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Qualitative Evaluation of a Hospital-Based Preceptor-Guided Clinical Orientation Program

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Walden University

College of Education

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Brian Eigelbach Martin

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Walden University
2020

Abstract

Qualitative Evaluation of a Hospital-Based Preceptor-Guided Clinical Orientation Program

by

Brian Eigelbach Martin

MS, Walden University, 2015

MBA, Baker College, 2003

BS, University of the State of New York, 1994

ADN, Eastern Kentucky University, 1980

Project Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Education

Walden University

December 2020

Abstract

Effective preceptor-guided clinical orientation programs (PGCOP) help new graduate nurses (NGNs) across the theory-practice gap to provide safe, effective, and efficient patient care. This constructivist-designed qualitative program evaluation study explored NGNs' and preceptors' perceptions of a local hospital's PGCOP as an effective transition vehicle. The conceptual framework combined Knowles' andragogical process model for learning with the new world Kirkpatrick model evaluation model. The sample included 7 NGNs who graduated in the past year and had no prior orientation experience and 5 preceptors employed by the study site for at least 1 year. A goal-free approach guided data collection with face-to-face semistructured participant interviews. Data analysis was emergent and performed simultaneously with data collection. Data were coded, categorized, and then aggregated into themes. Two cross-categorical themes, PGCOP facilitators and PGCOP barriers emerged. Orientation in smaller acute care areas appeared to expedite interactions between the NGN and preceptor, facilitating the PGCOP process and increasing NGN confidence. Orientation in the larger general medical-surgical units hampered NGN/preceptor interactions resulting in the NGNs feeling intrusive when asking questions of the preceptor, creating a barrier in the PGCOP process. The study culminated in a program evaluation report delivered to study site leadership. Application of the recommendations from this study could result in a theory-based training program for preceptors that promotes evidence-based practices increasing the effectiveness and safety of NGNs entering the organization.

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Acknowledgments

I would like to thank the following people: Dr. Carole Pearce for sticking by me throughout this process; Dr. Jeanne Sorrell for providing advice and gently guiding me in directions I had not considered; Dr. Tara Schickel for being a great cheerleader and allowing me to bounce ideas off her; and Dr. James and Wendy Kirkpatrick for the training they provided in the New World Kirkpatrick Model.

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Section 1: The Problem

The Local Problem

Transition-to-practice (TTP) is a process designed to assist the new graduate nurse (NGN) in advancing from the role of a student nurse to the role of a practicing nurse (Goode et al., 2018; Letourneau & Fater, 2015). Most hospitals begin the TTP process with a centralized orientation classroom experience (Wright, 2005), which exposes all new employees to information that defines the organization's culture (Spector, 2009), such as its mission, vision, values, and critical behaviors. Upon completion of the centralized orientation, NGNs begin a decentralized orientation (Wright, 2005), a period of clinical orientation and competency development based on one of the various available frameworks, such as a nurse residency program (NRP) or preceptorship program (Key & Wright, 2017; Missen, McKenna, & Beauchamp, 2014). The preceptor program is a common component of most orientation programs and a crucial part of TTP (Key & Wright, 2017).

A community hospital in a midsized mid-Atlantic city in the United States offers a multitrack orientation program that is discipline driven. All new employees attend a centralized general orientation program consisting of a 1-day classroom experience that familiarizes the new employees with the organization's culture. Each employee then progresses to a department-specific orientation. After 2 more days in the classroom covering general policy and procedure, the NGN is assigned a preceptor and begins the preceptor-guided clinical orientation programs (PGCOP) transition program. The length of the PGCOP depends on the acuity of the nursing unit. NGNs hired for general

medical-surgical units will receive a 6-week PGCOP. NGNs employed for more acute units, such as progressive care and intensive care, will receive an 8-week PGCOP. A yearlong NRP follows the PGCOP for NGNs. The preceptor academy program director (PAPD) stated that there might be some overlap in the PGCOP and NRP depending on the NGN's hire date.

A *preceptor* is an experienced nurse, considered an expert in their area of practice (Shepard, 2014), who functions as a role model assisting the NGN through the TTP process (Pasila, Elo, & Kaariainen, 2017). Preceptors are essential to successful NGN transition (Blegen et al., 2015; Key & Wright, 2017) and require training (Irwin, Bliss, & Poole, 2018; Silvestre, Ulrich, Johnson, Spector, & Blegen, 2017; Spector et al., 2015; Strauss, Ovnat, Gonen, Lev-Ari, & Mizrhi, 2016). The local hospital provides an 8-hour preceptor academy (PA) training program for interested nurses. The goal of the local hospital's leadership is to have enough trained preceptors to assign one preceptor to each NGN during PGCOP. According to the PAPD, this has not always been possible due to the rapid turnover of bedside nurses. Low preceptor support is related to decreased NGN retention and can affect NGN competence and patient care (Blegen et al., 2015). I recognized the need to investigate the effect of a preceptor's guidance on the NGN's transition, which prompted the inclusion of a research question exploring preceptors' perceptions of the effectiveness of the PGCOP.

There is not a documented history of the PGCOP. However, the PAPD related a remembered history. In 2001, a national organization purchased the local hospital. After the purchase, a corporate workforce convened to develop a clinical orientation program

based on the evidence available at the time. The workforce created a multipage print document listing various competencies to be completed by the NGN during the PGCOP. The checklist was to be checked off by the preceptor. This checklist form, for reasons unknown to the current nursing education staff, was revised in 2012. In 2014, the print version of the NGN competency check-off form was moved to an electronic version completed by the preceptor and reviewed by the unit manager during and after completing the PGCOP. There is no documented or remembered evidence of a formal or informal program evaluation of the PGCOP.

The local hospital's nursing leadership team recognizes the lack of formal program evaluation as a problem. According to the chief nursing officer, documented evidence demonstrating that the PGCOP provided by the local hospital is effective and meets the needs of transitioning NGNs does not exist. This omission of program evaluation is not uncommon. Chyung (2015) pointed out that training and development practitioners rarely perform improvement evaluations due to either environmental barriers or lack of expertise.

Problem in the Larger Population

Transitioning from a nursing student to an NGN can be difficult and anxiety-provoking (Goode et al., 2018; Key & Wright, 2017; Rusch et al., 2019). Many healthcare organizations expect new nurses to be work ready (Edward, Ousey, Playle, & Giandinoto, 2017; Phillips, Kenny, & Estermann, 2017; Rusch et al., 2019). This expectation is unrealistic because nursing students graduate from their nursing programs with a defined but limited skill set. During the transition period, role confusion is not

uncommon, with many NGNs struggling to assimilate into the hiring organization's culture. Role confusion (Phillips et al., 2017), job dissatisfaction (Missen et al., 2014), lack of confidence (Murphy & Janisse, 2017), burnout (Pasila et al., 2017), bullying (Lindfors & Junttila, 2014), and other issues contribute to the possibility of the NGNs becoming disillusioned and contemplating exiting the profession. These barriers to successful transition may contribute to one out of five new nurses leaving their employment within the first year of work (Key & Wright, 2017; Warren, Perkins, & Greene, 2018; Rusch et al., 2019).

The TTP program or preceptorship (Africa, 2017; Spector, 2009) is designed to support the NGNs after graduation and aid in TTP. However, not all TTP programs meet this goal. For example, ineffective orientation programs have been shown to lead to dissatisfaction among new hires with subsequent increases in attrition rates (Murphy & Janisse, 2017). On the other hand, an effective orientation program can decrease attrition by increasing NGN satisfaction (Lindfors & Junttila, 2014).

The success of TTP programs in assisting the transition from student nurse to practicing nurse is not just scrutinized at the local hospital level. TTP has been identified as a global issue (Arrowsmith, Lau-Walker, Norman, & Maben, 2015; Missen et al., 2014; Murphy & Janisse, 2017; Pasila et al., 2017) with research increasing internationally over the past few years. However, the research findings have not been generalizable due to variations in TTP programs (Anderson, Hair, & Todero, 2012; Missen et al., 2014; Ziebert et al., 2016). Arrowsmith et al. (2015) added that although

literature about TTP is abundant internationally, the experience of nurses undergoing transition has not been well investigated, suggesting a qualitative gap in the literature.

Rationale

Evidence of the Problem

In this study, TTP is a process that refers to transitioning from the role of student nurse to the role of a licensed, employed NGN (Pasila et al., 2017; Spector, 2009). The importance of an adequate process for transitioning the student nurse to NGN cannot be undervalued, especially with the current high turnover rates among NGNs and the nursing shortage (Key & Wright, 2017). New nurses face many difficulties in making the transition from student to graduate nurse. These difficulties include lack of confidence (Key & Wright, 2017), learning how to function in a rapidly paced healthcare system (Missen et al., 2014), lack of adequate training to care for highly acute patients (Letourneau & Fater, 2015), not feeling valued, and being bullied (Phillips et al., 2017).

NGNs pass state board licensing exams, but they are not prepared for professional practice (Kavanagh & Szweda, 2017). Spector (2012) reported that employer surveys conducted in 2001 and 2003 by the National Council of State Boards of Nursing (NCSBN) found that fewer than 50% of employers agreed strongly that new graduates were ready to practice. Kavanaugh and Szweda (2017) found that, of 5,000 NGNs evaluated, only 23% were deemed competent and work ready. The hiring organization then must step in to assist with TTP (Kavanagh & Szweda, 2017) through one of the various transition frameworks, such as nurse residencies, nurse internships, or preceptorships.

The study site provides a PGCOP, which has not been formally evaluated in the past. According to the chief nursing officer, the local hospital experienced a nursing turnover rate as high as 26.3% in June 2018, which was above the 14.6 % national rate reported in 2016 (Rosenbaum, 2018), requiring the use of contracted nurses. The chief nursing officer indicated that a program evaluation would be helpful to understand the PGCOP program better. The local hospital's leadership provided no goals or objectives for the program evaluation of the PGCOP.

The purpose of this study was to conduct a qualitative program evaluation of the PGCOP from the NGN and preceptor perspectives. The conceptual framework combined Knowles et al.'s (2015) andragogical assumptions and the New World Kirkpatrick Model (NWKM; Kirkpatrick & Kirkpatrick, 2016) of program evaluation. The study consisted of semistructured interviews of NGNs and preceptors who had recently completed the PGCOP. The data were transcribed, coded, and iteratively categorized until two themes emerged. This work culminated in creating a program evaluation report delivered to the local hospital's leadership team.

Definition of Terms

Bullying: Along with *horizontal violence*, a pattern of aggressive behavior directed toward a member of the workgroup (Condon, 2015; Gardiner & Sheen, 2016).

Centralized Orientation: Also called *classroom orientation* (Key & Wright, 2017) or *didactic orientation* (Murphy & Janisse, 2017), time spent in the classroom becoming familiar with the systems, policies, procedures, mission, vision, values, and critical behaviors of the organization (Wright, 2005).

Decentralized Orientation: Also referred to as *clinical orientation* (Cotter & Dienemann, 2016) or *unit orientation* (Key & Wright, 2017; Murphy & Janisse, 2017), time spent with a preceptor learning job specific (Wright, 2005) at the patient's bedside.

Effectiveness: Defined as "the degree to which something is successful in producing a desired result" (En.oxforddictionaries.com, 2018). Kirkpatrick and Kirkpatrick (2016) defined *program effectiveness* in terms of effective training—the knowledge and skills provided to training participants that can be applied by them on the job confidently.

New Graduate Nurse (NGN): A newly licensed nurse with no prior nursing experience who has graduated from their nursing program in the last 12 months (Baxter, 2010).

Orientation: A classroom learning activity separate from TTP (Spector, 2009) that is planned and circumscribed (Letourneau & Fater, 2015), where an NGN is exposed to the philosophy, role expectations, policies, and procedures required to function within the hiring organization (Spector, 2009).

Preceptee: Newly hired NGNs working with a preceptor as part of the orientation process (Blegan et al., 2014; Nielsen et al., 2017).

Preceptor: An experienced nurse, considered an expert in their area of practice (Shepard, 2014), who functions as a role model assisting NGNs through the TTP process (Pasila et al., 2017).

Preceptor-Guided Clinical Orientation Program (PGCOP): The local hospital provides a clinical orientation program that immediately follows general orientation. This

program is time limited, lasting 6 weeks for NGNs hired to work in general medical-surgical units and 8 weeks for NGNs working in acute care units. This orientation portion is designed for newly hired nurses, including NGNs, and is guided by a preceptor. This program does not include classroom time per the PAPD.

Preceptorship Program: Pairs the preceptor and preceptee for a set length of time to assist the NGN in the TTP process (Key & Wright, 2017). The goal of the preceptorship program is for the preceptor to provide clinical experiences for the preceptee resulting in improved nursing practice, organizational outcomes, and patient experiences (Ward & McComb, 2018) and to promote continued lifelong learning (Whitehead, Owen, Henshaw, Beddingham, & Simmons, 2016).

Residency Program: Designed to bridge the gap between school and employment but for a more extended period than a preceptor program (Edwards, Hawker, Carrier, & Rees, 2015).

Units of Analysis: The sample is the unit of analysis in a qualitative study (Merriam & Tisdell, 2016). For example, in a case study, each bounded system or case would be the analysis unit for that study. In this study, the unit of analysis will be the perceptions of the NGNs and preceptors about the effectiveness of the PGCOP.

Transition to Practice (TTP): A formal process for transitioning the NGN from a student nurse role to a licensed practicing nurse (Arrowsmith et al., 2015; Spector, 2012).

Significance of the Study

The PGCOP has not been formally evaluated since implementation. Hospital leadership does not have evidence to show if the program is effectively transitioning

NGNs into the workforce. An effective PGCOP could help alleviate some of the anxiety surrounding the transition from student nurse to NGN by providing NGNs with socialization into the organization (Cotter & Dienemann, 2016). The PGCOP could also support the NGNs in acquiring new knowledge and skills while strengthening current knowledge and skills through the opportunity to practice with an experienced nurse. Chyung (2015) noted that trainers rarely perform program evaluations either because of environmental barriers or a lack of knowledge on the trainer's part. Most transition program evaluations have focused on turnover rates and program costs, providing little information about the effectiveness of preceptor programs (Kozub, Hibanada-Laserna, Harget, & Ecoff, 2015). Evaluation of the PGCOP from the views of NGNs and preceptors could provide valuable information to the leadership team for making decisions about the value and quality (Chyung, 2015) of the current program. Information obtained from this qualitative program study and evaluation of graduate nurses' perceptions regarding the PGCOP process could also add to the existing literature about TTP programs.

Research Questions

The local hospital has not conducted a formal evaluation of its PGCOP since implementation. The purpose of the PGCOP is to assist NGNs in transitioning from the role of student nurse to the role of licensed, practicing nurse. However, documented evidence that the PGCOP is accomplishing that purpose for the local hospital does not exist. This study's purpose was to fill that information gap and tconduct a qualitative

program evaluation of the effectiveness of the PGCOP as perceived by both the NGNs who have completed the program and the preceptors who guide them.

RQ1: How do nurses transitioning from the role of student nurse to the role of NGN perceive the effectiveness of the preceptor-guided clinical orientation program at the local hospital?

RQ2: How do experienced nurses functioning as preceptors perceive the effectiveness of the preceptor-guided clinical orientation program at the local hospital?

Review of the Literature

The articles and books used in this literature review were located through various means, primarily through Google Scholar (2014–present). Google Scholar is linked to the Thoreau (2014–present) search services provided by the Walden University Library. Clinical Key for Nursing (2014–present) provided more current nursing research articles than those accessed through Google Scholar or Thoreau. Keywords used in the electronic searches included *andragogy, bullying, incivility, Kirkpatrick, new graduate nurses, nurses, nursing orientation, nurse residency program, orientation, preceptor education, preceptor, preceptor program, preceptor training, program evaluation, transition,* and *transition to practice*. A search of several professional nursing sites, including the NCSBN, the American Association of Colleges of Nursing, and the Commission on Collegiate Nursing Education, provided useful information for TTP resources and links. The references that accompanied the studies and books found through the various searches provided additional resources.

The following literature review includes two sections. This first section is a description of the conceptual framework used to guide the project, including a review and synthesis of the seven steps of the andragogical process model for learning (APM-L) and a synopsis of the four levels of the NWKM (Kirkpatrick & Kirkpatrick, 2016). The second section includes related research that supports the research questions and includes a review of orientation, preceptor program, nurse residency program, the transition process, and TTP for the NGN.

Conceptual Framework

A literature review revealed that TTP is a common concern for NGNs and healthcare employers (Kozub et al., 2015; Letourneau & Fater, 2015; Missen et al., 2014; Murphy & Janisse, 2017; Pasila et al., 2017). TTP is the bridge that marks the end of the new nurse's time as a student and the beginning of a career as a licensed practicing nurse. Therefore, TTP was the concept that grounded this study because a successful transition is the desired outcome of both the organization's leadership and the NGNs. Knowles et al.'s (2015) APM-L provided the theoretical framework. The APM-L was placed within the evaluative structure of the NWKM (Kirkpatrick & Kirkpatrick, 2016) to form the conceptual framework for this study.

Knowles et al. (2015) noted that evaluation was a weak point in the APM-L and referenced Kirkpatrick's (1975) program evaluation model as a model congruent with andragogy and usable in the evaluation step of APM-L. At the time of that reference by Knowles et al. (2015), Kirkpatrick's (1975) original program evaluation model was quantitative-based and focused on content. However, a year following the publication of

Knowles et al.'s (2015) book, Kirkpatrick and Kirkpatrick (2016) revised Kirkpatrick's original (1975) model, and it became the NWKM. The NWKM can be adapted to perform a complete qualitative program evaluation focusing on process (Kirkpatrick & Kirkpatrick, 2016). The focus on process aligns the NWKM with the APM-L, which is also a process model, but for adult education (Knowles et al., 2015).

The andragogical process model for learning. There is an abundance of learning theories available. Many learning theories are aimed at children, others at adults, and some at both. No one theory thoroughly addresses all that is known about adult learners, but all theories guide how to improve teaching and provide a guiding framework for research (Arghode, Brieger, & McLean, 2017). For this study, Knowles' andragogic assumptions, as expressed in the APM-L (Knowles et al., 2015), were used as the adult learning framework.

Researchers vary in their thoughts about andragogy. Andragogy is either considered a model (Arghode et al., 2017), a theory (Curran, 2014), or a set of assumptions (Knowles et al., 2015) developed by Malcolm Knowles that address the learning needs of the adult learner. Conaway and Zorn-Arnold (2015) stated that andragogy was built on two main points: the learner's centrality to the process of learning and the acknowledgment of the adult's knowledge and experience. Knowles et al. (2015) provided an excellent historical overview of andrology's development, culminating in the andragogic assumptions. The andragogic assumptions originally contained four assumptions (Knowles, 1980), which were later increased to five (Knowles & Associates, 1984). Currently, the andragogic assumptions include the following six assumptions: (a)

adults need to know why they should learn something, (b) adults need to be seen by others as self-directing, (c) adults have a more significant reservoir of adult experiences, (d) adults want immediate applicability learning, (e) the adult's orientation to learning is life-centered, and (f) the adult's motivation to learn is mainly internal (Knowles et al., 2015).

To capitalize on the andragogical assumptions, Knowles et al. (2015) developed the APM-L. The APM-L is a process model as opposed to a content model. In a content model of education, the instructor is in control of the learning curriculum and strategies. In the process focused APM-L, the instructor facilitates learning in collaboration with the participants through the following steps: (a) learner preparation, (b) climate preparation, (c) model for collaborative planning, (d) assessing learning needs, (e) developing program objectives to address assessed learning needs, (f) designing learning experiences, (g) conducting the designed learning experience, (h) evaluating learning outcomes, and (i) reassessing learning needs (Knowles et al., 2015). The goal of the APM-L is to provide the participants with the resources needed to seek out and acquire information and skills, thus becoming self-directed learners. A description of the APM-L steps follows.

Step I: Learner preparation. This preparatory step was a later addition (Knowles et al., 2015) to Knowles' (1984) first five steps of the andragogical learning process. The APM-L was created with the concept of self-directed learning in mind. Knowles realized that most adults had not learned how to be self-directing because they were conditioned by childhood educational experiences to be teacher dependent. Thus, this step's addition

instructs learners in the skills needed to be self-directed, which helps adult students (Knowles et al., 2015).

Step II: Climate preparation. The climate or learning environment can either be conducive to learning or a barrier. The physical environment includes lighting, temperature, access to amenities such as bathrooms, comfortable chairs, etc. Knowles et al. (2015) pointed out that many things, such as the size of the room or the color of the walls, are out of an instructor's control. However, clearly defined goals, open and honest feedback, and availability of adequate resources are under an instructor's control and can be conducive to the learning climate (Knowles et al., 2015).

Climate is more than the color of the walls, the room's temperature, or the arrangement of work areas. Climate includes understanding the impact that organizational culture has on the psychological well-being of the employee. Individuals should feel safe and accepted while operating within the organization. An organizational culture that promotes trust and respect is essential (Knowles et al., 2015).

Knowles et al. (2015) considered climate to be the most crucial element of human resources development. The model views the individual as an asset to be developed into a productive member of the organization. Even though it appears that human interactions are an essential consideration for climate construction in the APM-L, there is a lack of specifics in this area. For example, the adverse effects of bullying on the work environment and the learning climate are worthy of consideration. The concept of *bullying* figures prominently in the TTP literature (Gardiner & Sheen, 2016; Pasila et al.,

2017; Irwin et al., 2018; Phillips et al., 2017; Phillips, Kenny, Esterman & Smith, 2014; Regan et al., 2017)

Gardiner and Sheen (2016) described the culture of bullying in some organizations as horizontal violence, which is defined as hostile behavior toward a workgroup member. This behavior adds to stress for the NGN and is demonstrated by coworkers as unhelpful behaviors, rudeness, and the new team member's exclusion. As a result of horizontal violence, the NGN might be reluctant to ask for help from more experienced nurses. This reluctance to ask for help may negatively impact patient care and outcomes.

Rush, Adamack, Gordon, and Janke (2014) conducted a mixed-methods study to determine if transition programs limited the effects of bullying and horizontal violence experienced by NGNs. Thirty-nine percent of the nurses in a transition program and 39% of those not in a transition program encountered bullying (Rush et al., 2014). Rush et al. (2014) found that transition programs provided a supportive learning environment for NGNs and access to resources. The nurses in a supportive transition program reported a positive experience regardless of the bullying (Rush et al., 2014), a finding that was supported by Laschinger et al. (2016).

Laschinger et al. (2016) looked at predictors of nursing retention in Canadian nurses at 1 year of employment. Several attributes were explored, and of interest to this study was the finding that incivility by supervisors, other nurses, and physicians negatively impacted retention of NGNs. Bullying appeared to be on the rise in nursing (Laschinger et al., 2016). Lindfors and Junttila (2014) stated that bullying is associated

with higher turnover. From 26% to 33% of new nurses are bullied, 21.6% of nurses are bullied daily (Lindfors & Junttila, 2014).

Incivility, as defined by Laschinger et al. (2016), is a low-level intensity behavior expressed as either rudeness or disrespect. Whether the intent is to cause harm was an ambiguous finding. Overall, Laschinger et al. (2016) found that NGNs supported in their transition by the organization were satisfied with work. NGNs credited this satisfaction to working with a preceptor. However, the preceptor must be engaged, as pointed out by Irwin et al. (2018), who identified a link between bullying and harassment with disengaged preceptors. Laschinger et al. (2016) concluded that rising workplace bullying rates were concerning and suggested that management look at strategies to improve workplace environments.

Step III: Model for collaborative planning. Knowles (1980) pointed out that involvement and commitment have a proportional relationship. The more involved a person is in a decision-making activity, the more committed they are to the decision. The underlying andragogic assumption in this step is the learner's self-concept. Adult learners want to be responsible for their decisions and want others to know they can self-direct (Knowles et al., 2015). Knowles (1980) suggested that procedurally, the facilitator acts as a resource and guides the adult learner to plan their learning. Planning involves creating learning goals from assessed learning needs identified in the previous APM-L step (Knowles et al., 2015).

Knowles (1975) determined that the best way for learners to demonstrate a commitment to learning is through a learning contract, exemplifying two andragogic

principles: orientation to learning and motivation to learn. The learning contract can solve many problems (Knowles et al., 2015). Adults come to the learning experience with various backgrounds, experiences, education, learning styles, and motivations. The learning contract works around individual differences by allowing each learner to create their learning objectives in collaboration with the teacher. Collaborative creation of learning plan objectives promotes learner engagement by encouraging ownership of the plan. The learning contract leaves open the potential for a wide variety of learning resources that allow individual adult learners to learn the same thing using their choice resources. Lastly, the contract provides a structure for learning and provides a process for self-evaluation by the learner (Knowles, 1980; Knowles et al., 2015).

This study focuses on the NGN's needs as they transition from student to practicing nurse. Knowles et al. (2015) pointed out that the organization's needs also must be considered when planning learning experiences. Because adults desire to control their learning (self-directed), the learning contract addresses the tension created between the organization's needs and the adult's needs. Collaborative planning between the NGN (adult) and the preceptor (organization representative) could provide a reconciliation between the new nurse's learning needs and the organization's performance needs. Many of the steps used in the APM-L are also used to develop the learning contract. Those steps are: (a) diagnosing learning needs, (b) setting objectives, (c) identifying resources, (d) selecting strategies, and (e) evaluating learning. The process helps the learner develop a sense of ownership over their learning even though there might be learning requirements imposed by the organization (Knowles et al., 2015).

Step IV: Assessing learning needs. The APM-L emphasizes the self-diagnosis of learning needs by the adult learner. This process contains three phases: (a) constructing competencies that provide an ideal model against which to compare; (b) the designing of experiences adult learners can use to compare themselves against the ideal competency; (c) helping adult learners self-diagnose learning needs by measuring the gaps between where they are and where they would like to be concerning the ideal competency. Knowles (1980) claimed that this process resulted in the motivation to learn. Knowles et al. (2015) pointed out that the facilitator held some responsibility for exposing the learner to available resources and people who could serve as role models. This exposure to resources would assist the learner in self-diagnosis and provide something against which to compare.

Knowles (1980) advocated building the ideal competency model around the teacher, organization, societal expectations, and societal values. For example, in this study, competencies are built around the concept of the ideal nurse who provides safe, effective care in the hiring organization for the community it serves. Through a series of experiences such as simulation labs, testing, problem-solving exercises, and supervised bedside care, the nurse can receive feedback that allows self-assessment of strengths and weaknesses (Benner, 1994; Curran, 2014). The identification of knowledge gaps should create dissatisfaction resulting in motivation for self-improvement (Knowles, 1980).

TTP program goals include developing the competencies needed by the newly graduated nurse (Spector et al., 2015; Zigmont et al., 2015). Transition literature defines *competency* as the skilled performance (Quick, 2016) of patient care through the

integration of knowledge and skill under various conditions of practice (Lindfors & Junttila, 2014). However, the licensed nurse must be competent in self-directed learning for continued and future career development (Qamata-Mtshali & Bruce, 2017).

Knowles (1975) addressed the links between competency and self-directed learning. Over time, Knowles (1975) further clarified his position and moved from a discussion of pedagogy and andragogy as opposing concepts to presenting the learning assumptions of pedagogy and andragogy as a continuum. On one end of the continuum, the learner has no background in the subject and depends on teacher-directed education. On the other end of the continuum, the learner has a background in the subject matter, is independent of the teacher, and participates in self-directed education pursuits (Henschke, 2015; Knowles, 1975). Placement on the continuum depends upon the learner's mastery of the subject matter.

The pedagogy–andragogy (teacher-directed vs. self-directed) continuum exemplifies the preceptor's role in the PGCOP. Initially, the NGN requires pedagogical interventions from the preceptor in learning and applying the policies and procedures of the healthcare organization. As the NGN gathers knowledge and resources through the transition experience, they may become more independent and learn to use those resources gained through experience to guide self-direct future learning (Henderson, Ossenberg, & Tyler, 2015; Khaled, Gulikers, Biemans, & Mulder, 2015).

Step V: Developing objectives. Knowles et al. (2015) pointed out that the concept *objective* is defined differently depending upon the school of thought or the researcher. For example, behaviorists have stated that a goal must be precise, measurable, and

observable. On the other hand, Maslow (Knowles et al., 2015) considered goal formation a product of the interaction between the learner and the learner's experience. Knowles et al. (2015) clarified that objectives written for training should be terminal behavior-oriented objectives, and objectives written for education should be inquiry process-oriented.

These definitions, differentiated by activity and setting, create a paradox when applied to the PGCOP. The PGCOP at the local hospital is a combination of training required by various regulatory bodies and a continuation of the NGN's formal education. In applying Knowles' (1975) thinking about the pedagogy-andragogy continuum, perhaps training objectives for the new nurse should initially be behavior-oriented and preceptor devised. Goals can become inquiry process-oriented and preceptee established as the new nurse gains experience through the PGCOP and discovers the desire for more knowledge through experience.

Step VI: Learning plans. Using the APM-L design to assess the student's learning needs may uncover gaps in knowledge. The facilitator chooses the appropriate format and resources for learning based on the learning needs assessment findings. The learning is conducted in a sequence that meets the learner's needs (Knowles et al., 2015). The sequencing would be determined by where the learner falls into the pedagogical (teacher-directed)-andragogical (self-directed) continuum described by Knowles (1975).

Step VII: Conducting the designed learning experience. The APM-L considers the teaching-learning transaction (Knowles, 1980) as the responsibility of the teacher and the learner. The facilitator's role in the andragogic teaching-learning transaction is that of

a guide on the side instead of a sage on the stage. The facilitator is a resource, technical consultant, and co-learner guiding and sharing in the adult learner's knowledge (Knowles et al., 2015).

Step VIII: Evaluating learning outcomes and reassessing learning needs. Knowles et al. (2015) claimed that the assessment of education is challenging. To meet this challenge, the authors promoted Don Kirkpatrick's (1975) evaluation process as closely aligned with andragogic principles. Knowles (1980) considered evaluation to be a process that evaluated the adult learner's learning and the learning program's effectiveness. Knowles advocated self-assessment. The same process used in assessing learning needs is used in this step to determine the gains in competencies made as a result of the learning program (Knowles et al., 2015). Knowles (1980) referred to this process as re-diagnosis.

New world Kirkpatrick model. Knowles et al. (2015) referenced Kirkpatrick's (1975) program evaluation model as a model congruent with andragogy and useable in the APM-L evaluation step. At the time of that claim, Kirkpatrick's (1975) model focused on content and was built around quantitative research methods. However, Kirkpatrick's (1975) model was revised by Kirkpatrick and Kirkpatrick (2016) the year following Knowles, Holton III, and Swanson's (2015) publication and was retitled the New World Kirkpatrick Model (NWKM). The NWKM can be adapted to perform a complete qualitative, process-oriented program evaluation. The ease of use and focus of the model makes it a widely used program evaluation tool (Paull, Whitsed, & Girardi,

2016) to evaluate individual and organizational impacts (Reio Jr., Rocco, Smith, & Chang, 2017).

Kirkpatrick and Kirkpatrick (2016) outlined three reasons for evaluating a training program. First, an evaluation completed using formative and summative methods improves the program. Second, evaluation determines if learning was transferred (Cotter & Dienemann, 2016), as evidenced by the organizational results (Kirkpatrick & Kirkpatrick, 2016). Third, an evaluation demonstrates the organizational value of the training. The NWKM evaluation model is composed of four levels that are not necessarily sequential: reaction, learning, behavior, and results. The four levels are used in reverse when planning a training program (Kirkpatrick & Kirkpatrick, 2016).

Level 1: Reaction. Reaction evaluates how the participants responded to the training. Three different components are evaluated: engagement, relevance, and satisfaction (Kirkpatrick & Kirkpatrick, 2016). Kirkpatrick and Kirkpatrick (2016) noted that evaluations at this level could be both formative and summative. The authors leaned more towards formative evaluations to prevent the evaluator from wasting time and energy while evaluating Level 1. However, program content determines whether a formative or a summative evaluation is the best approach. For example, the PGCOP is an on-going and recurring program. The NGNs may not use all that they learn in the PGCOP for some time, so summative data collection about the program's relevance may need to be delayed (Kirkpatrick & Kirkpatrick, 2016) collected a few weeks or months after the training.

Level 2: Learning. This level of the NWKM considers five components knowledge, skills, attitude, confidence, and commitment. Summative evaluation for learning at this level can be accomplished through testing, teach-back, presentation, action planning, demonstration, individual interview, or focus groups. Teach back occurs when the participant learns something and then teaches it back to the class or instructor to evaluate their understanding of the material. Action planning occurs when the participant creates a plan to apply what they learned at the job site.

The five components of knowledge, skills, attitude, confidence, and commitment can be evaluated at the same time using the summative methods just listed (Kirkpatrick & Kirkpatrick, 2016). Kirkpatrick and Kirkpatrick (2016) did not go into great depth in describing each component of learning evaluation. This lack of detail may be because the NWKM is a tool for evaluating processes, not program content.

Level 3: Behavior. Kirkpatrick and Kirkpatrick (2016) stated that Level 3 is the most crucial level to address in the program evaluation process (Reio Jr. et al., 2017). The participant's ability to apply the learning when back on the job is assessed through monitoring and observation at this level. Improvements are made in performance as needed.

Kirkpatrick and Kirkpatrick (2016) pointed out that *required drivers* are an essential component of this evaluation level. Required drivers are processes put in place by the organization that reinforces, encourages, and rewards the learner's behavior. Drivers focus on support and accountability systems that promote organizationally defined critical behaviors of employees. Examples of support drivers include self-

directed learning, job aids, communities of practice, coaching, mentoring, and recognition programs. Examples of accountability drivers include interviews, observation, self-monitoring, work reviews, and surveys (Kirkpatrick & Kirkpatrick, 2016).

Critical behaviors are desired behaviors that have the most significant impact on organizational outcomes and are determined by their leadership. Critical behaviors are measurable, specific, and observable, according to Kirkpatrick and Kirkpatrick (2016). The Kirkpatrick's definition of a critical behavior (Kirkpatrick & Kirkpatrick, 2016) is like Knowles et al.'s (2015) terminal behavior-oriented objectives described earlier.

Kirkpatrick and Kirkpatrick (2016) discussed competencies briefly in Level 3. It is their opinion that competencies belong in Level 2 of the NWKM and should support critical behaviors. For example, a critical behavior described by policy might be that the nurse checks the patient's blood pressure every four hours (Level 3). The nursing competency supporting that critical behavior would be that the nurse possesses the skills and knowledge (Level 2) to take blood pressure accurately.

Level 4: Results. At this level, the contribution of the training to the business is demonstrated. Kirkpatrick and Kirkpatrick (2016) stated that most training professionals do not know how to perform this evaluation level, and Chyung (2015) agreed. Adequate evaluation requires knowing leadership's defined *leading indicators* and linking them with performance. For example, patient satisfaction is currently a lead indicator for hospital leadership established by the Centers for Medicare and Medicaid (Medicare.gov). Management of the patient's pain, for instance, is a nursing competency

(Level 2) that is a measure of performance (Level 3) that affects the patient satisfaction score (leading indicator).

Kirkpatrick and Kirkpatrick provide a list of leading indicators that may be tied to nursing TTP such as error prevention (Arrowsmith et al., 2015; Goode et al., 2018; Goode, Ponte, & Havens, 2016), employee satisfaction (Cotter & Dienemann, 2017; Gardiner & Sheen, 2016), turnover (Gardiner & Sheen, 2016; Goode et al., 2016), and employee job confidence (Gardiner & Sheen, 2016; Goode et al., 2016). The monitoring of leading indicators provides leadership the information needed to determine if critical behaviors' performance had the desired effect. It may take time before results manifest, requiring ongoing monitoring (Kirkpatrick & Kirkpatrick, 2016).

Summary. The combination of the APM-L and NWKM should provide a more comprehensive qualitative evaluation of the PGCOP than could have been achieved using either model alone. For example, using only the NWKM, the researcher might query participants about their perceived engagement in training to evaluate participant satisfaction in Level 1. The addition of Knowles, Holton III, and Swanson's (2015) APM-L to the conceptual framework allowed the development of more probing questions. For example, the researcher might query the participants to determine if workplace incivility incidents occurred (APM-L Step I, climate preparation) that may have created a barrier to their satisfaction (NWKM Level 1, reaction) with the effectiveness of the program. (Knowles et al., 2015).

Related Research

In reviewing the literature for this section, it was noted that four distinct concepts emerged that described different but related processes of transitioning the NGN from a student nurse role to a practicing nurse role. The four concepts are orientation, preceptor program, NRP, and TTP. The reader will note that similarities exist between the four concepts and that they tend to be used interchangeably in the literature.

Orientation. Various terms have been used in the literature, often interchangeably, to describe the process of orientation, including orientation, preceptorship, nurse residency, and TTP. For example, Cotter and Dienemann (2016) used the terms orientation and preceptorship interchangeably. Edwards et al. (2015) considered orientation, nurse residency, and preceptorship to be parts of the transition process. Gardiner and Sheen (2016) differentiated orientation from clinical experiences (preceptorship), but the terms were not defined. Henderson et al. (2015) differentiated between orientation and preceptorship and did provide some defining characteristics differentiating the two terms. Kavanaugh and Szweda (2017) equated orientation with residency in their study but did not define either term. Key and Wright (2017) differentiated between general orientation and clinical orientation. General orientation, however, was not defined. This small sampling of the literature shows that terms describing orientation are used interchangeably but often lack definitions, which would provide clarity for the reader. For purposes of this paper, *orientation* for the NGN will be defined as a classroom learning activity, separate from TTP (Spector, 2009), that is planned and circumscribed (Letourneau & Fater, 2015) where the NGN is exposed to the

philosophy, role expectations, policies, and procedures required to function within the hiring organization (Spector, 2009).

Preceptor program. A preceptor program is a clinical learning experience (Quek & Shorey, 2018) that pairs a preceptor [defined as an experienced nurse, considered an expert in their area of practice (Nielsen et al., 2017; Shepard, 2014), who functions as a role model (Missen et al., 2014, Pasila et al., 2017; Nielsen et al., 2017) assisting the NGN through the TTP process (Pasila et al., 2017)] with a preceptee for a set length of time to assist the NGN in the transition process (Key & Wright, 2017). Preceptorship has been identified as an effective means for learning in the clinical area that ensures the safe and effective delivery of care to patients (Nielsen et al., 2017). Pasila et al. (2017) found in their review of the literature that a wide variety of preceptorship programs exists.

Preceptorship of the NGN is designed to serve several purposes depending upon the perspective of the stakeholder. From the perspective of the hiring organization, an effective orientation can result in cost savings by increasing the retention of nurses (Brook et al., 2029; Kozub et al., 2015; Missen et al., 2014; Murphy & Janisse, 2017), increased job satisfaction for the NGN (Murphy & Janisse, 2017), reduced contracted labor usage (Letourneau & Fater, 2015), and integration of the new hire into the organizational culture (Murphy & Janisse, 2017). From the perspective of the NGN, orientation serves to: teach the NGN to respond effectively to practice challenges, adapt to a fast-paced healthcare environment (Letourneau & Fater, 2015), increase competence (Pasila et al., 2017), increase job satisfaction (Murphy & Janisse, 2017; Pasila et al., 2017), improve decision making and leadership skills of the NGN (Pasila et al., 2017),

and assist the NGN in the transition to professional practice (Letourneau & Fater, 2015; Missen et al., 2014; Murphy & Janisse, 2017). Orientation is considered accomplished when a person becomes “familiarized with something” (Pasila et al., 2017, p.18).

The preceptor’s role as a key educator in the TTP process is a requirement for the new nurse’s success (Cotter & Dienemann, 2016). Laschinger et al. (2016) found in their study of new nurses in Canada that 90% of the 406 study participants felt that a preceptorship facilitated their TTP. Lindfors and Junttila (2014) reported that preceptorship played a significant role in developing competency, developing professional behaviors, role adjustment, and job satisfaction of the NGN. Participants in a study by Ortiz (2016) reported that positive communication with their preceptor boosted their self-confidence. Cotter and Dienemann (2016) pointed out that the primary responsibility of the preceptor is to teach the NGN how to be reflective and think critically. Shepherd (2014), in a qualitative study, found that preceptorship did not affect critical-thinking skills and subsequently did not offer any recommendations. However, participants reported increased feelings of confidence and competence as a result of the experience. Irwin et al. (2018) found indications that preceptor programs improved new nurses' confidence and competence. Henderson et al. (2015) found that NGNs identified preceptors as instrumental in (a) increasing their comfort in the clinical area, (b) facilitating engagement with the nursing team, and (c) preventing feelings of isolation.

Preceptorship is a short-term (Nielsen et al., 2017) period of clinical orientation for the NGN aimed at role integration. During this time, the NGN is socialized by the preceptor to the practicing nurse's role (Cotter & Dienemann, 2016; Spector, 2012). The

goals and specific responsibilities of the preceptor and preceptee should be delineated (ANCC, 2016) by the healthcare organization for the program to be successful. This support requires the healthcare organization's commitment to providing professional development opportunities for the experienced nurse who desires to become a preceptor. (Cotter & Dienemann, 2016; Henderson et al., 2015; Strauss et al., 2016).

***Preceptor training*.** Preceptorships have been used by nursing, and other healthcare professions as a clinical learning method found to be helpful for the new nurse beginning their career (Quek & Shorey, 2018). Organizations have a substantial role in developing and maintaining preceptorship programs (Henderson et al., 2015; Ward & McComb, 2018) and supporting the preceptor (Blegen et al., 2015; Cotter & Dienemann, 2016). Researchers have recommended that organizations formalize the role and prepare the preceptor for the role (Edward et al., 2017; Henderson et al., 2015; Shaw, Abbott, & King, 2018; Valizadeh, Borimnejad, Rahmani, Gholizadeh, & Shahbazi, 2016). Quek and Shorey (2018) pointed out that preceptor training should be well-planned and executed. Despite these recommendations, it has been reported by researchers that preceptors have not always been provided with the formal training needed (Ortiz, 2016; Quek & Shorey, 2018; Shaw et al., 2018; Strauss et al., 2016; Valizadeh et al., 2016; Whitehead et al., 2016; Zigmont et al., 2015). Panzavecchia and Pearce (2014) pointed out in their study of UK nurses that the lack of organizational support for preceptors can result in demotivation and decreased role effectiveness. A lack of training can lead to feelings of inadequacy in the role (Panzavecchia & Pearce, 2014).

A brief review of the literature did not reveal the existence of a gold standard for preceptor training. However, content topics for preceptor training programs have been recommended by various researchers, such as preceptor roles and responsibilities (Cotter & Dienemann, 2017; Quek & Shorey, 2018; Spector et al., 2015), preceptor expectations (Cotter & Dienemann, 2017), adult learning theory or principles (Cotter & Dienemann, 2017; Spector et al., 2015), effective teaching strategies (Quek & Shorey, 2018), principles of feedback (Cotter & Dienemann, 2017; Edward et al., 2017; Ortiz, 2016; Spector & Echternacht, 2010; Spector et al., 2015), learning styles (Cotter & Dienemann, 2017; Edward et al., 2017), clinical reasoning (Spector et al., 2015), assessing competence (Spector et al. 2015), how to encourage reflective practice (Spector & Echternacht, 2010; Ortiz, 2016), how to promote the independence of NGNs (Ortiz, 2016), and how to promote a culture of safety (Spector et al., 2015). A few preceptor training models were reviewed in the literature, for example, see studies by Cotter and Dienemann, 2017; Delfino, Williams, Wegener, & Homel, 2014; Ward and McComb, 2018; and Zigmont et al., 2015.

