DREXEL UNIVERSITY
Office of Regulatory Research Compliance

TO: Marion Dugan ,
Provost / School of Education
Mailstop:

FROM:

Sreekant Murthy, Ph.D.
Vice Provost for Regulatory Research Compliance
Drexel University College of Medicine
1601 Cherry Street, Suite 10444, 3-Parkway, Philadelphia, Pa 19102
Tel: 215-255-7864 Fax: 215-255-7874

SUBJECT: **EXEMPT APPROVAL**

TITLE: A Phenomenological Investigation into Mentors' Helping Behaviors in a Nurse Residency Program: An Emerging Model

SPONSOR: Internal

PROJECT No: 1042523, PROTOCOL No: 17654 , ACTION No: 49309 Type: New Period: 1 Seq: 1 , DETAIL No: 245943

CURRENT APPROVAL: 06/12/2008

RE: 06/12/2008 Approved Exempt Category 2
Approval Includes: Number of Subjects to be enrolled 24; Research Proposal; Questionnaires (Generalized Questions for Focus Groups); Letter to Prospective Participant; Letter of Authorization from Pennsylvania Hospital, Nursing Education Depart

Date: 6/12/2008

On behalf of the Committee, I am pleased to inform you that the subject protocol has been reviewed and approved as **EXEMPT research** (45 CFR 46, 101(b) (1)) for the period indicated above. We operate under many Government requirements. As a result, this approval is granted with the following understandings:

1. If this is a sponsored project, then the study may not be activated until the Clinical Research Group has received BOTH a fully executed sponsored agreement AND appropriate letter(s) of indemnification by the sponsor. If this is not a sponsored study (designated "internal"), the costs of the project must be identified and a cost center designated. Please call 215-255-7857 if you have any questions regarding these procedures.
2. You must advise the IRB of the activation date. Use the attached form for this purpose.
3. Protected Health Information (PHI) cannot be collected without a Waiver of Authorization per HIPAA regulations.
4. Any change to the protocol must be submitted in writing and approved by the IRB in advance.
5. Any adverse reaction must be reported to the IRB as soon as it occurs.
6. Should the IRB decide to monitor your project directly, please cooperate fully. Failure to do so may result in withdrawal of this approval and notification to the sponsor and/or Federal agencies. Specific information regarding monitoring appears in the book: "Guidelines for Biomedical and Behavioral Research Involving Human Subjects", obtainable through this office or visit the website http://research.drexel.edu.
7. Whether or not this protocol is activated, the IRB will conduct a Continuing Review at least annually. Should you fail to respond to this Federally-required progress report, the project may become ineligible for re-approval and the IRB may choose not to consider other projects for approval.
8. A final progress report must be submitted to the IRB in format similar to that of a periodic report.

The IRB welcomes your research project into the list of approved protocols. Your compliance with the above conditions will help to protect the continuation of all research activity at the University. With your project and others like it, we look forward to additions to knowledge of human health and benefits to science, our patients, and society.

cc: Dept Chair, Tenet, and Drexel

1601 Cherry Street, Suite 10444, 3 Parkway • Philadelphia, PA 19102 • Phone 215-255-7857 • Fax 215-255-7874
www.research.drexel.edu • www.drexelmed.edu

MEMORANDUM
Institutional Review Board (IRB #3)
ACTIVATION NOTICE

TO: Institutional Review Board (IRB #3)
1601 Cherry Street, Suite 10444, 3-Parkway, Philadelphia, Pa 19102
Tel: 215-255-7864 Fax: 215-255-7874

FROM: Marion Dugan ,
Provost / School of Education

SUBJECT: ACTIVATION OF HUMAN RESEARCH PROTOCOL ENTITLED:
A Phenomenological Investigation into Mentors' Helping Behaviors in a Nurse Residency Program: An Emerging Model
PROJECT No: 1042523, PROTOCOL No: 17654, ACTION No: 49309 Type: New Period: 1 Seq: 1 , DETAIL No: 245943
DATE OF APPROVAL: 06/12/2008

Date: 6/12/2008

This is to inform the IRB that the subject protocol was activated* on __/__/____. I understand that a Periodic Report for Continuing Review or Final Summary is due on or before the above Expiration Date.

[ ] Yes [ ] No I have a copy of the University's Human Subjects Guidelines and Federal Wide Assurance (FWA) to the OHRP, as required in 45 CFR Part 46.

