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A Phenomenological Exploration of How Nursing Experience Shapes the Transitional Performance of Primary Care Nurse Practitioners

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Walden University
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Abstract

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MSN, University of Illinois at Chicago, 2010

BSN, Lewis University, Romeoville, Illinois, 2002

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Policy Administration

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Abstract

Poor access to healthcare and a shortage of primary care providers in underserved communities paved the way for reliance on advanced practice registered nurses (APRNs). This increased reliance on APRNs as primary care providers necessitates expanded public policy on APRN practice; however, information on APRN transitional experiences remains inadequate to inform policymakers effectively. Illinois' Nurse Practice Act requires APRNs to incorporate the scope of practice of registered nurses into their practice but does not describe what that experience should be. Using Kanter's theory of organizational structural empowerment and Benner's novice to expert nursing model as theoretical lenses to ground the research and analyze the data, this descriptive, phenomenological study explored how the nursing experience shaped the transitional performance of primary care nurse practitioners. The purpose of this study was to investigate new APRNs' perceptions of their transitional experiences. Data collection involved semistructured interviews of nine new APRNs using open-ended questions. After data coding and analyses, thematic analyses showed that a lack of structural empowerment diminished APRNs' transitional performance, while nursing experience enhanced transitional performance. Such findings can inform policymakers about the regulation of APRN practice. This study has two implications for positive social change: at the organizational level, it could decrease APRN attrition rates, and at the community level, it could boost healthcare access, and thereby decrease the number of deaths, the cost of disability, and the cost of healthcare.

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Dedication

To the Almighty God, who made way for me to acquire education to this level. To my husband, Fidel, and children, Fidel Jr., Byron, Chukwunonso, and Chidinma for your unflinching support, encouragement, and love that propelled me to the finish line of this journey. To my late mother, Rebecca, and my aunt, Mary, who taught me the value of education and encouraged me to attain higher life goals.

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I would like to thank all my study participants for their time and for being part of my success story. My gratitude goes to my friends and family for their support, prayers, and words of encouragement throughout this journey. Your prayers meant a lot to me.

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Chapter 1: Introduction to the Study

Trained advanced practice registered nurses (APRNs) provide both primary and specialized care in a plethora of healthcare settings, thus providing accessibility to cost-effective and efficient healthcare, especially to the underserved and rural communities of the United States (American Association of Nurse Practitioners [AANP], 2019a). In 2019, more than 290,000 APRNs practiced in the United States, with over 89% certified in primary care (AANP, 2019a, 2020). Illinois' Nurse Practice Act (2007/2018) requires APRNs to incorporate the scope of practice (SOP) of registered nursing with skills and training learned during APRN training and education. Under the Nurse Practice Act, APRNs must maintain a current RN license, APRN license, and national certification as APRN certification rests on the "knowledge and skills acquired throughout an APRN's nursing education, training, and experience" (para. 1). Thus, according to the Nurse Practice Act, experience is part of the APRN SOP.

However, Faraz (2017) and Rich (2005) noted the many different educational and experiential levels and pathways available on the journey to APRN. The uncertainty of how that varying experience impacts the transition from an RN to an APRN presents challenges that impact safety, public acceptance of APRN competence, and delineation of the APRN role due to patients refusing PCP care from APRNs. Thus, it is crucial to understand how prior RN experience impacts RN transition to APRN so that public policy can effectively address APRN transitional experience, increase APRN performance, and improve public confidence.

Because about 80 million Americans live in health professional shortage areas (HPSAs) with a ratio of 3,500 patients to 1 PCP, APRNs provide critically needed care (AANP, 2019a). APRNs serve as PCPs, thereby reducing the impact of the PCP shortage by providing preventive and curative services to the patients; as PCPs, they also reduce the burden of disease, disability, death, and the cost of health care (AANP, 2019a). AANP, Buerhaus et al. (2015), and Iglehart (2014) reported decreasing numbers of PCPs and increasing numbers of patients due to the influx of baby boomers. Buerhaus et al. expected the physician shortage to reach 45,000 to 66,000 doctors by 2020 and 2025, respectively. Thus, APRNs provide vital healthcare services and decrease the wait time for primary care by increasing PCP availability (AANP, 2019a). However, Buerhaus et al. and Iglehart noted that APRN attrition is rising. Abel (2018) associated attrition with the self-doubt that the RN-APRN transition brings concerning one's capability and proficiency. Furthermore, Poghosyan, Norful, and Martsolf (2017) posited that experienced APRNs tend to work in rural areas more than inexperienced APRNs, indicating a lack of self-confidence in the inexperienced APRNs.

While the Patient Protection and Affordable Care Act (2010) increased insurance coverage for many Americans, thus enabling HPSAs to afford needed healthcare. However, as insurance coverage increased, so did the associated need for APRNs (Litchman et al., 2018). Thus, the APRN Consensus Work Group and the National Council of State Boards of Nursing (NCSBN; 2008) APRN Advisory Committee developed the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, & Education (Litchman et al., 2018). Nonetheless, Faraz (2017) and Rich

(2005) posited that APRNs' different educational pathways inferred differing education, experience, and transitions. There are traditional pathways and non-nurse graduate pathways (Faraz, 2017; Rich, 2005). The traditional routes accept RNs with varying years of nursing experience, and non-nurse graduate programs admit non-nurse graduates of other fields (Rich, 2005). However, even though those non-nurse graduates complete and attain their RN license before completing the APRN program (Smith-Barrow, 2016), it remains unclear how their varying experience levels affect their transition from RN-APRN. Roberts and Goolsby (2017) emphasized APRNs' education and training as priority research areas because the differing nursing experience may impact skill and performance during practice.

Additionally, uncertainty exists about APRNs' performance with little or no prior nursing experience before transitioning to the APRN role (Codier et al., 2015; Hennessy, 2017; Rich,2005). According to Benner (1982), nurses gain experience during exposure to care and acquire skills through practice. Non-nurse graduates with no prior nursing experience have limited exposure to real-life nursing practice and experience (Benner, 1982). Twine (2018) noted a need for further research of the APRNs transition and related years of nursing experience necessary for the APRN program. Even though Schwartz and Gambescia (2017) reported a dearth of research on graduates' performance from non-traditional nursing programs, it remains unclear how RN experience impacts APRN practice. Additionally, while Illinois' Nurse Practice Act (2007/2018) requires APRNs to incorporate RN SOP into their APRN practice, the Act does not address the specifics of their transitional experience from RN-APRN.

To address this gap in the literature and inform future public policy, I qualitatively explored how an RN's experience affected the APRNs' transition and performance in primary care in Chicago, Illinois. Findings provide data that are vital to establishing the sound public policy needed to regulate the work environment of APRNs. Benefits to policymakers, administrators, nurse educators, and colleges include best practices to educate, prepare, and assist new APRNs, thus ensuring smooth transition and performance. In this chapter, I introduce the study with the (a) background, (b) problem statement; (c) purpose, (d) research question (RQ), (e) theoretical framework, (f) nature, (g) definitions, (h) assumptions, (i) scope and delimitations, (j) limitations, and (k) significance.

Background

With the enactment of the Patient Protection and Affordable Care Act (2010), more Americans became insured, thereby increasing the physician shortage and prompting a need for additional PCPs (Xue et al., 2016). The Patient Protection and Affordable Care Act enabled over 30 million additional Americans to obtain insurance coverage; APRNs stepped up to cushion the shortage of PCPs by providing primary care and specialized healthcare services (Fulton et al., 2017). Illinois' Nurse Practice Act (2007/2018) mandated that APRN practice include the RN SOP and APRN training skills, education, and experience. As a result, APRNs must earn their RN license before their APRN license, and APRNs must include RN SOP within their ongoing practices (Nurse Practice Act, 2007/2018). However, the Nurse Practice Act does not regulate the degree of RN experience that an APRN must have before attaining APRN licensing.

Furthermore, how RN-APRN transitional experiences impact new APRN performance remains unknown. This gap in public policy may predispose APRNs to perform similarly to new nurse graduates without any experience, which is a public safety concern. A public policy defining the supportive environment and experiences needed to transition new APRNs could enhance the safe practices of APRNs and thus better meet the growing need for their PCP-related services. However, effective public policy cannot be developed without information about how prior RN experience impacts RN-APRN transitional performance.

RN-APRN training includes all aspects of the transitional experiences that the APRN encounters during clinical supervision, the various stages of their professional growth, and their emotional well-being throughout the process (Arrowsmith et al., 2016; Cummings & Connelly, 2016; El-Banna et al., 2015; Farr, 2018; Teoh et al., 2013; Walker et al., 2017). APRNs are responsible for independently and collaboratively providing PCP services; therefore, public health and safety are dependent on an APRN's ability to diagnose and treat patients by combining nursing and medical models, clinical knowledge, and experiences (AANP, 2013; Shuler & Davis, 1993). Because the influences of RN-APRN experiences remains unknown, I extrapolated qualitative data from new APRNs' lived experiences of their RN-APRN transitions using Kanter's (1977, 1993) theory of organizational structural empowerment. I also used Benner's novice to expert nursing model to relate the influence of those experiences on APRNs' professional growth and skill level.

The Gap in Information

APRN training embraces PCP practice in various healthcare settings; yet, despite the research findings that the effectiveness of APRNs is comparable to physicians, concern remains about the performance of APRNs with limited nursing experience before transitioning to an APRN (Barnes, 2015; Codier et al., 2015; Hennessy, 2017; Rich, 2005). However, the influence of previous clinical experience on APRN transitional performance remains unclear. This missing information may contribute to the stakeholder wariness of APRNs' PCP skills, as reported by Hart and Bowen (2016), Dlamini et al. (2014), and Edward et al. (2017). However, my in-depth literature review revealed limited information on this topic.

The Need for This Study

APRNs provide vital PCP healthcare services to the public and ameliorate America's rising PCP shortage (AANP, 2019a; Dalen et al., 2017; Fodeman & Factor, 2015; Petterson et al., 2012; Vleet & Paradise, 2015). Nevertheless, APRN PCP-related service skills remain underutilized, and their competence is often questioned (Codier et al., 2015; Hennessy, 2017). In addition to stakeholders questioning APRNs' ability to provide PCP services, some new APRNs graduate unprepared to provide PCP services (Wallace & Boller, 2014). Furthermore, APRN turnover rates are twice those of physicians (Barnes, 2015; Buerhaus et al., 2015; Fitzpatrick & Gripshover, 2016; Iglehart, 2014). These issues relate to APRNs' transitional experiences, but the dearth of research in this area leaves little usable information for developing effective interventions.

Through this study, I describe to policymakers, nurse educators, and organizations factors that facilitate the successful transitional performance of RNs to APRNs. My findings may contribute to public policy on the preparation, training, and retainment of APRNs by adding to the information base of APRN transition and experience thus improving vital PCP services. Preparing APRNs to competently and confidently serve in PCP capacities is paramount; however, to accomplish this, it must be understood how RN-APRN transitional experience affects APRN performance.

Problem Statement

The problem is the lack of information about how the RN-APRN transitional experience affects APRN PCP-related performance, affecting public health and safety and fueling the rising APRN attrition rates (Fitzpatrick & Gripshover, 2016). Because APRNs provide vital PCP services and mitigate insufficient access to healthcare services (AANP, 2019a), it is imperative to public policy and health to increase understanding of RN-APRN transitional experience. The skills developed between training and experience encompass a vital part of new APRN capability; without it, frustration, chaos, and inconsistent performance levels in APRNs result (Fitzpatrick & Gripshover, 2016; Kleinpell & Kapu, 2017). For example, from my personal experience:

> the Chief Executive Officer of our healthcare providers' group urged all physician practices to incorporate APRNs into their groups to increase patient access to needed healthcare services. Some physicians offered resistance and refusal of the request, reporting instances of APRN overprescribing and inexperience resulting in public safety concerns. These physicians stated that overprescribing was due to

a lack of experience and familiarity with diseases and appropriate medication dosages.

In 2006, the Institute of Medicine (IOM, 2012) reported 1.5 million avoidable, unfavorable drug-related events that posed safety risks to the public. About 44,000 - 98,000 fatalities occur every year at hospitals from medical mistakes (IOM, 2012). Current public policy does not adequately define the prior RN experience necessary for new APRN transitional experience and safe performance (Faraz, 2017; Rich, 2005). However, to develop appropriate public policy, information about how RN-APRN transitional experience affects APRN performance is required. Through this study, I begin filling that information gap to inform policymakers, educators, and public health to increase public health and safety.

Purpose of the Study

The purpose of this descriptive phenomenological study was to explore how prior experience as an RN impacted role transition and the performance of a new APRN in primary care capacities in Chicago, Illinois. Through this study, I explored the lived experiences of new APRNs to understand and discover how prior experience, or lack of it, affected their transition and performance. I used Kanter's (1977, 1993) theory of organizational structural empowerment to decipher the experience necessary to APRN empowerment and Benner's (1982) novice to expert nursing model to ascertain the relationship between experience and performance. Understanding how prior RN experience affects APRNs' transition and performance is critical to effective public policy and public health. Through my research findings, I sought to inform public policy that is

essential to ensure the readiness of new APRNs' to administer and prescribe health care services.

Research Question

With this research, I explored the influence of RN-APRN transitional experience on new APRNs' performance in primary care capacities in Chicago, Illinois. While my RQ centered solely on how RN-APRN transitional experience affected new APRN performance, I split this single focus into two related RQs to gather the most in-depth data on that single phenomenon. This dual approach allowed me to use Benner's (1982) model and Kanter's (1977, 1993) theory more effectively to gather and analyze the phenomenological data needed to answer my RQ. Thus, my two RQs were:

RQ1: How do new APRNs internalize their role transition and performance considering the availability of organizational structural empowerments necessary for their professional responsibilities and SOP analyzed using Kanter's (1977, 1993) theory of organizational structural empowerment.

RQ2: How do new APRNs view and interpret their transitional performance as an APRN relative to their RN proficiency level gaged using Benner's (1982) from novice to expert nursing model?

Theoretical Framework

I used Benner's (1982) novice to expert nursing model and Kanter's (1977, 1993) theory of organizational structural empowerment to ground and interpret this study. Benner noted that a new nurse goes through five professional development levels: novice nurse, advanced beginner, competent, proficient, and finally, an expert nurse. I used

Benner's model to gauge participants' perceptions of their experience levels. Kanter posited that factors outside of an employee are responsible for the performance of employees. I used Kanter's theory to ground the study and identified and analyzed experiential resources, or lack thereof, that participants felt were critical to their transition experience. Thus, I used the combination of Benner's and Kanter's frameworks to decipher new APRNs' perceptions of their transitional experiences and ascertain what experiential resources affected their current APRN performance.

Kanter's Theory of Organizational Structural Empowerment

People's experiences and resulting successes largely stem from organizational structural empowerment (Kanter, 1977, 1993). Poghosyan, Norful, and Martsolf (2017) reported that organizational practices and environments were responsible for APRNs' productivity and performance. Thus, the roots of RN-APRN transitional experience intertwine with organizational supports. In 1977, Kanter recognized that most company management was procedural and inflexible, an insight that led to the theory of organizational structural empowerment. New APRNs start as novice APRNs, but how the availability of experiential resources during their transitional period influenced their performance remained unknown; thus, I grounded this study in Kanter's theory.

Theoretical Propositions of Kanter's Theory

Employees perform better when they have resources that enhance their performance (Kanter, 1977, 1993). Kanter's framework was the logical theory to ground this study due to its theoretical propositions. Kanter posited six constructs to organizational structural empowerment theory: employee empowerment, information

availability, formal power, informal power, resources, and support. I applied Kanter's constructs while considering new APRNs' perceptions of their lived experiences to analyze and explain how APRNs perceived and made meaning of their experience during transition and performance in their practice environment. Chapter 2 includes a detailed analysis of Kanter's theory and propositions.

Benner's Novice to Expert Nursing Model

The progression from novice to expert nurse indicates skills built over time from education, experience, and nursing practice exposure (Benner, 1982). Benner used Dreyfus and Dreyfus' (1980) five-stage general skill acquisition model as the novice to expert nursing model's foundation. Dreyfus and Dreyfus stipulated that to develop and gain any skills, people pass through five skill acquisition levels: novice, advanced beginner, competent, proficient, and expert. Benner adapted Dreyfus and Dreyfus' model specifically for nurses positing that new nurses start as novices with no initiatives and grow to become experts as they work and gain experience and skills. Benner, a nurse theorist, developed the novice to expert nursing model, positing that nurses undergo five professional growth stages as they work and gain experience. Benner related these stages to the characteristics of nurses' performance at each skill level.

Theoretical Propositions of Benner's Novice to Expert Model

Nurses start as novices with no experience; they rely on rules and protocols to guide their actions (Benner, 1982). Following Benner's model, nurses learn through knowledge and skills acquired in training and as they work. According to Benner, a

nurses' experiential learning brings about performance improvement, and a proficient nurse progresses to the next level.