The length and delivery of preceptor training programs are varied. For instance, Cotter and Dienemann (2017) reported that typical preceptor training programs tend to run 3 to 6 hours. The local hospital's preceptor training program is currently eight hours of total class time, according to the PAPD. A preceptor training program studied by Zigmont et al. (2015) totaled eight hours of training. The Virginia Nurse Internship Program provided a 2-day preceptor training workshop (Delfino et al., 2014). The Transition to Practice Model developed by the National Council of State Boards of

Nursing is provided via an online format that requires 10 hours to complete (Spector et al., 2015). The American Associations of Critical-Care Nurses offers an online course for nurses interested in becoming preceptors (Ward & McComb, 2018). Cotter and Dienemann (2016) discussed a blended preceptor training program that included commercially created modules, online modules, and facilitator-led classes. Preceptor education delivery is varied and occurs in the classroom, through online modules, or a blend of both.

The lack of standardization of preceptor training programs presents its own set of challenges. Other challenges to preceptor education and training can be gleaned from the literature. Preceptorship is stressful, which does not seem to be reduced over time by experience (Quek & Shorey, 2018). Preceptorship does not lighten the preceptor's workload but adds to it, for example, increased administrative work (Quek & Shorey, 2018). Often nurse managers do not understand or support the preceptor, affecting nurses' commitment to the preceptor role (Quek & Shorey, 2018). Organizational lack of support is evidenced by leadership when the assumption is that the preceptor has a lighter workload when assigned a preceptee and can take a larger patient load (Quek & Shorey, 2018; Trede, Sutton & Bernoth, 2016).

Another interesting challenge pointed out by Quek and Shorey (2018) is the indiscriminate pairing of preceptor and preceptee. The nursing manager must consider several things rather than resorting to the "warm body" or "who is available to do this" method of pairing preceptor and preceptee. Intergenerational differences, educational differences, and cultural differences should be taken into consideration. Trede et al.

(2016) stated that preceptors are primarily practitioners, not educators. Therefore, the role of the educator is viewed as an added responsibility by the preceptor. If the quality of the preceptor is not considered when pairing the preceptor and preceptee, then the preceptorship may be unsuccessful (Quek & Story, 2018).

Nurse residency program. Like preceptorships, nurse residencies are programs (Goode et al., 2016) designed to bridge the gap between being a student nurse and becoming a licensed practicing nurse (Edwards et al., 2015; Goode et al., 2016). Registered Nurses graduate from their professional programs with the foundational knowledge required to be a nurse. At this point, the NGN is considered an advanced beginner (Warren et al., 2018). What NGNs lack is the experiential knowledge needed to think critically and make complex decisions at the patient's bedside. The Institute of Medicine in 2010 (Cotter & Dienemann, 2016; Goode et al., 2016) advocated for NGNs to participate in a residency program to address this lack of experience. The NCSBN recommended nurses residency programs in 2009 (Letourneau & Fater, 2015). The American Nurses Credentialing Center launched an accreditation program in 2015 for nurse residency programs that addressed issues such as nurse satisfaction, teamwork, role socialization, and leadership skills, to list a few. Trained preceptors were key to this program. (Cotter & Dienemann, 2016).

NRPs are comprehensive, planned programs providing the NGN with clinical opportunities to facilitate transition (Letourneau & Fater, 2015). The goal of the NRP is to transition the NGN into a competent professional nurse (Warren et al., 2018). NRPs are generally longer in duration than a preceptorship, sometimes incorporating the

preceptorship program. Letourneau and Fater (2015) reviewed studies describing 16 NRPs published between 2006–2013 and found that the programs described lasted anywhere from 3 to 15 months, with 11 of the 16 programs reviewed lasting at least 12 months. Goode et al. (2016) pointed out in their study of nurse residency programs that differences in the programs, lack of evidence-based education for preceptors, and a lack of standards of program procedures contributed to the inability to compare nurse residency programs meaningfully. Despite the difference in the programs, Warren et al. (2018) noted that NRP outcomes were similar and positive.

Transition process. Chick and Meleis (1986) defined *transition* as a passage in time, moving from one life phase to another. Transition is both a process and an outcome. As a process, a period of transition is bounded with a beginning and an end. A transition occurs in sequences or phases with periods of both stability and instability. As an outcome, how a person makes meaning during a transition period depends upon their perception of the experience. Therefore, responses to transition events will be unpredictable because each person perceives things differently. For example, a person in transition might perceive the experience as either a barrier or an opportunity for personal growth. Transition is also dependent on situation and context (Chick & Meleis, 1986).

Chick and Meleis (1986) stated that there are a beginning and an ending stage to transitions. Bridges (2004) concurred and inserted a middle stage into the transition process. Transition, when viewed as a process, is not just about helping the NGN to move from one role to another. The NGN is ending their role as a student nurse and becoming something new, a licensed practicing nurse. As Bridges (2004) stated, a transition is "…a

difficult process of letting go of an old situation, of suffering the confusion of in-betweenness, and of launching forth again in a new situation" (p. 4). Arrowsmith et al. (2015) concurred with Bridge's (2004) comment. They added that the NGN's anxiety and discomfort is part of letting go of the old roles, developing new ones, and experiencing the confusion in between. Kumaran and Carney's (2014) phenomenological study of new nurses validated the feeling of loss of familiar reference points experienced by NGNs.

Transition to practice for the newly graduated nurse. Part of the transition process for the NGN is obtaining licensure as a registered nurse (RN). According to the National Council Licensure Examination for Registered Nurses, this step validates that the NGN is safe to practice as an entry-level RN in the United States (Letourneau & Fater, 2015). However, employers feel that NGNs often lack the competence and confidence required to practice safely. As a result, the NCSBN, Joint Commission, and Commission on Collegiate Nursing Education have recommended Nurse Residency Programs (NRP) to support the NGN transition from student nurse to practicing nurse (Letourneau & Fater, 2015).

TTP is a multidimensional concept (Ziebert et al., 2016) teeming with a variety of challenges for the NGN such as role socialization (Missen et al., 2014), quality orientation to the clinical area, an effective preceptor experience (Key & Wright, 2017), expansion of competencies (Murphy & Janisse, 2017), skill-building (Letourneau & Fater, 2015; Missen et al., 2014), adequate educational support, adequate clinical support (Missen et al., 2014), the struggle to build a new professional self (Arrowsmith et al., 2015), and building collegiality with experienced nurses (Lindfors & Junttila, 2014).

Overall, the NGN deals with a great deal of discomfort during the transition process, usually exhibited as anxiety and stress (Arrowsmith et al., 2015).

Of the many NGN transition challenges identified by researchers, two were consistently noted in the literature, confidence, and bullying. Increasing confidence was often mentioned as a primary concern of the NGN (Kavanagh & Szweda, 2017; Key & Wright, 2017; Letourneau & Fater, 2015; Lindfors & Junttila, 2014; Missen et al., 2014; Murphy & Janisse, 2017; Nielsen et al., 2017; Pasila et al., 2017; Phillips et al., 2017; Ward & McComb, 2018) followed by issues related to bullying (Lindfors & Junttila, 2014; Missen et al., 2014; Pasila et al., 2017; Phillips et al., 2017). TTP research suggested that resolution of the NGNs' concerns might result from a TTP program that used a preceptorship model of clinical orientation (Key & Wright, 2017; Pasila et al., 2017).

If a grand theory delineated the nurse's developmental stages, TTP would exemplify the middle stage of transition defined by Bridges (2004). The transition process marks the end of the student nurse stage and provides the bridge to the beginning of the next stage of transition as a licensed, practicing nurse. It is the role of nurse educators and staff development professionals to assist the NGN through the transition process's confusing middle stage. The PGCOP should be the process that helps the NGN transition into the nurse they need to be to move forward in their new role.

Implications

The APM-L (Knowles et al., 2015) provided the theoretical education model for this study. Interview questions explored topics that can be addressed by the APM-L. For

example, bullying or incivility may influence the learning climate; learning contracts may increase the NGN's commitment to planning and follow-through of the learning, and competency development of the NGN may or may not result from the TTP. Findings in these areas and the other steps of the APM-L are included in the content of the program evaluation report submitted to the leadership team of the local hospital after completion of this study.

The use of learning contracts might be a recommendation in the program evaluation report to improve NGN engagement. During data analysis, it might be found that bullying or incivility is an issue perhaps in the form of micro-aggressions that the NGN frequently confronts during the preceptor-guided clinical orientation program. It may be discovered that the preceptors are not adequately trained to guide the NGN through the TTP process. These and other yet unforeseen items may impact the content of the program evaluation report.

Summary

The purpose of this qualitative program evaluation study is an exploration of the perceptions that NGN and preceptors have about the effectiveness of the PGCOP provided at the local hospital. The goal is to determine through interviews of a convenience sample of NGNs who have completed the program within the past twelve months if the TTP provides the tools and resources (Knowles et al., 2015) needed to function as safe, confident, and competent nurses. The APM-L (Knowles et al., 2015) and NWKM (Kirkpatrick & Kirkpatrick, 2016) provided the conceptual framework from

which interview questions were created. The PGCOP will be evaluated using the process oriented NWKM of program evaluation (Kirkpatrick & Kirkpatrick, 2016).

The research methodology is reviewed in Section 2 of this study. Headings include qualitative research and design, participants, data collection methodology, data analysis methodology, study limitations, and data analysis results. A methodological discussion of data collection and analysis will conclude Section 2. Section 3 contains the project portion of the study, followed by reflections and conclusions in Section 4.

Section 2: The Methodology

Introduction

The goal of program evaluation is to provide information and recommendations for decision-making purposes (Halstead, 2019; Spaulding, 2014). The PGCOP provided by the local hospital has not been evaluated since it was implemented, potentially hampering hospital leadership's ability to make informed decisions about the program. The lack of prior evaluations inspired the following research questions:

RQ1: How do NGNs transitioning from the role of student nurse to the role of graduate nurse perceive the effectiveness of the PGCOP process provided by the local hospital?

RQ2: How do experienced nurses functioning as preceptors perceive the effectiveness of the PGCOP process provided by the local hospital?

Research Design and Approach

A generic qualitative inquiry (Kahlke, 2014; Patton, 2015) in the form of a basic qualitative study (Merriam & Tisdell, 2016) was used to conduct a qualitative program evaluation study of the PGCOP provided at the local hospital. NGN and preceptor interviews and any discoverable documents served as the "units of analysis…" for this program evaluation (Merriam & Tisdell, 2016, p. 38). The conceptual framework for this study was process oriented and combined the APM-L (Knowles et al., 2015) with the program evaluation structure of the NWKM (Kirkpatrick & Kirkpatrick, 2016). The problem, purpose, and research questions were derived from the conceptual framework, which also guided the development of interview questions and document analysis. A

goal-free approach to program evaluation provided additional guidance in developing data collection strategies (Spaulding, 2014; Youker, 2013, 2019). Data were analyzed and categorized by theme. An interpretation of the data was reported to the hospital leadership team in the form of a program evaluation report.

Generic Qualitative Inquiry

The generic qualitative inquiry approach (Patton, 2015), also known as basic qualitative inquiry (Kahlke, 2014) or basic qualitative study (Merriam & Tisdell, 2016), was not conceptualized within one of the traditional research frameworks, such as grounded theory, ethnography, and phenomenology (Kahlke, 2014). The generic qualitative inquiry approach relies on qualitative methodology to ask straightforward questions, make observations in naturalistic settings, and improve programs even though this approach is not aligned with a tradition (Patton, 2015).

A debate has occurred in the literature around the use of generic qualitative inquiry approaches. The observation that these approaches do not follow established methodologies, such as phenomenology, ethnography, and grounded theory, seemed to be at the heart of these discussions. Other issues identified in the discussions surrounding generic qualitative inquiry approaches included poorly developed studies, lack of complexity, lack of linkages, a lack of critical literature, the incongruence of design, and method slurring (Kahlke, 2014). Caelli, Ray, and Mill (2003) stated that the lack of guidelines for evaluation of generic qualitative inquiry is the real issue and recommended that researchers discuss their theoretical position, alignment between methods and methodology, rigor, and the lens used to analyze data in the study in the written report.

To avoid the pitfalls listed by Kahlke (2014) and meet the requirements suggested by Caelli et al. (2003), I decided to follow Merriam and Tisdell's (2016) basic qualitative study model. Merriam and Tisdell (2016) have built their research design around interpretive and constructivist philosophies. Their design works well in applied practice fields, such as nursing, human resources, and education (Merriam & Tisdell, 2016).

Justification of the Research Design

The purpose of this program evaluation was to discover the perceptions NGNs and preceptors have constructed about the effectiveness of the PGCOP. Data for a study such as this could be obtained quantitatively through surveys. However, numbers would not provide the detailed descriptions needed to understand unique experiences and variations in perspectives (Lodico, Spaulding, & Voegtle, 2010). Qualitative research meets the need for the rich, descriptive data required for this study.

The world is social, and reality is constructed as individuals interact and interpret the meaning of interactions. Qualitative research is an inductive inquiry method initially used in disciplines such as sociology and later adapted for educational research. Researchers use qualitative methodology to focus on social phenomena and explore the multiple perspectives that arise from interactions in a social setting (Lodico et al., 2010). One of the guiding philosophies behind qualitative research is constructivism, which emphasizes experience and meaning making (Merriam & Tisdell, 2016).

Constructivism is the philosophy that underlies all models of qualitative research, such as case study, phenomenology, grounded research, ethnography, and narrative analysis. Each model adds a specific focus; for example, case studies explore bounded

cases such as a program or individual. Phenomenology, an approach from philosophy, is used to understand the essence of human experience. Ethnography, from anthropology, is used as researchers strive to understand a group's culture. Narrative inquiry explores the story of a person's lived experience. From sociology, grounded theory researchers use qualitative data collection methods and analysis to create a theory grounded in the data (Merriam & Tisdell, 2016).

Kahlke (2014) pointed out that the established traditions do not always address the research question, the researcher's disciplinary lens, or the researcher's epistemological stance. Generic qualitative inquiry approaches provide more flexibility and allow the researcher to use the tools from traditional methodologies to design studies that address the research questions. This study was conducted within nursing's practice environment through a pragmatic, constructivist adult learning lens using generic qualitative inquiry—specifically, Merriam and Tisdell's (2016) basic qualitative study design. The basic qualitative study approach addressed this study's intent by allowing the flexibility to conduct a disciplinary-focused program evaluation that should provide the local hospital leadership with concrete answers to real questions for decision making.

Program Evaluation Approach

Several approaches can be taken when performing a program evaluation. The evaluator may choose either an objective-based approach, a consumer-based approach, a decision-based approach, an expertise-oriented approach, a participatory approach, or a goal-free approach. The objective-based approach builds data collection around the objectives set for the study. A focus on objectives can be restrictive and may divert the

evaluator’s attention away from the program's unforeseen outcomes. Sometimes unforeseen consequences can become more important than the objectives. A decision-based approach requires that the evaluator be directed by the program directors, which is not the case in this program evaluation. The local hospital does not have the resources for a participatory approach.

Furthermore, because PGCOP is an organizational training program, there are no consumers who would have a choice in attending this training. There are currently no formal objectives for the evaluation devised by hospital leadership, and the study does not depend on funding. Therefore, I decided that a goal-free approach for program evaluation would be used (Lodico et al., 2010; Patton, 2016; Spaulding, 2014).

Goal-Free Approach to Program Evaluation

The goal-free approach to program evaluation is a lesser-known evaluation approach that began to be promoted in the 1960s by researchers such as Cronbach, Scriven, and Stake (Youker, 2013). These researchers claimed that goal attainment was only part of an evaluation. They believed that the evaluator also had a responsibility to explore unintended program outcomes (Youker, 2013). The goal-free evaluator focuses on the effects that a program has on the consumer rather than on the program stakeholders' goals (Youker, Ingraham, & Bayer, 2014). The goal-free evaluator, unrestrained by the program objectives, can investigate all conceivable outcomes of the program. Those program outcomes, intended or unintended, indicate what the program is doing (Youker & Ingraham, 2013) rather than what it was created to do (Jabeen, 2016).

Scriven (1974, as cited in Youker, 2013) compared goal-free evaluation (GFE) to double-blind drug testing. The researcher conducting the drug study does not know who is receiving either the drug or the placebo and must search for intended and unintended effects. Only at the end, after data are collected and analyzed, does the evaluator learn the goals of the pharmaceutical study.

GFE principles were derived inductively by Youker (2013) from the double-blind methodology used by pharmaceutical companies. The four principles of GFE are:

1. Identify relevant effects to examine without referencing goals and objectives.
2. Identify what occurred without the prompting of goals and objectives.
3. Determine if what occurred can logically be attributed to the program or intervention.
4. Determine the degree to which the effects are positive, adverse, or neutral (p. 434).

The first principle blinds the evaluator to the objectives of the program. The intentional avoidance of program goals by the evaluator allows for a broader review of the program. This strategy prevents the evaluation from being restricted within the confines of the program goals (Youker, 2013).

Youker (2013) suggested having an assistant who shields the evaluator from any discussions about or knowledge of program goals with the program staff. An assistant was not feasible in this study. As a nurse, I already know that one of the overarching goals of an orientation program is to produce a nursing employee who is competent, safe, and ethical. However, I do not know the exact objectives of the PGCOP as it was

designed, nor did I interact during data collection with those stakeholders who had oversight of the program. This limitation on data collection should provide the same result as the suggested use of an assistant.

Youker and Ingraham (2013) pointed out several ideas a researcher might consider when contemplating GFE use. Because goal-based evaluators use goals as dependent variables, such evaluations may be more quantitatively focused (Youker & Ingraham, 2013). In contrast, GFE might be more appropriate for use in qualitative evaluations. Nonetheless, GFE can be used in quantitative and qualitative evaluations (Youker & Ingraham, 2013). A GFE may be more appropriate when the goals or objectives of the program under study are not written or stated by the client. Evaluation bias can be controlled (Jabeen, 2016) because GFE removes any historical relationships between the stakeholders and consumers (Youker & Ingraham, 2013). Lastly, GFE is not an evaluation model, but rather a methodologically neutral stance taken by the evaluator (Youker & Ingraham, 2013). A GFE approach can be used with compatible evaluation models that do not focus on goals evaluation (Youker et al., 2014), such as the NWKM of program evaluation used in this study.

To determine what to study, for researchers inexperienced with GFE, Youker (2013) suggested performing a needs assessment of the consumers to direct the evaluation. Another suggested approach was for an evaluator to collect data and then compare the program's performance outcomes with comparable competitor programs. Additionally, comparisons could be made with the standards created by regulatory bodies (Youker, 2013). Youker and Ingraham (2013) added that as the evaluator begins to

understand the program's functions through data collection, other study outcomes would emerge.

The study site leadership did not provide any program goals or objectives for the study. Because the study's goal was to understand the effectiveness of the PGCOP as perceived by the NGNs and preceptors, or the program consumers, the goal-free program evaluation was used within the structure of the NWKM (Kirkpatrick & Kirkpatrick, 2016) as a methodologically neutral stance. The GFE seemed to be the best evaluation approach option because the local hospital's leadership did not provide program evaluation goals. Therefore, the evaluation was based on consumer perceptions.

Participants

The purpose of this program evaluation was to understand the PGCOP through an exploration of NGN and preceptor perceptions about the program's effectiveness. Exploring the new nurses' and preceptors' perceptions should provide information about the strengths and weaknesses of the PGCOP, potential barriers to a successful PGCOP experience, and potential best practices within the PGCOP. Exploring the PGCOP as perceived by the NGNs and preceptors should also add to current knowledge about transition programs.

I decided to evaluate the program from the program consumers' perspective, i.e., the NGNs and the preceptors. This participant choice supported the choice of a goal-free program evaluation that focused on the consumer (Youker et al., 2014; Youker, Zielinski, Hunter, & Bayer, 2016). Research questions were formulated to understand the NGNs'

and preceptors' perceptions of the PGCOP process as a successful vehicle for NGNs transitioning to a practicing nurse role.

The potential participants of this qualitative program evaluation should provide credible, data-rich information that addresses the proposed research questions (Merriam & Tisdell, 2016). Based on these criteria, the participants invited to participate in the study should include the program users (NGNs) and the program providers (preceptors). Purposive sampling (Merriam & Tisdell, 2016) was used to select the individuals invited to participate in the proposed study.

Participant Selection Criteria

A review of the hiring metrics tracked at the local hospital through October 2018 did not provide any specific NGN information, such as voluntary turnover and retention rates. The data were not clean; full-time nurses, part-time nurses, as needed nurses, employed NGNs, and experienced nurses were lumped together in the statistical analyses provided by the study site. According to the chief nursing officer, that methodology did not allow for discerning the number of full-time NGNs hired in any given period.

Historically, the number of employed NGNs has been small each orientation cycle: perhaps one to two every 2 weeks according to the PAPD, which precluded using sampling methods such as maximum variation or snowball sampling (Merriam & Tisdell, 2016). Purposive sampling was the primary means used to select participants for the study. Convenience sampling also played a role (Merriam & Tisdell, 2016). I attempted to vary the sample by selecting NGNs who graduated from different nursing programs,

attained a different degree level such as an associate degree in nursing or bachelor's degree in nursing, and NGNs hired to work on various nursing units in the local hospital.

The following criteria were used to select NGN participants. The potential NGN participant had graduated from their nursing program within the past 12 months and would have licensure as a registered nurse. The NGN will not have worked in healthcare as an NGN before employment at the local hospital. Prior experience could have already helped the NGN transition from a student nurse to a practicing nurse. Therefore, the potential participant would no longer be considered an NGN.

The preceptor candidate was required to have completed the PA training provided by the local hospital within the last 6 to 12 months and have experience precepting at least one new nursing employee post training. The preceptor participant was required to have been employed by the local hospital for at least 1 year to familiarize them with organizational culture and their assigned unit. An allowance was made for experienced nurses working at the local hospital who also served as clinical instructors for local nursing schools.

Sample Size Justification

There is no answer about how to determine sample size, although resources available to the researcher, the questions asked, and the type of analysis can provide some parameters (Merriam & Tisdell, 2016; Patton, 2015). According to Patton (2015), the sample size seems to be a matter of breadth or depth in the study. A few information-rich participants would provide depth, whereas interviewing many participants might turn up

more variation in the data or increase the study's breadth. The sample size then really depends on the questions asked and the information sought.

This sample size was set at a minimum of five NGN participants and five preceptor participants who were not currently precepting one of the selected NGNs chosen for the study. I chose not to interview NGN/preceptor pairs because I was seeking an evaluation of the PGCOP experience, not an evaluation of the preceptor by the NGN and vice versa. Also, it turned out to be a challenge to recruit the required minimum sample set out in this study.

The sample size is emergent per Patton (2015). The goal (which was achieved) was to reach redundancy in responses (Merriam & Tisdell, 2016). If redundancy had not been achieved with the participant groups' proposed size, more participants would have been recruited if time and resources had allowed.

At the time of participant selection, the available preceptor pool contained 27 nurses who had attended preceptor training at the local hospital. The local hospital did not keep NGN hiring metrics. The PAPD estimated that a maximum of one to two NGNs was hired every two-week orientation cycle.

Participant Access

The chief nursing officer of the local hospital expressed interest in this program evaluation. At the time of participant recruiting and data collection, I was an internal employee of the local hospital, familiar with the leadership team and the nursing management team. The NGNs should be familiar with me because I facilitate the 3-day

general orientation before entering the PGCOP. I was not in a position to supervise or discipline any person participating in this study.

Participant Rapport

Gaining trust or developing rapport is just a matter of being open, honest, and consistent (Rubin & Rubin, 2012). In this instance, full disclosure about the study's nature, assurance of privacy, and open dialogue was provided to help the participants feel at ease with my presence. Merriam and Tisdell (2016) suggested five addressable issues usable in establishing trust and rapport: (1) the intentions of the investigator, (2) the anonymity of the participant with pseudonyms, (3) collaboration with the participant about who has the final say about study content, (4) compensation (if any), and (5) information about the time, place, date, and number of interviews. These guidelines were followed during discussions with the participants. Compensation for participation in the study was not offered. I maintained a neutral stance regarding the study participant's knowledge and experience. That is, my personal views about the PGCOP and its components were kept in check (Merriam & Tisdell, 2016) to aid in developing rapport.

I facilitated the 3-day general orientation that occurred for all new employees of the local hospital. During those 3 days, I interacted and became familiar with the new employees, including the NGNs. In most cases, I interacted with the nurses precepting the NGNs either through general orientation or in nursing professional development activities at the local hospital. Lastly, I am a registered nurse, which gave me many commonalities with NGNs and preceptors.

Confidentiality Considerations

The initial measure for assuring confidentiality and protection from harm was obtaining the IRB approvals for the study granted by Walden University and the study site. Merriam and Tisdell (2016) suggested treating the participant as a person, not as a subject. Patton (2015) added that the purpose of the interview should be explained to the participant. The researcher should also provide information about who will get the information, what will be done with it, and any risks or benefits. These activities were completed via consent and then reiterated at the beginning of each interview. As the interviewer, I was aware of the possible reactions that the interviewee might have to the interview questions. Where I thought the question might have been benign, it might have brought up memories that were uncomfortable or distressing for the interviewee. For example, the topic of bullying might arise during the interview. Bullying may have been a past or present issue for the participant, which might have elicited an unexpected emotional response. Merriam and Tisdell (2016) recommended that if discomfort should occur due to the interview process, resources be made available to the participant. This offer would include human resources and available employee assistance programs at the local hospital.

Informed consent was obtained from the participants. Lodico et al. (2010) stated that informed consent should include information about the procedures used, such as interviews and any risks involved in the proposed study. The participants were informed that their participation was voluntary and that they may withdraw from the study at any

time without repercussions. This information was discussed verbally and provided in a release document that was signed by the participants.

Newly Graduated Nurse Selection Process and Demographics

Potential NGN participants who started employment at the facility and completed clinical orientation within the last year were identified via rosters generated during general orientation. An email introducing the study was sent to all 34 potential NGN participants using Walden University's email system. A copy of the Walden IRB approved consent form (Approval # 05-01-19-0376229 exp. 4/30/2020) was attached to the email. The NGNs were requested to reply to the email with "I consent" if they were interested in participating in the study. The recruitment emails were sent on three different dates during June 2019. In the end, seven NGNs responded and consented to participate in the first round of semistructured interviews. All seven NGNs were accepted into the study.

Five of the seven NGN participants worked in a critical care area at the time of the interviews. One NGN worked on a general medical-surgical unit; the seventh participant worked on a step-down unit (patients that progressed from either an intensive care unit or required a higher level of care than found on a general medical/surgical unit). The group was composed of 6 women and one man. Four of the participants held an associate degree in nursing, and three held a bachelor's degree in nursing. All seven completed their licensure examples immediately after completing their nursing program.

The first round of NGN interviews concluded during July 2019. All interviews were transcribed, edited, and returned to NGN interviewees for participant review by

August 2019. The participants were requested to review the transcripts for any deletions, additions, or clarifications they might want to make. The participants were asked to notify me when they completed their review of the transcript to schedule a second interview. The first round of second interview requests was sent in August 2019. Three of the seven participant NGNs responded to the request for transcription review. Neither of the three respondents requested changes to the interview transcript. Also, neither of the three respondents acknowledged the request for a second follow-up interview.

Preceptor Selection Process and Demographics

A list of 27 preceptors who had been through the PA was obtained from the PAPD. An email was sent to twenty-seven potential preceptor participants using Walden University's email system. The email briefly described the study and included the IRB approved consent form. The preceptors were asked to reply to the email with "I consent" if interested in participating in the study. Preceptor recruitment letters were sent at the same time as the NGN letters during June 2019.

Initially, six preceptors responded to the request. The six volunteers were accepted into the study. Four preceptor interviews were conducted during July and August 2019. However, two of the initial respondents failed to follow through with scheduling an interview. A fifth and final preceptor volunteered and was interviewed in August 2019. All interviews were transcribed, edited, and returned to preceptor interviewees for participant review by December 2019. The participants were asked to review the transcripts for any deletions, additions, or clarifications they might want to make. The participants were asked to notify me when they completed their review of the

transcript to schedule a second interview. Three requests were sent for a second interview. None of the preceptor participants responded.

Three women and two men comprised the preceptor participant group. Two of the participants worked on a general medical-surgical unit. One participant previously worked on a step-down telemetry unit and recently transferred to a critical care area. Two of the participants worked in the float pool. The float pool is a group of registered nurses who regularly "float" to units in the hospital that may need extra nurses. Four of the five preceptors had attended PA training provided by the facility before the study. The remaining participant had not yet attended preceptor training but was scheduled to do so. However, this participant also served as a clinical instructor for one of the local nursing schools and was accepted into the study based on that experience and several years of precepting new nurses at the study facility. Editing of the preceptor transcripts was completed in November 2019, at which time coding and data analysis commenced.

Data Collection

Data collection activities may include interviews, observation notes, focus groups, demographics, and even document analysis (Merriam & Tisdell, 2016). My perspectives and theoretical orientation influenced the data that was collected in this study. I tend to be constructivist in my thinking and believe that people create meaning from their experiences based on their perspectives shaped by their culture and life experiences. The best way to understand the meaning of those experiences for the study participants is through qualitative data collection methods centered around interviews. Documents related to the PGCOP were also collected.

Interviews

Interviewing is the primary data collection tool used in qualitative research. Individual interviews are purposeful conversations held with participants to obtain data that address the research question(s). Interviewing allows the researcher access to the individual's understanding of how the world around them works (Merriam & Tisdell, 2016).

I used the APM-L and NWKM to develop a grid from which I created the interview questions (see Appendices B-D). I used a semistructured interview design that recognized the differences in individual perceptions (Merriam & Tisdell, 2016) and aligned with the goal-free approach. The goal-free approach acknowledges that program outcomes might be missed if formal approaches, such as structured interviews, were used (Spaulding, 2014). The goal-free approach also recognizes that there are variations in program participants' perceptions (Patton, 2015).

Interview questions were tailored to the role of the individual in the PGCOP. The NGN and preceptor interview questions were designed to focus on their experiences in the PGCOP and their perceptions about the program's effectiveness. Data obtained from the preceptors are essential because their engagement in the PGCOP process should affect the NGNs' experiences and perceptions.

The local hospital's chief nursing officer requested that the NGNs' and preceptors' interviews occur as unpaid time. As I contacted each NGN and preceptor participant to set up the interview times, I asked their preference for the interview time and date. A

private room in a building separate from the study site was used to conduct the interviews unless the interviewee indicated that they would prefer to meet off-site.

In hindsight, my data collection plan was ambitious. I had planned that the NGNs invited to participate in the study would be interviewed twice. The first interview would be scheduled within 1 month after completion of the PGCOP. I intended to record and transcribe the interviews within 3 days after the completion of the interview. During the first interview, a follow-up meeting would be scheduled within one to two months. At the second meeting, the NGN would be presented with a typed copy of the interview transcript to review, make corrections, additions, or deletions. Also, I planned to have follow-up questions seeking clarifying information from the first interview.

I planned that the preceptor participants would also be interviewed twice using the same format as the NGNs. The first interview will be scheduled within 1 month after completion of the PGCOP. The interviews would be recorded and transcribed within 3 days after the completion of the interview. During the first interview, a second meeting would be scheduled in the following one to two months. At the second meeting, the NGN would be presented with a typed copy of the interview transcript to review, make corrections, additions, or deletions. Also, I planned to have follow-up questions seeking clarifying information from the first interview.

At the beginning of this section, I stated that in hindsight, my plan was ambitious. Now that the data collection phase is completed, I realize that my plan was based on my assumptions and preconceived notions that people would be jumping at the chance to talk about their experiences in clinical orientation. I thought I would be fending off volunteers

right and left. However, I discovered that recruiting volunteers for the first round was difficult, and getting them back for a second interview was nearly impossible. I also discovered that transcribing and editing the data from one interview takes much longer than 3 days.

Observation

Observation occurs daily during interactions with the environment and helps people make sense of their world. However, observation, when used as part of the research, is different. Research observation is structured, systematic, and requires the researcher to pay attention (Merriam & Tisdell, 2016).

Observation in research serves several functions, two of which, creating context and triangulation, are essential in this type of study. Context is created when the researcher observes and describes the physical setting, who is active in the setting, and what occurs. Data obtained through observation can be triangulated with data acquired from interviews and document analysis to substantiate findings as they emerge from the data (Merriam & Tisdell, 2016).

However, during IRB negotiations, it was determined that observation would not be used as a data collection methodology for this study. I decided to leave this section about observation intact because observation is a valuable tool in qualitative research, and even if I did not formally observe groups and interactions in the environment, I did observe the reactions of the people that I interviewed and used those observations to direct the formulation and execution of more probing questions.

Documents

Merriam and Tisdell (2016) suggested that documents considered useable for qualitative research include artifacts such as meeting minutes or memorandums that might record processes or personal reflections, items more substantial than checklists. However, checklists might be considered a log that summarizes activities (Lodico et al., 2010).

The local hospital uses a commercially available digital education product that allows the preceptor to document tasks completed during the orientation process in the form of a checklist per the PAPD. Analysis of the checklist items could provide insight into the range of topics included in the PGCOP. However, document analysis should occur after interviews have been completed, transcribed, and thematically analyzed when following the GFE approach. Any documentation, digital or otherwise, could contain program goals and objectives. If these objectives are known before analyzing interview data, then interview data analysis could be biased, negating the purpose of a GFE (Youker, 2013).

The information contained in any documentation could be helpful later in the study. Actual written or inferred program goals could be collected from documents and compared to the goals deduced from the interview analysis. This document analysis methodology could help determine if the program is accomplishing what it was set out to do.

The orientation pathway checklists are public records (Merriam & Tisdell, 2016) entered into the employee's file upon completing the PGCOP. The PGCOP checklist may

provide some information about the program that cannot be obtained in other ways, such as observation. For example, the checklist could provide information that hints at the preceptors' process of clinical orientation. The full array of documents used in the PGCOP has not been collected during the proposal development process. Once the interview data analysis was complete, I reviewed any documents that emerged. The orientation pathway checklist and Case File: Preceptor handbook were the only documents retrieved and analyzed. The orientation pathway did not offer any clues about the preceptors' processes in facilitating the PGCOP. Neither document provided goals for the PGCOP.

Documents generated for and during the process of the PGCOP are not the only artifacts to be considered. I kept notes of my reflections on data as it was analyzed. Hunches were noted that might guide future interviews or observations. During interviews, observations were noted about the interviewee's facial expressions and body language as questions were asked and responses made. As I noted earlier, even though observation was not formally used, it was still part of the analysis. I also noted any biases or unexpected responses that I had to any data that I saw, heard, or read (Merriam & Tisdell, 2016).

Data Analysis

Data collection and analysis is a simultaneous process, according to Merriam and Tisdell (2016). Data from interviews, observation, and documents are analyzed as they emerge. The on-going analysis of data as it is collected can help determine what additional questions should be asked during the next interview, which activities or

settings should be observed, or which documents should be obtained and analyzed (Merriam & Tisdell, 2016).

An inductive, constant comparative method of data analysis is suggested (Merriam & Tisdell, 2016) and used in the study. This methodology is usually used in qualitative theory development but does not necessarily have to create a substantive theory. Only when a theory is produced is research, then considered grounded theory (Merriam & Tisdell, 2016).

Youker (2013) developed four principles for GFE, which are:

1. Identify relevant effects to examine without referencing goals and objectives.
2. Identify what occurred without the prompting of goals and objectives.
3. Determine if what occurred can logically be attributed to the program or intervention.
4. Determine the degree to which the effects are positive, adverse, or neutral (p. 434).

Youker's (2013) principles 3 and 4 provided the most guidance during data analysis. I realized as I sifted through, and at times, got lost in the data that not everything would be attributable to the PGCOP. For example, self-direction was a category that emerged during analysis, but in most cases, the ability to self-direct was a skill that the NGNs brought with them, not a result of the PGCOP. Once the analysis was complete, I would have to determine if the PGCOP resulted in positive, negative, or neutral effects.

Recorded interviews were transcribed and coded using MAXQDA 2018 (www.maxqda.com), a multi-use software program designed for quantitative, qualitative,

and mixed methods research. I originally planned to code any observation notes, researcher's notes, and documents using MAXQDA 2018. However, as I moved further into data collection, I realized this was not a necessary step, and only the interviews required coding for the emergence of categories.

The coded interview data were compared and aggregated into categories. The process was iterative, with data regularly analyzed and assigned or reassigned to categories as patterns in the data emerged. I found during this process that the interview data in each category spanned a continuum. The activities, interactions, and environmental factors that the NGNs encountered during the PGCOP that either facilitated or hindered the transition process marked the continuum's endpoints. As shown later in the document, the continuum endpoints were determined to be themes and were titled PGCOP facilitators and PGCOP barriers. PGCOP facilitators were those activities, interactions, and environmental factors encountered during the PGCOP perceived by the NGNs and preceptors as useful in promoting NGN transition. PGCOP barriers were those activities, interactions, or environmental factors perceived by the NGNs and preceptors as either distractions or discomforts that impeded, temporarily or permanently, the NGN transition process.

Validity and Reliability

Rigor in qualitative research assures a study's validity and reliability. Rigor in qualitative research can be either methodological or interpretive (Merriam & Tisdell, 2016). Merriam and Tisdell (2016) based their methodology on a constructivist paradigm in which methodological rigor achievement occurs through internal validity, external

validity, and reliability. Of note, Merriam and Tisdell (2016) chose to use the terms reliability and validity rather than credibility, consistency, and transferability. The terms are currently under reevaluation in the literature in response to postmodernism.

Internal validity. Internal validity is concerned with how well the research findings match reality. Internal validity is achieved through triangulation, member checks, saturation, peer review, and discrepant data (Merriam & Tisdell, 2016). All five of these methods were used in the study.

Triangulation was achieved in the study using multiple data collection methods, that is, interviews and documents. These two data sources were checked against each other using comparative data analysis. A comparison should result in an increased interval validity of the study (Merriam & Tisdell, 2016).

It was stated in the interview plan that on the second interview, interviewees would be provided with a transcript of their previous interview to make corrections, deletions, or additions. This activity is a form of member checking. The member check does two things. First, misinterpretations of the interview data are identified and corrected, providing a clearer view of the participants' perceptions. Second, researcher biases may become evident by correcting misinterpretations by member checking (Merriam & Tisdell, 2016). However, the participant follow-up was not as hoped. After multiple requests, three of the seven NGNs did respond, and no changes were requested to the interview transcripts. One preceptor of the five also responded and did not request any changes to the interview transcript.

Saturation or adequate engagement in collecting data is essential in getting as close as possible to understanding the phenomenon being studied. Saturation brings the researcher closer to understanding the perspective of the participant. Once the researcher begins to hear the same data repeatedly, saturation has been reached (Merriam & Tisdell, 2016). I noted that I started hearing the same information repeated towards the end of the NGN and preceptor interviews. The last interviews brought forward no new data, and I felt that saturation had been reached.

The program evaluation was a goal-free qualitative study. GFE avoids evaluation under the strict structure imposed by objectives and goals. This strategy allows for discovering unforeseen or discrepant cases that may turn out to be more critical (Spaulding, 2014). The goal-free approach should add to internal validity by opening the possibility of collecting data that may provide alternative explanations for the phenomena being studied. Finding no alternative explanations for the studied phenomena increases confidence in the evidence (Merriam & Tisdell, 2016). No discrepant data emerged during the NGN or preceptor interviews.

Lastly, the researcher's position must be clear (Merriam & Tisdell, 2016). For example, I used a constructivist lens to evaluate the PGCOP against andragogical principles (Knowles et al., 2015) using the program evaluation structure of the NWKM (Kirkpatrick & Kirkpatrick, 2016), both of which have constructivist leanings. I attempted to understand how the participants created meaning through their experiences within the PGCOP and how those meanings affected their perception of the effectiveness of the PGCOP. The results are summative based on my interpretation of the data.

Reliability. Reliability refers to the ability of independent researchers to replicate the findings of a quantitative study. However, replication is not possible in qualitative research because the subject of study, humans, are ever-changing. The closest that qualitative studies can come to reliability is through consistency. That is, the findings are consistent with the data. Several strategies can ensure consistency. Triangulation, member checks, and the researcher's position have already been discussed. Two other strategies that promote consistency are peer review and an audit trail. Peer review was built into the dissertation/project study process of review and commentary conducted by the project study committee. I also peer-checked with my office mate, who holds a Ph.D. in Nursing. The audit trail was created as I documented in my research journal during the collection and analysis of data. The journal should document how the data were obtained, how themes and categories were created, and the results of document analysis. The journal should also record my reflections, self-identified biases, hunches, new leads, or inquiry topics. This activity should continue through data analysis. The journaling process should allow the reader to follow my process (Merriam & Tisdell, 2016).

External validity. External validity is how well the study results can be applied or generalized to another group or situation. Generalizability cannot be achieved in qualitative studies because the researcher desires to understand the case or cases in-depth, not discover the general truth about many cases (Merriam & Tisdell, 2016). Transferability is a more appropriate goal in qualitative research, which depends on the study's internal validity. The researcher cannot know if the results of a study will be transferable to another situation. Therefore, it is incumbent upon the researcher to provide

enough descriptive information that other scholars can determine if the study results are transferable to their situation. Rich, thick descriptions of the data enhance transferability (Merriam & Tisdell, 2016).

This qualitative study includes a program evaluation. The data findings were analyzed for applicability to the PGCOP and hopefully will be transferable to similar program evaluation studies. Attention given by me to the strategies that address integral validity, reliability, and external validity should enhance the rigor of this qualitative study (Merriam & Tisdell, 2016).

Limitations

It was not possible to initially identify all the potential limitations of the study. I speculated while developing the proposal that three potential limitations might be considered. Those limitations were qualitative research in general, using a generic qualitative approach, and researcher bias. After the completion of data analysis, internal validity emerged as a limitation.

I originally stated that qualitative research could be self-limiting if proper design protocols are not followed when planning and conducting the study. This limitation can be averted by collecting multiple data sources compared via triangulation (Lodico et al., 2010). These statements made during the proposal phase were prophetic. As it turns out, I discovered during data analysis that because of my lack of experience as a qualitative researcher, the research questions were not defined as well as they might have been. I did create interview questions that produced a great deal of valuable and useful data but perhaps did not address the research questions as pointedly as they could have.

This study follows a basic qualitative research design (Merriam & Tisdell, 2016). A generic qualitative design is an approach that is less defined, which opens it up to criticism. Kahlke (2014) found three main criticisms of the generic design which are: lack of an established methodology which could result in atheoretical research; the literature lacks guidance for researchers using a generic design; and generic design researchers pick and choose elements from established designs which can result in study flaws. I followed Merriam & Tisdell's (2016) methodology for a basic qualitative design to develop this study design to address the generic qualitative design criticisms.

Researcher bias can negatively affect several elements of the study. As mentioned earlier, credibility can be affected by bias. To avoid this, I attempted to provide rich descriptions of the study's context and fieldwork descriptions. I also monitored myself for bias as I collected and analyzed the data, noting any biases in either a journal or in the data collection notes. I interpreted the collected data correctly and attempted to use multiple data types to enhance interpretation through triangulation. Because this study uses a constructivist-based methodology, the desire was to collect a sample that provided multiple perspectives. Those different perspectives must be represented correctly. Bias can prevent correct interpretation and requires a member check (Lodico et al., 2010). In this study, the conclusions that I made will undergo review by the research committee.

After data collection was complete, I determined that that process presented some limitations. The data collection goal was to collect data, create transcripts, and present those transcripts to the interviewees for participant review. Also, I had expected a second

follow up interview to discuss and clarify. That did not happen, which I believe limited the internal validity of the study.

