



Progress Report
Phase I Study of North Carolina Evidence-based
Transition to Practice Initiative Project

Foundation for Nursing Excellence

Prepared by the NCSBN Research Department

INTRODUCTION

In 2006, the Foundation for Nursing Excellence, created by the North Carolina Board of Nursing, received a two-year grant from BlueCross BlueShield of North Carolina Foundation to support a study that focuses on the role of transition programs in the development of the new graduate nurses. The Research Department at the National Council of State Boards of Nursing (NCSBN) conducted the analysis for the Foundation for Nursing Excellent on this project. The goals of the study are to examine the perceived progression of competence and confidence development of new nurses in three different types of orientation programs conducted in North Carolina hospitals, and to identify preceptor characteristics that impacted new nurse competence and confidence development.

RESEARCH QUESTIONS

There were four questions this research addressed:

1. What is the relationship of the type of transition to practice experience and progression of competency development among newly licensed RNs in North Carolina hospitals?
2. What is the relationship of the type of transition to practice experience and practice errors among newly licensed RNs in North Carolina hospitals?
3. What is the relationship of the type of transition to practice experience and risk for practice breakdown among newly licensed RNs in North Carolina hospitals?
4. What is the relationship of the preceptor characteristics to competency development among newly licensed RNs in North Carolina hospitals?

METHODOLOGY

This study used three repeated measures within a six month period starting in August 2007. Participation of this study was voluntary. Invitation letters were sent to all newly licensed RNs and their preceptors within 29 participating acute care hospitals in North Carolina. The participants were subcategorized in three comparison groups based on the type of orientation programs the agencies offered. Group A included two agencies that were using a standardized competency assessment and development system; Group B included eight agencies that provided activities specifically designed for a formal transition of the new nurses from school to work, and Group C included nineteen agencies that provided a more traditional orientation to the

specific agency and position to which the person was hired, but did not include a formal transition program. Each orientation program was reviewed based on the predetermined criteria and assigned to Group A, B or C.

The newly licensed RNs who voluntarily participated in this study were asked to fill in a Newly Licensed RN Survey designed by the North Carolina State Board of Nursing and NCSBN (Appendix A). The preceptors completed the Preceptor Survey (Appendix B). Both new RNs and their preceptors were asked to fill out the survey instruments every two months (Round 1 survey, Round 2 survey and Round 3 survey) over six months of the new nurses' employment.

Response Rates

The response rates for the new RNs were: 31.4% (160 of 510) for Round 1; 17.1% (87 of 510) for Round 2; and 17.9% (83 of 463) for the Round 3 survey. The response rates for the preceptors were: 38.8% (198 of 510) for Round 1; 21.0% (107 of 510) for Round 2; and 17.5% (81 of 463) for the Round 3 survey.

RESULTS

Demographic Characteristics of Newly Licensed Nurses

One hundred and eighty-eight (188) newly licensed RNs in North Carolina hospitals participated in this study which consisted of three-rounds of surveys (160 in the Round 1, 87 in Round 2 and 83 in Round 3). A total of 42 new nurses completed all three rounds of surveys (Table 1A). Table 1B lists the number of nurses who dropped out of this study due to termination, resignation or transfer. The detailed participation in each round of the study is presented in Table 1C.

Table 1A. Participation of the New RN Surveys (N=188)

Total Number of Participation	N	Percent
One Round of Surveys	88	46.8
Two Rounds of Surveys	58	30.9
Three Rounds of Surveys	42	22.3
Total	188	100.0

Table 1B. Agency Self-report of New Nurse Resignation, Termination, and Transfer

Comparison Group #	# new RNs resigned from agency	# new RNs terminated from agency	# new RNs transferred to another area in nursing within agency	# new RNs left nursing	Other
A	5	1	1	0	
B	15	3	11	1	2 (leave of absence)
C	9	11	6	0	

Table 1C. Participation of the Individual Survey (N=188)

Participation of Individual Survey	N	Percent
First Round 1 only	65	34.6
Round 2 only	17	9.0
Round 3 only	6	3.2
Round 1 & 2 Surveys only	23	12.2
Round 1 & 3 Surveys only	30	16.0
Round 2 & 3 Surveys only	5	2.7
Round 1 & 2 & 3 Surveys	42	22.3
Total	188	100.0

This report analyzed the data from all nurses and preceptors who participated in any given round of survey, even if that nurse subsequently left her or his position.

The general demographic information was asked only in the Round 1 survey. If respondents completed the Round 2 or Round 3 survey, or both, but not the Round 1 survey, their demographic information was not captured. Ninety-three percent of the responding new RNs were females ($n=147$) and the remaining 7% were males ($n=11$). Two RNs did not answer this question. The majority of them (86.7%, $n=137$) were White, 7.0 % ($n=11$) were of African-American descent, 3.8% ($n=6$) were American Indian/Alaska Native, 1.9% ($n=3$) of the respondents reported a Hispanic or Latino background, while 2.5% ($n=4$) reported their ethnic background as “other” without specification. The average age of the respondents was 30 years

($n=158$, $SD=7.85$) ranging from 19 to 52 years of age which is slightly younger than the average ages of the newly licensed RNs reported by two national studies conducted by NCSBN (average age=31.25, $SD=8.30$, Kenward and Zhong, 2006; average age=32.4, Li and Kenward, unpublished manuscript).

Educational Background of the New RNs

Almost three-fourths (73.4%, $n=116$) of the responding new RNs held associate degrees and 24.7% ($n=39$) obtained baccalaureate or higher degrees, 1.9% ($n=3$) held a diploma degree. Five new RNs (3.2%) graduated from a nursing program not located in the U.S. and 98.7% ($n=156$) of the respondents declared English as their first language. This study shows that for two of the 160 newly licensed RNs (1.3%) English was their second language. This represents a lower percentage of English as a second language speakers than that reported in the NCSBN transition to practice study (7.2%, Kenward & Zhong, 2006).

Professional Employment of the New RNs

About 11% of the RNs ($n=17$) reported previously working as an LPN/VN for an average of 2.4 years ($SD=1.94$). Nearly half (48.1%, $n=76$) of the RNs had worked as a nurse's aide for an average of 3.37 years ($SD=3.40$). Nine of them had previous experience as both an LPN and a nurse's aide. Therefore, more than half of the new RNs (53.2%, $n=84$) had previously worked as a nurse's aide or an LPN/VN, while 46.8% ($n=74$) of them have no previous nursing experience as either a nurse's aide or an LPN/VN. The 160 new RNs in the Round 1 survey reported an average of 2.29 months ($SD=1.29$) in their current position, and an average of 2.35 months ($SD=1.31$) experience as a registered nurse in any nursing position. The 87 new RNs who participated in the Round 2 survey reported an average of 3.96 months ($SD=1.55$) in their current and 4.69 months ($SD=4.25$) in any nursing position. The 83 new RNs in the Round 3 survey reported having been in their current position for an average of 6.08 months ($SD=1.34$) and in any nursing position for 6.73 months ($SD=4.07$). The respondents were evenly distributed in suburban (32.5%, $n=52$), urban or metropolitan settings (33.1%, $n=53$) and rural areas (34.4%, $n=55$).

Characteristics of Preceptors

Two hundred and forty-two (242) preceptors participated in this study (198 in the Round 1 survey, 107 in Round 2 and 81 in the Round 3 survey). A total of 39 preceptors participated in all three surveys (Tables 2A-B).

Table 2A. Total Participation of the Preceptor Surveys (N=242)

Total Participation	N	Percent
One survey	137	56.6
Two rounds of surveys	66	27.3
Tree rounds of surveys	39	16.1
Total	242	100.0

Table 2B. Individual Participation of the Preceptor Survey (N=242)

Participation	N	Percent
Round 1 only	106	43.8
Round 2 only	15	6.2
Round 3 only	16	6.6
Rounds 1 & 2 only	40	16.5
Rounds 1 & 3 only	13	5.4
Rounds 2 & 3 only	13	5.4
Rounds 1 & 2 & 3	39	16.1
Total	242	100.0

Ninety-nine (87.6%) preceptors and the nurses they were paired with submitted their surveys in the same round of the study (Table 2C). Fourteen preceptors submitted a survey in a round different from the round the nurses they were paired with submitted a survey. The remaining 129 preceptors submitted their surveys individually, but their corresponding new RNs did not participate in the study. In summary, a total of 80 paired surveys from both preceptors and new RNs were returned in the Round 1 survey, 28 in the Round 2 survey and 26 in the Round 3 survey.