Thus, nurses learn and gain more experience as they work. However, no public policy dictates the nursing experience level necessary for APRN education and practice (Codier et al., 2015; Faraz, 2017; Hennessy, 2017; Rich,2005; Twine, 2018). Through this research, I explored this phenomenon to inform policymakers and organizations of the experiential resources needed to support APRNs' transitional performance from their perspectives. Chapter 2 includes a detailed discussion of Benner's theory and propositions.

Nature of Study

In this study, I explored how new APRNs interpreted their performance as an APRN considering their level of proficiency as an RN. Additionally, through my RQs, I explored how new APRNs internalized their role transition and performance. Thus, I conducted semi-structured interviews to extract data consisting of new APRNs' perceptions of their transitional experiences and performance. A qualitative study uses in-depth interviews to obtain rich data from participants (Creswell, 2009); Moustakas (1994) recommended a qualitative research design when researchers need participants to explain their own experiences.

I used a phenomenological design. The philosophy of phenomenology is on comprehending people's experiences through their own voices as they share their perceptions about their experiences (Moustakas, 1994). Phenomenology involves studying a small number of participants (10 or fewer) to reach data saturation and

understand the meaning of the experience related to the study topic (Moustakas, 1994; Rudestam & Newton, 2015). Data saturation is crucial for the validity of phenomenological studies and occurs when interviews do not yield any new information (Fusch & Ness, 2015; Moustakas, 1994). I interpreted and analyzed the lived experiences of new APRNs during their transition from RN-APRN using Benner's (1982) and Kanter's (1977, 1993) frameworks to understand the essential meaning of their transitional experiences.

After obtaining the Walden University Institutional Review Board (IRB) approval, I sent out recruitment fliers requesting interested candidates to contact me as listed on the flier. I adhered to purposeful sampling and inclusion criteria. Purposeful sampling in a qualitative study draws qualified, knowledgeable participants who have lived experience of the phenomenon under study (Creswell, 2009; Ravitch & Carl, 2016). I emailed each candidate a demographic questionnaire and consent form. I selected the first 10 applicants who returned the consent form and met the study criteria. (To meet the study criteria, participants had to be APRNs, licensed in Illinois, board-certified, with up to 5 years of APRN experience, living in the Chicago, Illinois area, and working in a PCP setting.) Participants chose telephone or Zoom for the interview and selected a pseudonym for confidentiality. I used an IRB-approved interview protocol, with 10 open-ended questions, yielding about 1-hour interviews. I transcribed the data using NVivo transcription software and MS Word within 24–96 hours of each interview. All participants received a copy of their transcript through email and responded within 96

hours of receipt, verifying transcript accuracy, or noting corrections. I used a combination of NVivo software and manual coding to code and analyze data.

Definitions

The following definitions ensure the clarity of terminology throughout the study when that terminology may have inconsistent or profession-specific meaning not recognized by common populations.

APRN (aka NP): According to AANP (2019a), APRNs are RNs who are educated at a graduate degree level to evaluate, diagnose, treat, and order diagnostic investigations and medications for patients. According to Illinois Nurse Practice Act 2007/2018, APRNs embrace the following four roles: a) certified nurse-midwives (CNM), b) clinical nurse specialist (CNS), c) certified nurse practitioner (CNP), or d) certified registered nurse anesthetics (CRNA).

New APRN: For this research, new APRNs have 0 to 5 years of APRN experience. Benner (1982) reported that it takes 2 - 3 years to attain a competent proficiency level at the third level of Benner's novice to expert model.

Non-traditional APRN program: Rich (2005) reported that programs that admit non-nurse college graduates into APRN programs are non-traditional APRN programs.

Primary care: According to the American Academy of Family Physicians (AAFP; n.d.), primary care is the initial and ongoing care provided by primary care healthcare providers for clients. Per AAFP, primary care may be "health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis, and

treatment of acute and chronic conditions" (p. 1). For this study, I delimited CRNAs since they do not practice in primary care

RN: An RN is a nurse who holds a nursing diploma, associate degree, or BSN in nursing and has passed the National Council Licensure Examination (NCLEX-RN; graduatenursingedu, n.d.). RNs perform within an SOP outlined by NCSBN (2008).

SOP: Adams and Markowitz (2018) reported that SOP is the legal boundary placed by states on what APRNs are permitted to do.

Traditional APRN program: Programs that require RNs to have at least one year of working experience before entering graduate-level APRN programs (Rich, 2005; Schneider, 2020). Two examples include BSN and Master of Science in Nursing (MSN).

Transition: In this study, I used Phillips et al.'s (2014) definition of transition as a process of moving from one stage of professional level as new graduates to another through learning, acclimation, and interaction with a new environment and new groups of people.

Assumptions

In any study design, the researcher must consider multiple assumptions to account for participants and methodology (Calabrese, 2012). These assumptions are the researcher's opinions and principles related to various study aspects (Calabrese, 2012). Based on Kanter's (1977, 1993) theoretical framework, I assumed that:

a) Individual characteristics were not responsible for employee performance and productivity; instead, empowerment factors shaped employee performance.

This assumption was needed to eliminate individual characteristics as a potential variable.

b) I assumed that the participants truthfully communicated their perceptions and meanings of their experiences.

c) I also assumed that the participants remembered their lived experiences; however, they may not have recollected everything. Thus, I relied on triangulation and data saturation to overcome occurrences of faulty recollection.

d) I assumed that participants reflected on their experiences and presented them in words that best explained their perceptions of their lived experiences.

e) Since I had no way of verifying participant demographics, I further assumed that participants accurately completed and returned the demographic questionnaires, enabling me to delineate and analyze data.

f) I assumed that all participants kept their perceptions to themselves and did not share them with other participants because sharing those perceptions could cause participant-bias.

g) I assumed that a descriptive phenomenological study was the best design to answer the RQ.

h) I assumed that Benner's (1982) novice to expert nursing model and Kanter's (1977, 1993) theory of organizational structural empowerment provided appropriate lenses to aid my analysis and interpretation of how prior experience impacted the transition and performance of APRNs.

Scope, Delimitations, and Transferability

Research inherently has boundaries, known as scope and delimitations, that affect the transferability of study findings (Creswell, 2009; Moustakas, 1994; Rudestam & Newton, 2015). I designed this study to explore the impact of prior nursing experience and organizational support on the transitional performance of new APRNs in primary care in Chicago, Illinois; thus, I established its scope, delimitations, and transferability. The research scope establishes who, what, when, where, and how the study is conducted (Creswell, 2009; Rudestam & Newton, 2015). In contrast, delimitations are the limits purposefully placed on the study as the control mechanisms allowing scientific analysis and interpretation (Creswell, 2009; Rudestam & Newton, 2015). Thus, the scope explains the aspects of the study, the delimitations place limits on the study through inclusive and exclusive criteria, and together they dictate transferability.

Study Scope

To further understand how that transitional experience affected APRN performance, I focused the scope of this study on new APRNs' transitional performance as it interfaced with prior RN experience and available organizational structures for APRN practice. Thus, I built the study framework on Benner's (1982) novice to expert nursing model and Kanter's (1977, 1993) organizational structural empowerment theory because those frameworks focused data collection, analyses, and interpretation on the impact of RN-APRN transitional experience and performance. However, Fitzpatrick and Gripshover (2016) and Rich (2005) pointed out that APRNs graduate with different RN experience tenures, ranging from none to many years. Thus, the targeted participants in

this study encompassed a wide variety of new APRNs with varying levels of experience, including licensed and certified midwives (CNMs), NPs (CNPs), or clinical specialists (CNSs) in the Chicago area.

Because I resided in the vicinity, Chicago, Illinois, provided a cost-effective participant pool for my purposeful sampling, enabling various participant sources for data triangulation, thus increasing credibility and potential transferability. Because Illinois' Nurse Practice Act (2007/2018) mandates that all APRNs include RN SOPs in their practice, understanding how RN experience facilitates the transitional performance of new APRNs is critical to public policy; however, that data remains under researched. As Moustakas (1994) emphasized, people learn through experience and gain knowledge through lived experience; thus, I built this study design on a descriptive phenomenological methodology to include the scope of new APRNs' lived experiences.

Delimitations

To ensure that this research remained within my study design scope, I delimited participants to new APRNs with up to 5 years' experience, licensed in Illinois, board-certified, and working in primary care. Because memory lapse and blurry recollection may occur after many years of an event (Moustakas, 1984), delimiting participants' years of experience enhanced their recall of lived experiences related to their transitional experiences, thus ensuring that the data gathered remained within the scope of this study. Delimiting participants to only those practicing primary care ensured a similar practice environment. While there are four different roles delineated for APRNs (NCSBN, 2008), in this study, I delimited participants to APRNs practicing as PCPs. According to

NCSBN (2008), CRNAs provide a full spectrum of anesthesia-related care for individuals across all levels of acuity throughout the patient's life span; thus, CRNAs do not practice as PCPs. Although NPs are generally used interchangeably with APRNs, in this study, I used only APRNs to ensure consistency.

Using purposeful sampling, I further delimited participants to graduates from traditional and nontraditional programs to ensure that I explored the entire spectrum of transitional experience. Because English is my primary language, to ensure my complete comprehension and understanding of data gathered, participants had to be fluent in English. Participants were currently working in primary care in the Chicago area. These delimitations limited the transferability of the findings. However, they also strengthened transferability to related areas wherein this information gap exists, thus informing related public policy where it was most needed.

Transferability

Phenomenological research does not generalize findings; instead, findings are transferable to similar circumstances (Ravitch & Carl, 2016). Transferability refers to generalizing research findings in similar settings and contexts; it is the equivalent of external validity in a quantitative study (Lincoln & Guba,1985). This concept is essential because findings can inform related future actions and public policies. The transferability of this study's findings extended to policymakers, nurse educators, administrators, and organizations that influence APRN public policy, training, and practice in Chicago, Illinois, and similar areas with APRNs working in like settings with the equivalent years of experience. To ensure transferability, I outlined the study in detail (see Chapter 3). I

used audit trails, data triangulation, and thick, rich descriptions to represent the interview data during data collection, analyses, and interpretation. This study's scope and delimitations impacted transferability because participants' lived experiences and SOP settings vary. My APRN experience delimitations and interview participants also limited transferability across different groups with different tenures, sample pools, and settings. Participants' privacy impacts transferability because information identifying participants must remain private.

Limitations, Weaknesses, and Researcher Bias

Unlike delimitations, limitations are situations inherent in the research and beyond the researcher's control; they are weaknesses and become compounded by researcher bias (Creswell, 2009; Rudestam & Newton, 2015). Because phenomenological research is not generalizable, its transferability is limited to context-bound similar settings (Lincoln & Guba, 1985; Moustakas, 1994). Phenomenology depends on participant recall, which is causally related to the strength or weakness of each participant's memory and any biases influencing that recall (Moustakas, 1994). Additionally, while bias influences all research, qualitative research is particularly vulnerable to researcher bias due to the nature of qualitative researcher interpretation and potential bias (Creswell, 2009; Rudestam & Newton, 2015). Thus, there were several inherent limitations and potential biases in my descriptive phenomenological study.

Limitations

Because the interviews were audio-recorded, this study was inherently limited to APRNs willing to participate in one-on-one recorded sessions. Additionally, I depended

on transcript member checking via email for credibility; thus, member checking limited the study's credibility. According to Moustakas (1994), one of the challenges of qualitative human science research is the ability to differentiate and present imagined versus actual events. Participants' recall solely depends on the perceptions and feelings they attribute to their experiences (Moustakas, 1994). Thus, there was no way of confirming the credibility of participants' thoughts; therefore, I relied on saturation and triangulation to offset this limitation's weakness and strengthen my findings' credibility.

Weakness

Even though I gathered data to the point of saturation, as Ravitch and Carl (2016) noted, the study's small sample size remains a weakness, and limited the generalizability of the findings. Ravitch and Carl (2016) also noted that qualitative research is not generalizable because the participants' privacy must be protected; nonetheless, they emphasized that it is transferable by presenting a comprehensive depiction of the interview data and background. Therefore, to counter this weakness, I used rich, thick descriptions to represent my findings and strengthen transferability to similar contexts.

Dependability, which is akin to quantitative research reliability, is another inherent weakness of qualitative research (Ravitch & Carl, 2016). Dependability establishes that findings correctly reflect the data collected (Ravitch & Carl, 2016). However, Moustakas (1994) and Ravitch and Carl noted that sound research design, triangulation, rationale, and presentation of findings could increase dependability. Thus, I strengthened study dependability and ensured that data collection answered my RQ using data triangulation, a thorough presentation of research methods (see Chapter 3), and a

logical rationale for my choices and interpretations. I subjected my study report to the rigorous Walden review process to verify congruent interpretations. Thus, rigorous research design helped circumvent potential researcher bias.

Researcher Bias

While challenging, a researcher can limit bias through bracketing and reflexivity (Moustakas, 1994; Ravitch & Carl, 2016). Moustakas recommended that all researchers prepare for new knowledge by separating themselves from any prior related experiences. While I was the sole researcher, I also possessed knowledge and experience that could bias my interpretation of data; thus, I took rigorous steps to exclude my own potential biases. In my APRN practice, I only worked with APRNs possessing prior nursing experience; therefore, I prepared myself for new knowledge and bracketed myself from my personal APRN experiences and RN-APRN transitional performance. Additionally, I kept a reflexivity journal and documented my thoughts and emotions to ensure that they did not influence my data and interpretations. My committee's peer debriefing helped me resolve potentially biased emotions and highlighted omissions or errors in judgment.

Significance of the Study

Through this research, I sought to contribute to improved and expanded access to public healthcare by identifying experiential factors necessary for RN-APRN transition resulting in consistent, improved APRN performance and reduced attrition. I increased the understanding of policymakers, nurse educators, and organizations to better prepare new APRNs through my findings. Because the NCSBN (2008) reported that APRN attrition was lower in places that offer transition programs, my findings also revealed

factors that make APRN transition less stressful to build courage and confidence in new APRNs. Through this study, I added to the APRN safe practices information base by presenting APRNs' lived experiences during role transition. By expanding that information base, I informed the public on the transition of new APRNs, thus yielding positive social change.

Illinois' Nurse Practice Act (2007/2018) mandates that APRNs practice RN SOP as part of their portfolio; however, the policy-required RN experience is undefined, and how it affects APRN transitional performance is unknown (Codier et al., 2015; Faraz, 2017; Hennessy, 2017; Rich, 2005). Through this study, I delineated and explained RN-APRN transitional experience and how experiential resources impacted the transitional performance of new APRNs relative to proficiency level and public health and safety. This increased information base informed policymakers about RN-APRN transitional experiences to yield expanded and more effective public policy governing APRNs' preparation and transition from RN-APRN.

The Patient Protection and Affordable Care Act (2010) made health insurance available to many more Americans, thereby increasing their access to healthcare; however, the increase in access to care worsened the shortage of PCPs (Buerhaus et al., 2015). Trained APRNs provide both preventive and curative services to all populations, are expected to assuage the PCP shortage, and are more likely to work in HPSAs, where access to care is insufficient (AANP, 2019a; Buerhaus et al., 2015). The IOM (2001) report on the quality of health care systems emphasized clinician-patient communication, healthcare provider cooperation, and safe healthcare for all patients, yet inconsistent

performance and high attrition related to RN-APRN transitional experience hinders those directives. By filling the APRN transitional experience information gap, I informed improved public policy to expand positive social change. Improving the APRN transition ultimately reduces disease, disability, and death (AANP, 2019a). Improved APRN transition means increased access to healthcare services, especially for underserved communities and HPSAs, and increased availability of PCPs (AANP, 2019a; Buerhaus et al., 2015; Iglehart, 2014). Increased healthcare access implies that more people will receive preventive services, screening, immunizations, early interventions, and curative services (AANP, 2019a). The provision of timely preventive and curative services decreases disability, deformity, death, and reduces healthcare costs (AANP, 2019a). Thus, the positive implications of this study are significant.

Summary

Understandably, healthcare providers' training, transition, and safe practices remain paramount to any nation's health. Millions of people live in areas with inadequate access to health care due to physicians' shortage (AANP, 2019a; Buerhaus et al., 2015; Iglehart, 2014). APRNs serve more in the rural and underserved communities, providing access to healthcare for all, especially the underserved, thereby saving the public from disease, disability, death, and healthcare costs (AANP, 2019a). However, APRNs suffer inconsistent RN-APRN transitional experiences believed to result in varying performance levels and increasing attrition (Codier et al., 2015; Faraz, 2017; Hennessy, 2017; Rich, 2005). However, Illinois' Nurse Practice Act (2007/2018) does not define what encompasses prior RN experience, only that APRNs much possess and include such in

their SOP. Considering that there is minimal information on how prior RN experience impacts the transition from RN-APRN, this lack of adequate public policy is understandable. Thus, it is essential to begin filling that gap in the information base.