Data Analysis Results

A program evaluation was requested by hospital leadership when it was recognized that the PGCOP had not been evaluated in the remembered past. The hospital leadership team provided no goals or objectives to guide the program evaluation. I decided then to conduct a GFE (Youker, 2013; Youker et al., 2016) of the PGCOP through the lens of Knowles' APM-L (Knowles, Holton III, & Swanson, 2015) using the NWKM (Kirkpatrick & Kirkpatrick, 2016) to provide a program evaluation structure for the study. The decision to use a goal free evaluation guided the development of two consumer-focused research questions:

RQ1: How do nurses transitioning from the role of student nurse to the role of new graduate nurse perceive the effectiveness of the preceptor-guided clinical orientation program at the local hospital?

RQ2: How do experienced nurses functioning as preceptors perceive the effectiveness of the preceptor-guided clinical orientation program at the local hospital?

I performed two data analyses, each with a different focus. First, the NGN and preceptor data were analyzed, coded, and thematically assigned to categories following a goal-free approach. This analysis describes how the NGNs and preceptors perceived the PGCOP. The second analysis evaluated the program looking at the data through the lens of the conceptual framework.

Data Analysis of Research Question 1

The recordings (See Appendix E) of the NGN interviews were transcribed, edited for corrections, and loaded into MAXQDA2018 for coding. At this juncture, I should note that I had to go back and check my bias during the initial coding process. I initially coded the data units into one of the descriptors that composed the four NWKM levels (Kirkpatrick & Kirkpatrick, 2016) or the seven criteria of the APM-L (Knowles et al., 2015). I realized that this coding scheme defeated the purpose of the goal free approach (Youker, 2013) proposed for use in this study. I compiled and saved the results into a codebook for other uses and then re-coded the data units using open in vivo and descriptive coding. This coding process resulted in eighty-eight initial categories comprised of 366 data units. The eighty-eight categories were further compared and condensed (See Appendix F), which resulted in the emergence of three main categories; Program Effects (PE), Preceptor Effects (PrE), and Transfer of Learning (TL). These three categories are described in the following sections. Each of the broader categories concludes with a summary exploring the data through the conceptual framework lens.

Program effects. The PE category combined the data that, in my opinion, represented direct and indirect outcomes of the program and included three main subcategories: NGN satisfaction with the program, NGN use of resources, and NGN confidence building. A discussion of each follows.

***New graduate nurse satisfaction with the program*.** The NGNs were queried about their overall satisfaction with the PGCOP. I noted that the responses of the NGNs who were oriented in general medical-surgical areas differed in tone from those NGNs

who were oriented in critical care areas. The NGNs orienting in the medical-surgical areas were neither completely satisfied with their PGCOP experience nor completely satisfied with their preceptor experience.

> Interviewer: Okay. So, do you think that the orientation program, clinical orientation with your preceptor, was effective overall, for you?
>
> NGN7: I would like to have seen it be a little bit more different.
>
> Interviewer: In what way?
>
> NGN7: Well, I mean, as I said, having a preceptor that was very laissez-faire was, you know, devilish sort of, if it was nice to know that I had a little bit of safety net to fall back with, almost like I did in clinical practice as a student, but at the same time, I kind of wish that the acuity level of our patients was a little bit higher, and I wish that I had a little bit more side-by-side action with patient care, during those higher acuity sessions.

When I probed a little further, NGN7 had this to say:

> NGN7: I think the only time that they (referring to the preceptor) were like what? What? What? Was when I came to them with questions. I didn't know if I felt like I was being intrusive to what they were doing versus intrusive to what I needed to still accomplish.
>
> Me: So, what were they doing that was not what you were doing?
>
> NGN7: Well, they weren't with me.
>
> Me: Oh, they weren't with you. So, where was your preceptor parked when you were doing all of this patient care?

NGN7: Ahh, at the desk.

NGN3's response to the PGCOP experience, in general, was somewhat similar:

NGN3: I mean, I think it could have gone a little bit better, you know, like I said just because I've, I kind of felt like I meshed better with the first preceptor they had assigned me. But I mean overall, it's just an overwhelming experience.

NGN3's preceptor experience was exhausting at times:

NGN3: Well, there were times that...I just I don't know if he was intentionally trying to let me struggle and figure it out on my own or what, but it exhausted me, that's all I can say, because there were times that I felt like I had questions, and he was elsewhere or involved in a conversation, and I'm like sitting there for that computer going, I don't know how to answer this. I don't know what it's asking of me.

The five remaining NGNs oriented in critical care areas and expressed satisfaction with the PGCOP and their preceptors. Examples of NGN responses regarding satisfaction with the program included:

NGN5: Yes, definitely (was satisfied)

NGN2: I was very satisfied with it

NGN1: I would say very satisfied.

These NGNs had this to say about their preceptor experience:

NGN5: My preceptor really built my confidence. It was a lot of positive feedback. So, so when I got out of orientation, I kind of missed that positive feedback.

NGN6: Yeah, and then after that, I had preceptor 2, she goes by 2a. She's always fun to work with. I love working with her.

NGN2: Yes, So, I mean, I did get to see a ton of critical patients during orientation. I learned a ton. My orientation was really good. My preceptor was what made it really good.

NGNs 1,2,4,5, and 6, who oriented in critical areas, expressed satisfaction with the PGCOP and their relationships with their preceptors. NGNs 3 and 7, who oriented in more general medical-surgical areas, were not fully satisfied with their PGCOP experience or their relationships with their preceptors. Upon reflecting on these differences, I recognized disparities in the NGN's experiences that might explain the differences that these two groups of NGNs described.

NGNs 1,2,4,5, and 6 received orientation in critical care areas of the study site. In the critical care areas, the nurses' patient loads are smaller, usually one-two patients per nurse, and rarely as many as three. Also, critical care areas are much smaller units. This smaller physical area allows the NGNs to work closely and remain in sight of their preceptors. NGNs 3 and 7 received orientation in non-acute areas of the hospital. The patient load on the non-acute units average five patients, with a range of four-six patients. Also, the medical-surgical units are physically more spread out, sometimes covering three separate halls. Because the facility's practice is to assign medical-surgical patients based on the acuity level, the preceptor could have patients scattered throughout the unit, thus increasing the line of sight between preceptor and preceptee and decreasing the amount of time they could work together. The data also indicated that patient load is the

same for nurses with and without preceptees. It seems reasonable to hypothesize that the preceptors in critical care areas could give more attention to the needs of their preceptees than those preceptors working in the non-acute areas, which could result in higher satisfaction among the NGNs orienting in critical care areas.

NGN use of resources. The NGNs were asked if there was a time during clinical orientation when they recognized a gap in their experience or knowledge and what steps they took to get the information needed to address those gaps. Four subcategories emerged from their responses that included: addressing gaps in knowledge, I feel like a bother, inconsistencies, and self-directed behaviors.

Addressing gaps in knowledge. The subcategory, addressing gaps in knowledge, emerged when the NGNs were asked what resources they used to find answers to the gaps in their knowledge that they identified during the PGCOP. The NGNs reported using a wide range of information resources that included, but were not limited to, facility policies and procedures, nursing school textbooks, staff compiled information sources collected into binders, and human resources (preceptors, charge nurses).

> NGN7: I've used an outside resource for certain disease processes a few times. So, and I really love having that access to such a breadth of knowledge.
>
> NGN5: You go to My Resources…, observe what people do, read things as to how the things in the hospital are done.

My Resources is an area of the study site's intranet site that provides informational resources for nurses and other health professionals. The NGNs are introduced to this site in general orientation.

NGN6: Umm, basically, it was going home and like looking stuff up…and, I still have my textbook, my med-surg textbook. So…

NGN2: I make notes, like especially the first couple weeks of my orientation. If I saw something I'd never seen before, or if a doctor wrote an order for something or my preceptor was doing something that I didn't really understand, I would write it down and then try to make time at home to look it up and figure out why that happened, if I didn't have time to ask my preceptor right then.

All seven NGNs stated that when they were unclear about something or had questions, they would approach their preceptor or someone with whom they felt comfortable. However, barriers to acquiring information were reported as well.

NGN1: It just depends. I mean, I've been meaning to you know, like go home and I'm like, okay, need to study the cases, like the patients that I do get. But right now, I'm still at a point where I'd like, go home and have to decompress, and I can't think about work.

NGN1 was too overwhelmed and exhausted to think about looking at resources.

NGN3: There are many things, I mean there are still some, I mean there is still a lot that I don't know… I ask questions. I mean, you watch, and eventually, you learn that kind of stuff…

It was interesting to note that some of the NGNs experienced frustrations due to gaps in their knowledge not identified by their preceptors. For example, two NGNs had difficulty priming intravenous (IV) lines. Priming an IV line involves preparing the line for use by first removing the air from the line by running the medication or fluid through

the line. It had not been explained to the NGNs that the cap at the end of the tubing had to be removed first to allow the fluid to flow through the line. Both NGNs felt that the person explaining the procedure assumed they had gained experience with this procedure during their nursing school experience.

> NGN3: I don't even know if anyone really told me about taking the cap off, you know before you prime your lines…I think so, I mean, yeah and knowing more about you know, the I.V.s, how to hang, how to hang fluids, you know what I mean and how to connect and you know all of that 'cause I didn't really get a lot of experience like that in school. And so, for me, it was very overwhelming.
>
> NGN2: Not really, my Capstone, like the last semester, probably prepared me the most for anything, but before that, you know, I didn't know how to like even prime tubing, like the little stuff.

The experiences shared by NGN2 and NGN3 pointed out that as nurses become more experienced, the "little stuff" becomes tacit knowledge, which is challenging to teach. Scholars define *tacit knowledge* as practical knowledge gained through experience that is applied subconsciously and challenging to verbalize (Perez-Fuillerat, Solano-Ruiz & Amezcua, 2019). In nursing, the application of tacit knowledge would be exemplified by Benner's description of the expert nurse (Benner, 2001). The expert nurse does not rely on rules or algorithms to direct practice. A vast pool of experience allows the expert nurse to focus on each patient care situation intuitively. However, the expert nurse is probably not the best choice for a preceptor because they have difficulty articulating their knowledge (Benner, 2001).

I feel like a bother. The NGNs remarked that they felt that human resources were not always accessible in every situation. NGNs 1 and 5 developed the belief that the experienced staff would become annoyed with their continuous questioning. NGN3 expressed embarrassment about asking some questions.

> NGN3: …when I first started, it was like, you know, you're kind of like embarrassed to go hey, I really haven't used this. I don't, you know what I mean? Cuz it seems like something that I should already know before getting here…

The following responses from NGN1 perhaps provided a potential cause for the NGNs' perceptions that the experienced staff would feel annoyed with constant questioning.

> NGN1: So, I was like, I don't know if these people are going to like, accept me or like, think I'm stupid if I ask questions.
>
> NGN1: Like, are they going to think I am annoying, cuz, I'm always asking questions?
>
> NGN1: Yeah, at school, my friends, like, we all, like there was nobody that was stupid, we were all, like you know, we were all the same.
>
> NGN1: Yeah, it took me a while, it was like, I'm literally the least, I don't want to say least educated, but least experienced, so like, it took me a while to like get that in my head. Like I don't have to know everything, like nobody does, but these people have been, some of these people have been doing it for 20 years.

Inconsistencies. Several of the NGNs described inconsistencies with the preceptors. NGN7 reported that their preceptor was very "laissez-faire" in their approach

to orientation. NGN7 was expecting to be a little more “joined at the hip” with their preceptor. However, instead, NGN7 perceived that the preceptor spent most of the time sitting at the nurse’s station, leaving NGN7 with unanswered questions or without proper supervision at the bedside.

A few NGNs experienced turnovers in their preceptors, which created inconsistency issues.

> NGN3: I had started with one preceptor, which I thought really fit. He was very calm and calm, mild-mannered, and attentive, I guess is what I would say, and then they changed me (changed the preceptor). I don’t, I don’t know why they put me with someone else. I never really got around to asking, because I was just overwhelmed with everything. That really threw me for a loop because I had started learning Meditech with, you know, the first preceptor, and then the second preceptor. It was a little bit different how he went into stuff, and it was just like that just kind of set me back, you know, and I’m, and then getting to know the other one’s…, the second preceptor’s personality and trying to kind of mesh a little bit with that. You know, that was very trying for me.

NGN6 had five preceptors over the course of their PGCOP experience and stated,

> NGN6: Yeah, it was. I didn’t really have like a big issue with that (having five different preceptors). It was more like the charting and stuff because Preceptor 3; she has a lot of background. She was at the ICU at a sister facility. So, she has a more extensive background than Preceptor 1 did. So, there were some things that

> he (preceptor 1) was actually doing incorrectly that I didn't realize, so it was nice that she helped like, show me.

As noted in the above quote, NGN6 realized that one of the preceptors was "…doing things incorrectly." NGN1 pointed out that "…everyone has a little bit of a different answer." NGN 4 was asked to fill in the blank: it would have been helpful if my preceptor knew more about,

> NGN4: Specific Hospital policy. She wasn't at; she's an agency nurse. So, while she is really knowledgeable, we always had like, for some things, we had to refer to like the charge nurse or go and look in the policy.

They eat their young. I had initially placed this data in a subcategory under transition issues. As I reviewed and summarized this section, I realized that this data fit better within the NGN use of resources category. Experienced nurses are sometimes of the opinion that NGNs should not start their careers in critical care areas but should first spend some time in general medical-surgical areas sharpening skills and time management. Several NGNs experienced these less than supportive interactions, which may have also contributed to feelings of overwhelm and perhaps questioning their choices' wisdom.

> NGN5: Uh-huh, yes, yes… Well, a couple of times, yes, it was more direct. Sometimes it was more indirect when somebody would be talking to somebody else, and I'm right there.

NGN6: Oh yeah, I heard that it was, um, I don't think I ever heard it on day shift. It was all night shift; back when I was a PCA, I was PRN. So sometimes I would flip from days to nights, and it was a good majority of the night shift nurses there. At first, I was like kind of upset about it, and made me like rethink what I was, like my plan or whatever, and I heard it a lot through school, like in clinical. The nurses would be like, so what do you want to do afterwards, and I would tell him, and they're like, oh no, you need to go to med-surg first, and I heard it so much that it got to the point where I was like, okay,

NGN2: A lot of people say you should start out in med-surg. So, I was already nervous about just starting in (an acute care area).

NGN1: Yeah, because there were a couple of people, mainly like older nurses who, you know what they say, they eat their young like nobody should ever come straight to (an acute care area) or like, you know, that's so dangerous and...

NGN1 went on to say,

I feel like I'm never going to ask them a question. I'm like well, like, I can't trust you because you don't like what I'm like what you don't like, not that they don't like me, but they, just you know… I'm not going to go to them for anything, cuz they're going to just think I'm stupid or you know.

This interaction undermined NGN1's trust and closed off a potentially valuable source of information.

Self-directed behaviors. This subcategory surfaced during data analysis when I realized that several, but not all, the NGNs took the initiative to either seek out new

resources or tap into previous resources to find answers to questions. For example, NGN4 exhibited what I would consider self-directed learning behaviors.

> NGN4: Umm, it depends on what I had a question about if it was like something that we do here. I would look at like the policies that we have, or like if it was on drips and stuff, like the max titration stuff like that, I would look on like the policy that we like fill out and scan to the pharmacy, or like the little badge buddy. If it was like a knowledge-based question, I would talk to my preceptor first of all, and because I've been off orientation if I have a question about something, like I just go to the charge nurse, or pretty much anybody I work with. They are all really knowledgeable.

As a matter of clarification, drips and max titration refer to various IV medications given, for example, to improve cardiac function. The policy guiding this is a protocol developed by the physicians to guide the IV medications' adjustment for good effect. The badge buddy is a small placard given to the nurses to hang behind their name badges with information about managing the various IV drips.

Whereas other NGNs seemed to be waiting for someone to supply them with the information they needed, they did not take the initiative to explore the resources they were given.

> NGN3: I don't know if I really...if I really had any, I can just say, like, once I got on the floor and was orienting, it was, I found it all a bit confusing. I had a really hard time with...with (pause) Meditech (laughs) for one, learning that system (Meditech is the Electronic Medical Record used at the facility). I think it would

> help me to have like a printout ahead of time and if I would have been able to (pause) really make notes on, what kind of information is being asked of me and how to best answer that information, you know based on my assessment of the patient.

NGN3, and the other NGNS, attended a class which provided hands-on practice with the Meditech system before starting clinical orientation. The NGNs were also provided with a manual during the Meditech training. Later in the interview, NGN3 stated this about clinical orientation,

> Yeah, but it was kind of confusing because I was like several weeks in before they're asking for the binder. I didn't really know what to do with it. You know what I mean? And, and, I think that was you know, some of what kind of got off track, because I really didn't know, because honestly, I hadn't looked at the binder like I should have you know.

The binders that NGN3 referenced are given to the nurses on the first day of general orientation. The binders contain information needed by the newly employed nurse, such as computer logon information; general policies and procedures about attendance, dress code, etc.; and general information about clinical orientation. NGN3 appeared to be lost as a result of not looking at the information that was provided.

After some reflection, I decided that self-directed behaviors were not an outcome of the PGCOP. Several of the NGNs arrived from their educational institutions already possessing this skill. However, self-direction is a skill that can be built upon and used in the PGCOP.

The data within the category of using resources pointed out that both written and human resources are provided to the NGNs, as noted in the section "addressing gaps in knowledge." Because many of the NGNs appeared to be self-directed, they could utilize the resources they either brought with them or supplied by the study site. The ability to independently use resources was not a skill possessed by all NGNs; however, this skill may need to be assessed and developed at the beginning of the PGCOP.

The data indicated that policy and procedure were not followed consistently or always known by the preceptors, as suggested by NGN4 and NGN6. This lack of consistency has implications for preceptor training, explored in Section 3 of this study.

NGN confidence building. This category included perceptions about competence and appeared to be an outcome of the PGCOP that depended upon the NGN's relationship with their preceptor. For example,

> NGN7: I think my preceptor was kind of laissez-faire with me, until I was like, I got some problems, or I've got some questions. How do you deal with the situation? What is our facility's kind of nuts and bolts on it? So, I thought that was kind of interesting. I was expecting more of a, you're following me, we're now really tied at the hip. And it wasn't really that way, and I was like, okay.

NGN7 explained that the preceptor spent time sitting at the nurse's station, being an available resource if needed. Interestingly, NG7 felt this approach increased their confidence.

> NGN7: It did, and I think it's a double-edged sword. I think a lot of that confidence came from the aspect that my preceptor kind of gave me the laissez-

> faire kind of management style for precepting me and gave me the opportunity to say I'm here if you need me, I'll be right here, knowing that they are like working on everything else that was going on around us, and then being available, like for me to ask questions. And that really gave me a little bit more confidence in being able to traverse through aspects of nursing.

Even though NGN7 perceived being more confident due to this "laissez-faire" clinical orientation, I question if NGN7 was performing nursing tasks according to the policy and procedures of the study site if no one was present to observe.

At the other end of the spectrum, NGN1 believed that confidence increased because of a close relationship with the preceptor.

> NGN1: …like no way I want to be able to do this like without my buddy (preceptor)…

NGN5 stated, "My preceptor really built my confidence."

Several NGNs provided meaningful stories about experiences that they perceived to be instrumental in increasing their confidence at the bedside. NGN4 gained enough experience about stroke patients' care to make suggestions about tweaking the stroke scale form used to assess the comatose, intubated (on a ventilator) patient.

> NGN4: I actually did, like we still do the regular, or at least on Meditech, the NIH stroke scale for like an intubated, comatose patient, and like obviously their NIH (score) is going to be super high. So, I made a suggestion to our manager about tweaking it. I looked online to find like some (stroke scales) that were for intubated/sedated patients. She (manager) was saying we already had something

like that, but she wanted to show what I found to a nurse and a physician and stuff. So, I feel like, even though I was new, I still was able to contribute.

NGN6 was previously afraid that doctors might "…yell at me" and expressed an increase in confidence and comfort when talking with physicians due to their PGCOP experience. NGN4 stated that their critical-thinking skills improved due to the patient care experiences that occurred during PGCOP.

NGN4 provided the most poignant story. This experience provided a boost to NGN4's confidence and helped NGN4 find meaning in being a nurse.

NGN4: I don't know, like one of the first few weeks, I had a patient who ended up passing away. But his wife was very comfortable talking to me, and she, I wasn't even here as a Nurse Tech or whatever the day, I was here for orientation, and I went in there, and they were withdrawing care on him, and she wanted me to come in there and be with her, and it just made me feel really special. I mean, even though she was going through that terrible time. I was able to make it a little bit easier on her, and she told me that, and she told her sister, and her sister came up to me outside when I was leaving and was like, thank you so much for everything you're doing for my sister and stuff.

NGN7 presented a contrasting story in which confidence may have been eroded.

NGN7: Well, I mean as I said, having a preceptor that was very laissez-faire was, you know, devilish sort of if it was nice to know that I had a little bit of safety net to fall back with, almost like I did in clinical practice as a student…So, when it

doesn't go as planned, you just really do feel your safety net just kind of crumbling below you…

Summary of program effects data. Upon review, data in the program effect category seemed to address Steps I and II of the APM-L (Knowles et al., 2015). Step I of the APM-L focuses on preparing the learner to be self-directed. Step II of the APM-L addresses the learning environment.

Step I: Learner Preparation of the APM-L addressed the ability of the learner to be self-directed. Knowles et al. (2015) believed that the learner left their educational institutions dependent upon their teachers. Consequently, Knowles et al. (2016) believed that some type of preparation in self-directed learning was required before entering the workforce. Several of the NGNs demonstrated that this belief of Knowles was not necessarily so for every student. When asked how they addressed self-identified gaps in their learning, the NGNs responded that they used notes and texts from schools, looked at facility policy and procedure, searched available digital resources, and asked their preceptors or other available staff. However, one NGN did admit to not always looking at the available resources. Furthermore, one NGN explained that they were too exhausted to search for answers and just wanted to go home and decompress.

Most of the remaining data in the preceptor effects category came together in Step II: Climate Preparation. The climate in this study was not just about the physical environment in which learning occurred. Moreover, the data did suggest that the physical environment may have played a part in PGCOP satisfaction for the NGN, as exemplified by the differences in satisfaction between the NGNs orientating in critical care areas

compared to NGNs orientating in medical-surgical areas. Climate also refers to the study site's learning structure, or in the program effects category, the resources that existed and were made available to the learner (Knowles, 1980).

I mentioned previously that most of the NGNs used material resources that they brought with them. Some of the NGNs mentioned using the resources provided at the study site. The remainder of the Step II discussion addresses the one human resource that should have been the most available to the NGN, the preceptor.

The data suggested that the NGNs were mixed in their thoughts about the preceptors. At one end of the satisfaction continuum, three NGNs stated that they were satisfied with their preceptors. NGN4 expressed that the preceptor was knowledgeable. NGN5 stated that the preceptor built their confidence. Furthermore, NGN1 seemed to have bonded with the preceptor. All seven NGNs stated that they would approach their preceptor if they had a question. However, issues did emerge during data analysis.

NGN3 experienced a change in preceptors and felt that this caused a setback in learning because the new preceptor had different ways of doing things. NGN6 had five different preceptors. The number of preceptors did not seem to be an issue for NGN6. However, in the process of multiple preceptor turnover, NGN6 discovered that one of those preceptors had provided NGN6 with incorrect information. NGN7 perceived that their preceptor spent most of their time at the Nurses' station, whereas NGN7 expected to work side-by-side with the preceptor. Lastly, NGN4's preceptor was an agency nurse unfamiliar with hospital policy and procedure. These examples suggest issues with preceptor choice, training, and expectations put forth by the study site's leadership.

Lastly, Knowles (1990) divided the climate concept into three spheres of influence: the physical environment, interpersonal climate, and organizational climate. The concept of the interpersonal climate was built around several theoretical perspectives, one being humanistic psychology. Humanistic psychology suggests creating a trusting, safe, and respectful climate (Knowles et al., 2015). One of the NGNs made the statement that the more experienced nurses "eat their young" (Anderson & Morgan, 2016). This phrase is one that I have heard several times because I entered the field in 1974. This phrase also added a question to my semistructured interview, and it turned out that NGNs 1, 2, 5, and 6 each revealed experience with workplace incivility defined as "…low intensity behavior that is rude or disrespectful with ambiguous intent to harm others." (Laschinger et al., 2016, p.86). Workplace incivility is linked with high burn-out levels and turn over (Laschinger et al., 2016). Incivility could also be considered a discomfort using Kirkpatrick and Kirkpatrick's (2016) definition that could decrease engagement and learning.

Preceptor effects. Five subcategories emerged from the data. These subcategories coalesced into the category preceptor effects. Those subcategories included: bonding with the preceptor, suggestions for changes in the PGCOP, goals, feedback, and preceptor guidance.

Bonding with the preceptor. The relationships that the NGNs developed with their preceptors varied. I previously noted that NGN3 and NGN7 were not completely satisfied with their preceptors. On the other hand, based on the descriptions provided, it

might be inferred that NGN5 and NGN2 were very satisfied with their preceptor experience and considered their preceptors to be role models.

> NGN5: And just seeing somebody who has gained so much experience and has done so well kind of helps to know that you can achieve this, that a person can really be like a father figure or mother figure.
>
> NGN2: No, he let me figure it out, and the first couple weeks, I didn't know hardly anything I feel like, so he was always in the room with me. He would let me do things I knew how to do, but if not, he would just let me watch him, but he would always give me the opportunity.

In the end, six of the seven NGNs interviewed stated that they were satisfied overall with the orientation they received from their preceptors in the PGCOP. However, some of the NGNs expressed trepidation at losing the preceptor relationship.

> NGN2: Yes, but then, my first week on my own was just last week and, he was there on my first day. So, it was nice to have him kind of, someone I felt comfortable asking, but, I mean, I feel like anywhere my first on my own, I would be nervous. I feel like if my orientation was a year-long, I'd still be nervous.
>
> NGN1: But definitely when I first came out of my orientation, that was like, there's no I want to be able to do this like without like my buddy, but then I learned, you know, everyone's there to help, and no one is going to like, shoo you away.

Suggestions for changes in the PGCOP. I noted that the NGNs still harbored some concerns even though they expressed satisfaction with the orientation they received

from their preceptors. The fill in the blank statement; it would have been helpful for me if my preceptor knew more about_____, was designed to capture this information. Three of the NGNs provided interesting responses.

Interviewer: Okay. So, here's a fill-in-the-blank for you. It would have been more helpful for me if my preceptor knew more about…

NGN5: You mean professionally?

Interviewer: Just anything. It would have been more helpful for you if your preceptor knew more about what?

NGN5: About my personality.

Interviewer: It would have been helpful for me if my preceptor knew more about what?

NGN3: I guess, I guess my learning style.

Interviewer: So, if you had to answer this fill in the blank. It would have been more helpful for me if my preceptor knew more about what?

NGN4: Specific Hospital policy.

Goals. Goals and goal setting were learning activities covered in the PA and a strategy that the PAPD expects the preceptors to use in planning learning experiences for the NGN. Three of the seven NGNs indicated that goal setting occurred as part of the PGCOP. However, it was not a daily activity, but perhaps weekly or packaged as a form of feedback.

NGN2: Preceptor A, actually, it wasn't necessarily goals for the day, but it was goals for that week, which he has been precepting forever. Like I don't, he never

> doesn't have an orientee, but he does a really good job about saying okay, this week we're going to make sure that you're comfortable calling doctors. For this week, to make sure you're comfortable doing everything with the pumps, whatever. So, if we have 12 weeks to get their orientation, he kind of has it broken down like by Week 1, I think should be comfortable doing this, Week 2, you should be comfortable doing this. And that worked really well.

NGN2 reflected that this plan worked very well and attributed this to the preceptor's vast experience teaching new nurses. Four of the NGNS stated that goal setting did not occur.

> NGN6: Preceptor 1 and I tried to do the goal thing at first, and it was just it was when I was with him those few weeks where you're trying to make goals, thing for very crazy while people are dying. So, it just kind of fell by the wayside, like you're going to do whatever we need to do today.
>
> NGN7: No (response to the question, did you and your preceptor set goals?).
>
> NGN5: Indicated no

The reason provided by the NGNs for the omission of a goal-setting activity was that the unpredictability of each day made it challenging to complete goal setting with any consistency.

Feedback. The NGNs indicated that the feedback provided by their preceptors during the PGCOP was mainly formative, constructive, and typically rewarded positive behavior.

> NGN7: My preceptor did give me (feedback); they showed me what they wrote.

NGN5: My preceptor really built my confidence. It was a lot of positive feedback. So, so when I got out of orientation, I kind of missed that positive feedback.

NGN2: Yeah, if I did something he would, I mean, he would always say like, oh, you are really good with the patient and the patient's family. He would always tell me that he would never really say, I mean, he told me if I did something wrong, but never in like a derogatory way.

However, the NGNs were unaware of summative feedback. This lack of knowledge about summative feedback may have been my fault for not describing the difference between that term and formative feedback. I deduced this because the manager's evaluation at the end of the PGCOP was a summative report created from the NGN, preceptor, and manager's input that documented the NGN's overall performance.

Preceptor guidance. Several NGNs provided examples and stories about the guidance provided by their preceptors.

NGN6: If I was really like, I really don't know, then he'll be like, okay here, I'll show you. But they always wanted me to at least try.

NGN4: Umm, but my preceptor was really good at explaining everything and with any questions that I had.

NGN2: But I mean a lot of times if I don't understand something, I was comfortable enough with my preceptor to just ask, and if we had time, he did really good at explaining.

Summary of preceptor effects. The preceptor effects category's data seemed to coalesce mainly around Step II: Climate Preparation and Step III: Model of collaborative

planning of the APM-L. Step II addresses resources as previously discussed, clearly defined goals, and open, honest feedback. Step III of the APM-L addresses collaborative planning. The learning contract figured prominently at this step (Knowles e al., 2015)

The subcategory, bonded with preceptor, was previously addressed, but one new item came to light that seems worth considering. The data demonstrated the strength of the bond that some of the NGNs, for instance, NGNs 1 and 2, developed with their preceptors. Several of the NGNS expressed discomfort at the thought of losing their relationship with their preceptors. The study site does not currently have a mentoring program per the PAPD. The data in this category provides some evidence that such a program might be helpful.

The main subcategories in this section that addressed RQ1 were goals and feedback. Providing the learner with clearly defined goals is mentioned in Step II of the APM-L and explored more deeply under Step III, specifically in terms of the learning contract. I queried the NGNs about this, and the unanimous response was that learning contracts were not used during their orientation.

Three of the NGNs stated that goal setting did occur in some form during the PGCOP. The data did not reflect that the goal setting used the SMART goal format covered in PA. Four of the NGNs stated that goal planning did not occur.

Feedback, according to Knowles et al. (2015), is motivational for the learner when used in the process of diagnosing learning needs and improving learning. The NGNs stated that the feedback they received from their preceptors was formative and constructive.

Transfer of learning. I defined the *transfer of learning* category as any evidence in the interview that demonstrated incorporation by the NGN of cultural (professional or organizational) norms. For example, NGN7 casually mentioned AIDET in response to a question about identifying gaps in knowledge.

> NGN7:…you're talking it out before you do it, and then you know, even though we do our AIDET, you know, here, and we walk into the situation with a patient, you know, we kind of say this is who I am. This is what I am going to do; this is how long it's going to take; this is what you should experience if you have any type of discomfort, let me know, it will be done in a few minutes.

This reflection was interesting because AIDET (Announce, Introduce, Duration, Explain, Time) is a specific culturally defined practice that leadership expected would be used by each staff member when initiating a conversation with a patient, patient family, or visitor.

NGN5 discussed using "pressors" as if the word was a part of everyday language. A "pressor" or vasopressor is an intravenous medication used to regulate cardiac and hemodynamic functions (blood pressure). In the interview, NGN5 discussed how the improper administration of the pressor could cause an unwanted jump in blood pressure.

> NGN5: Yes, I did get feedback. It was more like, say, if I y'd in a pressor into, I mean something into a pressor that was at a faster rate, and the blood pressure jumped. Then they are like, oh, next time maybe do it this way, that way they don't get a bolus of the pressor, those kinds of things.

Two other NGNs explained their growing expertise with wound care. It was interesting hearing them use wound care-related jargon when telling their stories about their experiences with applying knowledge at the bedside (again presented to me as teach-back moments).

> NGN7: I can do a wound dressing in a heartbeat. And most patients are like, that was quick, thanks. And then the doctors appreciated the wound care that I was giving. So, when I get LSA in there and their like, looks good, keep it up. Or you might need to pack battle bit more or a little less or whatever.
>
> NGN3: So, like, fortunately, I got to do like a lot of wound care, you know, so I watched him, and then I was able to take the patient, you know, and do everything pretty much by myself. And she, the patient, you know, liked how I did her wound care, and everything so is it was really good?

***Summary of Transfer of Learning*.** Each of the NGNs provided an example from their orientation experience that demonstrated that transfer of learning occurred. The transfer of learning is essential in the NWKM (Kirkpatrick & Kirkpatrick, 2016). This topic will be explored in more depth in Levels 2 and 3 of the model later in this section.

Data Analysis of Research Question 2

The recorded preceptor interviews (see Appendix G) were transcribed, edited, and then loaded into MAXQDA2018 for coding. I avoided the bias that I first encountered in the NGN analysis and used in vivo and descriptive coding. The initial round of coding resulted in 209 data units. The second round of coding was comparative and resulted in 102 subcategories. The third and final round of comparison coding resulted in 40

subcategories of data (See Appendix H). Four categories emerged: preceptor function, preceptor training, preceptor satisfaction, and TTP issues. I felt that these four categories might adequately address RQ2- How do experienced nurses functioning as preceptors perceive the effectiveness of the preceptor-guided clinical orientation program at the local hospital?

Preceptor function. I defined *preceptor functions* as those activities performed by the preceptor while orienting the preceptee to the clinical area. Preceptor function included 18 subcategories: teach, supplement, orientation plan, needy vs. self-reliant, support, evaluation, preceptor/preceptee interaction, socialization, enough orientation, goal-setting resources, time management, experience, feedback, critical-thinking, confidence building, assessment needs, orientation guide. Five of these 18 subcategories dominated this category: goal setting, teaching, time management, critical thinking, and feedback. A discussion of each follows. Before that discussion, I would like to mention that the preceptor candidates must attend 8 hours of preceptor training at the facility before functioning in the role. I attended PA to produce this section of the study and discuss that experience at the end of this section. Going forward, I will mention if the category under discussion was part of the preceptor's training.

Goal setting. Goal setting was an activity covered in PA. The preceptors were expected to develop measurable goals with their preceptees to facilitate feedback about performance and plan future experiences. However, goal setting was not always accomplished and sometimes seemed impossible, according to several preceptor participants.

P5: But things happen, the plan gets ruined 20 times a day, and you know. I feel like a lot of time, I can stick to my plan. But there are times where you just can't.

P3: It's hard to plan their day because of the variety of patients that you get.

P1: it's kind of hard to set goals when you have six patients, and you don't know what the day is going to bring.

Goal setting for some of the preceptors was not always a consistent activity.

P2: Well, it depends on what phase we are in. If they are in the shadowing phase, I don't do any goal stuff right there. I just want them to strictly see how I work.

And when the preceptors set goals, they appeared broad and not measurable.

P5: I feel, especially when it's time for them to like start, like you're going to care for this one patient. This is your patient; you are going to have, you know, I feel like that's a good start like. I feel like that's the only goals may be that I really make with somebody though.

P1: It depends on what we're working on now, usually speeding up is a goal…But it's kind of hard to set a goal except for speeding up, talking to the patients, making sure that they're communicating an effective way.

P4: I umm, what I did, I made kind of a list, you know, of goals like by a week. I don't remember exactly what the goals were, but by Week 3, you'll take two patients, or you know.

Teaching. Several of the preceptors mentioned teaching as an activity in which they engaged with their preceptees. The preceptors' teaching moments involved

imparting tips, techniques, skills, wisdom gained from experience, and orientation to the unit.

> P2: One of the things I try to teach them is look, you're not the only nurse up here. You're not; you don't, you don't need to reinvent the wheel. I said if there's something you never done, grab the charge, grab somebody that's more senior, you know, I try to get them comfortable in being able to ask somebody else.
>
> P4: We also took a tour of 2A, and I showed her where everything was and gave her the code to the doors and things like that.
>
> P3: …because you have to explain things and show them what you're doing and why you're doing it.
>
> P5: I use, I have like my own I like, I show them how I organize. (referring to forms used to organize the day).

Time management. Time management was a topic covered in preceptor training and mentioned 16 times while interviewing the five preceptors.

> P4: So, we just kind of set goals like that, and then charting in a timely manner.
>
> P2: …cause see a lot of the new nurses I noticed, like brand new nurses, the biggest problem with them is time management…
>
> P1: And you have to have all the aspects, you have to be able to be pretty good at the computer system as well as time management and being able to instruct people.

P2 pointed out several times that time management skills seemed to take precedence over the fostering of critical-thinking skills:

> Even with some older nurses that the nurses for ten years and they come in here and are trying to, they have the critical-thinking skills, but you see it kind of slip a little bit when they are trying to manage their time…, And that was one of that nurse's biggest issues right there, "I got to be out of here by" (a certain time).

Critical thinking. The fostering of critical-thinking skills was covered in preceptor training and a topic of conversation in the preceptor interviews. Several times in the interviews, the preceptors linked critical thinking with time management. I probed a little deeper and asked the preceptors whether they had noted a focus on time management at the expense of critical thinking. P3 summed it up nicely.

> P3: If you give me, a preceptee, someone to precept, then it's understood that it takes additional time on top of anything that could happen throughout the day and that I may need an extra 30, 60 minutes at the end of this shift to wrap this up and do this well. Because we want to do it well, we want the nurse to be safe and comfortable and stay and to critically think. So, I think that'd be a real injustice…an extra 30 minutes to walk through critically thinking with that student should not have ever been an issue on any unit.

P2 commented, "…but she was always worried about her time management, so therefore that put that critical-thinking out the window right there." PTF3 had the most to say about critical-thinking and strongly felt that it was placed to the side because the NGNs were continuously reminded by management that overtime was unnecessary. Unfortunately, the other three preceptor participants did not mention critical thinking

during the interviews. However, all five preceptors commented about time management, which indicated its salience among the group.

Feedback. Feedback was another topic covered in preceptor training about which I queried the preceptors.

> P3: I just like to address things as it goes on because, honestly, as busy it is as it is, there may not be time to actually sit and do that.
>
> P1: No, it's throughout the shift because you don't have time to really meet, and at the end of the shift, everyone wants to leave. But at lunchtime, I try to spend lunchtime a little bit talking, if we can, and then also towards the end of the day while we are sitting waiting for the next shift. We might talk about some stuff.
>
> P2: I mean sometimes like you know, it's like hey, you did this good today, you did this good today, and then I'll follow up with like we need to work on this tomorrow, and then work on it tomorrow, and it's kind of a constant feedback, and I always try to get positive feedback no matter what else that's the biggest thing right there especially with new nurses is like, you know.

P5 reported providing feedback during the day. P4 provided formative feedback during the shift and at the end of the day as a summary wrap-up.

Interestingly, only one of the five preceptors mentioned the orientation pathway used to guide the PGCOP during feedback discussions. The orientation pathway is a digital evaluation form that lists the main items covered by the preceptor with the NGN during the orientation process. This tool is also used to develop a summative evaluation of the preceptees progression and satisfactory completion of the PGCOP.

One thing that was most interesting about the preceptor interviews was the things not mentioned. Every preceptor participant mentioned that it was essential to orient the NGN to where things were housed on the unit, such as the crash cart, break room, and other items needed to perform their jobs. They also felt that it was essential to introduce them to their co-workers, manager, and others who could help if needed.

> P5: Introduce them to, you know, the chart, anybody that we come across too, especially that first day, you know, this is so and so, they're a new a new nurse here, going to work this floor with you all, and you know, show him where everything is on the unit, the big important, where's the crash cart? Where's the supply room? That kind of thing. Who's the manager on that unit.
>
> P3: Um, who the charge nurse is, and that that's also a resource person for them. Where things are located, the codes to get in, the supplies and nourishment rooms, just orient them to the signs and what they mean as far as if they're NPO (nothing by mouth) or have restrictions on their...or need thickened fluids, or somebody needs to stay with them while they're eating or drinking so they don't just hand them something. Just safety and orient them to the unit.

However, none of the preceptors mentioned showing the NGNs how to access available information resources such as PolicyStat, the digital warehouse for facility policies, or Mosbys, which contains the approved nursing procedures used at the study site.

Summary of preceptor function. This category contained the five most mentioned subcategories from the preceptor interviews related to the preceptor function.

Four of those categories were covered in PA and included goal setting, feedback, time management, and critical thinking. Teaching, or how to instruct, was not a covered topic.

Step V of the APM-L discusses the setting of objectives or goals. According to the andragogical model, learners will resist goals unless they address their needs identified during self-assessment (Knowles et al., 2015). The PAPD teaches the preceptors to create goals that are Specific, Measurable, Attainable, Realistic, and Timely (SMART). Those goals are developed by the preceptor and based on outcomes decided by the preceptor (Case File: preceptor, 11/8/16). However, there was no mention of collaboration with the preceptee during the preceptor interviews.

The PAPD covered constructive feedback, and the PA handbook contains information about how to provide constructive feedback with a couple of case scenarios for practice. The interview data provided by the preceptors indicated that the feedback they provided to the NGNs was formative and, according to the NGNs, was also constructive. Feedback is not explicitly addressed in the APM-L but closely aligned with assessing learning outcomes (Knowles et al., 2015). The NWKM does not explicitly address feedback either; however, one of the model's goals is to transfer learning to behavior. (Kirkpatrick & Kirkpatrick, 2005; Kirkpatrick & Kirkpatrick, 2016).

Time management and critical thinking were covered during preceptor training—neither the APM-L nor the NWKM addresses either topic. The interview data indicated a conflict between the unit manager’s focus on time management and the preceptors’ focus on fostering the preceptee’s critical-thinking skills. This power struggle seemed to result

in the NGN focusing on managing their time rather than taking the extra time to address critical thinking needs to the preceptor's consternation.

Teaching, as a topic, was not covered in PA, although the PAPD briefly addresses adult learning theory. It seemed that, for the preceptors, teaching involved sharing wisdom gained from experience. The preceptors imparted tips and skills to the NGN, which seemed to exemplify a mentor (Daloz, 1999) more than a preceptor or educator.

Preceptor training. This category resulted from responses to two questions asked of the preceptors. I asked them what they felt would be necessary for a nurse transitioning to a preceptor's role to learn in PA. I also asked the preceptors if they felt that the training in its present form was helpful.

The category preceptor training includes 5 subcategories: better selection criteria, who should precept, training, felt-prepared, and additional preceptor experience. When asked about the helpfulness of the training, the responses were:

> P5: I don't know. Maybe, maybe, I mean it has helpful ideas, but maybe not necessarily how to do it.
>
> P1: No, I don't think so.
>
> P2: Ah, the one thing that I did like about the preceptor academy is… you know, even though I was kind of like at first, oh my here we go, we got this kind of stuff again, you know, it was like, you know, I've taught a lot of students.... But when I went through. It was a good refresher. First of all, the personality types of the what the one type that they use would like

the blue, the red, the green…Man, that right there is a really good tool I put in my basket.