NOTE:
The University Guidelines for Biomedical and Behavioral Research for the protection of human subjects have been posted on the Office of Research website.
There are two sets of Guidelines - one each for Medical and Non-Medical Research.
You must have a hard copy and read these Guidelines to make sure that these Guidelines are met.
To download a copy of the University Guidelines, follow the below instructions:

1. Go to http://research.drexel.edu
2. Click "Medical IRB" or "Non-Medical IRB" in Quick Links
3. Under "Go to", click "Medical IRB" or "Non-Medical IRB Guidelines"
4. Please keep a copy of the University Guidelines in your office.

____
(Signed) Dugan, Marion

* "Activated" means that the first new human subject was accrued, or an experimental procedure was performed, or records were reviewed under this protocol on or after the date of last approval: 06/12/2008.
Accordingly, this notice must be sent to the IRB ONLY for the FIRST such accrual since that date.

APPENDIX B

Revised Generalized Questions for Focus Groups

1. Describe how your transition from a SN to RN compared to your preconceived expectations of an autonomous nurse.
2. What aspects of the transition process to an autonomous RN do you feel is the most difficult?
3. What were the behaviors exhibited by your preceptors or mentors that were most helpful during your transition period?
4. Describe the behaviors exhibited by your preceptors or mentors that you found the least helpful?
5. What changes in your nursing education and training preparation do you feel would have helped you to feel better prepared as an independent autonomous RN?

APPENDIX C

Focus Group Demographic Data

1. Age
2. Gender
3. Ethnicity
4. Type of RN Program (Diploma, ADN, BSN)
5. At what stage (Weeks/Months) of your residency program are you currently at?
6. Were you previously employed in any capacity at Pennsylvania Hospital? If yes, please explain your role.
7. Do you have a designated preceptor or mentor?
8. If you had the ability to make any type of change, what aspect of the nursing profession would you adjust?

APPENDIX D

Participant Data Sheet

Participant Information

1. Date of Focus Groups ______________________________

3. Interview Yes or No

4. Date of Interview ______________________________

5. Place of Interview ______________________________

Researcher's Notes

______ Focus Group Completed Date ______

______ Interview Completed Date ______

Appendix E

Dear prospective participant,

I am a Doctoral candidate in the School of Education at Drexel University. As partial fulfillment of the requirements for the degree of Doctor of Philosophy in Educational leadership and Learning technologies, I am conducting a qualitative research study. My study will be examining the perceived helping behaviors of preceptors, mentors, and coaches as identified by new nursing graduates in Nurse Residency programs.

As nursing graduates in the transition period into the nursing profession your comments and perceptions are essential to my study. I hope to identify helping behaviors that aide in contributing to the success and retention of competent nurses within the profession.

If you are interested in participating, please inform your coordinator. The focus group session will last approximately forty five minutes, they will take place within your place of employment, and refreshments will be served. I will be audio recording the sessions for content accuracy and taking notes as an observer during the session. Additional interviews may be conducted for content clarity. Each participant will be guaranteed that all information obtained will be kept confidential. All participation is considered voluntary; therefore, withdrawal from the study can be done at any time.

Thank you for taking the time to consider my request.

Sincerely,

Michelle M. Murphy-Rozanski M.S.N., R.N., C.R.N.P
Doctoral Candidate, Drexel University
Dr. Marion Dugan
Chair, Drexel University

Please do not hesitate to call with any questions

Appendix F

Letter of Collaboration

June 2008

To Whom It May Concern:

Michelle Murphy-Rozanski is invited to participate and conduct research with our Nurse Residency Group at Pennsylvania Hospital. She will be working in a collaborative effort with me and the Graduate Nurses.

Please feel free to contact me with any questions and/or concerns.

Sincerely,

Christine Slavin, RN, MSN, CRNP
Nurse Residency Coordinator
Pennsylvania Hospital
Nursing Education Department
215-829-6591
christine.slavin@uphs.upenn.edu

Appendix G: **Initial Letter and Demographic Information Form**

Initial Letter Sample
Marion Dugan, Ed.D.
Drexel University School of Education
3141 Chestnut Street
Philadelphia, PA 19014

[Name]
[Residency Program]
[Address]
[City, State, Zip]

Dear [Title]:

I am the principal investigator for an exciting and opportune research study. I would appreciate your participation as a participant of an exceptional Nurse Residency Program in the city of Philadelphia. The principal researcher for this study is Mrs. Michelle Murphy-Rozanski. She has designed and will conduct this study in partial fulfillment of the requirements for a Doctor of Philosophy degree from Drexel University.

