Nurse Residency Program Pilot

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Abstract

Purpose: Nurse Residency programs (NRPs) have shown great promise in helping to transition the new RN to the role of a practicing nurse. This document describes the development of a nurse residency program pilot (NRPP) at a small rural hospital in Northern Michigan. This document describes a structured NRPP modeled after the National Council of State Boards of Nursing (NCSBN) transition to practice modules. The document demonstrates the benefits that a structured NRPP had in facilitating the development of relationships between hospital preceptors and newly hired registered nurses (NHRN). This document discusses how the NRPP incorporated evidence to support transition to practice RN (TTP-RN) acculturation into facility culture through the development of relationships between the preceptors and TTP-RNs. Further, this document incorporates the evidence from various transition and learning theories that were used in the construction of structured NRPP modules.

Data sources: Electronic search engines and databases retrieved relevant published research studies from AB/INFORM collection, OVID, MEDLINE, CINAHL, and ProQuest data banks; research dating from 1996 to 2017 are included. Collection and analysis of the data was conducted during and after completion of the NRPP.

Conclusion: This document emphasizes relationship building as a key approach used during implementation of a NRPP and describes the findings and implications related to this approach.

Nurse Residency Program Pilot

Nurse Residency programs (NRPs) are increasingly implemented to help combat the high nursing turnover rates and nursing shortages in healthcare facilities across the nation. Residency programs are more effective in transitioning new nurses to practice when they use a teaching-learning structure that involves supportive preceptors and focuses on new nurse transition theories (Condrey, 2015; Hatler, Stoffers, Kelly, Redding, & Carr, 2011; Letoumeau & Fater, 2015; Shinners & Fanqueiro, 2015). One common theme in the research is the importance of preceptors in building relationships with new nurses (Blegen et al. 2015; Bott, Mohide, & Lawlor, 2011; Cochran, 2017; Craven & Broyles, 1998; Dwyer & Revell, 2016; Hickerson, Terharr & Taylor, 2016; Honour, 2016; Hopkins & Bromley, 2016). The building of these relationships is a major component that should be addressed during transition of new nurses to practice. Nurse residency programs can offer important positive benefits to the health care organizations turnover rates; to derive the fullest impact that a NRP can provide, the program must be designed with a strong preceptor component, while utilizing structured educational approaches that promote relationship building.

Background

Nurse Residency Programs have sprung into healthcare facilities across the nation as excellent examples of an evidenced-based practice. The importance of nurse residency in the United States (US) is no longer up for debate; the evidence has proven the necessity of NRPs to promote better nurse and patient outcomes. The Institute of Medicine's (2011) "Future of Nursing" report challenges nursing to develop NRPs to assist the transition to practice for newly licensed registered nurses (RNs). The challenge to healthcare organizations is the development of a NRP that is affordable, customized to meet the needs of the organization, and based upon

nursing evidence.

Benner's (2001) and Duchscher's (2008) theoretical works provide a foundation for understanding the transitioning nurses' experience during their first year of practice. The newly licensed RN, called transition to practice registered nurse (TTP-RN), may have the academic and clinical preparedness but they need the support of a preceptor who understands the TTP-RN's unique needs. Research has identified several benefits of TTP-RN programs. These include increased TTP-RN confidence, improved teamwork and interprofessional collaboration, decreased stress, increased job satisfaction, and improved retention (Blegen et al., 2015; Hopkins & Bromley, 2016; Letoumeau & Fater, 2015; Ouellette & Blunt, 2015).

Purpose of Nurse Residency Program Pilot

The purpose of the nurse residency program pilot (NRPP) was to help facilitate TPP-RNs transition to practice at small rural hospital by developing relationships between preceptors and TTP-RNs. The NRPP provided a structure-customized orientation that included preceptor support for newly hired RNs as they started nursing practice. The NRPP was multifaceted, however the intent of the pilot was to take the hospital's current NHRN ninety-day orientation process and expand it into a structured TTP preceptor supported-experience. The education sessions in the structure orientation were developed to support the relationship development between the preceptors and NHRNs.

Significance of Nurse Residency Program Pilot

The long-term purpose of the NRPP was to increase the potential for the NHRN to establish a long-term relationship with the organization thereby reducing NHRN turnover rates. The focus on decreasing NHRN turnover at MCHC demonstrated a macro-systems level approach. NHRN turnover rate represented a significant loss of revenue as compared to the

overall healthcare system. As the focus on decreasing NHRN turnover drilled down to the individual nurses affected by the NRPP, this demonstrated a micro-systems level approach. The individual NHRN progress as well as the effectiveness of their preceptors was collected, and this data became the foundation of the intervention at the micro-systems level.

Problem Statement

The hospital is a rural facility in northern Michigan; the average daily census of 32 patients. This census has been slowly dropping over the last several years. Reviewing the operational and economic outcomes, one can see that the facility is suffering from serious economic downturns (Workforce Prescriptions {WRx}, 2017). The administrative leadership at the hospital identified a major problem in the organization regarding RN turnover rates. The Chief Nursing Officer and the Staff Nurse Educator emphasized the necessity to reduce RN turnover within the facility (personal communication, S. Hall, 2017). Requests were made for specific data regarding turnover at the hospital; however, this data was not made available.

Hiring of TTP-RNs is estimated to amount to 10-15% of hospitals' new hires. Failure to retain TTP-RNs cost hospitals approximately 125% of the TTP-RNs annual salary (Hansen, 2014). The Robert Wood Foundation (2014) reports an estimate of 17.5% of TTP-RNs leave their first job within one year and 33.5% within two years. Transition to practice register nurse turnover is costly and supports the need of TTP-RNs residency programs. Ultimately the cost of that turnover contributes to the rising costs of healthcare and impacts patient outcomes.

The administration's goal at the hospital was to reduce the nurse turnover rate. During collaborative discussions, the leadership at the hospital indicated the newly licensed RNs frequently hired into the facility with a goal of attaining one-year experience; frequently the newly hired RNs left within two years. Failure to address the unique needs of TTP-RNs resulted

in the hospital becoming a training ground for TTP-RNs. When the TTP-RNs gained experience, they moved to other facilities within a 50-mile radius. The high NHRN turnover rate had affected the nursing department's budget. The administration desired to become the healthcare employer of choice for nurses. To accomplish this, it would require several steps. One of the first steps was to develop an orientation process for TTP-RNs that differed from the standard new hire orientation process (personal communication S. Hall, 2017). At the request of the facility administration to improve TTP-RN retention, Jacksonville University DNP candidates (Lori Dewey and Barbara Barnes) collaborated with hospital personnel to create a TTP-RN customized residency program. Because the relationships between preceptors and NHRNs showed to be an important component that impacts retention, the NRPP was modeled after other established NRPs that have shown to support the development of relationships between preceptors and NHRNs.

Theoretical Framework

Adapted from the Institute of Healthcare Improvement (IHI), (2017), the framework of SBAR (situation, background, assessment, and recommendation) was used as a guide for the literature review for the development of the NRPP. This framework guided the literature review, the research question and the development of the training modules. Many theories were reviewed to ensure evidence-based research is used for the NRP pilot. These theories include Expert to Novice, The Theory of Transitions, Transition to Practice Theory, The Theory of Transition Shock, Constructivism Learning Theory, and Learner-Centered Theory.

Project Objectives

- Develop a structured NRPP for NHRNs at the hospital
- Provide interactive training sessions delivered to both NHRNs and preceptors

simultaneously that focus the discussion the unique struggles and learning needs of the NHRNs first four months of transitioning to a professional nurse.

- Develop relationships between the NHRNs and preceptors via the NRPP.
- Integrate NHRNs into the hospital's culture effectively
- Long Term: Improve job retention of NHRNs

Definitions of Terms

Transition to Practice Registered Nurse (TTP-RN). A graduate from an associate, diploma, or baccalaureate-nursing program who has taken or is scheduled to take the National Council Licensure Examination (NCLEX). The TTP-RN has not had previous employment as a licensed RN and is transitioning to the role of professional licensed nurse.

Newly Hired Registered Nurse (NHRN). In this project NHRN was defined as the TTP-RN who had been hired for and participated in the NRPP held at the hospital.

Preceptor. In the NRPP, the preceptor was an RN who engaged in supporting and orienting NHRNs to the hospital's nursing units. These preceptors were chosen for clinical, communication, and psychosocial skill sets, as well as a willingness to assist the NHRNs' integration into the culture. The preceptors were instrumental in facilitating the successful NHRNs transition to practice during the NRPP. It is important to understand the difference between a preceptor and mentor; according to Twibil and St. Pierre (2012), it is the length of commitment to the NHRN. Mentors provide continued support for new RNs as they develop within their profession; these relationships may last for years. Preceptors provide support for a defined time, while the NHRN completes orientation.

Nurse Residency Program (NRP). A structured orientation program designed specifically for newly graduated/licensed RNs. The primary goal of NRPs is to assist in the

transition to the role of professional nurse to improve retention during the first year of practice. Nurse residency programs vary in length, structure, content, and are currently not required or regulated by the federal and most state legislatures.

Nurse Residency Program Pilot (NRPP). For this project, NRPP was defined as a NRP developed by Jacksonville University DNP students. The NRPP was implemented at MCHC. The NRPP education sessions were modeled after the National Council of State Boards of Nursing's (NCSBN) transition to practice five comprehensive training modules for TTP-RNs (NCSBN, 2013). Criteria for inclusion in the NRPP was TTP-RNs hired by MCHC who began orientation at MCHC on July 17, 2017.

Novice to Expert. This nursing theory was developed and introduced by Patricia Benner RN, PhD, FAAN in 1982. Dr. Benner's work explains the transition through five levels of nursing experience. These levels include novice, advanced beginner, competent, proficient and expert. As a nurse moves through these levels of nursing experience, the nurse gains knowledge and skills and relies on past experiences to guide future actions. As this occurs the RN develops clinical expertise and, over time, becomes the expert. The length of time to become an expert is variable, but normally takes over three years (Petiprin, 2016). According to Benner's theory, the TTP-RN enters the workforce as an advanced beginner.

The Theory of Transitions. Afaf L. Meleis PhD, FAAN first published her work, the Theory of Transitions in 1985. This theory helps to predict individuals' responses during times of transition. The individual's ability to transition to a new role is determined by the ability to master new behaviors, sentiments, cues, and symbols associated with the role. Four major concepts of the Theory of Transitions include: nature of transitions, transition conditions including facilitators and inhibitors, patterns of response, and nursing therapeutics. Transitions

are complex, multidimensional, and fluid. As individuals experience transition there is a change in role identity, relationships, and behaviors that impact and shape the daily lives and environments of individuals experiencing a transition (Smith & Liehr, 2014).

Transition to Practice Theory. Developed by Judy Boychuk Duchscher, RN, BScN, MN, PhD a Canadian nurse researcher. The theory provides information on the RN's transition to nursing practice during the first 12 months of practice. During this time NHRNs experience an evolution and transformation both personally and professionally. The transition is a non-linear complex process with the predictable three stages of doing, being, and knowing (Duchscher, 2008).

The Theory of Transition Shock. This theory developed by Judy Boychuk Duchscher, RN, BScN, MN, PhD provides a framework to understand the first four-month adjustment process the TTP-RN experiences. This adjustment is non-linear, varies in length and intensity, and is developmental, intellectual, sociocultural, and physical. Transition shock varies in length and intensity. During the transition shock period the TTP-RN experiences intense emotions that include loss, doubt, confusion, and disorientation. These emotions can be debilitating emotionally and physically as the TTP-RN attempts to find stability (Duchscher, 2009).

Constructivism. A learning theory that surmises learning to be an active process where new knowledge is constructed and built upon from previous knowledge and experiences. To construct new knowledge, learners should reflect on previous experiences, ask questions, and apply the knowledge to create additional knowledge (Li, 2017).

Learner-Centered Teaching. This style of instruction falls under the learning theory constructivism. The focus of instruction is shifted from the instructor to the individual who is seeking the knowledge (Felder, 2017). Participants/students participate in many activities such as

case studies, role play, projects, problem solving, debates, self-reflection, debriefing, and presentations that facilitate critical thinking, communication, and application of the information to develop lasting knowledge and relationships.

Review of Literature

To guide the development of the NRPP, a clinical question was developed. "What components of a NRP are essential to improve the orientation of TTP-RNs?" This question was used to guide the following literature review. From the review of literature, the following research question was developed to evaluate the effectiveness of the implementation of a NRP. "Is participation in a structured NRP an effective method to develop relationships between the preceptors and TTP-RNs?"

