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Attitudes of New Graduate RNs Regarding Their Readiness for Practice Before and After Hospital Orientation

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ATTITUDES OF NEW GRADUATE RNs REGARDING THEIR READINESS
FOR PRACTICE BEFORE AND AFTER HOSPITAL ORIENTATION

by

Diane A. Young

A Dissertation
Submitted to the Graduate School,
the College of Nursing and Health Professions
and the School of Leadership and Advanced Nursing Practice
at The University of Southern Mississippi
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Philosophy

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ABSTRACT

The acuity level of patients continues to increase making it more vital than ever that new graduate Registered Nurses (RNs) be prepared to give safe, quality care when leaving their hospital's orientation program (Spector et al., 2015). Today, new graduate RNs need orientation programs that will ensure a smooth transition into nursing practice. This involves the ability to apply higher-level knowledge and skills in everyday practice situations, thereby, maintaining quality care (Henderson, Ossenberg, & Tyler, 2015).

The purpose of this study was to identify differences between new graduate RNs' opinions on readiness for practice, as measured by the Casey-Fink Readiness Practice Survey (Casey et al., 2011). The phases of Benner's (1984) skills acquisition theory was used to determine at which level each participant felt they belonged. These methods were used at the beginning of hospital employment, at 4 weeks of hospital orientation, and at 8 weeks of hospital orientation. Qualitative feedback regarding the effectiveness of hospital orientation programs was collected using a focus group interview at the end of orientation.

A mixed method, descriptive comparative design was used for this research. New graduate RNs from three hospitals in central Alabama were surveyed. A convenience sample of new graduate RNs was used for the survey portion of the research. A sufficient amount of responses to the Casey-Fink Readiness for Practice Surveys was not obtained in order to identify any significant changes from the beginning of orientation programs to the end. The focus group interview included five participants and identified several areas in need of improvement, most significantly the need for a designated clinical educator and consistent preceptors. These findings are significant, specifically

regarding ensuring new graduate RNs are ready for practice, which will help decrease turnover.

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DEDICATION

This work is dedicated to my sons, Allen and Matthew, who have stood by me through all of the challenges I faced throughout this process. It was their undying faith, love, and encouragement that kept me moving forward. My hope is that you both never tire of learning and keep pushing to meet all of your goals, even the ones you might not know are there yet.

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CHAPTER I - INTRODUCTION

Hospitals today need confident, qualified nurses to provide safe and effective nursing care to their patients. Acuity levels among patients in hospitals continue to rise, which increases the level of confidence, knowledge, and skills new graduate registered nurses (RNs) must possess to ensure safe, competent care (Spector et al., 2015). New graduate RNs are expected to come into the clinical setting with basic nursing skills and knowledge. However, clinical staff and supervisors are reporting that new graduate RNs need a higher level of knowledge and skills than those new graduate RNs they see (Missen, McKenna, Beauchamp, & Larkins, 2016). New graduate RNs need a directed and integrated transition into the healthcare team, which involves applying knowledge, skills, and abilities to everyday practice situations, thereby, maintaining quality care (Henderson et al., 2015).

To meet this demand, hospitals have stepped up their hospital orientation with emphasis on developing critical thinking skills, as well as patient care delivery skills. Some facilities have increased the duration and quality of orientation to ensure the new graduate RNs are confident enough to perform effectively in their jobs. Many new graduate RNs think they are rushed through orientation only to get them on the floor more quickly, so they can meet the nurse-patient ratio required by the hospital (Odland, Sneltvedt, & Sörlie, 2014). Kramer (1974) described this phenomenon as “reality shock.” Reality shock is “the startling discovery and reaction to the discovery that school-bred values conflict with work-world values; the work situation as perceived, experienced, and shared by new nurses and includes the total social, physical, and emotional response of the nurse to the unexpected, or undesired, aspects of the

profession" (Kramer, 1974, p. 4). This process involves four different stages: (a) honeymoon stage: the new graduate RN feels excitement over the new job and desires respect from others; (b) shock-rejection stage: new graduate RNs become overwhelmed due to the differences between the values learned during nursing school and the reality of the workplace, which leads to new graduate RNs perceiving the workplace as bad; (c) recovery stage: new graduate RNs begin learning to differentiate between the "good" and "bad" in the clinical setting; and (d) resolution stage: new graduate RNs seek to find a resolution between the differences in school and work. Once this resolution is reached, the new graduate RNs usually believe they are capable of providing quality care. To decrease the impact of reality shock experience in various surroundings, hospitals need to create a way to ease the transition from academia to the clinical setting.

Casey et al. (2011) identified four areas that contribute to new graduate RNs' comfort/confidence as a practicing nurse. The first area is clinical problem solving, which includes interdisciplinary collaboration, the ability to solve problems, and incorporating evidence in clinical decisions. The second area, learning techniques includes methods, such as simulation and reflective writing to strengthen skills and clinical decision making. The third area, professional identity measures how comfortable new graduate RNs are in communicating with patients and families, their satisfaction with choosing nursing as a career, and their readiness for assuming the role of a professional nurse. The fourth section consists of trials and tribulations, which measures ease of delegation, prioritizing care, the ability to recognize changes in patients' condition, and documentation. Within this fourth area, new graduate RNs comfort level when they deal with ethical issues is another measurement. This researcher examined if

there is a difference between new graduate RNs' opinions of readiness for practice, as measured by the Casey-Fink Readiness for Practice Survey (Casey et al., 2011) (Appendix A) at the beginning of hospital employment, at the end of 4 weeks of hospital orientation, and at the end of 8 weeks of hospital orientation.

The rise in nursing shortages within the midst of job stress, dissatisfaction, lack of peer support, and limited professional opportunities contribute to the attrition of nurses. Medical errors account for more 251,000 patient deaths each year (Anderson & Abrahamson, 2017). Practice errors make up the third leading cause of death within the United States (Makary & Daniel, 2016). The cost of medical errors is estimated at between \$17 and \$29 billion per year (Institute of Medicine [IOM], 2011).

To address these concerns, many clinical sites are increasing the number of new graduate RNs and developing more robust orientation programs. Hospitals administrators' aim for these more structured orientations is to facilitate the transition of the new graduate RNs from a novice or advanced beginner to a competent nurse. Other goals are to promote confidence and higher competency level among the new graduate RNs and to increase retention (Kumaran & Carney, 2014; Park & Jones, 2010). When an orientation program is efficiently and effectively implemented by hospitals and completed by the new graduate RNs, the quality of patient care increases; clinical outcomes improve; and hospitals realize decreases in length of stay, lower morbidity rates, lower mortality rates, and increased retention and job satisfaction of new graduate RNs (Copeland, 2017).

Statement of the Problem

Hospitals have a reasonable expectation that new graduate RNs will enter the profession prepared to practice. Staff nurse opinions of new graduate RNs do not reflect this expectation. Research conducted by Missen et al. (2016) about qualified nurses' opinions of new graduate RNs' clinical skills revealed new graduate RNs lacked proficiency in nursing skills. To address the concern for safe and effective care provided by new graduate RNs, hospitals have made efforts to increase the duration and quality of orientation programs.

New graduate RNs often report high-stress levels when transitioning into practice. Molinari and Bushy (2014) found that 25% of new graduate RNs left their jobs due to high levels of anxiety related to practice errors and patient safety. Kramer et al. (1974) described this transition to practice experience of new graduate RNs as "reality shock," which characterizes the conflict between qualification expectations and the reality of professional practice. The length of this transition to practice usually lasts from 12 to 18 months (Duschcher, 2009; Schoessler & Waldo, 2006). Typical hospital orientation programs range from 4 to 8 weeks. As more experienced nurses retire from practice, new graduate RNs must quickly fill the gap, but hospitals sometimes cut their orientations a little short (Spector et al., 2015). Longer orientation programs would most likely facilitate an easier transition into practice thus lessen the effects of a reality shock.

Benner, Sutphen, Leonard, and Day (2010) recognized a critical need for change. They emphasized, "Profound changes in nursing practice call for equally profound changes in the education of nurses and preparation of nurses to teach nursing" (p. 16). Nurse educators have a responsibility to prepare students with a quality nursing education

for safe and effective nursing care. This goal has been reaffirmed by several authors; for example, Sauter, Gillespie, and Knepp (2012) emphasized that educators are needed to teach and produce competent RNs who will provide continuous safe care.

A major role of nurse educators is to teach relevant nursing competencies, such as those associated with quality improvement, interdisciplinary collaboration, and leadership (IOM, 2011). Many of these competencies are not necessarily included in standardized testing and the NCLEX-RN preparation programs. Several researchers have reported findings of student nurses' opinions in their final semester and of new graduate RNs regarding their readiness for practice (e.g., Casey et al., 2011; Dlamini et al, 2014; Lea & Cruickshank, 2015; Usher, Mills, West, Park, & Woods, 2015; Watt & Pascoe, 2013; Wolff, Regan, Pesut, & Black, 2010; Woods et al., 2015). The results of these studies show diverse opinions about pre-licensure and new graduate RNs' readiness for practice. Researchers need more in-depth studies on competency in new graduate RNs' readiness for practice.

Research Questions

The first research question for this study was: Is there a significant difference in new graduate RNs' opinions on readiness for practice as measured by the Casey-Fink Readiness Practice Survey (Casey et al., 2011) at the beginning of hospital employment, at the end of 4 weeks of hospital orientation, and at the end of 8 weeks of hospital orientation? The second research question was: At which level of skills acquisition do the participants feel they meet at the beginning of orientation, at the 4-week mark and at 8 weeks, according to Benner's (1984) skills acquisition theory.

Purpose

The purpose of this study was to examine if there is a difference between new graduate RNs' opinions on readiness for practice, as measured by the Casey-Fink Readiness Practice Survey (Casey et al., 2011) and the phases of Benner's (1984) skills acquisition at the beginning of hospital employment, at the end of 4 weeks of hospital orientation, and at the end of 8 weeks of hospital orientation. Competent care and safe practice of new graduate RNs are important issues in health care in terms of professional standards, patient safety, and the quality of nursing care, especially because of an increasing nursing shortage and a high acuity of patients (Wright, 2014). Hayward, Bungay, Wolff, and MacDonald (2016) interviewed 12 RNs on reasons for leaving their jobs. Several factors lead RNs to leave their jobs: (a) higher patient acuity, (b) heavy workload demands, (c) poor working relationships among nurses and physicians, (d) lack of support from leadership, and (e) adverse effects on their health and well-being. The high acuity level of patients and shorter hospital stays challenge new graduate RNs more than ever to deliver safe and competent nursing care with confidence in their readiness for practice (Woods et al., 2015). Areas of comfort/confidence (clinical problem solving, learning techniques, professional identity, and trials and tribulations) on the Casey-Fink Readiness for Practice Survey (Casey et al., 2011) measure characteristics that contribute to comfort and confidence of new graduate RNs on their readiness for practice. These areas can provide valuable information regarding which areas are most in need of improvement.

Theoretical Framework

The theoretical framework for this study is Patricia Benner's (1984) novice to expert skills acquisition theory, which is a middle range competency theory. The scope of a middle range theory is narrow, specific, and relevant for practice and may be descriptive or explanatory (Fawcett & DeSanta-Medaya, 2013). Benner's (1984) theory is detailed in its explanation of different skills acquisition competency levels and RNs progression to the expert level. Nurses advance from level to level as each skill is taught, understood, and mastered (Altmann, 2007; Benner, 1984). Benner's skills acquisition theory was relevant for this research because this study was about new graduate RNs opinions of readiness for practice, as measured by the Casey-Fink Readiness for Practice Survey (Casey et al., 2011). New graduate RN participants of the study began their entry-level nursing practice at the advanced beginner's skills acquisition level according to Benner's explanation.