After a detailed examination of the literature, we have identified a significant gap to be explored. With the ever growing increase in the shortage of nurses nationally there is a need to evaluate and identify themes that will assist in easing the transition, recruitment, and retention of competent new nurses into the nursing profession. These themes are of significance to both the hiring Healthcare facilities and the educational institutions that prepare and train future nurses.

The purpose of our study is to answer this question: What are the perceived helping behaviors of preceptors, mentors, or coaches as identified by the graduate nurse during their Nurse Residency Program? Through this examination and synthesis of data, it is our desire to develop a model of helping behaviors for mentors or preceptors as described by new graduate nurses as they transition into the nursing profession in route to becoming a competent registered Nurse.

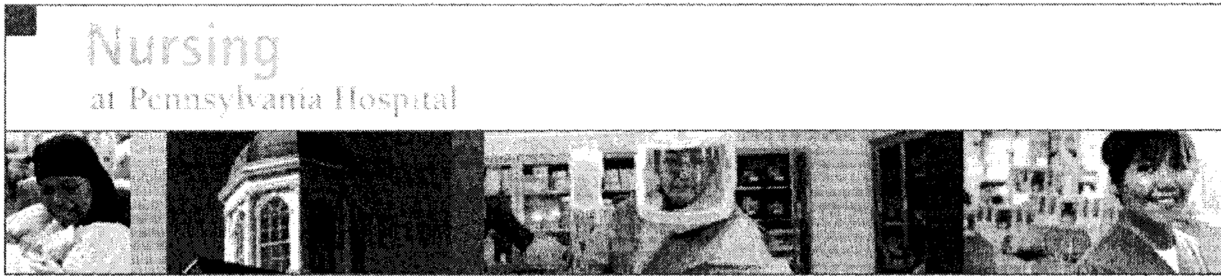
As previously described, this study is timely and exciting because of its potential significance to both the fields of Educational Leadership and Nursing Staff Development. The Nurse Residency Program you are currently attending correlates with the your initial transition into the nursing profession, therefore your contribution is very crucial for Nursing and Educational leaders to better prepare, recruit, and retain competent Registered Nurses within the profession.

Mrs. Murphy-Rozanski has developed a series of questions that will guide a forty-five minute focus group session. The questions are designed to guide you in discussing what behaviors or characteristics you identify as helpful from your preceptor, mentor, or coach in your Nurse Residency Program. All information will be confidential. You will remain anonymous in the final report of the results, and you may choose to withdraw yourself from the study at any time.

If you are interested in participating in the study, please return the enclosed demographic information form in the self-addressed, stamped envelope. Mrs. Murphy-Rozanski will be in touch with you to schedule the 45 minute focus group sessions, and to answer whatever questions you may have about the study. In the meantime, you may feel free to contact her via telephone (856-275-4225) or email (mmurphy822@aol.com).
I appreciate your consideration of participating in this study. Your experiences are invaluable as a resource for preparation, training, and most importantly retaining of future nurses within the profession.

Sincerely yours,
Marion Dugan, Ed.D.
Associate Professor
Drexel University School of Education

APPENDIX H



Nurse Residency Program

Pennsylvania Hospital offers a year-long series of learning and work experiences designed to support nurses as they transition into professional nursing practice. The goal of the program, based on Patricia Benner's From Novice to Expert, is to assist the graduate nurse's progress from advanced beginner to competent nurse.

This program offers nurses the opportunity for clinical practice in an environment committed to professional growth through nurse-patient relationships, evidence-based practice, and interdisciplinary collaboration. Participating nurses will receive a full salary and an excellent benefits package as well as dedicated preceptors and faculty for guidance and orientation throughout the program.

Criteria for Admission

- Graduation from an accredited BSN program within the last 6 months
- Good references from your school of nursing
- RN licensure or a temporary practice permit
- A willingness to commit to the one-year necessary to complete the Residency Program

Bring your nursing career to Pennsylvania Hospital where your skills will be highly valued. We offer ongoing training, an exceptional compensation program, and 100% prepaid tuition.

For more information on the nursing opportunities available, visit our Jobs web site. AA/EOE, M/F/D/V

http://pennhealth.com/nursing/pahosp/residency.html

Appendix I

Triangulation Matrix

Research Questions	Focus Group Questions	Audio Recording & Transcription of Focus Groups	Focus Group # 1	Focus Group # 2
What behaviors by preceptors, mentors, or coaches have been identified by new graduate nurses as most helpful during their transition period into the nursing profession?				
Do the new graduate nurses feel adequately prepared from their educational program for their transition into the nursing practice?				