Nurse Residency Programs

A review of the evidence was conducted to discover best practices used in residency programs. The databases searched were AB/INFORM collection, OVID, MEDLINE, CINAHL, and ProQuest. The literature search criteria included the following terms: nurse residency programs, preceptor role, preceptor support, newly hired registered nurses, newly licensed registered nurses, transition to practice, rural nurse residency programs, and NHRN acculturation. The search was limited to US studies and investigations identified through electronic search engines and databases. Citations and reference lists for research studies about NRP and preceptor support were reviewed to identify additional research that fit evaluation criteria. The topic nurse residency was narrowed to peer reviewed, full text articles published between the years 2009-2017 and sorted by relevance. The NCSBN and American Association of Collegiate Nursing (AACN) organization websites provided links to research studies conducted on NRPs associated with their programs. Research results from studies conducted on

NCSBN and Vizient/AACN residency programs were reviewed because of the large number of participants. The size of the study supported the validity and reliability of the data obtained from the research. If a research study spoke of the importance of the relationship between preceptors and TTP-RNs, it was included. Studies that discussed the transition to practice of advance practice nurses or other healthcare professionals were excluded.

Orientation programs for nurses have taken on new and innovative forms, recently, because of the Institute of Medicine's (IOM) report on the "Future of Nursing" (IOM, 2011); this report stresses the implementation of NRPs. The Joint Commission (2013) provides hospitals with minimal competency standards to meet during orientation, but NRPs have goals beyond ensuring competency. These goals include developing NRPs for the TTP-RN that can improve commitment to the organization, job satisfaction, and retention.

Two prominent NRPs that have yielded several research studies are the National Council of State Board of Nursing transition to practice project and the Vizient/AACN NRP. The NCSBN project developed five comprehensive training modules for TTP-RNs and one preceptor training module. These evidence-based practice modules can be followed and/or purchased and completed online. Quality and Safety Education for Nurses (QSEN) competencies serve as the structure (NCSBN, 2013). This project has been implemented in 105 hospitals in three different states (Spector et al. 2015).

The AACN has partnered with Vizient, an organizational management system, to provide a comprehensive NRP. This program is available for purchase by the organization desiring to implement a NRP. For thousands of dollars per year, Vizient/AACN staff help establish the NRP at the facility. Included in the purchase are things such as online training modules, face-to-face debriefing sessions, and preceptor and administrative support. Vizient/AACN's commitment to

provide support extends for one year. This program utilizes the structure of the AACN Essentials of Baccalaureate Education for Professional Nursing Practice (AACN, 2017). The Vizient/AACN residency program has been adopted by over 200 hospitals and is the state model for NRPs in Hawaii and Maryland (Vizient, 2016).

Since the turn of the century, the AACN has been in a long-standing relationship with the University of Health Consortium (UHC). The number of participants in this NRP has grown nationally; the UHC/AACN NRP has produced numerous positive outcomes over the ten-year longitudinal study from 2002-2012. However, like the AACN arrangement with Vivient, the UHC/AACN program must be purchased by the organizations for thousands of dollars and the training and evaluation is specifically managed in the facility by the UHC/AACN team (Goode, Lynn, McElroy, Bednash, & Murray, 2013).

These programs have proven effective, but there is an associated implementation cost for use of their resources. With limited resources, adoption of these programs may be prohibitive for smaller hospitals. Instead, smaller hospitals can use the nursing knowledge generated through the research studies conducted on these programs. The best practices can be incorporated into customized hospital TTP-RN residency programs to improve the orientation process.

Lin, Viscardi, and HcHugh (2014) completed a systematic review of 11 research studies conducted on NRPs' impact on job satisfaction. The study criterion for inclusion in the review were qualitative and/or quantitative, conducted in United States hospitals, had clearly defined interventions, and included the sample size. Seven of the studies were from the University Health System Consortium that uses the Vizient/AACN residency program. This program uses a curriculum based on Brenner's Novice to Expert Theory. The common theme in the findings from the systematic review was the need for qualified preceptors, the development of

relationships that created feelings of belonging in TTP-RNs and developing confidence in communication with other professionals. These three things, when accomplished in a NRP, positively impacted job satisfaction, decreased TTP-RN stress, and improve retention. This systematic review did not report findings on retention. The systematic review had a high percentage of studies from the Vizient/AACN residency program. Small rural hospital NRPs should be aware that their size and resources might limit their ability to replicate these studies' results.

The purpose of Letoumeau and Fater's (2015) integrated literature review was to determine the current state of NRPs after the "Future of Nursing" (IOM, 2011). report made its recommendations. The review included 25 articles and identified that most studies focus on retention, competency and performance. Five studies used the Casey-Fink Graduate Experience Survey and found that NRPs resulted in increased TTP-RN confidence. Other findings from the studies included increase job satisfaction, less turnover, and the cost of a NRP was a beneficial investment in the future of the organization. One very interesting finding was that no studies evaluated the impact of NRPs on patient outcomes. Perhaps this is because patient outcomes are impacted by a variety of factors and to attribute a change in patient outcomes to a NRP requires more extensive research.

Hopkins and Bromley (2016) conducted a cross sectional survey that asked nurse leaders and staff nurses to determine if participation in a NRP resulted in improved satisfaction of TTP-RNs interprofessional collaboration performance. It compared nurse leaders and staff nurses scores to the national benchmarks using the 2007 Nursing Practice Readiness Tool. The midwestern academic medical center was a member of the UHC/AACN residency program until 2013. Financial reasons required it to withdraw its membership and develop a customized

residency program. The study results were significant. Nurse managers and experienced nurses rated TTP-RNs who participated in a nurse residency 15 to 18% higher than the national average on their ability to communicate and be part of the team. This article did not discuss the contents or length of the TTP-RN program; it only evaluated its perceived impact on teamwork and collaboration.

Hatler et al. (2011) provided information on a TTP-RN program that had 30 participants. This program focused on providing additional training to preceptors on a dedicated TTP-RN unit. Preceptors were interviewed and selected from experienced preceptors and uniquely identified with the term “clinical scholar”. In addition to the routine training, TTP-RNs preceptors received five additional training sessions that focused on adult learning styles, assessing learning needs of the TTP-RN, how to create a plan for professional development of the TTP-RN, how to give constructive feedback, and effective communication skills. This training occurred through an electronic learning platform. The orientation process for the TTP-RN included four simulations, one every two weeks, that increased in complexity. The preceptor guided the TTP-RN through each simulation, debriefing, and evaluation. Lasater's Clinical Judgment Rubric was used for TTP-RN self-assessment. Very little data was provided in the article. However, one of the most significant qualitative statements was that participants indicated the supportive environment of the dedicated unit made all the difference in their transition to practice. This statement is supported with 94% of participants being employed at the end of six months. It was estimated this retention resulted in a cost saving of $800,000 to the organization with an unanticipated benefit of a 2% increase in patient satisfaction with nursing care.

Another study provided insight into who makes a successful preceptor. Shinners and

Fanqueiro (2015) conducted a quantitative study with 838 participant responses from 30 different hospitals that participated in a yearlong residency program. From a 52-item survey, the researchers were able to ascertain the top five characteristics preceptors should possess. These characteristics include the ability to provide timely constructive feedback, to facilitate the learning process through instruction, support, and encouragement, to facilitate the integration into the unit's culture, to provide a safe venue for critical thinking, clinical judgment, and self-reflection, and to model professional attitudes and behaviors. Although many preceptors are chosen because of these characteristics there is the opportunity to facilitate development of preceptor skills through education.

Blegen et al. (2015) longitudinal, randomized, study was from the NCSBN nurse residency program. The researchers selected 82 hospitals with NRPs. They assigned the hospitals to either the control group or intervention group. The intervention group had TTP-RNs and preceptors complete the NCSBN TTP-RN and preceptor training modules. The preceptor and TTP-RN were required to meet at least weekly. The control groups continued their current orientation and TTP-RN program practices. At the end of six months the Preceptor Evaluation Survey and Preceptor Self-evaluation tool was administered to both groups. The results revealed no statistical significance between the intervention and control groups. As a result, the researchers, based upon the answers obtained from the surveys, divided the hospitals into high preceptor support and low preceptor support groups. The results then revealed a higher number of intervention hospitals in the high preceptor support group. In the high preceptor support group, TTP-RN retention was 86% versus 80% in the low preceptor support group. A very important finding, therefore, was the preceptor supportive relationships with the TTP-RNs, not the NCSBN training modules, impacted retention.

Kim, Lee, Eudey, Lounsbury, and Wede (2015) research was obtained from a 12-15-week residency program funded by California to provide additional integrated didactic and clinical experience for TPP-RNs. At completion of the nurse residency, data was collected from TTP-RNs to examine perceived clinical competence, confidence, and professional role development. After the program, TTP-RNs assessed themselves as being more competent because of the program. From this survey the following results demonstrate the importance of the preceptor relationship: 95% believed it was important to develop a positive relationship with staff, 94% believed it was important to develop a positive relationship with the preceptor, and 91% believed it was important that the preceptor provide TTP-RNs regular evaluation and feedback on strengths and weaknesses.

Condrey's (2015) quality improvement project was implemented to increase retention of TTP-RNs. The project was a formalized training for preceptors who would orient TTP-RNs. The training consisted of completion of online modules where continuing education units were granted upon completion. The content included the role of a preceptor, adult learning styles, information including on transition to practice and reality shock, and how to provide constructive feedback. After completing the modules, there were two face-to-face meetings to reinforce the education. The program had a positive evaluation by the preceptors but there was no evaluation of the preceptors by the TTP-RNs or of the impact on retention. The authors concluded that if the preceptor education resulted in the retention of one additional TTP-RN it could result in a cost saving of approximately $85,000 to the hospital

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Ouellette and Blunt (2015) developed a quality improvement project with a goal of restructuring a current residency program using the team-based learning principles instead of the

traditional lecture. The researchers viewed NRPs as necessary for the preparation of TTP-RNs to provide competent safe care without extension in the duration of orientation. To meet this goal, the project focused on the education TTP-RNs received. They implemented training modules and interactive simulation. There was no formal data collection outlined in the article except managers and preceptors completed a survey on their perceptions of the TTP-RN preparedness. The results indicated TTP-RNs who participated in the program were more prepared for patient care and more collaborative than previous TTP-RNs. There was no data to review regarding TTP-RNs retention.

Dwyer and Revell (2016) conducted a literature review to determine what factors influence TTP-RNs' transition to practice. They reviewed 42 studies and synthesized the research into three categories, intrapersonal, interpersonal, and organizational influences on transition to practice. One of the findings from this literature review was that TTP-RNs felt empowered when in a job position of their choice and they experienced authentic leadership from administration and preceptors. This resulted in a commitment to the organization, increased job satisfaction and retention.

Bratt and Felzer (2012) study was included in Dwyer's and Revell's (2016) literature review and specifically determined what in residency programs impacted TTP-RNs commitment to the organization. Bratt and Felzer (2012) study included 468 TTP-RNs enrolled in the 12-month Wisconsin Nurse Residency Project between 2005-2008. The participants were in 16 cohorts, graduates of ADN programs, and working in urban hospitals on medical surgical units. With a one-year retention rate of 81%, the study results indicated that working in a desired position, participation in the NRP, and a supportive environment significantly predicted positive organizational commitment.

All TTP-RN programs reviewed had similar purposes. The primary purpose was to attract and retain TTP-RNs. Because of the unique needs of the TTP-RN, NRPs should become an organization's priority. This priority can be accomplished through educating preceptors, creating dedicated education units, and by integrating the TTP-RN into the culture of the facility. Several benefits of TTP-RN programs have been identified through the studies. These include improved teamwork and interprofessional collaboration, increased TTP-RN confidence, decreased stress, increased job satisfaction, and improved retention (Blegen et al. 2015; Hopkins & Bromley, 2016; Letoumeau & Fater, 2015; Ouellette & Blunt, 2015)

Some studies demonstrate it is not necessary to use the costly NCSBN modules or to partner with AACN to train preceptors or TTP-RNs (Blegen et al. 2015; Hatler et al., 2011). Several residency programs, such as the NCSBN residency program, provide a detailed outline with topics covered during their TTP-RN residency program (NCSBN, 2013). Many reviewed studies provide insight into the education topics in a NRP to facilitate the TTP-RN into the culture of the unit. These topics included education on the unique needs of the TTP-RN, communication, providing feedback, conflict management and how to provide a safe environment for TTP-RN professional growth (Condrey, 2015; Hatler et al., 2011; Shinners & Fanqueiro, 2015). This can be used to guide program development. Although TTP-RNs may need additional education on critical nursing skills, research does not support this type of education as being a determinant of success for TTP-RNs. Specific skill deficits can be addressed individually and do not need to be part of the formal TTP-RN program.

The article by Dwyer and Revell (2016) provided insight into additional considerations to improve TTP-RNs integration into the organization. When possible if a TTP-RN has a desire to work in a specific nursing area, it is beneficial to the organization to consider this for the TTP-

RN's job placement. This article supported the need to develop authentic leadership traits in administration, preceptors, and staff. Authentic leaders are role models of civility, respect, and create a supportive environment. This type of leadership creates within the organization opportunities to empower the TTP-RN. It provides access to information and opportunities for continued professional growth. When this is present in the work environment, job satisfaction improves, and the TTP-RN commits to the organization.