Table 2C. Total Number of Matching Preceptor and New RN Surveys (N=99)

Matching Survey	N	Percent
Round 1 only	57	57.6
Round 2 only	8	8.1
Round 3 only	7	7.1
Rounds 1&2 only	8	8.1
Rounds 1&3 only	7	7.1
Rounds 2&3 only	4	4.0
Rounds 1 & 2 & 3	8	8.1
Total	99	100.1*

The summary on the characteristics of the responding preceptors was based on the data from the 198 preceptors who provided such information. The study data shows that 9.8% of the respondents were male ($n=18$), and 90.2% ($n=165$) were female. The average age of the preceptors was 38.7 years old ($n=183$, $SD=10.15$) ranging from 21 to 62 years of age which is younger than the average age of the preceptors found in the NCSBN report (average age=42.2, Li & Kenward, unpublished manuscript). Fifteen of the 198 respondents did not provide their demographic information. The majority of the preceptors (90.2%, $n=165$) were White, 5.5% ($n=10$) were of African-American descent, 2.2% ($n=4$) were American Indian/Alaska Native, 1.1% ($n=2$) were Asians, and 1.1% ($n=2$) reported their ethnic background as “other” without specification. Only one respondent (0.6%) reported a Hispanic or Latino background.

The preceptors reported an average of 6.29 years of experience ($SD=6.95$) in their current position, and a total of 10.95 years of experience as a RN ($SD=9.01$). On average, these preceptors had over seven years’ experience of serving as a preceptor (Mean=6.99, $SD=6.88$), and they worked with the current new RNs for about 2 months (Mean=1.96, $SD=1.22$) during their first two months of employment. Over sixty percent of the responding preceptors (62.8%, $n=115$) held RN diplomas, 2.2% ($n=4$) held RN associate degrees and 32.2% ($n=59$) obtained baccalaureate or higher degrees. Five preceptors (2.7%) indicated their most recently completed basic type of nursing education program was either an LPN certificate or LPN associate degree.

* Percentage does not total to 100% due to rounding.

When asked about the special qualifications of being a preceptor, 77.3% of the respondents (153 of 198) reported that they worked more than one year on the current unit, 72.7% (144 of 198) were recommended by supervisors, 59.6% (118 of 198) received preceptor training in the hospital, 40.4% ($n=80$ of 198) received special training in coaching critical thinking and 12.1% of them (24 of 198) took related courses on their own. More than half of the preceptors in Group A reported that they received special training in coaching critical thinking (53.7%, 36 of 67), while 29.7% (19 of 64) in Group B and 37.3% (25 of 67) in Group C received such training. The preceptors in the three comparison groups reported similar qualifications in other perspectives.

This study also asked whether there were any workload changes for the preceptors. About 40% of the preceptors (37.2%, 73 of 196) indicated that they had no client care assignment while acting as a preceptor, 21.9% (43 of 196) reported having a reduced load, while the remaining 40.8% (80 of 196) declared a regular workload. Further analysis showed that 68.2% of the preceptors in Group A (45 of 66), 31.7% (20 of 63) in Group B, and 11.9% (8 of 67) in Group C declared that they did not have client care assignments during that time.

Transition to Practice

The 188 new RNs were fairly evenly distributed within three comparison groups (Table 3): 40.4% ($n=76$) in group A, 32.5% ($n=61$) in Group B, and 27.1% ($n=51$) in Group C. The 84 nurses who had previous work experience as a nurse's aide or an LPN/VN, were also evenly distributed within three groups (Group A, 40.5%, $n=34$; Group B: 29.8%, $n=25$ and Group C: 29.8%, $n=25$).

Table 3. Distribution of Respondents by Assigned Transition Group

Comparison Groups	Frequency	Percent
Group A: Standardized Assessment	76	40.4
Group B: Formal Transition	61	32.5
Group C: Traditional Orientation	51	27.1
Total	188	100.0

The majority of the new nurses (83.8%, 134 of 160) claimed that while in the program they worked the same schedule with their preceptors or mentors and 51.3% of them (82 of 160) were assigned one primary preceptor. Twenty new RNs reported that their preceptors took care of from 2 to 10 graduates at the same time (Mean=3.55, *SD*= 2.56). On average, these new nurses reported having spent 8.1 weeks (*SD*=3.46) in their transition programs, ranging from 0-24 weeks. The breakdown for the average length of time the new RNs spent in their program is as following: 8.06 weeks for Group A ranging from 4 to 24 weeks, 8.73 weeks for Group B ranging from 0 to 15 weeks and 7.52 weeks for Group C ranging from 2 to 16 weeks. About 80% of the new RNs (79.4%, *n*=127) reported that their program was designed to increase general knowledge and 66.9% (*n*=107) indicated that the program was designed to prepare for a specific nursing specialty for them.

This study asked how soon the new RNs were assigned their first patient care assignment and the number of patients they took care of at this first assignment (Tables 4A-C). On average, the new RNs in Group A took care of fewer patients (1.34) in their first independent assignment, but the new RNs in Group C took an average of 2.36 patients (Table 4A). The average days before independent assignments for a new RN in Group A was 25 days. It took about 38 days for the new RNs in Group B (Table 4C). The NCSBN report shows that in hospital settings, it took an average of 49.7 days for the new RNs to receive their first independent assignment (Li & Kenward, unpublished manuscript).

Table 4A. Average Patients in First Independent Assignment

	N	Mean	SD
Group A: Standardized Assessment	58	1.34	2.24
Group B: Formal Transition	45	1.93	2.39
Group C: Traditional Orientation	45	2.36	2.34
Overall	148	1.83	2.34

Table 4B. Average Clients in First Assignment

	N	Mean	SD
Group A: Standardized Assessment	66	2.91	1.56
Group B: Formal Transition	48	2.35	1.77
Group C: Traditional Orientation	46	3.04	1.73
Overall	160	2.78	1.69

Table 4C. Average Days to First Independent Assignment

	N	Mean	SD
Group A: Standardized Assessment	19	24.37	18.49
Group B: Formal Transition	22	37.86	39.84
Group C: Traditional Orientation	26	29.73	28.18
Overall	67	30.88	30.46

There were no statistically significant differences in client assignments among the three comparison groups (Table 4D).

Table 4D. ANOVA on Client Assignments among the Three Groups

	Df	F	Sig
Days before independent assignment	2	1.03	.36
Number of patients in 1 st assignment	2	2.33	.10
Number of patients in 1st independent assignment	2	2.48	.09

Quality of the Partnership between New Nurses and Their Preceptors

Both new nurses and their preceptors rated the quality of their partnership during transition using a 5-point scale, ranging from “1” for “Excellent” to “5” for “poor”. This study reveals that the majority of the new nurses (96.2%, $n=154$) rated the quality of their partnership with their preceptor as “good” or “excellent” and 3.8% of them ($n=6$) indicated that the partnership was “fair” in the Round 1 survey (Figure 1), while 97.4% (76 of 78) of the new RNs in the Round 2 survey and 90.9% (50 of 55) in the Round 3 survey rated the quality of the

partnership with their preceptor as “good” or “excellent”. There was not a single “poor” rating in any of the three rounds of surveys.

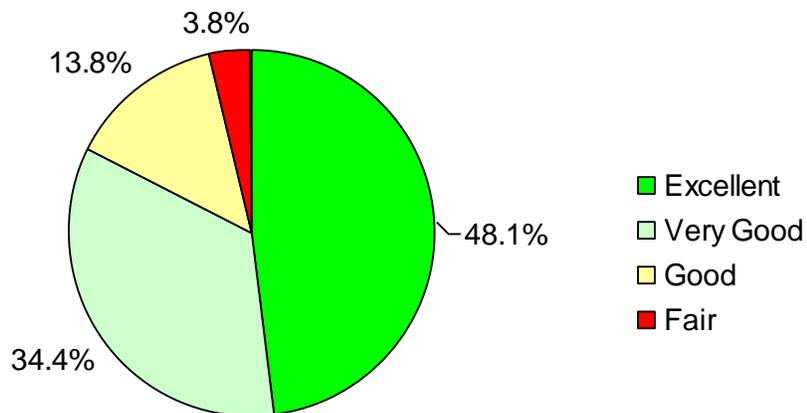


Figure 1. Partnership Rating by New RNs in the Round 1 Survey

The average rating scores on partnership were 1.73 ($SD=0.83$, $n=160$) in the Round 1 survey, 1.58 ($SD=0.78$, $n=78$) in the Round 2 survey and 1.78 ($SD=1.01$, $n=55$) in the Round 3 survey. There is no statistically significant difference in quality ratings among the three rounds of surveys ($F=1.16$, $df=2$, $P=.3$). The average rating scores on partnership quality reported in the Round 1 survey by the three comparison groups are illustrated in Figure 2. On average, the new RNs in Group A rated the partnership with their preceptor slightly better compared to the other two groups (a reversed scale, the lower the score, the better the quality), but the difference among the three comparison groups was not statistically significant ($F=.24$, $df=2$, $P=.79$). There were no statistically significant differences in the partnership ratings among new RNs in the three groups in the follow-up Round 2 ($F=.94$, $df=2$, $P=.40$) and Round 3 surveys as well ($F=.76$, $df=2$, $P=.47$).