Through this descriptive, phenomenological study, I used Benner's (1982) novice to expert nursing model coupled with Kanter's (1977, 1993) theory of organizational structural empowerment to begin filling that gap in the current literature. With this study, I explored factors that help APRNs transition and perform successfully in their new role of administering and prescribing care. Some literature indicated that organizational and environmental factors impact APRNs' successful transition and performance (Phillips et al., 2014; Walker et al., 2017). Thus, I also delineated and explained how those experiential resources impacted APRN transition. Thus, I answered the RQ: How does prior RN experience impact RN-APRN transition and performance?

Chapter 1 introduced the study by including (a) the background; (b) problem statement; (c) purpose of the study; (d) RQ, (e) theoretical framework; (f) nature of the study; (g) definitions; (h) assumptions; (i) scope, delimitations, and transferability; (j) limitations, weaknesses, and researcher bias; and (k) the significance of the study. Chapter 2 contains the literature review, (a) the literature search strategy, (b) theoretical foundation, (c) APRN history, (d) APRN practice model, (e) APRN transition, (f) role development challenges, (g) public policy concerns, and (h) deficiencies in the information. Chapter 3 details the research design and methodology, Chapter 4 the results, and Chapter 5 conclusions and recommendations.

Chapter 2: Literature Review

Illinois' Nurse Practice Act (2007/2018) requires APRNs to incorporate RN SOP and RN experience with the knowledge and skill they gained during APRN training (Nurse Practice Act, 2007/2018). But it is unknown how the vastly varied RN experience, or lack thereof, affects new APRN performance (Codier et al., 2015; Hennessy, 2017; Robert & Goolsby, 2017; Twine, 2018). Because APRNs have different educational preparations and RN experiences (Faraz, 2017; Rich, 2005) and Illinois' Nurse Practice Act does not define the RN experience needed for APRN accreditation, crucial data for public policy are missing.

APRNs constitute a substantial portion of healthcare practitioners in the United States (Hooker et al., 2016), especially in HPSAs (AANP, 2019a). However, Poghosyan, Norful, and Martsolf (2017) noted that few new APRNs work in such HPSAs thus providing minimal relief for the critical healthcare shortages within those HPSAs. Throughout this literature review, I aggregate information about the impact of experience on APRNs' transition and performance, and how that data relates to my RQ, theoretical framework, and research design while addressing the information gap. Thus, the review comprises (a) the literature search strategy, (b) theoretical foundation, (c) APRN history, (d) APRN practice model, (e) APRN transition, (f) role development challenges, (g) public policy concerns, and (h) gaps in the literature.

Literature Search Strategy

Through this study, I aggregated data for policymakers, educators, and other stakeholders on how the RN-APRN transitional experience impacted new APRNs to

develop more effective public policy on APRN training and practice preparation. Search parameters initially ranged from 2015 to 2020; however, the paucity of research in this area (Schwartz & Gambescia, 2017) resulted in a significantly expanded range, dating back to 2000. In some instances, my searches went further back to uncover further related literature. I scrutinized articles from peer-reviewed articles, published dissertations, government documents, professional websites, and news periodicals. I conducted an extensive, systematic literature search using numerous databases and Boolean combinations of keywords, phrases, authors, titles, and other search terms related to this study's various aspects.

Sources included databases, repositories, and libraries: CINAHL Plus with Full Text, CINAHL & MEDLINE Combined Search, EBSCOhost, Google Scholar, MEDLINE, ProQuest Central, PsycINFO, SAGE, and Thoreau Multi-Database-Complete. I also reviewed statistics and reports from government databases and professional websites, including: AANP, the Agency for Healthcare Research and Quality, the National Council of States Board of Nursing, and the Centers for Disease Control and Prevention.

Boolean keyword search combinations consisted of: *advanced practice registered nurse, Benner's theory, experience, graduate, Illinois statutes, Kanter's theory, malpractice, new advanced nurse practitioner, non-nurse graduate, nurse, nursing, organizational structural empowerment, performance, practitioner, proficiency, public policy, registered nurse, roles, staff, statutes, traditional,* and *transition*. While the searches yielded many topics related to APRN practice, such as cost containment and

leadership, I delimited the topics to role, experience, performance, and transition of traditional and nontraditional nurse practitioners.

APRN Policy Development

The Henry Street Settlement (HSS), established by Wald in 1893 to provide health care services to immigrants, paved the way for APRN practice (Keeling, 2015). During home visits, HSS nurses would administer physician-prescribed medications, as well as household remedies, to their patients (Keeling, 2015). The HSS led to the 1925 establishment of the Frontier Nursing Services (Keeling, 2015). Frontier Nursing Service nurses worked unaccompanied and with no onsite physician oversight (Keeling, 2015). These APRN forerunners became further established during World War II when the military temporarily elevated nurses to officer ranks as a mark of recognition. In the 1960s, these expert nurses became known as NPs (Keeling, 2015). According to Keeling, NPS found ways of providing healthcare access to rural communities wherein healthcare was scarce.

Ford, a public health nurse, provided access to rural communities by organizing clinics in local schools and churches (Ligenza, 2015). Ford and Silver, a like-minded pediatrician, developed the first certification program for NPs in Colorado (AANP, n.d.a). According to Keeling (2015), Ford and Silver's NP certification project was "designed to prepare professional nurses to provide comprehensive well-child care and manage childhood health problems" (p. 5). Per the AANP, 2 years later, in 1967, Boston College initiated "one of the earliest master's programs for NPs (para. 3). Following the inception of APRN programs, some physicians and nurses were not thrilled about the

new APRN discipline to encroach on traditional medical roles (Keeling, 2015). After that, the U.S. Secretary of Health, Education, and Welfare restructured the definition of nursing to include the APRN role expansion (Keeling, 2015). APRN programs continued to gain acceptance, and, in 1971, the U.S. Secretary of Health, Education, and Welfare declared that APRNs could serve as PCPs (Keeling, 2015). Logically, that declaration unlocked opportunities for increased access to healthcare services for HPSAs, eventually driving other legislature.

The Patient Protection and Affordable Care Act of 2010

In 2010, President Obama signed the Patient Protection and Affordable Care Act (2010) into law resulting in over 30 million Americans becoming eligible and requiring healthcare services (Fulton et al., 2017). However, the U.S. was already experiencing a shortage of physician PCPs estimated at 400 by 2020 (HRSA, 2013). Thus, the influx of people seeking healthcare undermined and worsened the capacity of the existing PCPs serving the nation (Xue et al., 2016). APRNs became the solution to the shortage of PCPs (Fulton et al., 2017). The Patient Protection and Affordable Care Act facilitated Medicaid expansion and payment reform resulting in more people demanding primary care services in the face of an already severe shortage of PCPs (Xue et al., 2016). Logically, APRNs' training included preventive and curative services and was more likely to work in areas deficient in PCPs.

APRNs, working as PCPs, increase healthcare access, providing high-quality, cost-effective services to all Americans, especially in HPSAs. (AANP, 2019a). Given Xue et al.'s (2016) report that the relaxation of APRN SOP made it possible for more

APRNs to work in the rural areas and serve vulnerable populations, policymakers need to formulate policies facilitating APRN transitional performance. Currently, new APRNs have a turbulent and difficult transition from RN-APRN, which results in a turnover rate twice that of physicians (Fitzpatrick & Gripshover, 2016). Thus, the AANP emphasized the pertinence in removing all restrictions and limitations on APRN practice to fully retain and utilize APRNs to help curtail the lack of PCPs and improve national healthcare. Because I explored the interface of prior nursing experience to the transitional experience of new APRNs in a primary care setting, I aggregated that data, thus, informing public policy on RN-APRN transition. Such additional information could help develop more effective public policies such as states' Nurse Practice Acts.

Illinois' Nurse Practice Act

All nurses in Illinois follow and abide by Illinois' Nurse Practice Act (2007/2018). Illinois' Nurse Practice Act embodies all professional and practical nursing regulations. The Act stipulates how nursing SOP in the State of Illinois. Under this Act, APRNs must have a current RN license, a current APRN license, and national certification. The Nurse Practice Act bases APRN certification on "knowledge and skills acquired throughout an APRN's nursing education, training, and experience" (para. 1). Thus, experience is a critical embodiment of the APRN portfolio; however, how prior nursing experience shapes APRNs' transition and performance remains unclear, inhibiting effective public policy. Furthermore, the Nurse Practice Act does not definitively define the RN experience required of APRNs.

The responsibility of APRNs in Illinois includes the SOP of RN practice (Nurse Practice Act, 2007/2018), but the SOP experience details are not detailed. Because APRNs incorporate their nursing experience into their new role as care prescribers, it is essential to understand how RN experience shapes this new role or, logically, the policy will fall short of the intended outcome. I explored the lived experiences of new APRNs through the lens of Benner's (1982) novice to expert nursing model and Kanter's (1977, 1993) theory of organizational structural empowerment to add to existing information and inform public policy.

Until recently, Illinois' APRN SOP was restrictive as APRNs were mandated to maintain collaborative agreements with physicians for practice; therefore, limiting what APRNs could do and further decreasing public healthcare accessibility (Nurse Practice Act, 2007/2018). In 2017, Illinois Governor Rauner signed into law an amendment to Illinois' Nurse Practice Act permitting APRNs to practice without a doctor's collaborative agreement if they have national certification in their specialty area (Korte, 2017). Korte noted that APRNs must have 4,000 hours of clinical experience with a doctor and 250 hours of continuing education before they may engage in independent practice; therefore, the relaxed SOP incorporated experience as a condition for autonomous practice (Korte, 2017; Nurse Practice Act, 2007/2018). However, because the Nurse Practice Act does not clarify the nature or degree of prior RN experience, research exploring how prior RN experience facilitates the APRN transitional performance is essential to inform potential policy improvement. Through this study, I explored, analyzed, and aggregated clarifying data associated with RN-APRN transitional

performance to inform future policy development. The Amendment to the Nurse Practice Act enhanced access to health care and cost-effectiveness for HPSAs, however the Act remains restrictive for APRN independent practice.

Logically, improved public policy enhancing RN-APRN can improve access to healthcare and cost containment. According to Faraz (2017), the first year of transition to practice for APRNs is incredibly stressful and challenging because they do not go through a residency program like their physician counterparts. Faraz noted that self-confidence and perceived competence are partly responsible for APRN attrition as the first year of practice is quite challenging for APRNs. Barnes (2015) reported that new APRNs' difficult transition from RN-APRN resulted in job resignations with APRNs' attrition twice that of the physicians. Thus, understanding RN-APRN transition is essential to improve associated public policy; however, to fully comprehend that transition, I began at the foundation, the APRN practice model.

Theoretical Foundation

Through this study, I discovered how prior RN experience influenced the performance and transition of new APRNs by exploring their lived experiences and perceptions; thus, the theoretical framework was critical. While I researched many potential models, I chose Kanter's (1977, 1993) theory of organizational structural empowerment to ground the study and Kanter's theory combined with Benner's (1982) novice to expert nursing model for focus, analyses, and interpretation. Benner's model provided the framework for experience-related analyses and interpretation, and Kanter's theory helped relate that experience to specific experiential resources related to

performance. With this dual framework, I explored new APRN transitional proficiencies identifying what resources APRNs perceived facilitated or hindered their successful transition from RN-APRN.

Kanter's Theory of Organizational Structural Empowerment

The organizational structural empowerment theory focuses on the resources necessary for employees to perform successfully (Kanter, 1977, 1993). While consulting for a large company, Kanter witnessed a procedural and unyielding management pattern, leading to a hierarchical system that establishes employees' upward mobility. Kanter's resulting research culminated in the seminal book, *Men and Women of the Corporation*, detailing the theory of organizational structural empowerment and associated concepts. Kanter explicated the importance of empowering subordinates by providing necessary resources for their job, including experiential resources.

Goal attainment requires power, information, and support; thus, employees are, in part, what their organizations make them (Kanter, 1977, 1993). Kanter identified "structure of opportunity, structure of power, and the proportional distribution of people" (p. 245) as the three main factors (building blocks) of the theory of organizational structural empowerment, which in turn have other prepositions and underpinnings. Structure of opportunity referred to opportunity for growth in the organization, proportion referred to employees' social group at work, and power referred to the ability to activate resources such as the visibility of the function, among others (Kanter, 1977, 1993). Kanter posited that an organizational structure could advance or discourage employees' performance without infringing on their distinctiveness or innate capabilities. Kanter also

noted that performance, behaviors, and relationships in the organization influence employees' performance. According to Kanter, empowering employees, information availability, support, and resources are keys to productivity, excellent performance, and reasonable outcome. Kanter noted that the "feedback loop connects position and response" (p. 249); clearly, feedback encourages or discourages employees.

Thus, if a healthcare environment has the structural elements Kanter (1977, 1993) recommended, new APRNs will thrive due to less stress and anxiety associated with the new role. Poghosyan, Norful, and Martsolf (2017) further noted that some organizational practices could impede the full potential of an APRN. Lack of support, resources, and information cause APRN practice to be inefficient and unproductive (Poghosyan, Norful, & Martsolf, 2017). If there is no clear understanding and integration of APRNs into the corporation, an APRN's role may be in jeopardy due to a lack of awareness by other providers and clients (Poghosyan, Norful, & Martsolf, 2017). Poghosyan, Norful, and Martsolf reported that employees and clients did not understand the APRNs' roles resulting in a lack of visibility that affected resource allocation and APRN performance. Therefore, optimum performance is dependent on the available resources and empowerment of new APRNs, a concept for which the theory organizational structural empowerment propositions account.

Theoretical Propositions of Kanter's Theory

The resources at the disposal of an employee affect job performance (Kanter, 1977, 1993). Kanter posited that employees fare better when given all resources necessary to accomplish their tasks. According to Kanter, the organizational structures

necessary for a good outcome for the employee and the organization are employee empowerment, information availability, organizational support, needed resources, and informal and formal power (Blanck & Engström, 2015; Mota, 2015). In this study, I focused on only the propositional structures related to my RQ and study design: employee empowerment, information availability, and organizational support. Poghosyan, Norful, and Martsolf (2017) reported that new APRNs require organizational policies that facilitate practice, especially as "many health care organizations lack a tradition of hiring APRNs and are unfamiliar with how to support the APRN role" (p. 2). Through my study, I aggregated data that may help public policy promulgate organizational policies to facilitate APRN transitional performance. According to Poghosyan, Norful, and Martsolf, newly hired APRNs (less than three years on the job) found their role as an APRN undefined and misunderstood by clients and other employees.

Logically, part of understanding if prior nursing experience influences the transitional experience of new APRNs includes identifying the role that organizational environments effected that transitional experience. Thus, Kanter's (1977, 1993) three theoretical propositions (employee empowerment, information availability, and organizational support) provided the needed structure to ground and focus this study. The three central propositions of Kanter's theory of organizational structural empowerment that I used to explain how prior experience or lack thereof impacted RN-APRN role transition and performance included: employee empowerment, availability of information, and support.

Employee empowerment. Employees are confident in exercising their responsibility if the necessary supplies are available for service because they are empowered when they have the experiential resources that enable attaining individual and corporate goals (Orgambídez-Ramos & Borrego-Alés, 2014). Empowering resources ensure access to information, such as support, technology, and supplies, facilitate employee performance (Kanter, 1977, 1993). Poghosyan, Shang et al. (2015) reported that organizations did not understand the APRN role and that, consequently, that lack of organizational understanding impeded the allocation of practice resources. An organizational practice can enhance or diminish an employee's effectiveness (Poghosyan, Shang et al., 2015). A new RN without prior experience is coming into a new role without much cushion and no situational experience (Benner, 1982). Benner emphasized that empowerment enabled employees to be confident, creative, and resourceful. Kelly and Mathews (2001) and Poghosyan, Norful, and Martsolf (2017) reported that new APRNs felt left out because the organization did not integrate their role with the other healthcare providers. While Kelly and Mathews noted that APRNs received ineffective assistance from other employees, Poghosyan, Norful, and Martsolf attributed the poor organizational APRN role understanding and inadequate support to a lack of integration.

Additionally, in their quantitative study of the new APRNs, Poghosyan, Norful, and Martsolf (2017) reported that some physicians did not trust new inexperienced APRNs' judgment. Poghosyan, Norful, and Martsolf's findings may be due to poor relationships and poor collaboration resulting from a lack of nursing experience. APRNs must maintain a good working relationship and cooperation with other team members

(Poore et al., 2014). Kanter (1977, 1993) posited that the organization fosters such relationships and open communication among all stakeholders. Thus, in a sub-optimal practice environment, new APRNs could have difficulties collaborating with physicians who do not trust their judgment.

Through experience, the practice environment entrenches and grounds practice (Benner, 1982) if APRNs' empowerment is part of the organizational structure (Poghosyan, Shang et al., 2015). Poghosyan, Shang et al. stressed that empowerment enables a new APRN to access all resources and interactions required to provide quality care with excellent outcomes. Poore et al. (2014) reported that new graduates often have poor communication and collaboration capability because they did not practice such interactions during training. Poore et al. noted that inadequate and insufficient communication was responsible for avoidable mistakes in health care. A new nurse must promptly communicate and collaborate with other healthcare providers to avoid adverse patient outcomes (Benner, 1982; Poore et al., 2014). However, Poore et al. found that APRNs did not acquire communication and collaboration skills during training.