Five competency levels comprise Benner's (1984) skills acquisition theory. The beginning or first level is the novice nurse, which characterizes the nursing student attending school before reaching the senior level in the program. At this novice level, students still refer to textbook meanings, use rules to make all decisions about which actions to take based on evidence of a given situation, and are unable to apply concepts. Actions are identifiable to novice nurses who have experience in the skill being learned. The ability to read a sphygmomanometer and recognize signs of a patient becoming agitated are two examples of the novice nurse's skills level. Mastering these skills require little training and experience (Benner, Tanner, & Chesla, 2009).

The second level, the advanced beginner, characterizes a nurse who is marginally capable of performing skills based on past student clinical experience, but still need considerable support and supervision (Benner, 1984). At this level, concepts can be applied in various situations. The advanced beginner is a task-oriented nursing student or new graduate RN, who recognizes changes in patient status and identifies prevailing family concerns. Advanced beginners are dependent on the experience and expertise of others while attempting independence but constantly questioning their ability to contribute.

The third level is competent. At this level, nurses have practiced in new or unusual situations, have learned how to manage these situations, and now follow through without having to think about what needs to be done. Competent nurses are astute enough to predict the needs of the patient because they are engaging in experiential learning.

The fourth level is proficient. Proficient nurses have an improved ability to understand situations of their patients and recognize when a situation is not proceeding as expected. Proficient nurses have an “increased perceptual acuity and responsiveness to a particular situation” (Benner et al., 2009, p. 104). This fourth level characterizes the transitional stage to an expert nurse.

The fifth level of skills acquisition is the expert. Benner (1984) described an expert nurse as having an “enormous background of experience” (p. 32). The key characterization is an increase in intuition. Expert nurses will identify the most notable aspects of a situation and implement the best practice response. They are highly proficient in their skills and performance and use intuition to guide their clinical

judgment and decisions. Nurses reach the expert level from experiences gained throughout their nursing practice career.

Many clinical sites and administrators expect that new graduate RNs should be at an advanced beginner level, or, in some cases, even at the competent level (Woods, 2015). The cost of patient care continues to rise while decreased billing reimbursements are often commensurate with reduction of nurses to provide quality care (Jianghua, Staggs, Bergquist-Beringer, & Dunton, (2016). This sharp double edge creates an intense difficulty for patient care administrators in allocating time and resources to assist new graduate RNs' transition into practice from an advanced beginner to a competent level of nursing practice.

The advanced beginner “demonstrates marginally acceptable performance, is efficient and skillful, [and] [requires] occasional support” (Wright, 2014, p. 8). During this phase, acceptable performance requires that knowledge constantly advances and develops. New graduate RNs often experience feelings of “terror in which they recognize that they are in over their heads and lose all capacity to plan or act” (Benner et al., 2009, p. 59).

Benner's skills acquisition theory is relevant for new graduate RNs who will most likely begin their nursing practice as advanced beginners and move toward the expert level. If new graduate RNs are at either the advanced beginner or the competent level when they enter into practice, the assumption would be that they should feel they are prepared for practice. By this same way of thinking, they would be considered competent at the end of the orientation program. Nurse educators and nurses in clinical practice apply Benner's (1984) novice to expert skills acquisition competency theory as a

framework for mentors and preceptors during the orientation of graduates. Mentors and preceptors are usually at the expert level and share their expertise (Benner, et al 2009). While Benner measures a new graduate RN at the advanced beginner level, this study attempted to determine at which competency level new graduate RNs most relate to at the beginning of employment, at the 4-week mark, and at the 8-week mark.

Operational Definitions

The following terms are the operational definitions for this study.

Readiness for Practice. "...[C]ompetent and having the knowledge, skills, and judgment that is required for such role performance" (Casey et. al., 2011, p. 646).

Participants' readiness for practice will be measured by the Casey-Fink Readiness for Practice Survey (2006) using a Likert-type scale from 1 to 4, with 1 being not confident and 4 being very confident in the section regarding the number of patients in which the new graduate RN is comfortable providing care. The next section, related to the current level of confidence in managing a patient care assignment on an adult Medical/Surgical unit is ranked 1 to 4, with 1 being strongly disagreed and 4 strongly agreed.

Readiness for practice will also be measured by Benner's (1984) skills acquisition theory, which measures competency levels like beginner, advanced beginner, competent, proficient, and expert. According to this theory, new graduate RNs should measure themselves as either advanced beginner or competent. Findings from this portion of the study were used to determine at which level each participant felt they belonged.

New Graduate RNs. New graduate nurses are persons licensed to practice as registered nurses and who are working one year or less (Jewell, 2013; Kramer, 1974; Morrow, 2009; Pennbrant, Nilsson, Öhlén, & Rudman, 2013). Descriptive statistics will

characterize new graduate RNs in a variety of ways, including nominal data such as gender, race, employment status, scholarship status, clinical setting, and participation in NCLEX-RN questions. Years of experience, age, total credit hours, clinical setting, preceptor, course content information, type of health care work experience, senior practicum preparation, type of nursing program, and school of nursing are ratio data which was collected to describe the participants.

New Graduate RN. New Graduate RN opinions mental position, emotion, or feeling some state regarding readiness for practice expressed by new graduate RNs. The Casey-Fink Readiness for Practice Survey will be used to measure nursing student's attitudes towards the four areas—Clinical Problem Solving, Learning Techniques, Professional and Trials, and Tribulations—which were identified by Casey et al. (2011) as areas that contribute new graduate RNs' comfort/confidence as a practicing nurse. This section uses the Likert-type scale with the participants rating their level of comfort/confidence on a scale of 1 to 4, with 1 being strongly disagree and 4 being strongly agree. Results were analyzed using a multivariate analysis of variance (MANOVA) test to determine any significant differences between groups (F value). If a significant difference is found, follow up analysis was performed to see which dependent variables differ.

Hospital Orientation Program: "...the process of introducing new staff to the philosophy, goals, policies, procedures, role expectations and other factors needed to function in a specific work setting. Orientation takes place for both new nurses and when changes in nurses' roles, responsibilities and practices occur" (American Nurses

Association, 2000). Participants were surveyed at the beginning of an orientation program, at 4 weeks and at 8 weeks.

Clinical Problem Solving: Includes interdisciplinary collaboration, the ability to solve problems, and incorporating evidence in clinical decisions. The results of this portion of the survey were analyzed using a MANOVA test to determine any significant differences between groups (F value).

Learning Techniques: The use of educational methods including simulation and reflective writing to strengthen skills and clinical decision making (Casey et al., 2011). The results from this portion of the survey were analyzed using a MANOVA test to determine any significant differences between groups (F value).

Professional Identity: The measurement of how comfortable new graduate RNs are in communicating with patients and families, their satisfaction with choosing nursing as a career, and their readiness for assuming the role of a professional nurse (Casey et al., 2011). The results from this portion of the survey were analyzed using a MANOVA test to determine any significant differences between groups (F value).

Trials and Tribulations: Casey et al. (2011) described trials and tribulations as a new graduate RNs' ease of delegation, prioritizing care, the ability to recognize changes in patients' condition, and documentation. The results from this portion of the survey were analyzed using a MANOVA test to determine any significant differences between groups (F value).

Comfort Level: Involves measuring the level of comfort of new graduate RNs when dealing with ethical issues (Casey et al., 2011). The results from this portion of the

survey were analyzed using a MANOVA test to determine any significant differences between groups (F value).

Assumptions, Limitations, and Delimitations

Assumptions

The assumptions for this research included:

1. Opinions of new graduate RNs on their readiness for practice are reported honestly and can be measured.
2. New graduate RNs have the potential to progress from advanced beginner to competent.
3. Participants will complete all three surveys.

Limitations

Limitations of a study include inadequate samples, problems with the study design and weakness in data collection and analysis (Polit & Beck, 2012). The study was limited to only three hospitals. Therefore, the ability to generalize the findings to the larger population of new graduate RNs will be impossible, which can cause an external validity threat. Internal validity threats were not identified for this study, as they occur mainly in experimental research.

Delimitations

Delimitations are defined as boundaries set by the researcher for the study (Polit & Beck, 2012). Participants were new graduate RNs surveyed at the beginning of employment, at the end of 4 weeks, then 8 weeks, of hospital orientation. A convenience sample was limited to three hospitals which prevent the findings from generalization to all new graduate RNs.

Significance of the Study

A significant global concern exists regarding new graduate RNs' preparation for clinical practice (Usher et al., 2015). Studies regarding the concept of readiness for practice have been conducted in Australia, Canada, and the United Kingdom (Morrell & Ridgway, 2014). These concerns, if actual concerns exist, have the potential to pose a threat to patient safety, employee morale, and confidence of new graduate RNs. If new graduate RNs are not confident in their readiness for practice, hospital orientation changes need to be implemented to correct the identified areas of weakness.

To ensure new graduate RNs are competent enough to provide quality health care, the confidence of new graduate RNs must be measured. These findings have the potential to isolate specific areas of nursing education and hospital orientation. If nursing education has a missing link, research findings to discover that missing link could contribute knowledge to inform administrators on how to strengthen hospital orientation programs. An increase opinion of readiness for practice facilitates a smooth transition from academia to practice. Knowledge regarding new graduate RNs' opinions of competency and readiness for practice could improve hospitals' retention rates of new graduate RNs (Kajander-Unkuri et al., 2015).

Findings from this research provide useful data for hospital and academic nurse educators for the creation of strategies to promote new graduate RNs' readiness for practice. This study's findings provide a comparison between new graduate RNs' opinions on readiness for practice at the beginning of hospital employment and readiness for practice throughout the orientation process. New graduate RNs must provide competent and safe care, encompassing an array of skills, including bedside nursing, the

building of relationships, the necessary system skills, and electronic documentation. The findings from new graduate RNs' opinions on their readiness for practice contribute knowledge to identify areas in need of improvement.

Summary

Chapter I consisted of a plan for gathering data from new graduate RNs on their opinions of their readiness for practice as measured at the beginning of employment, at the end of 4 weeks, then 8 weeks, of hospital orientation. The level of readiness for practice could affect new graduate RNs' ability to provide safe and competent care. Because new graduate RNs are expected to work independently soon after graduation, the confidence level in their readiness for practice is important. Identifying new graduate RNs' opinions on readiness for practice will provide a basis for a smoother transition into practice (Wright, 2014).

CHAPTER II – LITERATURE REVIEW

Introduction

The purpose of this study examined differences between new graduate RNs' opinions of readiness for practice, as measured by the Casey-Fink Readiness Practice Survey (Casey et al., 2011) at the beginning of hospital employment, at the end of 4 weeks of hospital orientation, and at the end of 8 weeks of hospital orientation. A search for literature was performed from the domains of nursing, new graduate RNs, readiness for practice, hospital orientation, orientation programs, and nursing theory. The databases used for the literature review included: CINAHL, Ovid, Science Direct, ProQuest, and Ebsco Host. Only articles within the past 5 years have been incorporated, except for landmark writings.

The literature review for this research is organized in two different sections. The first section assesses studies related to readiness for practice. The second section will include studies related to hospital orientation programs and their effects on readiness for practice.