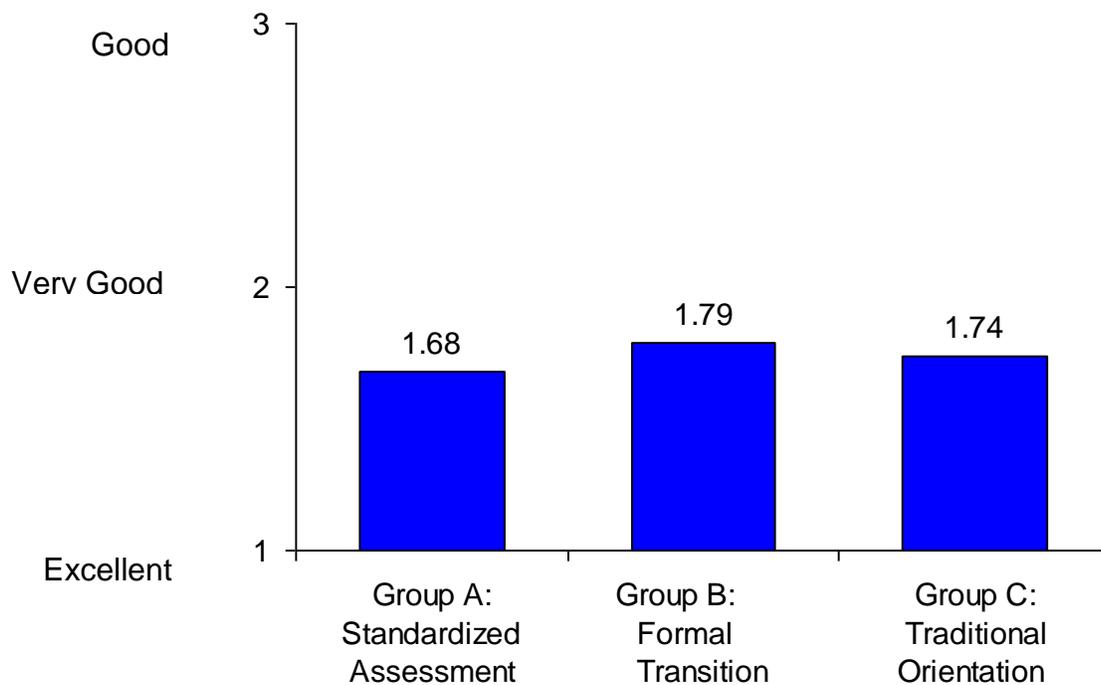


Figure 2. Quality Rating by Comparison Groups in the Round 1 Survey

A binary correlation analysis revealed a significant positive correlation between new nurses and their preceptors' ratings on their partnership in the Round 1 survey ($r = .37, n=77, P=.001$), i.e., the higher the quality ratings given by the new RNs, the higher the ratings given by their preceptors. There was no statistically significant correlations between the quality ratings between new RNs and their preceptors in the follow-up Round 2 ($r=.26, n=27, P=.19$) and Round 3 surveys ($r=.20, n=17, P=.44$).

Research Question 1: What is the relationship of the type of transition to practice experience and progression of competency development among newly licensed RNs in North Carolina hospitals?

The responding new RNs self-rated their performance on 35 items using a five-scale measurement with “1” indicating “Almost never” practice competently, and “5” indicating “Almost always” performed a good clinical practice. The content validity of the instrument was supported by a group of experts from the nursing boards and the construct validity was established by a factor analysis which yielded four-sub categories: (1) clinical reasoning and

judgment, (2) patient care delivery management skills, (3) communication and interpersonal relationships, and (4) recognizing limits and seeking help. An overall Cronbach's alpha of .93 was reported (Li & Kenward, unpublished manuscript). No detailed internal reliability tests were reported on the four subscales. The self-reported competency index was compiled using the average score of the 35 items evaluated. The responding new RNs rated their competency as fairly good based on a 5-point scale in all three rounds of surveys: 4.33 ($SD=.46$, $n=158$) in the Round 1 survey, 4.47 ($SD=0.37$, $n=82$) in the Round 2 survey and 4.31 ($SD=0.57$, $n=83$) in the Round 3 survey. Figure 3 illustrates the average of the self-reported competency scores among the three comparison groups across each round of survey.

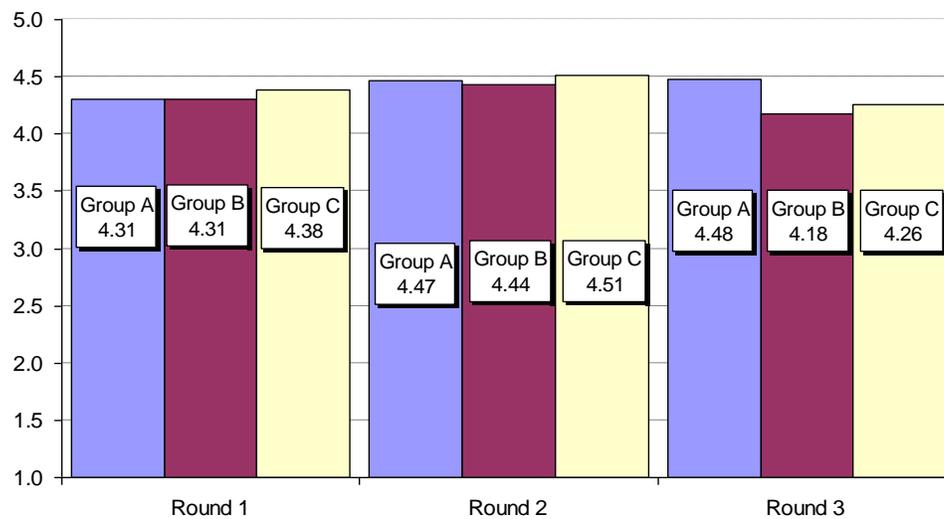


Figure 3. Competency Ratings in the Three Rounds of Surveys

No statistical significance was identified in self-reported competency scores among the three comparison groups in the Round 1 survey ($F=.44$, $df=2$, $P=.64$) and the follow-up surveys ($F=.22$, $df=2$, $P=.80$ for Round 2, and $F=2.09$, $df=2$, $P=.13$ for Round 3). No significant differences were found in the self-reported competency development for: (1) clinical reasoning and judgment, (2) patient care delivery and management skills, (3) communication and interpersonal relationships among three comparison groups. However, The Round 3 survey shows that there was a minor difference in the responding RNs' self-reported ability of recognizing limits and seeking help ($F=3.48$, $df=2$, $P=.036$). The average rating on this subcategory was 4.51 for Group A ($SD=.52$), 4.17 for Group B ($SD=.74$) and 4.56 for Group C ($SD=.49$). Considering the differences are minor, no practical significance was declared based on

the available data. Table 5A represents the means and standard deviations of the four subscales reported by new RNs in all three rounds of surveys. On average, the new RNs reported slightly higher competency scores in the Round 2 survey, but reported slightly lower competency scores in clinical reasoning and judgment in general. A similar trend was stated in the NCSBN report showing that the new RNs felt relatively less competent in the areas of clinical reasoning and judgment (Li & Kenward, unpublished manuscript).

Table 5A. Descriptive Statistics on Self-reported Competence Subscales in the Three Surveys

		Mean	SD	N
Round 1	Clinical reasoning and judgment	4.23	0.58	158
	Patient care delivery and management skills	4.35	0.45	158
	Communication and interpersonal relationships	4.39	0.50	158
	Recognizing limits and seeking help	4.42	0.66	158
Round 2	Clinical reasoning and judgment	4.36	0.52	82
	Patient care delivery and management skills	4.47	0.39	82
	Communication and interpersonal relationships	4.54	0.38	82
	Recognizing limits and seeking help	4.66	0.50	82
Round 3	Clinical reasoning and judgment	4.18	0.73	83
	Patient care delivery and management skills	4.36	0.56	83
	Communication and interpersonal relationships	4.36	0.55	83
	Recognizing limits and seeking help	4.41	0.61	83

Furthermore, ANOVA analyses were performed to test if there were any statistically significant differences in each of the 35 items related to self-reported competence among the three comparison groups. The Round 1 survey revealed a statistically significant difference in the new RNs' self-reported ability of performing technical skills safely and accurately among the three comparison groups ($df=2, F=3.41, P=.04$). There were no statistically significant differences in 35 items among the comparison groups in the Round 2 survey, but the Round 3 survey revealed statistically significant differences among the three comparison groups in the following items: (1) recognizing when the care demands of clients have exceeded the new RNs' capability ($df=2, F= 3.93, P=.02$); (2) managing time and organizing workload effectively ($df=2,$

$F=4.3$, $P=.02$); (3) recognizing implications of clinical presentation of clients ($df=2$, $F=3.18$, $P=.047$); (4) appropriately utilizing research findings in providing care ($df=2$, $F=3.91$, $P=.02$); and (5) understanding fully assignments, including physician's orders ($df=2$, $F=4.21$, $P=.02$). See Tables 5B-5G.