P4: Um, I think it did. I think that maybe, I mean, I know nobody likes going to classes…

The participants were mixed in their responses. Some stated that the training was not helpful; others were not quite sure. However, no one stated emphatically that the training in its present form was helpful. A follow-up question asking the preceptors what information or activities might have better prepared them elicited these responses.

P4: I don't know, more emphasis on new grads and conflict resolution…I'll end up forgetting that stuff I learned in preceptor academy. But I did keep the pamphlets and stuff.

P5: I don't know. It might sound silly, but like unless you're actually like doing it in that moment. Being told about what you should do and everything but in that moment example...

Interviewer: So maybe, some role-playing and stuff like that?

P5: Yeah!

It was interesting to note that a couple of suggestions for topics to add to the training included those already covered, such as conflict management. Out of this line of interviewing, the question of who qualified as a potential preceptor came up. When asked if anyone could or should be a preceptor, the responses were:

P5: No.

P4: Ah, no, I don't think, cause some people just aren't I don't know. They don't want to teach, the same people that won't take students. They are just not interested. It slows them up, you know.

P3: But once again, I wouldn't want to say it's not they're not properly trained. It may just be that person, that preceptor and some preceptors are...shouldn't be preceptors.

P1: And you have to have all the aspects, you have to be able to be pretty good at the computer system as well as time management and being able to instruct people. I mean, there's people that are good at two of those, and they can't teach a thing. They're good at what they do, but can they pass it on? I think, I think it's more of an attitude issue, and I think that it's something that needs to be screened by the um, the managers on the floor. I think that you know, maybe you put the word out and say, hey, we need some more preceptors. Do you have anybody on your floor you think would benefit from that and let them kind of make the decision cuz they kind of know who's good and who's not?

P1 pointed out that potential preceptors are currently chosen based on "who is good and who is not." This process indicates that a formal procedure for selecting preceptors does not currently exist within the organization and might be a subject of further inquiry or recommendations.

As mentioned earlier, I attended PA to prepare for the preceptor interview data analysis. The training covered 18 topics in 8 hours. Those topics included: the cost of nursing turnover, preceptor roles and responsibilities, preceptee responsibilities,

communication, time management, diversity and cultural differences, generational differences, adult learning theory, Patricia Benner's theory of nursing development (Benner, 1984), suggested preceptor/student interactions, goal setting, evaluating performance, feedback, phases of reality shock, conflict management styles, dealing with difficult situations, critical thinking, and a one minute preceptor tool (a guide to stimulate critical-thinking). Much information was covered, and honestly, my attention began to waver after the fourth topic. Little time was allowed for practical application of the material presented, such as role-playing and problem-solving. I left the training as a trained preceptor; however, I was not clear about the role expectations.

***Summary of preceptor training*.** The preceptors expressed the opinion that not everyone is qualified to be a preceptor and that sometimes, the managers choose people using a warm body methodology. This process is probably the result of high turnover. Four of the PA topics came up during the interviews, goal setting, feedback, time management, and critical thinking. Goal setting and feedback came up because I asked about the topic during the interviews. The preceptors mentioned time management and critical-thinking skills without prompting. I asked the preceptors what would have better prepared them to be preceptors. P5 summed the responses up perfectly when P5 stated," I don't know. It might sound silly, but like unless you're actually like doing it in that moment". The preceptor clarified this remark by stating that being able to practice the skills would have been helpful. Kirkpatrick and Kirkpatrick (2005) stated that the trainer should provide the learner with the opportunity to immediately apply what they have

learned so that learning began to transfer to behaviors. Besides their initial training in PA, none of the preceptors reported having additional training.

While analyzing the data in the preceptor training category, I realized that the PGCOP is part of a more extensive program for the preceptors, including the initial selection of nurses to be preceptors, PA, and implementation of the behaviors learned in PA, which is the PGCOP. In terms of the NWKM, PA would exemplify Level 2: learning and the PGCOP would exemplify Level 3: behaviors. For the NGNs, the PGCOP would embody Level 2: learning.

Preceptor satisfaction. The category preceptor satisfaction included four subcategories: frustrations, inconsistent orientation, preceptor support, and like being a preceptor. The preceptor satisfaction category also provided commentary on the preceptors' perceived effectiveness of the program. I asked the preceptor participants if they enjoyed being a preceptor. This question touched on their satisfaction with the role or their NWKM Level 1: reaction to the PGCOP. They had this to say:

> P5: Yeah, I don't mind. I feel like I do well with it, with them, you know, I'm nice, and I'm safe for them.
>
> P3: I like being a preceptor.
>
> P1: I do, my mother was a teacher, and my stepfather was a teacher, and they wanted me to be one, and I guess I have a little bit of that in me.
>
> P4: I did, yes, I really enjoy it, and I wish we could hire some more nurses so I could do it more often.

I asked the preceptors if they were provided with any support after completing training and started working with their first preceptees.

P5: Indicated no.

P1: Yeah, I think it would be really beneficial. (when asked if support were provided after preceptor training).

P5: No, actually nobody really did help out… and I was worried that I wasn't doing a good job.

The preceptor participants also expressed some frustration about the NGNs receiving an inconsistent orientation due to various factors.

P1: Yeah. Yeah. Yeah, and I have a big problem with that too because, as a preceptor, you spend all your time trying to get them to do it this way, and then you get switched up. That was a problem we had. On top of that, which is a big complaint of mine, all these extra classes they have to go to and meetings they have to go to and trying to fit in the EKG classes and everything else during their orientation. There's, I'll have, I'll have my orientee for a week. I may not see them for two weeks, and then they come back to me for another week, and then, my example, I was off for a week too. So then they had to be with somebody else and then come back, and they are with me again, and then something happens, and we only have two, and one of the orientees was straggling, so I had to take her instead of mine, and things got switched up all the time.

P2: I mean I think the biggest problem that the preceptors, a lot of them have is, is, is the fact that first of all, sometimes you get bounced around between other

preceptors, and sometimes you get put with somebody that's technically not a preceptor, but due to manning (staffing) we can only have that person that day. I think that's really the only big clinical side.

***Summary of preceptor satisfaction*.** Overall, the preceptors were satisfied with their roles. They did express some dissatisfaction or discomfort about no follow up from leadership after completion of PA. The preceptors also expressed dissatisfaction with the program's inconsistencies, for example, the switching of the NGNs' preceptors. Two NGNs identified the switching of preceptors as a distraction that interfered with and temporarily set back their learning. The preceptors complained about orientation classes that pulled the NGN away from the unit for several shifts at a time. The preceptors felt that this last practice interfered with the PGCOP process.

Transition to practice issues. The last category in this section included TTP issues. The category, TTP issues, emerged from 13 subcategories: demeaning, hit the ground running, lateral violence (later changed to workplace incivility), reaction to new staff, overwhelmed, preceptee misuse, NGNs not prepared by the school, shock, needy, dissuaded, miscommunication, and abandon.

P5 noted that the NGNs' educational experience does not prepare them.

P5: Because it's every..., they don't, I mean they don't know how to do anything. I mean, I didn't know how to do anything in school either. They have no; there's no organizational skill. There's no, I mean when they come in for clinical (as a student), they're not really seeing with the whole day is looking like, they're seeing, oh, they are going to go do this skill. They're going to go do this skill. I

want to do this skill. They're not seeing really like all the 50 phone calls, and the, you know, the discharge planning and getting somebody a walker and making sure their sisters coming to pick them up, or the admission Med Recs not done. You know the stuff that's not really what you think nursing is, but it is.

Two preceptors provided examples of behaviors that might describe workplace incivility (Laschinger et al., 2016)

P5: Because like, they don't get to do the handoff report. That's a big thing, report giving. I had a nurse giving report, and the oncoming nurse was so rude about the whole thing. She was like this is unorganized. And yeah, I was in another patient's room doing something real quick. And I said go ahead and start the report, and I'll be right here. When I came back, I could tell that the oncoming nurse was flustered and angry, and then you know, my nerves could tell that that was you know, and she was like, what is wrong? Don't worry about it, you know, it's no big deal. We got her all the information, it's fine. But you know, you should start with, you know, name, birthday, code status, allergy, you know why they're here, you know? She was kind of going like, you know, she was giving all the information kind of crazy, you know. But it was okay. I mean, she is figuring it out, you know. That nurse should have been more patient.

P1: But some of the biggest problems that I've seen out of other preceptors is that they want to, they feel like it's an opportunity to put all their work off on somebody.

Several preceptors provided some insight into how staff reacted to new hires. This reaction may, in part, explain why the NGNs felt so overwhelmed at times.

> P3: Unfortunately, it seems more and more in the latter years of being here that it is. The nurses are so busy and overwhelmed and short-staffed, and we've been running at a max of 5 (patients) instead of the ideal 4 for so long. I think nurses are just kind of yeah, no, they, they are just like, you know, my plate is full. I understand that to take a nursing student or a new nurse, especially a new grad. It does lengthen your the time that it takes you to do tasks because you have to explain things and show them what you're doing and why you're doing it. So, I understand it takes more time. I think if you're overwhelmed when you walk in the door, you know, I think it if you've been working extra shifts because it's a short staffing and you had the max of 5 in a rough week at I think more and more. It used to be kind of at a taboo to say no to take a student, you know, and now. I just really can't right now.
>
> P1: It's a mixed bag. Sometimes they like them, because we're getting new staff. But then other times they don't like them because for like that first six months that means that they (meaning the established employees) can get pulled (to another unit) before, if we have too much staff. That's something we got going on right now as we have two new staff members, actually three new staff members that can't get pulled unless they pick up extra, but that generally means that they're the regular staff is going to get pulled.

P3 also provided insights that might add a clarifying point about why NGN voluntary turnover occurs at the study site.

> P3: But I also think it's just important to not give them misleading ideas. I have, I have encountered disgruntled new hires because they say, they report that they were told it was a four to one ratio, that they were going to get an x amount of orientation, and it was going to let you know they wouldn't be pulled for this amount of time, and this kind of expectations and we try to stick to that as much as we can, but there's never, never guarantees in there. You know, honestly, I think I got three weeks of full orientation before I started, it was short, and I needed to go out on the floor. But I've been an LPN for eight years, and I love getting out there and doing, and I thought people they are going to ask questions too, I wasn't ever left alone, but I don't mind taking a team because of how am I going to know I can do it, if I don't do it, right? So, I hate that the misconception that there's teams of four. There are hardly ever teams of four. We do get pulled. We go where the staff, where were most needed because we work for this facility, not this particular unit, and that is hard. Yeah, we're going to take time and orient you so you can do things properly but is not a slow pace. It's not, you know, we've extended people's orientations and all kinds of things, and they still leave.

Summary of transition in practice issues. This category does not address the PGCOP per se but rather is a commentary on the organizational environment that may affect the outcome of PGCOP for the NGNs. For example, the preceptors perceive that the NGNs come from their educational experience unprepared to hit the ground running

because their clinical experience does not fully prepare them for the work environment. The hiring organization often expects the new graduate to be ready to function fully as a professional nurse. This more than likely creates discomfort for the NGN. Evaluating the organizational environment as perceived by the NGN and preceptor is not the purpose of this study. However, it could lay the foundation for future studies.

Summary of Preceptor Data Analysis

A large amount of the preceptor data links to Step II: Climate Preparation of the APM-L. The preceptor data validated the NGNs' perceptions that goal setting was not a consistent activity and, at times, seemed to be impossible due to the unpredictability of the day. The preceptor data also validated the NGNs' experience of feedback being formative, constructive, and helpful. The preceptors provided examples of interactions that they witnessed, which validated the perceptions of the NGNS that work incivility occurs.

The preceptor training included 18 topics with little time built in for experiential activities. The preceptors suggested that being able to practice the concepts covered in training would have been beneficial. The only topics covered in preceptor training mentioned during the interviews were goals, feedback, time management, and critical-thinking. There seemed to be a conflict between time management (manager focus) and critical thinking (preceptor focus). Developing the NGNs' critical-thinking skills seemed to be more critical from the preceptor's perspective. Management's focus on time management confounded that training at times.

Overall, the preceptors seemed satisfied with their role but did offer a critique of the PGCOP and PA. A couple of the preceptors did not know if they were performing as expected because they received no feedback about their performance. The preceptor group shared their belief that not everyone was cut out to be a preceptor and reported that the role was often assigned based on who was available at the time, whether that nurse had been through PA training or not. The training covered much material, and little time was allotted for practicing new skills. The preceptors felt unsupported by leadership once they completed training and began functioning in the preceptor role. There were also opinions expressed about the flow of the PGCOP, assignment of preceptors and preceptees, and issues with consistency of assignments. Some of the preceptors commented that regardless of the training, they did things their way.

> P3: I think there needs to be some areas that probably need to be worked on a little bit. I mean because every preceptor kind of goes in and which, I would expect this, but kind of goes in with their own kind of way to do it…

Cross-Categorical Thematic Summary of RQ1 and RQ2 Findings

This section provides a cross-categorical review of the findings from RQ1 and RQ2. The combined data may provide a clearer picture of what aspects of the PGCOP were perceived by the NGNs and preceptors as either effective or ineffective. During data analysis, I noted that the activities, interactions, and environmental factors encountered during orientation could either promote or impede the NGNs' transition path. This observation led to the deployment of two themes around which the NGN and preceptor data seemed to aggregate. Those themes are *PGCOP Facilitators* (PF), defined as those

activities, interactions, and environmental factors encountered during the PGCOP perceived by the NGNs and preceptors as useful in facilitating NGN transition. I defined *PGCOP barriers* (PB) as those activities, interactions, or environmental factors perceived by the NGNs and preceptors as either distractions or discomforts that impeded, temporarily or permanently, NGN transition.

Preceptor-Guided Clinical Orientation Program Facilitators

The NGNs who received orientation in critical care areas appeared to be satisfied with their preceptors and PGCOP experience. Their level of satisfaction differed from their counterparts who received orientation in medical-surgical areas. I concluded that the satisfaction expressed by the NGNs' orienting in critical care areas might have been the result of environmental factors that promoted interaction with their preceptors. The critical care areas are small, 12 bed units and the patient assignments are usually one-two patients with as many as three patients in rare instances. The layout of the unit and small patient loads allows the staff to be in direct sight of each other. Knowles et al. (2015) pointed out that the physical layout of a space affected learning quality in the APM-L. Smaller spaces encourage interaction, immediate feedback, and encourage learners to participate in the learning process. Accessibility of resources, human resources, in this case, was also found by Knowles et al. (2015) to be crucial to active learning, which lent support to the NGNs' perceived satisfaction with their preceptors.

Many resources critical for learning (Knowles et al., 2015) were available to the NGNs. Most of the NGNs were proactive in using the resources provided at the study site and those they brought with them from their educational experience. All seven NGNs

reported that they could ask questions of their preceptors or other individuals with whom they felt comfortable. I think the level of self-direction demonstrated by this group of adult learners was higher than Knowles et al. (2015) would have expected.

Six of the 7 NGNs expressed the perception that their confidence had increased due to the PGCOP. The NGNs supported this perception by sharing patient care stories that demonstrated their increased confidence. Confidence is increased through participation in training and distinguished by the trainee's belief that they can perform on the job those things that they learned in training (Kirkpatrick & Kirkpatrick, 2016). Knowles et al. (2015) link confidence and commitment to supporting behaviors. The more confident a trainee is, the less support and direction they will need. However, the perceived level of support needed by the NGN, for example, NGN7, does not negate the importance of the preceptors' role as an observer in patient care activities until the NGN has demonstrated competence. As Knowles et al. (2015) pointed out, the learner may not know the new situation's requirements.

According to the NGNs, the feedback provided by the preceptors was formative, constructive, and positive. As Kirkpatrick and Kirkpatrick (2016) pointed out, required drivers such as constructive feedback that reward and recognize critical behaviors are supportive. Required drivers promote the application of learning on the job.

Preceptor-Guided Clinical Orientation Program Barriers

I noted that the NGNs who orientated in the medical-surgical areas were not completely satisfied with their preceptors or with the PGCOP experience. I attributed this dissatisfaction to the units' physical layout and the size of patient assignments at this

level of care. The medical-surgical units have two-three halls that contain about 40 beds. Current practices at the study site make no allowance for the addition of a preceptee to the preceptor's work assignment. The preceptor may have a patient load of four-six patients spread over two-three halls, plus a preceptee to supervise. The preceptee may follow the preceptor for a shift or two at the beginning of the PGCOP but then is responsible for providing care for one-two patients while the preceptor cares for the rest of the patient team. The NGN's patient load increases each week until they are taking care of the full team. This patient care arrangement decreases the preceptor's availability when they are providing care to the rest of the team. According to Knowles et al. (2015), decreasing interaction between the trainer and the trainee decreases the immediacy of feedback, which decreases the effectiveness of learning. However, P1 may have successfully navigated around this issue by using a team approach to orientation rather than splitting the team between themselves and their NGN. This team approach to the assignment of patients during the PGCOP is a subject for further investigation.

Three of the NGNs reported that they felt like their constant questions would be considered annoying by the experienced staff. I failed to probe more in-depth for a reason, but I believe the preceptor and NGN interviews provided a possible cause for the NGNs' perceptions. A couple of the preceptors stated that many nurses do not want to teach and do not want to precept. Three of the NGNs reported that they overheard experienced staff in the critical care areas express their belief that new graduates did not belong in acute care because it was not safe. After hearing these remarks, one NGN stated that asking questions of this group of experienced nurses was no longer an option.

These overheard comments closed off several potential sources of information for this NGN. Another NGN commented that experienced nurses “eat their young,” a comment I have heard continuously throughout my 40-year career and suggest episodes of incivility. I propose that knowing that these attitudes existed may have made it difficult for some NGNs to approach experienced staff, other than their preceptor, to ask questions.

A couple of the NGNs experienced a turnover in their preceptors. NGN3 experienced only one change in preceptors. However, this one change created a setback for NGN3, who had to learn the new preceptor’s ways of doing things, which differed from the original preceptor. Another NGN reported having six preceptors. This NGN liked the variety of working with different experienced people but, at the same time, recognized as a result of being exposed to so many different preceptors that one of the preceptors had provided correct information. These preceptor inconsistency situations resulted in distractions or discomfort for these NGNs that temporarily hindered learning (Kirkpatrick & Kirkpatrick, 2016).

While most of the NGNs seemed to be self-directed, two of the NGNs struggled. It was evident in NGN3’s responses that NGN3 did not seek answers but seemed to be waiting for someone to provide them with the answer. NGN3, for me, exemplifies Knowles’ point that adults have been conditioned to be dependent upon teachers (Knowles et al., 2015). Another NGN was so exhausted at the end of the day that all this NGN wanted was to go home and disconnect after work.

NGN7 perceived that their preceptor was seated at the nurses’ station while NGN7 performed patient care. Interestingly NGN7 believed that their confidence had

increased as a result of this arrangement. During the interview, NGN7 seemed to be confident and committed to learning, which, according to Knowles et al. (2015), indicated independence and a decreased need for support. If unsupervised, though, there was no assurance that NGN7 provided care according to the study site's policies and procedures.

Most NGNs reported that goal setting was not something that occurred as an independent collaborative activity based on self-identified gaps in learning as expected in the APM-L (Knowles et al., 2015). Preceptor data supported the NGN perceptions about goal setting. Goals appeared to be decided by the preceptors without collaborating with the preceptee. The main reason given by the NGNs and preceptors for the lack of goal setting seemed to be environmental. According to the preceptors, it was not easy to plan a day that was continually expected to change.

Conclusions

It appears that NGN satisfaction with the PGCOP appeared to be mostly dependent upon the NGN/preceptor relationship. The quality of that relationship seems to be affected by environmental factors such as the unit's size and the preceptor's workload. Smaller units, such as critical care, and smaller workloads, seemed to contribute to NGN satisfaction. Different staffing patterns and workloads on the physically larger units might increase NGN satisfaction in these areas. For example, P1 used a team-oriented approach to the PGCOP that seemed to mitigate these environmental issues.

The study site provided several material and human resources for NGNs, the most important being the preceptor. Most of the NGNs were proactive in their use of resources

indicating skills in self-directed learning. However, this was not true for all NGNs. It may be beneficial to provide initial training in self-directed learning, as Knowles et al. (2015) suggested. Most of the NGNs stated that their confidence increased as a result of the PGCOP. This finding suggests that they participated in their learning and were allowed time to practice new skills and knowledge.

Feedback was a skill covered in PA that appeared to be used frequently by the preceptors. The NGNs reported that the feedback they received was formative, constructive, and rewarding. However, one preceptor did tell an NGN that they did not think that the NGN would make it through orientation. Again, the ability to practice and role model feedback skills during preceptor training might prevent future situations such as this.

This section looked at the NGNs' and preceptors' perceptions of the PGCOP. The PGCOP was perceived positively in some respects and negatively in others. For me, there was an underlying theme of inconsistency. The data suggested inconsistency issues with the selection of, support of, and training of the preceptors. The data also suggested that the preceptors did not consistently apply what they learned in PA during their PGCOP experiences, with one preceptor admitting that they did things their way. Changes in the PA and increased leadership support of the preceptor group could address these issues.

Program Evaluation

This next section will look at that data again but through a program evaluation lens. The APM-L and NWKM provide the conceptual framework around which the

program is evaluated. The section will conclude with a summary of the data analysis results as they relate to programming.

Step I: Learner Preparation

Step I of the APM-L addresses learner preparation. The APM-L was created with the concept of self-directed learning in mind. Knowles realized that most adults had not learned how to be self-directing because they were conditioned by childhood educational experiences to be teacher dependent. Thus, this step is a "how-to" that instructs learners in the skills needed to be self-directed. This training has been shown to be helpful for adult students (Knowles et al., 2015).

Self-direction did not seem to be an intended outcome of the PGCOP, but rather self-direction was a skill that the NGNs either had or did not have when they arrived from their institutional setting. For instance, when asked how they addressed self-identified knowledge gaps, the NGNs stated that they used class notes, textbooks, and the study various resources found at the study site. The NGNs also stated that they could approach their preceptors and other staff with whom they felt comfortable asking questions. However, the use of resources was not the case for all the NGNs. For instance, NGN3 admitted to not looking at some of the resources and, as a result, felt lost at times. It might help front-load the NGNs with some knowledge and skills in self-direction before beginning the PGCOP. The preceptors may benefit from this information too.

Step II: Climate Preparation

Knowles et al. (2015) pointed out that many things, such as the size of the room or the color of the walls, are out of the instructor's control. However, clearly defined

goals, open and honest feedback, and providing adequate resources are under the instructor's control. These items can be conducive to the learning climate (Knowles et al., 2015).

Three NGNs stated that goal setting did occur, whereas four NGNs stated that it did not. The NGNs that experienced goal-setting activities explained that goal setting was not a consistent activity and that when it did occur, it was most often during formative feedback sessions. The preceptor data validated this information.

Most of the NGNs indicated that the feedback provided by their preceptors during the PGCOP was formative, constructive, and typically rewarded positive behavior. Analysis of the preceptor interview data validated this perception. NGN2 stated that the feedback would be missed once the PGCOP was completed.

However, feedback, if misused, can create a barrier. NGN3's preceptor shared with NGN3 that he did not think NGN3 would make it through orientation and gave NGN3 the impression that he did not quite know what to do with NGN3. This feedback created a distraction and discomfort for NGN3, which may have hindered learning and weakened NGN3's confidence.

It did not escape my attention during the data analysis that the preceptors' feedback was often linked with confidence-building. Several of the NGNs commented that feedback from their preceptor increased their confidence. Reports of increased confidence indicated that the NGNs were provided with opportunities to practice new knowledge and skills (Kirkpatrick & Kirkpatrick, 2016).

The use of resources by the NGNs was discussed in Step 1 of the APM-L. The study site provided many resources, both digital and human, for the NGNs to access. All seven of the NGNs stated that they could ask their preceptors for information. Five of the NGNs used their texts and notes from school and the study site's digital resources. Two of the NGNs did not access all available resources for various reasons, reflecting a possible lingering teacher dependence, as described by Knowles et al. (2015).

I wanted to look at bullying in the workplace because this was a topic mentioned frequently in the transition literature and does affect the work climate. I later changed the term bullying to workplace incivility based on the definition provided by Laschinger et al. (2016). The NGNs and preceptors provided examples of interactions and behaviors that appeared to be workplace incivility, which again creates a distraction and discomfort that decreases engagement (Kirkpatrick & Kirkpatrick, 2016).

Step III: Model for Collaborative Planning

The objective stressed in Step III of the APM-L is to collaboratively develop goals for the learner based on assessed learning needs (Knowles et al., 2015). Goal setting requires that the facilitator, in this study, the preceptor, act as a resource guiding the NGN to develop their learning. The descriptive analysis of the NGN and preceptor data already pointed out that collaborative goal setting was not a consistent activity. According to the NGNs, if goal setting did occur, those goals were preceptor derived during formative feedback moments. The preceptors' responses indicated that when they set goals, those goals were nebulous and not measurable. For example, a goal mentioned by one of the preceptors was for the NGN to increase speed.

Knowles (1975) promoted the use of the learning contract, a collaborative tool, as the best way for a learner to demonstrate a learning commitment. As an employee at the site, and from querying the NGNs, I know that learning contracts are not used in the PGCOP. I will propose the use of learning contracts as a recommendation in Appendix A.

Step IV: Assessing Learning Needs

The APM-L (Knowles et al., 2015) emphasizes the adult learner's self-diagnosis of learning needs. Several pieces of data made me think that this did occur to some extent. For example, when I asked the NGNS how they obtained information when they identified gaps in their knowledge, five stated they used texts, class notes, resources provided by the study site, and human resources.

The PAPD gives the NGNs a competency exam before they begin PGCOP. This testing aims to assess learning needs and identify the strengths and weaknesses of the NGNs' knowledge. This information is supposed to be used to develop an individualized learning plan for the NGN. Several NGNs stated that they either did not remember receiving the exam or did not see the results.

Interviewer: On Thursday at the end, they gave you a test, the competency exam. Do you know if that was ever used to kind of direct your orientation?

NGN6: Ummm.

Interviewer: Did you ever hear anything about it?

NGN6: No, I don't think so.

NGN4: Like the competency?

Interviewer: That competency exam, yes.

NGN4: No, once I took it like I haven't heard anything else.

This preceptor data validated the NGNs' statements.

Interviewer: Do you or do you know if people are using those test results to kind of guide orientation?

P1: I don't know, that's above my paygrade. Nobody really shares that with me.

Step V: Developing Objectives

In this step, Knowles et al. (2015) discussed the formulation of learning goals. Goal design depends on the school of thought. For example, behaviorists have stated that goals should be measurable, observable, and precise. The study site incorporates the behaviorist approach to goal development and teaches the preceptors to create goals that are Specific, Measurable, Attainable, Relevant, and Time-Based (SMART) (Case file, 2016). The NGN and preceptor data established that formal goals were not collaboratively developed in the PGCOP process, and that goal setting was inconsistent.

Step VI: Learning Plans

This step relies on assessing the needs of the learner. According to this step, the preceptor would, based on assessment, provide appropriate resources and plan sequential learning experiences for the NGN. No evidence indicated that formal planning of educational experiences for the NGN occurred. P1 summed up their idea of the planning process for NGN skills development:

P1: Oh, yeah, yeah, and I let everyone know. Hey, if you all have anything interesting going on, tubes need to be put in, or catheters, I said, let us do it.

Step VII: Conducting the Designed Learning Experience

Knowles (1990) addressed the caliber of the instructor in this step. He stated that a process for selecting learning instructors should not be relied upon for providing a good teacher because, more than likely, the persons selected were either trained or experienced in pedagogical traditions. Knowles (1990) stated that the program administrator must train instructors through pre-service and in-service programs. This step is considered the most critical aspect of the program administration (Knowles, 1990).

The study site provided a pre-service training program for experienced nurses who either volunteered or were selected to be preceptors. As a reminder, the current program addresses 18 topics presented over eight hours. Role-playing and other practice activities are minimal, depending on how much time is available. The preceptors identified this lack of hands-on practice as an issue and suggested that preceptor training includes more practice time. The preceptor training program does not provide in-services or training updates after the initial pre-service program, according to the PAPD.

Step VIII: Evaluating Learning Outcomes and Reassessing Learning Needs

Knowles (1975) stated that evaluation was the most challenging task of the APM-L. He suggested using Kirkpatrick's four-level program evaluation methodology because it was congruent with andragogical principles. The remainder of this section will explore the data using the program evaluation methodology of the NWKM (Kirkpatrick & Kirkpatrick, 2016).

Level 1: Reaction. Level 1 of the NWKM addresses the participants' reactions to the training program and is the easiest level to evaluate, according to Kirkpatrick &

Kirkpatrick (2016). Level 1 includes three evaluation components: customer satisfaction, engagement, and relevance (Kirkpatrick & Kirkpatrick, 2016). Data analysis of the NGN interviews indicated that the reactions of the NGNs to the PGCOP were mixed. As previously discussed, the NGNs orienting in acute care had reported a more satisfactory experience than the NGNs orienting in medical-surgical areas.

Relevance. Relevance refers to the training participants' ability to apply what was learned on the job (Kirkpatrick & Kirkpatrick, 2016). The relevance of the PGCOP was not discussed per se during the NGN interview process. However, Kirkpatrick and Kirkpatrick (2016) pointed out how clear the learner is about expectations, and the learner's ability to discuss what was learned (see Level 2: learning) are indicators of relevance.

After the PGCOP, NGN1 and NGN4 stated that they understood the expectations of a nurse employed at the study site. NGN5 discovered that the expectations were not that clear when gaps in knowledge began to appear after completing the PGCOP. NGN2 thought that expectations were clear until NGN2's skill set was challenged by an unexpected increase in patient load, which resulted in NGN2 feeling overwhelmed. NGN3 seemed to be overwhelmed throughout the PGCOP.

Engagement. Engagement is the degree to which participants are actively involved in their training or how attentive and present they are (Kirkpatrick & Kirkpatrick, 2016). During the interviews, NGNs 2, 5, 6, and 7 provided examples demonstrating that they were engaged in learning while participating in the PGCOP. However, in a few situations, the NGNs could not fully engage in the PGCOP due to

either a perceived distraction or discomfort. For example, NGN1 reported being physically or mentally tired, which created a barrier to engagement.

> NGN1: It just depends. I mean, I've been meaning to you know, like go home and I'm like, okay, need to study the cases, like the patients that I do get. But right now, I'm still at a point where I'd like, go home and have to decompress, and I can't think about work.

Kirkpatrick and Kirkpatrick (2016) pointed out that engagement increases as distractions and discomfort are resolved and stated that the easiest way to decrease or remove distractions and discomfort is through formative evaluations conducted during the training. The NGN and preceptor data demonstrated formative feedback use throughout the PGCOP, which should have helped to mitigate the effects of any perceived distractions or discomforts. However, I cannot comment on that feedback quality because I could not observe those interactions.

I do question whether the NGNs were always provided with relevant or adequate training. My skepticism resulted from other comments made by three of the NGNs during the interview process. For example, NGN6 discovered through the process of having different preceptors that their original preceptor had provided them with incorrect information. NGN4 stated that their preceptor was an agency nurse (a nurse contracted for a short period to fill a workforce gap). This preceptor did not know hospital policy and procedure, which was problematic for NGN4. NGN7 perceived that their preceptor spent their time at the nurses' station while NGN7 provided patient care without direct

supervision. These examples point to inconsistencies in the application of PA principles and preceptor/NGN assignments.

Satisfaction. Satisfaction is the easiest component of Level 1 to evaluate per Kirkpatrick and Kirkpatrick (2016). Six of the seven NGNs expressed overall satisfaction with the PGCOP. Initially, I thought this was a good response, but after reflecting upon the data, I realized that this was the NGN's first exposure to an orientation process. I was not sure that the NGNs had a foundation for evaluating the content of the PGCOP. Instead, I wondered if the NGNs' feelings of satisfaction with the PGCOP resulted from other factors. For example, several of the NGNs expressed evidence of a satisfying relationship with their preceptors. This positive relationship may have influenced the NGNs' feelings of satisfaction with the PGCOP. The effect of the preceptor/NGN relationship on the NGNs' level of satisfaction with the PGCOP would be an interesting study.

Level 2: Learning. Level 2 of the NWKM focuses on learning: the extent to which the participants gain the knowledge, skills, confidence, commitment, and attitude needed to perform effectively on the job based on their level of participation in the training (Kirkpatrick & Kirkpatrick, 2016). Kirkpatrick and Kirkpatrick (2016) list several types of quantitative and qualitative data that can be collected to assess Level 2 learning, such as knowledge tests, role play, presentation, teach-back, and simulation, to list a few. For this study, the data were collected qualitatively through semistructured interviews.

Knowledge. Knowledge can be assessed in several ways. Pre- and post-testing are the most common. However, that was not a practical approach for this study. During the interviews and while analyzing the data, I was alert to the NGNs' statements that indicated that knowledge transfer had occurred. For example,

> NGN7: …you're talking it out before you do it, and then you know, even though we do our AIDET, you know, here, and we walk into the situation with a patient, you know, we kind of say this is who I am. This is what I am going to do; this is how long it's going to take; this is what you should experience if you have any type of discomfort, let me know. It will be done in a few minutes.

AIDET is an acronym for Announce (your presence), Introduce (yourself), Duration (how long this will take), Explain (what you are doing), and Thank You. The use of AIDET by staff is an expectation at the study site.

Kirkpatrick and Kirkpatrick (2016) pointed out that the learner could not discuss concepts unless they knew the material. The ability to demonstrate learning transfer is an indicator of the relevance of the material for the learner. Kirkpatrick and Kirkpatrick (2016) pointed out that the training should be relevant, engaging, and beneficial for the learner.

Preceptors 1, 2, and 3 provided evidence that they assessed the knowledge acquisition and comfort level of their preceptees. For example:

> P3: I think once you know your student and know your new hire and you get to talk with them and see where they're at, what they need, what do you need from me is often a question I ask.

Skill. Assessing skill requires that the participant does something (Kirkpatrick & Kirkpatrick, 2016). Because observation was not a data collection method used in this study, I asked the NGNs to describe one patient care situation during which they felt they had accomplished something. Their responses provided me with data that demonstrated skill acquisition. For example,

> NGN7: I can do a wound dressing in a heartbeat. And most patients are like, that was quick, thanks. And then the doctors appreciated the wound care that I was giving. So, when I get LSA (medical group) in there, and they're like, looks good, keep it up. Or you might need to pack a little bit more or a little less or whatever.
>
> NGN3: So, fortunately, I got to do a lot of wound care, so I watched him, and then I was able to take the patient and do everything pretty much by myself. And she, the patient, liked how I did her wound care...

Kirkpatrick and Kirkpatrick (2016) pointed out that when the learner participates in a meaningful activity, such as those described by NGNs 7 and 3, it builds positive attitudes. It also helps build the commitment and confidence to perform these activities (Kirkpatrick & Kirkpatrick, 2016). The preceptors are instrumental in identifying and providing activities that may be meaningful to the NGN. For example,

> P1: Oh yeah, yeah, and I let everyone know. Hey, if you all have anything interesting going on, tubes need to be put in, or catheters, I said, let us do it.

Confidence and commitment. Commitment and confidence-building occur when the participant is given ample practice, the time to discuss learning, and is encouraged to ask questions during the training. During this time, the trainer can conduct formative

assessments about the participant's attitude and inquire about barriers that may prevent the participant from performing the skill on the job. Identified barriers should be removed, or there will be little impact from the training (Kirkpatrick & Kirkpatrick, 2016).

I asked the preceptors what they did to build the confidence of their preceptees. They had this to say:

> P3: (Asks her preceptees) ...what are you uncomfortable doing, so I can see what is available to be done, even on another team that we can go do together to get you more comfortable doing it.
>
> P1: I almost always have them do all admissions and discharges and things like that...
>
> P2: ...and it's kind of a constant feedback, and I always try to give positive feedback no matter what else, that's the biggest thing right there, especially with new nurses...

Several of the preceptors mentioned feedback as a tool to build confidence.

Regarding the PA, the preceptors suggested more time to practice the skills covered during the training. The preceptors also pointed out that they were not supported by nursing leadership after the PA. The preceptors were not always sure that they were doing the right thing while training their preceptees.

Timing. As already mentioned, Level 2 evaluations should be formative, which the data confirmed was the case per the NGNs and preceptors. A quick, easy way to evaluate Level 2 is to ask the participant if they think they can apply their learning on the

job. Even though the NGNs were not explicitly asked if they could apply what was learned during data collection, there appeared to be ample evidence in the transfer of learning category to indicate that this was the case to some degree. It did appear from the data that the preceptors had difficulty applying learning gained from PA, such as goal setting.

If a formative evaluation is provided correctly and efficiently, then there is little need to conduct a delayed summative evaluation of the training per Kirkpatrick & Kirkpatrick (2016). An exception would be if there were indications of erosion of knowledge, skills, commitment, confidence, or attitude since completing the training. These problems are usually the result of Level 3 issues, behavior, or an issue with applying learning on the job (Kirkpatrick & Kirkpatrick, 2016).

Level 3: Behavior. Level 3 evaluates the degree to which critical behaviors are applied on the job by the training participants. Participants should come away from the training with a clear idea about expectations once they get back on the job. This expectation is often unclear, as the NGN data demonstrated. As part of program development, leadership and the training staff should collaborate to devise a plan to help people perform the behaviors learned during the training and hold people accountable. Level 3 is a performance improvement and monitoring system, not just another evaluation level (Kirkpatrick & Kirkpatrick, 2016).

Kirkpatrick and Kirkpatrick (2016) pointed out that Level 3 behaviors need to be defined, particularly those few critical behaviors that will impact organizational success. Evaluating those behaviors requires observation on the job. In this qualitative study in

which observation was not used as a data collection tool, Level 3 was evaluated in part by simply asking the participants if they understood what was expected of them after the PGCOP was complete. The responses were mixed:

NGN7: Yeah, for the most part, I did.

NGN5: A lot of it is, some of its not…

NGN6: Uh-Huh (response to the question, … did you feel pretty much that you knew what was expected of you here as a nurse?

NGN4: Yes, and no. (NGN4 went on to describe a situation for which NGN4 was not prepared).

NGN3: Yeah, I mean, for the most part…I don't really; there are still parts that I don't understand…

This ambivalence about understanding expectations may be due, in part, to a lack of written objectives for the PGCOP, improper use of learning assessment tools, and lack of formal goal-setting, as discussed earlier. The NGNs had no information, particularly goals for the PGCOP, against which to evaluate this question.

The preceptors were also ambivalent about expectations. P4 stated that the expectations of the preceptor role were clear during training. Whereas P1 stated that preceptor training never offered "…a clear vision of what was expected." and was disappointed with training.

It would be natural to assume that competencies would fall under the Level 3 program evaluation. However, competencies are more of a Level 2 or evaluation of learning activity, as discussed under Level 2: Learning. In Level 3, critical behaviors that

the NGNs must consistently exhibit to achieve the desired goals of the organization are identified. In Level 2, the competencies (knowledge and skills) required to perform those identified critical behaviors are planned (Kirkpatrick & Kirkpatrick, 2016). This fluidity of the NWKM shows that the model is not just a recipe to be followed but rather a dynamic tool in which what is planned at each level affects the other three. The fluidity of the model is crucial to keep in mind when evaluating the PGCOP against the NWKM (Kirkpatrick & Kirkpatrick, 2016) and when making suggestions for program improvement.

Required drivers are also an essential component of Level 3. Required drivers are processes put into place that reinforce, monitor, encourage, and reward critical behaviors. Required drivers also provide accountability. For example, a preceptor providing positive feedback to an NGN for a job well done would be a reinforcer. NGNs and preceptors provided evidence of reinforcing and rewarding behaviors. For example:

> P2: Depends on the nurse. I mean sometimes like you know, it's like hey, you did this good today, you did this good today, and then I'll follow up with like we need to work on this tomorrow and then work on it tomorrow, and it's kind of a constant feedback, and I always try to get positive feedback no matter what else that's the biggest thing right there especially with new nurses is like, you know. The NGNs appreciated this rewarding behavior.
>
> NGN5: My preceptor really built my confidence. It was a lot of positive feedback. So, so when I got out of orientation, I kind of missed that positive feedback.

A driver plan should also be in place for the preceptors after they complete preceptor training and continue functioning in the role. I asked the preceptors if they were provided with any support after completing training and began working with their first preceptees.

P5: Indicated no.

P1: Yeah, I think it would be really beneficial. (when asked if support were provided after preceptor training).

P2: No, actually, nobody really did help out… and I was worried that I wasn't doing a good job.

Training provided throughout the year to update preceptors on the latest trends would be reinforcing. An annual breakfast recognizing preceptors for their hard work would be reinforcing and encouraging, or a driver of performance (Kirkpatrick & Kirkpatrick, 2016).

***Level 4: Results*.** The PGCOP does not have defined goals or objectives for the program, only skills to be achieved by the NGNs using a checklist and the preceptor's opinion. At this level of the NWKM, the task is to evaluate the program based on leading indicators or measurable goals defined by the stakeholders. Because there are no goals, it is beyond this study's scope to align the results of the PGCOP with organizational goals (Kirkpatrick & Kirkpatrick, 2016). However, some inferences can be made from the goal-free data.

Conclusions

Based on the steps of the APM-L and levels of the NWKM, I deduced from the data analysis that several NGNs entered the PGCOP with self-directed skills, while two of the NGNs seemed to lack these skills. Before conducting this study, I would not have considered self-directed skill development necessary. However, based on Knowles et al. (2015) recommendations regarding training in this area, perhaps self-direction development for the NGNs should be added as a goal of the PGCOP.

Goal setting, which is part of Steps II and III of the APM-L, was an expectation of the preceptors by the PAPD. However, according to the data, goal setting was not consistently performed, if at all. The preceptors attributed this omission to the unpredictability of the day. The goals mentioned by the preceptors during the interviews did not follow the SMART goal format taught in PA (Case file, 2016). For example, one preceptor stated the goal was to "speed up." There was also no evidence that goal setting was a collaboration between the NGN and preceptor and based on the NGN's self-assessment.

The preceptors were instructed to provide feedback during the PA. The NGNs reported that their preceptors provided feedback often and that the feedback was rewarding and constructive. Two of the NGN participants stated they would miss receiving the feedback after completion of the PGCOP.

The NGNs indicated that their preceptors built their confidence. According to Kirkpatrick and Kirkpatrick (2016), confidence results from ample practice and ample

support (Knowles et al., 2015). I believe that confidence-building should be a goal of the PGCOP and formally operationalized as part of preceptor training.

There were indications that incivility occurred in the workplace. These behaviors can be a barrier to learning because they can be a distraction or discomfort (Kirkpatrick & Kirkpatrick, 2016). It may be beneficial to add incivility training to the PA curriculum.

Knowles et al. (2015) advocated the use of the learning contract. Learning contracts put the andragogical principles of motivation to learn and orientation to learning into practice and engages the learner in planning and communicating their plan to their facilitator, or in this case, the preceptor. The learning contract reconciles the needs of the learner with the needs of the organization and improves competence. Learning contracts might solve several of the preceptors' problems by providing a structure for addressing, for instance, goal setting and NGN learning need assessment.

As individuals, most of the NGNs entered the PGCOP with self-directed skills. They were able to identify their learning needs, and proactively sought answers in the available resources. The study site also had digital learning needs assessment testing in place. The purpose of the testing was to identify the strengths and weaknesses of the new nurse. The results were supposed to be provided to the preceptor to help tailor the PGCOP to focus on developing the nurses' areas of weakness. The education department delivers the test results to the manager. After review, the manager was to supply the test results to the preceptor and NGN to individualize the NGN's PGCOP experience. The interview data indicated that the NGNs and preceptors did not see these results. Perhaps educating the managers in their role in this process would be helpful.