Readiness for Practice

Several descriptions were found relating to readiness for practice. Readiness for practice is defined as:

Having a generalist foundation and some job-specific capabilities, providing safe client care, keeping up with the current realities of nursing practice, being well equipped with the tools needed to adapt to the future needs of clients, and possessing a balance of doing, knowing and thinking. (Wolff et al., 2010, p. 1)

Wolff et al. (2010) conducted qualitative research that involved a focus group to identify four areas of readiness for practice: (a) having a generalist foundation and some job-specific capabilities; (b) providing safe client care; (c) keeping up with the current realities and future possibilities; and (d) possessing a balance of doing, knowing, and thinking. The results of this study found that all participants reported that being ready meant being prepared to perform entry-level competencies and having some “job-specific” capabilities. Participants also agreed that safe client care is an important component of nursing practice. Results regarding keeping up with current realities and future possibilities showed that participants feel that new graduate nurses should be capable of performing in the current environment, as well as being adaptable to the ever-changing healthcare environment. Responses regarding possessing a balance of doing, knowing, and thinking agreed that these are basic entry characteristic of new graduate readiness in clinical practice.

Another group of researchers described readiness for practice as being competent and having the knowledge, skills, and judgment required for effective performance as a nurse (Casey et al., 2011). They conducted a study of 429 senior BSN students to identify factors that influence self-perceptions of senior nursing students regarding readiness for practice and their confidence level with nursing skills. The Casey-Fink Readiness for Practice Survey (Casey et al., 2011) was the instrument used for the study. The criterion for participation was that schools must have provided a rigorous clinical practicum, which included a mentorship with a nurse practitioner. Casey et al. (2011) identified the following areas that needed improvement: “delegating of tasks, handling

multiple patient assignments, calling the physician, responding to a change in patient condition, and treating a patient who is dying” (p. 651).

These researchers found that 3% ($n = 14$) of those surveyed believed they were independent in all skills. Under the comfort/confidence subscale, respondents reported feeling comfortable communicating with interdisciplinary team members ($M = 3.20$, $SD = 0.57$); however, rated themselves low regarding communication with physicians regarding patient care issues ($M = 2.88$, $SD = 0.68$). Confidence was shown regarding their ability to problem solve ($M = 3.29$, $SD = 0.52$) and their ability to identify actual or potential safety risks ($M = 3.28$, $SD = 0.49$). Confidence was also showing in their ability to take actions to solve problems ($M = 3.19$, $SD = 0.48$), and use current evidence to make clinical decisions ($M = 3.22$, $SD = 0.53$). Participants showed less confidence regarding care for a dying patient ($M = 2.60$, $SD = 0.75$).

In the area of Learning Techniques (2 items), respondents felt that simulation experiences helped them feel ready for clinical practice ($M = 2.63$, $SD = 0.85$) and that writing reflective logs provided insights into clinical decision-making skills ($M = 2.37$, $SD = 0.81$). The Professional Identity area of the survey (5 items) showed confidence in dealing with patients and family members. Participants reported dealing with patients and family as the skill they are most comfortable performing ($M = 3.47$, $SD = 0.55$), as well as asking for help from others ($M = 3.66$, $SD = 0.50$). Respondents reported satisfaction with their choice of nursing as a career ($M = 3.61$, $SD = 0.55$) and felt prepared to begin their role as a professional nurse ($M = 3.24$, $SD = 0.59$). They also believed their clinical instructor provided feedback about readiness to assume an RN role ($M = 3.31$, $SD = 0.70$).

The Trials and Tribulations section (6 items) showed participants were at ease with delegating tasks to the nursing assistant ($M = 3.03, SD = .62$). Few respondents found prioritizing patient care needs difficult ($M = 1.87, SD = 0.56$), recognizing a significant change in the patient's condition ($M = 1.81, SD = 0.56$), and documenting in the electronic medical record ($M = 1.65, SD = 0.66$). Respondents rarely felt overwhelmed by ethical issues associated with patient care responsibilities ($M = 1.79, SD = 0.59$). Participants felt that practicing skills more than once ($M = 3.21, SD = 0.63$) was a strategy that contributed to an increase in self-confidence.

Usher et al., (2015) measured two separate cohorts' perceptions regarding readiness for practice. Areas measured involving comfort/confidence levels included: professional identity, ethical practice, and systems of care. These areas were measured on a 4-point Likert scale. Any item with mean scores less than 2.5 signify overall disagreement, whereas means scores above 2.5 signify agreement with the statements. In the professional identify section, both cohorts describe somewhat low levels of confidence. Both cohorts agree that their clinical preceptors did give feedback regarding their readiness for practice and conveyed confidence in their ability to problem solve. The ability to practice skills more than once and to participate in simulation experience was reported to be helpful in preparation for practice by both cohorts. All respondents reported feeling confident they were ready for the professional nursing role.

Within the ethical practice arena, confidence in communicating with patients from diverse backgrounds was reported as high by both cohorts. The cohorts both felt comfortable with the delegation of tasks to nursing assistants and neither group felt overwhelmed concerning ethical issues regarding patient care. All respondents felt they

were not comfortable taking care of a dying patient. The 2012 cohort did not feel that reflective logs provide insights into clinical decision-making skills, whereas the 2013 cohort agreed that they were helpful. Both cohorts were confident in their ability to recognize safety hazards and both felt the same level of comfort communicating with interdisciplinary team members.

In the area of systems of care, both cohorts dispute any claims of difficulty with patient documentation or prioritization of patient care. However, the 2012 cohort were more in support of these statements ($p = 0.002$, $p = 0.01$, respectively). Dlamini et al. (2014) surveyed 31 participants who participated in 2 focus groups discussions. Among the participants were 6 nurse educators, 6 unit managers from the health care facility where students practice, 4 nurse leaders, and 15 registered nurses from the clinical practice setting, who worked in the units where general nursing students are allocated for clinical placement. The researchers asked three questions: (a) what are your views regarding the recent graduates in terms of their clinical proficiency, (b) what factors could have influenced their competency, and c) how.

Two categories were identified during the data analysis. The first category was “at graduation” in which the theme “not ready for practice” was identified. The nurse leaders and nurse educators believed that new graduates had the theory down but were not competent in the clinical area. A second theme “comparing graduates” emerged from a difference of opinion regarding preparation for practice between those nurses who completed a three-year diploma program followed by a two-year nursing degree and those who received their training through an apprenticeship model. The college degree graduates had not had time to practice between the three-year diploma and two-

year degree, leaving them less prepared than those in the apprenticeship model. The third theme “support us” relates to new graduates’ reports of a lack of orientation programs when entering into clinical practice.

Category 2 entitled “during preparation” identified two themes. The first theme, “no passion for nursing,” describes the stakeholders’ opinions that new graduates do not enjoy nursing and view it as a gateway to other careers. The stakeholders believed this opinion was especially true of the college prepared graduates. The second theme “devaluing of clinical practice component during training” identified a discrepancy between theory preparation and clinical preparation. Stakeholders perceived that more emphasis was put on passing the theory part and not as much on the clinical part of the program. As a result, new graduates were not competent in practice.

Woods et al. (2015) conducted a descriptive study using the Casey-Fink Readiness for Practice Survey. The study was sent to 235 third year BSN students at 5 campuses and external students. A total of 113 questionnaires were completed, giving a response rate of 48%.

The participants’ results from the Comfort/Confidence subscales were as follows:

Professional Identity (7 items). The survey showed that participants were confident in their ability to communicate with physicians regarding patient care ($M = 2.96, SD = 0.74$). Respondents also reported receiving feedback regarding readiness to assume an RN role from their clinical preceptor ($M = 3.35, SD = 0.71$). Confidence in problem solving was strong ($M = 3.20, SD = 0.55$). Respondents reported they had opportunities to perform skills and procedures more than once ($M = 3.03, SD = 0.85$),

and 75% of respondents agreed that simulation experiences were helpful in feeling prepared for clinical practice ($M = 2.63$, $SD = 0.85$). Participants reported feeling ready for the registered nursing role ($M = 3.22$, $SD = 0.69$) and a high level of satisfaction with their choice of nursing as a career ($M = 3.62$, $SD = 0.58$).

Ethical Practice (9 items). In the area of ethical practice, those surveyed reported being comfortable interacting with patients from diverse backgrounds ($M = 3.46$, $SD = 0.52$) and also felt comfortable delegating tasks to nursing assistants ($M = 2.97$, $SD = 0.60$). Participants did not feel overwhelmed by ethical issues arising during patient care ($M = 1.97$, $SD = 0.63$). They also reported using current evidence to make clinical decisions ($M = 3.27$, $SD = 0.47$). Participants reported feeling confident in their problem solving abilities ($M = 3.22$, $SD = 0.51$) and were also confident in the care of a dying patient ($M = 2.94$, $SD = 0.74$). Confidence in their ability to identify actual or potential safety risks ($M = 3.25$, $SD = 0.50$), and interdisciplinary communication were skills in which respondents felt confident ($M = 3.19$, $SD = 0.53$). Respondents disagreed with the assertion that writing reflective journals helped to gain insight into clinical decision-making skills ($M = 2.36$, $SD = 0.83$).

Systems of Care (4 items). Patient care documentation was reported as a skill with which most respondents felt comfortable ($M = 1.71$, $SD = 0.59$). A small number of respondents identified they had difficulty with prioritization of patient care needs ($M = 1.72$, $SD = 0.53$) and with the recognition of a change in patient condition ($M = 1.83$, $SD = 0.74$). Participants felt comfortable asking for help from others ($M = 3.50$, $SD = 0.61$).

The authors report that the majority of respondents reported feeling confident when managing 2 patients (65%), less than half reported confidence in care for 3 patients (48%) and only 35% reported high levels of confidence managing 4 patients. The authors ran a Spearman's Rank Order correlation which revealed a small statistically significance inverse correlation regarding age and confidence when caring for 3 patients ($r(97) = -.217, p = .033$). The researchers found that confidence in managing multiple patients decreased with age (Woods et al., 2015).

Questions about nurse graduates' readiness for practice continue to be widespread. Researchers examined to what degree students believed they were not ready for their career in nursing (Morrell & Ridgeway, 2014). Using interpretive phenomenology, Morrell and Ridgeway extrapolated the following themes from student nurses: "being used as an extra set of hands, mentors appearing to treat student practice documentation as unimportant, high staff expectations, importance of a mentor, students feeling that they lacked knowledge, and students feeling unsupported and stressed" (Morrell & Ridgeway, 2014, p. 518).

El Haddad, Moxham, and Broadbent. (2016) conducted a grounded theory study surveying Australian acute care Nursing Unit Managers (N) and Bachelor of Nursing Program Coordinators (BNPCs) regarding their view of readiness for practice. Sixteen BNPCs and NUMs were surveyed using semi-structured interviews. The results from this study found that these two groups perceive new graduates differently based on their own perspectives and expectations of what readiness for practice means.

In 2010, the World Health Organization (WHO) reported the need for education regarding collaboration and communication with other health professionals. Durkin and

Feinn (2017) surveyed traditional and accelerated BSN student nurses to examine self-efficacy in relation to interprofessional collaboration and communication. The researchers surveyed 239 traditional and 114 accelerated BSN students using Mann et al's Self-Efficacy for Interprofessional Experiential Learning Scale (SEIEL). This measurement tool is a 16-item instrument, with each item identifying an aspect of the student role as it relates to collaborating and communicating with members from different professions. Results revealed accelerated BSN students averaged significantly higher than traditional BSN students on the interprofessional team evaluation and feedback subscale ($p = .006$) and overall self-efficacy ($p = .041$). The authors concluded that being aware of differences between traditional and accelerated BSN students could aid faculty in developing effective experiences for interprofessional learning, contributing to the new graduate's readiness for practice.

Hospital Orientation

Odland et al. (2014) interviewed 8 new graduate RNs in a qualitative study using a phenomenological hermeneutic method with narrative interviews and text analysis. The researchers found that new graduate RNs reported they did not feel prepared as they anticipated. These nurses reported various orientation periods, depending on the circumstances on individual units. Some nurses' experiences involved having just three duties while under the mentorship of an experienced nurse. Others described their orientation period as a 4-week training period followed by a mentorship for 1 year. Experiences ranged from having three duties at the beginning under the mentorship of an experienced nurse to a 4-week training period following by mentorship for 1 year. Lack of available personnel was reported as one factor in the lack of an orientation program.