Some organizations do not fully understand APRNs' roles and do not integrate them into organizational structures (Poghosyan, Liu et al., 2017; Wallace & Boller, 2014). Poghosyan, Liu et al. noted that higher numbers of inexperienced APRNs felt stakeholders misunderstood APRN roles and all APRNs felt that they were not part of the organizational management. Lack of organizational support adversely affects employees' quality and efficiency (Kanter, 1977, 1993). However, Kelly and Mathews (2001) noted that APRNs with prior experience were more familiar with the organizational practices

and personnel due to prior work experience. Poghosyan, Norful, and Martsolf (2017) reported that poor adjustment to the practice environment leads to burnout, job dissatisfaction, and high turnover rates.

Information availability. APRNs need feedback on their performance and adequate information about the organization's practices, technology, and any other detail that is peculiar to the role of APRN (Dillion et al., 2016). Some of the organizational challenges that new APRNs face include role description and service measurement (Jokiniemi et al., 2015). Kanter (1977, 1993) noted that feedback induces reaction. Thus, new APRNs must receive feedback to improve performance. Applying Kanter's availability of information proposition, new APRNs have no means of evaluating the outcome and quality of their service when feedback is unavailable. Poghosyan, Norful, and Martsolf (2017) noted that new APRNs might be unaware of the organizational practices because the environment is unique. Lack of knowledge of the organization's policies can lead to dissatisfaction and job termination (Poghosyan, Norful & Martsolf, 2017). Thus, because new APRNs possess limited practice experience within the organizational environment, all information necessary must be available. Access to information may help decrease employee anxiety associated with transitioning to the new role (Kanter, 1977, 1993). According to Dillon et al. (2016), the same is correct for APRNs as organizational support and feedback are necessary for their successful transition from RN-APRN.

Organizational support. Support is a crucial element of organizational structural employment (Kanter, 1977, 1993). In a qualitative study of the transition to participants'

first position as an APRN, Kelly and Mathews (2001) found that support and encouragement helped new APRNs gain courage and self-assurance. Kelly and Mathews further noted that experienced nurses also found encouragement useful. Experienced nurses are aware of the power of encouragement, support, and help from other providers (Laschinger et al., 2003). Kelly and Mathews posited that a lack of organizational support for APRNs led to their disillusionment. Support aids and reinforces employees (Kanter, 1977, 1993); thus, support is crucial for new APRNs. While support is a constructive process to building a successful employee (Kanter, 1977, 1993), if support is unavailable, new APRNs may flounder (Kelly & Mathews, 2001). Logically, such a practice environment would not augur well for new APRNs who are adjusting to new positions. In practice, new employees want to know whom to talk to in times of need and how well they are performing (Kanter, 1977, 1993). Therefore, support is vital to the performance of new APRNs.

Staff nurses and APRNs in Laschinger et al.'s (2003) studies related that support was imperative to efficiency and efficacy. Thus, good collaboration and organizational support make the environment conducive to care, autonomy, growth, and advancement. Poghosyan, Norful, and Martsolf (2017) examined and compared APRN patient panels, job satisfaction, turnover intentions, and organizational structures of APRNs in two groups: less than 3-years (newly hired) and more than 3-years (experienced). Poghosyan, Norful, and Martsolf reported that both APRN groups did not have adequate organizational support for their practices, and the inexperienced APRNs had twice the attrition rate. The inexperienced nurses believed the organization lacked understanding of

APRNs' role and felt the physicians did not have confidence in them, resulting in the lack of organizational support (Poghosyan, Norful, & Martsolf, 2017). Because the experienced APRNs in this study did not have the same perceptions about the physicians, prior experience may have played a part in how they related to the physicians. Likewise, the more experienced APRNs might also have had different understandings of the environment because of familiarity with a similar environment in previous assignments or work life. Kanter's (1977, 1993) organizational support proposition aided my exploration of this phenomenon.

Assumptions of Kanter's Theory

To ensure that I maintain the high integrity of Kanter's (1977, 1993) theory, I ensured my study design met all assumptions of the theory of organizational structural empowerment. Kanter put forth five assumptions about the person-organization relationship necessary for the secure application of the theory of organizational structural empowerment:

a) An employee's outcome in the organization is not limited to job interaction; it extends to the organizational environment. Knowing how organizations situate employees in the organizational power and opportunity structures is essential because understanding the person-organization relationship is critical to managing work experiences.
b) Employees adjust their behavior relative to their perception. Some employees have dignity given to them by their organizations, while organizations inhibit

other employees. Expressions of dignity include "recognition, reward, status, autonomy, and control" (p. 251).

c) Employee behavior results from "a sense-making process involving present experiencing and future projecting rather than psychological conditioning in which the dim past is a controlling force" (p. 252). Employees have the freedom to react unless their responsibility is restrictive.

d) Constraint placed on employee's responsibility exerts influence on the employee. Consequently, an employee may not accomplish all tasks, thus, avoid unfavorable or unusual tasks.

e) Competence, "sex, background, or conformity" could all be factors preventing performance measurement as well as any other factor restricting or limiting employees' capability (p. 253). Thus, an employee has limitations relative to the job and the organizational environment that controls their actions.

Similar Prior Theoretical Application of Kanter's Theory

Researchers have used organizational structural empowerment theory to evaluate the impact of organizational policies on employees since 1977 (Blanck & Engström, 2015; Kanter, 1977, 1993; Laschinger et al., 2003; Mota, 2015; Poghosyan, Shang, et al., 2015). Blanck and Engström studied the perceptions of the district nurses prescribing exercise in Sweden and their relationship to structural resources using Kanter's theory. Blanck and Engström found that the nurses who identified with organizational structural empowerment elements had favorable opinions about prescriptions and that nurses who had more resources to prescribe did so more often. Blanck and Engström attributed the

low rate of prescriptions to formulary restrictions, which, in turn, affected their proficiency. Poghosyan, Shang et al. examined APRNs practice environments using Kanter's theory of organizational structural empowerment. Poghosyan, Shang et al. found that a lack of organizational role clarity and poor organizational relationships presented APRNs' challenges. Lack of role clarity can influence how other employees and clients accept the APRN, while a poor relationship with the administrators can hamper collaboration (Poghosyan, Shang et al., 2015). Logically, the availability of resources enabling the fulfillment of APRN's SOP impacts transitional performance.

Another similar prior theoretical use of Kanter's (1977, 1993) theory also included an in-depth credibility analysis of the theory. Laschinger et al. (2003) conducted a secondary analysis of three different studies to validate Kanter's organizational structural empowerment theory. Laschinger et al. employed two studies from staff nurses and one from acute care APRNs. Laschinger et al. studied the relationship between organizational structural empowerment and hospitals characterized by positive nurse-physician relationships and autonomy. Laschinger et al. determined that the theory of organizational structural empowerment was reliable ($r = 0.56$) for determining participants' perceptions of empowering organizational structures, such as autonomy, practice control, and physician collaboration, impacting their professional practice.

Additionally, Mota (2015) used Kanter's theory to explore oncology nurses' structural empowerment, inquiring about their perceptions of structural empowerment and the availability of information, support, opportunities, and resources needed to meet responsibilities. Kanter's theory aided Mota in answer their RQ, which is like the nature

of my study. Through my study, I discovered new APRNs' perceptions of organizational structural empowerment and what it meant to their transitional performance relative to their proficiency.

Rationale for the choice of Kanter's Theory

I selected Kanter's (1977, 1993) theory of organizational structural empowerment due to its successful similar previous use, its extensive use by other scholars, and the excellent fit it provided to focus my study toward answering my RQ. Laschinger et al. (2003) choose Kanter's theory to explore what factors facilitated and empowered participant's proficiency and performance. Similarly, I explored the organizational factors that impacted APRNs transitional performance relative to prior nursing experience. Kanter delineated factors necessary for employees to be successful and productive in the organization. According to Kanter, organizational structural empowerment includes experiential resources such as support, information, and empowerment that enhance employee performance. Poghosyan, Shang, et al. (2015) reported that the availability of experiential resources enhances new APRNs' performance but found that administrators did not share information with new APRNs as much as they did with physicians leading to poor outcomes. My study explored and explained the perception of new APRNs on experiential resources available for their practice during transition relative to their performance and skill level as an RN.

New APRNs encounter challenges relative to their role and organizational support as they navigate the new practice environment. According to Dillon et al. (2016), organizational support and feedback are crucial for the successful transition of APRNs.

Through my study, I explored how new APRNs of various skill levels interpreted organizational resources' influence on their transitional performance to determine if those resources contributed to their transitional-related stress. Kanter's (1977, 1993) theory of organizational structural empowerment grounded my analyses, thus explaining APRNs' perceptions of empowering structures to answer my RQ. As posited by Kanter, I considered support and feedback as organizational structural empowerment that impacted employee performance.

The availability of HIT facilitates support and feedback and reduces errors in healthcare (IOM, 2012). Feedback enables performance review and elicits a necessary reaction (Kanter, 1977, 1993). The public's safety is paramount to the scope of APRN practice (Nurse Practice Act, 2007/2018). The IOM (2001) recommended that healthcare systems ensure and render safe care, foster communication, and encourage providers' collaboration. Poghosyan, Norful, and Martsolf (2017) reported that new APRNs are given fewer resources for their practice than the physician but did not research how this impacted the transitional experience of new APRNs. Blanck and Engström (2015) studied the perception of the district nurses prescribing habits in Sweden and their relationship to structural resources and found that restricted resources diminished the number of prescriptions. Logically, favorable public policies for APRN transition from RN will facilitate APRNs' transitional performance. Kanter's theory of organizational structural empowerment provided an optimal grounding framework to investigate this information gap.

Relationship of Kanter's Theory

The relationship of Kanter's prepositions to my study relates to explaining those factors in new APRNs practice environment that facilitates or hinders transitional performance. Through this study, I explored how work environment resources available to new APRNs impacted their transitional performance. With the theory of organizational structural empowerment, Kanter (1977, 1993) posited that employees' resources determine and empower employee performance. Kanter posited that the employees' organizational environment, including support, information, and empowerment, is responsible for employee performance. I explored how new APRNs internalized their transitional performance considering the organizational structural empowerment, the experiential resources at their disposal relative to APRN self-reported proficiency levels. Kanter also posited that employee empowerment extends from the organization and includes the entire spectrum of the person-organization relationship. Because I explored how new APRNs perceive relationships, interactions, and information available for their transitional experience, Kanter's theory provided a perfect foundation to answer my RQ.

How the RQs Relate to Kanter's Theory

With this study, I explored the impact of RN-APRN transitional experience on APRN performance, inquiring:

> RQ1: How do new APRNs internalize their role transition and performance considering the availability of organizational structural empowerments necessary for their professional responsibilities and SOP analyzed using Kanter's (1977, 1993) theory of organizational structural empowerment.

RQ2: How do new APRNs view and interpret their transitional performance as an APRN relative to their RN proficiency level gaged using Benner's (1982) from novice to expert nursing model?

Transition to an APRN from an RN is challenging, confusing, and chaotic (Fitzpatrick & Gripshover, 2016). A turbulent transition period can disenfranchise a new APRN from continuing with the nursing profession (Barnes, 2015). The practice environment is key to how employees perform (Kanter, 1977, 1993). According to Kanter, employees' performance is dependent on empowering resources from the organization. Such factors as information, support, and resources are responsible for employees' performance (Kanter, 1977, 1993); thus, the organizational structural empowerment theory provided the structure necessary to answer my RQ.

Benner's Novice to Expert Nursing Model

Due to the complexity of the healthcare field, Benner (1982) recognized a need to study experienced and novice nurses for "long-term and ongoing career development" (p.402). Benner adapted Dreyfus and Dreyfus' (1980) model of skill acquisition, thus, developing the novice to expert nursing model. Dreyfus and Dreyfus noted five skill attainment stages and growth: novice, advanced beginner, competent, proficient, and expert levels. Benner conducted interviews and participant observations of 51 experienced nurse clinicians, 11 new graduate nurses, and five senior nursing students in six different hospitals to ensure the feasibility of Dreyfus and Dreyfus' model. Through observation and interviews, Benner identified the performance of nurses at different proficiency levels. Thus, Benner confirmed the foundational applicability of Dreyfus and

Dreyfus' model to develop the nursing model. According to Stinson (2017), nursing researchers widely use Benner's novice to expert nursing model.

A nurse grows incrementally in skill from novice to expert through experience and education (Benner, 1982). Benner further emphasized that nurses learn experientially; therefore, as nurses engage in real-life situations, they advance from novice to expert over time. Stinson (2017) added that it takes at least a year for a nurse to progress from novice to advanced beginner. The theoretical propositions of Benner's model define each level of proficiency.

Theoretical Propositions of Benner's Model

The novice to expert nursing model outlines five levels of clinical proficiency, which Benner (1982) labeled and described as:

1. Novice: This group of nurses has no experience. Their performance is based on rules and protocols given to them as a guide to their work.
2. Advanced beginner: These nurses have acquired some experience but cannot distinguish between "aspect and attributes" and remain guided by rules (p. 404). Aspects being "the recurrent meaningful situational components" (p. 404). Thus, these nurses are unable to prioritize care.
3. Competent nurse: It takes 2-3 years of nursing practice to attain a competent level. At this level, the nurse can determine what aspects and attributes are most essential and can establish long-term care goals and plans. However, the nurse still "lacks speed and flexibility" (p. 405).

4. Proficient nurse: A nurse gains the proficient level as they continue working and gaining experience. At this level, the nurse anticipates and sees the whole situation, has gained much experience, and can anticipate and plan how to solve problems.
5. Expert nurse. The expert nurse performs without depending on rules and guidelines. Instead, the expert nurse relies on a wealth of experience to promptly reach decisions, uses intuition for decision making, and is very experienced.

Similar Prior Theoretical Application of Benner's Model

Nursing researchers widely use Benner's (1982) novice to expert nursing model (Brown & Sorrell, 2017; Garland, 1996; Nyikuri et al., 2019; Stinson, 2017). Brown and Sorrell (2017) examined the challenges of novice nurse educators' transitions from practice to the classroom using Benner's model as the theoretical foundation for their qualitative study. To understand participants' challenges and solutions, Brown and Sorrell interviewed seven faculty members with an average of 1.6 years of teaching experience. Brown and Sorrell found that novice educators needed more guide and support from expert educators. Brown and Sorrell further contended that the experienced clinicians transitioning to nurse educators were having difficulties with the new role and could leave as a result. Likewise, Garland (1996) studied the self-reported surgical nurses' competency level to identify the progress levels that best fit nurses' proficiency levels. Garland used Benner's model combined with demographic data to collect nurses' clinical experience and work assignment data. Garland found that nurses transition from

novice to expert level at different speeds and intensities. Similarly, through my study, I will explore how new APRNs' prior nursing experience interfaces with transitional primary care performance.

My approach was akin to Nyikuri et al.'s (2019) to understand the meaning APRNs attach to their transitional performance relative to their prior nursing experience. Nyikuri et al. explored nurses' perspectives of neonatal nursing expertise and the profession's development in Kenyan hospitals. Nyikuri et al. aligned their study to Benner's (1982) novice to expert nursing model to ask neonatal nurses their perceptions eliciting the nurses' experiences relative to the profession. The nurses reported that building experience started at employment (Nyikuri et al., 2019). Nyikuri et al. emphasized the need to establish programs to develop expert nurses, as outlined by Benner. Using Benner's model as the framework, Stinson (2017) studied the relationship between RNs' clinical experiences and clinical decision-making processes in a critical care environment.

Stinson conducted a descriptive correlational study to answer the RQ: What is the relationship between nurses' clinical experience and clinical decision-making in a critical care environment? Stinson used a 40-item scale self-report instrument that presented questions such as "the search for alternatives and options, canvassing of objectives and values, evaluation and reevaluation of consequences, and search for information…" (p. 55). Stinson's participant sample included critical care RNs (n = 413), wherein Stinson noted that "lower scores meant negative perception of decision making, while higher scores represent a positive perception of decision making" (p. 55). Stinson found no

differences in scores among the five proficiency levels of Benner's (2001) theory of novice to expert level. However, Stinson noted that the critical care nurses in this study scored higher than other nurses in other studies, possibly because they had longer clinical experience than nurses in other studies.

Although quantitative, Stinson (2017) identified the impact of more clinical experience on clinical decision making and noted that 83.1% of the sample was at the expert nurse level. Stinson's finding of higher scores of clinical decision-making in nurses with more clinical years corroborates Benner's (1982) theory of expert-level performance. The sample in this study was skewed, and so the results may be different if there were equal numbers of nurses representing each proficiency level. Stinson's study was relatable to my research question of how prior nursing experience influenced the nurses' transitional experience who experienced the phenomenon. Although Stinson's study was quantitative, it validated Benner's expert theory performance. Similarly, I explored participants' lived experiences to discover how their proficiency level interfaced with their new responsibilities and decision-making skill. Clinical decision-making is fundamental to healthcare practice (Stinson, 2017); therefore, it is crucial for APRN practice.