Table 5B. Descriptive Statistics on New RNs' Self-reported Ability of Performing Technical Skills Safely and Accurately in the Round 1 Survey

	N	Mean	SD
Group A: Standardized Assessment	62	4.58	0.67
Group B: Formal Transition	47	4.49	0.83
Group C: Traditional Orientation	44	4.84	0.43
Overall	153	4.63	0.68

Table 5C. Descriptive Statistics on New RNs' Self-reported Ability of Recognizing When the Care Demands of Clients Exceeded Their Capability in the Round 3 Survey

	N	Mean	SD
Group A: Standardized Assessment	27	4.30	0.67
Group B: Formal Transition	28	4.14	0.97
Group C: Traditional Orientation	26	4.69	0.47
Overall	81	4.37	0.77

Table 5D. Descriptive Statistics on New RNs' Self-reported Ability of Managing Time and Organizing Workload Effectively in the Round 3 Survey

	N	Mean	SD
Group A: Standardized Assessment	27	4.41	0.69
Group B: Formal Transition	28	3.96	0.74
Group C: Traditional Orientation	27	3.85	0.77
Overall	82	4.07	0.77

Table 5E. Descriptive Statistics on New RNs' Self-reported Ability of Recognizing Implications of Clinical Presentation of Clients in the Round 3 Survey

	N	Mean	SD
Group A: Standardized Assessment	28	4.53	0.64
Group B: Formal Transition	28	4.32	0.67
Group C: Traditional Orientation	27	4.07	0.73
Overall	83	4.31	0.69

Table 5F. Descriptive Statistics on New RNs' Self-reported Ability of Appropriately Utilizing Research Findings in Providing Care in the Round 3 Survey

	N	Mean	SD
Group A: Standardized Assessment	28	4.11	1.10
Group B: Formal Transition	28	3.21	1.31
Group C: Traditional Orientation	26	3.46	1.27
Overall	82	3.60	1.28

Table 5G. Descriptive Statistics on New RNs' Self-reported Ability of Understanding Fully Assignments, including Physician's Orders in the Round 3 Survey

	N	Mean	SD
Group A: Standardized Assessment	28	4.46	0.79
Group B: Formal Transition	28	3.79	0.96
Group C: Traditional Orientation	27	4.03	0.90
Overall	83	4.09	0.92

There is not enough data for longitudinal analysis at this point because among the 42 new RNs who participated in all three surveys, only 17 of them reported remaining in the transition program after the first two months of employment. An independent *t*-test revealed that the nurses with previous work experience as a nurse's aide or an LPN/VN reported higher perceived competency scores compared to the new RNs without such experience (4.38 versus 4.28), but the difference was not statistically significant ($t=-1.38$, $df=156$, $P=.17$). To explore whether a new

RNs' previous nursing experience (worked as a nurse's aide or an LPN/VN had a confounding effect on the outcomes of the current transition programs, the current study further compared the perceived competency scores reported by those nurses without any previous nursing related experience. Table 5H represents the mean and standard deviation of self-reported competency scores by the new RNs without previous work experience. One-way analysis of variances revealed no statistical differences among the three comparison groups ($F=.18$, $df=2$, $P=.84$). There were no significant differences in self-reported competency scores among the new nurses without prior experience in the Round 2 and Round 3 surveys and no significant differences among these nurses in any of the 4 subscales.

Table 5H. Self-reported Competence by New RNs without Prior Nursing Experience

	N	Minimum	Maximum	Mean	SD
Group A: Standardized Assessment	31	3.53	4.94	4.30	.40
Group B: Formal Transition	23	3.06	5.00	4.22	.60
Group B: Traditional Orientation	20	3.09	4.94	4.30	.51

A binary correlation analysis revealed statistically significant correlations between the self-reported competency scores and the partnership ratings in all three rounds of surveys ($r=-.24$, $P<.001$ in Round 1. $r=-.32$, $P<0.01$ in Round 2, and $r=-.53$, $P<.001$ in Round 3). Note that a lower score for the partnership rating indicated a better quality. The current data shows that the better the quality rating on partnership with preceptors, the higher the perceived competency levels the new RNs declared. In addition, there were no statistically significant relationships between the new RNs' self-reported error scores and their perceived competency scores ($r=-.12$, $P=.13$) as well as the four subscales that were identified in the Round 1 survey. However, statistically significantly negative relationships between self-reported errors and competency were present in the follow-up surveys ($r=-.27$, $P=.02$ in Round 2; $r=-.52$, $P<.001$ in Round 3), which means that the higher the competency score a new RN declared, the fewer the self-reported errors. This finding reflects a similar tendency illustrated in the NCSBN report, showing that the more competent the new RNs perceived themselves to be, the less the practice errors made (Li & Kenward, unpublished manuscript).

Furthermore, current data revealed no statistically significant correlations between the new RNs' perceived competence and the length of time they worked in the current position ($r=.08$, $n=158$, $P=.32$) nor in any nursing position ($r=.08$, $n=158$, $P=.34$). There were no statistically significant differences between the new RN' self-reported competency and their corresponding preceptors' ratings in all three rounds of surveys. Round 1: $t= -0.69$, $df= 68$, $P=.49$; Round 2: $t=1.03$, $df=25$, $P=.31$; Round 3: $t=1.41$, $df=25$, $P =.17$.

Q 2: What is the relationship of the type of transition to practice experience and practice errors among newly licensed RNs in North Carolina hospitals?

The new RNs were asked whether they made any practice errors in the past 30 days. "Practice error" was defined as incidents or occurrences that resulted in harm to clients or had the potential to place the client at risk for harm. About 30% of the nurses reported having committed practice errors in the past 30 days (35.4%, 56 of 158) in the Round 1 survey. The rate of nurses who made errors by group B is 29.2% (14 of 48) which is lower compared to the other two groups (Group A: 40.0% and Group C: 35.6%). See Table 6A. Thirty-nine percent (32 of 82) of the new RNs in the Round 2 and 55.4% (46 of 83) in the Round 3 survey self-reported having committed practice errors. There were no statistically significant associations between committing errors and the comparison groups in the Round 1 ($\chi^2=1.42$, $df=2$, $P=.49$), Round 2 ($\chi^2=0.58$, $df=2$, $P=.75$), and Round 3 surveys ($\chi^2=4.86$, $df=2$, $P=.09$). Furthermore, the data shows that 34.5% (29 of 84) of nurses with previous nursing experience and 36.5% (27 of 74) of those without previous experience reported having errors during the first two month's of practice. Again, the difference is not statistically significant ($\chi^2=0.07$, $df=1$, $P=.87$). We further assessed the error rates in the new RNs without prior experience. The percentages of new RNs in Group A (41.9%, 13 of 31) and Group C (45.0%, 9 of 20) that reported having errors were almost two times higher compared to those in Group B (21.7%, 5 of 23). However, though it shows an interesting trend, due to the low sample size, the current data fail to reach a statistically significant association between committing errors and the comparison groups ($\chi^2=3.18$, $df=2$, $P=.20$, Table 6B).

Table 6A. Self-reported Practice Errors by Comparison Groups

	Reported no practice error		Reported One or more errors		Total
	N	% of Row Total	N	% of Row Total	
Group A: Standardized Assessment	39	60.0	26	40.0	65
Group B: Formal Transition	34	70.8	14	29.2	48
Group C: Traditional Orientation	29	64.4	16	35.6	45
Total	102	64.6	56	35.4	158

Table 6B. Self-reported Practice Errors by New Nurses without Prior Experience

	Reported no practice error		Reported One or more errors		Total
	N	% of Row Total	N	% of Row Total	
Group A: Standardized Assessment	18	58.1	13	41.9	31
Group B: Formal Transition	18	78.3	5	21.7	23
Group C: Traditional Orientation	11	55.0	9	45.0	20
Total	47	63.5	27	36.5	74

Nurses were asked if they had been involved in any of six different kinds of errors. An error index was developed by summing the occurrence of these 6 practice errors measured in the survey using a 3-point scale, with “1” for “no occurrence”, “2” for “Occur once” and “3” for “More than once”. Therefore, the potential scores ranged from a low of 6 to a high of 18 points. The correlation analysis revealed no statistically significant correlation between the self-reported practice errors and the total length of time employed as a nurse in the current position ($r=0.02$, $n=158$, $P=.78$) as well as in any nurse position ($r=.03$, $n=158$, $P=.75$). Finally, paired t-tests revealed no statistically significant differences between the new RNs’ self-reported errors and their corresponding preceptors’ ratings in all three rounds of surveys. Round 1: $t=.34$, $df=68$, $P=.74$; Round 2: $t=-.90$, $df=25$; $P=.38$; Round 3: $t=-1.44$, $df=25$, $P=.16$). On average, the practice errors rated by the preceptors were higher than the students’ self-ratings in the round 2

and round 3 surveys (Table 6C). However, the NCSBN report (Li & Kenward, unpublished manuscript) shows that apparently the preceptors were aware of fewer errors that the new RNs reported having made. Due to the low sample size, no statistically significant differences were identified.