This factor led to a feeling of being thrown out into the reality of patient care while feeling unprepared for the role.

Park and Jones (2010) performed an integrated review of research of 17 studies involving orientation programs lasting from 6 weeks to 1 year. These programs incorporated classroom learning, clinical experience along with a preceptor. Seven of the studies reported an increase in self-confidence. Anderson et al (2012) reviewed 20 studies. In this review, findings identified a need for standardized curricula and program procedure during orientation. Issues highlighted from this review included poorly described interventions among the nurse residency programs, lack of consistency in evaluation tools, variations in program length, and lack of standardized evidence-based curriculum (Goode, Reid-Ponte & Sullivan-Havens, 2016).

In a study conducted by Chappell, Richards, and Barnett (2014), 4,000 nurses were surveyed to evaluate the relationship between new nurse graduates and their clinical leadership skills. The study began when they entered into practice. The study assessed two areas: the relationship between new graduates and their clinical skills and between new nurse graduate transition into practice and their clinical skills. This research involved the University of Colorado Hospital/American Association of Colleges of Nursing (UCH/AACN), the Versant program or curricula developed by the organization itself. Transition programs lasting at least 24 weeks showed a positive impact on clinical leadership skills. The UHC/AACN program curriculum showed the most positive impact on new nurse graduates with the Versant program curriculum showing the next greatest impact. Perceived overall quality of a new graduate nurse transition program was the strongest predictor of clinical leadership skills ($r = 0.041, p < .01$). Clinical experience

and new graduate nurse transition program characteristics accounted for 6.9% of the variance in clinical leadership skills and 12.6% of the variance among RNs with assigned mentors ($p < .01$).

Between 2010 and 2015, Kavanagh and Szweda (2017) surveyed over 5,000 new graduate RNs using the Post hire and prestart Performance-Based Development System (PBDS) assessments to measure entry-level competency and practice readiness. This tool includes a combination of video vignettes and narrative clinical situations to measure different competencies associated with clinical judgment. These competencies include the ability to recognize and manage patient problems. The PBDS also measures additional competencies including differentiation of urgency and nursing care rationale. The results of this study found an average of 23% of new graduate nurses scored in the acceptable “safe to practice independently”, 23% failed to recognize changing patient conditions or level of urgency, while 54% successfully identified changes in patient conditions but failed to manage to problem effectively. Overall, aggregate baseline data collected from this study revealed that only 23% of newly graduated RNs demonstrated entry-level competencies and practice readiness.

Conclusion

The literature review confirmed the importance of orientation programs for the success of new graduate RNs. The review also indicated a lack of confidence among new graduate nurses. However, none of the studies discussed a relationship between the use of hospital orientation programs and the new graduate RNs’ opinions regarding readiness for practice. While many studies have been conducted looking into the impact of orientation programs, little information is available regarding new graduate RNs’ opinion

regarding their own self-confidence from the time of graduation to the time they complete an orientation program.

CHAPTER III - METHODOLOGY

Research Design and Approach

The design for this research is a mixed method, descriptive comparative design. Polit and Beck (2012) defined descriptive research as, “Research that typically has as its main objective the accurate portrayal of people’s characteristics or circumstances and/or the frequency with which phenomena occur” (p. 725). This researcher examined the data for the difference between new graduate RNs’ opinions of readiness for practice and competency level, as measured by the Casey-Fink Readiness for Practice Survey (Casey et al., 2011) and focus group discussions.

Investigators generally use descriptive comparative designs to test for a significant difference between two or more variables. For this study, a comparative design is the best choice because the researcher analyzed the data to determine if there is a difference between graduate RNs’ opinions of readiness for practice, as measured by the Casey-Fink Readiness for Practice Survey (Casey et al., 2011). Additional questions related to the new graduate RNs’ perception of where they fall on Benner’s (1984) skills acquisition theory was added to the survey. Focus groups were used at the end of the 8-week period in order to collect comprehensive information regarding attitudes, insights, and viewpoints related to the hospital orientation experience (Then, Rankin & Ali, 2014).

Setting and Sample

This convenience sample size was selected from three hospitals. The sample consisted of new graduate RNs at the beginning of hospital employment and followed each group through their hospital orientation program repeating the survey at the end of 4 weeks of hospital orientation and at the end of 8 weeks of hospital orientation. The

measurement of new graduate RNs' opinions occurred at three separate intervals if they meet the employment or orientation level required for the study, meaning that new graduate nurses were asked to complete the survey on three different occasions. At the end of the 8-week period, a focus group was convened to allow participants to give insight into their experiences and opinions regarding their orientation. This survey was administered during June and August of 2018 to BSN graduates.

Instrumentation and Materials

Instrument – Casey Fink Readiness for Practice Survey

The Casey-Fink Readiness for Practice Survey (2011) includes three sections (see Appendix B). The first section is composed of demographic data, including age, gender, ethnicity, and practicum and work experience information. The second section consists of an assessment of the new graduate RNs confidence level in performing in both clinical and communication areas. Of a set of 18 skills, the participants will identify 3 of those skills in which they do not feel confident in performing without assistance or supervision. If there is an additional skill the student is uncomfortable performing, not included in the 18 skills, the student will add it under additional skills. The third section consists of the new graduate RNs' opinions on comfort level in performing multiple patient assignments. The new graduate RN participants will rate their comfort level on a 20-item scale using a 4-point Likert-type scale (1 = strongly disagree, 2 = disagree, 3 = agree, and 4 = strongly agree) (Casey et al., 2011).

Content validity for the Casey-Fink Readiness for Practice Survey was documented by a panel of expert nursing directors and nurse educators (Casey et al.,

2011). The experts were recruited from academia and private hospitals. A literature review was used to build the content of the instrument.

For reliability, an exploratory factor analysis was performed by surveying 162 BSN students from programs in Denver, Colorado. This survey used factor analysis to confirm the results of the exploratory factor analysis. Polit and Beck (2012) explained that confirmatory factor analysis is preferred to exploratory factor analysis because confirmatory factor analysis tests the hypothesis related to the items under each factor. Exploratory factor analysis has the “dimensionality of a set of items [that] emerge empirically” (p. 368). This confirmatory factor analysis surveyed 267 BSN students from three different nursing programs in Denver, Colorado. The Statistical Package for the Social Science (SPSS) (2018) version 19 software was used to perform the exploratory factor analysis with AMOS version 19 software being used for the confirmatory factor analysis. Results yielded overall internal reliability on Cronbach’s coefficient alpha of r (0.69) for 20 comfort/confidence items.

The Kaiser criterion initially was for the researcher to use up to 8 factors, but the most translatable resolution for the confirmatory factor analysis in this study was to use a 4-factor set of correlated subscales. Those subscales on the Casey-Fink Readiness for Practice Survey were clinical problem solving, learning techniques, professional identity, and trials and tribulations.

Casey et al. (2011) used factor loading and theoretical considerations when identifying similar concept categories, or factors. Analysis of the subscales was performed in the following manner:

Cronbach's alphas for the subscales ranged from 0.50 (for the two-item learning techniques subscale) to 0.80 (for the seven-item clinical problem-solving scale). In the independent validation sample (the confirmatory factor analysis), the same four factors provided an adequate fit for the observed data ($\chi^2/df = 2.00$, Confirmatory Fit Index (CFI) = 0.86, Root Mean Square Error of Approximation = 0.06). This level of fit was considered acceptable, although a CFI value less than 0.90 still indicates room for improvement. (Casey et al., 2011, p. 649)

Focus Group

Participants were invited via email to attend a focus group at the end of the eight-week period. Participation in the discussion will be purely voluntary. The focus group was held in a neutral setting away from the clinical site. The questions used for the focus group discussion were derived from analyses of the Casey-Fink information. These guided interview questions were developed to further understand the major areas identified as either very high or very low confidence and comfort levels. Additionally, participants were asked about specific experiences in orientation that they view as most and least valuable in increasing their confidence and comfort. Questions related to the focus group portion of the study were sent to a panel of experts to ensure clarity and validity (Appendix B). Finally, participants were provided an opportunity to respond to open-ended prompts. The discussion should take approximately 30 minutes.

Procedures

A comparative mixed method descriptive study using a quantitative and qualitative approach was administered online by using Qualtrics Survey Software (2017) to a convenience sample of new graduate RNs. Emails containing an explanation of

participation in the study and the link to the survey was sent directly to the director of the education department of each hospital who forwarded the link to the new graduate RNs participating in their orientation program (Appendix C). Participation was voluntary and could be discontinued at any point without repercussions by not continuing. The aims of the study were included in the email, along with the researcher's contact information.

Each participant was assigned a random code, which they used for each survey. This code ensured that the same participants were taking the surveys each time. The codes did not identify the participant. The codes were used only to ensure the same people are participating at each interval. The new graduate RN participants completed a multiple-choice questionnaire at the beginning of hospital employment, at the end of 4 weeks of hospital orientation, and at 8 weeks of hospital orientation. They answered yes or no on an item about their entry level preparedness: bachelors-prepared entry level or associate degree-prepared entry level.

At the 8-week mark of the orientation program, a group of 6-8 participants was convened for a focus group discussion. The discussion was audiotaped; no participants were identified by name. Code names were assigned to each participant to protect his/her identify. For example, participant 1, participant 2, etc. The discussion was transcribed by a professional transcriptionist. The researcher identified themes using a thematic approach and include the themes in the results of the study.

Participants were not identifiable, so their anonymity was protected. Participants were assured that any data collected would remain anonymous and confidential. Incentives by monetary compensation were not awarded to participants. Approval was obtained from The University of Southern Mississippi's Institutional Review Board (IRB

18060406) (Appendix D), as well as the participating hospitals prior to initiation of this study. Participation in the study was completely voluntary.

Data Analysis

Participants were not identifiable, so their anonymity was protected. Participants were assured that any data collected would remain anonymous and confidential.

Incentives by monetary compensation were not awarded to participants. Approval was obtained from The University of Southern Mississippi's Institutional Review Board (IRB 18060406) (Appendix D), as well as the participating hospitals prior to initiation of this study. Participation in the study was completely voluntary.

Description of the Variables

The dependent variable is the opinions of new graduate RNs about their readiness for practice, as measured by the Casey-Fink Readiness for Practice Survey (Casey et al., 2011). The Casey-Fink Readiness for Practice Survey has three sections. The first section includes the nominal categorical demographic data, as well as pre-graduation practicum experience data including information regarding hours of the practicum, clinical location, preceptor information, and course content. The second half of the first section consists of ordinal data about the new graduate RNs' confidence with clinical and relational skill performance. From a list of 18 skills and procedures, new graduate RNs will identify which 3 skills are at the top of the least comfortable performing independently. If there are skills not listed, participants have the option of adding items.

The second section produces ordinal data dealing with the participant's level of comfort in multitasking or handling multiple patient assignments. This section consists of a 20-item survey to which new graduate RNs will respond on a Likert-type scale as

follows: 1 = strongly disagree, 2 = disagree, 3 = agree, and 4 = strongly agree regarding their level of confidence with each item. The third section contains two qualitative, open-ended questions requesting the respondents' narrative comments on reasons for entering nursing and their opinions regarding what would be helpful to better prepare them to be comfortable entering practice (Casey et al., 2011).

Research Questions

The first research question was: Do hospital orientation programs contribute to new graduate RNs' beliefs regarding their readiness for practice based on the Casey-Fink Readiness for Practice Survey?