Cochran (2017) conducted a literature review of journal articles written between 2011 and 2014 to determine if TTP-RN NRPs improved retention and what were the best practices used in TTP-RN programs. From the literature review, Cochran was able to conclude that NRPs do improve retention. For the best results these programs should be 12 months long and structured. The best practices include a primary focus on the TTP-RN and preceptor relationship to assist and support TTP-RNs during their role transition to professional nurse. Incivility, feeling devalued and unsupported, as well as the inability to effectively deal with conflict and stress were all contributors to the high turnover of TTP-RNs during the first year (AL-Dossary et al, 2014; Booth, 2011; D'Ambra & Andrews, 2014; Spiva et al., 2013 as cited in Cochran, 2017). Along with these topics, situations TTP-RNs will encounter during their first year of practice should be discussed during the NRP. These topics include "delegation, prioritization, conflict resolution, communication skills, leadership, critical thinking skills, and professional socialization"(Cochran, 2017, p.57).

Most of the articles reviewed have TTP-RN residency programs that were one year in length. This may be a result of the size of the studies and the healthcare systems involved. A yearlong TTP-RN program is economically not feasible for many small hospitals. Hatler et al. (2011) discussed an effective TTP-RN program that was four months with continued support for

one year. Creating a TTP-RN program that allows the development of supportive relationships between the TTP-RN and preceptor is a common theme throughout the literature. These relationships should be a priority when developing a TTP-RN residency program. A four-month TTP-RN program at small hospitals only requires modifications of their current orientation preceptor programs. These programs can be developed to include specific education and support for both preceptors and TTP-RNs. This small change has the potential to improve retention by the development of relationships between preceptors and TTP-RNs.

Transition to Practice

The Theory of Transitions developed by Afaf L. Meleis PhD, FAAN helps to predict individuals' responses during times of transition. Dr. Meleis theorizes that the individual's ability to transition to a new role is determined by his/her ability to master new behaviors, sentiments, cues, and symbols associated with the role. Four major concepts of the Theory of Transitions include: nature of transitions, transition conditions including facilitators and inhibitors, patterns of response, and nursing therapeutics. Transitions are complex, multidimensional, and fluid. As individuals experience transition, there is a change in role identity, relationships, and behaviors that impact and shape the daily lives and environments of individuals experiencing a transition. When experiencing a transition, individuals are considered vulnerable and as a result may experience health and psychosocial issues (Smith & Liehr, 2014).

Transition to practice RNs are experiencing a role change. They are transitioning from the role of student where they have had the protection and guidance of didactic and clinical faculty. As students they have had constructive, timely, ongoing feedback. Guidance in decision-making and affirmation of achievement through grades and NCLEX success has served as

encouragement and motivation to accomplish the goal of becoming a nurse. The defined nursing therapeutics of the Theory of Transitions requires a comprehensive, multidisciplinary approach to assessing readiness for transition (Smith & Liehr, 2014). Successful transition of new nursing graduates requires intentional education to produce the best transition outcomes. Discussion on the transition to practice in nursing education, if provided, may be limited to a brief lecture. The information at the time has little impact and may be forgotten. During a NRP, TTP-RNs and their preceptors should be allowed time to explore what physical and psychosocial changes TTP-RNs may experience as they transition from students to nurses (Duchscher, 2008).

Duchscher (2008), a respected Canadian nurse researcher on the transition to practice and developer of the Transition to Practice Theory for nursing graduates, explains that the transition to practice is not a linear process. The new graduate during the first 12 months of practice will experience an evolution and transformation both personally and professionally. This is a complex process but based upon her research there is predictability that the new nurse will progress through many stages. These stages are doing, being, and knowing.

In Duchscher's (2008) research study, she uses the behaviors of learning, performing, concealing, adjusting, and accommodating to explain what is occurring during the first three months of practice for new RNs. Dr. Duchscher calls this the doing stage. During this time, the new graduate begins with feelings of excitement that quickly change to feelings of unpreparedness. This can be a result of workload, a conflict between the TTP-RN's and realistic expectations, professional responsibilities, lack of support, and the multiple changes occurring simultaneously in the TTP-RN's personal life. Failure to provide a formalized mentoring process results in the TTP-RN not having someone to provide practice support and not knowing whom to trust with questions, concerns, and feelings of inadequacy and uncertainty. Without this support

the TTP-RN experiences heightened anxiety, doubt, stress, and even though they entered practice as an advanced beginner the TTP-RN begin to lose confidence in their abilities and are at risk for losing credibility with their colleagues. The preceptor can put things into perspective to assist the TTP-RN in the process of identifying unrealistic self-expectations.

Dr. Duchscher (2008) explains that along with what is occurring professionally, TTP-RNs experience many changes in their personal lives. They may have to begin repaying school debt and begin to accumulate more debt as they make major purchases that have been put on hold for the last four years. They experience relationship changes. College friendships may or may not continue. Reestablishing of old relationships that have been put on hold or diminished while completing four years of nursing education can be challenging as these relationships have not evolved but instead have been stagnant.

In Duchscher's (2008) theory, stage 2 begins month four and can last until month nine. The being stage is a time of recovery from what they were experiencing during the first three months. It requires the new graduate to experience the behaviors of searching, examining, doubting, questioning, and revealing. The excitement of being a new nurse has diminished and the culture shock has passed. The TTP-RN continues to experience feelings of inadequacy, incompetency, exhaustion and powerlessness and will have times of questioning their decisions to become a nurse. During these times of searching, examining, doubting, and questioning, the TTP-RN self-reveals the answers that continue to increase comfort in the nursing role. The amount of time spent on each tends to be individualized to each TTP-RN's timetable. During this time the TTP-RN may withdraw from work and refuse overtime. There is a desire for familiarity, stability and predictability at work. The TTP-RN begins to take work home less than before and does not require as much personal time to debrief from work. It is not until around the ninth

month that the TTP-RN begins to think about long-term goals, new challenges and becomes rejuvenated.

Duchscher's (2008) final transition stage is knowing. The TTP-RN continues the process of recovering. Ideally during this time, the TTP-RN can begin to relax and enjoy what has been accomplished. The TTP-RN has accepted the separation of college relationships and has transferred the need for supportive relationships to coworkers. It is during this time managers and mentors should assist TTP-RNs in outlining two and five-year goals that encourage professional growth. By the 12th month, most have achieved stability and are comfortable and confident in the nursing role. The TTP-RNs reflect on where they have been and where they are today. They can contribute to the education of nursing students and new nurses. The TTP-RNs continue to experience stress, but the contributing factors shift to the frustration of dealing with the institution or healthcare system.

Since all TTP-RNs walk through the Transition to Practice Theory stages, it is prudent to put in place processes to support the transition. These processes should be fluid to meet the specific needs of individual TTP-RNs. It appears to be time sensitive, and the failure to provide intentional support through TTP-RN programs may impact retention. Support and encouragement of the TTP-RN's personal life and activities will also encourage commitment to the organization.

From ten years of research, four qualitative studies, and review of over 100 articles, Duchscher (2009) developed the Theory of Transition Shock. This theory provides a framework to understand the adjustment process the TTP-RN experiences. The adjustment process is developmental, intellectual, sociocultural, and physical. Transition shock is not linear, and the length and intensity vary. The goal of NRPs is to minimize the impact and length of this period

of transition.

According to Duchscher (2009), during the transition shock period the TTP-RN experiences loss, doubt, confusion, and disorientation. The TTP-RN experiences intense emotions that can be debilitating emotionally and physically resulting in exhaustion as there is an attempt to stabilize emotions. Even when sleeping, the TTP-RN dreams about work. The TTP-RN's primary fears are incompetency, causing harm to a patient or self, and not being able to transition to the role of professional nurse. It is during this time when TTP-RNs need support and trust from preceptors who will assist them in re-establishing trust in themselves. Preceptors are essential to assisting TTP-RNs integration into the culture of the facility and unit.

Preceptors

The TTP-RNs require support during clinical transition from student to practicing nurse. This support can be provided in NRP. When the NRP offers NHRNs the support of well-trained, facility-supported preceptors, it has been shown to significantly improve NHRN outcomes (Blegen et al, 2015; Bott, Mohide, & Lawlor, 2011; Cochran, 2017; Craven & Broyles, 1998; Hickerson, Terharr & Taylor, 2016; Honour, 2016). The literature describes creating a culture of belonging as one important strategy to improve job satisfaction and longevity, success, and skill competency (Lewis-Hunstiger, 2013). Therefore, the preceptor must be trained to intentionally develop a sense of belonging with the NHRN. Research has concluded that preceptors should be skilled in their role, further they should be prepared for the responsibilities of guiding, evaluating and acculturating new nurses in their role (Sherwood & Barnsteiner, 2012).

Moving beyond the importance of the NRP, there are important factors that can make a significant difference in the outcomes of NRP. One of these factors is the facility support of the preceptors that work directly with the NHRN. Because the preceptor is the individual that is

facilitating the transition, it is the preceptor that should receive global support (Horton, DePaoli, Hertach, & Bower, 2012; NCSBN, 2013; Sharpnack, Moon, Waite, 2014; Spector et al., 2015; Welding, 2011). The facility's support towards the preceptor's role is manifested in simple things, such as encouraging the preceptor in their role and allowing the preceptor release-time to work with and properly evaluate the NHRN. More global support for the preceptor can be achieved through conscientious staffing decisions such as reducing the preceptor's case load and scheduling the NHRNs on the same shift with the same patient assignment (Blegen et al, 2015). When facility leadership, staff, and others effectively support preceptors, a culture of belonging is promoted that leads to a successful transition of NHRNs.

It is the development of supportive relationships between preceptors and TTP-RNs that is key to improving job satisfaction and ultimately decreasing TTP-RN turnover. These relationships are key to facilitate TTP-RNs into the culture of the unit and organization. Financial resources should be directed toward the selection and training of preceptors with characteristics that TTP-RNs have identified as key to successful integration into the unit's culture. Therefore, to produce the best outcomes overall, the NRP should incorporate the support of a well-trained, facility-supported preceptor. (Bott, Mohide, & Lawlor, 2011; Cochran, 2017; Hickerson, Terharr & Taylor, 2016; Honour, 2016; Craven & Broyles, 1998).

Education Strategies

There are many studies that support the notion that active learning improves students' retention of facts and information (Masolo, 2009; Masolo, & Fisher, 2015). Action should be incorporated into learning to facilitate the experience and improve acquisition of the skill. "Self-scaffolding" a term coined by Bickhard (1992) occurs when the learner creates his own conditions for supporting higher-level functioning. "Self-scaffolding occurs in the context of

problem solving; for example, when a person uses an already known way of solving a problem to solve a similar but novel problem" (Greiner & Knebel, 2003, p.128)

Duchscher (2009) indicates formal education sessions during NRP should use "creative, interactive ways to accommodate various learning styles..." and that each session should involve practice with role-play. Active learning using "contextually based scenarios" that engage the novice/beginner RN and relate to the "stages of transition and the experience of transition shock" facilitates the NHRN's transition to practice more effectively (Duchscher, 2009, p. 1110). Further, research indicates that cooperative learning promotes active learning that intentionally "…organizes student activity around a pedagogically meaningful task in which students must cooperate for task success" (Fero, Witsberger, Wesmiller, Zullo, & Hoffman, 2009, p.17).

Constructivism is considered one of the most important processes for successful learner centered learning, deeper critical thinking, and more advanced creative problem-solving capabilities (Li, 2012). The overlapping image of curriculum, psychological and assessment theories (Li, 2009) shows the structure of constructivism and the resultant process of assessment. This type of learning features the peer evaluation as well as the ongoing self-evaluation of the student's own progress.

Debriefing is another form of active learning that focuses on the learner. Bringing the activity to a conclusion in a debriefing session helps to contribute to the students' learning. Debriefing promotes the development of best teaching practices (Dreifuerst, 2012). Numerous articles and studies have been written about debriefing after simulation. In contrast, there are few studies conducted on debriefing activities, assignments or other avenues besides simulation.

As the facilitators, the instructors must understand the concepts of learner-centered teaching and constructivism learning in preparation of the learning modules. The tenets of both

teaching/learning theories are "... intentional structures are often difficult to create and maintain, and thus require a degree of flexibility and innovation on the part of the instructor" (Fero, et al., 2009, p.18). Therefore, instructors intentionally construct the learning environment and activities to build upon these tenets.

Summary of Findings

Retention is directly related to job satisfaction which in turn may be directly related to the effective acculturation of employees. Research has determined that NRPs are effective in reducing turnover rates. However, the research stresses the importance of a structured residency program that addresses and supports the needs of the TTP-RN. The TTP-RN unique learning needs are defined by the concepts of transitions theories. Evidence based research modules from notable nursing organizations provide excellent guidelines from which nursing leaders can build facility specific NRPs.