Rationale for the Choice of Benner's Model

Like Brown and Sorrell (2017) and Stinson (2017), I used Benner's (1982) novice to expert model as a framework for my study to understand the experiential challenges of new healthcare providers. Specifically, I used Benner's model to explore how prior nursing experience influenced APRNs' performance levels by exploring how prior RN

experience interfaced with new APRNs' RN-APRN transitional performance from the APRNs' perspectives. How the APRNs interpreted their transitional experiences concerning their previous RN performance provided a critical understanding of how the new APRN incorporated RN SOP into their APRN portfolio.

How Benner's Model Relates to This Study

Through this research, I explored the impact of prior RN experience on the transitional performance of new APRNs; thus, a framework providing performance level structure was critical. Benner's (1982) model provided precisely the structural focus needed to identify nurses' performance levels. Benner developed the model precisely to gauge nurses' experience, proficiency, and capability by categorizing prior nursing experience and decision-making skills similarly to how researchers use paradigms. These principles and the model propositions made Benner's model a perfect framework for my study.

How the RQs Relate to Benner's Model

Through my RQ, I explored how new APRNs viewed and interpreted their transitional performance from RN-APRN, considering their level of proficiency using Benner's (1982) novice to expert nursing model. Benner lists five proficiency levels, thus, providing a valuable structure in identifying the specific proficiency levels needed to answer my RQ. Benner noted that the nursing practice description is context-free, whereas my research was context-bound and added to existing descriptions of nursing proficiency levels associated with new APRNs' performance.

APRN Development Considerations

APRNs are emersed in clinical supervision, public health and safety, professional growth, and emotional well-being throughout their transitional training, and each plays a role in how an APRN develops the skills to deliver independent PCP services (Arrowsmith et al., 2016; Cummings & Connelly, 2016; El-Banna et al., 2015; Farr, 2018; Teoh et al., 2013; Walker et al., 2017). Each of these environments influences how a new APRN develops, transitions, and performs (Benner, 1982; Kanter, 1977, 1993). Thus, literature considering each of these environments helped provide insight into the gap in the information base.

Clinical Supervision and APRN Experience

Illinois state recently relaxed APRN practice from requiring written collaborative agreement with a physician to allow APRN practice without a physician agreement after accumulating 4,000 hours of clinical practice and 250 hours of continuing education (Nurse Practice Act, 2007/2018). APRNs' requirement to acquire clinical practice and continuing education infers an expectation for experience before having independent practice. According to Fulton et al. (2017), APRNs receive clinical practice in various healthcare services and graduate with different levels of clinical performance. However, the varying levels of clinical experience may impact how APRNs perform. Supervised clinical rotation requirements apply to nurses during training; however, after graduation, nurses work independently (Herron, 2017). Dillon et al. (2016) studied 34 acute care APRNs using a correlational-comparative design and found that years of experience did not impact transition. Dillion et al. reported that most participants had more years of

nursing experience, which could be responsible for their finding. Because APRNs administer and prescribe care, understanding their transitional experience to APRN is a matter of public health and safety.

Public Health and Safety

Public health and safety are paramount to healthcare delivery (Nurse Practice Act, 2007/2018). Thus, any factor that improves safe patient care is essential. All stakeholders want to know that any patient care is safe and effective and that the healthcare provider can provide such care (Kavanagh & Szweda, 2017). While the NCSBN (2008) ensures safe nursing practices and public safety, about 44,000 - 98,000 fatalities occur every year at hospitals from medical mistakes (IOM, 2012). In 2006, the IOM reported 1.5 million avoidable unfavorable drug-related events (IOM, 2012). These circumstances brought healthcare services safety to the forefront of public policy concerns (IOM, 2012). While the IOM mandates that graduate nurses use sound clinical judgment to ensure patients' safety (Herron, 2017), Benner (1982) noted that inexperienced novice nurses do not use critical thinking in completing tasks. Thus, newly graduated APRNs may struggle with decision-making. Herron concluded that "experiential learning combined with collaboration" will better prepare new nurse graduates (p. e390).

Logically, the safety of the public and safe practices motivate nursing's governing bodies to ensure that all licensed nurses operate within their SOP. According to Illinois' Nurse Practice Act (2007/2018), APRNs should incorporate an RN SOP, education, training, and experience into their SOP. However, unsafe practices occur at any level or place of care either from human, technological, or system failure (NCSBN, 2008).

Through this study, I delineated these experiences related to the level of the APRN's practice using Kanter's (1977, 1993) theory of organizational structural empowerment to facilitate understanding of those experiences.

Finding ways to reduce healthcare errors is beneficial to the public, and health information technology (HIT) is one of many methods of medical error reduction (IOM, 2012). Kanter (1977, 1993) noted that the employee's resources determine how successful and productive an employee becomes. Thus, the availability of HIT for healthcare workers helps decrease medical errors. According to Dillon et al. (2016), APRNs' successful transition must include organizational support and feedback. Kanter supported feedback as a form of organizational structural empowerment that boosts employee performance. Feedback encompasses evaluation based on performed actions (Merriam-Webster, n.d.a). I grounded this study with Kanter's theory of organizational structural empowerment combined with Benner's (1982) novice to expert theory to understand how APRNs' transitional experiences influence their professional growth.

Stages of Professional Growth

Nurses learn from training and hands-on experience (Benner, 1982). Because attaining an RN license is a prerequisite to becoming an APRN (Faraz, 2017; Rich, 2005), their nursing experiences are a fundamental part of an APRN's training. Husserl (1954/1970), Beyer (2016), and Rudestam and Newton (2015) posited that people acquire knowledge through description. Nurses acquire knowledge partly through description, acquaintance, and classroom instruction (Rudestam & Newton, 2015). Clearly, nurses gain experience from various sources; however, how that experience affects their

transition to APRN remains unclear. Benner (1982) posited five nursing practice levels related to how experienced a nurse is, from novice to expert.

During the transition from RN-APRN responsibility, the new APRNs start as novices (Benner, 1982). Benner noted that a new nurse goes through five stages of professional growth, "a novice, advanced beginner, competent, proficient, and expert" (p. 402). Nurses evolve from having no experience at the beginning of practice to expert nurses with good clinical decision-making capability and knowledge (Benner, 1982). A nurse's successful progression to the expert level relies on past experiences and takes more than five years of clinical practice to attain (Stinson, 2017). According to Benner, novice nurses lack experience and depend on rules for task performance. Benner reported that relying on rules for performance has the inherent danger of an inability to prioritize care. Benner posited that experience helps a nurse acquire direct knowledge through hands-on practice, which compels them to act in a way designed to achieve good results. Subsequently, Benner added that if past exposure to a similar situation did not produce the desired effect, the nurse did not adopt the failed action and instead initiated what experience demonstrated to produce a good outcome.

Clearly, experience helps guide the actions of APRNs. Stinson (2017) studied nursing experiences and decision-making using a correlational mixed-method design and found no differences in scores among the five stages described by Benner (1982). However, Stinson reported that nurses with more experience demonstrated more favorable clinical decision-making skills. Thus, experience confers desirable decision-

making skills. Fitzpatrick and Gripshover (2016) reported that new APRNs found gaps between training and practice, leading to anxiety and lack of confidence.

Transition Shock, Confidence, and Attrition

New APRNs face high levels of strain; as noted by Fitzpatrick and Gripshover (2016), "the stress of transition shock can cause anxiety, insecurity, and exhaustion, which may lead to role dissatisfaction, suboptimal performance, and possible failure in the workplace" (p.e419). Fitzpatrick and Gripshover posited that new APRNs face the challenges of new responsibilities and transition from administering physician orders to prescribing orders. Monaghan (2015) posited that new nurse graduates required more time during clinical skill acquisition training and, thus, lacked confidence in their capabilities and readiness to practice.

Confidence

The nursing experience exposes nurses to different skills and hands-on practice, which invariably confers some level of expertise and confidence over time (Benner, 1982; Faraz, 2016). Faraz noted that an APRN possessing nursing experience more confident about their new APRN role. A new nurse graduate is a newly qualified nurse that lacks self-confidence (Monaghan, 2015). Logically a new APRN who obtained the status of an RN during the APRN program is also a newly qualified nurse inclined to lack confidence and readiness for practice. Ortiz (2016) posited that confidence was essential for a new graduate nurse rendering safe patient care.

Although the theory-practice gap continues to shrink, there remains a lack of confidence and readiness among new nurse graduates (Monaghan, 2015). A new nurse

goes through stages of professional growth as they engage in the practice of nursing (Benner, 1982). Benner discussed the stages a new nurse goes through before they become experts and posited that, in the beginning, the new nurse only adheres to rules and grows to use of knowledge gained through experience as they acquire skills. Although nurses go through education, training, and clinical rotation before graduation, moving into a new role as a PCP responsible for diagnosing and treating patients may cause APRNs anxiety and uncertainty (Faraz, 2016). Ortiz explained transition theory as the stages a new nurse graduate goes through:

1. Doing (first 3-4 months)
2. Being (next 4-5 months)
3. Knowing (final 8-12 months; p. 19)

According to Ortiz, during the first stage, the new nurse exhibits a lack of confidence, which affects their competency and the quality of care given to patients. Cummings and Connelly (2016) found that nursing experiences gained from repeated stimulation of clinical practices increased nursing students' confidence and logical decision-making. Fitzpatrick and Gripshover (2016) explained that a lack of confidence and unpreparedness could affect APRN transitional performance.

Transition Shock

New nurse graduates find differences between what they learned in the classroom and the workplace reality (Ortiz, 2016). Arrowsmith et al. (2016) emphasized that novice nurses have higher anxiety and emotional distress during role transition than experienced nurses. Ortiz also noted that new nurses experience anxiety, a lack of confidence, and

feelings of inadequacy for their responsibilities. According to Teoh et al. (2013) and Monaghan 2015), new nurses suffer reality shock when confronted with situations different from their beliefs. Fitzpatrick and Gripshover (2016) concluded that novice APRNs experience transition shock from the gap between knowledge acquired from their training and successful performance requirements.

Thus, experiencing real-life situations may help new graduates learn and gain knowledge (Benner, 1982; Faraz, 2016). According to Illinois' Nurse Practice Act (2007/2018), all practicing nurses must be qualified to practice nursing and maintain public confidence. The Nurse Practice Act further stipulated that APRN practice should include RN SOP, skills obtained during APRN training, education, and experience. According to Jones et al. (2014), APRNs with nursing experience found their new role less challenging. Thus, nursing experience may increase the confidence of novice nurses.

Attrition

As new APRNs realize that the knowledge acquired during training is sometimes not practicable in their work-setting, they often get disillusioned (Faraz, 2016; Fitzpatrick & Gripshover, 2016). Monaghan (2015) determined that a lack of confidence may cause new graduates to avoid undertaking specific duties, limiting opportunities to acquire knowledge through practice. According to Fitzpatrick & Gripshover (2016), new APRNs experience "transition shock described as disorienting, confusing and doubt-ridden chaos" (p. e419), consequently causing a lack of self-confidence, poor performance, and turnover intentions. As a result, the turnover rate of APRNs is high, twice that of the physicians (Fitzpatrick & Gripshover, 2016). Thus, discovering and ameliorating the

factors responsible for the high turnover of new APRNs will boost the number of PCPs available for healthcare services, consequently increasing accessibility to PCPs and decreasing disease burden, deformity, disability, and cost.

The IOM (2011) called for full practice authority and attrition reduction of APRNs. NCSBN (2008) attributed the 25 % first-year new nurse graduates' attrition to role transition. Fitzpatrick and Gripshover (2016) reported that novice APRNs' attrition rates are nearly twice that of physicians and related the phenomenon to the turbulent RN-APRN transition experience. By exploring RN-APRN transitional experiences to further understand the phenomenon's impact on APRN performance, I also uncovered factors contributing to APRN attrition.

The work environment, the complexities of HIT, and transitional experience encompass an APRN's ability to administer and prescribe safe healthcare (Barnes, 2015; Benner, 1982; Kanter, 1977, 1993; Rich, 2005; Walker et al., 2017); yet how their transitional experience affects their performance remains unknown. The uncertainty of complex healthcare environments makes it crucial for employers to have policies to support new APRNs' practices (Walker et al., 2017). Nurses gain skills and experience from their work environment (Benner, 1982). Walker et al. noted that new nurses need their employer's assistance to gain "skills and experience" (p. 505). Kanter (1977, 1993) noted that employee performance hinges on the resources available to carry out their responsibilities; one of these resources is the feedback mechanism. Thus, the practice environment is critical to how well the new APRNs transition and perform in their new roles. Thus, examining and understanding new APRN graduates' experiences revealed

factors hampering the provision of quality care. However, Barnes and Rich expressed concern that a lack of RN experience influences new APRNs' performance. I explored how prior experience as an RN impacted APRNs' transitional performance to begin filling the gap in the current information base.

APRN Practice Model

The training model and education of APRNs guide the healthcare services they provide and are prime research areas for the APRN professional body (Roberts & Goolsby, 2017). According to Litchman et al. (2018), in 2008, the APRN Joint Dialogue Group enacted the APRN Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, & Education to guide state nursing boards on APRN licensure, accreditation, certification, SOP, roles, and education. Litchman et al. contended that the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, & Education fostered uniform approaches to safety and quality healthcare across states.

One such approach, the Shuler Nurse Practitioner Practice model, depicts APRNs as healthcare providers who render holistic patient-centered healthcare through preventive services, diagnosis, and treatment of diseases (Shuler & Davis, 1993). Per the Shuler Nurse Practitioner Practice, APRNs consider many factors that impact a patient's wellbeing, including culture and faith (Shuler & Davis, 1993). An assumption of the Shuler Nurse Practitioner Practice model is APRNs' ability to positively influence the health behavior of the patients (Shuler & Davis, 1993). Though many APRN functions and specialties vary, some tasks that remain common to every APRN include teaching,

counseling, and observing disease manifestation (Lowe et al., 2017). Thus, the versatility of combining medical and nursing models within their practices enables APRNs to curtail the worsening of the physician shortage compounded in 2010.

With the advent of the Patient Protection and Affordable Care Act (2010), 32 million uninsured Americans gained access to health insurance, resulting in increased access to healthcare leading to an increased need for PCPs (Wallace & Boller, 2014). PCPs serve as the patient's point of contact for healthcare services (AAFP, n.d). Because APRNs receive training to provide primary medical services and advanced practice nursing skills (Keeling, 2015), logically, APRNs help aggregate some of that increased demand. However, APRNs must have the confidence, competence, and skill to transition to their new role wherein they are responsible for making critical medically related decisions, administering, and prescribing care (Owens, 2018). Therefore, confidence, skill, and competency are necessary for successful transitional performance, critical thinking, and decision-making; however, the nursing experience necessary to ensure APRNs' smooth transitional performance remains unknown.

Critical Thinking and Decision-making

While the correlation between clinical experience and decision making is unclear, Stinson (2017) reported that critical care nurses with increased clinical experience possessed better clinical decision-making skills. Decision-making is salient to APRN duties, as Benner (1982) noted that expert nurses use intuition for decision-making; however, how prior nursing experience interplays with the transitional performance of new APRNs remains unknown. Poor decision-making ability results in flawed reasoning

and poor judgment (Herron, 2017). Herron conducted a phenomenological study of 14 nurses with less than 18 months' practice to determine how well prepared the nurses were to recognize and prevent complications in their patients. Herron found that participants were not well prepared to care for extremely sick patients. Heron noted that, as students, the nurse participants were not exposed to emergencies during their training and, therefore, not prepared to handle emergencies after graduation. Herron's findings support the theory that prior nursing experience impacts APRN performance, indicating a need to understand the prior experience better. Herron also noted that new nurse graduates are not proficient in critical thinking. Critical thinking enables a nurse to assess and collect pertinent information on a patient's health status, determine the best action to take, and evaluate the outcome of those actions (Herron, 2017). Thus, critical thinking skills help nurses detect and intervene early to save a patient's health from getting worse and consequently achieve a good outcome. Therefore, flawed diagnostic reasoning and acumen endanger the patient's clinical outcome, is fraught with complications, and increases healthcare costs.

Good clinical insight produces better patient outcomes both in emergent and non-emergent situations (Herron, 2017). The IOM (2001) recommended educational preparation that empowers new nurse graduates' clinical judgment for positive patient results. During training, nursing students receive guidance in decision making but do not gain experience, resulting in graduates with inadequate clinical reasoning experience (Herron, 2017). As the new nurse graduate's clinical judgment and confidence become evident, those inadequacies compromise their practice resulting in poor performance and

attrition (Herron, 2017). Thus, inadequate clinical experience may be a factor in improving RN-APRN transitional performance and reducing attrition.