Table 6C. New Nurses Self-reported Errors and Corresponding Preceptor’s Ratings

	Round 1 (69 pairs)		Round 2 (26 pairs)		Round 3 (26 pairs)	
	Mean	SD	Mean	SD	Mean	SD
New Nurses	6.48	0.85	6.42	0.86	7.35	1.52
Preceptors	6.43	0.65	6.65	1.20	8.00	2.25

Q3: What is the relationship of the type of transition to practice experience and risk of practice breakdown among newly licensed RNs in North Carolina hospitals?

This study asked new nurses whether any risks for practice breakdown (unsafe practice) occurred in the past 30 days. More than seventy percent of the responding RNs (77.8%, 123 of 158) in the Round 1 survey, 75.6% (62 of 82) in the Round 2 and 75.9% (63 of 83) in the Round 3 surveys reported that certain risks occurred in practice at least once. The most frequently occurring situation reported in the Round 1 survey included charting errors: delayed in charting (52.5%, 83 of 158), or charted on a wrong client record (30.4%, 48 of 158). In addition, 23.4 % (37 of 158) of the respondents reported having made errors in performance of a skill or intervention and 21.5% (34 of 158) declared contributing to the delay in procedure or treatment. The Round 1 survey shows that 33.3% of the new nurses in Group B reported that no risk factors occurred in practice, 22.2% of the new nurses in Group C and 13.8% in Group A reported having no risk factors in the Round 1 survey (Table 7A). The RNs in Group B reported lower risk in the Round 1 survey compared to Group A and this finding is statistically significant ($\chi^2=6.09$, $df=1$, $P=.013$). Group C also reported fewer errors, but these differences were not statistically significant. No statistical association between the reported occurrence of risk factors and comparison groups were identified in the follow-up Round 2 ($\chi^2=0.27$, $df=2$, $P=.88$) and Round 3 surveys ($\chi^2=0.17$, $df=2$, $P=.92$).

Table 7A. Self-reported Risk for Practice Breakdowns by Comparison Groups

	Reported no risk for errors		Reported one or more risks for errors		Total
	N	% of Row Total	N	% of Row Total	
Group A: Standardized Assessment	9	13.8	56	86.2	65
Group B: Formal Transition	16	33.3	32	66.7	48
Group C: Traditional Orientation	10	22.2	35	77.8	45
Total	35	22.2	123	77.8	158

Furthermore, nurses with previous nursing experience reported a lower perceived risk for practice breakdown compared to those without previous experience (72.6% versus 83.8%). The difference is not statistically significant ($\chi^2=2.84$, $df=1$, $P=.07$). The risk factor reported by the new RNs without previous experiences is presented in Table 7B.

Table 7B. Risk for Practice Breakdowns among Nurses without Prior Experience

	Reported no risk		Reported one or more risks		Total
	N	% of Row Total	N	% of Row Total	
Group A: Standardized Assessment	1	3.2	30	96.8	31
Group B: Formal Transition	7	30.4	16	69.6	23
Group C: Traditional Orientation	4	20.0	16	80.0	20
Total	12	16.2	62	83.8	74

In line with the previous finding, a statistically significant association between the reported risk for practice breakdown and transition groups A and B were identified among the new nurses without prior experience ($\chi^2=7.75$, $df=1$, $P=.008$). Data from this study shows that the new RNs in Group B reported lower risk factors compared to those in Group A regardless of their previous experience in nursing. Eighty percent of the new RNs without prior experience in Group C reported having one or more risks. No statistically significant associations in self-

reported risk factors were identified between Group C and the other two transition groups for the new RNs without prior experience.

Additionally, the same 3-point scale used for compiling error index was applied to describe the occurrence of the 16 risk factors. The new RNs tended to report more risks for practice breakdown when they practiced a longer period of time. A binary correlation analysis further revealed no statistically significant positive correlations between the new RNs' self-reported risks for practice breakdown and the length of time they were employed as a nurse in the current position ($r=0.01$, $n=158$, $P=.92$) nor in any nurse position ($r=0.02$, $n=158$, $P=.80$).

This study further shows that more than a quarter of the respondents (27.9%, 44 of 158) felt “often” or “always” overwhelmed by client care responsibilities in the Round 1 survey, while 19.5% of the respondents (16 of 82) in the Round 2 survey and 27.7% (23 of 83) of the respondents in the Round 3 survey expressed the same worries. Further analysis shows that there was a slightly higher percentage of the new RNs in Group A (33.8%, 22 of 65) that felt overwhelmed in the Round 1 survey compared to Group B (27.1%, 13 of 48) and Group C (20%, 9 of 45). Due to the low sample size, no statistical analysis could be performed.

Finally, this study compared new nurses' reflection on the risks for practice breakdown with their preceptor's report. A paired t-test revealed a statistically significant difference in the risk score given by newly licensed nurses and their preceptors ($t=2.97$, $df=68$, $P=.004$) in the Round 1 survey. The newly licensed nurses reported a comparatively higher risk score compared to that from their preceptors (20.04 versus 18.06). There are no statistical differences identified between new nurses and their preceptors in the following Round 2 ($t=1.02$, $df=25$, $P=.32$) and Round 3 surveys ($t= -1.70$, $df=25$, $P=.87$). Table 7C.

Table 7C. New Nurses Self-reported Risks and Corresponding Preceptor's Ratings

	Round 1 (69 pairs)		Round 2 (26 pairs)		Round 3 (26 pairs)	
	Mean	SD	Mean	SD	Mean	SD
New Nurses	20.04	5.02	19.08	4.05	23.23	6.88
Preceptors	18.06	2.86	18.12	3.47	23.65	10.21

Q4: What is the relationship of the preceptor characteristics to competency development among newly licensed RNs in North Carolina hospitals?

This study examined whether the preceptors' work experience or education/training had a direct impact on the new RNs' self-reported competency development. Correlation analysis shows no significant relationships between the new RNs' perceived competence and the length of their preceptor's or mentor's experience ($r=.11$, $P=.40$), nor with their preceptors' work experience in nursing ($r=.18$, $P=.11$). There was a negative correlation between the new RNs' perceived competence and the number of new RNs the preceptor served at one time ($r=-.20$, $P=.53$), which means that the more new RNs a preceptor took care of at one time, the lower the competency score a new RN reported. This finding was not statistically significant. See Table 8.

Table 8. Correlation between Preceptor's Characteristics to New RNs' Perceived Competence

	R	N	P
Length of preceptor experience	.11	57	.40
Length of work experience in nursing	.18	78	.11
Number of new RN supervised at one time	-.20	12	.53

Furthermore, the workload change for the preceptors when working as a preceptor had no impact on the new RNs' perceived competence ($F=.38$, $df=2$, $P=.68$), even though the new RNs tended to report a slightly higher competency score (4.44) when their preceptors had a reduced work load compared to those who had no client assignment (4.33) or with the regular workload (4.37). Furthermore, there is no statistical difference in new RNs' perceived competence in regards to their preceptors' educational degrees (under or above baccalaureate degrees, $t=.29$, $df=67$, $P=.77$).

Finally, whether a preceptor received special training in coaching critical thinking had no significant impact on a new RNs' self-reported competence ($t=.37$, $df=77$, $P=.71$). Based on the current data, none of the other qualification requirements for the preceptors significantly effected the new RN's perceived competency development.

Confidence Issue

This study also asked the newly licensed nurses to rate their confidence level in nursing performance using a 6-point scale, ranging from “1” for “Not at all confident” to “6” for “Over confident”. Half of the new RNs in the Round 1 survey felt “confident” or “very confident” of their work (50.0%, $n=80$), while 49.4% ($n=79$) felt “Somewhat confident” and only one (0.6%) respondent felt “Not at all confident”. More than sixty percent (64.4%, 56 of 87) of the new RNs in the Round 2 survey and 68.7% (57 of 83) in the Round 3 survey felt “confident” or “very confident” of their work. A breakdown analysis in the Round 1 survey showed that 56.5% of the new RNs in Group C (26 of 46), 48.5% (32 of 66) in Group A, and 45.8% (22 of 48) in Group B declared that they felt “confident” or “very confident”. No statistical significance was present in the new nurses’ self-reported confidence level among the three comparison groups in the Round 1 survey ($F=.24$, $df=2$, $P=.79$). None of the follow-up surveys found any statistical differences ($F=.27$, $df=2$, $P=.77$ for Round 2 and $F=1.74$, $df=2$, $P=.18$ for Round 3).