The second research question was: Does new graduate RNs' level of confidence increase as they progress through a hospital orientation program?

The third research question was: Does new graduate RNs' perception of competency level based on Benner's (1984) skills acquisition theory increase as they progress through a hospital orientation program?

Analytical Tools

Descriptive statistics yielded means, standard deviations, and range scores for each of the variables. Inferential statistics were analyzed using a MANOVA to determine any significant differences between each survey and the variables (F value). No significant differences were found, therefore, no follow up analysis was performed to see which dependent variables differ. These analyses were performed by entering data into SPSS version 19 (2013) software for analysis.

Qualitative data obtained during the focus group interviews will be analyzed using an inductive thematic analysis to provide meaning to the quantitative results. The

audio recordings during the focus group interviews will be downloaded to password-protected audio digital files on a secure USB flash drive. Participants in the interviews and focus groups were assigned a code known only to the researcher and maintained in a codebook that was kept secured in a locked filing cabinet in a locked private office. A professional transcriptionist transcribed all interviews and focus group recordings verbatim with voice inflections and sounds described in parentheses. The transcripts were examined for emerging themes using the thematic approach. The researcher obtained guidance from the statistician on statistical analysis and interpretations. The dissertation chair assisted with the narrative responses.

Protection of Participants' Rights

An informed consent email (See Appendix A) detailing the background and purpose of the study will be sent to prospective participants. Contained in the email were instructions for accessing the survey through a web link. Although clicking the link to access the survey implies consent, participants may withdraw from the survey at any point in time without penalty. A thorough description and purpose of the study were emailed to the participants, along with a link to the survey. There were no known or foreseeable risks to the participants. Participants remained anonymous.

Data from the study will be kept electronically by the researcher for a period of three years. These data will be stored on a specifically designated, individual USB flash drive and stored in a locked file cabinet. No identifying information of each participant was collected or stored with data results.

Summary

In Chapter III, the goal was to outline the research method used in order to answer each research question. This researcher described the approach, the study sample, the procedure for data collection and the focus group interview. The comparative mixed method was used to examine the attitude of new graduate RNs regarding their readiness for practice. In Chapter IV, the results of the study will be discussed.

CHAPTER IV – RESULTS

The purpose of this study was to assess new graduate RNs' opinions regarding their readiness for practice as measured by the Casey-Fink Readiness for Practice Survey. New graduate RNs were surveyed at the beginning of orientation, at the 4-week mark, and at 8-weeks of orientation. Data were compiled into a dataset and analyzed using IBM SPSS version 22. In this chapter, findings from those surveys will be presented and discussed.

Participant Demographics

The mean age for participants in all 3 surveys is 23.77 ($SD= 2.53$) and a range of 22 to 34 years of age. In the first survey with 27 respondents ($N = 27$), 2 were male (7.4%) and 25 were female (92.6%). For the second survey of 6 respondents ($N = 6$), 1 participant was male (16.7%) and 5 participants were female (83.3%). In the third survey at the 8-week mark, with 3 respondents ($N = 3$), 1 was male (33.3%) and 2 were female (66.7%). For the first survey, 19 respondents ($n = 19$) were Caucasian (70.4%), 6 ($n = 6$) were black (22.2%) and 2 ($n=2$) were Asian (7.4%).

Table 1

Frequencies Describing Gender and Ethnicity

		Baseline (<i>N</i> = 27)	
		<i>n</i>	%
Gender	Male	2	7.4
	Female	25	92.6
Ethnicity	Caucasian	19	70.4
	Black	6	22.4
	Asian	2	7.4

Data regarding each participant’s senior practicum experiences are listed in Table 2. When asked “What previous health care work experience have you had?”, the majority of respondents in the first survey reported having had nursing assistant experience (40%) with the second largest form of experience being student externship (20%). From these data, student externship is the most reported type of previous work experience among respondents from all three surveys.

Participants were also asked to identify their clinical area of employment. From the first survey at the beginning of orientation, 40.7% reported working in adult M/S (*n* = 11) and adult ICU each (*n* = 11), with 11.1% (*n* = 3) in OB, and 3.7% in both pediatrics (*n* = 1) and mental health (*n* = 1). Adult M/S and Adult ICU were the most common clinical areas of employment from all three surveys.

When asked if their clinical practicum experience was at their current place of employment 50% of respondents at the beginning of orientation reported yes. For the question regarding what area their clinical practicum was located, 88.9% (*n*=24) chose urban and 11.1% (*n*=3) chose rural at the beginning of orientation. When asked if they

were required to answer NCLEX questions during their senior practicum, twenty-one ($n = 21$) chose yes (77.8%) and six ($n = 6$) chose no (11.1%).

Table 2

Frequencies of Categorical Variables Describing Senior Practicum Experience

		Baseline ($N = 2$)	
		N	%
What previous health work have you experienced?			
	Nursing Assistant	10	40
	Medical Assistant	3	12
	Volunteer	2	8
	Student Externship	5	20
	Nurse Intern	1	4
	Other	4	16
What is your clinical area of employment?			
	Adult M/S	11	40.7
	Adult ICU	11	40.7
	OB	3	11.1
	Pediatrics	1	3.7
	Mental Health	1	3.7
Was your clinical practicum experience at your current place of employment?			
	Yes	14	51.9
	No	13	48.1
What area was your clinical practicum located			
	Urban	24	88.9
	Rural	3	11.1
Were you required to complete NCLEX questions during experience?			
	Yes	21	77.8
	No	6	22.2

Respondents were also asked to identify how many NCLEX-RN questions they were required to answer, as well as clinical hours completed, hours spent with a charge nurse and number of primary preceptors, as found in Table 3. Twenty-six ($N = 26$) responded to this question at the beginning of orientation. The mean number of questions answered was 321 ($M = 321$), the standard deviation was 546 ($SD = 546$) with a range of 50–250 questions.

Table 3

Number NCLEX Questions

	Baseline ($N = 26$)		
	<i>M</i>	<i>SD</i>	Range
Number of NCLEX questions completed	321	546	50-250
Clinical hours completed	141	47	40-240
Hours spent with charge nurse	54	64	0-240

Respondents were next asked to select three skills in which they were least comfortable performing independently. Table 4 lists these skills for all three surveys. In the first survey, the top three skills identified were chest tube care (51%), charting/documentation (40%), and giving verbal report and responding to emergency/Code Blue (CODE)/changing patient condition tied for third place at 29% each. For participants who remained and responded at 4 weeks, responding to emergency/CODE/changing patient condition moved into first place with 100% choosing

this item. Bladder catheter insertion was the second highest at 50% with blood draw/venipuncture and IV start tying for third place at 33% each. For the final three participants at 8 weeks, chest tube care and responding to emergency/CODE/changing patient condition tied for first place, followed by bladder catheter insertion, charting/documentation, electrocardiogram (EKG)/telemetry monitoring, trach suctioning and wound care/dressing changing each at 33%. In reviewing these results, the skill that was consistently ranked high in all three surveys was responding to emergency/CODE/changing patient condition.

The data show that the new graduate RNs did become more comfortable with all skills with the exception of chest tube care and responding to emergency/CODE/changing patient condition. Since the majority of respondents did report feeling more comfortable with the majority of the skills, listed, the data support the assumption that new graduate RNs do become more comfortable

Table 4

Skills Least Comfortable Performing Independently

Skill	Baseline (N = 27)	
	n	%
Chest tube care	14	51
Charting/Documentation	11	40
Responding to emergency/CODE/changing patient condition	8	29
Giving verbal report	8	29
Assessment skills	7	25
NG Tube/Dobhoff care	7	25

Blood draw/venipuncture	7	25
EKG/telemetry monitoring	6	22
Trach care/suctioning	6	22
Blood glucose monitoring	5	18
Bladder catheter insertion	4	14
IV/PCA pump operation	4	14
Wound care/dressing change	4	14
IV medication administration	3	11
IV start	0	0

Table 5 describes the new graduate RNs' level of confidence in caring for different numbers of patients. While only 33% of respondents reported feeling extremely confident caring for two patients at the beginning of orientation, this rose to 100% at the 8-week mark. Conversely, caring for four patients dropped from 38% feeling somewhat confident down to only 33% at the 8-week mark. None of the respondents reported feeling extremely confident caring for 5 patients at the beginning of orientation as opposed to 33% at the 8-week mark.

Table 5

Level of Confidence Managing Patients

Number of Patients	Baseline (N = 2)	
	N	%
Level of confidence managing 2 patients	Extremely confident	9 33
	Somewhat confident	16 59
	Neither confident nor not confident	0 0

	Somewhat less confident	1	3
	Not confident at all	1	3
Level of confidence managing 4 patients			
	Extremely confident	1	3
	Somewhat confident	10	38
	Neither confident nor not confident	6	23
	Somewhat less confident	6	23
	Not confident at all	3	11
Level of confidence managing 5 patients			
	Extremely confident	0	0
	Somewhat confident	6	24
	Neither confident nor not confident	2	8
	Somewhat less confident	10	40
	Not confident at all	7	26

The first research question is: Do hospital orientation programs contribute to new graduate RNs' beliefs regarding their readiness for practice based on the Casey-Fink Readiness for Practice Survey?

Table 6 lists where the new graduate RNs felt they fell according to Patricia Benner's skills acquisition theory. At the beginning of orientation fifteen ($N = 15$), 57% felt they were at the advanced beginner level, while nine ($N = 9$) or 34% felt they were still at the novice stage. At the 4-week mark, none of the remaining respondents chose the novice state while four ($N = 4$) 66.7% identified themselves at the advanced beginner level. At the 8-week mark, all three ($N = 3$) chose a separate state, advanced beginner ($N = 1$), competent ($N = 1$) and proficient ($N = 1$).

Research question three asks: Does new graduate RNs' perception of competency level based on Benner's (1984) skills acquisition theory increase as they progress through a hospital orientation program? The data provide some support of the assumption that new graduate RNs' perception of competency level does increase as they go through the orientation program. At the beginning of the program, 34% of respondents identified at the novice stage. This decreased to 0% by the 4th and 8th week of orientation.

Table 6

Patricia Benner's Skills Acquisition

Skills Acquisition Level	Baseline (N = 26)		4 Weeks (N = 6)		8 Weeks (N = 2)	
	n	%	n	%	N	%
Novice	9	34	0	0	0	0
Advanced Beginner	15	57	4	66.7	1	33
Competent	22	7	1	16.7	1	33
Proficient	0	0	1	16.7	1	33

Perception of Readiness for Practice

The CFRPS measures readiness for practice with a 20 question confidence/comfort section. Perception of readiness to practice was measured by presenting students with a list of 20 items on the confidence/comfort section. The participants rate their level of confidence/comfort in performing key nursing activities using a 7 – point Likert scale (1 = Strongly Disagree to 7 = Strongly Agree).

Table 7 summarizes the data from questions falling into clinical problem-solving. This provides a self-report from the respondents regarding their level of comfort/confidence performing key activities that relate to the perception of readiness for practice. The clinical problem-solving subscale included questions regarding confidence communicating with physicians, confidence in ability to problem solve, using current evidence to make clinical decisions, comfort with communicating and coordinating care with interdisciplinary team members, comfort in knowing what to do with a dying patient, comfort taking action to solve problems and confidence in identifying actual or potential safety risks to patients.

Table 7

Comfort/Confidence/Skill Level

Clinical Problem Solving	Baseline (<i>N</i> = 27) Mean	SD
Confidence communicating with physicians	3.69	1.408
Problem solving	2.83	.924
Use of current evidence	2.54	1.029
Communicating with interdisciplinary team	2.92	1.017
Caring for dying patient	3.54	1.303
Solving problems	2.88	.864
Identifying safety risks	2.65	.936

The top scored items for the three time periods were confidence communicating with physicians ($M = 3.69, 2.50, 1.67$ and caring for dying patient ($M = 3.54, 2.50, 2.67$).