Other issues mentioned included, but were not limited to, agency nurses functioning as preceptors, preceptors who provided incorrect information, changing preceptors during the PGCOP, perceiving that staff would get tired of constant questioning, and hearing staff making non-supportive comments. These issues have implications for the selection, training, and scheduling of preceptors. In the bigger picture, an evaluation of the culture to assess the impact of issues, such as incivility, might be helpful.

Three issues stood out in the NWKM program evaluation that should receive further consideration. First, the lack of program objectives makes it difficult for the trainee to discern job expectations. Second, a required driver plan to ensure consistency in applying behaviors learned during the PGCOP and PA was not identified. Third and last, there is a lack of evidence of ongoing preceptor training and support from leadership.

Section 3: The Project

Introduction

An evaluation of the PGCOP had not occurred since its implementation per the PAPD. The lack of evaluation is expected because program appraisal is a low priority for educators (Lewallen, 2015). Therefore, the leadership team had no information on which to base decisions about the program. This project evaluation report is a deliverable for the study site leadership team (see Appendix A). This report summarizes the study and includes recommendations for improvements to the PA. The following is a discussion of the goals and rationale for this program evaluation report, a review of relevant literature, and a discussion of social change implications.

Description and Goals

I explored the perceptions that NGNs and preceptors held about the effectiveness of the PGCOP provided by the study site. As I analyzed and reflected on the data, I understood that even though the PGCOP is a standalone program, it is more than that. It is part of the orientation continuum at the study site that flows along two streams of activity. First, NGNs participate in general orientation. The NGN then progresses to the PGCOP, where the unit manager assigns a preceptor to guide them. After completion of the PGCOP, the NGN disengages from the preceptor and enters a residency program. Second, the experienced nurse enters the PA. Upon completion of the PA training, the manager assigns the preceptor with an NGN for the PGCOP. In my opinion, the PGCOP is implementing the skills and knowledge acquired by the preceptors during PA.

The data analysis uncovered several unanticipated opportunities for exploration, perhaps due to performing a study based on goal-free precepts. My initial goal was to explore the effectiveness of the PGCOP from the perspectives of the NGNs and preceptors. However, during data analysis, I determined that interactions with the preceptors affected the NGNs' perspectives of the PGCOP. It appeared that the PGCOP was only as successful as the preceptors who implemented the program. Furthermore, those preceptors were a product of the training received in PA. I decided to take a step back and focus the program evaluation report on the PA (see Appendix A).

The study site leadership is the primary audience for this program evaluation report, specifically nursing leadership. The recommendations found in the project evaluation report (Appendix A), if implemented, will impact future NGNs, preceptors, and nursing management. Any improvements in the PA should also impact the study site patients and the surrounding community by improving healthcare delivery. The program evaluation report aims to provide the leadership team with the information needed to make future decisions about the PA, affecting the PGCOP.

Rationale

A program evaluation report provides executives with information to determine if action is needed (Keuntjes, 2019). A program evaluation report relieves the audience of the additional work of evaluating the study and provides the information in a summarized form written with the audience in mind. The audience for this program evaluation report included the system director of education and research, chief executive officer, chief nursing officer, assistant chief nursing officer, chief operating officer, various directors,

nurse managers, and preceptors. The program evaluation report was the best format for disseminating information to this group.

Review of the Literature

During data collection, I noticed several NGNs commented that they would miss the feedback received from their preceptors. The NGNs also seemed to be saddened by losing the relationships developed with their preceptors during the PGCOP. This finding highlighted that the study site does not have a mentorship program following PGCOP. Another term frequently mentioned, along with preceptorship and mentorship, is coaching. Coaching is a skill set separate from but used during precepting and mentoring activities. The PA does not explicitly address coaching or coaching skills.

The study preceding this section presented general background information about preceptors and precepting. However, that information was scattered throughout the paper; the following literature review gathers that information into one section with updated resources and considerations. A discussion of mentoring and coaching follows this update. The literature review ends with exploring the executive summary's use as a potential format for summarizing the study findings into a program evaluation report for the anticipated audience. Google Scholar, which links to the Walden library through the Thoreau search system, was used to search for *preceptor, preceptor training, mentor, nursing mentor, nursing coach*, *executive summary*, and other variations and combinations of these terms.

Preceptors

The NCSBN defined a *preceptor* as a licensed nurse sought out by a student to serve as a role model, mentor, or teacher in the clinical setting (L'Ecuyer, von der Lacken, Malloy, Meyer, & Hyde, 2017). Lee, Lin, Tseng, Tsai, and Lee-Hsieh (2017) defined *preceptorship* as pairing a preceptor with an NGN for a real-time practice experience. Preceptors have described themselves as experienced nurses who support confidence and growth in the preceptee by serving as facilitators or advisors (L'Ecuyer, Hyde, & Sahtto, 2018). Various definitions of the term *preceptor* appear in the literature because the role is not well defined (L'Ecuyer et al., 2017) and often confused by nurses (Kowalski, 2019). For instance, the NCSBN definition of a preceptor described above more accurately describes mentorship, as shown later in this review. The following is a summary of descriptions of the experienced nurse as a preceptor found in the literature. I have included examples from the data analysis for emphasis where applicable.

Preceptor functions. NGNs require support during the transition process (Chan et al., 2019; Hugo, Botma, & Raubenheimer, 2018; Murry, Sundlin, & Cope, 2019), and healthcare organizations rely on preceptors to provide this support (Lee et al., 2017; Miller, Vivona, & Roth, 2017). Hugo et al. (2018) defined three levels of support that also describe, in part, the role of the preceptor: cognitive, tangible, and emotional.

Cognitive support includes strategies that build critical-thinking skills (Hugo et al., 2018). The study data indicated that at least one of the preceptors struggled with their desire to focus on their preceptee's critical-thinking skills while competing with management's desire for the preceptee to focus on time management. This conflict

created some frustration for the preceptor and indicated a lack of goal alignment between managers and preceptors. This conflict in goals might warrant further future evaluation by the study site leadership, education for the managers, or a collaborative meeting between preceptors and managers to define orientation goals.

Tangible support includes orientation to the physical environment, policies, and procedures (Hugo et al., 2018). The preceptors indicated that they oriented the NGNs to the unit, coworkers, and the physical layout. However, the preceptors did not mention orientation to facility resources, such as finding policies and procedures. One NGN shared that one of their five preceptors provided them with incorrect information. Another NGN had a contracted nurse as a preceptor. The contracted nurses did not know facility policy and procedure requiring the NGN to go to other information sources.

Fostering the ability to access resources is an example of emotional support (Hugo et al., 2018). The NGNs orienting in critical care could access their preceptors readily, whereas the NGNs orienting on medical-surgical units felt intrusive when approaching their preceptors. Reflecting on this difference led to an understanding that NGNs' feelings of intrusiveness were probably a result of the nursing unit's physical layout. Knowles et al. (2015) indicated that the physical layout of the workspace does affect learning. Critical care areas are small, open, and confined. At the study site, the critical care areas held 12 patient beds with a patient assignment of one-two patients per nurse, rarely three. This set up gave the NGNs direct sight of their preceptors and encouraged collaboration in patient care activities.

The medical-surgical units contained 40-plus patient beds and covered three separate hallways. Because the facility assigns patients based on acuity, a medical-surgical nurse might have five-six patients in three different halls. There are no differences made in the assignments for nurses with preceptees, according to the PAPD, an issue also encountered by Chan et al. (2019). Therefore, the NGN on the medical-surgical unit might be down one hall taking care of one patient while the preceptor is in another hall caring for the rest of the assigned team. This arrangement decreased the time spent together and removed the preceptor from the preceptee's line of sight. The physical separation of NGN and preceptor probably contributed to the NGNs' feelings of intrusion when they approached their preceptor for something. One NGN had the perception that their preceptor just sat at the nurse's station when, in fact, that nurse was probably engaged in activities required for taking care of the other four or five patients on the team. Nursing leadership might want to consider a different type of assignment for medical-surgical nurses who have preceptees, such as a patient assignment keeping the preceptor/preceptee team on one hall of the unit rather than spreading the patient assignment over three separate halls.

Preceptors have been deemed necessary in assisting NGNs in making the transition from the educational institution to the healthcare setting or work environment. (Chan et al., 2019; Hugo et al., 2018; Lee et al., 2017; Miller et al., 2017; Powers, Herron, & Pagel, 2019). Preceptor functions include mentoring, observing, assessing, and evaluating NGNs. Preceptors serve as role models and are involved in socialization (L'Ecuyer et al., 2017; Powers et al., 2019) and developing students' critical-thinking

skills, confidence, and competence (L'Ecuyer et al., 2017). There appears to be some agreement on the role of the preceptor internationally. For instance, Ireland's nursing board describes similar functions for the preceptor, including taking responsibility for preceptee learning, setting objectives, providing learning opportunities, providing feedback, and evaluating performance (McSharry & Lathlean, 2017). Interestingly, as laid out by McSharry and Lathlean (2017), these preceptor functions align with the steps of the APM-L (Knowles et al., 2015).

Preceptor selection and qualifications. The NCSBN believes preceptors should be clinically competent in their practice area and serve as role models (L'Ecuyer et al., 2018). A poll of nursing directors and deans supported the NCSBN's position and stated that clinical competence was a critical attribute of the preceptor (L'Ecuyer et al., 2017). However, the only explicit NCSBN requirement is that the preceptor's licensure is at the NGN level or higher. For example, a nurse prepared at the Bachelor of Science in Nursing level cannot serve as a preceptor for a nurse practitioner because the nurse-practitioner license is at a higher level of practice than the BSN. A difference in nursing licensure levels between preceptor and preceptee was not information sought out during data collection at the study site.

The literature indicated that preceptor selection seemed to depend on either availability, years of experience, years of service, attendance in preceptor training, skillfulness, or the exhibition of good judgment (L'Ecuyer et al., 2017). Unfortunately, turnover and the nursing shortage have resulted in the study site choosing preceptors based on availability at times, per the PAPD. Researchers (Cotter & Dienemann, 2016;

L'Ecuyer et al., 2017) have identified the need for more definitive selection criteria. Potential preceptor selection criteria mentioned in the literature include the minimum of a BSN, a positive attitude toward teaching and learning, excellent communication skills, experience as a staff nurse, ability to stimulate critical thinking, and professional values (L'Ecuyer et al., 2017).

However, preceptors seemed to receive minimal training for the role, and support is sometimes lacking (Chan et al., 2019; L'Ecuyer et al., 2017). The administration's lack of support was a topic brought up by the preceptors interviewed for this study. The preceptors reported that they felt unsupported and unsure if they were performing optimally in the role once they finished preceptor training.

One other consideration under preceptor selection is the pairing of the preceptor with the preceptee. Often this is a random pairing that can result in mutual frustration for both parties (Chang, Lin, Chen, Kang, & Chang, 2015) and can interfere with learning (Hugo et al., 2018). Chang et al. (2015) recommended pairing preceptors with preceptees using one of several options, such as the preceptees learning needs, education, or personality.

Preceptor barriers and benefits. The literature is replete with examples of barriers that hamper preceptor effectiveness. Examples of obstacles included nurses who consider precepting a burden (Chan et al., 2019) and are not committed to the role (L'Ecuyer et al., 2017), a finding validated by several preceptor participants studied. Occasionally experienced nurses are asked to function as preceptors despite their lack of preceptor training, competence, or willingness because they happen to be available for

the job (L'Ecuyer et al., 2018). Lack of time (Chang et al., 2015; L'Ecuyer et al., 2017; Rodriguez-Garcia, Medina-Moya, Gonzalez-Pascual, & Cerdenete-Reyes, 2018) and feeling overworked (Chang et al., 2015; L'Ecuyer et al., 2017) are issues with which some preceptors struggled. Other challenges include having students who may not be motivated, lack of support, and unclear expectations (L'Ecuyer et al., 2017). Preceptors often felt unsupported by the administration (Chang et al., 2015; L'Ecuyer et al., 2018; McSharry & Lathlean, 2017), a finding also validated by the preceptors interviewed for this study.

A further issue noted by researchers is the lack of or gap in the monitoring of preceptors' facilitation of clinical learning (Hugo & Botma, 2019). This observation is a critical management behavior often omitted in program implementation, according to Kirkpatrick and Kirkpatrick (2016). The NWKM provides direction for addressing this program development issue in Level 3 (Kirkpatrick & Kirkpatrick, 2016).

Regardless of the barriers, the preceptor model offers several benefits. Preceptor effectiveness has demonstrated a correlation with the successful adjustment and TTP of new nurses (Clipper & Cherry, 2017; L'Ecuyer et al., 2018). Preceptorship provides the preceptor with a sense of satisfaction gained through knowledge sharing, assimilating new nurses into the organization, and contributing to the profession (L'Ecuyer et al., 2017). Nash and Flowers (2017) noted that preceptors helped preceptees to develop professional identity, guided their safe practice, provided feedback, assisted in socialization, and helped them transition to the workforce.

Preceptor training. An extensive review of available literature regarding preceptor training is beyond the scope of this paper. However, the literature reviewed for this section does make one point clear; to be effective, preceptors require training (Chang et al., 2015; Clipper & Cherry, 2017; Kang, Chiu, Lin, & Chang, 2016; L'Ecuyer et al., 2018; Piccinini, Hudlun, Branam, & Moore, 2018; Powers et al., 2019). Even though not mandated or standardized, scholars have recognized preceptor training programs as necessary to provide the preceptors with the knowledge and skills to function in the role (Chang et al., 2015) and positively affect NGN transition (Lee et al., 2017). However, preceptors frequently report being unprepared for the role (Miller et al., 2017; Powers et al., 2019), and although considered clinical experts, preceptors are not necessarily expert teachers (Powers et al., 2019).

The desired results of preceptor training mentioned in the literature include increased patient safety (Chang et al., 2015; Powers et al., 2019) and effective performance (Chang et al., 2015). Preceptor training also benefits the preceptor by enhancing teaching behaviors (Lee et al., 2007). Powers et al. (2019) pointed out that a focus on preceptor training would be beneficial for the NGNs' TTP experience and ability to provide patient care safely.

As previously mentioned, the preceptor role has not been well defined (L'Ecuyer et al., 2017). As a result, there are varied opinions about what topics are important to cover in training. Topics suggested by scholars include preceptor roles and responsibilities (L'Ecuyer et al., 2017; Lee et al., 2017; Powers et al., 2019), learning styles (L'Ecuyer et al., 2017; Lee et al., 2017; Powers et al., 2019), personality

differences (L'Ecuyer et al., 2017), and critical thinking (L'Ecuyer et al., 2017; L'Ecuyer et al., 2018; Lee et al., 2017). Additional suggested topics include feedback (L'Ecuyer et al., 2017; Powers et al., 2019), performance evaluation (L'Ecuyer et al., 2017; L'Ecuyer et al., 2018), teaching and learning strategies (L'Ecuyer et al., 2017; L'Ecuyer et al., 2018; Lee et al., 2017; Powers et al., 2019), and communication (L'Ecuyer et al., 2018; Lee et al., 2017). In a study by Chan et al. (2019), the preceptor participants identified five important training topics: critical-thinking, teaching techniques, prioritizing, conflict management, and teamwork.

Chang et al. (2015) emphasized that because 80% of preceptor training occurred in a classroom environment that preceptor skills remained inadequate after the training. The preceptor training program design does not necessarily consider the preceptors' needs (Chang et al., 2015; Lee et al., 2017). The preceptors interviewed concurred that more time to practice the classroom skills would have been helpful. Powers et al. (2019) supported the addition of an experiential component to preceptor training. Therefore, collaboration with preceptors in the training design, an adult learning principle (Knowles et al., 2015), would ensure that the preceptors can help the new nurse transition to their new role.

Clipper and Cherry (2017) explored designing a preceptor training program based on Duchscher's theory of Transition Shock© (Duchscher, 2012). Using this model, the authors determined that the preceptor should focus on socialization, building interpersonal relationships, support systems, and confidence-building with the preceptee. Clipper and Cherry (2015) recommended that preceptor training program topics include

roles and responsibilities, defining and validating competency in the preceptee, learning styles, facilitating learning, useful feedback, and preceptee evaluation. These are many of the same topics listed previously in this section. However, unlike the previously suggested topics, Clipper and Cherry's (2015) list evolved from theory and was shown to improve new nurses' transition experience. Duchscher's Stages of Transition Theory© and Transition Shock© models provide a scaffold for building a comprehensive transition program for NGNs (Murry et al., 2019). The study site may want to explore the applicability of Clipper and Cherry's (2017) work in conjunction with Duchscher's (2012) Transition Shock model and Stages of Transition theory.

Mentors

After reviewing several articles for this section, it became clear that the distinction between preceptor and mentor is not always evident in the nursing literature, an observation supported by Zhang, Qian, Wu, Wen, and Zhang (2016). Researchers commented that nurses seem to be confused by these terms (Chan et al., 2019; Kowalski, 2019). Frequently the terms, preceptor, and mentor are used interchangeably in the literature (Bengstsson & Carlson, 2015; Chang et al., 2015; Clipper & Cherry, 2015; Edward, Ousey, Playle, & Giandinoto, 2017; Van Rooyen, Jordan, ten Ham-Baloyi, & Caka, 2018; Zhang et al. 2017). Scholarly articles by Kowalski (2019), Nowell, Norris, Krklas, & White (2017), and Zhang et al. (2017) emerged during the search in which the authors provided various descriptions of a mentor. Kowalski's (2019) definition seemed to fit best in this discussion, "Mentoring is most often defined as a professional relationship in which an experienced person assists another typically less experienced

person or nurse in developing specific skills and knowledge that will enhance the less experienced person's professional and personal growth" (p. 493).

There are differences between a preceptor and a mentor (Nielson et al., 2017; Quek & Shorey, 2018; Zhang et al., 2017). A preceptor is a clinically knowledgeable person who serves as an evaluator of the novice nurse within the clinical environment (Kowalski, 2019; Zhang et al., 2017). The preceptor demonstrates and assures clinical competency. On the other hand, a mentor is an experienced role model committed to and supportive of the novice during their transition. The mentoring relationship moves beyond knowledge sharing and continues after the novice's successful transitioning (Zhang et al., 2017). Both the preceptor and mentor are concerned with the development of the novice nurse. The preceptor has a more specific focus on developing clinical competency in the novice, whereas the mentor's focus is on the personal and professional development of the novice (Tiew, Koh, Creedy, & Tam, 2017; Zhang et al., 2017) over a more extended period.

Quek and Shorey (2018) stated that the distinction between preceptorship and mentorship lies in adding a third party. In preceptorship, the preceptor is assigned to the preceptee by a third party, the manager. Without that step, a preceptorship does not occur. The relationship between a mentor and mentee is a voluntary one that resembles a friendship that can exist for several years. Often the mentoring relationship exists beyond the work environment (Quek & Shorey, 2018).

Daloz (2004) focused on mentoring in education and likened mentoring to a journey and the mentor as a lifelong guide. Daloz stated that mentors promote the

novice's generic abilities, such as critical thinking, taking diverse perspectives, empathy, and taking action when unsure. Daloz noted that the adult makes an environmental change (Daloz, 2004) when entering higher education. This change appears to me to be similar to the experience of the newly graduated nurse (NGN) who has left the familiarity of the educational system to enter the workforce. The person, in this case, the NGN, must adapt to a new environment. Mentors then are the "interpreters of the environment" (Daloz, 2004, p. 453) for the novice and help the novice understand how the new environment works.

Daloz (2004) concluded that mentors do three things. Mentors support, challenge, and provide a vision for their mentees. The NGN experiences various stressors during the transition period, such as those listed in Duchscher's work on Transition Shock © (Clipper & Cherry, 2018; Duchscher & Windey, 2018). Duchscher aggregated the stressors experienced by NGNs into four categories: knowledge, roles, responsibilities, and relationships (Duchscher & Windy, 2018). Daloz asserted that mediating various tensions, such as balancing work (roles and responsibilities) and family (relationships), is the "mentor's art" (Galbraith, 2004, p. 454). The expectation then is that the mentor will provide the correct balance of support and challenge so that the novice feels safe to function (Galbraith, 2004) while developing professionally and personally (Zhang et al., 2017).

Mentor benefits. Research demonstrates the benefits that mentorship programs provide. Mentorship facilitates new graduate transition (Edwards et al., 2017; Zhang et al., 2017) and reduces stress (Tiew et al., 2017; Zhang et al., 2017). Mentorship reduces

turnover and, subsequently, turnover costs (Zhang et al., 2017). Mentorship also increases nursing competency (Zhang et al., 2017), confidence, and decision-making (Zhang et al., 2017).

Mentor training. Like preceptors, mentors require training (Zhang et al., 2017). However, none of the articles reviewed prescribed an agenda for mentor training. Even so, pertinent topics are identifiable in research that discusses the desirable attributes of a mentor. Potential topics for mentor training might include role modeling, support strategies, facilitation, advising, socialization (Zhang et al., 2017), coaching, and leadership (Tiew et al., 2017).

Zhang et al. (2017) and Tiew et al. (2017) advocate careful matching of mentors with mentees. However, this involves introducing a third party into the process, which Quek and Shorey (2018) stated differentiated preceptorship from mentorship. Nielson et al. (2017) agreed that mentorship was a voluntary process.

In the final analysis, research regarding the effectiveness of nursing mentorship on satisfaction, stress, and professional socialization is lacking (Zhang et al., 2017). Tiew et al. (2017) pointed out that there is little research about NGNs' perceptions of mentorship. Williams, Scott, Tyndall, and Swanson (2018) found a lack of published findings of the value of mentoring that were reliable. However, other researchers have shown that mentorships are effective overall (Edward et al., 2017; Tiew et al., 2017) and rely on a good mentor/mentee relationship (Zhang et al., 2017).

Coaches

Coaching is another term that is often confused with precepting and mentoring (Kowalski, 2019). Coaching is considered a nursing best practice (Dyess, Sherman, Opalinski, & Eggenberger, 2017). Coaching promotes self-discovery (Dyess et al., 2017), empowers others to set goals and find answers (Kowalski, 2019), and increases clinical effectiveness (Dyess et al., 2017). Coaching is about collaboration. We hold the solutions within ourselves but sometimes need support to reach professional goals (Kowalski, 2019). Coaches are reaffirming (Kowalski, 2019).

Dyess et al. (2017) defined *coaching* as "collaborative, time-limited, and a relationship-based process focused on conversational discourse to support goal achievement" (p. 374). Coaching is an art and a science (Dyess et al., 2017). The science of coaching is built upon evidence, theory, and critical thinking. The art of coaching involves asking open-ended questions and active listening (Dyess et al., 2017).

Coaching models have typical phases: a pre-coaching phase, an active coaching phase, and a follow-up phase. The pre-coaching phase is a time for building the coaching relationship and assessing needs and opportunities. Decisions about the goals and purpose of coaching occur in the active phase. Once goals are determined, then a plan and commitment to act are collaboratively developed. In the follow-up phase, the plan is carried out, followed by feedback (Dyess et al., 2017).

Coaching is very similar to and seems to follow the steps of the anagogical process model of learning (Knowles et al., 2015) used as part of the conceptual framework. In review, the steps of the APM-L are (a) prepare the learner, (b) prepare the

climate, (c) planning, (d) needs assessment, (e) setting goals, (f) designing a learning plan, (g) the learning activities, and (h) evaluation. The pre-coaching phase includes e. The active phase of coaching encompasses e, f, and g. Follow-up would be h.

Dyess et al. (2017) recommended that leaders who have invested in learning to coach can profoundly influence staff engagement and performance. Coaching then seems to support Level 1: reaction of the NWKM (Kirkpatrick & Kirkpatrick, 2016), which focuses, in part, on engaging the participants in the training. The NWKM is also part of the conceptual framework of the study. Coaching seems to be a training activity that has implications for trainers, for example, the PAPD and preceptors and mentors.

Conclusion

Kowalski (2019) delineated the differences between a preceptor, a mentor, and a coach because the terms create some confusion for nurses. In the literature review, I noted that researchers also demonstrated the same lack of clarity when defining and discussing the preceptor role. Understandably, the preceptor might also provide some level of mentoring and coaching to their preceptees. I am recommending in the project that the PA include education that differentiates precepting from mentoring and coaching. I am recommending that the leadership of the study site consider developing a mentoring program. I am also recommending that all nurses receive coaching skills training because this skill could be useful during the provision of patient care and education.

Executive Summary

I was unable to locate information or examples of program evaluations in the literature. Therefore, I modeled the program evaluation content (Appendix A) on the

content typically found in an executive summary according to the literature. The executive summary provides a comprehensive overview of a larger document (Common Assignments: Executive Summaries, 2020; Keuntjes, 2019; Writing an Executive Summary, 2019); in this case, a project study. A summary should contain enough information for the reader to quickly decide on a course of action (Common Assignments: Executive Summaries, 2020; Writing an Executive Summary, 2019). Frequently, for decision-making purposes, the executive summary is the first place the reader will look (Keuntjes, 2019; Peek, 2020).

The audience for an executive summary is usually organizational leaders (Writing an Executive Summary, 2019). The purpose of the summary is to describe an analysis of a problem and then make recommendations based on its conclusions. The summary should be concise, attention-grabbing, and perhaps spur the reader to explore the larger document (Keuntjes, 2019).

There are no set guidelines for formatting an executive summary; however, the organization may have guidelines (Writing an Executive Summary, 2019). Keuntjes (2019) recommended including these main headings in developing the summary; purpose, problem, analysis, results, and recommendations (Keuntjes, 2019). Ashford University recommended level headings for main points that follow the order of the larger document. When discussing recommendations, include the benefits of those recommendations (Writing an Executive Summary, 2019). Walden University (Common Assignments: Executive Summaries, 2020) recommends an introduction, listing the main

points written as sentences, in the same order as found in the larger document, followed by a conclusion.

Implementation

The study site changed ownership during the data analysis phase of the study. Therefore, the audience has changed. The titles are still the same, but the people occupying those positions are new. There is also a new organizational structure. The system director of education and research has requested a copy of the program evaluation report (see Appendix A). The study site leadership and the study participants will also receive a copy. The distribution of the program evaluation report will be electronic with a read receipt in December 2020.

Project Evaluation

The study project is a program evaluation report that summarizes the study's pertinent findings and makes recommendations based on those findings (see Appendix A). The program evaluation report's goal is to provide information to the study site leadership in order that they may be able to make informed decisions about the direction of the PA and, subsequently, the PGCOP. The program evaluation report provides a suitable format for presenting qualitative data (Merriam & Tisdell, 2016).

Social Change Implications of the Study

An evaluation of the PGCOP had not occurred since its inception in 2016. One of the main goals of the PGCOP is to provide the NGN with the clinical skills needed to deliver safe, effective patient care. Preceptors, experienced nurses, are used in the

PGCOP to monitor and evaluate the NGNs as they gain experience at the bedside. However, preceptors require training.

The study data provided evocative information that redirected me to look instead at the PA because the PGCOP appears to implement the knowledge and skills gained in PA by the preceptors. Experienced nurses, who are interested, receive training through the PA, a homegrown program provided by the study site. The use of Knowles' andragogy (Knowles et al., 2015) in the study resulted in recommendations for the PA based on adult learning theory.

If implemented, those recommendations should help the study site leadership create a more robust PA program for preceptors. The NGNs would benefit from these recommendations through the PGCOP experience. Ultimately though, the result should be increased patient satisfaction through improved healthcare. Another measure of the program's effectiveness could be decreased turnover in the NGN population and increased NGN satisfaction with the program. If successful at the local hospital, the organization can spread the updated PA program throughout the hospitals owned by the system, positively impacting preceptor satisfaction, NGN satisfaction, and patient satisfaction.

Conclusion

This section of the paper achieved several goals. Those goals included a brief description of the study, some of the more pertinent results of the study, rationale for the project format (see appendix A), findings, recommendations, implementation of the project, and a literature review. The literature review looked specifically at three related

but different concepts, preceptors, mentors, and coaches. The literature review included information about the executive summary format that guided the development of the program evaluation report (Appendix A).

There seemed to be several themes mentioned repeatedly in the literature reviewed for the project. One theme that stood out as a potential area for future work is that there appears to be no gold standard definition of a preceptor. The lack of a gold standard definition of the preceptor creates confusion in the research. Lerner et al. (2015) indicated that the lack of a gold standard created a barrier to advancing science in a particular area and made it difficult to compare studies. Researchers often interchange the preceptor with the mentor, as noted in the literature review. Preceptors may provide some mentoring, but the two concepts have different foci. Preceptorship focuses on competency, skill development, and socialization to the worksite. Mentorship focuses on professional and personal development. Preceptorships are assigned; mentorships either evolve from working relationships or are sought out by the mentee. A systematic review of the literature to define the term preceptor would add clarity to future research.

The next section will complete this project study. I will discuss the limitations of the study. A discussion of the strategies used to recognize and diminish bias will follow. Section 4 will also include information about the project's strengths and the use of those strengths in future work. My reflections about the project will come next and suggestions for future research that might expand the current findings.

Section 4: Reflections and Conclusions

Introduction

The study's purpose was to explore NGN and preceptor perceptions about the effectiveness of the PGCOP provided at the study site. A goal-free approach to data collection guided data collection and analysis. This approach removed potential stakeholder bias and allowed for discovering the intended and unintended outcomes of the PGCOP. As a result, it became clear during data analysis that the PGCOP would only be as effective as the preceptors are. The preceptors' effectiveness depended on their training. Therefore, I focused on the PA in the project.

In Section 4 of this study, I share my reflections and conclusions about the study. This section consists of five topics: (a) project strengths and limitations; (b) possible alternative approaches to the study; (c) scholarship, project development, leadership, and change; (d) reflections; and (e) implications, including applications and direction for the future. A conclusion summarizing the study will complete Section 4.

Project Strengths and Limitations

The historical information available about the PA did not ground the development of the program in theory. The project provided a remedy for this omission by evaluating the PA using the APM-L (Knowles et al., 2015) and the NWKM (Kirkpatrick & Kirkpatrick, 2016). This theory-based evaluation resulted in recommendations for improvements to the PA based on adult learning theory.

The NWKM used in project development is a tool capable of guiding a program's evaluation or development. The NWKM also aligns with the APML (Knowles et al.,

2015), and when used together as a conceptual framework, any issues identified in the PA can be diagnosed and addressed. For instance, participant engagement is assessed in Level 1: reaction of the NWKM. If the participant's engagement level is assessed as low by the NWKM, Knowles' work in learning contracts provides a methodology for increasing participant engagement (Knowles, 1975). Another benefit of a preceptor training program built on theory is an avenue for the future scientific study of the program and the production of evidence-based practices (Leung, Trevena, & Waters, 2016).

This project was limited in a few ways. For instance, the project was process-oriented rather than content-oriented, reflecting the conceptual framework (APM-L and NWKM) used in the study. Therefore, I recommended little content for the PA in the project recommendations. I did note various training topics mentioned in the literature and created an example curriculum in the program evaluation report (see Appendix A) but felt that program content was in the subject matter expert's purview. The PAPD would seem to be the appropriate person to develop program content. Also, the PAPD should be attuned to the desired outcomes of the organization.

I felt that another limitation in the program evaluation report resulted from the lack of a clear definition of a preceptor. There is no gold-standard definition for a preceptor in the literature. Researchers rarely defined the term in their studies and often interchanged a preceptor's role with the role of a mentor. This lack of definition made it difficult to delineate the role and responsibilities of the preceptor.

Recommendations for Alternative Approaches

Walden University allows four approaches to the project, a curriculum plan, a professional development/training, policy recommendations, and an evaluation report. I chose to pursue the latter. The qualitative study program evaluation report was developed from NGN and preceptor perceptions about the effectiveness of the PGCOP. The goal-free approach to data collection and analysis provided me with opportunities to develop the project following one of several possible paths. I choose to focus on the PA because I felt the data indicated that the PGCOP was only as effective as the preceptors who guided it.

The conceptual framework and program evaluation report used the APM-L (Knowles et al., 2015) and the NWKM (Kirkpatrick & Kirkpatrick, 2016). Both are process models. Therefore, I used the project to evaluate the process, not the program's content, culminating in a project evaluation report (Appendix A). A small portion of the program evaluation report is a sample curriculum that nursing leadership at the study site might develop further and deliver to the NGNs and preceptors jointly.

I chose to conduct a qualitative study from a constructivist perspective because I was curious about discovering the meaning that the PGCOP had for consumers of the program. I could have conducted a positivist-based study and generalized, for instance, that the preceptors' application of feedback techniques increased the satisfaction levels of the NGNs attending the PGCOP. This approach might have resulted in the development of a professional training program about constructive and formative feedback. Alternatively, I could have explored the marginalizing effects of the PGCOP on NGN

morale from a critical perspective. This approach might have resulted in policy recommendations for diversity and inclusion. However, I felt that it was more important to explore the program consumers' experiences and make recommendations that might improve the overall experience.

Scholarship, Project Development, and Leadership and Change

The doctoral study process was a surprise even after the graduate program coursework leading up to the study. Although I learned a great deal from the classes, I do not believe the coursework thoroughly prepared me to design research and conduct research. I gained experience reading summaries of research presented in the professional journals; however, I felt it would have helped to deconstruct and analyze a complete research study during one of those classes. Writing the prospectus was the most challenging and time-consuming part of the process and the part of the process for which I felt the least prepared.

The study and project development process has resulted in developing new skills and strengthening previous skills. I believe that my writing has improved. For instance, as I moved into Section 3 of the document, I found myself attempting to be more concise and choosing my words more carefully to express what I intended to communicate. I can think more critically about what I have read and what I am writing. I have always been a big-picture person, and I believe this process has increased my ability to intuitively pull several concepts together into a whole that makes sense.

I have been considering what I would like to do once I finish this program of study. I am currently semiretired. However, I would like to teach, perhaps introductory

educational theory, to start. While conducting literature reviews, I discovered that I enjoyed reading through systematic literature reviews that focused on defining a particular subject. For instance, I found that there seemed to be no gold standard definition for preceptor and mentor in nursing literature. I think it would be an exciting project to pursue in the future.

The track that I took in the project, focusing on the PA program, was just one direction I could have pursued. There remains a potential to look at the data from different perspectives, each leading to different conclusions and recommendations. For instance, one theme I noted in the data was the preceptors' lack of consistency in implementing the knowledge and skills gleaned from PA. It would be interesting to look at how implementing a driver package that promotes consistency would affect organizational results.

The results of this study, the program evaluation report might have been presented in several different ways. I could have created a course curriculum for preceptor training; I might have created a PowerPoint presentation or made policy recommendations. A project evaluation report seemed to be the best format for clearly providing the results. Also, a project evaluation report seemed the best method for providing the study site leadership with the information needed to make future decisions about the PA and, subsequently, the PGCOP. Lastly, a project evaluation report is a stand-alone product that does not require an accompanying presentation.

The data showed that many of the NGNs entered the PGCOP with self-directed learning skills. The educational attainments over my lifetime have left me in a unique

position. I am a registered nurse with a master's degree in business administration, a master's degree of science in adult learning, and soon, a doctorate in education. I know from many years of experience that leadership often task undergraduate level nurses to develop or restructure programs and processes. Rarely, in my experience, are these restructuring activities completed with an eye on research and evidence-based practices. I believe that with my blend of education that I could provide credible leadership in these endeavors. This perspective would not have occurred before this program. This stance also assures that any changes in processes or programs will be research and evidence-based.

The literature is lacking in presenting the perspective of the expert nurse who transitions to the preceptor role. This lack of representative research leaves a research/practice gap that could affect healthcare quality (Miller, Vivona, & Roth, 2017). Hopefully, this study and the accompanying program evaluation report will add to this area of inquiry's knowledge base, leading to improvements in PA and PGCOP provided at the study site.

The qualitative study and subsequent project were specific to one local hospital. As such, the results are not generalizable to the broader population. However, I think the conceptual framework that I constructed for this study could guide research. The project evaluation report demonstrates the utility of the NWKM (Kirkpatrick & Kirkpatrick, 2016) in program development and evaluation, which may be useful to other researchers.

Reflections on the Importance of the Work

During the literature reviews for this study and project, I noted a lack of studies exploring new graduate orientation programs and preceptor training from the consumer's perspective. This observation, coupled with the fact that the study site leadership did not prove goals for the study, led me to use a goal-free approach. Imposed goals tend to create a bias by guiding the researcher to look at only the data addressing the stakeholders' objectives. This focus, in turn, may cause the researcher to overlook the unintended goals of the program. Thus, unintentionally omitting essential data. I think that if leadership had directed me to evaluate specific objectives, then I may not have noticed the inconsistency of the application of the PA by the preceptors. I might not have noticed that the NGNs orienting in medical-surgical areas had a different orientation experience than those orienting in critical care areas. Even though this is a novice's first attempt at formal research, I may have provided useful information to the literature by using the GFE approach to data collection.

Educationally, I learned a lot during this qualitative study and project development process. I had some familiarity with quantitative research before this, both educationally and occupationally. I never had attempted qualitative work and wanted the experience. I learned, and this may apply to quantitative research, that it is all in the planning. I realize now that a solid plan will provide concrete evidence.

Occupationally, I learned what the NGN endures while transitioning from a student nurse's role to a practicing nurse. Most of this information came from the work on Transition Shock© by Duchscher (2008, 2012), which I stumbled across during my

literature reviews. I learned from reading multiple literature reviews that the role of the preceptor is not well defined. It also became apparent at the worksite that preceptors are neither well trained nor supported in their roles. I believe that the program evaluation report will show that making changes to the PA program may result in a cohort of well prepared and supported preceptors. In turn, the NGNs should enter a PGCOP that addresses their individual learning needs and transition issues through collaboration with a prepared preceptor.

Implications, Applications, and Direction and Directions for Future Research

The project may impact several levels. Individually the recommended changes to the PA could help increase the professional identity of the experienced nurse. A restructured PA that incorporates aspects of the APM-l (Knowles et al., 2015) could lessen NGNs' transition anxiety. Aligning the PA with the NWKM (Kirkpatrick & Kirkpatrick, 2016) could bring internal consistency and accountability to the program, which the data analysis indicated were lacking in the PA and PGCOP.

The program training improvements just discussed should positively affect the patient experience. Evidence-based care delivered by NGNs trained in a program supported by theoretical precepts should result in higher patient and staff satisfaction levels. Improved patient experience should, in turn, raise the confidence of the community served by the study site.

The study site could also benefit from the recommended program changes. A reduction in NGN turnover could occur due to improved satisfaction with the preceptor/preceptee experience. There could be a reduction in medical errors as a result

of consistency in training. Reputation in the community could improve due to word-of-mouth reports about positive customer experiences.

No evidence was found that suggests the PA was developed around any particular learning theory or evidence-based practices. Redesign of the PA using a program development and evaluation tool such as the NWKM (Kirkpatrick & Kirkpatrick, 2016), along with an adult learning theory such as the APM-L (Knowles et al., 2015), would address the trainee's learning needs. I believe a model such as this would address the various barriers, distractions, and discomforts encountered and reported by both the NGN and preceptor participants.

If the study site chooses to make the recommended changes to the PA, I suggest a plan of on-going formative and summative evaluation. The study site leadership would then have the current information needed to make appropriate changes to the program and to address issues as they arise. I recommend the provision of adult learning theory education for the study site leadership. I also recommend that the study site adopt a training program development model and evaluation, such as the NWKM (Kirkpatrick & Kirkpatrick, 2016), applicable to all training programs. For future research, I recommend developing a gold standard definition of a preceptor, work that I may pursue.

Conclusion

Newly graduated nurses are not ready to function in a patient care area immediately after graduating and passing their state board exams. They leave the educational system with theoretical knowledge and a circumscribed set of skills. These NGNs rely on experienced nurses to enculturate them to the work environment and guide

them across the theory to practice divide. The reliance of the NGN on experienced nurses requires that those experienced nurses receive training as preceptors. Training based on theoretical principles and evidence-based practices may result in practice consistency for the preceptor, decreased transition stress for the NGN, and desired organizational results.

References

Africa, L. (2017). Transition to practice programs: Effective solutions to achieving strategic staffing in today's healthcare systems. *Nursing Economic$, 35*(4), 178–183. Retrieved from http://www.nursingeconomics.net

American Nurses Credentialing Center. (2016). *2016 Practice transition accreditation program application manual.* Retrieved from https://www.nmhanet.org/files/Documents/PTAPAccreditationManualANCC2016.pdf

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

Anderson, L. B., Morgan, M. (2017). An examination of nurses' intergenerational communicative experiences in the workplace: Do nurses eat their young? *Communication Quarterly, (65)*4, 377–401. https://doi.org/10.1080/01463373.2016.1259175

Arghode, V., Brieger, E. W., & McLean, G. N. (2017). Adult learning theories: Implications for online instruction. *European Journal of Training and Development, 41*(7), 593–609. https://doi.org/10.1108/EJTD-02-2017-0014

Arrowsmith, V., Lau-Walker, M., Norman, I., & Maben, J. (2015). Nurses' perceptions and experiences of work role transitions: a mixed methods systematic review of the literature. *Journal of Advanced Nursing, 72*(8), 1735–1750. https://doi.org/10.1111/jan.12912

Baxter, P. E. (2010). Providing orientation programs to new graduate nurses. *Journal for Nurses in Staff Development, 26*(4), E12–E17. https://doi.org/10.1097/NND.0b013e3181d80319

Bengstsson, M., & Carlson, E. (2015). Knowledge and skills needed to improve as preceptor: Development of a continuous professional development course. *BMC Nursing, 14*(51) 1–7. https://doi.org/10.1186/s12912-015-0103-9

Benner, P. (1994). From novice to expert. In *EAE604 curriculum and competencies: A collection of readings related to competency-based training* (pp. 127–135). Retrieved from https://files.eric.ed.gov/fulltext/ED384695.pdf

Benner, P. (2001). *From novice to expert: Excellence and power in clinical nursing practice* (Commemorative Edition). Upper Saddle River, NJ: Prentice Hall Health.

Blegen, M. A., Spector, N., Ulrich, B. T., Lynn, M. R., Barnsteiner, J., & Silvestre, J. (2015). Preceptor support in hospital transition to practice programs. *The Journal of Nursing Administration, 45*(12), 642–649. https://doi.org/10.1097/NNA.0000000000000278

Bridges, W. (2004). *Transitions: Making sense of life's changes* (2nd ed.). Cambridge, MA: De Capo Press.

Brook, J., Aitken, L., Webb, R., MacLaren, J., & Salmon, D. (2019). Characteristics of successful interventions to reduce turnover and increase retention of early career nurses: A systematic review. *International Journal of Nursing Studies, 91,* 47–59. https://doi.org/10.1016/j.ijnurstu.2018.11.003

Caelli, K., Ray, L., & Mill, J. (2003). “Clear as mud”: Toward greater clarity in generic qualitative research. *International Journal for Qualitative Methods, 2*(2), 1–13. https://doi.org/10.1177/160940690300200201

Chan, H., So, W., Aboo, G., Sham, A., Fung, G., Law, W., … Chair, S. (2019). Understanding the needs of nurse preceptors in acute hospital care setting: A mixed-method study. *Nurse Education in Practice, 38,* 112–119. https://doi.org/10.1016/j.nepr.2019.06.013

Chang, C., Lin, L., Chen, I., Kang, C., & Chang, W. (2015). Perceptions and experiences of nurse preceptors regarding their training courses: A mixed-method study. *Nurse Education Today, 35,* 220–226. https://doi.org/10.1016/j.nedt.2014.08.002.

Chick, N., & Meleis, A. I. (1986). Transitions: A nursing concern. In P. L. Chinn (Ed.), *Nursing research methodology* (pp. 237–257). Boulder, CO: Aspen Publications.