Statistically significant correlations were present between the new RNs’ perceived confidence and the length of nursing practice in their current position ($r=.20$, $n=160$, $P=.01$) and any nursing positions ($r=.20$, $n=160$, $P=.01$) in the Round 1 survey, showing that the new RNs’ self-reported confidence increased when they get more practice experience. No statistically significant relationship between the new RNs’ self-reported confidence and the length of practice were identified in the Round 2 and Round 3 surveys. Interestingly, the current data shows that the new RNs’ confidence level is positively related to practice errors in the Round 1 survey ($r=.16$, $n=158$, $P=.046$). This means that a high confidence level might be related to more practice errors. Due to a weak correlation coefficient and the low significance level, no definitive conclusion can be drawn at this point. Further analysis showed negative relationships between the new RN’s confidence levels and self-reported errors in the follow-up surveys ($r=-.15$, $P=.18$, $n=82$ in Round 2; $r=-0.27$, $P=.02$, $n=83$ in the Round 3). Therefore, additional study is needed to clarify the relations between confidence levels and self-reported errors in the future. It is likely that one’s confidence reflects more on the characteristics of a nurse rather than their ability for safe practice.

Overview of Nurses' Competence Development from Pre and Post Surveys

The current study was designed to use the longitudinal data to get an overview on the new RNs' performance over the six months after being hired. However, the current data shows that 42 new RNs completed all 3-round surveys and 59.5% (25 of 42) of them were no longer in the transition program after the first two months of employment. This study took a look over the new RNs' competence development and practice errors among the 100 nurses who participated in at least two rounds of the three surveys: 23% (n=23) were from Round 1 & 2 surveys, 30% (n=30) from Round 1 & 3 surveys, 5% (n=5) from Round 2 & 3 surveys, and 42% (n=42) from Round 1 & 2 & 3 surveys (Table 1C). The first and subsequent ratings relating self-reported competence, practice errors and risk factors are presented in Tables 9A-C. The data from the 100 new RNs who participated in at least two of three surveys reported a slightly higher competency score (Mean= 4.38) in the subsequent survey compared to that reported in the previous one (Mean=4.35). By using paired t-test, no statistically significant differences were found ($t=.75$, $df=94$, $P=.45$, Table 9A).

Table 9A. First and Subsequent Self-reported Competency Scores by New RNs

	Mean	N	SD
Competence Ratings in First Survey Completed	4.35	95	.42
Competence Ratings in Subsequent Surveys	4.38	95	.48

This study shows that 67.7% of the new RNs (67 of 99) did not report making any mistakes in the first survey completed, while 46.9% (45 of 96) of them reported safe practice in the subsequent survey. The paired t-test further shows that the perceived practice errors reported by the new RNs were significantly higher in the subsequent surveys ($t=3.53$, $df=94$, $P=.001$, Table 9 B). In line with the findings from self-reported errors, the new RNs in the subsequent surveys also reported statistically significantly higher practice risks in the subsequent surveys compared to that reported in the first survey completed ($t=2.12$, $df=94$, $P=.04$, Table 9C).

Table 9B. First and Subsequent Self-reported Practice Errors

	Mean	N	SD
Self-reported Errors in First Survey Completed	6.55	95	.92
Post Self-reported Errors in subsequent Surveys	7.04	95	1.33

Table 9C. First and Subsequent Self-reported Risks for Practice Breakdown

	Mean	N	SD
Self-reported Risks in First Survey Completed	19.6	95	4.82
Self-reported Risks in Subsequent Surveys	20.7	95	5.48

Further analysis shows that in the subsequent surveys, only 27% ($n=27$) of the new RNs reported that they currently participated in orientation or internship/externship programs. Therefore, there are insufficient amounts of data to support additional breakdown analysis. These new RNs were fairly evenly distributed among the three comparison groups: 9 in Group A, 11 in Group B, and 7 in Group C. Independent t -tests revealed that the new RNs who remained in the transition programs reported statistically significant fewer errors compared to those who were not in the programs (6.52 versus 7.25, $t=-3.08$, $df=78.2$, $P<.01$). In addition the new RNs who remained in the transition programs also reported fewer risks for practice breakdown compared to those who were not in the program (19.3 versus 21.2, $t=-1.61$, $df=94$, $P=.11$). The new RNs also reported significantly longer mandatory hours per week in the subsequent survey compared to that in the first survey completed (1.24 versus 0.56, $t=3.05$ $df=99$, $P<.01$). In addition, statistically significant relationships were identified in the new RNs' self-reported risks and the mandatory hours they worked in both the first ($r=0.23$, $P=.02$) and the subsequent surveys ($r=0.28$, $P=.01$). Data from the 100 new RNs shows that the longer the mandatory hours worked, the more risks for practice breakdown were reported. The new RNs also reported a slightly lower perceived confidence in the first survey completed (2.63 in the first surveys versus 2.76 in the subsequent ones), however, the difference was not statistically significant ($t= -1.81$, $df=99$, $P=.07$).

Finally, in the respondents' comments, several responding new RNs believed that the transition programs are important and prepared them well for practice. They also felt very positive about their preceptors as well as other nursing staff. However, very few new RNs reported an unsafe environment and too heavy of a workload which caused unsafe practice at work. The preceptors mainly had positive comments about new RNs. A detailed summary of comments is listed in Appendix C.

DISSCUSSION

This study shows that no transition approach is significantly superior to others in all perspectives. The new nurses in Group C reported an insignificantly higher perceived competency score than the other two groups. Based on self-report, the new RNs in Group B were at lower risk for practice breakdown and had fewer practice errors during the first two month transition period. In addition, there was no statistically significant correlation between the characteristics of preceptors and new RNs' perceived competency development. The underlying reasons could be: (1) due to the features of transition, not every new nurse was assigned a preceptor; (2) the preceptors are taking care of more than one new nurse, therefore, the characteristics of preceptors may not directly affect certain new RNs; (3) even though more than two hundred preceptors participated in the survey, the matching preceptors and the new RNs was very low, only eight pairs of preceptor and new RN cohort completed all three rounds of surveys which prevented further breakdown analysis; (4) several preceptor surveys submitted in Round 2 and Round 3 were completed by RNs' supervisors or the preceptors who worked with the new RNs in the past month, the lack of updated daily contact could dilute their impact on the transition outcomes. With broader participation, the paired correlation between preceptors and the corresponding new graduates could be further explored.

Considering the low participation in all the surveys, inconsistent self-reported data from new RNs and their preceptors, as well as the lack of meaningful practical differences of some findings among the three groups, no optimal transition model could be identified at this point in the study. Several factors related to the transition process were addressed in the following:

- (1) The majority of the responding new RNs rated very positive about the quality of the partnership with their preceptors during transition.
- (2) Quality of partnership has a direct relationship with how competent a new RN feels about their nursing practice.
- (3) There are no differences in self-reported competency development and safe practice during transition in regards to a new RNs' previous nursing work experience.

A summary of the statistically significant findings is given in Table 10.

Table 10: Summary of Statistically Significant Findings

	Statistical Significance
Relationship between the quality of partnership and new RNs' self-reported competency scores	Three rounds
Performing technical skills safely and accurately between Groups B & C	Round 1 Survey
Differences in self-reported risks between Groups A & B	Round 1 Survey
Differences in self-reported risks between new RNs and their preceptors	Round 1 Survey
Correlation between new RNs' perceived confidence and length of practice	Round 1 Survey
Correlation between new RNs and their preceptors' ratings on partnership	Round 1 Survey
Recognizing limits and seeking help between Groups B & C	Round 3 Survey
Recognizing when the care demands of clients exceeded their capability between Groups B & C	Round 3 Survey
Managing time and organizing workload effectively between Groups A & C	Round 3 Survey
Recognizing implications of clinical presentation of clients between Groups A & C	Round 3 Survey
Appropriately utilizing research findings in providing care between Groups A & B	Round 3 Survey
Understanding fully assignments, including physician's orders between Groups A & B	Round 3 Survey
Correlation between new RNs' confidence and self-reported practice errors	Rounds 1 & 3
Correlation between self-reported competency and error scores	Rounds 2 & 3

Finally, data from the 100 new RNs showed increases in the errors and risks in the subsequent surveys. That could be caused by the fact that the majority of new RNs (73%) were no longer in the transition programs in the later stage of their transition period which could make these new RNs face more challenges of taking responsibility of safe practice on their own. Furthermore, it is also possible that as the time went on, the new RNs might have different workloads or assigned more difficult tasks or more patients compared the ones when they just got started. Additional study will be needed to clarify this issue.