The lowest scoring item for the three time periods was identifying safety risks ($M = 2.65, 2.17, 1.67$). Use of current evidence was also one of higher scored items at the 8-week mark but was one of the lower scored items at the beginning of the study.

The learning techniques subscale including questions regarding how simulation helped the new graduate RN feel prepared for clinical practice and if writing reflective journals/logs provided insights into their own clinical decision-making skills. The professional identify subscale includes areas related to confidence communicating with patients from a diverse population, whether the clinical instructor provided feedback about readiness to assume an RN role, comfort in asking for help, satisfaction in choosing nursing as a career and readiness for the professional nursing role. See table 8 below. Both items scored high with simulation preparation for clinical practice having mean scores of 3.00, 3.17 and 2.00 over the three time periods. Reflective journals/logs had higher mean scores at 3.65, 4.83 and 4.00.

Table 8

Learning Techniques Mean and Standard Deviation of Variables

Learning Techniques	Baseline ($N = 27$) Mean	SD
Simulation preparation for clinical practice	3.00	1.50
Reflective journals/logs	3.65	1.648

The third subscale measures items related to professional identity. These items include caring for patients from diverse populations, feedback from clinical instructor

regarding readiness for practice, comfort in asking for help, choosing nursing as a career and readiness for a professional nursing role. Table 9 displays the results of this subscale. Mean scores were low to moderate for each item.

Table 9

Professional Identity Mean and Standard Deviation of Variables

Professional Identity	Baseline (N = 27) Mean	SD
Patients of diverse population	2.35	1.441
Feedback from clinical instructor	2.38	1.359
Asking for help	1.85	.784
Nursing as a career	1.65	.797
Ready of professional nursing role	2.69	1.087

The last subscale, trials and tribulations, addresses areas including comfort delegating tasks to nursing assistants, difficulty documenting care in the electronic medical record, difficulty prioritizing patient care needs, whether or not the new graduate RNs feel overwhelmed by ethical issues in their patient care responsibilities, difficulty recognizing a significant change in the patient's condition.

Table 10

Trials and Tribulations Mean and Standard Deviation of Variables

Trials and Tribulations	Baseline (<i>N</i> = 26)	
	Mean	SD
Delegating tasks to nursing assistant	2.96	1.587
Difficulty documenting care	3.85	1.736
Difficulty prioritizing patient care	4.23	1.366
Overwhelmed by ethical issues	3.50	1.449
Difficulty recognizing change in patient condition	3.58	1.391

Table 11

Comfort/Confidence Summary

	Baseline (<i>N</i> = 26)		
	<i>M</i>	<i>SD</i>	Range
Clinical problem solving	21	4.96	7-29
Learning techniques	7	2.03	2-11
Professional liability	11	3.82	5-23
Trials and tribulations	18	4.63	8-29

Despite the small size (*N* = 26), Pearson correlations were conducted to examine relationships between continuous level variables. There was a negative correlation between time spent with the charge nurse and trials and tribulations ($p = -.586$). This

finding was an unexpected correlation since one would expect time spent with the charge nurse to increase the new graduate RNs confidence when dealing with trials and tribulations. There was a positive correlation ($p = .611$) between clinical problem solving and professional identity. This correlation matches Benner's skills acquisition theory meaning more experience leads to a different stage in a nurses' identity, such as from advanced beginner to competent.

Table 12

Pearson Correlation of Comfort/Confidence Subscales and Hours with Charge Nurse

	Hours spent with charge nurse	Clinical Problem Solving	Learning Techniques	Professional Identify	Trials and Tribulations
Hours spent with charge nurse	--	.010	.076	-.094	-.586**
Clinical problem solving		--	.497	.611**	.019
Learning techniques			--	.267	-.366
Professional identity				--	.256
Trials and tribulations					--

A one-way ANOVA was conducted to determine differences among race in relation to clinical problem solving, learning techniques, professional liability and trials, and tribulations subscale scores as found in Table 14. A statistically significant

difference was found among the ethnic groups in relation to clinical problem solving ($F_{(2, 21)} = 5.630, p = .011$). Another significant difference was found in relation to learning techniques ($F_{(2, 22)} = 4.502, p = .023$). Post hoc comparisons using the Tukey HSD test indicated that the mean score for the Caucasian group ($M = 22.76, SD = 3.86$) was significantly different from the Black group ($M = 17.0, SD = 5.09$) and the Asian group ($M = 14.0, SD = 0.00$) related to clinical problem solving.

Focus Group Study

A focus group was conducted at the end of the 8-week orientation. Participation in the group was voluntary and was held at a neutral location. This interview was used to explore the new graduate nurses' opinions regarding which aspects of orientation were effective and which were less effective. Five new graduate RNs participated in the focus group. The participants were all female. The new graduate RNs' clinical area ranged from the Emergency Department, Cardiovascular Intensive Care Unit (CVICU), Critical Care Unit (CCU) and Surgical Care Unit (SICU). Whether or not these participants responded to all three surveys is unknown.

The interview took place at a neutral location. Participation was voluntary and the participants were advised they were free to leave the interview at any time. The researcher reminded the participants that their identity would be kept confidential and that they would be identified only by pseudonyms. The purpose of the pseudonym is to both protect their privacy and to encourage honest and open discourse. Pseudonyms were chosen by the researcher and the names of famous nurses in history, as well as the founder of the American Red Cross were used (Florence Nightingale, Clara Barton, Mary Breckinridge, Dorothea Dix, and Margaret Sanger). The researcher also reminded the

new graduate RNs that the purpose of the study was to determine new graduate RNs' opinions regarding their readiness for practice throughout their hospital orientation program and the purpose of the focus group interview is to collect qualitative data. The guided focus group interview was audio-recorded. The recording was then transcribed and reviewed for identifiable themes. The interview took approximately 30 minutes to complete.

The participants were first asked to give their overall impression of their hospital orientation program. The overall impression of the orientation programs was positive. However, some participants were more satisfied with their orientation experience than others. Florence described the orientation experience as "chaotic". Clara stated, "It's a mess." Florence went on to explain her comment of "chaotic" regarding her experience:

Well, whenever we first came on, we didn't have an educator in our department, so they were in the process of changing all of that. So, we didn't have a clue what we were doing. And, like, this person would get told this information and this person would get told that information, and it would not correlate. So, I would be like I'm just going to show up or whatever.

Mary and Dorothea, who both work in the same area, had a different impression of their orientation experience. Mary describes her experience as "phenomenal" and Dorothea stated, "It's been great in our area". Clara differentiated between the classes and the clinical experience: "The classes down here have been great. On the floor, it's been kind of crazy".

Next, the new graduate RNs were asked in what ways they felt the orientation program prepared them for practice. Florence felt it provided her with valuable

resources: “I think it was good resource-wise. So, if I didn’t know what to do for my patient, I knew which nurses were good at helping me out.” Mary stated: “The classes have been pretty good. I’m mean, I’m a hands-on learner so the classes don’t do as much as being on the floor for me but being on the floor’s been great.” Clara, who was from a unit without an educator gave the following input: “I wish things were more broken down. There are certain things on the floor that I haven’t gotten to see yet. Even if I could take a day to do things that are on my orientation list because I haven’t gotten to do half the things that are on my orientation list.” Margaret, Dorothea, and Mary all felt they were given opportunities to perform skills and become familiar with the equipment. The preceptors on their floors ensured they were involved whenever an opportunity to gain experience arose. Margaret elaborated: “My preceptor...she’s very good ...if there’s something I haven’t seen, she’ll let me go with someone else to see it. Mine is very good at making sure I have a very rounded experience.”

Several felt the size of the unit impacted the ability of new graduate RNs to gain experience. Dorothea explained: “On our unit, that’s just kind of the way it is. If there is something you haven’t had the opportunity to do, you can just go do it.” While Florence stated: “Yea, ours is so big you might not even know that a patient is having something done until it’s done. And they’re like “Oh, I wish we had known”. There are so many nurses on there, they are not going to know what you need.”

Regarding what elements of the orientation programs participants felt contributed most in preparing them for practice, the overall consensus was having a designated preceptor. Those new graduate RNs who had multiple preceptors felt they wasted a lot of

time getting to know each preceptor and how they worked and vice versa. Florence explains:

It's like you have to start all over. I mean, I have two main people who orient me because one of them is part-time. I mean, they're both wonderful and everyone I've been with is wonderful. It's hard to come on to a unit expecting the person you've been working with for a week to be there and they're not there.....and you get stuck with someone totally different that you don't know how they operate and they don't trust you because they don't know where you're at....and so it keeps putting you back steps.

Participants were next asked for recommendations or suggestions they would like to make regarding orientation. Participants felt that presentations given by other departments, such as Pharmacy, should be tailored more to what nurses can use. For example, when pharmacy is educating nurses about a particular medication, they should focus more on what the medications are used for and not as much on how it works in the body. Mary Breckinridge gives this explanation: "Going into a little bit more detail about what dopamine and albutamine are used for, instead of just saying it acts on this receptor. Just be like "it increases blood pressure". I feel like that would have been more helpful."

Two themes emerged from the interview. The first and most prominent theme was the benefit of having a designated educator to guide new graduate RNs through their orientation, once they moved to their chosen clinical areas of practice. Those participants without a designated clinical educator felt they were behind in the orientation process. Since there was no one person guiding the process, these new graduate RNs felt they had to restart with each new person assigned to them. In contrast, those participants who

were assigned a clinical educator felt more self-confident and had a more positive orientation experience.

The second theme was the size of the individual units. Those participants whose clinical areas were relatively small felt they were kept on task because it was easy for all nurses on the unit, not just the educator, to know what skills they needed. Therefore, the nurses would seek out the new graduate RNs to ensure they were able to practice the skill when those skills were ordered. Those participants in larger clinical areas felt they missed out on opportunities to practice skills because they did not have the closeness of a smaller unit. Therefore, nurses were not often aware of which skills and experiences the new graduate RNs needed.

In regard to research question number one: Do hospital orientation programs contribute to new graduate RNs' beliefs regarding their readiness for practice based on the Casey-Fink Readiness for Practice Survey? Data from the Casey-Fink Readiness for Practice Survey, as well as the focus group study, supports the assumption that new graduate RNs do feel more prepared for practice as they go through and complete the orientation program.

The second research question was: Does new graduate RNs' level of confidence increase as they progress through a hospital orientation program? The comfort/confidence subscale, as well as comments from participants of the focus group, do support the assumption that new graduate RNs' level of confidence does rise from the beginning of orientation to the end of orientation.

The third research question was: Does new graduate RNs' perception of competency level based on Benner's (1984) skills acquisition theory increase as they

progress through a hospital orientation program? The data from the question regarding where graduate RNs rate themselves in regards to Benner's skills acquisition theory indicate that new graduate RNs do feel they rise either from the novice level to advanced beginner or from advanced beginner to competent.

Summary

The purpose of this study was to explore any differences between new graduate RNs' opinions on readiness for practice, as measured by the Casey-Fink Readiness Practice Survey (Casey et al., 2011) and the phases of Benner's (1984) skills acquisition at the beginning of hospital employment, at the end of 4 weeks of hospital orientation, and at the end of 8 weeks of hospital orientation. This chapter serves as an examination of data resulting from analysis of the three surveys, as well as the focus group interviews. The data were presented and interpreted to identify areas addressing the three research questions put forth in Chapter III.

CHAPTER V – DISCUSSIONS, CONCLUSIONS, AND RECOMMENDATIONS

This chapter will discuss the results of the study. Recommendations for nursing practice and future research will be provided. Limitations of the study will be identified and final conclusions regarding the findings from the study will be discussed.