Confidence and Nursing Experience

APRN practice contains both nursing and medical underpinnings (Shuler & Davis, 1993); thus, APRNs confidently use their nursing knowledge and skills in their APRN practice. Additionally, APRNs combine nursing and medical models for practice (Shuler & Davis, 1993). Illinois' Nurse Practice Act (2007/2018) mandated every professional nurse to combine RN SOP into APRN SOP. A novice nurse graduate does not have experience and is at a loss in new and challenging circumstances (Benner, 1982). Non-traditional APRNs are new nurse graduates accustomed to only nursing skills learned during training; thus, they do not accumulate RN experience before APRN practice (Rich & Rodriquez, 2002). APRNs need to instill confidence in the public (Nurse Practice Act, 2007/2018). Nurses exude confidence by being sure of their clinical judgment (Herron, 2017). Herron noted that proficiency as a nurse occurs with years of caring for patients and making patient care decisions. Kim and Kim (2015) found that years of experience consistently affected nurses' competency with various clinical backgrounds.

Inadequate professional skills and low self-confidence lead to poor judgment in administering and prescribing healthcare and predispose APRNs to lawsuits (Croke, 2003). Malpractice lawsuits against nurses continue increasing (Budryk, 2016; Croke, 2003). Croke noted that independence in professional practice predisposes nurses to error. During RN employment, a nurse gains exposure to various situations that demand

professional skill, knowledge, and clinical judgment(Benner, 1982). Kolb (1984) developed the experiential learning cycle, positing that people learn from experiencing new situations, which creates a unique experience that brings about change (Poore et al., 2014). Therefore, practice reinforces and refines knowledge through experience.

Logically, any new circumstance or opportunity leads to knowledge acquisition; thus, nurses learn by practicing in real-life situations at work. Barnes (2015) conducted a quantitative study using a convenient sample of RNs and found that degree and type of experience influenced RNs' transitional experiences. Barnes' convenient sample may not be generalizable due to the sampling method's potential bias. Echoing Benner (1982), Barnes noted that nurses are disposed to experiential learning when caring for patients with similar characteristics. Logically APRNs employed in environments like their previous RN experiences feel confident about performing prescribing care for patients in familiar settings. By grounding this study with Kanter's (1977, 1993) theory, I researched and discovered the practice environment most conducive for RN-APRN transitional performance, thus addressing my RQ and informing public policy on APRN transition.

Any environment, familiar or otherwise, depends on the organizational environment and the employees' experience levels (Kanter, 1977, 1993). Mota (2015) explored oncology nurses' perceptions of structural empowerment and found the presence of empowerment structures and a significant need for structural improvement. Using Benner's (1982) model in conjunction with Kanter's theory, I analyzed and identified RN-APRN transitional challenges related to prior RN experience and organizational empowerment; thus, I reported both separate and combined findings. Because the APRN

practice model combines both nursing and medical aspects (Shuler & Davis, 1993), the nursing aspect of the SOP may present problems related to some new nurse graduates' lack of experience and, thus, lack of clinical intuition.

Clinical Intuition

RN experience predisposes nurses to reinforce or refine their actions and enhances their intuitive clinical judgement through the knowledge acquired from practice (Poore et al., 2014). Intuition is a feeling that a person harbors concerning a prevailing situation that cannot be logically analyzed (Herron, 2017). Benner (1982) noted that experienced nurses use intuition to arrive at clinical decisions. Intuitive clinical judgment becomes more meaningful as nurses gain clinical experience (Herron, 2017). Expert nurses use intuition during patient management, while new nurses cannot interpret this feeling (Benner, 1982). Miller and Hill (2018) reported that nurses notice some quantifiable physical symptoms during intuitive reasoning, especially nurses with more nursing experience. These quantifiable symptoms lead nurses to quickly and efficiently attend to patients' needs and prevent deterioration and death (Miller & Hill, 2018). Rosciano et al. (2016) reported that all nurses, regardless of their experience, use intuition. In a cross-sectional descriptive correlational study, Rosciano et al found that nursing experience had no relationship to the use of intuition; thus, leaving a gap in understanding the phenomenal relationship. Rosciano et al. did not state how frequently both groups, experienced and non-experienced nurses, utilized intuition in clinical reasoning.

Medical practitioners use intuitive reasoning, which is a characteristic of an expert nurse, as Benner (1982) outlined. Stinson (2017) classified the five levels outlined in Benner's model as novice (less than 6-months of clinical experience), advanced beginner (6 months to 12 months of clinical experience), competent (1 to 3 years of clinical experience), proficient (4 to 5 years of clinical experience), and expert (over 5-years of clinical experience). Stinson used the critical components of intuitive reasoning to establish nurses' proficiency level, including pattern recognition, similarity recognition, common sense understanding, skill salience, and deliberative rationality. Thus, experience may be a key factor of RN-APRN transitional performance.

RN-APRN Transition

A nurse's transition to an APRN role is complex and demanding (Fitzpatrick & Gripshover, 2016; McLellan et al., 2015). The challenges of transitioning are private and job-related (MacLellan et al., 2015; Moran & Nairn, 2017). MacLellan et al. noted that "levels of knowledge and skills, educational preparation, and professional recognition of clinical expertise within a defined area of clinical practice are precursors" of APRN role transition (p. 393). Thus, the experience and skill levels of new APRNs without prior nursing experience are likely to be different from that of an APRN with RN experience. Transitioning from an RN to an APRN can be daunting and impact performance (Twine, 2018). According to Dlamini et al. (2014), interacting and mixing with others at work helps new nurse graduates to overcome transitional challenges and gain confidence in their abilities. Therefore, familiarity with the practice environment and the people in it

might increase new graduate nurses' confidence and performance. Through this study, I explored these factors.

Lack of clinical experience is another problem within the APRN role (Whitlow, 2015). During clinical practice, nurses confront opportunities to collaborate and interact with other healthcare team members (Andregård & Jangland, 2015). According to Andregård and Jangland, the APRN role's journey is complex and influenced by many factors that correlate with Benner's (1982) assertions regarding the relationship between nursing experience and competence. Cantlay et al. (2017) found that experienced nurse graduates were ready to practice, however a few were not confident to undertake the full responsibility for their tasks. A new APRN who is not confident about their new role will have professional identity and growth challenges (Andregård and Jangland, 2015). Barnes (2015) emphasized that a lack of professional identity hinders professional growth; thus, professional identity helps new APRNs gain self-confidence in their new role. Barnes also noted that a lack of experience portends a more prolonged role transition and that tension during the transition was responsible for increased attrition. Because the IOM (2011) reported that high attrition rates were a problem in the nursing profession, advocating research examining potential turnover mitigation, I explored the transitional confidence of new APRNs as well.

In a qualitative case study exploring the challenges of novice nurse educators' transition from practice to classroom, Brown and Sorell (2017) found that some participants were unprepared, and all participants found the transition very challenging. Brown and Sorell used the board of nursing's self-study to assess the participants'

background with less than 2-years of experience as nurse tutors. Brown and Sorell reported some challenges corresponded to Benner's (1982) novice level of the novice to expert nursing model. Brown and Sorell reported that participants faced unfamiliar content and lacked adequate experience and skill to carry out nurse educator roles. Factors like unfamiliarity and inadequate ability could stem from transitional training or practice.

APRN Training

Before 1990, the NP program was a certification program; whereas, after 1990, NP programs evolved to a graduate-level education program (Barnes, 2015; Pulcini, & Wagner, 2002). Entry levels for NP programs vary in content and delivery from one university to another through online, in person, or a hybrid of both (Chavez et al., 2018; El-Banna et al., 2014; Rich, 2005). Additionally, there are bridge programs for candidates with an associate or bachelor's degree in non-nursing fields who want to become NPs (Schneider, 2020). To become an APRN, one must be a graduate of an accredited APRN program and have either an MSN or Doctor's Nursing degree (AANP, 2013). While discussion continues about requiring a DNP for entry-level in APRN practices, that stipulation does not yet exist (AANP, n.d.b). APRNs receive training in specific patient populations and specialties (AANP, 2013; NCSBN, 2008). Per the NCSBN, there are four roles for APRNs:

a) CNP is "responsible and accountable for health promotion, disease prevention, health education, and counseling as well as the diagnosis and management of acute and chronic diseases" (para. 3). CNPs are PCPs trained

to provide initial, ongoing, and comprehensive healthcare clients in various primary care settings.

b) CNS is trained "for diagnosis and treatment of health/illness states, disease management, health promotion and prevention of illness and risk behaviors among individuals, family groups and communities" (para. 4). CNS also manages "the nurse and nursing practice, as well as the healthcare organization and system" (para. 4).

c) CRNA "provides a full spectrum of patients anesthesia care and anesthesia-related care for individuals across the life span whose health status may range from healthy to all levels of acuity" (para. 5).

d) CNM "provides a full range of primary healthcare services to women throughout their lifespan, including gynecological care, family planning services, preconception care, prenatal and postpartum care, childbirth and care of the newborn" (para. 6).

According to the NCSBN (2008), APRNs can further specialize and certify in various populations, including family and individuals across lifespans, neonatal, pediatrics, gender-related services, and psychiatry (p. 1). During the clinical practicum, APRNs train in specialty-specific areas, remain supervised during clinical rotations, and are not in charge of patient care decisions (AANP, 2013). According to AANP (2013), all APRNs become nationally certified in their specialty. To be eligible for state licensure after completion of an accredited APRN program, APRNs must pass the national certification in their specialty (NCSBN, 2008). Additionally, some states only award an

APRN license after completing the nursing board examination and certification (AANP, n.d.b). Lowe et al. (2017) reminded that, although APRNs often follow various educational and training routes and perform functions relevant to their specialties, tasks common to all of them include teaching, giving advice, and observing disease manifestation.

The different paths to becoming an APRN include traditional and non-traditional alternatives (Rich, 2005). Traditionally, a registered nurse with an ADN must obtain a BSN before proceeding to MSN (Schneider, 2020). Alternatively, it is also possible to enroll in an MSN bridge program, which allows an RN to earn a BSN and MSN simultaneously (Schneider, 2020). There are also accelerated programs for non-nurse graduates of other non-nursing backgrounds, like Animal Science, who are interested in becoming APRNs (Smith-Barrow, 2016). Schneider and Smith-Barrow also noted that training for non-nurse graduates includes both undergraduate and graduate programs. Additionally, some programs require 1-year of RN experience before enrolling in an APRN program, while others do not require any experience (Rich, 2005). The prerequisite for RN work experience to enter an APRN program is to ensure exposure to the healthcare environment and clinical aspects of nursing, which are essential for decision making (Rich, 2005). According to Rich and Smith-Barrow, while the traditional students have some RN experience, students in accelerated programs often do not possess any RN experience.

Even so, novice nurses, regardless of their type of training, have a narrow approach instead of a broad intervention to a new or complicated problem (Cormier &

Whyte, 2016). Cormier and Whyte noted an absence of research examining accelerated second-degree nurses and traditional nurses' clinical performance. Cormier & Whyte found that the second-degree graduate nurses recognized clinical problems faster than traditional nurses and attributed the variance to the second-degree nurses' maturity and age. All Cormier and Whyte's participants were from different nursing programs and had no prior nursing experience. According to Cormier and Whyte, novice nurses are not capable of "decision making based on situational perception and comprehension of the multidimensional nature of the situation" (p. 139). Cormier and Whyte's findings correlated with Benner's (1982) assertion that novice nurses cannot identify situations due to a lack of experience. Furthermore, Barnes (2015) recommended that admission into an APRN program requires a curriculum that considers the impact of experience on practice. Raftery and Tori (2015) noted that new APRNs gain exposure to opportunities to acquire knowledge from experienced APRNs through mentoring and gain some experience through practice.

APRN Mentoring

Novice APRNs can interact with experienced APRNs through mentoring (Andregård & Jangland, 2015; MacLellan et al., 2015; Raftery & Tori, 2015). Mentoring is a way experienced APRNs nurture, teach, and enhance the transition of new APRNs to the role of APRN practice (Raftery & Tori, 2015). During mentoring, new APRNs gain knowledge through practice in diagnosing and treating patients, collaborating with other healthcare providers, and interacting with their practice environment (Raftery & Tori, 2015). MacLellan et al. posited that mentorship and a conducive environment help

ameliorate anxiety and role confusion that confronts new APRNs. In a meta-analysis of qualitative studies, Andregård and Jangland also found that new APRNs had no confidence in their ability and knowledge to carry out their responsibilities due to role ambiguity. Andregård and Jangland reported that new APRNs relied on mentoring to grow their expertise and professionalism.

Additionally, MacLellan et al. (215) noted that experienced APRNs impacted the professional identity, efficiency, and capability of new APRNs during the mentorship. As Raftery and Tori (2015) remarked, it takes an experienced APRN to guide a new APRN to avoid the transitional difficulties associated with the lack of experience in a new role. Logically, mentoring increases experience twofold: (a) from the combined experience of both mentor and mentee and (b) by providing the experiential resource of mentoring to the new APRN. Raftery and Tori posited that, through quality mentoring, new APRNs would flourish and mentor other incoming APRNs, thereby increasing the workforce. Barnes (2015) reported that nursing experience enhanced transition into practice, while limited experience triggered a prolonged practice transition.

APRN Practice Environment

APRNs practice in various healthcare settings following their specialty and population-specific certification (Dubree et al., 2015; NCSBN, 2008). Although literature often uses APRN and NP titles interchangeably, it is pertinent to know that not all APRNs are NPs. As Dubree et al. noted, each role has subtle differences, and all APRNs practice according to their license and certification. CNMs, CNPs, and CNSs practice as PCPs (NCSBN, 2008); however, NCRAs do not. To ensure consistency in this study, I

used only APRNs practicing as PCPs. Following the inception of the Patient Protection and Affordable Care Act (2010), the need for APRNs to render primary care services increased (Hart & Bowen, 2016), yet how the practice environment facilitates the transitional performance of new APRNs in primary care settings continues under-researched. Poghosyan, Norful, and Martsolf (2017) noted the dearth of information on healthcare organization's ability to provide a favorable environment for APRN practice; however, how new APRNs view those resources' availability remains unclear.

Clearly, experience impacted APRNs' view of their practice environment; however, I found minimal literature about how prior RN experience impacted APRNs' view of empowering resources associated with their practice environment. Poghosyan, Norful, and Martsolf (2017) found that both experienced and inexperienced APRNs confront challenging organizational environments; however, novice APRNs have a higher tendency to change jobs than do experienced APRNs. Poghosyan, Norful, and Martsolf's findings infer a necessity to explore the impact of prior experience on APRNs' perceptions of available organizational SOP structures. Poghosyan, Norful, and Martsolf reported that organizations that lack adequate work resources and have a weak relationship between APRNs and the administrators result in decreased job efficiency, dissatisfaction, and high attrition in new APRNs. Logically, experienced APRNs are more apt to overcome organizational challenges due to prior experiences and exposure. Organizational structures conducive to the APRN workforce are essential for a new APRN's successful practice (Poghosyan, Norful, & Martsolf, 2017). Poghosyan, Norful, and Martsolf noted a "need to understand what organizational structures are important for

newly hired NPs" (p. 2). Thus, it is crucial to integrate APRNs into the organization (Poghosyan, Norful, & Martsolf, 2017). Through this research, I explored APRNs' perceptions of organizational empowerment resources. I began addressing the organizational structures information gap identified by Poghosyan, Norful, & Martsolf by identifying essential APRNs practice resource needs.

Complicating structural issues, new APRNs reported poor role visibility, a lack of physicians' trust, and the lack of integration at various organization levels (Poghosyan, Norful, & Martsolf, 2017). Using Kanter's (1977, 1993) organizational structural empowerment theory to consider prior nursing experience, I delineated these issues' various aspects. Kanter's theory helped me rationalize and describe the differences between the factors reported by Poghosyan, Norful, and Martsolf and how they influence APRNs' transitional performance and retention, thereby increasing access to healthcare services. The lack of integration results from situations where organizations, employers, and employees are not well informed about APRNs' role (Poghosyan, Shang, et al., 2015). Poghosyan, Shang et al. reported that some organizations do not integrate APRNs into their managerial staff, resulting in cascading role failure as the APRN role remains obscure. As a result, Poghosyan, Shang et al. noted that new APRNs experience role ambiguity and poor collegial socialization in the early part of their practice. Therefore, APRNs need to be part of the team of professional healthcare providers to perform to the full capability of their training effectively. Fitzpatrick and Gripshover (2016) advocated for a successful workplace relationship and "joining a novice NP group" (p. e419) as ways to decrease transition distress related to the new APRN practice environment.

Transition distress causes detachment from one's usual social circle, a strange new environment, new requirements, and new expectations (Moran & Nairn, 2017). Moran and Nairn described the transition as moving from a "place of comfort and familiarity towards a place of unknown territory" (para. 6). Logically, leaving school and enter an unfamiliar territory to practice a new and challenging role may be daunting to a new APRN. According to Barnes (2015), a problematic transition impacts APRN performance. To this effect, exposure to a familiar background might offer some hope. One way to gain that exposure is by functioning as an RN in a healthcare setting (Benner, 1982). A well-integrated APRN is part of the professional group, a resource, and a leader to other nurses (Andregård & Jangland, 2015). New APRNs need to collaborate with other healthcare providers as a team to ensure safe patient care (Andregård, & Jangland, 2015). The IOM (2010) recommended collaboration among healthcare providers to provide safe patient care.