APPENDIX J

Table 1: Demographic Information

Demographic Information	Focus Group # 1	Focus Group # 2	Focus Group # 3
Questions			
Age	25, 24, 24, 33, 33, 24,	35, 34, 27, 23, 44, 47,	39, 25, 32, 28, 23, 28, 23
Gender	6 females	5 females, 1 Male	4 females, 3 Males,
Ethnicity	Korean-American, White, Caucasian, White, Caucasian-Hispanic, Asian Indian	Native American, 4 Caucasian, African American,	Asian, White, 5 Caucasian,
Type of RN Program (Diploma, ADN, BSN)	2 BSN (ACE), 3 BSN, 1 ADN	5 BSN, 1 ADN	5 BSN, 1 ADN, 1 Diploma
At what stage (Weeks/Months) of your residency program are you currently at?	All on Day one of NRP December 2007, 3 May 2008, 2 June 2008,	All on Day one of NRP 5 June 2008, 1 February 2008	14 months, 11 months, 5 @ 12 months,
Were you previously employed in any capacity at Pennsylvania Hospital? If yes, please explain your role.	4 were not previously employed, 1 Nurse Extern, 1 Nurse Tech	None of the 6 were previously employed at PA Hospital	6 were not previously employed at PA Hospital, 1 was a PT Care Tech,
Do you have a designated preceptor or mentor?	4 Have one designated preceptor, 2 have multiple preceptors	6 had designated preceptors, 4 had more than one, some up to 3 to 6	1 had no assigned preceptor, 2 had 1 preceptor, 2 had 2 preceptors, 2 had 4-8 preceptors
If you had the ability to make any type of change, what aspect of the nursing profession would you adjust?	↑Staffing issues with administration & hospital staff, 5 left blank	↑Nurse-Nurse communication & help, Teaching aspects of teamwork, Addressing nurse to nurse interactions, Nurse patient ratios, 2 blank	3 Ratio of Pt to nurse, Management of realistic expectations of interactions with the staff, what to expect during the orientation period, and 4 addressed nurse to patient ratios in clinical settings, different pt satisfaction surveys, classrooms with actual hospital education and how to interact with management, Have instructors teach in a facilitative manner as opposed to a parochial manner, teach on Doctor-nurse

interactions,

Appendix K

Focus Group Question 1

Focus Group Question 1	Audio Recording & Transcription of Focus Groups	Focus Group # 1	Focus Group # 2	Focus Group # 3
Describe how your transition from a SN to RN compared to your preconceived expectations of an autonomous nurse.	**#1-** "I didn't feel as prepared as I would have liked to", and "I would plan out my day and then something always seems to throw me off". ---------------------- **#2-** "I'm constantly running", "Some days I feel like if I don't laugh, I will cry", "I feel like its hard to keep your sanity some days", and "The work can push you to your breaking point", "the patients are more demanding than I thought, they don't seem to appreciate anything you do for them", "I am often mentally and physically exhausted, and a lot of the patients think you don't do anything for them" **# 3-** "Nursing school is all theory, and most of what is taught is not the reality of nursing", "you go through school with blinders on, and get out in to the field and have all of these unrealistic expectations put on you", "I felt very awkward in my ability to do everything, the skills, my plan of care, and my communication skills, school is not like the real world".	Felt inadequate on skills training (specifically IV insertions), time management skills, prioritizations of patients & tasks, Did not feel prepared as they would have liked to	Felt inadequate on tasks & skills training (specifically IV insertions), time management skills, prioritizations of patients & tasks, Did not feel prepared as they would have liked to, much higher lack of gratitude from pts, feel like "I'm constantly running", have to laugh so I won't cry, Extremely exhausted mentally & physically, "hard to keep your sanity, have a short "breaking point"	School is all theory & not realistic on the job of an RN, In school it's like you "have blinders on-it's unrealistic on what to expect, Much harder than anticipated, can't perform time management like they wanted to, the pace is much faster than anticipated, felt very awkward & incompetent, felt inadequate on every aspect of nursing, the care, skills, communication, techniques-just running around,