Summary of the Results

The purpose of the study was to assess new graduate RNs perceived readiness for practice at the beginning of orientation, at 4-weeks and 8-weeks of orientation.

Participants for this study consisted of new graduate RNs from three major hospitals in Alabama. The Casey-Fink Readiness for Practice Survey (CFRPS) was used as the survey tool to collect data.

The first research questions sought to determine if hospital orientation programs contribute to new graduate RNs' beliefs regarding their readiness for practice based on the Casey-Fink Readiness for Practice Survey. The survey instrument included individual items related to perceived readiness for practice. The number of respondents for the Casey-Fink Readiness for Survey was too low to make a determination whether or not orientation programs impacted new graduate RNs' opinions regarding their readiness for practice.

However, the focus group interview did reveal some insight into this question. Comments made by participants, such as "I hate to brag but I love my unit. I feel like I've learned so much. I feel so much more confident" and regarding the preceptor assigned for orientation "My preceptor...she's very good ...if there's something I haven't seen, she'll let me go with someone else to see it. Mine is very good at making sure I have a very rounded experience", would indicate that new graduate RNs' beliefs

regarding their readiness for practice does increase as they move through the orientation program.

The second research question was: Does the new graduate RNs' level of confidence increase as they progress through a hospital orientation program? The same comments supporting the first research question also supports the second research question. Again, there was not a sufficient enough number of respondents to make this determination from the Casey-Fink Readiness for Practice Survey. However, the information gathered from the focus group interview did support the assumption that, with a strong, organized orientation program, new graduate RNs' confidence level does increase as they progress through the orientation program.

Research question number three addresses whether the new graduate RNs' perception of competency level based on Benner's (1984) skills acquisition theory increase as they progress through a hospital orientation program. Of those respondents who participated in all three surveys, the data collected did show that the majority of respondents did progress from either novice to advanced beginner or advanced beginner to competent.

Theoretical Framework

The theoretical framework for this study was Patricia Benner's (1984) novice to expert skills acquisition theory, which is a middle range competency theory. Benner's (1984) theory is detailed in its explanation of different skills acquisition competency levels and RNs progression to the expert level. Nurses advance from level to level as each skill is taught, understood, and mastered (Altmann, 2007; Benner, 1984). New graduate RN participants of the study will begin their entry-level nursing practice at the

advanced beginner's skills acquisition level according to Benner's explanation. Benner's theory asserts that nurses move up through different stages of skills acquisition as they become more experienced and confident. Benner's theory suggests that new graduate RNs should be at the advanced beginner state when they first enter into practice.

This study was conducted over an 8-week period and sought to determine if new graduate RNs feel they are at the advanced beginner level at the beginning of orientation and if that changes by the end of the 8-week orientation period. Of the 26 ($N = 26$) respondents at the beginning of the study, 34% rated themselves at the novice level and 57% rated themselves at the advanced beginner level. By the end of the 8-week period, each of the three ($N = 3$) respondents were equally divided among the advanced beginner, competent and proficient stage. Although this number of respondents is too low to be statistically significant, it shows that of the 3 who remained in the study, 2 out of the 3 progressed beyond advanced beginner.

Comparison with Relevant Literature

Due to limited responses to the surveys, no reliable comparison can be made with existing literature regarding the three research questions.

Focus Group Interviews

The focus group interview unearthed similar responses to those in the study conducted by Odland et al. (2014). In the Odland et al (2014) study, respondents identified a lack of available personnel as one factor in the lack of an introductory program. This factor led to a feeling of being thrown out into the reality of patient care while feeling unprepared for the role. This finding is similar to the new graduate RNs'

responses in this study which identified the lack of a clinical educator as a factor in poor orientation.

A 20 study review conducted by Anderson et al. (2012) identified a need for standardized curricula and program procedures. Issues highlighted from this review included poorly described interventions among the nurse residency programs, lack of consistency in evaluation tools, variations in program length, and lack of standardized evidence-based curriculum (Goode et al., 2016). This finding is also consistent with new graduate RNs input from this study which identified inconsistent preceptors, differing orientation experiences among units and lack of follow through to ensure the new graduate RNs were moving through the items on their orientation evaluation tools as needed.

Implications for Change

As stated in Chapter I, there remains a global concern regarding readiness for practice among new graduate RNs (Usher et al., 2015). Readiness for practice and an efficient and effective hospital orientation program can impact patient safety, employee morale, and the confidence of the new graduate RNs. As noted in the responses of some participants of the focused group interview, hospital orientation programs can have a significant impact on new graduate RNs confidence level and readiness for practice. Hospital orientations programs must identify new graduate RNs weaknesses and ensure that those weaknesses are addressed before they leave the orientation program. These measures would not only ensure the new nurses are ready for practice but could potentially improve retention rates (Kajander-Unkuri et al., 2015).

This study suggests a need for hospital orientation programs to provide a smooth transition from academia into the clinical area. The programs should provide each new graduate RN with the same level of education and preparation, regardless of where they will be practicing. When the experiences are not consistent throughout the program, new graduate RNs begin to feel lost, frustrated and left behind. In order to ensure a smooth transition into clinical practice hospital orientation programs must continuously monitor and evaluate the new graduate RNs' progression while in the program. Feedback from the new graduate RNs is essential to identify weaknesses in the orientation program.

Recommendation for Action

Results from this study should be communicated to the participating hospitals to help them identify areas of weaknesses reported. Although the individual hospitals were not identified in the study, all hospital orientation programs can take the information gained from the new graduate RNs' experiences to strengthen their own programs. Schools of nursing can also benefit from the results of this study to identify areas in which the new graduate RNs felt they were the least confident. Although data was limited throughout the 8-week study, nursing education programs can take the data from the initial study conducted at the beginning of orientation to identify areas in need of improvement in their curricula.

Recommendations for Further Study

The study should be repeated utilizing a larger population of hospitals and new graduate RNs. The lack of respondents in this study limited the researcher's ability to make strong conclusions regarding results from the Casey-Fink Readiness for Practice portion of the study. Although the data was limited throughout the full 8-weeks of the

study, areas of strengths and weaknesses could be identified at the entry point of orientation. Expanding the study to include a wider geographical area would not only provide a larger population but potentially identify differences among new graduate RN experiences unique to a particular geographic area.

Another recommendation would be to not only survey BSN graduates but to also include associate degree (ADN) graduates to identify any differences among these two groups. Since both groups take the same NCLEX examination, similarities and differences among these two program graduates assist not only the nursing education programs but also the hospitals in identifying any needs that might be particular to each group. Again, including ADN graduates would give researchers a larger population to survey, as well as potentially gaining additional information regarding the similarities and differences among the two different degree program types.

Conclusion

Overall, the new graduate RNs identified similar themes expressed previously in the literature. Both nursing education programs and hospital orientation programs must shift their efforts to acknowledge and understand the complexity of the clinical areas entered into by new graduate RNs. Efforts between nursing education programs and hospital orientation programs need to include a creative collaboration to provide new graduate RNs with the education and clinical experiences necessary to ensure their readiness for practice.

With high patient acuity and high nurse to patient ratios continuing to cause challenges to even seasoned nurses, it more important now than ever to ensure that new graduate RNs enter into practice armed with the knowledge and training needed to give

safe, quality care. Nursing education programs and hospital orientation programs are the first line of defense when it comes to preparing new graduate RNs. If these two types of programs are not communicating to identify areas in need of improvement, neither program will grow and strengthen in order to ensure all is being done to properly prepare new graduate RNs for practice.

APPENDIX A – Casey-Fink Readiness for Practice Survey

Casey-Fink Readiness for Practice Survey

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(Adapted, Young, 4/2/2008)

Please fill in the blank or circle the response that represents your individual profile.

1. **Age:** _____ years

2. **Gender:**
 - a. Female b.
 - Male

3. **Ethnicity:**
 - a. Caucasian (white)
 - b. Black
 - c. Hispanic d.
 - Asian
 - e. Native American f.
 - Other
 - g. I do not wish to include this information

4. **What previous health care work experience have you had:**
 - a. Nursing assistant b.
 - Medical assistant c.
 - Volunteer
 - d. Unit secretary e.
 - EMT
 - f. EMT - Paramedic
 - g. Student Externship
 - h. Nurse Intern or Advanced Care Partner
 - i. Other: (please specify)

5. **Currently employed:**
 - a. Yes
 - b. No

6. **If yes (question #6), are you employed in a healthcare related position:**
 - a. Yes
 - b. No

7. **Please share the major reasons why you chose nursing as a career.**

8. **Date of employment:** _____

9. If enrolled in a hospital orientation program, please select the week of orientation in which you are in at this time.

- a. Beginning of orientation
- b. Week 4
- c. Week 8

10 Degree earned at graduation.

- a. ASN
- b. B S N

11. Clinical Area of Employment

- a. Adult M/S
- b. Adult ICU
- c. Oncology/BMT
- d. OB (L&D, POSTPARTUM)
- e. Pediatric M/S
- f. Pediatric ICU
- g. NICU
- h. Mental Health
- i. Ambulatory Care Setting
- j. Rehabilitation
- k. Emergency Department
- l. OR/Perioperative Setting
- m. Other:

12. Was your clinical practicum experience at your current place of employment?

- a. Yes
- b. No

13. What setting was your clinical practicum experience located:

- a. Urban setting
- b. Rural setting

14. How many clinical hours were you required to complete during your senior practicum?

_____ Hours

15. How many hours did you spend with your unit charge nurse?

_____ Hours

16. How many primary preceptors did you have during your senior practicum experience?

_____ Preceptors

17. Were you required to review NCLEX-RN questions during your senior practicum course?

- a. Yes
- b. No

18. If yes (question 21) how many questions/week did you review? #

Questions

19. What did YOU do to prepare for your senior practicum experience: (may select more than one answer)

- a. Practiced skills in learning lab
- b. Participated in simulation assignment
- c. Developed a care plan
- d. Brought medication reference or PDA to clinical
- e. Set daily goals with preceptor
- f. Met with preceptor prior to the start of clinical experience
- g. Oriented to facility/tour unit
- h. Discussed personal learning needs with clinical faculty
- i. Did nothing to prepare
- j. Other: _____

List three skills/procedures you are most uncomfortable performing independently at this time?

Select from the list below.