APRNs provide safe and cost-effective healthcare services in their practice setting (AANP, 2019a); however, APRNs' responsibilities differ from one healthcare setting to another (Lowe et al., 2017). Additionally, Lowe et al. noted that the duty of an NP changes relative to the environment of practice and the patients' needs. AANP (2013) reported that APRNs work in "ambulatory, acute, and long-term care as primary and specialty care" (para. 1). In long-term facilities, APRNs work in the physicians rendering preventive and curative services, diagnosis, case management, teaching, and health promotion (Chavez et al., 2018). Chavez et al. noted that APRNs collaborate with other health care providers to provide both acute and chronic disease management and reported

that long-term facilities with APRN service decreased their treatment rate request. Chavez et al. noted that a decreased service request rate is beneficial in decreasing the cost burden resulting from the increasing number of older Americans requiring health care services.

With a projected old-age dependency ratio decreasing from "three and a half working-age adults to every single retirement-age person in 2020 to two and a half working-age adults to every single retirement-age person by 2060," America is a graying nation (U.S. Census Bureau, 2019, para.7). Thus, there are significantly fewer working-age adults to care for older people. Older generations are predisposed to chronic medical conditions, multiple diseases, and mobility problems (Morilla-Herrera et al., 2015). Morilla-Herrera et al. reported that multiple diseases, recurrent hospitalizations, multiple medications, and deficiency of self-care are prevalent problems in older adults. With the projected increase in the population of older Americans (aged 65 years and over) above the population of children by 2035 (U.S Census Bureau, 2019), better preparing and retaining APRNs that care for older Americans is crucial. APRNs that work in long-term care have notably decreased the mortality rate, hospitalization, and self-care deficit in older Americans dwelling in long-term care facilities (Morilla-Herrera et al., 2015). However, no research demonstrated the transitional performance characteristics of the APRNs in those roles. Morilla-Herrera et al. defined long-term facilities as places where health services provide care for chronically sick and impaired patients.

APRNs perform many duties and functions for chronically sick and impaired patients, including diagnosis, physical exams, ordering diagnostics, and prescribing

medications and therapies (Owens, 2018; Schneider, 2020). The older generation is predisposed to chronic medical conditions, including multiple diseases and mobility problems, limiting their activities (Morilla-Herrera et al., 2015). Morilla-Herrera et al. reported that the presence of various diseases, recurrent hospitalizations, multiple medications, and self-care deficiency are also problems prevalent in older adults. Fortunately, Chavez et al. (2018) found that long-term facilities with APRN services had a decreased rate of treatment requests. A decrease in the rate of a service request is beneficial in reducing the cost burden that is likely to arise from the number of older Americans requiring health care services (Chavez et al., 2018). Still, I found no research demonstrating the characteristic of those APRNs that successfully impacted the positive outcomes in older Americans' care in various facilities.

APRNs provide vital healthcare in various environments like communities, hospitals, physicians' offices, military installations, prisons, long-term care facilities, and senior and assisted living homes (Nurse Journal, 2018). However, nurse graduates' transitional challenges often include a lack of professional experience, intuition, education, and unfamiliar or challenging environments (Benner, 1982; Hennessy, 2017; Stinson, 2017). In my study, I explored how prior nursing experience and available resources interfaced with the transitional performance of new APRNs; thus, analyzing the associated challenges in APRNs' role development.

Challenges of Role Development

Throughout their role development, APRNs face various challenges, including role identity, collaboration, clarity, role recognition, organizational policies, and

inadequate resources (Jokiniemi et al., 2015). Organizational support overcomes many of these challenges (Kanter, 1977, 1993) and experience (Benner, 1982). Kanter developed the theory of organizational structural empowerment, from which I examined the influences of organizational feedback and resources on RN-APRN transitional performance, providing the structure for exploring such perceptions and their impact on performance. Benner detailed the novice to expert nursing model, from which I analyzed the impact of prior RN experience on RN-APRN transitional performance to rank nursing proficiency levels.

One thorny issue of transition to the role of APRN is how well the APRN will fit in and integrate with other professionals (Andregård & Jangland, 2015). A Team approach to healthcare provides a safe and reduced cost of care to patients (MacLellan et al., 2015). An environment that allows APRNs to integrate and collaborate with other professionals augurs a precursor for safe care (IOM, 2011). However, Kanter (1993, 1977) posited that it is the organization's responsibility to provide feedback and resources for employees to thrive.

Organizational Feedback and Resources

APRNs rely on the organization for the resources that facilitate and ensure collaboration with other healthcare providers and the efficiency and effectiveness of the healthcare services that the APRNs provide (Poghosyan, Norful, and Martsolf, 2017). Kanter (1977, 1993) posited that employee performance is related to the organization's resources, and collaboration is integral for the actualization success. Sullivan (2018) noted that continuing education for nurses should include team collaboration with

physicians and other healthcare providers, including educating the physicians about how to collaborate with APRNs. Additionally, APRNs collaborate with other health care providers to provide acute and chronic disease management (Chavez et al., 2018; Poore et al., 2014). Thus, it is critical to understand how the environment impacts the APRNs' ability to collaborate with other healthcare providers during the transition from RN-APRN. As APRNs practice independently, they will begin to acquire experience in interacting with others as healthcare providers.

The new nurses become conscious of timely intervention as experience teaches them how to manage critical circumstances (Benner, 1982; Poore et al., 2014). According to Bazzell and Dains (2017), collaboration is vital because it will help cushion the clinical challenges new APRNs face when confronting the gap between what they learned and what they practice, thus, enabling professional advice when necessary. Feedback and collaboration are vital organizational factors that impact new APRN performance (Benner, 1982). Benner and Kanter (1977, 1993) noted that feedback elicits reaction; thus, performance improvement logically follows any negative feedback, and confidence grows from positive feedback. Brown and Olshansky (1997) reported that new APRNs' confidence in receiving positive feedback improved, confirming Benner's and Kanter's assumptions. Brown and Olshansky also noted that positive feedback from the patients resulted in increased APRN self-assurance about their judgment and patient outcomes, which, in turn, enhanced APRN future performance. The impact of feedback on new APRNs underscores the necessity to understand APRNs' perceptions about organizational structural empowerment.

Empowerment, support, and clarity are contingent on each other (Kanter, 1977, 1993). Role clarity influences relationships and collaboration with other healthcare providers (Poghosyan, Norful, & Martsolf, 2017). According to Kanter and Mota (2015), a lack of formal power (role recognition), informal power (collaboration), and needed resources mitigate the effectiveness and efficiency of employees. Thus, APRNs need clarity about their responsibilities and feedback on their performance to collaborate effectively and provide optimal healthcare services to patients.

However, role ambiguity plagues new APRNs (Poghosyan, Norful, & Martsolf, 2017). In an interpretive literature review of APRN novice workforce transition into primary care, Faraz (2016) reported that role ambiguity, professional relationships, intrinsic, and extrinsic obstacles challenged APRNs. Likewise, APRNs in Jokiniemi et al.'s (2015) qualitative study expressed ambivalence about their role and the lack of organizational understanding. Jokiniemi et al. posited that organizations' rigidity, ranking, inadequate resources, and lack of feedback negatively affected the APRNs' performance. According to Poghosyan, Norful, and Martsolf, new APRNs perceive collaboration and administrator relationships differently due to a lack of role clarity, patients' poor role perceptions, and lack of cohesion with other workers. However, why inexperienced APRNs perceive role clarity differently than experienced APRNs remains unclear.

Intrinsic and extrinsic obstacles, like self-doubt and disillusionment, relate to the workplace and a lack of clinical support (Faraz, 2016). Benner (1982) noted that nurses progressively transform from one competency level to another in their professional

practice as nurses, thus, gaining confidence and insight. All professionals undergo some transformation following graduation to practice leading to different performance levels (Cherniss, 1995). Furthermore, as those professionals continue evolving in their profession, their philosophy changes in response to their practice environment (Cherniss, 1995). Cherniss noted that novice professionals had trouble advancing from the student role to the professional role because they experienced job frustration and burned out in the first year. Cherniss attributed this negative change to a lack of support and decreased human and financial resources. Logically, support resources influence new APRNs' experience in the first year of practice and transitional performance.

Additionally, new APRNs reported that the available ancillary practice support inadequate, but that support was less than the support available for the physicians (Poghosyan, Norful, & Martsolf, 2017). Because some organizations are not cognizant of the role of new APRNs, many administrators do not adequately provide resources for APRNs SOP (Poghosyan, Shang, et al., 2015), which may account for the lack of adequate support for APRNs. According to Andregård and Jangland (2015), how organizations support APRN transition and collaboration among healthcare colleagues impacts APRN transitional performance from the start of their practice. For example, Codier et al. (2015) noted that a poor organizational welcome and acceptance of non-nurse graduates results from organizational skepticism about the APRN’s ability in their new work environment. Logically, new APRNs feel unwanted, subsequently impacting their professional practice, which could be leading to disillusionment and job abandonment.

New APRN dissatisfaction and job abandonment are related to APRNs' perceived lack of organizational empowerment and poor relationships with the administrators (Poghosyan, Norful, & Martsolf, 2017). Feelings of abandonment stem from a lack of organizational support and empowerment (Kanter, 1977, 1993). Per the IOM (2011), it is essential to retain new APRNs to curb the decline in the number of PCPs; thus, policymakers must develop more effective public policy on APRN role transition. My findings inform policymakers of potential interventions that organizations and colleges could provide new APRNS to increase APRN role clarity and job satisfaction.

Role clarity equates to structure, and job satisfaction improves performance resulting in reduced stress and subsequent attrition (Kanter, 1977, 1993). Andregård and Jangland (2015) noted that the first year of APRN practice is stressful even for experienced APRNs. Compounding that stress, APRNs sometimes find themselves in organizations wherein employees do not understand the APRN's role (Andregård & Jangland, 2015). Andregård and Jangland noted that APRN roles are frequently viewed differently from one team member to another. For example, doctors frequently see APRNs as new resident physicians, employees identify APRNs as medical assistants, and yet others feel APRNs are complementary staff (Andregård & Jangland, 2015). Confusion about job responsibility makes the work environment unpalatable for any new professional (Kanter, 1977, 1993). According to Andregård and Jangland, a "lack of understanding of the NP role as a PCP may limit managers' abilities to create productive NP practice environments" (p. 48). Clearly, organizations must know and implement resources that facilitate new APRN roles.

Furthermore, an organization versed in an employee's professional role will extend that understanding to all employees, significantly reducing role ambiguity (Kanter, 1977, 1993). Thus, the organization is responsible for creating a suitable environment for all employees to thrive, especially the new APRN (Poghosyan, Norful, & Martsolf, 2017). Logically, new APRNs may not practice their full academic training and skills if some team members in the organization are uninformed about their role. Andregård and Jangland (2015) posited that a lack of APRN role understanding and responsibility leads to conflicts, explicitly noting that doctors admitted not knowing what an APRN can do. That role ambiguity and unhealthy practice environment caused significant stress for the new APRNs (Andregård & Jangland, 2015). Role familiarity among team members significantly facilitates collaboration among team members (Kanter, 1977, 1993). Andregård and Jangland confirmed the principle of role familiarity, finding that team collaboration improved after other team members understood the APRNs' roles.

In long-term care, APRNs work together with various healthcare professionals to ensure quality, safe, and effective healthcare for all patients (Morilla-Herrera et al., 2015). One way to ensure IOM's (2011) goal attainment is to improve collaboration between nurses, physicians, and other team members (Sullivan, 2018). Kanter (1977, 1993) explained that a symbiotic relationship between the organization and employee affects employees' performance. Poghosyan, Norful, and Martsolf (2017) attributed inexperienced APRNs' role transition difficulty to the APRNs' new organizational environment and unfriendly welcome. Poghosyan, Shang, et al. (2015) and Kanter

reported that the lack of employer encouragement caused reduced employee productivity and adverse outcomes. According to Kanter, employees that work in an environment with clear role distinctions have less stress, which positively impacts employee job performance. Brown and Olshansky (1997) found that nurses transitioning to APRNs pass through four stages: 1) laying foundations, 2) launching, 3) meeting challenges, and 4) broadening perspectives which correlated to Benner's (1982) novice to expert nursing model. Brown and Olshansky also noted that, at the launching phase, new APRNs often feel like imposters due to their lack of experience. Thus, I also explored new APRNs' perceptions about their lived experiences during the transition as those experiences interfaced with prior RN experience and organizational structures for their SOP.

Learning through Experience

When an organization commits to giving employees adequate resources and feedback, those employees perform well (Dillon et al., 2016), which, logically, provides expanded opportunity for experiential knowledge and improvement through continued job performance. Nugroho and Afif (2014) confirmed this assumption, reporting that Riyad nurses' performance was affected by "organizational commitment, job satisfaction, personal, and professional variables" (para. 4). An APRN's practice builds on RN skills (NCSBN, 2008), underscoring the need to understand how RN proficiency levels impact new APRNs' transitional performance and their perceptions of organizational structural empowerment.

Experiential knowledge is a means of acquiring knowledge through work or activity and is crucial for skill acquisition (Benner, 1982). Benner emphasized that skills

developed from hands-on and learning are continuous. Kolb (1984) posited that learning comes from the activity and takes place with each new contact or experience. Barnes (2015) and Benner noted that experience is a catalyst for obtaining skill and nursing proficiency. According to Benner, nurses progress from novice to expert practitioners as they practice; thus, experience elevates their proficiency and confidence level.

However, new APRNs lack confidence about their role performance, resulting in self-doubt (Maclellan et al., 2015). According to Fitzpatrick and Gripshover (2016), new APRNs come from a variety of backgrounds with different levels of experience in healthcare and are subject to "disorienting, confusing, and doubt-ridden chaos" (p. e419). Fitzpatrick & Gripshover noted that new APRNs experienced "anxiety, insecurity, and exhaustion," and APRNs believed that they required more education and support to overcome it (p. e419). Kanter's (1977, 1993) theory of organizational structural empowerment, in conjunction with Benner's (1982) novice to expert nursing model, will help me understand the lived experiences of new APRNs and factors that produced such alarming feelings. According to Fitzpatrick and Gripshover, while physicians receive extra training following medical school, new APRNs do not.

Many new APRNs have no experience practicing what they studied (Fitzpatrick and Gripshover, 2016). Benner noted that nurses gain confidence and increase in proficiency as they practice, emphasizing that experience is key to competent practice. Logically, novice APRNs' feelings of inadequacy may be due to a lack of previous RN experience.

A lack of experience is a likely precursor to burnout due to the significant stress associated with a new role (Cherniss, 1995). Because a lack of nursing experience influences how non-nurse graduate APRNs practice (Rich, 2005), the lack of prior RN experience may be subjecting non-nurse graduate APRNs to challenges associated with their lack of experience. Hart and Bowen (2016) emphasized that nursing experience is beneficial to APRNs' new daring role. Hart and Bowen found that many new APRNs described their roles as tedious, often felt incompetent and overwhelmed, and thought that nursing experience could help mitigate those challenges. All nurses progress in professional competency through education and on-the-job learning (Benner, 1982), which correlates with AANP's (2013) statement that APRNs must engage in lifelong learning and professional development.

In their retrospective study of the APRNs' educational preparedness, Hart and Bowen (2016) recommended prior experience to increase APRNs' ability to practice after graduation. Jones et al. (2014) conducted a qualitative research study examining how APRNs felt about their practice preparation. After interviewing 23 APRNs, Jones et al. found that some APRNs without prior experience were not competent enough to care for older adults and found that APRNs with prior RN experience were confident in their abilities. In a research study of factors that influence employee performance, Nugroho and Afif (2014) reported that the level of education did not affect employee performance and argued that "job exposure and long work experience positively impacted knowledge, skill, and leadership" (para. 4). Nugroho and Afif also noted that APRNs gain exposure to nursing and long work experience through prior nursing experience. Nugroho and Afif

posited that APRNs who worked as RNs before attaining APRN licensure were familiar with the roles of different cadres of nurses and the practice environment.

Prior nursing experience and orientation are facilitators of role transition (Barnes, 2015). Benner (2004) noted that "the science of medicine and nursing are broad and multidisciplinary and require translation into particular practice situations" (p. 189). According to Benner, unfamiliar practice circumstances challenge nurses; however, each practice situation presents an opportunity to learn and subsequently translates into knowledge that is usable in practice. Each presenting condition demands astute diagnoses and situational knowledge application (Benner, 2004). Thus, nurses learn each day at work as they encounter new tasks and challenges.