Chyung, S. Y. (2015). Foundational concepts for conducting program evaluations. *Performance Improvement Quarterly, 27*(4), 77–96. https://doi.org/10.1002/piq.21181

Clipper, B., & Cherry, B. (2015). From transition shock to competent practice: Developing preceptors to support new nurse transition. *The Journal of Continuing Education in Nursing, 46*(10), 448–454. https://doi.org/10.3928/00220124-20150918-02

Conaway, W. & Zorn-Arnold, B. (2015). The keys to online learning for adults: The six principles of andragogy. *Distance Learning, 12*(4), 37–42. Retrieved from https://www.researchgate.net/publication/299540188_The_Keys_to_Online_Lear

ning_for_Adults_The_Six_Principles_of_Andragogy

Condon, B. B. (2015). Incivility as bullying in nursing education. *Nursing Science Quarterly, 28*, 21–26. https://doi.org/10.1177/0894318414558617

Cotter, E., & Dienemann, J. (2016). Professional development of preceptors improves nurse outcomes. *Journal for Nurses in Professional Development, 32*(4), 192–197. https://doi.org/10.1097/NND.0000000000000266

Curan, M. K. (2014). Examination of the teaching styles of nursing professional development specialists, part I: Best practices in adult learning theory, curriculum development, and knowledge transfer. *The Journal of Continuing Education in Nursing, 45*(5), 233–240. https://doi.org/10.3928/00220124-20140417-04

Daloz, L. A. (1999). *Mentor: Guiding the journey of adult learners* (2nd ed.). San Francisco, CA: Jossey-Bass.

Daloz, L. A. P. (2004). Mentorship. In M. Galbraith (Ed.), *Adult learning methods: A guide for effective instruction* (pp. 451–571). Malabar, FL: Krieger Publishing Company.

Delfino, P., Williams, J. L., Wegener, J. M., & Homel, P. (2014). The impact of the Vermont nurse internship project/partnership model on nursing orientation. *Journal for Nurses in Professional Development, 30*(3), 122–126. https://doi.org/10.1097/NND.0000000000000060

Duchscher, J. E. B. (2012). *From surviving to thriving: Navigating the first year of professional nursing practice.* Saskatoon, Canada: Saskatoon Fastprint.

Duchscher, J. B., & Windey, M. (July/August 2018). Stages of transition and transition

shock. *Journal for Nurses in Professional Development,* 228–232. https://doi.org/10.1097/NND.0000000000000461

Dyess, S. M., Sherman, R., Opalinski, A., Eggenberger, T. (2017). Structured coaching programs to develop staff. *The Journal of Continuing Education in Nursing,* 48(8), 373–378. https://doi.org/10.3928/00220124-20170712-10

Edward, K. Ousey, K., Playle, J., & Giandinoto, J. (2017). Are new nurses work ready – The impact of preceptorship. An integrative systematic review. *Journal of Professional Nursing*, *33*(5), 326–333. https://doi.org//10.1016/j.profnurs.2017.03.003

Edwards, D., Hawker, C., Carrier, J., & Rees, C. (2015). A systematic review of the effectiveness of strategies and interventions to improve the transition from student to newly qualified nurse. *International Journal of Nursing Studies*, *52,* 1254–1268. https://doi.org/10.1016/j.ijnurstu.2015.03.007

Gardiner, I., & Sheen, J. (2016). Graduate nurse experiences of support: A review. *Nurse Education Today, 40,* 7–12. https://doi.org/10.1016/j.nedt.2016.01.016

Goode, C. J., Glassman, K. S., Ponte, P. R., Krugman, M., & Peterman, T. (2018). Requiring a nurse residency for newly licensed registered nurses. *Nursing Outlook, 66,* 329–332. https://doi.org/10.1016/j.outlook.2018.04.004

Goode, C. J., Ponte, P. R., & Havens, D. S. (2016). Residency for transition into practice: An essential requirement for new graduates from basic RN programs. *The Journal of Nursing Administration, 46*(2), 82–86. https://doi.org/10.1097/NNA.0000000000000300

Halstead, J. A. (2019). Program evaluation: Common challenges to data collection. *Teaching and Learning in Nursing, 14,* A6–A7. https://doi.org/10.1016/j.teln.2019.04.001

Henderson, A., Ossenberg, C., & Tyler, S. (2015). 'What matters to graduates': An evaluation of a structured clinical support program for newly graduated nurses. *Nurse Education in Practice, 15,* 225–231. https://doi.org/10.1016/j.nepr.2015.01.009

Henschke, J. A. (2015). *Focusing on the six major themes in the global perspective of andragogy: A June 2015 update.* Retrieved from https://works.bepress.com/john_henschke/86/

Hugo, L., Botma, Y., & Raubenheimer, J. E. (2018). Monitoring preceptors' supportive role: A measuring instrument for increased accountability. *Nurse Education Today, 67,* 83–89. https://doi.org/10.106/j.nedt.2018.06.006.

Hugo. L., & Botma, Y. (2019). Looking beneath the surface of a preceptor-training programme through a realist evaluation. *Education and Program Planning, 73,* 195-203. https://doi.org/10.106/j.evalprogplan.2019.01.005.

Irwin, C., Bliss, J., & Poole, K. (2018). Does preceptorship improve confidence and competence in newly qualified nurses: A systematic literature review. *Nurse Education Today, 60,* 354–6. https://doi.org/10.1016/j.nedt.2017.09.011

Jabeen, S. (2016). Do we really care about unintended outcomes? An analysis of evaluation theory and practice. Evaluation and Program Planning, *55,* 144–154. https://doi.org/10.1016/j.evalprogplan.2015.12.0100149-7189/

Kahlke, R. M. (2014). Generic qualitative approaches: Pitfalls and benefits of methodological mixology. *International Journal of Qualitative Methods, 13,* 37–53. https://doi.org/10.1177/160940691401300119

Kang, C., Chiu, H., Lin, Y., & Chang, W. (2016). Development of a situational initiation training program for preceptors to retain new graduate nurses: Process and initial outcomes. *Nurse Education Today, 37,* 75–82. https://doi.org/10.106/j.nedt.2015.1.022

Keuntjes, K. (2019, November 11). What is an executive summary? Retrieved from https://rasmussen.libanswers.com/faq/171743

Kavanagh, J. M., & Szweda, C. (2017). A crisis in competency: The strategic and ethical imperative to assessing new graduate nurses' clinical reasoning. *Nursing Education Perspectives*, *38*(2), 57–62. https://doi.org/10.1097/01.NEP.0000000000000112

Key, B. A., & Wright, V. H. (2017). Cognitive apprenticeship during preceptorship. *Journal for nurses in professional development, 33*(6), 301–306. https://doi.org/10.1097/NND.0000000000000394

Khaled, A., Gulikers, J., Biemans, H., & Mulder, W. (2015). How authenticity and self-directedness and student perceptions thereof predict competence development in hands-on stimulation. *British Educational Research Journal, 41*(2), 265–286. https://doi.org/10.1002/berj.3138

Kirkpatrick, D. L. (1975). *Evaluating training programs*. Madison, WI: American Society for Training and Development.

Kirkpatrick, D. L. & Kirkpatrick, J. D. (2005). *Transferring learning to behavior: Using the four levels to improve performance.* San Francisco, CA: Berrett-Koehler Publishers, Inc.

Kirkpatrick, J. D. & Kirkpatrick, W. K. (2016). *Kirkpatrick's four levels of training evaluation*. Alexandria, VA: ATD Press.

Knowles, M. S. (1975). *Self-directed learning: A guide for learners and teachers.* Englewood Cliffs, NJ: Cambridge Adult Education.

Knowles, M. S. (1980*). The modern practice of adult education: From pedagogy to andragogy* (Revised and Updated). Englewood Cliffs, NJ: Cambridge Adult Education.

Knowles, M. S. (1990). *The adult learner: A neglected species* (4th ed.). Houston, TX: Gulf Publishing Company.

Knowles, M. S. & Associates. (1984). *Andragogy in action: Applying modern principles of adult learning*. San Francisco, CA: Jossey-Bass.

Knowles, M. S., Holton III, E. F., & Swanson, R. A. (2015). *The adult learner: The definitive classic in adult education and human resource development* (8th ed.). New York, NY: Routledge.

Kowalski, K. (2019). Differentiating mentoring from coaching and precepting. *The Journal of Continuing Education in Nursing, 50*(11), 493–494. https://doi.org/10.3928/00220124-20191015-04

Kozub, E., Hibanada-Laserna, M., Harget, G., & Ecoff, L. (2015). Redesigning orientation in an intensive care unit using 2 theoretical models. *Advanced Critical*

Care, 26(3), 204–214. https://doi.org/10.1097/NCI.0000000000000088

Kumaran, S., & Carney, M. (2014). Role transition from student nurse to staff nurse: Facilitating the transition period. *Nurse Education in Practice, 14,* 605–611. https://doi.org/10.1016/j.nepr.2014.06.002

Laschinger, H. K. S, Cummings, G., Leiter, M., Wong, C., MacPhee, M., Ritchie, J., …Read, E. (2016). Starting out: A time-lagged study of new graduate nurses' transition to practice. *International Journal of Nursing Studies, 57,* 82–95. https://doi.org/10.1016/j.ijnurstu.2016.01.005

L'Ecuyer, K. M., von der Lacken, S., Malloy, D., Meyer, G., & Hyde, M. J. (2017). Review of state boards of nursing rules and regulations for nurse preceptors. *Journal of Nursing Education, 57*(3), 134–141. https://doi.org/10.3928/01484834-20180221-02

L'Ecuyer, K. M., Hyde, M. J., & Shatto, B. J. (2018). Preceptors' perception of role competency. *The Journal of Continuing Education in Nursing, 49*(5), 233–240. https://doi.org/10.3928/00220124-20180417-09

Lee, Y., Lin, H., Tseng, H., Tsai, Y., & Lee-Hsieh, J. (2017). Using training needs assessment to develop a nurse preceptor-centered training program. *The Journal of Continuing Education in Nursing, 48*(5), 220–229. https://doi.org/10/3928/00220124-20170418-07

Lerner, E. B., McKee, C. H., Cady, C. E., Cone, D. C., Colella, M. R., Cooper, A., …Swienton, R. E. (2015). A consensus-based gold standard for the evaluation of mass casualty triage systems. *Prehosp Emerg Care, 19*(2), 267–271.

https://doi.org/10.3109/10903127.2014.959222

Letourneau, R. M., & Fater, K. H. (2015). Nurse residency programs: An integrative review of the literature. *Nurse Education Perspectives, 36*(2), 96–101. https://doi.org/10.5480/13-1229

Leung, K., Trevena, L., & Waters, D. (2016). Development of a competency framework for evidence-based practice in nursing. *Nurse Education Today*, (39), 189–196. https://doi.org/10.1016/j.nedt.2016.01.026

Lewallen, L. P. (2015). Practical strategies for nursing education program evaluation. *Journal of Professional Nursing, 31*(2), 133–140. https://doi.org/10.1016/j.profnurs.2014.09.002

Lindfors, K. & Junttila, K. (2014). The effectiveness of orientation programs on professional competence and organizational commitment of newly graduated nurses in specialized healthcare: A systematic review protocol. *JBI Database of Systematic Reviews and Implementation Reports, 12*(5), 2–14. https://doi.org/10.11124/jbisrir-2014-1532

Lodico, M. G., Spaulding, D. T., & Voegtle, K. H. (2010). *Methods in educational research: From theory to practice* (2nd ed.). San Francisco, CA: Jossey-Bass.

McSharry, D. & Lathlean, J. (2017). Clinical teaching and learning within a preceptorship model in an acute care hospital in Ireland; a qualitative study. *Nurse Education Today, 51,* 73–80. https://doi.org/10.1016/j.nedt.2017.01.007.

Merriam, S. B. & Tisdell, E. J. (2016). *Qualitative research: A guide to design and implementation* (4th ed.). San Francisco, CA: Jossey-Bass.

Miller, J., Vivona, B., & Roth, G. (2017). Work role transitions-expert nurses to novice preceptors. *European Journal of Training and Development, 9410*6, 559–574. https://doi.org/10.1108/EJTD-10-2016-0081

Missen, K., McKenna, L., & Beauchamp, A. (2014). Satisfaction or newly graduated nurses enrolled in transition-to-practice programs in their first year of employment: A systematic review. *Journal of Advanced Nursing, 70*(11), 2419–2433. https://doi.org/10.1111/jan.12464

Murphy, L. J., & Janisse, L. (2017). Optimizing transition to practice through orientation: A quality improvement initiative. *Clinical Simulation in Nursing, 13*(11), 583–590. https://doi.org/10.1016/j.ecns.2017.07.007

Murry, M., Sundin, D., & Cope, V. (2019). Benner's model and Duchscher's theory: Providing the framework for understanding new graduate nurses' transition to practice. *Nurse Education in Practice, 34,* 199–203. https://doi.org/10.1016/j.nepr.2018.12.003

Nash, D. D., Flowers, M. (2017). Key elements to developing a preceptor program. *The Journal of Continuing Education in Nursing, 48*(11), 508–511. https://doi.org/10.3928/00220124-20171017-08

Nielsen, K., Finderup, J., Brahe, L., Elgard, R., Elsborg, A. M., Engell-Soerensen., …Sommer, I. (2017). The art of preceptorship. A qualitative study. *Nurse Education in Practice, 26*, 35–45. https://doi.org/10.1016/j.nepr.2017.06.009

Nowell, L., Norris, J. M., Mrklas, K., & White, D. E. (2017). A literature review of mentorship programs in academic nursing. *Journal of Professional Nursing, 33,*

334–344. https://doi.org/10.1016/j.profnurs.2017.02.007

Omer, T. A., Suliman, W. A., & Moola, S. (2016). Roles and responsibilities of nurse preceptors: Perception of preceptors and preceptees. *Nurse Education in Practice. 16,* 54–59. https://doi.org/10.1016/j.nepr.2015.06.005

Ortiz, J. (2016). New graduate nurses' experiences about lack of professional confidence. *Nurse Education in Practice, 19,* 19–24. https://doi.org/10.1016/j.nepr.2016.04.001

Panzavecchia, L., & Pearce, R. (2014). Are preceptors adequately prepared for their role in supporting newly qualified staff? *Nurse Education Today, 34,* 1119–1124. https://doi.org/10/1016/j.nedt.2014.03.001

Paull, M., Whitsed, C., & Girardi, A. (2016). Applying the Kirkpatrick model: Evaluating an interaction for learning framework curriculum intervention. *Issues in Educational Research, 26*(30), 490–507. Retrieved from www.iier.org

Pasila, K., Elo, S., & Kaariainen, M. (2017). Newly graduated nurses' orientation experience: A systematic review of qualitative studies. *International Journal of Nursing Studies, 71*(June), 17–27. https://doi.org/10.1016/j.ijnurstu.2017.02.021

Patton, M. Q. (2015). *Qualitative research & evaluation methods* (4th ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Peek, S. (2020). A guide to writing an executive summary for your business plan. Retrieved from https://. uschamber.com/co/start/startup/how-to-write-an-executive-summary

Perez-Fuillerat, N., Solano-Ruiz, M. C., & Amezcua, M. (2019). Tacit knowledge: Characteristics in nursing practice. *Gaceta Sanitaria, 32*(2), 191–196. https://doi.org/10.1016/j.gaceta.2017.11.002

Phillips, C., Kenny, A., & Estermann, A. (2017). Supporting graduate nurse transition to practice through a quality assurance backup loop. *Nurse Education in Practice, 27*, 121– 27. https://doi.org/10.1016/j.nepr.2017.09.003

Phillips, C., Kenny, A., Estermann, A., & Smith, C. (2014). A secondary data analysis examining the needs of graduate nurses in their transition to a new role. *Nurse Education in Practice, 14*, 106–111. https://doi.org/10.1016/j.nepr.2013.07.007

Piccinini, C. J., Hudlun, N., Branam, K., & Moore, J. M. (2018). The effects of preceptor training on new graduate registered nurse transition experiences and organizational outcomes. *The Journal of Continuing Education in Nursing, 49*(5), 216–220. https://doi.org/10.3928/00220124-20180417-06

Powers, K., Herron, E., & Pagel, J. (2019). Nurse preceptor role in new graduate nurses' transition to practice. *Dimensions of Critical Care Nursing, 38*(3), 131–136. https://doi.org/10/1097/DCC.0000000000000354

Qamata-Mtshali, N., & Bruce, J. (2017). Self-directed learning readiness is independent of teaching and learning approach in undergraduate nursing education. *Nurse Educator, 43*(5), 277–281. https://doi.org/10.1097/NNE.0000000000000493

Quek, G. J. H., & Shorey, S. (2018). Perceptions, experiences, and needs of nursing preceptors and their preceptees on preceptorship: An integrative review. *Journal of Professional Nursing, 34*, 417–428.

https://doi.org/10.1016/j.profnurs.2018.05.003

Quick, J. (2016). From novice to expert: A surgical care practitioner's reflection on their role development. *Journal of Perioperative Practice, 26*(10), 225–228. https://doi.org/10.1177/175045891602601003

Regan, S., Wong, C., Laschinger, H. K., Cummings, G., Leiter, M., MacPhee, M., Rhéaume, A., …Read, E. (2017). Starting out: Qualitative perspectives of new graduate nurses and nurse leaders on transition to practice. *Journal of Nursing Management, 25*, 246–255. https://doi.org/10.1111/jonm.12456

Reio, Jr, T. G., Rocco, T. S., Smith, D. H., & Chang E. (2017). A critique of Kirkpatrick's evaluation model. *New Horizons in Adult Education & Human Resource Development, 29*(2), 35–53. https://doi.org/ 10.1002/nha3.20178

Rodriguez-Garcia, M., Medina-Moya, J. L., Gonzalez-Pascual, J. L., & Cerdenete-Reyes, C. (2018). Experiential learning in practice: An ethnographic study among nursing students and preceptors. *Nurse Education in Practice, 29*, 41–47. https://doi.org/10.1016/j.nepr.2017.11.001

Rosenbaum, M. (2018). Will 2018 be the year healthcare addresses it's turnover problem? *Becker's Hospital CFO Report*. Retrieved from https://www.beckershospitalreview.com/finance/will-2018-be-the-year-healthcare-addresses-its-turnover-problem.html

Rubin, H. J., & Rubin, I. S. (2012). *Qualitative interviewing: The art of hearing* (3rd ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Rusch, L., Manz, L., Hercinger, M., Oertwich, A., & McCafferty, K. (2019). Nurse

preceptor perceptions of nursing student progress toward readiness for practice. *Nursing Education, 44*(1), 34–37. https://doi.org/10:1097/NNE.0000000000000546

Rush, K. L., Adamack, M., Gordon, J., & Janke, R. (2014). New graduate nurse transition programs: Relationships with bullying and access to support. *Contemporary Nurse, 48*(2), 219–228. https://doi.org/10.1097/NND.0000000000000497

Rush, K. L., Adamack, M., Gordon J., Janke, R., & Ghement, I. R. (2015). Orientation and transition programme component predictors of new graduate workplace integration. *Journal of Nursing Management, 23,* 143–155. https://doi.org/10.1111/jonm.12106

Scriven, M. (1974). Pros and cons about goal-free evaluation. In W. J. Popham (Ed.), *Evaluation in education: Current applications* (pp. 34–67). Berkeley, CA: McCutchan.

Shaw, P., Abbott, M., & King, T. S. (2018). Preparation for practice in newly licensed registered nurses. *Journal for Nurses in Professional Development, 34*(6), 325–331. https://doi.org/10.1097/NND.0000000000000487

Shepard, L. H. (2014). Student perceptions of preceptorship learning outcomes in BSN programs. *Journal of Nursing Education and practice, (4)*5, 73–84. https://doi.org/10.5430/jnep.v4n5p73

Silvestre, J. H., Ulrich, B. T., Johnson, T., Spector, N., & Blegen, M. A. (2017). A multisite study on a new graduate registered nurse transition to practice program:

Return on investment. *Nursing Economics$, 35*(3), 110–118. Retrieved from www.nursingeconomics.net

Spaulding, D. T. (2014). *Program evaluation in practice: Core concepts and examples for discussion and analysis* (2nd ed.). San Francisco, CA; Jossey-Bass.

Spector, N. (2009). A transition to practice regulatory model: Changing the nursing paradigm. *Dean's Notes, 31*(2), 1–2. Retrieved from https://www.ajj.com/sites/default/files/services/publishing/deansnotes/nov09.pdf

Spector, N. (2012). Transition to practice: An essential element of quality and safety. In Mer, Kim *Quality and safety for transformational nursing: Core competencies.* New Jersey: Pearson Publishers.

Spector, N., Blegen, M. A., Silvestre, J., Barnsteiner, J., Lynn, M. R., Ulrich, B., … Alexander, M. (2015). Transition to practice in hospital settings. *Journal of Nursing Regulation, 5*(4), 24–38. https://doi.org/10.1016/S2155-8256(15)30031-4

Spector, N., & Echternacht, M. (2010). A regulatory model for transitioning newly licensed nurses to practice. *Journal of Nursing Regulation, 1*(2), 18–25. https://doi.org/10.1016/S2155-8256(15)30346-X

Strauss, E., Ovnat, C., Gonen, A., Lev-Ari, L., & Mizahi, A. (2016). Do orientation programs help new graduates? *Nurse Education Today, 36,* 422–426. https://doi.org/10.1016/j.nedt.2015.09.002

Tiew, L. H., Koh, C. S. L., Creedy, D. K., & Tam, W. S. W. (2017). Graduate nurses' evaluation of mentorship: Development of a new tool. *Nurse Education Today, 54,* 77–82. http://doi.org/10.1016/j.nedt.2017.04.016

Trede, F., Sutton, L., & Bernoth, M. (2016). Conceptualizations and perceptions of the nurse preceptor's role; A scoping review. *Nurse Education Today, 36,* 268–274. http://doi.org/10.1016/j.nedt.2015.07.032

Valizadeh, S., Borimnejad, L., Rahmani, A., Gholizadeh, L., & Shahbazi, S. (2016). Challenges of preceptors working with new nurses: A phenomenological research study. *Nurse Education Today, 44,* 92–97. http://doi.org/10.1016/j.nedt.2016.05.021

Van Rooyen, D. R. M., Jordan, P. J., ten Ham-Baloyi, W., & Caka, E. M. (2018). A comprehensive literature review of guidelines facilitating transition of newly graduated nurses to professional nurses. *Nurse Education in Practice, 30,* 35–41. https://doi.org/10.1016/j.nepr.2018.02.010

Ward, A. E., & McComb, S. A., (2018). Formalizing the precepting process: A concept analysis of preceptorship. *Journal of Clinical Nursing, 27*(5-6), e873-e881. https://doi.org/10.1111/jocn.14203

Warren, J. I., Perkins, S., & Greene, M. A. (2018). Advancing new nurse graduate education through implementation of statewide, standardized nurse residency programs. *Journal of Nursing Regulation, 8*(4), 14–21. https://doi.org/10.1016/S2155-8256(17)30177-1

Whitehead, B., Owen, P., Henshaw, L., Beddingham, E., & Simmons, M. (2016). Supporting newly qualified nurse transition: A study in a UK hospital. *Nurse Education Today, 36,* 5–63. https://doi.org/10.1016/j.nedt.2015.07.008

Williams, F. S., Scott, E. S., Tyndall, D. E., & Swanson, M. (2018). New nurse graduate residency mentoring: A retrospective cross-sectional research study. *Nursing Economic$*, 36(3), 121-127. Retrieved from www.nursingeconomics.net

Wright, D. (2005). *The ultimate guide to competency assessment in health care* (3rd ed.). Minneapolis, MN: Creative Health Care Management, Inc.

Writing an Executive Summary. (, 2019). Retrieved from https://writingcenter.ashford.edu/writing-executive-summary

Youker, B. W. (2013). Goal-free evaluation: A potential model for the evaluation of social work programs. *Social Work Research, 37*(4), 432–438. https://doi.org/10.1093/swr/svt032

Youker, B. W. & Ingraham, A. (2013). Goal-free evaluation: An orientation for foundations' evaluations. *The Foundation Review*, *5*(4), 51–61. https://doi.org/10.9707/1944-5660.1182

Youker, B. W. (2019). What, how, and why?: A comparative analysis of 12 goal-free evaluations. *Journal of Multidisciplinary Evaluation, 15*(33), 16–29. Retrieved from http://www.jmde.com

Youker, B. W., Ingraham, A., & Bayer, N. (2014). An assessment of goal-free evaluation: Case studies of four goal-free evaluations. *Evaluation and Program Planning, 46,* 10–16. https://doi.org/10.1016/j.evalprogplan.2014.05.002

Youker, B. W., Zielinski, A., Hunter, O. C., & Bayer, N. (2016). Who needs goals: A case study of goal-free evaluation. *Journal of Multidisciplinary Evaluation, 12*(27), 27-43. Retrieved from www.jmde.com

Ziebert, C., Klingbeil, C., Schmitt, C. A., Stonek, A. V., Totka, J. P., Stelter, A., & Schiffman, R. F. (2016). Lessons learned. *Journal for Nurses in Professional development, 32*(5), E1-E8. https://doi.org/10.1097/NND.0000000000000278

Zhang, Y., Qian, Y, Wu, J., Wen., & Zhang, Y. (2016). The effectiveness and implementation of mentoring program for newly graduated nurses: A systematic review. *Nurse Education Today, 37*, 136–144. https://doi.org/10.1016/j.nedt.2015.11.027

Zigmont, J. J., Wade, A., Edwards, T., Hayes, K., Mitchell, J., & Oocumma, N. (2015). Utilization of experiential learning, and the learning outcomes model reduces RN orientation time by more than 35%. *Clinical Simulation in Nursing, 11*(2), 79–94. https://doi.org/10.1016/j.ecns.2014.11.001

Appendix A: The Project

"I feel like I learned, I don't know, just how to be a nurse, really." (NGN1)

Program Evaluation Report

Transitioning from a nursing students' role to a New Graduate Nurse (NGN) can be difficult and anxiety-provoking (Key & Wright, 2017). During the transition period, role confusion is not uncommon, with many NGNs struggling to assimilate into the hiring organization's culture. Barriers to a successful transition, such as role confusion (Phillips, Kenny & Estermann, 2017), job dissatisfaction (Missen, KcKenna, & Beauchamp, 2014), lack of confidence (Murphy & Janisse, 2017), burnout (Pasila, Elo, & Kaariainen, 2017), and bullying (Lindfors & Junttila, 2014) may contribute to one out of five new nurses leaving their employment within the first year of work (Key & Wright, 2017; Warren, Perkins, & Greene, 2018). Kirkpatrick and Kirkpatrick (2016) label these barriers as distractions and discomforts that interfere with engagement and learning. The preceptor's educator role in the transition to practice process is a requirement for the new nurse's success. (Cotter & Dienemann, 2016). However, the educator's role is secondary to the nursing role (Trede, Sutton, & Bernoth, 2016).

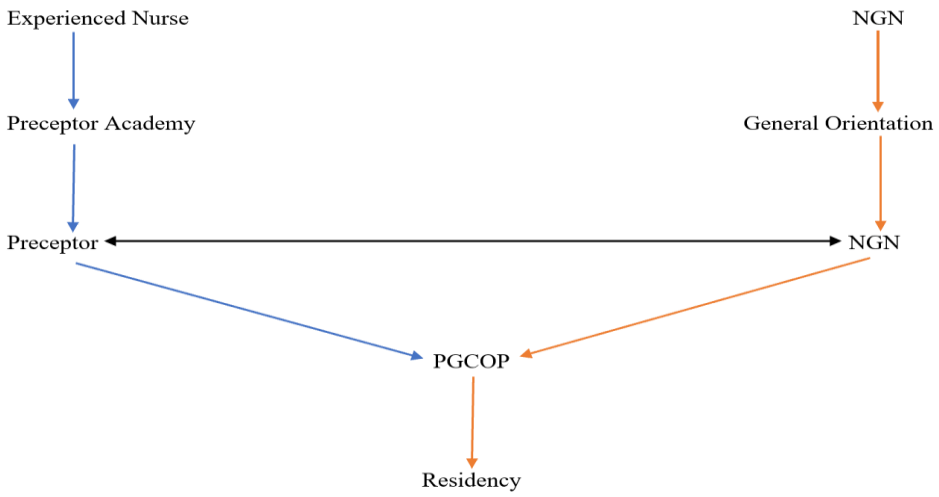
A doctoral research study resulting in this program evaluation report explored the perceptions of seven new graduate nurses (NGNs) and five preceptors regarding the effectiveness of the preceptor-guided clinical orientation program (PGCOP) provided by the local hospital. This program evaluation report has a twofold purpose. First, to collapse the findings of the study data into a form usable by the local hospital. Second, to suggest recommendations for program change drawn from the analysis of the research study data

and based on the andragogical process model of learning (APM-L; Knowles, Holton, & Swanson, 2015) and the New World Kirkpatrick Model (NWKM; Kirkpatrick & Kirkpatrick, 2016).

The Orientation Process for the Newly Graduated Nurse

The newly graduated nurse (NGN) advances through the three-stage orientation process provide at the local hospital. The first stage is a general orientation program that is attended by all new employees. Stage two for the NGN is the PGCOP. At this stage, the nursing manager pairs the NGN with a preceptor who, preferably, has attended Preceptor Academy (PA) and will assist in the NGN's transition from nursing student to professional nurse. After the PGCOP, the NGN enters the third stage of orientation, a year-long NGN residency program designed to assist the NGN with professional development.

NGN Orientation Process



Newly Graduated Nurse

For purposes of the research study, the NGN participant graduated from a nursing program within the past year. Any NGN employed as a nurse elsewhere before employment at the study facility was not considered for inclusion in the study. Prior experience would have already helped the NGN make the transition from student to practicing nurse.

Preceptor

The preceptor is an experienced nurse, considered an expert in their area of practice (Shepard, 2014), who functions as a role model and educator assisting the NGN through the transition to practice (Pasila, Elo, & Kaariainen, 2017). Preceptors are essential to successful NGN transition (Blegen et al., 2015; Key & Wright, 2017) and require training (Irwin, Bliss, & Poole, 2018; Silvestre, Ulrich, Johnson, Spector, & Blegen, 2017; Spector et al., 2015; Strauss, Ovnat, Gonen, Lev-Ari, & Mizrhi, 2016). The experienced nurse chosen to be a preceptor attends PA training provided by the study site's preceptor academy program director (PAPD). After training, the new preceptor is paired with an NGN by the unit manager and begins the PGCOP process. During the PGCOP process, the preceptor should consistently apply the knowledge and skills gained from PA training.

Preceptor Academy

PA is an 8-hour didactic experience facilitated by the PAPD. I attended PA to understand better the expectations placed upon the experienced nurse functioning in a preceptor's expanded role. PA covers 18 topics which include the cost of nursing

turnover, preceptor roles and responsibilities, preceptee responsibilities, communication, time management, diversity and cultural differences, generational differences, adult learning theory, Patricia Benner's theory of nursing development (Benner, 2001), suggested preceptor/student interactions, goal setting, evaluating performance, feedback, phases of reality shock, conflict management styles, dealing with difficult situations, critical thinking, and a one minute preceptor tool (a guide to stimulate critical thinking). The training does include some exercises such as a communication style inventory and the visual, aural, read/write, kinesthetic (VARK) learning styles inventory. However, the time allotted for the completion and discussion of the exercises is limited. The preceptor participants suggested that more practice time would be beneficial. The PAPD provides the preceptor trainees with a 56-page handbook that contains the contents of the training titled Case file: Preceptor: Mission Notes and Resources, which was last updated November 8, 2016.

The Problem

The problem addressed by the study was the lack of documented evidence of a formal or informal program evaluation of the PGCOP. According to the chief nursing officer, there has not been an evaluation of the PGCOP in remembered history. A review of the literature indicated that the omission of program evaluation is not that uncommon. Chyung (2015) pointed out that training and development practitioners rarely perform improvement evaluations due to environmental barriers or lack of expertise. Knowles et al. (2015) pointed out that evaluation is the weakest step in the APM-L, supporting Chyung's (2015) observation. Knowles et al. (2015) recommended using Kirkpatrick's

(1975) program evaluation as a model congruent with andragogy and useable for the evaluation step of the APM-L.

Conceptual Framework

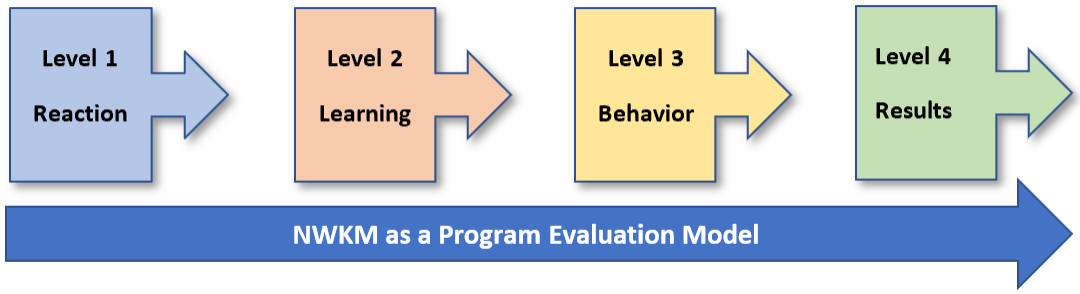
The APM-L and NWKM informed the study. However, the NWKM took the leading role in developing the recommendations found later in this program evaluation report. A brief description of the APM-L and the NWKM follows.

Andragogical Process Model for Learning. Andragogy is considered either a model (Arghode, Brieger, & McLean, 2017), a theory (Curran, 2014), or a set of assumptions (Knowles et al., 2015) developed by Malcolm Knowles that conceptualized a framework for adult learning. Andragogy is built on two main points. First, the learner is central to the process of learning, and second, andragogy acknowledges the adult's knowledge and experience (Conaway & Zorn-Arnold, 2015). There are six andragogical assumptions, (a) the adult needs to know why they should learn something, (b) adults need to be seen by others as self-directing, (c) adults have a more significant pool of adult experiences, (d) adults want immediate applicability of new learning, (e) the adult's orientation to learning is life-centered, (f) and the adult's motivation to learn is mainly internal (Knowles et al., 2015).

To capitalize on these andragogical assumptions, Knowles et al. (2015) developed the APM-L. The APM-L is a process model as opposed to a content model. The difference is that by following a content model of education, the instructor controls the learning curriculum and strategies. Whereas, in a process-oriented model, the facilitator collaborates with the learner and guides the learning experience. The steps of the APM-L

include (a) learner preparation, (b) climate preparation, (c) collaborative planning, (d) learning needs assessment, (e) developing learning objectives, (f) designing the learning experience, (g) conducting the learning experience, (h) evaluating learning outcomes, and (i) reassessing learning needs. The overarching goal of the APM-L is to provide the participants with the resources needed to seek out and independently acquire information and skills, thus becoming self-directed learners (Knowles et al., 2015).

NWKN. Knowles et al. (2015) admitted that evaluation was a weak point in the APM-L and recommended Kirkpatrick's (1975) program evaluation model as congruent with andragogy and useable in the evaluation step of the APM-L. The NWKM can be adapted to perform a complete qualitative, process-oriented program evaluation. The ability to use the NWKM as a process-oriented evaluation meshes well with the process-oriented APM-L. The ease of use and focus of the model makes it a widely used program evaluation tool (Paull, Whitsed, & Girardi, 2016) to evaluate individual and organizational impacts (Reio Jr., Rocco, Smith, & Chang, 2017). When sequencing the levels of the NWKM from one through four, the NWMK functions as a program evaluation tool. The model becomes a program development tool when sequencing from level four to one. The following section describes the levels of the NWKM when used as a program evaluation tool (Kirkpatrick & Kirkpatrick, 2016).



Level 1: Reaction. At Level 1, the trainer evaluates how the participants responded to the training. The evaluator appraises three components at this level: engagement, relevance, and satisfaction (Kirkpatrick & Kirkpatrick, 2016). Kirkpatrick and Kirkpatrick (2016) pointed out that these appraisals could be formative and summative. The authors leaned more towards formative evaluations to prevent the evaluator from wasting time and energy. However, the program content determines whether a formative or a summative evaluation is the best approach. For example, the PGCOP is an on-going and recurring program. The NGN may not use all that they learn in the PGCOP for some time, so summative data collection about the program's relevance may need to be delayed (Kirkpatrick & Kirkpatrick, 2016) and collected a few weeks or months after the training.

Level 2: Learning. The trainer considers five components when evaluating at this level: knowledge, skills, attitude, confidence, and commitment. Strategies for evaluating the trainee at this level include testing, teach-back, presentation, action planning, demonstration, individual interview, or focus groups. For example, teach-back, also used as a health literacy strategy, occurs when the participant learns something and then teaches it back to the class or instructor. Action planning occurs when the participant

creates a plan to apply what they learned when back at the job site, which fits the APM-L steps nicely.

Level 3: Behavior. Kirkpatrick and Kirkpatrick (2016) stated that Level 3 is the most critical level to assess in the program evaluation process (Reio Jr. et al., 2017) and is often the most overlooked. At this level, the evaluator uses observation and monitoring activities to assess the participant's ability to apply the learning when back on the job. The preceptor, unit educator, unit manager, or all three can perform monitoring and observation functions. The team then rewards the participant's performance or makes improvements based on observed behaviors.

Kirkpatrick and Kirkpatrick (2016) pointed out that *required drivers* are essential in sustaining level 3 *critical behaviors*. Critical behaviors are the behaviors that must be consistently performed, leading to desired organizational results. Required drivers are those support and accountability processes put in place by leadership that reinforces, encourages, and rewards the learner's desired critical behaviors. Examples of support drivers include self-directed learning, job aids, communities of practice, coaching, mentoring, and recognition programs. Examples of accountability drivers include interviews, observation, self-monitoring, work reviews, and surveys (Kirkpatrick & Kirkpatrick, 2016).

Level 4: Results. Evaluating the contribution of learning to the business occurs at this level. Kirkpatrick and Kirkpatrick (2016) stated that most training professionals do not know how to perform this evaluation level. Adequate evaluation requires knowing organizational *leading indicators* and linking them with performance. For example,

patient satisfaction is currently a leading indicator for hospital leadership established by the Centers for Medicare and Medicaid (Medicare.gov). Management of the patient's pain (a patient satisfier), for instance, is a nursing competency (Level 2) that is a measure of performance (Level 3) that affects the patient satisfaction score (leading indicator), which impacts organizational results (Level 4). The monitoring of leading indicators provides the information needed for leadership to determine if the performance of critical behaviors is having a positive effect on organizational outcomes. It may take time before results manifest, requiring on-going monitoring at this level of evaluation (Kirkpatrick & Kirkpatrick, 2016).

Purpose and Design

The purpose of the doctoral study was twofold. First was an exploration of NGN and preceptor perceptions of PGCOP effectiveness. The second was to perform a program evaluation. The research questions that guided the study were:

RQ1: How do nurses transitioning from the role of student nurse to the role of new graduate nurse perceive the effectiveness of the preceptor-guided clinical orientation program at the local hospital?

RQ2: How do experienced nurses functioning as preceptors perceive the effectiveness of the preceptor-guided clinical orientation program at the local hospital?

Seven NGN and five preceptors volunteered to participate in a semistructured interview. The sampling procedure was criterion-based and purposeful. The NGN sample included nurses who graduated from their nursing program within the past twelve months and had not had previous healthcare experience as a nurse. The preceptor sample

included nurses who: (a) completed the PA classes provided by the local hospital within the last 6 to 12 months, (b) experienced precepting at least one new nursing employee, and (c) were employed by the local hospital for at least one year. All participants signed consent forms that described the nature and purpose of the study. Walden University IRB and the local hospital system IRB approved the study.

Findings

The research questions guided the development of the semistructured interview questions. I recorded and transcribed the interview data. Coding of the interview data ensued, followed by categorizing similarly coded data and, finally, theme development. Two cross-categorical themes emerged from the data. These themes do not align with any particular category or datum but can function as the endpoints of a continuum. Those endpoints are:

- PGCOP facilitators – those activities, interactions, and environmental factors encountered during the PGCOP that the NGNs and preceptors perceived as useful in facilitating NGN transition.
- PGCOP barriers - those activities, interactions, or environmental factors that were perceived by the NGNs and preceptors as either distractions or discomforts that impeded, temporarily or permanently, NGN transition.

Two research questions guided the doctoral study. Research question one asked how the NGNs transitioning from the student nurse's role to the role of NGN perceived the effectiveness of the PGCOP at the local hospital. The NGNs did experience distractions and discomforts that created temporary barriers to progression in the PGCOP.

Those incidents included the change of a preceptor in midstream, which created a setback because the two preceptors functioned differently. One NGN had five different preceptors and realized that the first provided incorrect information. One NGN had an agency nurse who was unfamiliar with hospital policy and procedure. Several of the NGNs orienting in acute care overheard disparaging comments made by experienced nurses about NGNs' safety working in critical care areas. The NGNs orienting on medical-surgical units felt they were intrusive when they approached their preceptors with questions. However, in the end, the data suggested that the NGNs found the PGCOP to be effective. The NGNs valued the feedback provided by their preceptors. The NGNs orienting in critical care areas valued the relationships they developed with their preceptors. The NGNs were able to state that their confidence increased as a result of the PGCOP. A comment by one of the NGNs and echoed by another summed up their perception of the program's effectiveness. "I feel like I learned, I don't know, just how to be a nurse, really." (NGN1)

Research question two asked how the experienced nurses functioning as preceptors perceived the effectiveness of the PGCOP provided at the local hospital. The data did not provide a clear-cut answer to the question. One preceptor commented that much work went into the process only to have the newly hired nurse leave.

Two primary issues emerged during data analysis. First, the data showed that the knowledge and skills attained in PA were applied inconsistently by the preceptors, if at all. Second, the preceptors did not find the PA training to be practical. The preceptor responses included comments such as the PA contained too much material, the material was forgettable, and that there needed to be more time to practice the skills. Several of

the preceptors commented that nursing administrative guidance and support was lacking after the completion of PA.

I asked the preceptors what they thought a nurse needed to know to function in a preceptor's role. It was interesting that several of the nurses suggested content that already existed in the PA agenda, such as conflict resolution. This finding seemed to support one of the preceptor participants' predictions that the material would be forgotten soon after training.

While analyzing the data and considering these responses, I realized that PGCOP is a part of a more extensive process and does not stand independently. The PGCOP should be the implementation of the knowledge and skills attained by the preceptor trainees in the PA. Therefore, the success and effectiveness of the PGCOP depend upon the application of knowledge and skills gained during PA that the preceptors can perform confidently and consistently when orienting the NGNs.

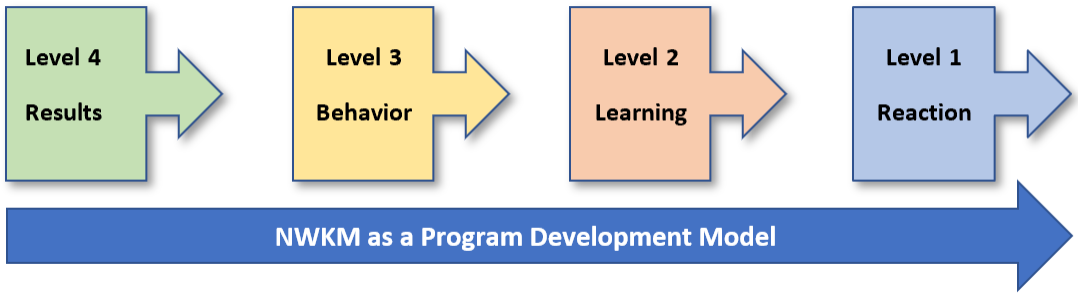
Recommendations

I have based the following recommendations on the data analysis results, the conceptual framework, and the literature. Overall, the NGNs perceived that the PGCOP was effective, and they expressed satisfaction with the outcomes they achieved. However, the data did not provide a clear answer about the preceptors' perception of the program's effectiveness.