1. _____
2. _____
3. _____
4. _____ I am independent in all skills listed below

List of skills

- Assessment skills
- Bladder catheter insertion/irrigation
- Blood draw/venipuncture
- Blood glucose monitoring device
- Central line care (dressing change, blood draws, discontinuing)
- Charting/documentation
- Chest tube care
- EKG/Telemetry monitoring and interpretation
- Giving a verbal report
- Intravenous (IV) medication administration
- Intravenous (IV) starts
- IV pumps/PCA pump operation

Medication
 administrati
 on NG
 tube/Dobhof
 f care Pulse
 oximetry
 Responding to an emergency/CODE/changing patient condition
 Trach care/suctioning
 Wound care/dressing change/wound vac
 Other _____

Please answer each of the following questions by placing a mark inside the box/circle:

What is your current level of confidence in managing a patient care assignment on an adult Medical/Surgical unit:

NOT CONFIDENT

VERY CONFIDENT

	1	2	3	4	5
Caring for 2 patients					
Caring for 3 patients					
Caring for 4 patients					

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
1. I feel confident communicating with physicians.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I am comfortable communicating with patients from diverse populations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I am comfortable delegating tasks to the nursing assistant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I have difficulty documenting care in the electronic medical record.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I have difficulty prioritizing patient care needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. My clinical instructor provided feedback about my readiness to assume an RN role.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I am confident in my ability to problem solve.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I feel overwhelmed by ethical issues in my patient care responsibilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I have difficulty recognizing a significant change in my patient's condition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I have had opportunities to practice skills and procedures more than once.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I am comfortable asking for help.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I use current evidence to make clinical decisions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I am comfortable communicating and coordinating care with interdisciplinary team members.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Simulations have helped me feel prepared for clinical practice.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Writing reflective journals/logs provided insights into my own clinical decision-making skills.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I feel comfortable knowing what to do for a dying patient.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I am comfortable taking action to solve problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I feel confident identifying actual or potential safety risks to my patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I am satisfied with choosing nursing as a career.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I feel ready for the professional nursing role.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. According to Patricia Benner's skills acquisition theory, there are five levels of competency. Please select the competency level you most identify with at this time:

- A. Novice - Have had no experience of the situations in which they are expected to perform. Novices are taught rules to help them perform.
- B. Advanced Beginner - Can demonstrate marginally acceptable performance, those who have coped with enough real situations to note, or to have pointed out to them by a mentor, the recurring meaningful situational components.
- C. Competent - Develops when the nurse begins to see his or her actions in terms of long-range goals or plans of which he or she is consciously aware.
- D. Proficient - Perceives situations as wholes rather than in terms of chopped up parts or aspects, and performance is guided by maxims. Proficient nurses understand a situation as a whole because they perceive its meaning in terms of long-term goals.
- E. Expert - No longer relies on an analytic principle (rule, guideline, maxim) to connect her or his understanding of the situation to an appropriate action. The expert nurse, with an enormous background of experience, now has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions

What could be done to help you feel more prepared to enter the nursing profession?

APPENDIX B – Focus Group Interview Questions

Guided Focus Group Interview Questions

What is your overall impression of the orientation program?

In what ways do you feel the orientation program prepared you for practice?

What elements of the orientation program do you feel contributed most in preparing you for practice?

What elements of the orientation program do you feel contributed least in preparing you for practice?

Are there recommendations you have or suggestions you would like to make regarding orientation to practice?

As we conclude this focus group I have one final request. Please share anything that you wanted to share and didn't. Please share anything you feel that we have missed.

APPENDIX C – Informed Consent

June 1, 2018

Dear New Graduate RN:

I am interested in learning about your perception of confidence and readiness for entering the nursing profession.

The purpose of this letter is to ask you to take part in this study. If you agree to participate, please complete the attached survey, Casey-Fink Readiness for Practice Survey ©2008. This survey should take approximately 10-15 minutes to complete. All of your answers will be kept completely confidential. The study results will have no identifying information on it and no individual identities will be used in any reports or publications that may result from this study. Participation in the study implies consent. You are free to leave the survey at any point.

The survey asks for your thoughts on being a new graduate RN at the beginning, at 4 weeks and at 8 weeks of your hospital orientation program. There is no benefit to you for participating in this study and there will be no reimbursement provided. There will be no financial costs to you as a result of taking part in this study. The survey results may help schools and colleges of nursing better prepare nursing students in the future.

Thank you in advance for assisting with and taking the time to participate in this study.

Diane A. Young, MSN, RN
Ph.D. Candidate
The University of Southern Mississippi

APPENDIX D - Institutional Review Board Approval



INSTITUTIONAL REVIEW BOARD

118 College Drive #5147 | Hattiesburg, MS 39406-0001

Phone: 601.266.3997 | Fax: 601.266.4377 | www.usm.edu/research/institutional.review.board

NOTICE OF COMMITTEE ACTION

The project has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

- The risks to subjects are minimized.
- The risks to subjects are reasonable in relation to the anticipated benefits.
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Projects that exceed this period must submit an application for renewal or continuation.

PROTOCOL NUMBER: 18050406

PROJECT TITLE: Attitudes of New Graduate RNs Regarding Readiness for Practice at the Beginning, at 4 Weeks, and at 8 Weeks of Hospital Orientation as Measured by the Casey-Fink Readiness for Practice Survey

PROJECT TYPE: Doctoral Dissertation

RESEARCHER(S): Diane Young

COLLEGE/DIVISION: College of Nursing

DEPARTMENT: Leadership and Advanced Nursing Practice

FUNDING AGENCY/SPONSOR: N/A

IRB COMMITTEE ACTION: Expedited Review Approval

PERIOD OF APPROVAL: 06/05/2018 to 06/04/2019

Edward L. Goshorn, Ph.D.

Institutional Review Board

APPENDIX E – Tables of Data Over Time

Table A1.

Frequencies Describing Gender and Ethnicity

	Baseline (N = 27)		4 Weeks (N = 6)		8 Weeks (N = 2)	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Gender						
Male	2	7.4	1	16.7	1	33.3
Female	25	92.6	5	83.3	1	66.7
Ethnicity						
Caucasian	19	70.4	6	100	3	100
Black	6	22.2	0	0	0	0
Asian	2	7.4	0	0	0	0

Table A2.

Frequencies of Categorical Variables Describing Senior Practicum Experience

	Baseline (N = 27)		4 Weeks (N = 6)		8 Weeks (N = 2)	
	n	%	n	%	N	%
What previous health care work experience do you have?						
Nursing Assistant	10	40	3	16.7	0	0.0
Medical Assistant	3	12	1	5.6	0	0.0
Volunteer	2	8	0	0	1	33.3
Student Extern	5	20	1	5.6	1	33.3
Nurse Intern	1	4	0	0	0	0.0
Other	4	16	1	5.6	1	33.3
What is your clinical area of employment:						
Adult M/S	11	40.7	3	50.0	0	0.0
Adult ICU	11	40.7	1	16.7	1	33.3
OB	3	11.1	1	16.7	1	33.3
Pediatrics	1	3.7	0	0.0	0	0.0
Mental Health	1	3.7	1	16.7	1	33.3
Was your clinical practicum experience at your current place of employment?						
Yes	14	51.9	3	50	1	33.3
No	13	48.1	3	50	2	66.7
In what area was your clinical practicum?						
Urban	24	88.9	6	100	3	100
Rural	3	11.1	0	0	0	0
Were you required to complete NCLEX questions?						
Yes	21	77.8	5	83.3	2	66.7
No	6	22.2	1	16.7	1	33.3

Table A3.

Number of NCLEX Questions

	Baseline (<i>N</i> = 27)			4 Weeks (<i>N</i> = 6)			8 Weeks (<i>N</i> = 2)		
	<i>M</i>	<i>SD</i>	Range	<i>M</i>	<i>SD</i>	Range	<i>M</i>	<i>SD</i>	Range
Number of question completed	321	546	50-250	150	70.71	50-250	133	125	0-250
Clinical hours completed	141	47	40-240	139	59.2	40-216	171	33.3	135-200
Hours spent with charge nurse	54	64	0-240	60	59.1	12-135	59	66.4	12-135

Table A4.

Skills Least Comfortable Performing Independently

Skill	Baseline	4		8		
	(N = 27) n	%	Weeks (N = 6) n	%	Weeks (N = 3) n	%
Chest tube care	14	51	2	33	2	67
Charting/Documentation	11	40	1	16	1	33
Responding to emergency/CODE/changing patient condition	8	29	6	100	2	67
Giving verbal report	8	29	1	16	0	0
Assessment skills	7	25	0	0	0	0
NG Tube/Dobhoff care	7	25	0	0	0	0
Blood draw/venipuncture	7	25	2	33	0	0
EKG/telemetry monitoring	6	22	1	16	1	33
Trach care/suctioning	6	22	1	16	1	33
Blood glucose monitoring	5	18	0	0	0	0
Bladder catheter insertion	4	14	3	50	1	33
IV/PCA pump operation	4	14	0	0	0	0
Wound care/dressing change	4	14	0	0	1	33
IV medication administration	3	11	0	0	0	0
IV start	0	0	2	33	0	0

Table A5.

Comfort/Confidence/Skill Level Over Time

Clinical Problem Solving	Baseline (N = 27)		4 Weeks (N = 6)		8 Weeks (N = 3)	
	Mean	SD	Mean	SD	Mean	SD
Confidence communicating with physicians	3.69	1.408	2.50	1.378	1.67	.577
Problem solving	2.83	.924	2.50	.548	1.67	.577
Use of current evidence	2.54	1.029	1.83	.753	2.00	1.00
Communicating with interdisciplinary team	2.92	1.017	2.33	.816	1.33	.577
Caring for dying patient	3.54	1.303	2.50	.548	2.67	1.528
Solving problems	2.88	.864	2.33	.516	1.67	.577
Identifying safety risks	2.65	.936	2.17	.408	1.67	.577

Table A6.

Learning Techniques Mean and Standard Deviation of Variables over Three Time

Periods

Learning Techniques	Baseline (N = 27)		4 Weeks (N = 6)		8 Weeks (N = 3)	
	Mean	SD	Mean	SD	Mean	SD
Simulation preparation for clinical practice	3.00	1.500	3.17	1.722	2.00	1.00
Reflective journals/logs	3.65	1.648	4.83	1.169	4.00	3.00

Table A7.

Professional Identity Mean and Standard Deviation of Variables Over Three Time

Periods

Professional Identify	Baseline (N = 27)		4 Weeks (N = 6)		8 Weeks (N = 3)	
	Mean	SD	Mean	SD	Mean	SD
Patients of diverse population	2.35	1.441	2.00	.000	1.67	.577
Feedback from clinical instructor	2.38	1.359	1.83	.408	1.67	.577
Asking for help	1.85	.784	1.67	.816	1.00	.000
Nursing as a career	1.65	.797	1.33	.516	1.33	.577
Ready for professional nursing role	2.69	1.087	2.00	.894	1.33	.577

Table A8.

*Times and Tribulations Mean and Standard Deviation of Variables Over Three Time**Periods*

Trials and Tribulations	Baseline	SD	4 Weeks		8 Weeks	
	(N = 27) Mean		(N = 6) Mean	SD	(N = 3) Mean	SD
Delegating tasks to nursing assistant	2.96	1.587	1.83	.753	2.00	1.00
Difficulty documenting care	3.85	1.736	2.17	.753	3.33	3.215
Difficulty prioritizing patient care	4.23	1.366	2.17	1.169	2.00	.000
Overwhelmed by ethical issues	3.50	1.449	2.67	.816	1.67	.577
Difficulty recognizing change in patient condition	3.58	1.391	2.33	.816	2.67	.577

Table A9.

Comfort/Confidence Summary

	Baseline (<i>N</i> = 27)			4 Weeks (<i>N</i> = 6)			8 Weeks (<i>N</i> =2)		
	<i>M</i>	<i>SD</i>	Range	<i>M</i>	<i>SD</i>	Range	<i>M</i>	<i>SD</i>	Range
Clinical problem solving	21	4.96	7-29	16	4.07	12-23	13	3.05	10-16
Learning techniques	7	2.03	2-11	8	2.60	4-12	6	4.00	2-10
Profession- al identity	11	3.82	5-23	9	1.94	7-12	7	2.00	5-9
Trials & tribulations	18	4.63	8-29	11	3.54	5-15	11	2.51	9-14

APPENDIX F – IRB Approval Letter



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PROTOCOL NUMBER: 12345678
PROJECT TITLE: How to Achieve IRB Approval at USM
PROJECT TYPE: New Project
RESEARCHER(S): Jonas Doe
COLLEGE/DIVISION: College of Education and Psychology
DEPARTMENT: Psychology
FUNDING AGENCY/SPONSOR: N/A
IRB COMMITTEE ACTION: Expedited Review Approval
PERIOD OF APPROVAL: 01/02/2015 to 01/01/2016
Lawrence A. Hosman, Ph.D.
Institutional Review Board

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