Further, research has concluded that preceptors are key in the role of guiding, evaluating and acculturating NHRNs during orientation and transition to practice. The relationships developed during NRPs are essential and can impact transition. Experiencing positive relationships and a sense of belonging to the organization are important facilitators to new graduate nurses' transition success. When preceptor support from the facility leadership and unit staff is evident during the NRP, it has been shown to significantly improve NHRN outcomes.

Project Design

The development of the TTP-RN residency program required collaboration with the hospital's nurse educator and human resource manager. Input from these individuals helped guide the project goals, timeframe, schedule, and information and education provided to the nurse executive council, nurse managers, unit staff, participating preceptors, and TTP-RNs.

Implementation, success, and sustainability of the TTP-RN residency program is dependent upon the organization's support.

The new hire RN orientation at the hospital consisted of a one-week orientation to policies, procedures, and the electronic medical record (EMR). A preceptor was assigned to the new RN for unit orientation for three months. There were no supportive education sessions for preceptors or the new hires during this time. The NRPP expanded the orientation process to a 12-week orientation with specifically designed education/support sessions to assist TTP-RNs to develop relationships with preceptors. The NHRN spent four weeks on the acute care floor, three weeks on the critical care floor, two weeks in the emergency room, two weeks on the maternal child unit, and one to two weeks on the post-anesthesia care unit or operating room. Orienting to these areas allowed the NHRNs to have a basic understanding how these units work collaboratively in the hospital. In the future, these experiences may assist NHRNs to determine which unit they want to work on when a position becomes available.

The recommendations for best practice of NRP implementation include ongoing education sessions (Bratt, 2013). During the 12 weeks, NHRNs and their preceptors engaged together in four monthly learning sessions. These monthly education sessions emphasized the importance of many pertinent topics. The session topics choices were guided by the NCSBN Modules available online in an overview format (NCSBN, 2013). Topics that addressed the preceptor role, the NHRN unique needs, how to give/receive effective feedback/evaluation, goal planning, stress management and conflict resolution, were presented in the sessions. During the education sessions the facilitators utilized evidence-based teaching practices such as constructivism, learner-centered learning, debriefing, role play and active learning (Li, 2012; Masolo, 2009; Masolo & Fisher, 2015).

Attendance of the nurse educator at NRPP education sessions helped to prepare leadership to duplicate and continue with the NRPP beyond the DNP project requirements. Formative evaluations of the NRPP occurred in the form of a survey at the completion of each education session. At the completion of the final education session, preceptors and NHRNs filled out the Preceptor Evaluation Tool and debriefed with NRPP facilitators. The outcomes were presented to hospital nurse managers and made available to guide future TTP-RN onboarding policies and processes.

Goal of the Project

The goal of this DNP NRPP was to facilitate the development of the relationships between preceptors and TTP-RNs at the hospital. The goal of these relationships was to facilitate the integration of TTP-RNs into the hospital's culture. Relationships have been found to be an important component to retention. These relationships were evaluated using the Preceptor Evaluation Tool at the final education session. The long-term goal is to improve NHRN retention. Although it was not part of this project, due to time constraints, at one year the long-term goal of the NRPP would demonstrate an increase in retention of the participants.

Setting

The setting for the NRPP was a small rural hospital in Northern Michigan. This facility was recently purchased, February 2015, and became part of larger Healthcare system. The hospital is a non-profit private facility with 97 acute care bed capacity, 67 physician providers, and provides acute, critical, emergency, routine surgical, and obstetric services to people in seven counties (Munson Healthcare Cadillac Hospital, 2017). Requests for the number of nursing staff was made but the information was not made available.

Population

Participants in the NRPP included three TTP-RNs hired by the hospital that began orientation on July 17, 2017. The anticipated number of participants was six, however this did not occur. Instead, administration chose to recruit only three TTP-RNs for the NRPP. The TTP-RNs recruited were recent BSN graduated students from the same college and cohort. They had successfully completed the NCLEX prior to or during the first month of orientation. Only one of the TTP-RNs had a previous clinical education experience at the hospital. All three TTP-RNs completed the final evaluation using the Preceptor Evaluation Tool.

The nurse educator selected five nurses, one from the emergency room, two from the critical care unit and two from the acute care unit to participate in the program and serve as preceptors for the NHRNs. These preceptors had already completed the standardized preceptor orientation for the hospital. The administration determined that the preceptors were to receive additional $1.00 per hour compensation when precepting. The preceptors were to attend the four education sessions. The TTP-RNs were to be assigned to the preceptors' units and scheduled with the preceptors who attended the NRPP education sessions. Preceptors did not rotate with the NHRNs during the NRPP. When the NHRN was scheduled to orientate to the preceptors' units, the intention was that the NHRNs and NRPP preceptors would be assigned together. However, this did not consistently occur. The education sessions allowed all the NHRNs and preceptors who attended the education sessions to begin developing relationships that continued during the unit's orientation. These relationships decreased the TTP-RNs' stress of orientation and facilitated integration into the unit's culture. Statistically, one preceptor did not participate; one preceptor attended one session; one preceptor attended two sessions; two preceptors attended three sessions. However, none of the preceptors were able to attend all four of the education

sessions. At the end of the pilot, only three preceptors completed the evaluation of the program using the Preceptor Evaluation Tool.

Timeline

- May – June 2017 – This was completed by the hospital and was pre-proposal
    - Recruitment of TTP-RNs - Completed by hospital administration
        - Receive a sign on bonus and bonus upon completion of the NRPP
        - Benefits begin on the start date
        - Hired to work acute care for one year
        - Will be on probation for 90 days (standard hospital policy)
    - Recruitment of preceptors for the NRPP – Completed by nurse educator
    - Hospital schedulers provided dates and times for NRPP to ensure preceptors were scheduled for the education sessions - Completed by nurse educator and human resource representative
- June-July 2017 – Jacksonville Institution Review Board Approval
- July 17, 2017 NRPP began.
    - Routine orientation to hospital policies and computer training for TTP-RNs - Conducted by nurse educator and human resources
- July 20, 2017 – DNP students began implementing NRPP education modules
    - Education Session #1 – Conducted by DNP students
        - Held at Private Non-profit College
        - Time: 12:00 – 4:00pm
        - Lunch provided
        - Nurse educator, human resource representative, three NHRNs, and three

preceptors attended

- Module 1 (*Appendix A)*

- August 18, 2017
  - Education Session #2 – Conducted by DNP students
    - Held at hospital
    - Time: 1:00 – 4:00pm
    - Light snacks provided
    - Nurse educator, three NHRNs, and three preceptors attended
  - Module 2 (*Appendix B)*
- September 22, 2017
  - Education Session #3 – Conducted by DNP students
    - Held at hospital
    - Time: 1:00 – 4:00pm
    - Light snacks provided
    - Nurse educator, three NHRNs, and three preceptors attended
  - Module 3 (*Appendix C)*
- October 20, 2017
  - Education Session #4 and Celebration of completion of 12-week orientation
    - Conducted by DNP students
    - Held at hospital
    - Time: 1:00-4:00pm
    - Lunch and cake provided
    - Nurse managers, nurse educator, human resource representative, NHRNs,

and one preceptor attended

- Module 4 (*Appendix D)*

Four of the five selected preceptors for NRPP had participated in at least one education session. During the NRPP, NHRNs rotated to each unit and orientated with the NRPP preceptors when available. At times in the acute care and critical care units, NHRNs were not consistently paired with NRPP preceptors. There were no NRPP preceptors designated in the surgical and obstetric rotations. After the fourth module, the three NHRNs were assigned to their permanent units and completed the additional orientation required for these units. Depending on the permanent unit and shift, the assigned unit-specific preceptor may not have been an NRPP participant. Even if assigned a new preceptor, the NRPP preceptors committed to providing continued support as needed because of the relationships that had developed. Two NHRNs started on the critical care unit and one on the acute care unit. This orientation continued until the nurse educator, unit manager, assigned unit preceptor, and NHRN determined it was completed. For up to 12 months, the nurse educator will provide additional support to the preceptor and NHRN as needed. After completion of the fourth module, the formal NRPP was considered completed.

Implementation

The hospital nursing leadership requested the development of a NRPP; however, as with any change, resistance can be expected. Unit managers were concerned about the length of time of the NRP and its immediate impact on staffing. To gain support for the NRPP from the unit managers, research and evidence on the benefits of a NRPP was provided to the nurse educator who presented the evidence and proposed NRPP format to the nurse managers. At this meeting nurse managers were given the opportunity to express concerns, present ideas, and assist in

developing the timeline for the NRPP. From this meeting, bonuses and benefits were suggested, determination of which nursing units to include in the four-month orientation, and an agreement was made to pilot the NRP. Preceptors and TTP-RNs schedules were to be synchronized with time scheduled to attend the education sessions. The DNP students developed the education sessions and implementation took place during July, August, September, and October 2017 in collaboration with hospital administration, nurse educator and human resource representative. Refer to the above timeline for NRPP details.

Fiscal Considerations

The majority of the NRPP cost was absorbed by the DNP students. The hospital committed to providing financial incentives to both NHRNs and preceptors who participated in the NRPP. Bonuses provided to the NHRNs and preceptors, NHRN benefits beginning the first day of employment, and the extra 16 hours of pay for the four education sessions were expenses the hospital agreed were important for the NRPP. The overall cost to the hospital for the NRPP including bonuses, additional $1.00 per hour for preceptors when precepting a NHRN, time for hours spent in education sessions, was not made available.

The actual total number of additional hours of pay for attendance for the NRPP education sessions was 39 hours for NHRNs and 30 hours for preceptors and did not result in overtime pay. The extra hours for preceptors would have been more if recruited preceptors had attended all four education sessions. Nurse managers were to budget more staff hours to cover the time that the preceptors were working with the NHRN and attending the education sessions; however, the NRPP attendance by preceptors and information obtained from the debriefing revealed this did not consistently occur. The reasons this did not occur were primarily related to inadequate staffing for patient care needs. In reflection, because it was a new program, not all managers

understood the importance of attendance at education sessions to develop relationships between preceptors and NHRNs.

Time and materials used for planning and developing of the education sessions was the responsibility of the DNP students. Baker College of Cadillac agreed to allow the first education session to take place on campus at no cost. Additional training took place at the hospital using their resources. The cost for the lunch provided during the first training session, snacks for the other two sessions, presentation materials, certificates of completion, and tokens of appreciation is estimated to be less than $500.00. The final session's lunch was provided by the hospital. Because of the timing, grant money was not available prior to implementation of the program. The Love of Learning grant from Phi Kappa Phi (2017) application was submitted July 2017. This grant offered a $500 professional development award that was to be used to present NRPP findings at the Michigan Nursing Summit in 2018. However, the grant was not awarded for this project and the DNP students incurred all costs of materials used in the NRPP education sessions.

The NRPP was designed in consideration of the limitations of a small hospital's budget. The cost of program continuation will be primarily the payment of training session hours for preceptors and NHRNs and any incentives provided by the hospital. Financial sustainability for this project will be established with decreasing RN turnover and rehiring orientation expenses. Cost should not be a deciding factor for the future implementation of the NRP by the hospital nurse educator.

Ethical Considerations

The project was presented to the Jacksonville University Doctoral Project Review Committee. Upon committee approval of the project, Jacksonville University Institution Review

Board (IRB) approval was requested and received. The hospital does not have an IRB. A letter was received from hospital indicating they would accept the IRB approval obtained from Jacksonville University.

The DNP students identified a few ethical concerns that needed to be acknowledged and appropriate measures put in place to protect the participants. The first was that all NHRN participants were graduates of the BSN program where the DNP students are faculty. This brought a preexisting relationship between the NHRNs and the DNP students that could have negatively or positively influenced the success of the NRPP. While in an academic environment there is a hierarchy established between students and faculty. It had the potential to impact the dynamics of the training. The hierarchy was addressed, and attempts were made to eliminate this during the first interactive session.

The second ethical concern was the NHRNs hired knew they would participate in the NRPP. The participants received a sign on bonus and another bonus on completion of the NRPP, received benefits the first day of hire, and signed a commitment for one year of employment at the hospital. These incentives are variables that had the potential to impact long-term retention and increase the commitment to the NRPP and organization. Although participation in the program was mandatory, completion of surveys at the end of the training sessions was optional. In addition, completion of the Preceptor Evaluation Tool and debriefing with DNP students at the final session was optional. Participants could participate in all or any part of the evaluation process of the NRPP. An informed consent was obtained from all participants who elected to participate in the evaluation of the NRPP.

One final concern was the sample size. This project had a small sample size, placing limits on the application of results to other NRPs. However, the program did not have a goal of

generating nursing knowledge that could be duplicated. Instead the program took current knowledge generated from large NRPs and modified it to create a cost effective NRPs for the hospital that hires less than 20 TTP-RNs a year.