The NGN and preceptor data suggested that the success of the PGCOP seemed to depend upon the preceptors' consistent application of the knowledge and skills acquired during PA. Even though the study focus was on the PGCOP, it became evident during

data analysis that improving the PA might mitigate inconsistency issues identified by the NGNs and preceptors, thereby reducing distractions and discomforts experienced by the NGNs. Therefore, the recommendations will focus on improving preceptor training.

Kirkpatrick and Kirkpatrick (2016) stated that the goal of effective training is to provide relevant skills and knowledge to trainees and the confidence for on-the-job application (Kirkpatrick & Kirkpatrick, 2016). The program development path of the NWKM (Kirkpatrick & Kirkpatrick, 2016) will be used to structure recommendations for improving PA. The recommendations are process-focused, leaving content evaluation in the hands of the subject matter expert.



Level 4: Results

Level 4 aims to ensure that training outcomes support leadership's desired organizational results, specifically a return on expectations for the stakeholders (Kirkpatrick & Kirkpatrick, 2016). At the onset of developing a program, the leadership team's goal is to create a results statement based on the organizational mission and financial reality. For example, an organizational mission statement might be, "We are a non-profit healthcare center dedicated to improving community health through cost-

efficient clinical care and community service." Such a statement is missing from the PA and is needed to identify Level 3: behaviors.

Once the results statement is in place, the leadership team can begin identifying leading indicators that measure returns on expectations. Kirkpatrick and Kirkpatrick (2016) define *leading indicators* as short-term observations demonstrating that required behaviors will impact desired results. The leading indicators measure the return on expectations and can be internal or external. For example, external vendors such as Medicare (Medicare.gov) and Leapfrog publicly report healthcare measures derived from evidence-based practice such as patient satisfaction scores. An example of leading internal indicators might be employee satisfaction with the PGCOP or voluntary turnover rates of NGNs.

Level 3: Behaviors

Once Level 4: results are determined, then the identification and selection of Level 3: behaviors begin. These are critical behaviors that, when applied consistently, positively impact the leading indicators selected at Level 4 and, ultimately, organizational results. Identifying critical behaviors is the crux of developing the training program and, once identified, inform the planning of Level 2: learning.

Identifying and putting in place a required driver package is also an integral part of Level 3: behavior. Required drivers are processes put into place by organizational leadership that reward, encourage, recognize, and monitor Level 3: behaviors. Knowles et al. (2015) pointed out in the climate preparation step of the APM-L that from a behavioralist point of view, rewards are likely to increase engagement and motivation

(Knowles et al., 2015). Engagement is a goal of the training and evaluated in Level 1 of the NWKM.

Probably the most significant hurdle at this point is ensuring the implementation and on-going surveillance of the required drivers. At this step, the management team's task becomes consistent monitoring and adjusting of identified critical behaviors and the associated required drivers. For example, the manager might require that the preceptor complete a short, written evaluation of the preceptee's achievements and learning needs every week as part of monitoring critical behavior. The manager can then use the document in a weekly review meeting to adjust the learning plan created through the collaboration of the preceptor and preceptee.

The study data lacked evidence of identifiable critical behaviors. Critical behaviors should emerge from the data as defined performance expectations for the preceptor. An example might be evidence of collaboration between the preceptor and preceptee on the development of a learning plan based on diagnosed learning needs, otherwise known as a learning contract (Knowles et al., 2015).

Critical behaviors should be specific, observable, measurable, defined in terms of the expected outcome, and include an acceptable level of performance (Kirkpatrick & Kirkpatrick, 2016). The Case File: Preceptor (11/08/2016) provided to the preceptors includes a list of preceptor responsibilities and expectations. For example, one expectation is that the preceptor "guides, facilitates, supervises, and monitors the employee in achieving learning objectives." (Case file: Preceptor, 11/08/2016, p. 3). This expectation is neither specific, observable, nor measurable. This expectation neither

includes an expected outcome nor an acceptable level of performance. A better goal might be, the preceptor will observe the preceptee (performing a treatment or activity), provide feedback to the preceptee about their performance, and document their observations in the online clinical pathway at the end of each day of orientation.

Learning Contracts. The learning contract is a collaborative learning plan developed by the learner and the facilitator or, in this program evaluation report, the preceptor and PAPD. The use of learning contracts engages the learner and encourages them to take charge of their learning, becoming self-directed. Learning contracts also make the learning goals clear and avoid extreme behaviors (Knowles et al., 2015), which meshes well with identifying critical behaviors in Level 3.

Past research shows that when adults learn organically, they learn more deeply and are highly self-directed, more so than when taught. (Knowles et al., 2015). However, this kind of learning is personal and loosely structured. Learning that improves competence on the job has to take into account the desired outcomes of the organization. Learning contracts help reconcile the needs of the adult learner with the needs of the organization. Learning contracts include the following steps: diagnosing learning needs, creating learning objectives, resource identification, learning strategies, and evaluating learning. Collaborative planning leads to a feeling of ownership of the plan by the trainee. Collaborative planning also increases commitment to the plan by the learner (Knowles et al., 2015), a goal of Level 2: learning Kirkpatrick & Kirkpatrick, 2016).

Level 2: Learning

Planning learning that results in the preceptors' consistent performance of the critical behaviors identified in Level 3 occurs in Level 2. The training goal is to provide an opportunity for the learners to acquire, based on their level of participation, the knowledge, skills, attitude, confidence, and commitment to perform on-the-job consistently (Kirkpatrick & Kirkpatrick, 2016). The original Kirkpatrick model did not include commitment and confidence. Their inclusion by Kirkpatrick and Kirkpatrick (2016) closed a gap that existed between Levels 2 and 3 of the NWKM. The addition of confidence and commitment also helps prevent the waste that occurs when addressing performance issues. People have the knowledge and skills but do not perform because they lack confidence, commitment, or both (Kirkpatrick & Kirkpatrick, 2016).

Knowledge. Once the training is complete, the learner should be able to state, "I know it." Pre-testing and post-testing is not a recommendation of the NWKM. Instead, Kirkpatrick and Kirkpatrick (2016) suggest using various activities that test participant knowledge. For example, as experienced nurses, preceptors have a pool of experience (Knowles et al., 2015). The PAPD could, for instance, facilitate a round table discussion during PA about a concept such as critical thinking. The preceptor trainees could then identify key strategies to use in the PGCOP. This exercise would be a demonstration of knowledge.

Skills. The learner can state, "I can do it right now." The evaluation of skills requires demonstration. Role-playing, peer observation, and feedback are examples of activities that help in skill acquisition (Kirkpatrick & Kirkpatrick, 2016).

Attitude. The learner can state, “I believe this will be worthwhile to do on-the-job.” One strategy would be to build a discussion about attitude into the PA curriculum. As far as assessing attitudes, course evaluations are useful. Also, weekly meetings with the manager would allow the manager to assess the preceptor’s attitude (Kirkpatrick & Kirkpatrick, 2016).

Confidence. A confident learner can state, “I think I can do it, on-the-job.” Again, course evaluations help assess confidence, along with weekly manager meetings (Kirkpatrick & Kirkpatrick, 2016). The manager can simultaneously assess several items at this level: knowledge, skills, attitude, confidence, and commitment, with one short meeting.

Commitment. “I will do it on the job.” (Kirkpatrick & Kirkpatrick, 2016). Allowing the trainee to participate in their learning planning increases commitment to the learning (Knowles et al., 2015). Course evaluations and weekly manager meetings are useful in assessing the preceptors’ level of commitment.

A few points about preceptor training emerged during data analysis that may require further consideration. Several of the preceptors stated that time to practice the skills covered in PA would be beneficial. One preceptor commented that the material in the PA would soon be forgotten. The use of activities can impact Level 2 and Level 1 of the NWKM. Activities allow for evaluation of learning (Level 2) and increase engagement (Level 1), which in turn enhances learning and builds confidence and commitment (Level 2) (Kirkpatrick & Kirkpatrick, 2016).

APM-L embraces the concept of self-directed learning. However, Knowles et al. (2015) found it necessary to add a step to the APM-L, which focused on preparing the learner because adults tend to be teacher-dependent due to prior educational experiences. Teacher dependency makes it difficult for adults to participate in planning learning (Knowles et al., 2015). I found this to be somewhat accurate in data analysis. A majority of the NGNs appeared to be self-directed and used either the resources they brought with them or those provided by the study site. However, introducing the NGNs to or directing them to consult resources was not evident in the preceptor interviews. Knowles et al. (2015) recommended adding learning how-to-learn topics to the training program, such as proactive learning versus reactive learning and identifying resources. The accessibility of resources by the trainee partially addresses requirements in Step 2 of the APM-L (Knowles et al., 2015). Adding the topic of learning-to-learn to PA may provide the preceptors with strategies to assist the NGNs in becoming more self-directed.

Level 1: Reaction

Level 1 of the NWKM evaluates the participant's reaction to training. Training should be relevant, engaging, and favorable. Engagement relates to learning—the more engaged the participant, the higher the learning attained. Kirkpatrick and Kirkpatrick (2016) pointed out that distractions and discomforts decreasing engagement, which in turn interferes with learning.

The PA program covers 18 topics in 8 hours. According to the PAPD, the time to practice knowledge and skills depends on how much time is available after covering the didactic material. Several preceptors stated that practice activities would be beneficial.

Only two of the topics covered in PA received mention in the preceptor interviews, critical thinking and time management. Several preceptors suggested adding topics that were already part of the PA program, such as conflict resolution. This data could indicate that there is too much material packed into the 8 hours of class time.

Recommendations based on the New World Kirkpatrick Model of Program Evaluation Levels

Level 4: Results: Create a results statement incorporating the organizational mission and financial reality into the mission statement of the PA. A results statement will provide an anchor for the training and allow identification of leading indicators to measure the success of the program.

Level 4: Results: Identify the internal and external leading indicators that would indicate a return on expectations for the PA. For example, a decrease in NGNs' voluntary turnover would be an internal leading indicator that might indicate NGN satisfaction with the PGCOP and organization.

Level 3: Identity critical behaviors to be consistently performed by the preceptors to achieve the leading indicators' desired results. The preceptor responsibilities and expectations found on page three of the handbook (Case file: Preceptor, 11/08/2020) could be re-written as specific, measurable, attainable, realistic, and timely (SMART) goals and used as critical behaviors. For example, one responsibility states that the preceptors "supervise the employee's performance of skills/nursing activities to assure safe practice." Re-written as a critical behavior, this might state, the preceptor observes and documents the preceptee's skills/nursing activities in the Nursing Orientation

Pathway daily. This statement is measurable, directs accountability, and provides the information need for monitoring and adjusting desired behaviors during review meetings.

Level 3: Develop required drivers that hold the preceptor accountable to perform the identified critical behaviors. Drivers include processes that reward, recognize, monitor, encourage, and reinforce critical behaviors (Kirkpatrick & Kirkpatrick, 2016). The preceptor data suggested that leadership support after PA was lacking, indicating the lack of a required drivers process. Leadership may want to consider implementing recognition processes, such as quarterly breakfasts for the preceptors and increasing their support with weekly review meetings to monitor and adjust. Perhaps a preceptor council could be put in place as a forum to discuss best practices and barriers encountered in the PGCOP.

Level 3: Revise the preceptor responsibilities and expectations found in the Care File: Preceptor (11/08/2016) handbook into clearly defined performance expectations using a SMART goal approach.

Level 3: I recommend using learning contracts (Knowles, 1975; Knowles et al., 2015) for both preceptor and NGN training. A learning contract will provide a collaboratively designed learning plan that ensures consistent application of the critical behaviors identified in Level 3. The leadership team might consider the following suggestions:

- Add training about learning contracts to the PA curriculum. This training should include practicing developing learning contracts using case scenarios, perhaps.

- Re-purpose the existing Nursing Orientation Pathway currently in use for the PGCOP as a learning contract.
- Identify and put into place drivers that ensure timely monitoring and adjusting of the learning contract, such as weekly learning contract review meetings between the unit manager, preceptor, and NGN.

The University of Waterloo (https://uwaterloo.ca/centre-for-teaching-excellence/teaching-resources/teaching-tips/tips-students/self-directed-learning/self-directed-learning-four-step-process) provides many resources for the development and implementation of learning contracts.

Level 2: I recommend including adult learning activities into the PA that will demonstrate knowledge and skill acquisition, such as role-playing, case scenarios, round table discussions, and teach-back. Activities should increase the engagement of the learner and will help build confidence and commitment.

Level 2: Add *learning how-to-learn* information and strategies into the PA curriculum that the preceptors can apply in the PGCOP to help the NGNs become self-directed learners (Knowles, 1975). For example, perhaps require the preceptors to help the NGNs identify resources that will assist in self-directed learning as a critical behavior.

Level 1: I recommend the division of the PA into two sessions, each limited to four to six topics. I propose that section 1 covers the necessary information needed for the day-to-day management of the preceptee. Section 2 would cover more advanced topics. Perhaps leadership might also consider adding modules to the learning management

system quarterly to update the preceptors about the latest evidence-based practices. These modules could also provide continuing education units.

Sample Agenda for Preceptor Academy and the Preceptor-Guided Clinical Orientation Program.

The University of Waterloo breaks the APM-L down into four independent learning steps: (a) readiness to learn, (b) setting learning goals, (c) engaging in the learning process, and (d) evaluation of learning (https://uwaterloo.ca/centre-for-teaching-excellence/teaching-resources/teaching-tips/tips-students/self-directed-learning/self-directed-learning-four-step-process). Two options might be considered by nursing leadership; first, this format could guide the restructuring of the PA curriculum into basic and advanced training. Second, this format could also be the foundation for introducing a learning class geared towards helping the NGNs transition from being a student nurse to becoming a professional nurse. I recommend the preceptors, and their NGNs attend this sample agenda and work as teams in practicing the material.

A sample curriculum for both the PA and PGCOP might include these topics spread over two sessions:

- Readiness to Learn (administer a readiness to learn inventory)
- Giving and accepting constructive criticism
- Time management/organizational skills
- Introduction to nursing and healthcare resources available at the study site (policy and procedure, learning management system, online nursing resources, for example)

- Setting Learning Goals, including how to create SMART goals.
- Developing the learning contract. Here, I suggest using the Nursing Orientation Pathway as a guide. The preceptor and NGN can review the pathway, identify knowledge gaps, and develop a learning contract to address those gaps.
- Engaging in the Learning Process
- Learning styles (Might use the VARK inventory).
- The deep approach to studying and learning (https://uwaterloo.ca/centre-for-teaching-excellence/teaching-resources/teaching-tips/tips-students/self-directed-learning/self-directed-learning-four-step-process)
- Evaluating Learning
- Self-reflection
- Self-evaluation

Summary

This program evaluation report begins with a summary of the study from which the recommendations for program improvement emerged. One finding in the NGN and preceptor data suggested that the success of the PGCOP seemed to depend upon the preceptors' consistent application of the knowledge and skills acquired during PA. This lack of consistency could result from several factors, such as covering too many topics during the initial preceptor training, the lack of well-formulated goals for the PA, or the lack of an accountability package based on program drivers (Kirkpatrick & Kirkpatrick, 2016).

The recommendations listed in this program evaluation report primarily point to the need for the PA to be re-developed based on adult learning theory and with future program evaluation in mind. I chose the APM-L by Knowles et al. (2015) and the NWKM of program evaluation (Kirkpatrick & Kirkpatrick, 2016) as the conceptual framework for this study. However, any adult learning theory and program evaluation tool can suffice and build a foundation for continuous program evaluation and improvement.

References

Arghode, V., Brieger, E. W., McLean, G. N. (2017). Adult learning theories: Implications for online instruction. European Journal of Training and Development, 41(7), 593–609. https://doi.org/10.1108/EJTD-02-2017-0014

Benner, P. (2001). *From novice to expert: Excellence and power in clinical nursing practice* (Commemorative Edition). Upper Saddle River, NJ: Prentice Hall Health.

Blegen, M. A., Spector, N., Ulrich, B. T., Lynn, M. R., Barnsteiner, J., & Silvestre, J. (2015). Preceptor support in hospital transition to practice programs. *The Journal of Nursing Administration, 45*(12), 642–649. https://doi.org/10.1097/NNA.0000000000000278

Chyung, S. Y. (2015). Foundational concepts for conducting program evaluations. *Performance Improvement Quarterly, 27*(4), 77-96. https://doi.org/10.1002/piq.21181

Conaway, W., & Zorn-Arnold, B. (2015). The keys to online learning for adults: The six principles of andragogy. *Distance Learning; Greenwich, 12*(4), 37–42. Retrieved from https://www.researchgate.net/publication/299540188_ The_Keys_to_Online_Learning_for_Adults_The_Six_Principles_of_Andragogy

Cotter, E., & Dienemann, J. (2016). Professional development of preceptors improves nurse outcomes. *Journal for Nurses in Professional Development, 32*(4), 192–197. https://doi.org/10.1097/NND.0000000000000266

Curan, M. K. (2014). Examination of the teaching styles of nursing professional

development specialists, part I: Best practices in adult learning theory, curriculum development, and knowledge transfer. *The Journal of Continuing Education in Nursing*, *45*(5), 233–240. https://doi.org/10.3928/00220124-20140417-04

Irwin, C., Bliss, J., & Poole, K. (2018). Does preceptorship improve confidence and competence in newly qualified nurses: A systematic literature review. *Nurse Education Today, 60,* 35–46. https://doi.org/10.1016/j.nedt.2017.09.011

Key, B. A., & Wright, V. H. (2017). Cognitive apprenticeship during preceptorship. *Journal for nurses in professional development, 33*(6), 301–306. https://doi.org/10.1097/NND.0000000000000394

Kirkpatrick, D. L. (1975). *Evaluating training programs*. Madison, WI: American Society for Training and Development.

Kirkpatrick, J. D. & Kirkpatrick, W. K. (2016). *Kirkpatrick's four levels of training evaluation*. Alexandria, VA: ATD Press.

Knowles, M. S., Holton III, E. F., & Swanson, R. A. (2015). *The adult learner: The definitive classic in adult education and human resource development* (8th ed.). New York, NY: Routledge.

Lindfors, K. & Junttila, K. (2014). The effectiveness of orientation programs on professional competence and organizational commitment of newly graduated nurses in specialized healthcare: A systematic review protocol. *JBI Database of Systematic Reviews and Implementation Reports*, *12*(5), 2–14. https://doi.org/10.11124/jbisrir-2014-1532

Missen, K., McKenna, L., & Beauchamp, A. (2014). Satisfaction or newly graduated nurses enrolled in transition-to-practice programs in their first year of employment: A systematic review. *Journal of Advanced Nursing, 70*(11), 2419–2433. https://doi.org/10.1111/jan.12464

Murphy, L. J. & Janisse, L. (2017). Optimizing transition to practice through orientation: A quality improvement initiative. *Clinical Simulation in Nursing, 13*(11), 583–590. https://doi.org/10.1016/j.ecns.2017.07.007

Pasila, K., Elo, S., & Kaariainen, M. (2017). Newly graduated nurses' orientation experience: A systematic review of qualitative studies. *International Journal of Nursing Studies, 71*(June), 17–27. https://doi.org/10.1016/j.ijnurstu.2017.02.021

Paull, M., Whitsed, C., & Girardi, A. (2016). Applying the Kirkpatrick model: Evaluating an interaction for learning framework curriculum intervention. *Issues in Educational Research, 26*(30), 490–507. Retrieved from www.iier.org

Phillips, C., Kenny, A., Estermann, A., & Smith, C. (2014). A secondary data analysis examining the needs of graduate nurses in their transition to a new role. Nurse Education in Practice, 14, 106–111. https://doi.org/10.1016/j.nepr.2013.07.007

Reio, Jr, T. G., Rocco, T. S., Smith, D. H., & Chang E. (2017). A critique of Kirkpatrick's evaluation model. *New Horizons in Adult Education & Human Resource Development, 29*(2), 35–53. https://doi.org/ 10.1002/nha3.20178

Shepard, L. H. (2014). Student perceptions of preceptorship learning outcomes in BSN programs. *Journal of Nursing Education and practice, (4)*5, 73–84. https://doi.org/10.5430/jnep.v4n5p73

Silvestre, J. H., Ulrich, B. T., Johnson, T., Spector, N., & Blegen, M. A. (2017). A multisite study on a new graduate registered nurse transition to practice program: Return on investment. *Nursing Economics$, 35*(3), 110–118. Retrieved from www.nursingeconomics.net

Spector, N., Blegen, M. A., Silvestre, J., Barnsteiner, J., Lynn, M. R., Ulrich, B., Fogg, L., & Alexander, M. (2015). Transition to practice in hospital settings. *Journal of Nursing Regulation*, 5(4), 24–38. https://doi.org/10.1016/S2155-8256(15)30031-4

Strauss, E., Ovnat, C., Gonen, A., Lev-Ari, L., & Mizahi, A. (2016). Do orientation programs help new graduates? *Nurse Education Today, 36,* 422–426. https://doi.org/10.1016/j.nedt.2015.09.002

Warren, J. I., Perkins, S., & Greene, M. A. (2018). Advancing new nurse graduate education through implementation of statewide, standardized nurse residency programs. *Journal of Nursing Regulation, 8*(4), 14–21. https://doi.org/10.1016/S2155-8256(17)30177-1

Appendix B: Interview Question Grid

INTERVIEW QUESTIONS FOR NGNS

	REACTION	LEARNING	BEHAVIOR	RESULTS
LEARNER PREPARATION	3			See grid below
CLIMATE PREPARATION	4; 5			
BULLYING	4; 5			
COLLABORATIVE PLANNING		6; 7		
LEARNING CONTRACTS				
ASSESSING LEARNING NEEDS		6; 11		
COMPETENCY		13		
DEVELOPING OBJECTIVES				
LEARNING PLANS		13		
CONDUCTING THE PLANNED LEARNING EXPERIENCE		8	8; 14	
EVALUATING LEARNING OUTCOMES		9; 10; 12; 13	9; 10; 14	
REASSESSING LEARNING NEEDS		9	9	
	OUTCOMES SUGGESTING SUCCESSFUL TRANSITION			
INCREASED SATISFACTION				✓
EMPLOYEE ENGAGEMENT				✓
INCREASED SELF-CONFIDENCE				✓
ORGANIZATIONAL COMMITMENT				✓
TEAMWORK				✓
ROLE SOCIALIZATION				✓
INCREASED COMPETENCE				✓
ADJUSTING TO NEW ROLE				✓
ADEQUATE SUPPORT				✓
SENSE OF BELONGING				✓
INTENT TO STAY				✓

Appendix C: NGN Semistructured Interview Tool

NGN INTERVIEW QUESTIONS

Demographic Data

DATE:

INTERVIEWEE #

1. Did you graduate from an associate degree or bachelor's degree nursing program?
2. What unit will you be working on when clinical orientation is completed?
3. On what date did you take your NCLEX exams?
4. When did you graduate your nursing program?

COMMENTS

NGN interview questions focusing on the APM-L and NWKM.

1. What did you expect to get from your clinical orientation experience? (Probe: How did the actual experience differ from what you expected?)
2. Clinical experiences in nursing school cannot expose you to everything. Eventually you will recognize gaps in your knowledge and experience. It is expected. Was there a time during clinical orientation when you recognized a gap in your experience or knowledge? (Probe: What steps did you take to find the information you needed? Did you have difficulty finding the resources you needed or were they readily available? Did you ever feel frustrated because you could not find the answers that you needed?)
3. How would you describe the transition from being a nursing student to becoming a practicing nurse? (Probe: Has the process been difficult? When you left nursing school what did you lose in the process? For example, friends. Have those losses been replaced here? If not yet, do you think they could be?)

4. During clinical orientation, how comfortable and welcome did you feel on the unit?
   A. How would you assess the atmosphere on the unit?
   B. Who did the most to help you feel comfortable on the unit?
5. At the end of your general classroom orientation you took some exams that tested basic nursing knowledge. Describe how the results of those exams were used in planning your clinical orientation learning experiences?
6. Describe a time that you and your preceptor worked together to develop goals for your orientation. (Probe: examples of collaborative planning, whether the NGN felt a part of the process, if goal planning was not done, how did that feel?).
7. When providing patient care, did your preceptor allow you to figure out how to complete the work before you attempted it or step in and do it for you? (Probes: if the preceptor stepped in and did the work, how did that make you feel? Did you make suggestions about approaches to patient care? Were those suggestions considered?)
8. How would you describe the feedback that you were given about your performance? (Probe: Who provided the most feedback? Was the feedback constructive? How often was feedback given? Did feedback occur during the course of the day or was it provided during an end of the day meeting?)
9. Provide some examples of how you were encouraged, or rewarded for your work by others? (Probe: who provided the encouragement or positively commented on your work? Progress?)

General Questions

10. Was your preceptor available to you when you needed their advice or direction (yes/no question)?
    A. If not, what happened that prevented your preceptor from working with you?
11. It would have been helpful for me if my preceptor knew more about_____(what?)
12. How satisfied are you with your clinical orientation experience (reaction)?
    A. If unsatisfied, what would have made the experience better?
    B. What did you find was most helpful?
13. Can you provide some examples of how your clinical orientation experience increased your confidence?....competence (learning)? What else about you changed as a result of the orientation program?
14. Describe the support your received during clinical orientation.
15. What did you achieve during clinical orientation that made you feel proud (reaction, engagement)?
16. Once clinical orientation was completed did you feel that you knew what was expected of you as a nurse in this organization?
17. Now that orientation is over, do you think that this a place where you would continue to work? (Probe: If not, why not?)
18. Do you think the PGCOP was effective in preparing you to work at this hospital?
19. What would effective look like to you?

Appendix D: Preceptor Semistructured Interview Tool

PRECEPTOR INTERVIEW QUESTIONS

Demographic Data

1. How long have you worked at SMEH?
2. What it your home unit?
3. How many nurses have you precepted?
4. Did you attend preceptor academy?
5. Have you completed any addition preceptor training classes?

Date _____

Interviewee # _____

Preceptor interview questions focusing on the APM-L and NWKM.

1. What steps do you take to make sure that your preceptee is socialized to the unit (Probe: Out of curiosity, how do the staff generally react to a new employee? Did your preceptee ever express any concerns about the unit?)
2. How did you plan the day's activities with your preceptee? (Probe: Describe how you and your preceptee began and ended the shift on a usual day.)
3. Were you and your preceptee able to set goals for the day? (Probe: Was your preceptee able to attain the goals that were set for the day? If not, what do you think prevented your preceptee from being successful?)
4. Do you enjoy being a preceptor?

COMMENTS

PRECEPTOR INTERVIEW QUESTIONS

5. How did you and your preceptee know that orientation goals had been met? (Probe: Did you and your preceptee meet frequently to discuss what had been learned that day? Describe a typical feedback meeting with your preceptee.)

6. Do you believe that the training provided by the hospital adequately prepared you to be a preceptor? (Probes: If not, then what information or activities do you think might have helped you better prepare?

7. Do you think the PGCOP is effective in preparing the NGN to work at this hospital? (Probe: If not, then what can be done differently to help prepare the NGN?

8. Are learning contracts used as part of the PGCOP? (Using this question to determine if some method was used to include the NGN as a contributor/partner in the learning process. Could also indicate engagement.)

9. Do you supplement with their own teaching materials that are not part of the traditional PGCOP program?

Appendix E: Sample NGN Interview Transcript

NGN1

Me: Okay. Well, just so you know, this is confidential anything you say will not be held against you. I have a review board looking at this, so there should be no way to identify anybody. It's a qualitative study. So, I may have to use, I may use a quote now and then but then again, there won't be any units mentioned, there will be no identifying stuff. So, and then of course what I hear in here, I will, this is school, not work. So, whatever I hear here, I won't be saying out there. Okay, just between you me and the recorder.

Me: So, are you an ADN or BSN?

NGN1: BSN

Me: And you're working in ICU?

NGN1: Uh huh

Me: And did you take your NCLEX right after you finished school, or did you wait a while or

NGN1: I gave myself a month, studying and all that jazz.

Me: And when did you graduate your nursing program?

NGN1: December 14th

Me: Of last year?

NGN1: Yeah.

ME: So, before you started clinical, of course you had kind of been working here already, but before you started clinical orientation as a nurse, what did you expect, what did you expect it would be like?

NGN1: Oh gosh, I didn't like, I don't know what I expected, but I didn't expect, I didn't know that they did so much, cuz like you know, you see people doing stuff, but you don't like know what goes into it until you actually have to do it.

Me: So, you mean a nurse, you didn't know a nurse had. Okay...

NGN1: Like all the, I don't know, just a lot of...a lot more that goes into it than what you see on the outside.

Me: Okay, so it was different than what you were expecting.

NGN1: Yeah.

Me: Yeah, and do you feel like school prepared you for that?

NGN1: Not really, my Capstone, like the last semester probably prepared me the most for anything, but before that, you know, I didn't know how to like even prime tubing, like the little stuff.

Me: That's interesting that you said that because I had somebody else tell me that too, and simple stuff, like just take the cap off so it'll go.

NGN1: Little stuff, like I would, I didn't know. Like they don't tell you that.

Me: Yeah, and it's good for us to know because we don't think to tell you that kind of stuff, because it's so ingrained into our day that it's so automatic that we just don't think about those little steps that you need to do. That is a problem. That makes sense.

NGN1: Yeah. They gave us a lot of like education, but not like the simple stuff that we need. Like that we're going to be doing every day.

Me: Yeah. I had one person tell me that they didn't even know how to turn on a Dynamapp (blood pressure machine). So yeah, so that's something that we need to be aware of here too. So, like we were just talking about, they can't expose you to everything in school, so you probably recognize that you had gaps in your knowledge.

NGN1: Yeah.

Me: So, what did you do when you recognize, when you (had gaps in your knowledge) ..., how did you deal with it?

NGN1: Umm, well that one, I kind of, like the basic stuff I was thankful I learned during like, like Capstone* that really helped me when I came here, but I know some people will come, as a new nurse, and not know how to do any of that. Even, I guess some people don't have the Capstone that like my school did but like other gaps. It's just depends. I mean, I've been meaning to you know, like go home and I'm like, okay need to study the cases, like the patients that I do get, but right now I'm still at a point where I'd go home and have to decompress, and I can't think about work. But I do want to, I've been meaning to sit down with some of my books. I still have to read up on stuff we get here frequently so that I understand it a little more in-depth, instead of just taking care of it. You know?

Me: So, you know where to go find the information that you need?

NGN1: Yeah, I really want to, but it's just like, when I leave here right now I'm like. I'm getting to the point where I feel more comfortable where I can go home and actually like take in more information. But at first, I was like there's no way I can go home and like actually think about work still (laughs)

Me: It really does take a year before you even start feeling somewhat comfortable with anything that you're doing. Any time that you change jobs you'll see that it's going to take a year to get comfortable with it. So, I mean this is a little bit harder cause you are going from school straight into being a professional, Well, you have responsibilities now.

Do you ever get frustrated though? I mean, so if you're at work and you find that there's something you don't know and you're trying to find an answer. Do you know where at work to find the answer?

NGN1: I wouldn't say so. I mean, I know people I can ask, like that I trust to ask. There'll be times when I'm going to look up a policy and I know to check that policystat but sometimes it's like 10 pages (the policy). So, I'm like, I don't have time to read this, like, and I want to know it, but I don't have time to read it, so I just ask somebody. And so, like I want to know the full policy, but it's 10 pages long, so and you know, like you will ask people, and everyone has a little bit of a different answer. So…

Me: Yeah.

NGN1: And then the Manager has all these binders put together, I'm like, I don't have time to look at a binder. They are huge. And, I'm like, I don't even know what binder to look at or if, you know. And I have all those things that the Educator gave me too. But that's another thing. Like I don't have time to ever actually...like, I know it's in there, and I can go look for it. But it's just easier to just ask somebody.

Me: So, I'm getting a feeling that with everything that has been given to you that you're just kind of feeling overwhelmed with all of it.

NGN1: Yeah, like each day gets better, but the very, like, first, gosh, probably like 3 or 4 months. I just felt like way over my head, and it's a lot better now that there were times I was like, oh my gosh, why did I pick this career, like this is too much

Me: Yeah, well I've been doing for 40 years. You'll be okay.

MGM2: Yeah, no, but it really has gotten a lot better.

NGN1: Okay. So, when you were in school, you know, you were familiar with the people there. You had your classes you went to, you had your instructors, you had that

institution, and then you came here, out of that school. Did you think it was, so how is that transition for you, from going from something you knew to something you did not know it all?

NGN1: I guess I mean, I kind of knew it, yeah, but like I said, school, they kind of know like what you haven't learned yet as to where when you come here and with your preceptor they don't know what you don't know, you know, cuz like in school you take certain semesters and you're doing that stuff that semester, but here ,like, until your preceptor gets to know you, they don't know like, what you don't know or what you know, where your weaknesses are. So that was kind of tough for me, except to be why I don't even know what you're talking about.

Me: Okay, so when you left school, when you graduated, what did you leave behind? What do you think you lost?

NGN1: Nothing (under her breath) sup...my frien...like, you know my friends there. Like that support (intertwined in my next statement)

Me: And I think you were getting ready to say support.

NGN1: Yeah, but I found support now. But at first, it's scary cuz, like since I worked here, I kind of knew you know, like what people I could like lean on and stuff, but it was definitely scary because I went from being a PCA to a nurse. So, I was like I don't know if these people are going to accept me or think I'm stupid if I ask questions.

Me: Oh, I've been in the health care since 1974 and I still ask lots of questions, so it's okay.

NGN1: Like, are they going to think I am annoying, cuz, I'm always like asking questions

Me: But if you don't ask enough questions then they well think, well, she thinks she is better than us.

NGN1: Yeah, so it's like

Me: But yeah, you know, you're stuck. But it's better to ask.

NGN1: Yeah, at school, my friends, like, we all, like there was nobody that was stupid, we were all, like you know, we were all the same.

Me: There was nobody that was stupid there. Yes, but I understand what you are saying.

NGN1: Yeah, it took me a while, it was like, I'm literally the least, I don't want to say least educated, but least experienced, so like, it took me a while to get that in my head. Like I don't have to know everything, like nobody does, but these people have been, some of these people been doing it for 20 years. (unintelligible remark)

Me: So, but you know too there's new technology coming out all the time. So even the people that have been doing for 20 years still have to learn.

NGN1: Yeah

Me: So yeah, you will be fine. So, did you feel comfortable well, you already worked up there, so did you feel comfortable with everybody up there, or did this change in role make you...I think you were a little bit anxious about whether they would accept you or not.

NGN1: Yeah, cuz there were a couple of people, mainly like older nurses who, you know what they say? They eat their young like nobody should ever come straight to critical care or like, you know, that's so dangerous and...

Me: They were saying this to you?

NGN1: Yep, like people I worked with, but um, it was only a couple of people, but it definitely made me like, and people still say it. It's not really, it's more so like the flex people (nurses who float from unit to the next when needed) who are like, we hate going to the acute care units because of so many new grads, and like if something goes wrong. They will even say it now like, it's not like that anymore, our staff are more accepting, they've grown to know me, but some of the flex people still say it. Just like in acute care there are so many new people, if something goes wrong they are not going to know what to do. So..

ME: And the flex people are saying that right now? So, how does that make you feel?

NGN1: I feel like I'm never going to ask them a question. I'm like well, like, I can't trust you cuz you don't like what I'm like, what you don't like, not that they don't like me, but they, just you know,

ME; They don't see any value in you and...

NGN1: Yeah, so I'm like well and that's how it makes me feel, like I'm not going to go to them for anything, cuz they're going to just think I'm stupid or you know.

Me: That's good thing to yeah, that's good to know. I mean, yeah, something we need to work on.

NGN1: And I do understand where they are coming from, because I don't like to be, just me, and new people. Like I want people there that have experience, but at the same time most of them started out there too, so. I'm like you were in the same position, you know, what 5 or 6 years ago, so it's not all of them, but definitely.

Me: I know, but that's rough.

NGN1: Yeah,

Me: Like everything else, that'll pass.

NGN1: Yeah.

Me: It'll be okay. So, was there anybody in particular that was most helpful to you up there?

NGN1: Um, probably, well, Preceptor 1 was my preceptor on days. So, he of course and then Preceptor 2 on nights and co-worker always, just because co-worker is, I don't know, I just trust co-worker.(NGN1 went to school with co-worker)

ME: Okay, so you've got a group.

NGN1: Oh yeah.

Me: Okay, when you went through orientation here, on that last day they made you take some exam, that proficiency exam.

NGN1: (under her breath) I don't remember that, I took it before anyway before. I don't know if I took it again though.

Me: Anyway, did anybody? Okay, so if you did take it before

NGN1: Like the EKG stuff and then the...

Me: Yeah, there was one on rhythms, and then...

MGN2: Yeah, I took it, I didn't take that again though. I've only taken that once.

Me: And the other one? (jumbled conversation) so did they use that for your orientation? To help tailor your orientation. Do you know? Did you ever see it?

NGN1: Not that I know of. No.

Me: That's good, that's what we need to know. So, did you and your precept...., was there a time that you and your preceptor ever sat down and just set out some goals for the day for you or...?

NGN1: Yeah, Preceptor 2 was really good, like in general, like just telling me like what I needed to improve on and when I went from P1 to P2, P1 kind of like updated P2 on...You know, what I needed to improve on what I was doing okay with and P2 wasn't like afraid to tell me, P2 would just kind of tell me in the moment, you know,

Me: So, as you were doing it. It wasn't like till later; it was like a now thing (jumbled words)

NGN1: So, we didn't actually like sit down and talk about it, but it would be like in the moment. He would.

ME: Okay, you really, I mean, I know it is kind of hard to plan out your days because you never know about admissions and discharges and stuff. So, there really wasn't a today we're going to work on or look at this, it was just kind of as it happened.

NGN1: And I know he had hoped, like we will get, like towards the end of my orientation, like a patient that did like code or something, which we never did. But that was his one thing, like he wasn't really comfortable with, like NGN1 has never gotten this type of patient. So, when NGN1 does get one, NGN1 is not going to know what to do, but you can't plan to have that stuff.

ME: No, no you can't. You can't go to the floor and ask a patient; will you arrest for me so I can take care of you later? Okay, so, when you were working with your preceptor, did, and you came across something that you were not quite sure about, did they help you work it out, or let you work it out yourself, or did they just kind of step in and do it for you?

NGN1: He would let me do it. And if he saw I needed help or if like, I asked, he would help. Like this was more towards like, kind of middle

Me: So, they wouldn't just jump in and shove you out of the way and say, I'm going to do this.

NGN1: No.

Interviewer: Okay, that's good. So, you mentioned a little bit about feedback that you had gotten, it sounded like it was in the moment feedback. Did you regularly get, like at the end of the day, kind of like a recap of what happened today? Or was it just that you went....

HGN2: So, usually just as we went. By the time 7 a.m. came around, you know, I'd get like, "You did good today", but never like an actual like, what, like in specific,

Interviewer: So, who gave you the most feedback, your preceptors?

NGN1: Yeah

Interviewer: Was it like constructive feedback?

NGN1: Uh-huh

Me: Inaudible.

NGN1: Oh, no

Interviewer: Okay, that's good. So, did your preceptors encourage you? Did your co-workers encourage you?

NGN1: Yeah, I think they got better, like, you know, like the longer I was there.

Interviewer: So apparently it was your preceptor that provided you the most encouragement and feedback for everything.

NGN1: Yeah. And that's still who, like, I feel most comfortable with, so, just because like, we are together, well, me and P2, like 3 months.

Interviewer: Okay, so you pretty much had the same people.

NGN1: Yeah. Which was a blessing.

Interviewer: You had someone on day shift and when you went to nights you had the same person all the time. So that's good. It sounds like you worked well with them or they worked well with you.

NGN1: Yeah

Interviewer: So, was your preceptor, well, it's acute care, so things are a little bit different. So, was your preceptor pretty much always available to you when you had questions and stuff?

NGN1: Yeah

Me: Um, just out of curiosity. What's the patient load up there?

NGN1: Two

Interviewer: 2 to 1?

NGN1: Uh-huh. Or 1 to 1 depending on...

Me: So even when you were with your preceptor, you might have had two patients.

NGN1: Yeah

Interviewer: Okay, yeah, I figured. On the floor it's a little bit different.

NGN1: Yeah

Interviewer: Okay, so I have a fill-in-the-blank for you. It would have been helpful for me if my preceptor knew more about. What?

NGN1: Oh gosh. I don't know.

Interviewer: I had one person say, "my learning style".

NGN1: I don't know, I felt like P2 and, I don't know, I wouldn't say....

Interviewer: You all meshed pretty well?

NGN1: Yeah, honestly there isn't anything like that, that sticks out for me.

Interviewer: Okay, that's good, so as far as your orientation in acute care with your preceptors, how satisfied are you with that experience?

NGN1: I would say very satisfied. Cause it could have, I know like, a couple of the people on days, they flopped around preceptors and that would have, no, that would have changed my opinion on it. That makes it really difficult.

Me: I had someone tell that they started out with one preceptor, and a few weeks in they switched to another one and that was like starting all over again.

NGN1: Yeah, well, it's hard, cause they learn, you know, how, like what your learning style is and what you know and then when they switch, they don't know.

Me: And then plus you get a new person in there. They may do something different.

NGN1: Yeah, and it's hard, it was even hard going from P1 to P2 because they still do stuff different. So, it was like, well, you know, which one, which one am I going to do? Well, I don't want to make this person mad because I am going to do it different, but....

Me: Well, and as you learn more and as you read, and like you said, you get to where you don't have to decompress so much. You can look stuff up, you'll develop your own way of doing it, but it will be within the policies and procedures of the hospital. So...

NGN1: Yeah, cause neither of them are wrong. But, it's like...they're different.

Me: So, do you think that your clinical orientation, spending time with your preceptor has increased your confidence?

NGN1: Yeah, I think so. Just because, probably like the last month I was kind of doing stuff on my own, but they were like my little fall back. Like I always have my buddy, like I was able to do stuff, but I had him for, for you know, if I needed him, and that is still how I kind of feel.

Me: Yeah, so he's maybe it's kind rolling to mentor role?

NGN1: Yeah,

Me: Oh, that's good. Um, so what about competence? Do you feel more competent than you did?

NGN1: Yeah, didn't think I would.

Me: You didn't think so?

NGN1: Starting out, I was like, I'm not cut out to do this.

Me: You're finding out differently.

NGN1: Yeah

Me: You'll be fine. Okay. so, you became more confident? You got more competence. Anything else about you changed, you think? ...as a result of orientation?

NGN1: I think the confidence is the main thing and that's still you know, every shift gets better. But definitely when I first came out of my orientation, that was like, there's no I want to be able to do this like without like my buddy, but then I learned, you know, everyone's there to help and no one is going to like, shoo you away.

Me: That's good. And yeah, other feedback that I have gotten is that every day gets a little bit better.

NGN1: Yeah, it really does.

Me: So, you already told me about the support you got during orientation. What's something that you achieved during orientation to make you feel really proud of yourself?

NGN1: I guess just everything. Cause I came in you know, and I was like, like I wasn't, I couldn't have taken care of like even a basic patient. So, I feel like I just, I don't know, expanded my knowledge a lot because like, you come out of school and you're like, yeah, I do know a lot, but I don't know anything in the hospital setting...so

Me: You have a lot of theory but no practice.