Critical Issues for the Follow-up Studies

As a logical step, The North Carolina Foundation for Nursing Excellence plans to conduct the phase II study focusing on newly licensed RNs in settings other than acute care and newly licensed practical nurses in all settings, including, but not limited to acute care. Based on outcomes of the Phase I study, attention should be paid to two issues:

(1) Sample size

The current study shows that the small sample size is troublesome for the statistical analysis. Even though participation in this study is voluntary, the organizer or agencies may introduce some merit-based award system to make this study more interesting for the nurses and attract more participants.

(2) Avoid misunderstanding

The current study reveals that quite a few participants (both new RNs and their preceptors) misunderstood the questions. For example some respondents were confused about the types of actual transition activities given to the new RNs. Some new RNs declared that they did not attend any transition or orientation. The data further shows that the transition programs many RNs thought they participated in were different from the ones actually given by the agencies. On the other hand, more than 30% of the responding new RNs reported having had more than a two-month transition and one nurse even reported having a six month transition training already in the first round of surveys. A hot line with a contact person who can answer the questions of the participants in real time could help to eliminate these errors. This may also be helpful for raising the response rates in general.

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Appendix A: Newly Licensed RN Survey

Appendix B: Preceptor Survey

Appendix C: Comments

Comments from Newly Licensed Nurses and Preceptors
Round 1 Survey from New RNs
Many of my answers represent experience from my graduate nurse/ nurse extern period. I also do not work on a hospital floor. I work in an outpatient wound clinic that also provides care for hospital inpatients.
Have Only been nursing for 3 months, and am currently being oriented to my unit, so I have supervision for the biggest part of my duties at this time.
The nurse to patient ratio is too large. Quality patient care is given as best as possible but 6 -7 patients limits the attention you can provide , as well as the overwhelming amount of charting and documentation that must be completed by the nurse for all of their assigned patients.
I am impressed that an ADN program has prepared me so well.
As a new nurse, I think that there needs to be a bigger emphasis on actual hands on nursing care. There is so much book learning, I have felt inadequate as a nurse. There have been many things that I have never done or even seen done. It is almost as if I am learning how to be a nurse now. I think that nurses who have been in the field for some time have a higher expectation of what new nurses should know, when the truth is if it were in a book, I might know it, as far as hands on, I know very little. It is very scary not knowing how to really take care of a patient, and dangerous!!!
Allow preceptor to focus on precepting only instead of taking a full load of patients and being

preceptor and also functioning as unit team leader. I feel this is way too much of a load for 1 person to carry out.

I feel that working nights does not afford new grads the opportunities for learning that working days does. ½ should be days and 1/2 nights.

As a new nurse some of the errors and overwhelming but with proper help you can get through this.

assignments are not "accepted"..they are given

You can never feel as though you know everything. Classrooms or even clinical rotations can never truly prepare you 100% for your nursing experiences.

Many problems have resulted from the transition form paper charting to computerized documentation. Our department transitioned during the middle of my preceptorship, so it has been a learning curve for physicians, experienced nurses and new grads.

I'm in a critical care internship program and it will not be completed until 6 months after my hire date. My learning curve is steeper than that of the average new RN in med-surg. Thus, my responses indicate my lack of comfort with certain areas of my practice that are very new to me.

Although I have shortcomings as noted in the "to err is human" section, I try to learn from all my mistakes and though I continually try to improve, my biggest fault regarding those "err"s stem from computer entry of orders or paperwork, of which, both take time to master.

As a new grad in the ED I sometimes find myself torn between completing all my work and doing so safely. I really focus on providing safe care and try to remind myself that the speed will come with experience--but it's still a tough environment sometimes!

we have recently decided to keep plan of care with the unit secretary, this has caused me to miss several orders, and several parameters with which I should have had to contact physician and make him aware.

Round 2 Survey from New RNs

In the OR, precharting is sometimes necessary due to the fast nature of some cases. But before ever submitting a chart, I review each entry.

* trouble identifying appropriate MD orders(not feeling comfortable enough to challenge) * SBAR communication, recommendations. Do not know what to recommend M D ask what I wanted for confused /agitated pt. on PCA-Morphine pump. Luckily, I suggested Haldol (out of the blue), I had already taken self-control button out of reach of (PCA) patient. But, I could have easily asked for ativan which might not have been a good choice for someone on PCA Morphine.

I had one great preceptor. But, on my own I have learned my own way of doing things, but not violating orders or policy and procedures.

Q 17- Delayed in charting due to work load , not by choice

I feel there were many things I was not told in orientation and maybe assumed I knew. Now, I am having difficulty because I didn't know those things and I make mistakes. Also, in our facility is it very hard to get up with a doctor. You have a lot of run around to find the doctor and I think that affects my time to care for my patients.

As a new nurse, I have been told to just ask for help when you feel overwhelmed or need it. Now that I am on my own, I find that this is a way over rated false sense of security. I will ask questions for general knowledge and I feel I am doing okay with my load of patients of care. However, I have found recently, when things get hectic for me, usually it is hectic for everyone. I recently had a situation where every patient I was caring for was needing

something done immediately. In trying to "handle" my patient load, got very behind, and when I ask for help, didn't really feel I got it because everyone seemed to be dealing with the same situation. That particular day, I ended up working 1 and 1/2 hours past my shift just to finish what I had to finish. That day turned into an enter week of chaos. This left me feeling like I had probably overlooked something, did things incorrectly, and feeling like a total idiot. When I expressed my feelings to some of the other nurses, it was sort of an "okay" type attitude. Some nurses where understanding and offered some supportive comments, but I still felt like very inadequate in my abilities.

Working in an operating room requires different skills, use of instruments, and time organization. My orientation period is longer than the traditional floor nurse. I will circulate through many specialties with different preceptors for an estimated 9-12 months. Many times a day I may feel overwhelmed by the amount of new information. However, I feel that and have received much support from my coworkers and management. the one med error- I started an IV, and was given an antibiotic (that came to the holding area with the pt.) to hang on the tubing I set up. the mistake (wrong med with chart) was missed by 3 nurses and was caught by anesthesia. The MD changed the order and an incident report was filled out. The pt was not harmed and now I am more careful about checking orders for med handed for me to give.

Being that I work in an emergency dept., I feel like sometimes I am being pulled in many different directions, which is why I need to improve on time management and prioritization. Overall it has gone well. I have learned a remarkable amount of knowledge in a short time.

I have enjoyed my experience this far in my orientation to critical care. However, because there are quite a few new graduates in this area, I have not had one consistent preceptor. Having more than one preceptor and working day-night rotate has been difficult, yet rewarding. I have learned that there are many ways to accomplish the same tasks. I am learning to identify and utilize the practices that are best, safest and fit my own personal style. Over the past couple of months I have witnessed my own growth as a nurse. I am excited to see what the future holds!

I have had a wonderful experience working with my preceptor. The ED department has been a wonderful place to work. I have been supported and encouraged! it's been a great experience!

Patient to nurse ratio is too high.
This survey pulled out many issues I worry about ALL the time. I spend a lot of off time worrying about my actions at work. I am often overwhelmed but told I am doing fine. I have caught and addressed several emergent poss. fatal complications but worry about missing one while running around so busy.
I often seek other nurses for assistance or answers. The nursing staff is always reliable and receptive. The overwhelmed feeling is getting less and less.
One of the benefits received in my mentorship was the fact that it was agreed that I have an extended preceptorship. Otherwise I would not have accepted the position I am currently employed at. Because of this, I feel my period of training and orientation has been an exceptionally good experience.
Round 3 Survey from New RNs
I am starting to feel more confident in my practice. However, I do feel overwhelmed often with my responsibilities. I always ask for help if I don't understand something, and if I get behind in pt. care someone is always willing to help when I need it, or answer my questions.
Over the past two months I have finally begun working in my home unit, Previously I had worked on a cardiac unit. When I began ICU, I felt as if I was starting all over again as a brand new nurse. However, I found that over a couple of weeks I was able to grasp concepts quicker and easier than before. I realized that my work on the cardiac unit allowed me to learn basics about time management prioritization and hospital procedure. Such an extensive orientation has allowed me to integrate new concepts with information learned in nursing school. I have NOT felt overly rushed. I have been allowed to progress at a decent, steady pace. I now also have one steady preceptor who is able to identify my strengths and weaknesses and personalize

experience to fit my learning needs.

The unit I work on puts all of nurses on the units at risk. The environment is not safe. The management does not listen to the nursing concerns.

The one time I missed x-ray info on client.