Data Analysis Plan

In consultation with Ryan Butterfield, DrPh, Clinical Assistant Professor of Health Informatics at Jacksonville University (personal communication, May 2017), a data analysis plan was developed. Prior to any data collections all participants signed a voluntary informed consent. Participation in the NRPP was part of the terms of NHRNs' employment. However, participating in the data collection was voluntary. As the NRPP developed, there were various points of data collection. No demographic statistics were collected due to the size of the NRPP and concerns of the participants' anonymity.

Measurement Tools. The groups of individuals surveyed were NHRNs and preceptors. Data collection began after each education session. Using anonymous brief four-question paper surveys, constructive feedback on each education session was obtained. The data was tabulated and transcribed to an Excel spreadsheet. The qualitative information obtained from these surveys was used to guide future education sessions in the NRPP and will be used for future NRP orientations *(Appendix E).*

The Preceptor Evaluation Tool was administered by in the NCSBN's TTP residency program at six months (Blegen et al., 2015). Spector et al. (2015) created the Preceptor Evaluation Tool to evaluate the perception of the "preceptor experience" (p. 1). It was given to both the preceptor and the NHRN. This tool was created from the Moore's Preceptor Evaluation Survey and Roth and Johnson's Preceptor Self Evaluation tool. It is a 23-item survey divided into two sections, 18 questions under preceptor activities and five items under preceptor context.

An exploratory factor analysis of the two sections was completed and determined to be internally consistent and conceptually valid. “Reliability was acceptable with Cronbach’s alpha being .969 and .862” (Spector et al., 2015, p.1). Permission from the NCSBN was obtained for use of this evaluation tool.

The Spector et al. (2015) Preceptor Evaluation Tool uses a 5-point scale, where 1=disagree and 5=agree. In the NCSBN TTP-RN study, participant hospitals were divided into high preceptor support and low preceptor support groups for evaluation of the NHRNs and preceptor perceptions of the preceptor experience/relationship development. Higher scores were present in high preceptor and lower scores in low preceptor support hospitals. The 23 questions on the tool were divided into three categories, the preceptor activities, preceptor context scores, and the total of the two sections. Higher positive ratings by preceptors and NHRNs in high preceptor support hospitals in each category provided support for the validity of the tool.

After completion of the forth education session, the Preceptor Evaluation Tool was administered to determine if the NRPP results would be similar to the results from the NCSBN study’s high preceptor support hospitals. The results from the Preceptor Evaluation Tool would support the effectiveness of the NRPP in developing the preceptor and NHRN relationship. The Preceptor Evaluation Tool was administered electronically via Google survey to the three NHRNs and three preceptors at the end of the final education session. These three preceptors had attended at least two of the four education sessions. Two of these preceptors were absent from the final session but completed the survey within two weeks when contacted via email *(Appendix F)*.

Using a debriefing guide, qualitative data was solicited, audiotaped and transcribed after the final education session. This debriefing occurred between DNP students, one preceptor, and

three NHRNs who participated in the NRPP. Using similar questions developed for the post education surveys, the DNP students debriefed with participants about NRPP successes, challenges, and opportunities for future program improvement *(Appendix G).*

Statistical Analysis and Results. Upon the completion of the NRPP intervention, data was entered and analyzed using an Excel spreadsheet. Preceptor Evaluation Tool surveys were sorted in two categories, surveys completed by preceptors and surveys completed by NHRNs. Descriptive statistics were completed for NHRNs' and preceptors' results from the Preceptor Evaluation Tool. These were run on each section, questions 1-23, 1-18, 19-23. Means were determined for each question, each section, and completed survey. These means are displayed alongside the NCSBN study means for comparison. The absolute difference versus statistical significance between the means was identified due to the small number of participants in the pilot (*Appendix H)*

It was the goal to run independent T-tests, with an alpha adjustment of 0.1, and non-parametric testing using the using the Kruskal-Wallis H test to identify differences between the pilot means and the NCSBN study means. Unfortunately, to run these tests the standard deviation of the NCSBN means was required. This information was solicited from the primary author of the paper via email with no response.

Although the sample size was too small, two sample *t*-tests were conducted to compare the means for the perception of the development of the relationships from the NRPP preceptors and the NHRNs for each section. The variances for each section were found to be different. In each section the observed means were similar between the two participant groups and it was not expected to demonstrate any statistical difference. The results of the *t*-tests assuming unequal variance were reported (*Appendix H, Tables 13, 14, 15*) with a significance level of 0.1. The p-

value for the *t*—tests (0.8090 for questions 1-23, 0.7546 for questions 1-18, and 1 for 19-23), were all greater than 0.1. These results did not demonstrate any evidence of difference between the two participant groups. More details can be found in *Appendix H*.

Study Variables. The study variables incorporated into this DNP project were based off the clinical practice question: Is participation in a structured TTP-RN NRP an effective method to build constructive relationships between preceptors and NHRNs? The independent variable (IV) was the participation in the NRPP. Participation was considered a nominal statistical measurement. The dependent variable (DV) was the mean score obtained from the Preceptor Evaluation Tool completed by the NHRNs and preceptors. Rating quality of preceptor experience using a Likert scale is considered an ordinal statistical measurement. The Preceptor Evaluation Tool provided data regarding the preceptor experience that was used to support that the development of relationships had occurred during the NRPP. Preceptors and NHRNs completed surveys after every session and participated in the final debriefing to provide additional insights into the benefits of the NRPP.

Data Stewardship. The surveys, digital audiotapes, data collected, and analysis were stored on encrypted password protected devices. The Google Survey was deleted after analysis to avoid inadvertent public access. De-identified quotes and portions of the final analysis were shared but actual digital recordings and surveys were not provided to the hospital to minimize participant risk. Upon completion of the project all surveys and digital recordings were destroyed.

Sustainability. For sustainability, the nurse educator attended all the education sessions to help her understand the unique needs of TTP-RNs, learner centered instruction methods, and ways to foster relationships between NHRNs and preceptors. Throughout the NRPP and

education sessions, the nurse educator's collaboration was encouraged. This approach will facilitate the continuation and implementation of future NRPs with minimal additional DNP students' support. The nurse educator received copies of resources with permission to modify as necessary for future use in NRPs at the hospital. It is the administration's goal to run the program with TTP-RNs during summer 2018. Ongoing monitoring of retention rates for 2017 and 2018 by the hospital may demonstrate if the NRPP helped to achieve the goal of improved retention.

Implications of Results

The goal of the NRPP was to facilitate the development of the relationships between NRPP preceptors and TTP-RNs. The Preceptor Evaluation Tool was used to measure the effectiveness of the pilot on the development of relationships among participants. Initially the NRPP means were compared to the NCSBN means with minimal differences. Descriptive statistics and comparison of the means between the NRPP preceptors and NHRNs supported the effectiveness of the education sessions in creating a supportive preceptor experience and the development relationships (*Appendix H)*.

Comparison of the question mean scores of NCSBN study preceptors and NHRNs were not available. For the NRPP the mean scores from NHRNs and preceptors were compared for each question. The first 18 questions on the Preceptor Evaluation Tool allows participants to assess the preceptors' activities. The preceptors' mean score for each question was either the same or higher than the mean score from the NHRNs except for question 3, 12, and 15. Questions 3 and 12 addressed problem solving of ethical concerns and development of clinical reasoning skills. It is interesting to note that the NHRNs score rated these higher. Although preceptors rated themselves lower, the NHRNs mean score on these questions indicate TTP-RNs perceived they had received the support necessary in clinical decision making. Question 15

addressed the teaching of information technology. It is possible that preceptors were not required to provide significant amounts of additional technology guidance. The NHRNs may have been adequately prepared in the use of technology. Question 5 had the highest absolute difference, 0.67. This question asked about the preceptor's encouragement to use evidence-based practice. This discrepancy although minor, was noted (*Appendix H, Table 16)*.

The last five questions on the Preceptor Evaluation Tool were in the category Preceptor Context and assessed the preceptors' ability to assist the NHRNs integration to the clinical setting. Three of the five questions NHRNs mean scores were lower than preceptors mean scores. These discrepancies were all supported during the clinical debriefing where NHRNs discussed the difficulty of not having a preceptor on the unit who had participated in the NRPP and patient assignment loads were not adjusted for NHRNs and preceptors (*Appendix H, Table 16)*.

In the NRPP, the Preceptor Evaluation Tool had three questions receive a score of 5 from both the NHRNs and preceptors. These included questions:

4. My preceptor provided me with the information I needed to care for my patients.

13. My preceptor helped me to interpret clinical situations.

18. My preceptor celebrated my successes with me.

Additionally, every other question received a combined mean score of 4.33 or higher except Question 20 received a combined mean score of 3.5.

20. My preceptor's patient assignment was adjusted to give us time to work together during the shift.

This mean score demonstrated a lack of administrative support to the preceptors' role. Although this had a minimal impact on the relationship development goal, it warrants noting and has the

potential to impact future NRPs. This was discussed with hospital leadership at the conclusion of the pilot. The leadership agreed and indicated this would be addressed for future NRPs.

The post module surveys consistently demonstrated participant satisfaction and perceived enhanced relationships. This was demonstrated with a 1-4 Likert scale (1-Poor 2-Fair 3-Good 4-Excellent) where all participants rated each statement as 4 for all modules (*Appendix I).* The fourth statement "Enhanced my relationship with preceptors/new hires" was included to solicit preceptors' and NHRNs' perceptions of relationship development during the education sessions. Every survey from every participant at every session rated the education session as an excellent way to enhance relationships between preceptors and NHRNs. Additionally, the feedback obtained from the open-ended question on the surveys "What in the training session enhanced your relationship with preceptors/new hire RNs?" provided additional support that the education sessions did result in relationship development. The following is a sample of the responses:

"Getting comfortable talking with them and learning about them"

"RELATE to each other; common ground; new and old nurses"

"The ability to discuss and share personal experiences in a safe environment."

"Sharing stories and learning from experienced nurses how they have handled conflict in the past."

"We know each other better than we would a new hire [that did not participate in NRPP]. Feel like we relate better."

"Just being there to share experiences with them [the resident] and interact with them more on a personal level"

"Sharing experiences and stories"

Feedback derived from the second module evaluations determined the length of time for

the training sessions should be reduced by one hour. This change was reflected at the final debriefing as a beneficial adjustment. Other suggestions from module evaluations included more breaks and use of shorter videos. The participants did not identify any presented content that should be eliminated from the training sessions, but one participant did request additional training on how to handle difficult relationships with staff members and patients. One preceptor participant indicated a desire for learning about different approaches to precepting. Another preceptor indicated a lack of understanding as to his/her role in the program. This was also a key finding during the final debriefing.

A debriefing *(Appendix H)* occurred with participants at the completion of the final training session. An audio recording of the debriefing was transcribed. Upon review of the recording, key findings indicated relationships had developed and were vital to supporting the NHRN's transition into the hospital's culture. One participant indicated it was helpful that the preceptor "introduced us to others, showed us where everything was at, they helped us transition more easily, and they were a helpful guide". The NHRNs shared that the most beneficial aspects of the training sessions were that the sessions provided a venue to understand what "we were going through" and "we were learning that our feelings were not out of the ordinary". The NHRNs indicated it was "nice being able to talk about some experiences on the floor, it was a safe place to talk about things that others on the floor may not understand". One NHRN indicated the biggest strength of the program was having the consistent preceptors that were part of the NRPP. The relationships formed during the training sessions provided a level of comfort that allowed NHRN participants to seek out these preceptors for support because they trusted them. Regarding this, one NHRN stated, "When any of the three consistent preceptors were not on the unit, it just threw me off".

From the debriefing, participants identified communication concerns. Many individuals at the facility exhibited a lack of understanding of the expectations for program. Statements such as "no one knew from the beginning what the expectations were." "No one knew who I was; when I told them I was a resident, they asked me if I was a doctor." One NHRN stated, "in front of patients I was being introduced as a student, they did not know anything about the program".

During the NRPP there was an inconsistency in how patient assignments were made for preceptors and NHRNs. Inconsistencies occurred with preceptors who participated in the NRPP and also when non-participant preceptors were paired for the day with NHRNs. In some instances, preceptors and NHRNs divided the patient assignment each taking their own patients and in other instances the NHRNs took the full assignment with the preceptor acting as a support. During the NRPP debriefing, participants preferred to be considered as a "single unit." Being considered a single unit allowed the NHRNs to complete the patient care assignment with the preceptor acting as a guide and support person. At times NHRNs and participant preceptors' schedules were not synchronized. Although surveys and feedback demonstrated positive overall results, these inconsistencies during the NRPP and failure to synchronize schedules impacted the quality of the NHRNs' and preceptors' overall perceptions of the NRPP experiences.