NGN1: Yeah. So, I feel like I learned, I don't know, just how to be a nurse really.

Me: Okay, that's a big achievement.

NGN1: Yeah You know, like even though I did, I did have my capstone, but it was different you know, cause we could only do so much...different floor, different hospital.

Me: Was your capstone like a 120-hour thing?

NGN1: But mine was at a long term rehab facility. So, it's a whole total, like a different thing. It was a different hospital, different goals. So, I mean I learned a lot of basic stuff, but I didn't learn like the stuff I am doing.

Me: But that's good that you saw something different.

NGN1: Yeah, I learned how to do tubing over there, that, and my assessment. (Sidebar conversation).

Me: So how long have you been out of orientation now?

NGN1: 3 months almost.

Me: So, do you feel that you know what is expected of you now in this organization?

NGN1: Yeah

Me: So now that you're out of orientation, do you think this is a place you're going to stay for a while?

NGN1: I might have to stay two years, at least. I think after that I might I don't know. I hear people say this all the time like you're young and like you want to see more like, you know, I just want to say, I thought about at some point getting just like a PRN job at somewhere just because like we are kind of behind on technology here. So, it will be nice to see, and we know we ship off half our patients we can't do certain things. So just want to see more, but then at the same time that's a lot more learning to right now.

Me: Yeah, you've got to get good at what you are doing right now. 2 years is well, okay. So, if you look at Patricia Benner's novice to expert, which the CNO says is the theory we are using here, it takes about three years to really be a competent nurse. I guess at that point in time, and then when you go to something new that you go back to being sort of a novice or beginner.....

ME: So, do you think that your orientation with your preceptor prepared you to work at this Hospital?

NGN1: Yeah

Me: Okay, so we are done with those questions.

Appendix F: NGN Data Codebook Categories and Subcategory Example

Table F1

NGN Codes with Frequencies

1 Transfer of learning	14
2 Program effect	
2.1 NGN learning needs assessment	7
2.2 NGN satisfaction	6
2.2.1 Intent to stay	5
2.2.2 Effective	6
2.3 NGN use of resources	36
2.3.1 Self-directed	10
2.3.2 Inconsistent resources	13
2.3.3 Addressing gaps in your knowledge	8
2.3.4 I feel like a bother	6
2.4 NGN confidence	30
2.4.1 Competence	6
3 Preceptor Effects	
3.1 Complaints	
3.1.1 Preceptor doesn't know me.	3
3.1.2 Dissatisfaction with preceptor	6
3.2 feedback	10
3.2.1 Formative feedback	7
3.2.2 Rewarded behavior	7
3.3 Goals	8
3.4 Relationship with preceptor	9
3.5 Preceptor guidance	12
3.5.1 available	8
4 Transition Issues	
4.1 confusing.	4
4.2 Barrier to self-direction/learning	4
4.2.1 devalued	1
4.2.2 advancing too quickly	7
4.2.3 Anxiety	4
4.3 Exacerbation of transition issues	14
4.3.1 stupid	2
4.3.2 Feeling an inequity	1
4.3.3 overwhelmed	15
4.3.4 Feeling unprepared	4
4.3.4.1 Not prepared	6
4.3.5 expectations	15
4.3.6 They eat their young	2
4.3.7 dissuade	7
4.3.8 comfortable	14
5 Unit	1
5.1 ICU	5
5.2 5B/C	1
9.1 BSN	3
9.2 ADN	4

Appendix G: Preceptor Interview

Me: Hello, you know this is like all confidential your name won't be anywhere. Nobody will know anything there will be relation (?) but I write up the write up it'll all be in generalities. So, nobody should be able to tell who's or who said what if I do use some quotes which I might?

P1: Okay?

Me: So how long have you been here, at this facility?

P1: I came in 19? I want to say 1999 but I signed on staff in 2001.

Me: Okay, and what's your home unit right now?

P1: [redacted]

Me: [redacted], and how many nurses do you think you have precepted? Kind of ballpark...

P1: How many have I precepted? Oh...

Me: More than 10?

P1: Yes

Me: More than 20?

P1: Maybe around 20.

Me: Okay. That's a lot, did you go through the training, the preceptor Academy?

P1: Yes, several times. Because you have to retake it every now and then or something, I don't know where

Me: Well, I think they update the stuff.

P1: Yeah if it pops up, I'll come back.

Me: Have you done any additional preceptor training other than what they offer here?

P1: No

Me: Okay, that's the demographics now for the big questions. So, what do you do to make sure, what steps do you take to make sure that your preceptee is enculturated or socialized to the unit?

P1: Like orientated to the unit?

Me: Socialized

P1: With the staff?

Me: Uh-huh

P1: Let them know who's good at what. You know, some people are better at IVs than others, some people are better at helping out if you're drowning, that sort of thing. Getting used to the staff. Just being there in general you kind of get the feel of who can help you out and who's better to go to with questions and stuff.

Me: Okay, so you help them network.

P1: Yeah, yeah, help them network. Help them figure out where stuff is.

Me: So, in general, how do, um, your preceptees, um, react...How do employees on the floor usually react to new employees?

P1: It's mixed bag. Sometimes they like them, cuz we're getting new staff. But then other times they don't like them because, for like that first 6 months that means that they (note: meaning the established employees) can get pulled (note: to another unit) before if we have too much staff. That's something we got going on right now as we have two new staff members, actually three new staff members that can't get pulled unless they pick up extra, but that generally means that they're, the regular staff is going to get pulled.

Me: I hadn't thought about that. That is kind of thing isn't it?

P1: Yeah, it is.

Me: Hum, so, if the staff aren't too happy with them or that or do, they, does the new employee know, does the new person know that, I mean...

P1: I think that they get the sense of it.

Me: Have you ever had a preceptee express any concerns about that kind of thing?

P1: Not that I can recall. Cuz I think we kind of cut it off at the pass by talking about it ahead of time.

Me: Okay, with the staff or with the employee?

P1: With the, with the new staff.

Me: With a new person. You kind of let them know, okay, this might happen. Yeah Okay, that's good. That's a good idea. So, do you plan your daily activities with your preceptee? Or, do you just like, here's our assignment, let's go.

P1: Ahh, it depends on what week it is. (Note: the orientation pathway is broken down by week into broad categories of goals) I usually go by week and the comfort level of the preceptee. I've had preceptees that are, were already CNAs. So, they were really comfortable with the computer system. They just needed to get the RN aspect of it. So that went a lot smoother and sometimes they started off with a full team from week one, just because they knew, they knew the basics of everything else. The new the layout of the unit. They knew the computer system. They just needed to go over like medications and procedures and things like that and that that takes time as well.

Me: So, you actually follow, there is a plan. Orientation plan, you actually follow it, it sounds like.

P1: Typically, with a brand-new nurse I, I, week one, for at least the first day or two. You're following me.

Me: Okay, Yeah. So, we're going to just go to talk about the new nurses the brand-new straight out of school nurses. We'll kind of narrow that down. So, let me ask you this because this came up when I was interviewing a new nurse. When you have a preceptee, do you have a full team during that time and they're (note: the NGN) taking like one patient, then two, then then three or what? How does that work?

P1: We have one team, two people, one team. So, I mean if I don't like on our floor, we have six patients, so we would have those six patients. When they start taking patients, they take one of those six patients or two of those six patients then I take the rest.

Me: Okay, so you're probably busy with those other five and so maybe not always available to that preceptee.

P1: No, no, no, no, no. No, I, I, we split it up, but we work together still.

Me: Oh, okay

P1: You will be responsible for those two patients or whatever, we'll say two patients. You are responsible for those two patients charting and meds and everything. But generally, I have them help me with everything else. We do the meds together when

everybody else, we go to every room together. They see me do my assessments. I watch them do their assessments.

Me: Oh, okay.

P1: Yeah, so and then when I start feeling comfortable with stuff like this, and they start feeling comfortable with the pumps and stuff. I might say hey, why don't you go fix the beep in this room even though it's mine, but, ah no, we go together for everything. I tell them, I said, I will not abandon you, I will not ever abandon, I'm not going to throw you to the Wolves, cuz I've seen some preceptors do that, saying go take your patients.

Me: I have a feeling this is going to be very interesting process.

P1: Yeah

Me: I've got [redacted] who probably does it right and then we'll see (inaudible)

P1: (Laughs)

Me: Okay, that's good, I mean you're giving me a lot of good foundation. So cuz I really didn't know.

P1: Yeah, yeah, we have an extern on our floor right now and I witnessed the nurse that she was with say, here go give report at shift change, and I'm like, what the hell? What, that should not even be happening.

Me: So, I know stuff happens, I've been there. So, do you set goals with them for the day or I mean so you, you say, it sounds like you go by the plan, the orientation plan. So, do you that, kind of like to set goals.

P1: It depends on what we're working on now, usually speeding up is a goal, but it's kinda hard to set goals when you have six patients and you don't know what the day is going to bring. I almost always have them do all admissions and discharges and things like that, but you can't say today we're going to do an NG tube cuz you don't know if that is going to happen.

Me: Oh yeah, I mean that's got to come up. So, it's kind of like, but you can kind of like, well, if this happens then we'll make sure you see it.

P1: Oh, yeah, yeah and I let everyone know. Hey, if you all have anything interesting going on, tubes need to be put in, or catheters, I said, let us do it. But it's kind of hard to set a goal except for speeding up, talking to the patients, making sure that they're communicating in an effective way. Getting a lot more done while you're in the room. I try to try to teach him, you know, witness your surroundings, clean up the room as you're

going to make sure you're doing all that stuff. But other than that, it's kind of hard to set goal per se,

Me: Okay. Yeah, I can see what you are saying. And I know, I know. Well, and your day is never really your own.

P1: Yeah

Me: But you try to do it

P1: Yeah, if they are having some kind of problem in particular. Yeah, that will be like an ongoing goal. We will fix this problem; we will need to work on that.

Me: Okay. Do you like being a preceptor?

P1: I do, my mother was a teacher and my stepfather was a teacher and they wanted me to be one and I guess I have a little bit of that in me.

Me: Yeah, but in a particular industry, not just teaching. So, how do you.... Okay, so eventually you got sit down evaluate this whole orientation process. So how do you know you and your preceptee know that the orientation goals have been met?

P1: Ah, constant communication, we talk, how do you feel? D,o you feel comfortable? Is there anything else that you'd like to work on, and I try to get that out at the very beginning that way you can kind of, you can set those goals. Okay. Well, they really like to they've done a ton of catheters and it's cool. But they want had never done in NG then you know that that might be a goal to try to do that. But just constant communication with them and see, are you feeling comfortable? What do you feel you need to work on? As you go along you can see, okay, well, they're handling, they're handling two patients, we're moving three patients. They're getting all their charting done. So, you know, they're feeling comfortable with the charting, they're doing it correctly cuz I'm constantly monitoring their, what they're putting in the computer system, and we'll talk about it. Okay, you did this in this in this, but you forgot to chart on this. So just communication,

Me: Okay, yeah, that's good. I mean, that's good. That's what, that's how you do it. So, did you all meet at the end of the day to say okay, here's what happened today? Any questions? What did you see new? That kind of stuff?

P1: No, it's throughout the shift cuz you don't have time to really meet and at the end of the shift everyone wants to leave. But a, lunch time, I try to spend lunchtime a little bit talking, if we can, and then also towards the end of the day while we are sitting waiting for next shift. We might talk about some stuff.

Me: Okay. So, you do it throughout the day.

P1: Yeah

Me: Okay. So, thinking back on, like I guess if you can, when you were first precepting people, and you went through the class? Do you think the class that's provided actually prepares you to be a preceptor here? (Looked like he might be struggling with answering this one). You can say no, now this won't, this is just between you and me.

P1: No, I don't think so. I think it has, it does to a point. But some of the biggest problems that I've seen out of other preceptors is that they want to, they feel like it's an opportunity to put all their work off on somebody.

Me: Oh, okay.

P1: Just like I said, you know, here go do report. I've actually heard and seen, not seen so much, but I heard a preceptor that was on day shift say okay. Here's your assignment ,1 through 7. Go take care of them. I'll be up here at the desk if you need me. I'm not lying. Now this is been a little while.

Me: Yeah, but it happens, and I know it does

P1: Yeah, and I just shake my, shake my head every time, it's like, oh my God.

Me: So then, what do you think in that class then, what would actually be beneficial to cover for, I mean I know the instructor goes, they go over a lot of stuff and its good information.

P1: Yeah, yeah,

Me: But as far as actually putting it to practice. What do you think would be really helpful?

P1: To add to it?

Me: Yeah, to add to or to change? Or is there anything or is just an attitude?

P1: I think, I think it's more of an attitude issue and I think that it's something that needs to be screened by the um, the managers on the floor. I think that, you know, maybe you put the word out and say hey we need some more preceptors. Do you have anybody on your floor you think would benefit from that and let them kind of make the decision cuz they kind of know who's good and who's not.

Me: Rather than just letting people say I'll do it?

P1: Yeah. Yeah.

Me: I think you're right and I have read in the literature where some, a lot of places do that. They have a screening process.

P1: Yeah.

Me: Yeah, that's a good idea.

P1: I have somebody that I think would be good. And then I didn't know, I didn't know that they weren't as good as I thought they were. And someone brought that to my attention. I'm like, oh, oh, okay. But yeah, I was ready to recommend somebody and now he's not ready.

Me: Yeah. I mean, it's you've gotta have, you've got to want to teach but you still don't want to push it off on somebody else.

P1: And you have to have all the aspects, you have to be able to be pretty good at the computer system as well as time management and being able to instruct people. I mean, there's people that are good at two of those and they can't teach a thing. They're good at what they do, but they can they can't pass it on.

Me: You know, just as an aside. Shirley has decided that we are going to follow Patricia Benner's novice to expert theory, nursing theory. Have you ever looked at that?

P1: I'm sure I've seen it at one point.

Me: It's a little bitty book and the paper is really short. But anyway, basically what she said, and it was from somebody else's study of looking at airline pilots, how they learn to be a pilot. There's five steps that go through from novice to expert well, the expert nurse has been doing it for so long that all their knowledge is like implicit. It's like they've seen it, they've done it, it's all embedded up in here, but they can't explain it.

P1: Not always.

Me: Yeah, they can walk into a room and look at somebody and say, "Oh yeah, it's going to be a bad day" and you've got your new nurse going, "How do you know that? Well? (overhead page) Yeah, so anyway. She says that your best people for precepting or like, not the novice because they're still really task-oriented trying to figure out what's going on. But your Advanced beginner, your competent nurse because they are still a little bit on task, but they've also seen enough that they kind of know what's going on. So, yeah, so if you have somebody that's really been at it a long time, it's really kind of hard for them to explain unless they're in that teaching mode all the time where they can go back.

So just that's just something interesting about what you just said. Kind of ties into that. So yeah, so I thought a question it's not in here. But while you're talking so they got those new unit educators out there. They should be supplementing, I would think, what you are doing as preceptors. Do you see any that happening?

P1: Well, I've seen her come to meetings and I've seen her actually round on the units, usually at the beginning of my shift since the end of her shift, but I've seen her come in sometimes in the mornings to catch some of the new people and talk to him.

Me: Oh, okay. So, some of that starting.

P1: Yeah, she's offered her services, but I haven't seen her do anything above and beyond right now other than just round and talk to people

Me: Okay, that is starting up, she is fairly new, I was just kind of wondering and then after you get out of preceptor class, and you get your first preceptee, is there a follow-up? I mean, does anybody, do you think it would be beneficial for? How do I put this? Okay, so right now it is the instructor doing that.

P1: Yes.

Me: So, do you think it would be beneficial for the instructor or somebody like that to come along and say so, how's it going? check in with you with your first preceptee?

P1: Yeah, I think it would be really beneficial

Me: Yeah? Okay

P1: For both, and you know, I know that you have these classes that the new hires go to and stuff and I've gotten feedback from people on my class

Me: Yes, and you are changing that up (Note: he teaches a computer documentation class)

P1: Some stuff we've been talking about for years actually. Yeah, it's, I would think it's very beneficial. That way we can adjust accordingly and see what works and what doesn't work.

Me: I would think I would think some follow-up just like with the new yeah, okay. I was kind of wondering about that. (Looking over the questions) I know learning contracts aren't used.

Me: Do you supplement, like with your preceptees, do you supplement them with any information other than what it's like in the orientation plan or...

P1: Before I started teaching this computer class. I was handing them that I was handling my little hand out that I had because what we do in the class is just a basic stuff for meditech and it doesn't tell you what you should chart on a daily basis and that's what my stuff, that I call meditech 2.0, did so that's what I that's what I handed to them and I even handed it to the CNAs that were coming in to help them out, because I thought it was very beneficial to people and I don't think that anybody was covering that.

Me: Yeah, you are probably right about that. I worked over at Our Lady of Peace in 2008. So, I use Meditech over there. And I know that once you get in the system and find out where everything is it's just like it comes automatically doing that, but it's finding all that stuff and getting through that DOS system. So when they finish orientation, so when the new nurses get done with orientation their last day like today, they're going to take a competency exam just kind of tell us where they are and their knowledge and where they need strength building and that kind of stuff and we really focus orientation. Do you or do you know if people are using those test results to kind of guide orientation?

P1: I don't know, that's above my paygrade. Nobody really shares that with me. As for the floor, I mean, I kind of communicate with the unit manager and say hey, I think he or she is doing a good job. I think they can come out early from orientation. We've done that a couple times. We've had some people that know they need a little bit more time. We had somebody one time that we had to switch preceptors several times, he was Vietnamese and I don't know if you just didn't get it, but he was frustrating a lot of people

Me: Was it like a communication issue, you think?

P1: I think his English was fine but, I don't know, maybe it was a cultural thing, but he was frustrating to people. I know, I had him for a short while and he was with somebody else and I think he actually went to somebody else as well. He did get out of orientation, but I mean, we had to go through some steps.

Me: Do they typically leave you with the same person? I mean, does the orientee just basically have one main person they are with during the time, or do they switch all that?

P1: They should

Me: I was kind of wondering about it because it sounded like the nurse that I interviewed had a couple different Orien... or preceptors.

P1: Yeah.

Me: And the problem for her was "I got used to doing it this one way and then I get this other person and then they want me to do it their way".

P1: Yeah. Yeah. Yeah, and I have a big problem with that too because as a preceptor you spend all your time trying to get them to do it this way and then you get switched up. That was a problem we had. We had three orientees at one time and no one set person and then somebody couldn't do a certain week, or they couldn't do a certain day. So they had to be with somebody else on the day that they picked up, On top of that, which is a big complaint of mine, all these extra classes they have to go to and meetings they have to go to and trying to fit in the EKG classes and everything else during their orientation. There's, I'll have, I'll have my orientee for a week. I may not see them for two weeks and then they come back to me for another week and then, my example, I was off for a week too. So then they had to be with somebody else and then come back and they are with me again and then something happens and we only have two and one of the orientees was straggling, so I had to take her instead of mine and things got switched up, all the time.

Me: Yeah, I know that, it, yeah, it's probably kind of hard to get you both on the, cause things do come up like vacations and stuff like, but I mean...

P1: Which was pre-planned before they came

Me: Yeah, so can't they just, I mean don't they just like say, Okay Shane, here is your orientee for the next 6 weeks they are on your schedule.

P1: They should, but that's not what happened recently

Me: Is that a common thing or this is an unusual kind of circumstance?

P1: No, this is the first time it's happened. Like I said with three orientees, we lost one of the orientees, so we went down to two but.

Me: How did use lose her?

P1: She went to the ER, she wanted to go to the ER originally then someone she knew got hired in the ER, so she asked again, and they said okay sure and they let her go.

Me: I guess if you want to retain somebody, that's what you do, but they're still yeah,

P1: But yeah, I had her for a short while and then they switched me to the other people. But yeah, it's it was very uncommon. Usually you do get one person, that's it. Rare occurrence that they are not with you. This is the most interrupted I've been during an orientation process and it frustrated me to no end.

Me: I think they're looking to do something to do something different those classes because I think that a common complaint from everybody. I'm not I personally am not

part of that. So, I'm not really sure what would be better to do all those classes before they hit the floor after they've been on the floor for a while.

P1: We try to adjust, like on some of those days that they had to come in and they tried to make up their hours. So, we let them go to the floor and work with the secretary and putting orders in and then some of them went to umm, put in IVs in the cath lab. So, I mean they got some of their other experiences out of the way while they were away from us, but still it was, it was frustrating.

Me: Yeah, so if you have an orientee and you get pulled, um..., does the orientee go with you?

P1: Yep

Me: Okay, well that's good.

P1: Yep. It's good for them to experience what it's like to be pulled but then they're also not on their own either. So, it's not a frightful experience and plus you can help him and say okay with this is this is the fourth floor. This is where their stuff is, you know, this is what to expect.

Me: That was really, those were all really the main questions. I had only taken 23 minute 24 minutes. Can you think of anything else that might be helpful to know?

P1: I think that's about it.

Me: Yeah, you gave me a lot of really good information to base the rest of my interviews on.

Appendix H: Preceptor Data Codebook Categories and Subcategories Example

Table H1

Preceptor Codes with Frequencies

6 Preceptor function	
6.1 Needy vs. self-reliant	1
6.2 Support	2
6.3 Evaluation	1
6.4 Preceptor/student interaction	2
6.5 Communicating in an effective way	2
6.6 Socialization	5
6.7 Enough orientation	4
6.8 Orientation plan	1
6.9 Goal setting	16
6.10 Resources	4
6.11 Supplement	6
6.12 Teach	22
6.13 Time management	16
6.14 Experience	5
6.15 Feedback	10
6.16 Critical thinking	14
6.17 Confidence building	8
6.18 Assessing needs	3
6.19 Orientation guide	2
7 Preceptor satisfaction	
7.1 Frustration	1
7.2 Inconsistent orientation	6
7.3 Preceptor support	5
7.5 Like being a preceptor	4
7.6 Frustrations	3
8 Preceptor training	
8.1 Better selection criteria	2
8.2 Who should precept	2
8.3 Preceptor training	13
8.4 Not all are cut out	2
8.5 Felt prepared	5
8.6 Additional preceptor experience	5
9 Transition issues	
9.1 Shock	1
9.2 NGNs not prepared out of school	1
9.3 Needy	1
9.4 Eat their young	1
9.5 Dissuade	1
9.6 Reaction to new staff	5
9.7 Pulled	7
9.8 Overwhelm	5
9.9 Orientee misuse	5
9.10 Miscommunication	1
9.11 Lateral violence	1
9.12 Hit the ground running	1
9.13 Demeaning	1
9.14 Abandon	2

Appendix I: Preceptor Academy Goals

At the end of the session, the participant will be able to:

- Establish need for preceptor training program
- Identify roles of the orientation team
- Compare and contrast the differences in preceptee characteristics: Student, New Graduate, Experienced, and Internal Transfer
- Compare and contrast principles of effective communication, communication styles, time management strategies, and effective problem-solving strategies
- Identify approaches for precepting those with generational and cultural differences
- Incorporate various learning styles into the orientation plan by prioritizing learning needs
- Understand Benner's Novice to Expert theory as it relates to the orientation process
- Define Competency and the elements of competency validation
- Construct an orientation plan that includes evaluation and appropriate feedback
- Prioritize learning needs by creating and revising SMART goals
- Summarize the phases of reality shock with preceptor actions to assist the preceptee within each phase
- Compare and contrast potential conflicts and challenges of precepting including resolution strategies.
- Apply preceptor strategies to situations that may become difficult during the orientation process
- Define and discuss critical thinking strategies
- Understand documentation responsibilities of the preceptor to guide them in their orientation plan.

Appendix J: Interpretive Summary of NGN1 interview

I recognized that the data analysis section contained a large volume of data. By itself, the data analysis might not make an impact because there is such a large amount of information to sift through. At the suggestion of a reviewer, I include an interpretive summary of one NGN's transcribed interview. This particular NGN's reflections seemed to summarize the PGCOP experience best. The three categories of program effects, preceptor effects, and transfer of learning that emerged during data analysis are exemplified in this summary.

NGN1's expectations coming into the PGCOP seemed typical of most of the NGN group. It appeared that NGN1's educational experience did not provide NGN1 with clear expectations about what being a nurse at the worksite entailed. Kirkpatrick and Kirkpatrick (2016) pointed out that expectations should be clear after training.

NGN1: I don't know what I expected, but I didn't expect, I didn't know that they did so much, cuz like you know, you see people doing stuff, but you don't know what goes into it until you actually have to do it. A lot more goes into it than what you see on the outside.

Initially, NGN1 was overwhelmed and exhausted by the PGCOP experience. Kirkpatrick and Kirkpatrick (2016) pointed out that learner discomfort decreases engagement, which seemed to be the case for NGN1. NGN1 had this to say about being able to address self-identified gaps in knowledge and the use of resources (Knowles et al., 2015):

I've been meaning to you know, like go home and I'm like, okay I need to study the cases, like the patients that I do get, but right now I'm still at a point where I'd go home and have to decompress, and I can't think about work. But I do want to; I've been meaning to sit down with some of my books. I still have to read up on stuff we get here frequently so that I understand it a little more in-depth, instead of just taking care of it.

It appeared that the abundance and perhaps the detail of printed material was overwhelming and time-consuming for NGN1, which was also a discomfort. The go-to resource for NGN1 in this situation seemed to be human.

I know people I can ask, like that I trust to ask. There'll be times when I'm going to look up a policy, and I know to check that policystat, but sometimes it's like ten pages (the policy). So, I'm like, I don't have time to read this, like, and I want to know it, but I don't have time to read it, so I just ask somebody.

However, over time, NGN1's discomfort decreased, which appeared to increase NGN1's level of engagement in the PGCOP. NGN1 was then able to use all available resources and engage in self-directed learning (Kirkpatrick & Kirkpatrick, 2016; Knowles et al., 2016).

When I leave here right now, I'm like. I'm getting to the point where I feel more comfortable where I can go home and actually like take in more information. But at first, I was like there's no way I can go home and like actually think about work still (laughs) (increased comfort, using resources)

Kirkpatrick and Kirkpatrick (2016) stated that learner confidence increases with practice and the opportunity to ask questions. Knowles et al. (2015) asserted that learner

confidence grows as a result of support and direction received from, in this situation, the preceptor. NGN1's reflections of the PGCOP showed how, over time, NGN1's comfort level increased.

NGN1: Like each day gets better, but the very, like, first, gosh, probably like 3 or 4 months, I just felt like way over my head. And it's a lot better now, and there were times I was like, oh my gosh, why did I pick this career, like this is too much.

At school, my friends, like, we all, like there was nobody that was stupid, we were all, like you know, we were all the same.

I found support now. But at first, it's scary cuz, like since I worked here, I kind of knew you know, what people I could lean on and stuff, but it was definitely scary because I went from being a PCA to a nurse. So, I was like, I don't know if these people are going to accept me or think I'm stupid if I ask questions. Like, are they going to think I am annoying, cuz, I'm always like asking questions?

It took me a while, it was like, I'm literally the least, I don't want to say least educated, but least experienced, so like, it took me a while to get that in my head. Like I don't have to know everything like, nobody does, but these people have been, some of these people been doing it for 20 years.

NGN1's confidence increased over time as well, and NGN1 credited the preceptors. NGN1 seemed to look upon the preceptor as a role model, which Knowles et al. (2015) stated is needed for the learner to develop a realistic model of what he or she wants to become.

Interviewer: So, do you think that your clinical orientation, spending time with your preceptor has increased your confidence?

NGN1: Yeah, I think so. Just because, probably like the last month, I was kind of doing stuff on my own, but they were like my little fallback. Like I always have my buddy, like I was able to do stuff, but I had him for, for you know if I needed him, and that is still how I kind of feel.

NGN1 experienced what NGN1 perceived as inappropriate behaviors by a group of experienced nurses during the PGCOP. This uncomfortable experience resulted in NGN1 disengaging from a potentially valuable human resource.

There were a couple of people, mainly like older nurses, who, you know what they say? They eat their young like nobody should ever come straight to critical care or like, you know. They will even say it now like, it's not like that anymore, our staff are more accepting, they've grown to know me, but some of the flex people still say it.

I feel like I'm never going to ask them a question. That's how it makes me feel, like I'm not going to go to them for anything, cuz they're going to just think I'm stupid. I do understand where they are coming from, because I don't like to be, just me, and new people. Like I want people there that have experience, but at the same time most of them started out there too, so. I'm like you were in the same position, you know, what 5 or 6 years ago.

It seemed that leaving the comfort and familiarity of the educational institution created some discomfort for NGN1 because NGN1 did not know what to expect at the workplace. The following reflections show how that initial discomfort changed into

comfort as relationships developed. NGN1 was able to replace prior networks with new ones. It also helped that NGN1 developed a friendship with a co-worker.

At school, they kind of know like what you haven't learned yet as to where when you come here and with your preceptor, they don't know what you don't know, where your weaknesses are. So that was kind of tough for me, except to be why I don't even know what you're talking about.

Interviewer: So, did your preceptors encourage you? Did your co-workers encourage you?

NGN1: Yeah, I think they got better, like, you know, like the longer I was there.

Interviewer: So, apparently, it was your preceptor that provided you the most encouragement and feedback for everything.

NGN1: Yeah. And that's still who, like, I feel most comfortable with, so, just because like, we are together, well, me and P2, like three months.

Preceptor 1 was my preceptor on days. So, he, of course, and then Preceptor 2 on nights and co-worker (alias) always, just because co-worker is, I don't know, I just trust co-worker.

NGN1's preceptors provided feedback, which NGN1 seemed to value. Kirkpatrick and Kirkpatrick (2016) pointed out the usefulness of formative feedback as a tool to increase learner engagement.

Preceptor 2 was really good, like in general, like just telling me like what I needed to improve on, and when I went from P1 to P2, P1 kind of like updated P2 on...You

know, what I needed to improve on what I was doing okay with, and P2 wasn't like afraid to tell me, P2 would just kind of tell me in the moment.

By the time 7 a.m. came around, you know, I'd get like, "You did good today," but never like an actual like, what, like in specific.

NGN1'a preceptor allowed NGN1 the opportunity to practice, which aided in the development of confidence. This reflection also demonstrates how NGN1 evolved from being dependent upon the preceptor to becoming independent. Knowles et al. (2015) asserted that the adult learner, when placed in a new situation, needs guidance or a pedagogical approach until the learner becomes gains enough knowledge to become self-directing and then requires an andragogical approach.

He (the preceptor) would let me do it. And if he saw I needed help or if like, I asked, he would help. Like this was more towards like, kind of middle.

Starting out, I was like, I'm not cut out to do this. I think the confidence is the main thing and that's still, you know, every shift gets better. But definitely, when I first came out of my orientation, that was like, there's no I want to be able to do this like without like my buddy, but then I learned, you know, everyone's there to help, and no one is going to like, shoo you away.

Cause I came in, you know, and I was like, like I wasn't, I couldn't have taken care of like even a basic patient. So, I feel like I just, I don't know, expanded my knowledge a lot because like, you come out of school and you're like, yeah, I do know a lot, but I don't know anything in the hospital setting

NGN1 expressed satisfaction with the PGCOP and reflected upon the preceptor experience.

Interviewer: Okay, that's good, so as far as your orientation in acute care with your preceptors, how satisfied are you with that experience?

NGN1: I would say very satisfied. Cause it could have, I know like, a couple of the people on days, they flopped around preceptors, and that would have, no, that would have changed my opinion on it. That makes it really difficult. It's hard, cause they learn, you know, how, like what your learning style is and what you know and then when they switch, they don't know. It's hard. It was even hard going from P1 to P2 because they still do stuff different. So, it was like, well, you know, which one, which one am I going to do? Well, I don't want to make this person mad because I am going to do it different, because neither of them are wrong. But, it's like...they're different. (inconsistency, satisfied, discomforts)

Me: Yeah, so he's maybe it's kind rolling to mentor role?

NGN1: Yeah,

Me: Oh, that's good. Um, so what about competence? Do you feel more competent than you did?

NGN1: Yeah, didn't think I would.

Me: You didn't think so?

NGN1: I feel like I learned, I don't know, just how to be a nurse, really.

NGN4's interview concluded with pretty much the same statement, "That was actually the first moment where I was like, I'm actually like doing nursing stuff." As a

group, the NGNs who oriented in acute care areas felt that the PGCOP was effective as a transition program. NGN3 and NGN7, who oriented in medical-surgical areas, agreed but felt that some things could be improved.

Appendix K: Interpretive Summary of Preceptor Interview

In the previous section, I provided a descriptive analysis of the data. That, by itself, does not provide a clear overview of the preceptor's perceptions of the PGCOP because of the amount of data presented. I include an interpretive summary of an interview conducted with P1, an experienced nurse who functions as a preceptor. Three of the four categories that emerged during data analysis are exemplified in this summary. Those categories are preceptor function, preceptor training, and preceptor satisfaction,

P1 begins the orientation process by showing the new hire around the unit and introducing them to the staff. Introduction to the workgroup provides the NGN with resources for learning (Knowles, 1980.)

Interviewer: So, what do you do to make sure, what steps do you take to make sure that your preceptee is enculturated or socialized to the unit?

P1: Let them know who's good at what. You know, some people are better at IVs than others, some people are better at helping out if you're drowning, that sort of thing. Getting used to the staff. Just being there in general, you kind of get the feel of who can help you out and who's better to go to with questions and stuff.

P1 described a workplace situation caused by organizational staffing practices that created some resentment of the NGNs by the established staff. P1 recognized that the experienced staff could potentially express this resentment to the NGNs as inappropriate workplace behaviors. However, P1 took steps to mitigate the issue. Climate is an essential consideration in the APM-L (Knowles et al., 2015). An uncomfortable workplace decreases the learner's engagement (Kirkpatrick & Kirkpatric, 2016).

Interviewer: How do employees on the floor usually react to new employees?

P1: It's mixed bag. Sometimes they like them, cuz we're getting new staff. But then other times they don't like them because for like that first six months, that means that they (note: meaning the established employees) can get pulled (note: to another unit) if we have too much staff. That's something we got going on right now as we have two new staff members, actually three new staff members that can't get pulled unless they pick up extra, but that generally means that they're, the regular staff, is going to get pulled.

Interviewer: Hum, so, if the staff aren't too happy with them or that or do, they, does the new employee know, does the new person know that I mean...

P1: I think that they get the sense of it.

Interviewer: Have you ever had a preceptee express any concerns about that kind of thing?

Not that I can recall. Cuz I think we kind of cut it off at the pass by talking about it ahead of time.

Knowles et al. (2015) stated in the APM-L that planning, which includes goal setting, is a collaborative activity between the learner and learning facilitator, which would be the NGN and preceptor in this case. This statement by P1 indicates an on-going assessment of the NGN's learning needs. However, there was no indication in the interview data that collaborative planning occurred.

Ahh, it depends on what week it is. (Note: the orientation pathway is broken down by week into broad categories of tasks to be completed by the new hire) I usually go by

week and the comfort level of the preceptee. I've had preceptees that are, were already CNAs. So, they were really comfortable with the computer system. They just needed to get the RN aspect of it. So that went a lot smoother and sometimes they started off with a full team from week one, just because they knew, they knew the basics of everything else. The new the layout of the unit. They knew the computer system. They just needed to go over like medications and procedures and things like that and that that takes time as well.

I noted in the data analysis that the NGNs who oriented in the medical-surgical areas were not that satisfied with the experience that could be a result of the workplace climate (Knowels et al., 2015). One assumption I made was that the size of the unit and the patient assignment increased the amount of physical separation between the preceptor and preceptee on the medical-surgical units. The following statements by P1 seems to indicate that physical separation is either not an issue or P1 has found a team approach to the orientation that diminishes the separation issue. This process could be investigated further as a best practice.

Interviewer: When you have a preceptee, do you have a full team during that time, and they're (note: the NGN) taking like one patient, then two, then three, or what? How does that work?

P1: We have one team, two people, one team. So, I mean, if I don't, like on our floor, we have six patients, so we would have those six patients. When they start taking patients, they take one of those six patients or two of those six patients, then I take the rest.

No, no, no, no, no. No, I, I, we split it up, but we work together still.

Interviewer: Oh, okay

You will be responsible for those two patients or whatever, we'll say two patients. You are responsible for those two patients charting and meds and everything. But generally, I have them help me with everything else. We do the meds together when everybody else, we go to every room together. They see me do my assessments. I watch them do their assessments.

Yeah, so and then when I start feeling comfortable with stuff like this, and they start feeling comfortable with the pumps and stuff. I might say hey, why don't you go fix the beep in this room even though it's mine, but, ah no, we go together for everything. I tell them, I said, I will not abandon you, I will not ever abandon, I'm not going to throw you to the Wolves, cuz I've seen some preceptors do that, saying go take your patients. P1 discussed a couple of examples of inappropriate behaviors exhibited by co-workers towards new or inexperienced staff.

Yeah, yeah, we have an extern on our floor right now, and I witnessed the nurse that she was with say, here go give report at shift change, and I'm like, what the hell? What, that should not even be happening.

No, I don't think so. I think it has. It does to a point. But some of the biggest problems that I've seen out of other preceptors is that they want to, they feel like it's an opportunity to put all their work off on somebody.

Just like I said, you know, here go do report. I've actually heard and seen, not seen so much, but I heard a preceptor that was on day shift say okay. Here's your

assignment ,1 through 7. Go take care of them. I'll be up here at the desk if you need me. I'm not lying. Now this is been a little while.

Goal setting, which is a step in the APM-L (Knowles et al., 2015), was a topic of the conversation again. P1 reiterated the fact that it is challenging to set goals because the course of the day is unpredictable. The example goal of speeding up that P1 mentioned was not measurable and did not follow the SMART approach covered in the PA (Case file, Nov 8, 2016).

Interviewer: So, do you set goals with them for the day or I mean so you, you say, it sounds like you go by the plan, the orientation plan.

P1: It depends on what we're working on now, usually speeding up is a goal, but it's kinda hard to set goals when you have six patients, and you don't know what the day is going to bring. I almost always have them do all admissions and discharges and things like that, but you can't say today we're going to do an NG tube cuz you don't know if that is going to happen.

Interviewer: Oh yeah, I mean, that's got to come up. So, it's kind of like, but you can kind of like, well, if this happens then we'll make sure you see it.

Oh, yeah, yeah and I let everyone know. Hey, if you all have anything interesting going on, tubes need to be put in, or catheters, I said, let us do it. But it's kind of hard to set a goal except for speeding up, talking to the patients, making sure that they're communicating in an effective way. Getting a lot more done while you're in the room. I try to try to teach him, you know, witness your surroundings, clean up the room as you're

going to make sure you're doing all that stuff. But other than that, it's kind of hard to set goal per se,

Interviewer: Yeah, but in a particular industry, not just teaching. So, how do you.... Okay, so eventually, you got sit down evaluate this whole orientation process. So how do you know you and your preceptee know that the orientation goals have been met?

During this reflection, P1 provided data that suggested some collaborative planning with the preceptee did occur during the PGCOP. However, it seemed to be more in the format of formative feedback that occurred in the moment rather than being a planned activity.

Ah, constant communication, we talk, how do you feel? Do you feel comfortable? Is there anything else that you'd like to work on, and I try to get that out at the very beginning that way you can kind of, you can set those goals. Okay. Well, they really like to they've done a ton of catheters and it's cool. But they want had never done in NG then you know that that might be a goal to try to do that. But just constant communication with them and see, are you feeling comfortable? What do you feel you need to work on? As you go along you can see, okay, well, they're handling, they're handling two patients, we're moving three patients. They're getting all their charting done. So, you know, they're feeling comfortable with the charting, they're doing it correctly cuz I'm constantly monitoring their, what they're putting in the computer system, and we'll talk about it. Okay, you did this in this in this, but you forgot to chart on this. So just communication,

No, it's throughout the shift cuz you don't have time to really meet and at the end of the shift everyone wants to leave. But at lunch time, I try to spend lunchtime a little bit talking, if we can, and then also towards the end of the day while we are sitting waiting for next shift. We might talk about some stuff.

P1 made several comments when asked about PA. P1 again discussed some incidents of what P1 perceived as inappropriate behavior in the workplace, suggested that a better way to select nurses to be preceptors might be helpful, and that preceptor support would be helpful.

Interviewer: Okay. So, thinking back on, like I guess if you can, when you were first precepting people, and you went through the class? Do you think the class that's provided actually prepares you to be a preceptor here? (Looked like he might be struggling with answering this one). You can say no, now this won't, this is just between you and me.

P1: No, I don't think so. I think it has, it does to a point. But some of the biggest problems that I've seen out of other preceptors is that they want to, they feel like it's an opportunity to put all their work off on somebody.

Just like I said, you know, here go do report. I've actually heard and seen, not seen so much, but I heard a preceptor that was on day shift say okay. Here's your assignment ,1 through 7. Go take care of them. I'll be up here at the desk if you need me. I'm not lying. Now this is been a little while.

I think, I think it's more of an attitude issue and I think that it's something that needs to be screened by the um, the managers on the floor. I think that, you know, maybe

you put the word out and say hey we need some more preceptors. Do you have anybody on your floor you think would benefit from that and let them kind of make the decision cuz they kind of know who's good and who's not.

And you have to have all the aspects, you have to be able to be pretty good at the computer system as well as time management and being able to instruct people. I mean, there's people that are good at two of those and they can't teach a thing. They're good at what they do, but they can they can't pass it on.

Interviewer: So, do you think it would be beneficial for the instructor or somebody like that to come along and say so, how's it going? check in with you with your first preceptee?

P1: Yeah, I think it would be really beneficial

P1 validated that the competency exams give to the NGNs by the study site were not used for orientation as planned. P1 validated that communication with the manager regarding the new hires' orientation occurred. I also noted that P1 stated that orientation is ended early for the new hire if the new hire is progressing rapidly. Lastly, P1 voiced some complaints about the NGN's schedule of required classes and how those classes interfered with the PGCOP process.

Interviewer: So, when the new nurses get done with orientation, their last day like today, they're going to take a competency exam to just kind of tell us where they are with their knowledge, and where they need strength building. The kind of stuff to really focus orientation. Do you or do you know if people are using those test results to kind of guide orientation?

P1: I don’t know, that’s above my paygrade. Nobody really shares that with me. As for the floor, I mean, I kind of communicate with the unit manager and say hey, I think he or she is doing a good job. I think they can come out early from orientation. We’ve done that a couple times.

Yeah. Yeah. Yeah, and I have a big problem with that too because as a preceptor you spend all your time trying to get them to do it this way and then you get switched up. That was a problem we had. We had three orientees at one time and no one set person and then somebody couldn’t do a certain week, or they couldn’t do a certain day. So they had to be with somebody else on the day that they picked up, On top of that, which is a big complaint of mine, all these extra classes they have to go to and meetings they have to go to and trying to fit in the EKG classes and everything else during their orientation. There’s, I’ll have, I’ll have my orientee for a week. I may not see them for two weeks, and then they come back to me for another week, and then, my example, I was off for a week too. So then they had to be with somebody else and then come back, and they are with me again, and then something happens, and we only have two, and one of the orientees was straggling, so I had to take her instead of mine, and things got switched up all the time.

The experienced nurses seemed to enjoy the preceptor role, and the NGNs felt that the orientation they received from their preceptors was effective. The areas of the PA process with which the preceptors seemed to be least satisfied were with training and support. The preceptors felt that there should have been more opportunities for practicing

skills during PA. P2 stated, “I’ll end up forgetting that stuff I learned in preceptor academy.” The preceptors also suggested that some support for the role would be helpful.