Our internship program has been cut short. I am being assigned permanently to a unit I have not yet been to, and do not want to work in. I am not ready to take care of these patients. This knowledge of the impending change in my employment, has colored my performance in my current unit of rotation. I am less confident overall now than I was a few weeks ago. I am frightened for my patients and for my own license as I will soon be turned loose with only a resource person and expected to take a full load after only 5 days of orientation in my new assigned unit.

Q 22- I charted on wrong client record: corrected.

I changed units in Oct. and I love my new place, It's awesome!

I hate getting 2 to 3 admission back to back it is not safe for me or the patients. You can not give good care in these situations.

We started new computer entry for data collection and delays in charting were a result of getting familiar with that program.

Great floor and profession. I have learned that good and knowledgeable staff are key to help develop my foundation for nursing.

Round 1 Survey from Preceptors

The new nurse I am orienting is an LPN. I had been an LPN for 4 years 2 of which I worked on this unit. I graduated the same time she did from an ADN program. I was a little worried at first about me orienting her, because I wanted her to have a good experience. I think everything has gone good. To me it makes sense to have an LPN show and LPN how to do the job. Yes there were always an experienced RN available for me to ask questions to if I did not know the answer or when I had something new to me come up. Over all I think everything went smoothly.

we chart meds now before giving them due to new pt id scanning.

This seems to portray a very negative picture of my orientee, but she's good... just inexperienced, shy and never worked in our facility even with clinicals.

my new grad is awesome!

This particular new grad has been exceptional in most all aspects unlike previous new grads I have precepted.

error section did allow for meds given late that did not cause harm or even potentially cause harm. Some sections should have been split up because I had to keep scrolling back up to see which was "fairly often, occasionally" etc.

I participated in this preceptor program as a new grad myself. What a great experience. Practicing new skills and building confidence was very important. I would advise any new grad to participate in a program like this.

The new nurse grad that I work with is truly exceptional. She has an unusual confidence that I rarely see in someone her age and experience level. She has great team work skills and has a great capacity for empathy and concern for her patients.

I was very please at the confidence and knowledge my nurse exhibited. The school of nursing this new nurse went to had her well prepared to enter the work force as a nurse.
New Nurse has adapted well to new position. Continues to improve on time management and prioritizing. Novice at seeing the big picture. Learns quickly. becoming more confident in delegation. Overall good experience so far.
Items Related to communication issues -SDA & ENS: - changes have been made in orientation plans and philosophy of unit and not communicated to clinical coaches, except by word of mouth. -SDA has never oriented fully herself to our patient population and she is only capable of taking care of the most basic assignments in unit herself. - Orientee clinical hours have been decreased each week that they are pulled out for classes and labs that are too basic for their level of orientation. - SDA/ENS have made demeaning remarks to coaches and orientees about certain people in unit as well as night shift that "does nothing they need to learn"
Q30- currently enrolled in BSN Program
Q 19- option 2 was stated as little opportunity. Q 20- stated client falls but not due to nurses error- preceptee handled very well. Q 21 - stated delayed charting due to situation beyond control Comments- I've only had this preceptee for 1 week. She had a tough week but hung in there and performed well according to her expertise at that point. I think she is going to be an excellent nurse.
I was a paramedic for twelve years prior to returning to nursing school. The medication error that occurred was one even I may have made. We have tried to eliminate these errors by labeling bags differently and double checking meds with both a nurse and the pcp.
We started a one-week structured classroom orientation program this year, bringing in

different staff nurses & nurse managers to teach specific topics. The feedback from the graduates so far has been very positive.
While my answers pertain to my current nurse, I spent time as well, opposite shift, with another new graduate. I have attempted to answer these questions as they pertain to my current assignee but may have biased some with my previous assignee. Both new nurse graduates have wonderful potential. I hope the staff will continue to nurture them well after orientation ends. However, I do fear that they will soon be "thrown to the wolves."
Have MSN
Some of the answers do not reflect this graduate due to the fact she cannot be in the role of a new RN graduate at present
hospital documentation program is fraught with hindrances to the performance of patient care and documentation in a timely fashion. system is difficult for even the most technologically and clinically skilled nurses. my preceptee evaluated by this survey was exceptionally skilled and intelligent. time management is his weakness and that should correct itself with experience.
I serve as the CNS responsible for the new hire's OR orientation
The questions asked were actually very important. It would benefit me now, to try to observe the new graduate with some of these questions in mind.
concerned about patient/ nurse ratio being unsafe and being told by your supervisors that you will take more patients that you feel is safe and that you can handle.

I have been a RN for many years and have participated in the orientation of nurses throughout my career in other facilities . The program currently being offered to new grads at Onslow Memorial Hospital is one of the most complete, comprehensive and supportive programs I have had the privilege to participate in, and it shows in the positive outcomes of these nurses in their independence and knowledge base working within the department that is often very acute and with many team members. I applaud OMH endeavors.

I ENJOY PARTICIPATING IN THE PRECEPTOR DUTIES. I TREAT NEW GRADUATES WITH RESPECT AND PATIENCE. I'VE BEEN IN THEIR SHOES. I UNDERSTAND WHAT IT TAKES TO RETAIN A NEW GRADUATE.

I would for more training to be offered for the clinical coach.

This new nurse actually spent 10 weeks on orientation instead of 8. This new nurse felt uncomfortable calling physicians initially but is now more confident and is no longer fearful.

Round 2 Survey from Preceptors

the delay in charting was due to the new nurse putting patient care first.

This nurse is no longer on orientation and works a different shift from me.

This nurse is an exceptional person with history of being a teacher for the past 13 yrs. She enjoys educating her patients and family. She is truly a valuable access to our unit.

I cannot commend the effectiveness of the new nurse academy enough. The preceding preceptorship allows the new RN a specific place to turn when he/she is overwhelmed, has questions of doubts oneself. to be able to visualize the transformation of a new uncertain nurse become more confident, independent and an asset to the team is very gratifying.

[the new nurse] was an LPN for more than 2 years in our same unit- her transition has been

impressive.

Fortunately I am working with an excellent new graduate with strong clinical skills and good critical thinking. Unfortunately we have had little support from the units education team and continue to have poor and inconsistent communication with the SDA in charge of orientation.

Q 2- precepted 1 day.

this orientee is one week away from finishing up her orientation. she is confident in her care of patients and skill level. She asks appropriate questions concerning plan of care and orders. She recognizes the need to call physicians when the situation calls for it. She still needs to work on seeing the big picture and delegation but these things will come with experience. She is going to make a fine surgical nurse.

Q 10-Client falls occurred during first week, not her fault though. Q 11-delayed in charting was a heavy day. - my mentoree was very confident in her role. She is going to be an excellent asset to our department. I was pleased and honored to have the opportunity to precept her.

Q 17- medication error was giving medication late.

Q13- To my knowledge, none of these occurred. However, she has her own assignment and I have on also. We also do not always work the same days of the week.

NEW NURSE CHARTED ON WRONG CLIENT BUT READILY RECOGNIZED THE ERROR AND RECTIFIED THE SITUATION

This new nurse I am evaluating was only given 2 weeks of orientation on nights. The few errors that were made were all minor and could have been prevented had our facility given her more of an orientation. It is my opinion that all new grad orientation should be at least 6 weeks on days and 6 weeks on nights.

I think that orientation on an ICU Service need to be longer than 16wks. I feel that the new RN need to have a small group discussion @ the end of the week to talk about their pts, go over

poc and review what transpired to help improve their knowledge base.
gave BP med before checking BP x1
Remember when I precept new grads I am into details. I have a style where first I want to know everything a new grad knows e.g. I'm right there for every assessment until she is so comfortable with assessments-lungs, heart etc she can pick up the slightest change. Then I constantly teach prioritizing and time management. They have plenty of time in life to be on your own but whether it is a student I precept or a new grad I like to give them a passion for nursing and be there with them teaching how to get a total look of your patient to really know them so when subtle changes happen he or she will be able to act quickly without hesitation. Bottom line it's not task oriented activity so you can get back to the desk to visit with your peers, but we are nurses doing a job to touch and change lives.
charting delayed due to very busy shift
Round 3 Survey from Preceptors
New nurse delayed in charting- comment 'All RN's Do This DAILY'
Shannon is an excellent nurse who just needs more experience. My only wish for her is that she would seek out something to do during downtime.
New nurse in now on shift for which she was hired and in her last week with a preceptor on that shift. (total of 2 weeks with that preceptor on her new shift)
Several instances were reported that the nurse was given a workload unfair considering that she is a new nurse

this new nurse has had difficulty with other hospital staff. This new nurse has shown poor judgment in several communications with the respiratory therapy staff which has lead to further conflicts. Management has been notified of the outburst and lack of professionalism shown several times.

Answers are not applicable because my new nurse was forced to take a position that she did not want and promptly got another job at another facility!

sometimes when urgent issues arise with a patient, the nurse would ignore contact precautions to assist the patient but always completed proper hand washing afterwards.