Discussion

This NRPP was not for generating new nursing knowledge, but to replicate previous study results and implement evidence-based research. In this NRPP, interactive content specific to the needs of the TTP-RN education sessions were developed and implemented with the goal of enhancing the relationship between the TTP-RN and preceptor. This NRPP was designed to address the needs of a small rural hospital with the understanding that use of evaluation tools would not produce data of statistical significance. The interpretation of the data focused on

clinical differences between NRPP preceptors and TTP-RN means and the NCSBN study results. Even though the results from the collected data are not statistically significant, the NRPP results mimicked the results obtained by the NCSBN study of high preceptor support hospitals. Relationship development between TTP-RNs and preceptors is important for the effective transition of TTP-RNs.

A key finding from this NRPP included relationship building as imperative for the successful transition of the NHRN. Relationship building was accomplished by the use of interactive learning center education approaches that addressed the transition of the NHRNs. These topics were varied and based upon the facilities culture. However, based upon the literature and also supported by feedback received from participants of this NRPP, incorporation of transition theories, learner centered activities and intentional relationship building activities should be the foundation for successful NRPs. When using these three principles, healthcare leaders can develop cost effective NRPs within their organizations to address morale, competency, and retention of the TTP-RNs. It does not appear that logistical oversights in the NRPP significantly impacted the development of relationships between the NHRN and preceptors.

The goal for the structured NRPP, was to facilitate the development of the relationships between preceptors and TTP-RNs to facilitate the integration of the NHRNs into the organization's culture. This was accomplished through the structured education sessions on pertinent topics designed to foster relationships between the preceptors and the NHRNs. By expanding and modifying the facility's current orientation process with a NRPP, minimal financial expense resulted in very satisfied TTP-RNs. In implementing the structured NRPP, the original hypothesis of the importance of building relationships with TTP-RNs, was supported. In

addition, based upon the literature, it is anticipated that the TTP-RNs' satisfaction will result in improved retention. This will directly have a financial benefit for the hospital. All interviewed stakeholders at the hospital expressed positive support for the NRPP and indicated that it would be replicated in 2018.

Limitations and Recommendations

The primary limitation of this project was the small number of participants that prevented gathering of statistically significant data. To avoid this limitation in the future, a proposed solution would be to run the project in multiple small hospitals for a larger participant pool. Another solution would be to run the program three to four times at the same hospital and combine the data. Another limitation was the inconsistency of preceptor participation. Although hospital managers were to plan adequate staffing to ensure preceptor participation, it was identified throughout the education sessions that this did not occur. Preceptors stated they were not able to leave the unit to attend training sessions. If the program is to successfully continue, it is essential for hospital administration to support preceptors by ensuring their ability to attend training sessions.

A lack of communication resulted in confusion for participants and unit staff. A final recommendation is for those responsible for the program to take steps to educate all key stakeholders on the similarities and differences of the facility's standardized orientation program and the transition to practice nurse residency program. This education can facilitate the acceptance of the program and help the NHRN transition to practice.

Conclusion

With a hiring preference for the BSN prepared nurse and integration of high fidelity simulation into curriculum, the minimal competency standard of TTP-RNs is increasing. More

education, more time, more opportunities to practice skills, and more high-fidelity simulations may logically appear to be the way to improve the TTP-RNs assimilation into nursing practice. However, skill knowledge will not necessarily result in increased retention of TTP-RNs.

Nurse Residency programs are increasingly implemented to help combat the high nursing turnover rates and nursing shortage in healthcare facilities across the nation. Successful transition to practice is not dependent on expensive, large, lengthy TTP-RN residency programs, but on the ability of the program to develop relationships between the TTP-RN and the organization. This concept cannot be underscored enough; the building of these relationships is a major component that should be addressed during transition of new nurses to practice. To be successful in transitioning new nurses to practice effectively, NRPs must be designed with a strong preceptor component, while utilizing structured educational approaches that promote the development of relationships between the new nurses and preceptors.

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Appendix A

Nurse Residency Program Pilot **Module #1** *(4 hours)*		
Objective		**Activity**
Lunch Meet and Greet (30 minutes)		
Provide a brief program overview. *Participants will have a basic understanding of the NRRP* ***Discuss rural health nursing*** *Participants will have a more comprehensive understanding of Rural Health*		**20-minute program overview and consent forms signed** ”**30-minute** (Remember how many different types of patients, different diagnoses seen during last 2 clinical days)
5-minute stretch-break		
Discuss Theory of Transition Shock *Participants will have a more comprehensive understanding of Rural Health*		**40-minute Theory of Transition Shock** Preceptors and others sharing “stories
15-minute refresh break		
Building a relationship # 1 Understanding Self *Participants will have a better understanding of their own personality type.*		**20-minute Introduction to topic “Personality types”** **30-minute activity:** Go to the link (will provide link to participants) and take the personality quiz. Discuss findings as a group and reflect on various effective ways to communicate with each other.
5-minute stretch-break		
Building a relationship # 2 Understanding Others *Participants will apply their understanding of personality types.*		**20-minute Introduction to the topic “Communication”** **30-minute activity**: Practicing giving and receiving feedback
Provide opportunity for goal setting *Participants will set goals for the next month.*		**10-minute Goal Setting**
Evaluation: *The Module*		**5-minute survey**

Appendix B

Nurse Residency Program Pilot Module #2 *(3 hours)*		
Objective		**Activity**
Offer opportunity to review goals accomplishments. *Participants will discuss successes and opportunities for improvement*		**30-minute Revisit Participant Goals from previous module, Transition Shock Theory, Rural Health Nursing**
Provide overview of the impact of incivility in the workplace. *Participants will have the tools necessary to address incivility in the workplace.*		**20-minute Introduction to the topic "Civility"** **40-minute activity:** Various scenarios depicting issues and practicing ways to address incivility.
10-minute break--provide nutritious food/snacks and water.		
Provide overview of methods for conflict management *Participants will have the skills necessary to engage in conflict management in the workplace.*		**20-minute Introduction to the topic "Conflict Management"** **40-minute activity:** Various scenarios depicting issues and practicing ways to provide feedback.
10-minute stretch-break		
Provide opportunity for goal setting *Participants will set goals for the next month.*		**10-minute Goal Setting**
Evaluation: *The Module*		**5-minute survey**

Appendix C

Nurse Residency Program Pilot Module #3 *(3 hours)*		
Objective		**Activity**
Offer opportunity to review goals accomplishments. *Participants will discuss successes and opportunities for improvement*		**15-minute Revisit Participant Goals from previous module, civility, conflict management**
Provide information on stress in the workplace *Participants will recognize triggers for stress in the workplace*		**20-minute Introduction to the topic "Sources of Stress"** **40-minute activity:** Importance of preceptor guidance to minimize stress Scenarios that cause stress
10-minute break--provide nutritious food/snacks and water.		
Provide information on ways to destress the workplace *Participants will have the skills necessary to reduce in the workplace*		**40-minute Creating a Healthy Work Environment Introduction to topic "De-stressing"** Ted Talks EI Self-Assessment with a focus on Empathy Laughter **30-minute activity:** Tools to assist with stress management Revisit goals
10-minute stretch-break		
Provide opportunity for goal setting *Participants will set goals for the next month.*		**10-minute Goal Setting**
Evaluation: *The Module*		**5-minute survey**

Appendix D

Nurse Residency Program Pilot **Module #4** *(3 hours)*		
Objective		**Activity**
Offer a non-threatening venue for participant to get acquainted with nurse managers *Participants will become more familiar with hospital administration*		**30-45 minute** **Lunch provided by hospital** **15-minute activity:** Introductions and specific questions designed by program leaders to open dialogue between participants and hospital administration
10-minute mingling break--		
Provide the opportunity to review transition shock. *Participants will identify progress through role transition*		**20-minute Revisit transition shock theory** **20-minute Introduction to the topic "The next year for residents"**
Provide information on what to expect during the next year of role transition. *Participants will have appropriate expectations and goals for the next year.*		**20-minute Rural Health: The Joys and Excitement of Providing Care** **10-minute: Setting of future goals**
15-minute break provide celebration cake *Presentation of Certificates of Completion* *Signing of Human Resources Paperwork*		
Evaluation and Feedback *The Module* *Evaluation of Preceptor Experience Tool*		**40 focus group involving participants** Solicit qualitative information for refinement of nurse residency program

Appendix E

Training Sessions Evaluation Tool

Please rate the following 1-4 (1-Poor 2-Fair 3-Good 4-Excellent)

Objectives of Training Session were met:	1	2	3	4
Appropriate teaching strategies were used:	1	2	3	4
Comfortable surroundings:	1	2	3	4
Enhanced my relationship with preceptors/new hires	1	2	3	4

I found the following most helpful:

I found the following least helpful:

I would have liked to learn about:

To improve this Training Session, I would:

Additional Comments:

Appendix F

Preceptor Evaluation Tool					
Evaluation of Preceptor Experience by New RN and Preceptor					
Participants: Circle one Preceptor New Hire Nurse Please answer the following questions on a scale of 1 disagree to 5 agree					
	Disagree (1)	Somewhat Disagree (2)	Neutral (3)	Somewhat Agree (4)	Agree (5)
1. My preceptor provided me with feedback about my strengths.					
2. My preceptor helped me to determine appropriate patient priorities.					
3. My preceptor demonstrated how to problem solve ethical concerns.					
4. My preceptor provided me with the information I needed to care for my patients.					
5. My preceptor encouraged me to use evidence-based practice.					
6. My preceptor kept other nursing staff aware of what I could do.					
7. My preceptor provided me with feedback about what I needed to improve.					
8. My preceptor encouraged me to engage in self-reflection.					
9. My preceptor helped me to learn from errors or near misses (potential errors).					
10. My preceptor allowed me the independence that I needed.					
11. My preceptor considered my learning style (my preference for learning by observing, reading, experiencing, or reflecting)					

12. My preceptor taught me to ask questions (such as -What if? or -What could these symptoms mean?) as a way to develop my clinical reasoning skills.					
13. My preceptor helped me to interpret clinical situations.					
14. My preceptor demonstrated ways to help patients become partners in their care.					
15. My preceptor taught me how to use information technology for patient care.					
16. My preceptor was instrumental in helping me to establish relationships with people on the interdisciplinary team.					
17. My preceptor explained institutional policies to me.					
18. My preceptor celebrated my successes with me.					
19. The continuity of my learning experience was ensured even when I did not work with my primary preceptor.					
20. My preceptor's patient assignment was adjusted to give us time to work together during the shift.					
21. My preceptor explained the roles of the people who work on my unit.					
22. My preceptor and I had time to discuss what was expected of me.					
23. There was a supportive environment for the preceptor experience in the practice setting.					

Created by: Nancy Spector; Mary A. Blegen; Josephine Silvestre.; Mary R. Lynn; Jane Barnsteiner & Beth Ulrich

Appendix G

Debriefing Tool

What did you find most helpful during the NRRP and education sessions?

What did you find least helpful during the NRRP and education sessions?

What topics would you have liked included during the NRRP?

What do you think could improve the next NRP?

How did the NRP training sessions enhance your relationship(s) with preceptors/new hire RNs?