APPENDIX L

Focus Group Question 2	Audio Recording & Transcription of Focus Groups	Focus Group # 1	Focus Group # 2	Focus Group # 3
What aspects of the transition process to an autonomous RN do you feel is the most difficult?	# 1-Time management, knowing available resources, where things are & who to contact for what, knowing the chain of command, policies & protocols. Helping you to figure out what to do first. It's hard to put in order which task to do next. Feeling very stressed & nervous & not knowing what to do. ----------------------------- # 2- Time management . Knowing what to do when you have 3 bad patients, & I do the ABCs, & all 3 have priority issues. Compared to nursing school, I can see now why students were a burden to the RNS, students don't help, they drag you down. It's almost impossible to get everything done. Feel very stressed & overwhelmed. Feel like I don't know what I'm doing. --------------------------- # 3- Time management, dealing with multiple patients & trying to get everything done that needs to be done. The distractions, prioritizing, skills & tasks. External distracters, families, doctors, other staff. I feel awkward & stupid. Too much to do & too little time to do it. Feeling	Time management of multiple Pts, available supplies & resources, lack of self -confidence, anticipation of what's next & what they don't know,	Time management of multiple Pts, non-cooperation by pts, available supplies & resources, lack of self-confidence, not knowing what questions to ask, Felt more like an aide rather than RN	The pace is much harder, time management with multiple patients, too many things to do with constant interruptions from staff, pts, families, docs & staff, feeling very overwhelmed on a daily basis, too many external demands other than being able to focus on their patients, the acuity levels, prioritizing everything,

overwhelmed.

Appendix M

Focus Group Question 3	Audio Recording & Transcription of Focus Groups	Focus Group # 1	Focus Group # 2
What were the behaviors exhibited by your preceptors or mentors that were most helpful during your transition period?	# 1-Structure & having the autonomy to do what needs to be done, but knowing they are there available when I need. Ability to be autonomous but not doing it for you. Very calm, not anxious. Multiple preceptors were helpful. --- # 2-My preceptor said "see one, do one" Their pushing me was overwhelming but now it's helpful. I found it helpful to have a few different preceptors, I got to see a few different ways of doing things & then find a way to make it my own. My preceptor works fast, I liked the autonomy. Preceptor knew policies, procedures. He showed me how to find out the information that I needed to know. Taught me how to deal with the other co workers on the unit, how to communicate. ---------------------------- # 3-She would show me & then explain to me what she was doing & why. No unrealistic expectations of me. I felt safe to approach her or ask a question. Multiple preceptors helped a lot. I liked the autonomy, the availability of my preceptor.	"By the book- allowed for a very structured orientation period, providing an autonomous setting but being readily available, providing assistance with nursing care	"watch one, do one", "let me just get in there & do what I needed to do", calm demeanor, multiple preceptors were helpful allowing for different displays of similar techniques, good assessment skills, good documentation skills, very knowledgeable of policies & procedures, encouraged you when you were overwhelmed, completed tasks in a rapid manner, "She pushed me to do better",

Appendix N

Focus Group Question 4	Audio Recording & Transcription of Focus Groups	Focus Group # 1	Focus Group # 2	Focus Group # 3
Describe the behaviors exhibited by your preceptors or mentors that you found the least helpful?	**# 1-** Doing things for me & not letting me do it for myself. She would say "I'll take care of it" At the end of the day, I didn't know what was done & not done. Unrealistic expectations, Expecting us to be more aware of everything & not realizing what we know. **# 2-** Overwhelmed, unrealistic expectations. I wasn't sure exactly what everything for that patient included. I had multiple preceptors that all had different ways of doing things & they would tell me "that wasn't right, do it this way" & it was very confusing for me for the skills & documentation & my time management skills. **# 3-** Her being laid back didn't offer me a lot of direction & structure on how & why to do something. I didn't like the ones that did stuff for me instead of showing me how to do it for myself.. She was abrasive & demeaning & humiliating in front of the other staff. The clinical educator on the floor was often a negative on the floor, she was really pushing unrealistic expectations	"Doing things for me & not letting me do it myself", Unrealistic expectations of skills and knowledge & ability to do more, Documentation differing from one nurse to another, inability for flexibility in doing a good job,	"unrealistic expectations early on in orientation", "made me feel anxious by having to watch something once & then be ready to do it on my won without assistance", personality conflicts, multiple preceptors was not productive, no continuity of explanations & expectations, no organization for new nurse,	Unrealistic expectations, humiliations on how to demonstrate a new pump in front of all the nurses on the unit, "right in my face & not allowing me to do what I needed to do", demeaning & abrasive in her critique, abrasive speech, unrealistic expectations, "a reluctant preceptor"

APPENDIX O

Focus Group Question 5	Audio Recording & Transcription of Focus Groups	Focus Group # 1	Focus Group # 2	Focus Group # 3

What changes in your nursing education and training preparation do you feel would have helped you to feel better prepared as an independent autonomous RN?