Please share any additional comments:

Appendix H

Table 1

Study Variables		
Type	Variable	Level of Measurement
Independent:	Participation in the NRPP	Nominal
Dependent:	Mean Score on Preceptor Evaluation Tool	Ordinal

Table 2

Perceptions of Preceptor Experience by NHRNs and Preceptors		
	Hospital NRPP (Mean)	NCSBN High Preceptor Support Hospitals (Mean)
NHRN evaluation of preceptor experience	n= 3	n= 405
Preceptor experience all	4.59	4.16
Preceptor activities	4.67	4.20
Preceptor context	4.33	4.04
Preceptor evaluation of preceptor experience	n= 3	n=285
Preceptor experience all	4.67	4.32
Preceptor activities	4.76	4.37
Preceptor context	4.33	4.12

NCSBN High Preceptor Support Hospitals (Mean) data obtained from the Preceptor Evaluation Tool administered to NCSBN residency program participants (Blegen et al., 2015; Spector et al., 2015)

Table 3

Perceptions of Preceptor Experience by NRPP Hospital NHRN and Preceptors			
	NRPP Hospital NHRN evaluation of preceptor experience (mean)	NRPP Hospital Preceptor evaluation of preceptor experience (mean)	Absolute Difference
	n= 3	n= 3	
Preceptor experience all	4.59	4.67	0.08
Preceptor activities	4.67	4.76	0.09
Preceptor context	4.33	4.33	0.00

Table 4, 5, 6

NRPP Preceptor/NHRN Descriptive Statistics	
Questions 1-23	
Mean	4.63
Standard Error	0.12
Median	4.72
Mode	4.87
Standard Deviation	0.30
Sample Variance	0.09
Kurtosis	1.63
Skewness	-1.36
Range	0.78
Minimum	4.09
Maximum	4.87
Sum	27.78
Count	6
Confidence Level(95.0%)	0.32

NRPP Preceptor Descriptive Statistics	
Questions 1-23	
Mean	4.67
Standard Error	0.10
Median	4.61
Mode	#N/A
Standard Deviation	0.18
Sample Variance	0.03
Kurtosis	#DIV/0!
Skewness	1.29
Range	0.35
Minimum	4.52
Maximum	4.87
Sum	14
Count	3
Confidence Level(95.0%)	0.45

NRPP NHRN Descriptive Statistics	
Questions 1-23	
Mean	4.59
Standard Error	0.25
Median	4.83
Mode	#N/A
Standard Deviation	0.44
Sample Variance	0.19
Kurtosis	#DIV/0!
Skewness	-1.71
Range	0.78
Minimum	4.09
Maximum	4.87
Sum	13.78
Count	3
Confidence Level(95.0%)	1.09

Table 7, 8, 9

NRPP Preceptor/NHRN Descriptive Statistics	
Questions 1-18	
Mean	4.71
Standard Error	0.11
Median	4.78
Mode	4.72
Standard Deviation	0.28
Sample Variance	0.08
Kurtosis	4.03
Skewness	-1.91
Range	0.77
Minimum	4.17
Maximum	4.94
Sum	28.27
Count	6
Confidence Level(95.0%)	0.29

NRPP Preceptor Descriptive Statistics	
Questions 1-18	
Mean	4.76
Standard Error	0.04
Median	4.72
Mode	4.72
Standard Deviation	0.06
Sample Variance	0.00
Kurtosis	#DIV/0!
Skewness	1.73
Range	0.11
Minimum	4.72
Maximum	4.83
Sum	14.27
Count	3
Confidence Level(95.0%)	0.16

NRPP NHRN Descriptive Statistics	
Questions 1-18	
Mean	4.67
Standard Error	0.25
Median	4.89
Mode	#N/A
Standard Deviation	0.43
Sample Variance	0.19
Kurtosis	#DIV/0!
Skewness	-1.71
Range	0.77
Minimum	4.17
Maximum	4.94
Sum	14
Count	3
Confidence Level(95.0%)	1.07

Tables 10, 11, 12

NRPP Preceptor/NHRN Descriptive Statistics	
Questions 19-23	
Mean	4.33
Standard Error	0.20
Median	4.3
Mode	3.8
Standard Deviation	0.50
Sample Variance	0.25

NRPP Preceptor Descriptive Statistics	
Questions 19-23	
Mean	4.33
Standard Error	0.35
Median	4.2
Mode	#N/A
Standard Deviation	0.61
Sample Variance	0.37

NRPP NHRN Descriptive Statistics	
Questions 19-23	
Mean	4.33
Standard Error	0.29
Median	4.4
Mode	#N/A
Standard Deviation	0.50
Sample Variance	0.25

Kurtosis	-1.71	Kurtosis	#DIV/0!	Kurtosis	#DIV/0!
Skewness	0.22	Skewness	0.94	Skewness	-0.59
Range	1.2	Range	1.2	Range	1
Minimum	3.8	Minimum	3.8	Minimum	3.8
Maximum	5	Maximum	5	Maximum	4.8
Sum	26	Sum	13	Sum	13
Count	6	Count	3	Count	3
Confidence Level(95.0%)	0.53	Confidence Level(95.0%)	1.52	Confidence Level(95.0%)	1.25

Table 13

t-Test: Two-Sample Assuming Unequal Variances

Questions 1-23 - Alpha 0.1

	NRPP NHRNS	*NRPP Preceptors*
Mean	4.59	4.67
Variance	0.193	0.033
Observations	3	3
Hypothesized Mean Difference	0	
df	3	
t Stat	-0.264	
P(T<=t) two-tail	0.8090	
t Critical two-tail	2.353	

Table 14

t-Test: Two-Sample Assuming Unequal Variances

Questions 1-18 - Alpha 0.1

	NRPP NHRNS	*NRPP Preceptors*
Mean	4.67	4.76
Variance	0.186	0.004
Observations	3	3
Hypothesized Mean Difference	0	
df	2	
t Stat	-0.358	
P(T<=t) two-tail	0.7546	
t Critical two-tail	2.920	

Table 15

t-Test: Two-Sample Assuming Unequal Variances

Questions 19-23 - Alpha 0.1

	NRPP NHRNS	*NRPP Preceptors*
Mean	4.33	4.33
Variance	0.253	0.373
Observations	3	3
Hypothesized Mean Difference	0	
df	4	
t Stat	0	
P(T<=t) two-tail	1	
t Critical two-tail	2.132	

Table 16

Preceptor Evaluation Tool			
Evaluation of Preceptor Experience by New RN and Preceptor (NRPP)			
Questions	**NHRN Means**	**Preceptor Means**	**Absolute Difference**
1. My preceptor provided me with feedback about my strengths.	4.67	4.67	0.00
2. My preceptor helped me to determine appropriate patient priorities.	5.00	4.67	0.33
3. My preceptor demonstrated how to problem solve ethical concerns.	4.67	4.33	0.34
4. My preceptor provided me with the information I needed to care for my patients.	5.00	5.00	0.00
5. My preceptor encouraged me to use evidence-based practice.	4.00	4.67	0.67
6. My preceptor kept other nursing staff aware of what I could do.	4.67	5.00	0.33
7. My preceptor provided me with feedback about what I needed to improve.	4.33	4.67	0.34
8. My preceptor encouraged me to engage in self-reflection.	4.67	4.67	0.00
9. My preceptor helped me to learn from errors or near misses (potential errors).	4.67	5.00	0.33

10. My preceptor allowed me the independence that I needed.	4.67	5.00	0.33
11. My preceptor considered my learning style (my preference for learning by observing, reading, experiencing, or reflecting)	4.67	5.00	0.33
12. My preceptor taught me to ask questions (such as -What if? or -What could these symptoms mean?) as a way to develop my clinical reasoning skills.	5.00	4.67	0.33
13. My preceptor helped me to interpret clinical situations.	5.00	5.00	0.00
14. My preceptor demonstrated ways to help patients become partners in their care.	4.33	4.67	0.34
15. My preceptor taught me how to use information technology for patient care.	4.67	4.33	0.34
16. My preceptor was instrumental in helping me to establish relationships with people on the interdisciplinary team.	4.67	5.00	0.33
17. My preceptor explained institutional policies to me.	4.33	4.33	0.00
18. My preceptor celebrated my successes with me.	5.00	5.00	0.00
19. The continuity of my learning experience was ensured even when I did not work with my primary preceptor.	4.00	4.33	0.33
20. My preceptor's patient assignment was adjusted to give us time to work together during the shift.	3.67	3.33	0.34
21. My preceptor explained the roles of the people who work on my unit.	5.00	4.33	0.67
22. My preceptor and I had time to discuss what was expected of me.	4.33	4.67	0.34
23. There was a supportive environment for the preceptor experience in the practice setting.	4.67	5.00	0.33
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Appendix I

Module #1 session Evaluation	RS-1	RS-2	RS-3	PR-1	PR-2	PR-3
Objectives of Training Session were met:	4	4	4	4	4	4
Appropriate teaching strategies were used:	4	4	4	4	4	4
Comfortable surroundings:	4	4	4	4	4	4
Enhanced my relationship with preceptors/new hires	4	4	4	4	4	4

Module #2 session Evaluation	RS-1	RS-2	RS-3	PR-1	PR-2	PR-3 Absent
Objectives of Training Session were met:	4	4	4	4	4	NA
Appropriate teaching strategies were used:	4	4	4	4	4	NA
Comfortable surroundings:	4	4	4	4	4	NA
Enhanced my relationship with preceptors/new hires	4	4	4	4	4	NA

Module #3 session Evaluation	RS-1	RS-2	RS-3	PR-1	PR-2	PR-3
Objectives of Training Session were met:	4	4	4	4	4	4
Appropriate teaching strategies were used:	4	4	4	4	4	4
Comfortable surroundings:	4	4	4	4	4	4
Enhanced my relationship with preceptors/new hires	4	4	4	4	4	4

Module #4 session Evaluation	RS-1	RS-2	RS-3	PR-1	PR-2 Absent	PR-3 Absent
Objectives of Training Session were met:	4	4	4	4	NA	NA
Appropriate teaching strategies were used:	4	4	4	4	NA	NA
Comfortable surroundings:	4	4	4	4	NA	NA
Enhanced my relationship with preceptors/new hires	4	4	4	4	NA	NA

Appendix J

Debriefing Transcript: Debriefing with NHRNs (referred to as residents) and Preceptors after NRPP completion October 20, 2017.

Debriefing Participants: Two DNP Students, Three NHRNs, One Preceptor

Introduction:

Surveys cannot catch all the important information. The qualitative data on surveys will not be statistical significant, because it is not a large enough study. We chose to debrief in a verbal format. The debriefing was recorded on 2 phones and then transcribed. Additionally, one DNP student took notes on a lap top of the non-verbal communication that occurred. The transcription was not shared with hospital administration.

DNP Student 1:

Anything we find in this pilot is not considered statistically significant; it is important to us. We decided to use this debriefing tool. We hope that you can be honest and share your your thoughts, feelings. We really would like your input.

DNP Student 2:

What did you find was helpful about the NRPP during the time on the unit with the preceptors and for the preceptors, what did you find the most helpful? Consider the clinical as well as

during the educational sessions

Preceptor:

Being able to teach them and help get them prepared as a new RN and we can pass on our experience and knowledge, to make them more at ease

Resident:

It was helpful in that the preceptor knew us, they introduced us to others on the unit. They showed us where everything was at. They helped me so much with charting. Specifically guided me through the process of "Powerchart" (the Electronic medication record [EHR]). This helped us transition much more easily; the preceptors were so helpful as a guide through this transition.

DNP Student:

Working with "Powerchart" with the preceptor on the unit was very effective.

Resident:

I think the biggest strength was being with the consistent preceptor all the time. Twice I was thrown with other RNs. If something bothered me and if they were not there or I was not with them, it just threw me off. Any of the 3 preceptors, I would be able to talk to them about it later when I saw them again, and that would help me feel better. I talked to the other preceptors, but I do not have the same relationship that I had with the other 3 preceptors that were consistently here [in the NRPP]. When they weren't there, it just threw me off. (stated this twice). Like, (Preceptor 1) being with me in the acute care. (Preceptor 2) or (Preceptor 3) in ICU every day, really helped.

DNP Student:

Having the same preceptor as often as possible was very helpful.

DNP Student:

Even though she was here [education sessions] only once, it still gave you a level of comfort [on the unit] to talk to her?

Resident:

For sure.

DNP Student:

Even though (Preceptor Name) was only here once, you could tell that she had amazing buy in for the project; she clearly was there for you guys.

Resident:

She was an amazing preceptor.

Resident:

In the OR, we did not have a preceptor at all-did not have a preceptor--felt like an inconvenience the whole time I was there like nobody knew I was coming, nobody knew what to do with me. The manager was really busy. It was the 2nd week. No one knew who I was; when I told them I was a resident, they asked me if I was a Dr.? (Laughter) I not a student, I am an RN, I took my boards.

Resident:

Rotating through OR; it was very unorganized in OR.

DNP Student:

So, we will make sure that the OR department knows what the program is and how to best work with the resident RNs. When they do this again, we can suggest they have structure so that the resident has the ability to state what they wanted.

Resident Summary:

Some good leaders, but there were a lot that did not know the program. The two places I went

including OB, in front of patients I was being introduced as a student, they did not know anything about the program and no preceptor was assigned in those areas; the experience made the resident feel very discouraged and regretted he/she had went into nursing. Critical care was like a breath of fresh air—indicates that she "really wanted this"

ER was not an observation because I was assigned to a preceptor (all three residents agreed)

Resident:

I told them what I wanted to do [rotated through at the end]. It was so limited in what you could do in OR, (The month before, this resident was told by the other residents during an education session to go in and tell OR staff what she wanted to do. This resident asked specifically to start IVs. and they let her start IVs while in the OR).

Resident:

So, did I [tell the OR staff specifically]. (This resident rotated through OR the middle of the NRPP rotation)

DNP Student:

What was helpful about the educational sessions?

Resident:

Talking about the transition we were going through. That we were learning the feelings were not out of the ordinary

Resident:

Liked hearing that the more experienced nurses they feel that way too and how they overcame that, I thought that was very beneficial.

DNP Student:

The bond grew the more we were able to share with each other. We felt more comfortable.

Resident:

Nodding yes.

Resident:

And it was nice being able to talk about some experiences on the floor; a safe place to talk about things like I could vent about it; where others on the floor may not understand and would think that I was bashing, complaining or whining.

DNP Student:

And in response to that I want to say that all of you were extremely professional, it was taken in the context it was given. It did not come out negative or sound like bashing.

Preceptor:

Every new nurse goes through and experience this; I would like to share that I was in those shoes, we are here for you even though you feel like it is really overwhelming; it is normal.

DNP Student:

Normal, and a safe place to talk about it; good to know.

DNP Student:

What did you find the least helpful?

Preceptor:

You would talk to others; no one knew from the beginning what the expectations were. I had to talk to (unit manager), to find out what was going to happen, and that OB and OR will be observational. That's a long time to be orientation. But, (unit manager), said, treat it like orientation.

Preceptor:

(Residents) had 2 patients and then the preceptor had 3 patients. I would have my resident take

all 5 patients with me. So, there was not consistency. Preceptor to preceptor it was not the same.

Resident:

I had a hard time with that particular preceptor. (This acute care preceptor and resident apparently had issues when working together and giving patient care. The preceptor went and complained to the nurse educator and the resident was switched to another preceptor. The preceptor apparently did not have a relationship with the resident. Had not attended any of the NRPP education sessions. The resident did not feel comfortable with this preceptor; the resident consequently did not do as well as he/she could have. Resident states "had a hard time with" the preceptor).

Resident:

It was like that with all the preceptors except (the preceptor in attendance at the debriefing) She was the only one that gave me all 5 patients and then we did them together. All the rest asked me: "ok which patients do you want? They would split up the patients, the resident takes 2 and the preceptor takes 3. (This practice was highly discouraged by the residents and preceptor. Instead, treat the resident and preceptor as 1 unit, rather than have the resident take 2 while the preceptor takes 3 different patients. Consider the resident/preceptor unit as 1 nurse—this would be much more like the current orientation practices).

"Like, [the preceptor] did not take any patients and her role was just to be there for me [while I took 5 patients]".

P**receptor:**

"I recommended that the 2 nurses be considered as one unit" (further discussion, preceptor highly recommends that the resident and preceptor work as one unit—taking all 5 patients; the preceptor gets assigned 3-5 patients and the resident takes them (focusing as one nurse).

So, they did not count her as resident with the preceptor. Treat the resident like they are on orientation—count them as 1.

Resident:

Resident was counted as 1 RN and the preceptor as 1 RN

Resident:

That happened with us; we'd get 5 patient and late admits.

Preceptor:

I cannot oversee the resident, all 5 patients and then additional patients

DNP Student:

Treat them like a "unit"

Question: Do you think that the experiences of the OR and the OB were beneficial experience to go/rotate through?

Resident:

For this hospital to understand the entire hospital and what they offer to the community roles and responsibilities of those nurses, I think "yes"

Resident:

It helped me gain more empathy for what everyone else does---not 2 weeks.

Resident:

I think one day; literally! I think 1 day in OB; 1 day in OR. I hated coming into the OR for 2 weeks. There was the lack of focus, it was too much

Resident:

I was supposed to be there 7-330 in OB; I literally left ½ hour early; I was not going to sit down and do nothing. That is costly and boring. There was not anything to do, nothing more to clean. I

went home.

DNP Student:

Do you think one day in each unit is sufficient?

Resident:

Yes!

Resident:

I do not know if you get the full grasp of what they do in one day. It's like when I went to OB I was able to be in C-sections, I was able to do 24-hour care, I was able to be with laboring mothers, you know couplet care. So, there is a lot they do on that unit. I think 1 week is sufficient up there.

Resident:

I did see fetal demise.

Resident:

I got to see a lot there it's just that, I didn't really do much or use my skills. I could have maybe in a day or two grasped if I maybe want to learn more about this. Or maybe you could put it in as an option that if you really like OB or OR you could extend it and get an extra week at the end if you felt you needed it. But I don't think it's for everybody.

Resident:

On the first day in OR I told them what I wanted to learn. I followed a patient all the way through the process. Second day I went just in surgical. I want to do surgical with the nurse all day. Third day I did nothing but eyes. That was Wednesday, so I had that eye day experience. Day 4 I did nothing but preop. Then my last day was postop. So, I broke it down to get a grasp

Resident:

It helped that I had been there and prepped you guys. Like you are going to have to be responsible for yourself to keep busy. You guys had time to think about it. I did not. I was just thrown into it.

DNP Student:

Do you think a suggestion could be for the surgical department that they would have a structure that they would walk you through? One day you are with the circulator, one day you are with preop, one day you are with PACU, so you would have the total experience?

Resident:

Then you would have that total experience. But I agree, no more than a week there.

Preceptor:

You had the week where all the surgeons were not there. If it is going to be a week when all the surgeons are available, Tuesdays are the best days. These are big ortho days.

Resident:

I kind of got lucky to. Because when I was down there, two of those days I was only there for half a day. EKG training

Resident:

I did gain though. I did gain respect for those nurses and I have an appreciation.

Preceptor:

My thought is to give them a choice. At the beginning you have the 5 units. You have to do ICU, you have to do 3rd floor and ER. And maybe if someone does not want to do OB or OR . Maybe at the beginning just pick 4 out of the 5. Or if they want to go to all 5 just make it an option.

Resident:

Cafeteria plan.

Resident:

Because a lot of the time when I was in OB I spent more time doing ancillary things rather than doing nursing things. And sometimes I would question what is this contributing to my growth as a nurse. Like when I am sitting here folding laundry, or you know doing housekeeping type stuff

Preceptor:

I think this is how that unit functions too.

Resident:

They have a PCA that does that stuff. They didn't know what to do with us.

Resident:

So just for me, for me to stay busy because I need to stay busy those were the kind of things I would have to do to stay busy. And not that it isn't important to do those kinds of things but when the majority of your day is just comprised of cleaning, I'm sorry but that kinda sucks.

Resident:

I think it is important to understand you are not above anyone else. You should pitch in and do those kinds of things but not on a daily basis.

Preceptor:

But when you are there as part of your rotation to see how things work it is not beneficial. I mean it is important to see what they do but it is not what you are there for. You are there to learn.

Resident:

Literally I would be like, what can I do to help you? And there was just nothing

Resident:

I was like the queen of making triage beds because it was something I knew how to do, and

nobody has to teach me because nobody could really teach me things up there because they were so busy.

DNP Student:

We talked a lot about that. What about the actual education sessions? Are there things that were not helpful? Are there things that you would change?

Resident:

I didn't really find anything not helpful. Everything kind of applied to the whole transition. It applied to communication. Today with goal setting keeping that whole process going and continual growth. I didn't find anything

Resident:

Yah all information was useful. I don't think anything was fluff.

Preceptor:

I would just say working more with scheduling in the unit. Making sure the preceptors are not on those days (*not on the days when education sessions are occurring)*

Resident:

Really hard because everyone is scheduling themselves.

Preceptor:

The other thing was I actually went down and talked to (scheduler). You put me on these days and I need off these days.

DNP Student:

Were there any topics you thought we could have included or you would have like to have included?

Resident:

Not that I can think of.

Resident:

Maybe more about rural healthcare. Because that is interesting. Certification where do we stand with that? Are people listening?

DNP Student:

No, we have not been actively pursuing that, but I know that it is (MCHC DON's) desire. Maybe down the road.

Resident:

Let's face it probably there are more of us in rural health care as far as geographical coverage than there is in urban healthcare that is densely populated but when you think of percentage of our nation geographically, square mileage.

DNP Student:

Maybe you, since it seems to be kind of a passion of yours, you will be part of approaching the ANA and saying let me help develop this. That is exciting that it could start from our rural area.

Preceptor:

We could have last week but they were never at their table. All the times we were down stairs there was never anybody at their table. (*Conference where the ANA was present*)

DNP Student:

We talked a little bit about some things that could improve the next residency program and one of the things was keeping the preceptors with the residents, so they don't have to be split off and to go with someone else, also thinking about adding some structure, decreasing the time in OR and decreasing the time in OB. What other thoughts would improve for the next time?

Resident:

If you were not to decrease the time, then maybe you look at getting a preceptor in those units (OB and OR). I think it would have been an all-around different experience with a preceptor.

DNP Student:

And if we do decrease the time, it may be still good to have a preceptor?

Resident:

We would get more out of our time.

Resident:

And I think that also all the preceptors need to understand what this program is, what the outcomes are, what the expectations are, and understand what paperwork needs to be filled out. Stuff like that. Because not all of them knew.

DNP Student:

Can you clarify that a little bit for me, so I can make sure I understand? So, there is paperwork that (*the preceptor's name)* did not know needed to be filled out?

Resident:

I did not have (preceptor).

DNP Student:

You mean preceptors that were not here or is this in general?

Resident:

We have this book with paperwork.

Resident:

Yah, some of them didn't know what we were doing, what the purpose of the program was or things like that.

Preceptor:

And I think a lot of it could be eliminated if everyone knew, if it was clear everyone knew at the start that this was orientation. Cause those are orientation books essentially.

DNP Student:

So, it is important they understand that this is just a different type of orientation?

Resident:

We're still employees.

Resident:

I got asked if I was getting paid, if I was an employee, if I was going to stay here, if I was still in school. Like all those things

Resident:

One time I was down in the ER and someone looked at my name tag and said you're the nurse president? No, I am not the nurse president, I am a nurse resident. It was funny but most of them had absolutely no idea what we were.

DNP Student:

Do you know if information was sent out in a blanket email to all the staff?

Resident:

There were papers posted on bulletin boards. Cause I mentioned it the first week to (nurse educator). Because nobody knows why I'm here. I'm over telling people why I'm here. She stated, "she would send out another email, but I emailed everyone, and I have posters posted." So, I guess people didn't take the time to read it I guess.

Preceptor:

Well it was just poor communication all around. I didn't know quite honestly. I knew we were going to be getting them. The first session they were sitting here talking about "Oh I go to this

place first." You know, and no one had ever communicated. And I'm like Oh am I going to get someone? I knew I was, but no one told me until (resident) showed up the very first day with me and I'm like Oh I guess you are with me today. The other thing was that I was calling the supervisor usually the night before and saying hey. just so you know I have (resident) or (resident) with me so were only taken this amount of patients. Otherwise it was not written it was just poor communication between (nurse educator), the managers, scheduling, and the supervisors.

DNP Student:

How do you think the training session enhanced your relationships with each other? The preceptors and new hire RNs?

Preceptor:

It really helped. We were able to establish relationships with them so that when they did come to the floor they knew us, they already trusted us and met us.

Resident:

We were able to share. You guys were able to share your professional experiences with us in an open setting.

DNP Student:

So, the training sessions helped to start building the relationships before you even hit the floor between the preceptors and the nurses?

Resident:

Yes, when I went to my first day on critical care and my first day on acute care I knew which nurse's face to look for from being here.

DNP Student:

(Preceptor name), have you precepted a lot or is this your first time?

Preceptor:

Well I have helped towards the end of somebody's orientation process if their preceptor had a day off or whatever. I have helped if they were not able to switch a day. I've helped a day or two here.

DNP Student:

What is the difference between having someone go through this pilot versus someone who comes to the floor without doing this type of a program? Was there any difference or not?

Preceptor:

Really there wasn't supposed to be, but it was the way it all panned out for us

Resident:

On your floor. The difference was that we were able to go to all 5 departments and have that experience.

Preceptor:

The difference with them on the other floors is it sounds like they treated them like job shadowing. Where as if they were a new hire they would have started on that first day.

DNP Student:

Was this transition easier?

Resident:

Going from being in this residence to starting technically my first day on the floor on Sunday, I'm not nervous. I feel pretty good. I feel like I can handle it.

DNP Student:

So, it built your confidence. It may be provided a safe feeling or safety net.

Resident:

And I know there are things I'm going to need help with, but I have a relationship with all the nurses now and I know everyone who will be there on Sunday and that if I have questions they will answer me, they are not going to get annoyed with me. They all know I ask questions and they are fine with it.

DNP Student:

What additional comments would you like to share with us?

Resident:

I'm just grateful to have the experience. I have a lot better understanding even if I never work OR, OB, or ED. I have a lot better understanding of what goes on down there. It was real eye opening because you are on that floor and you hear them complain about another floor and then you go to that floor and you see why those situations are the way they are. So, it may be helpful for maybe all employees to have this cross training, so they have a better understanding of each other's roles and responsibilities. They could have a lot greater appreciation for one another.

DNP Student:

Did you appreciate the changing of the hours? I know we had planned on going to 5:00 for every session and after the second session we ended early and you indicated you liked only 3 hours. Was that a better amount of time?

Resident:

I think so.

Resident:

Brevity is always better.

Written Feedback from a Preceptor who was not able to attend the debriefing:

"I have enjoyed this program very much! I loved all three of the residents and have learned a lot from having them with me! I feel that this program did expose them to many different areas and helped them feel stronger in their assessment skills and nursing judgment. I hope that this program will continue here at the hospital. I also found (DNP Students) very kind and helpful. They put a lot of work into developing. Thank you for including me in it☺"