IV skills, phlebotomy training. Having a full shift of clinical. More hands on IV meds, IV flow rates. Do more RN work, not CNA or tech work. Research & theory class, they didn't help me for what I need to do on the floor. Do a more rigorous lab course. More application of pharmacology specific in each course. I didn't know the order of who to contact for physicians.

"Writing APA papers don't help me to take care of my patients" It would be better to go the lab, and have a few fake patients, & having to critically think through the situation then to go on the floor & work as an aide. Do more patient assessment & overall care, not bed baths. More critical thinking exercises, & case studies. My orientation here helped address how to communicate with the patients, it was addressed in orientation ,not really at school.

Skills, phlebotomy. Independent practicum's would be more helpful instead of being in a clinical group, you rely on friend too much. More hands on, basic skills. More collaboration of the faculty to student, less parochial, talking down to the students. More facilitative & supportive environment.

IV Phlebotomy skills, working full shifts on clinical instead of shortened days, More hands on, more technical training in the computers and documentation, more application of pharmacology, specific leadership skills, ACE programs do not offer enough clinical time to do basic skills, more communication skills with physicians & staff,

Not prepared at all, Should teach real world expectations of pt care & responsibilities for new grads, "writing APA papers does not help with skills & critical thinking", need more "hands on", stop doing CNA work on clinical, do more case studies & practical applications, work more in a sim lab setting with multiple pts, use lab setting to set up critical thinking scenario's with smaller groups and the clinical instructors instead of bathing 4 regular patients, give more direction on how to speak to the pt & families in specific situations,

Hands on skills, more independent practicum's, allow or total care responsibility of multiple patients, communication skills amongst physicians & staff, change the educational culture-nurses are still eating their young, have schools change the parochial atmosphere where you talk down to the adult student instead of engaging them.

APPENDIX P

Of the Research Questions	
What behaviors by preceptors, mentors, or coaches have been identified by new graduate nurses as most helpful during their transition period into the nursing profession?	
Do the new graduate nurses feel adequately prepared from their educational program for their transition into the nursing practice?	
Conclusions	***Implied Helping Behaviors***
GNs desire to be autonomous in the practice setting; they want to learn to develop an independent style of nursing that is both safe and efficient. GNs are often anxious or unsure of their abilities, they still desire autonomy.	**A Plan for Continuous Monitoring** Monitoring the new GN as they develop an independent style and working techniques.
GNs emphasized the need for a supportive and nurturing work environment where a mentor is readily available to provide guidance and structure to the novice nurse transitioning into an advanced beginner.	**Mentors Role Model desired outcomes** Mentors role modeling desired behavioral outcomes. Emphasizing continued support in the transition process.
GNs desire organizational structure in the NRP with realistic expectations clarified in order to provide safe and competent care.	**Clear expectations at all levels of transition** Stating clear and specific expectations at each level of transition.
GNs do not feel adequately prepared upon entry into practice.	**Individual Profile on Strengths/Needs with continuous developmental feedback** Encourage and discuss the GNs strengths to focus on positive attributes during the transition period.
Nursing education programs need to incorporate a more facilitative learning environment for students. GNs emphasize the need of more simulation labs, case scenarios, dialoguing, and hands on and technical training.	**Program uses simulation labs and Case Study Training** Using simulation labs and case study training sessions to enhance the GNs learning.

Appendix Q

Mentor's Helping Behaviors in a Nurse Residency Program

Conclusions	Implied Helping Behaviors	Nurse Residency Program Objectives
GNs desire to be autonomous in the practice setting; they want to learn to develop an independent style of nursing that is both safe and efficient.	A plan for continuous monitoring. ⇒	**Program Objectives**
GNs emphasized the need for a supportive and nurturing work environment where a mentor is readily available to provide guidance and structure to the novice nurse transitioning into an advanced beginner.	Mentors role model desired outcomes. ⇒	**Instructional Objectives**
GNs desire organizational structure in the Nurse Residency Program with realistic expectations clarified in order to provide safe and competent care.	Clear expectations at all levels of transition. ⇒	**Program Objectives**
GNs do not feel adequately prepared upon entry into practice. Nursing education programs need to incorporate a more facilitative learning environment for students.	Individual profile on strengths/needs of the GN with continuous developmental feedback. ⇒	**Student Learning Objective**
GNs emphasize the need of more simulation labs, case scenarios, dialoguing, and hands on and technical training.	Program uses simulation labs and case study training. ⇒	**Student Learning Objective Instructional Objectives**