While some APRNs feel their prior RN experience was helpful for the APRN role, others reported that they were unprepared for their new APRN roles (Twine, 2018). Twine conducted an integrative literature review of first-year APRNs' transitional experiences, reporting that the APRNs were not ready for their role and wished they had more training. Twine found that some APRNs used "past nursing experience to fill knowledge gaps related to the perception of preparedness" (p. 56). Likewise, Schram et al. (2018) posited that "new graduate nurses are novices who can have difficult transitions in critical areas, as knowledge, skills, and critical thinking develop over time with experience" (p. 353). Thus, all APRNs may not be ready for practice on their own due to difficulties with knowledge, skills, and critical thinking. According to Barnes (2015), RN experience impacts transition.

Trends in technology and short hospital stays result in a significant need for experienced nurses (Benner, 1982). Benner posited that a novice RN depends on rules and regulations because they do not have any experience with their tasks and cannot volunteer judgment. According to Benner, discretionary judgment is crucial for decision-making in nursing. Therefore, a new APRN's responsibility builds on nursing skills and prescribing care. In Benner's novice to expert nursing model, experience lays the foundation for proficiency progression stages: novice, advanced beginner, competent, proficient, and expert nurse. Barnes (2015) also posited that the type of experience APRNs had as RNs impacted their performance in similar fields. Thus, if a new APRN works in a similar setting where they had prior nursing experience, their performance will be better.

RN experience before becoming an APRN is a foundation from which new APRNs build their practice and skills (NCBSN, 2008). Jokiniemi et al. (2015) reported that experience, skill, and knowledge were pertinent APRN performance factors and emphasized that nursing experience is the bedrock of APRN performance. Likewise, Benner (1982) found that RN experience is beneficial for competency, progression, and development, and the lack of prior nursing experience negatively impacts judgment and healthcare service outcomes. Nurses are lifelong learners (Jensen, 2007). Skår (2010) emphasized that nurses learn as they work and interact with their work environment, patients, and other professionals; thus, nurses learn through experience.

Furthermore, new APRNs learn and develop a plethora of skills in their first year of practice (Bazzell & Dains, 2017). Bazzell and Dains noted that in the first year of

practice, new APRNs must "learn new skills, increase their knowledge, and evolve into their new role" (p. e375). According to Bazzell and Dains, in a 2004 survey, only10 % of new APRNs were entirely ready for practice whereas, 51 % were not ready. Barnes (2015) noted that APRN job abandonment was twice that of physicians and linked that phenomenon with the APRNs' new role and poor transition to their new position. According to Chernis (1995), the new APN graduates' perception of their roles changes as the APRN changes following transitional experience in primary care due to the learned theory versus the practice experience gap.

The theory-practice gap confronts every new nurse (Arrowsmith et al., 2016), and, as they practice in supporting organizations, they gain experience and get comfortable with their clinical practice (Brown & Olshansky, 1997). It is pertinent to explore how these new graduates see their roles and the factors that impact the new APRNs since this data could inform future policy requirements for APRN programs. Critical discretionary decision-making in nursing builds on nursing skills and during the transition (Benner, 1982); it is also reliant on organizational support and empowerment (Kanter, 1977, 1993). Alarmingly, however, Stinson (2017) and Hennessy (2017) reported stakeholder doubt about the performance of RNs who graduated from Accelerated Second Degree BSN programs because they do not have prior nursing experience.

Stakeholders Perception of APRNs' Prior Clinical Experience

The stakeholders in healthcare settings include patients, policymakers, physicians, APRNs, nurses, administrators, employers, nurse educators, and the community. Illinois'

Nurse Practice Act (2007/2018) required all nurses to gain public confidence, thus, stakeholder confidence; however, many scholars report apprehension of ARPN skill (Andregård & Jangland, 2015; Jakimowicz et al., 2017; Pino-Jones et al., 2019; Poghosyan, Norful, & Martsolf, 2017). Andregård and Jangland and Pino-Jones et al. found that physicians preferred APRNs with prior clinical exposure. Andregård and Jangland reported that some physicians believe APRNs are dependent and required supervision, considerable specialty experience, and should know the practice environment. Jakimowicz et al. specifically noted that a lack of trust and confidence might cause stakeholders to refuse APRN services.

Clearly, it is just as crucial for APRNs to earn the patients' trust and confidence as it is for the physicians. As part of the healthcare team, it is critical to service, patient care, and productivity for other team members to value each team member's skill (Poghosyan, Norful, & Martsolf, 2017). Poghosyan, Norful, and Martsolf related that team members' confidence in APRN judgment and patient care is crucial. Having good judgment and confidence makes way for effective communication and collaboration with other healthcare providers (Benner, 1982). However, Andregård and Jangland (2015) found that new APRNs lacked trust and respect from some nurses. Poghosyan, Norful, and Martsolf echoed this lack of confidence concerning physicians' trust in inexperienced APRNs' judgment compared to experienced APRNs.

Nurses must gain the public's confidence (Nurse Practice Act, 2007/2018); however, if physicians and other collaborators do not have confidence in the nurse, logically, neither will the public. Andregård and Jangland (2015) reported that physicians

feel APRNs need supervision and extensive experience, without which those physicians felt the new APRNs are dependent. In a systematic review of studies investigating patients, nurses, and doctors' experiences with APRNs, Jakimowicz et al. (2017) found that those stakeholders had reservations about APRNs related to "responsibility, trust, and accountability" (p. 1).

APRNs collaborate with other healthcare providers (Poghosyan, Norful, & Martsolf, 2017). Unfortunately, Dlamini et al. (2014) found role conflict between new APRNs and experienced RNs relating to responsibilities. Andregård and Jangland (2015) noted that conflicts might also arise due to unfamiliarity with the healthcare environment and team. Andregård and Jangland did not delineate if all the APRNs had prior RN experience before becoming APRNs. According to Poghosyan, Liu et al. (2017), APRNs thrive in an organizational environment that enhances collegial relationships, yet Poghosyan, Norful, and Martsolf found that physicians did not trust new APRNs' judgment. Poghosyan, Norful, and Martsolf also noted that experienced APRNs felt that physicians trusted their judgment.

With Wald's establishment of the NP program, initiated by Ford and Silver, APRNs stepped into a daring new role as primary health care providers (Keeling, 2015). Sadly, some organizations, physicians, and nurses still do not support the APRN program due to its lack of clear boundaries in medicine and nursing (Jakimowicz et al., 2017; Keeling, 2015). Through my research, I explored and delineated organizational and prior RN experiential factors that impacted new APRN transitional performance to inform

policymakers and organizations about empowering resources and prior RN experience impacting new APRN transition.

APRN Public Policy Concerns

The objections to APRNs stemmed from the fierce opposition of medical groups and other stakeholders who did not accept the evolution of APRNs becoming PCPs despite legislation allowing such (Chesney & Duderstadt, 2017). APRN requirements include national board certification, state-level APRN licensure and registration, an RN license, and the completion of graduate-level nursing education, including a BSN indicating strenuous national and state-level oversight in addition to rigorous educational achievement (AANP, n.d.b). The IOM recommended allowing nurses to perform all services according to their training to increase healthcare access for the anticipated millions of new patients resulting from the Patient Protection and Affordable Care Act (2010; Sullivan, 2018). According to Illinois' Nurse Practice Act (2007/2018), the full extent of APRN training includes all skills and knowledge APRNs learned as professionals during APRN programs in addition to RN SOP.

APRNs evaluate, treat, and manage acute and chronic illnesses; educate and teach patients about their disease; and coordinate their care (AANP, n.d.b). CNPs, CNSs, CRNAs, and CNMs all practice as APRNs (AANP, 2013; NCSBN, 2008); however, APRN is a broad classification embracing various nurse providers (Dubree et al., 2015); therefore, not all APRNs are PCPs. Dubree et al. noted that, regardless of the type of APRN program, "each specialty has specific nuances to their scope of practice and the climate surrounding their practice" (p. 44). All APRN students must have between 500 to

600 hours of clinical rotations in their program-specific settings (Twine, 2018). Supervised clinical rotations occur during training to ensure safe healthcare services (Herron, 2017). As a result of the supervision requirement, new APRNs often consider early practice supervision as a necessary safeguard tool (Gardenier, 2015). While Gardenier noted that some novice APRNs might see supervision as a safeguard, Gardenier also posited that APRNs with prior RN experience in a similar field or specialty might not need the clinical rotation safeguard. While public safety is at the heart of policies guiding APRN practice (IOM, 2001), national policy expands the country's need for APRNs, state policy dictates APRN licensing and limits APRNs' practice ability, and the gap in those policies remains.

Nationwide Considerations

APRNs are a significant population of U.S. healthcare providers overseen by public policy and organizational structures adhering to the Patient Protection and Affordable Care Act (2010). ACA made health insurance coverage available for more Americans, and therefore, more people can access healthcare. The Patient Protection and Affordable Care Act made it possible for more Americans to obtain preventive and curative healthcare services (National Academies of Sciences, Engineering, and Medicine, 2016). The National Academies of Sciences, Engineering, and Medicine reported that Patient Protection and Affordable Care Act would cause a shortage of PCPs and advocate removing restrictions on APRNs' SOP to help solve the problem. Squires and Anderson (2015) explained that the Organization for Economic Cooperation and

Development (OECD) reported a shortage of physicians before implementing the Patient Protection and Affordable Care Act, which worsened after the Act's implementation.

Before the Patient Protection and Affordable Care Act (2010), the OECD reported that the US had fewer practicing physicians than the median OECD country (Squires & Anderson, 2015). Squires and Anderson found that the average annual U.S. physician visits per person in 2012 were four. Canadian and Japanese citizens averaged 7.7 and 12.9, respectively (Squires & Anderson, 2015). The low number of physicians and hospitals in the U.S. makes accessibility to healthcare services, both preventive and curative, unavailable for many Americans (AANP, 2019a; Squires & Anderson, 2015). The AANP and the IOM (2001, 2012) strongly advocated APRNs as healthcare providers to help increase access to and reduce the cost for healthcare services in the United States.

While U.S. healthcare access is lower than other developed nations, U.S. healthcare expenditure is the highest and has a less favorable healthcare report than other developed nations (Squires & Anderson, 2015). Squires and Anderson reported that, although the U.S. outspent other developed nations in healthcare, the United States. has fewer hospitals and physicians. Squires and Anderson also found that, before the Patient Protection and Affordable Care Act, U.S. had 2.6 physicians per 1,000 residents. In comparison, other OECD countries had 3.2 physicians per 1,000 residents, and the shortage worsened after the Act (Squires & Anderson, 2015). According to the AANP (2019a) and Squires and Anderson, the influx of newly insured health care users, coupled with the aging population, means more clients and more demand for healthcare and makes the prevailing shortage of PCPs worse.

APRNs practice as PCPs according to their educational preparation and training, increase access to primary care and preventive services and help deliver cost-saving high-quality healthcare services improving public health overall (IOM, 2012). For example, Rantz et al. (2017) reported that Medicare spends about $14 billion every year for avoidable patient readmissions to nursing homes. If APRNs working in those nursing homes could have fully practiced according to their training and capability, much of that Medicare expenditure would be avoidable (Rantz et al., 2017). The AANP (2019b) noted that APRN practice policy restrictions diminish the impact of APRN services to the nation and restricts access to healthcare for millions of Americans living in HPSAs, however those restrictions exist at the state level.

State Individuality

The tenth amendment of the U.S. Constitution affords states the prerogative to determine the SOP for APRNs (Chesney & Duderstadt, 2017). The States' power to establish SOP tailored to the States' needs gave rise to variable SOPs across State lines (Chesney & Duderstadt, 2017), meaning that APRNs in some states have full practice authority while others are restricted. The AANP (2019a) noted that, from the inception of APRNs, some states have yet to implement full practice authority to APRNs.

Following the legislation allowing APRNs to serve as PCPs, various states such as Alaska and Arizona immediately adopted APRNs' PCP status (Adams & Markowitz, 2018; Phillips et al., 2014). In contrast, other states such as Illinois and Indiana maintained physician oversight and collaborative agreements for APRNs' practice (Adams & Markowitz, 2018; Phillips et al., 2014). Other states that continue exerting

restrictions on APRN SOP include California, Texas, and Oklahoma (Chesney & Duderstadt, 2017). Chesney and Duderstadt posited that the SOP restriction resulted from states' legislative patterns, refusal to embrace change, paucity of knowledge among legislators and the public, and physician organizations' refusal to accept APRNs as PCPs.

APRNs received full practice authority to increase access to primary care for all persons who need healthcare services (Chesney & Duderstadt, 2017). Xue et al. (2016) examined the influence of SOP on healthcare delivery. Xue et al. reported that states with the least restrictions on APRNs' SOP increased healthcare utilization among rural citizens and at-risk populations. APRNs are more likely to work in rural settings than other healthcare providers in states where the SOP is not restrictive (AANP, 2013). APRNs in Texas have restrictive SOP; although Texas has many rural communities, only thirteen percent of APRNs work in rural settings due to Texas' restrictive APRN policy (AANP, 2013). AANP also noted that 56% of APRNs in Vermont practiced in rural areas due to Vermont's favorable SOP policy. Clearly, a restrictive state policy that impedes ARPN utilization for PCP healthcare services contributes adversely to public healthcare accessibility.

APRN Inability to Practice

APRNs' inability to fully practice places limitations, further worsening the shortage of PCPs and public healthcare access, especially for HPSAs (AANP, 2019a). APRNs are more likely to work in rural areas than physicians, and 89% of APRNs work as PCPs (AANP, 2019a), however any restriction limits public healthcare access. According to Moran and Nairn (2017), Illinois' 2017 relaxation of APRN SOP was a step

in the right direction, but continued restrictions still decrease public healthcare access. Illinois' Nurse Practice Act (2007/2018) requires APRNs to obtain 4,000 hours of clinical practice with a physician and 250 hours of continuing education before autonomous practice. Illinois' restriction increases the scarcity of PCPs; decreases access to healthcare, preventive, and curative services; and prolongs appointment wait for times and duration (AANP, n.d.a). The AANP (n.d.a) admonished that those restrictions consequently increased the likelihood of disease, disability, deformity, and expensive healthcare costs as complications resulting from a lack of timely care. While policies such as Illinois' Nurse Practice Act are evolving toward alleviating the problem, incomplete data regarding experience requirements further compounds and convolutes APRN full practice ability.

Experience Requirements

Some states require supervised practice before APRNs can become independent practitioners, some require RN experience, and some require other experience-related factors to allow APRNs to acquire experience before practice (Gardenier, 2015). Gardenier noted that no study demonstrated a need for experience before APRNs practice independently. However, Gardenier also indicated that requiring APRNs to gain experience while working under supervision may alleviate reluctant policymakers' anxiety. A policy like Illinois' Nurse Practice Act (2007/2018) addresses the experience factor by including experience into the APRN SOP. Xue et al. (2016) noted that SOP dictates the degree APRNs can practice within their training. According to Poghosyan,

Norful, and Martsolf (2017), APRN SOP includes education, training, and experience; however, APRN experience is an elusive component of states' Nurse Practice Acts.

Some APRNs graduate without any RN experience due to the undefined nature of the public policy regulating APRN practice (Rich, 2005), and SOP laws vary between states (Poghosyan, Norfolk, & Martsolf, 2017). For example, Illinois' Nurse Practice Act (2007/2018) mandates that APRNs practice with knowledge gained from their education, training, and experience. However, Illinois' Nurse Practice Act does not delineate quantity, type, when, where, or what that RN experience encompasses; thus, APRNs graduate with experience ranging from none to thousands of hours. Thus, the glaring gap in the information needed to develop sound public policy relating to ARPN full practice revolves around APRNs' prior RN experience.

Gaps in the Literature

Nurses gain experience by providing care, and they acquire skills through practice (Benner, 1982); Illinois' Nurse Practice Act (2007/2018) mandates APRN SOP include RN SOP. However, how prior RN experience impacts APRN performance remains unknown, subsequently undermining any public policy intent toward regulating APRNs' prior RN experience. Thus, there are practicing APRNs with no prior nursing experience, which compounds existing feelings of uncertainty and distrust of APRNs (Codier et al., 2015; Hennessy, 2017; Rich, 2005). Additionally, APRNs are a significant healthcare workforce and expected to ameliorate the shortage of physician PCPs (Poghosyan, Norfolk, & Martsolf, 2017); unfortunately, new APRNs have high turnover rates relating

to RN-APRN transitional experiences (Barnes, 2015). However what transitional experiences most impact APRN performance and turnover remain unknown.

Speculation exists attributing APRN turbulent role development and transition to APRN distress due to a lack of prior RN experience and organizational support (Barnes, 2015). Twine (2018) noted that APRNs with meaningful prior RN experience found that prior experience a significant boon for their practice but did not delineate how the lack of prior RN experience impacted APRN practice. Twine advocated the need for further research about RN-APRN transitional experience, reporting that existing literature did not indicate the essential nature of the successful APRN transition's prior experience. Kleinpell and Kapu (2017) echoed the necessity to evaluate APRN performance and role transition.

RN-APRN transitional challenges may overwhelm new APRNs, causing poor performance and job abandonment, further compounding healthcare providers' shortage and reducing public healthcare access (AANP, 2019a; Fitzpatrick & Gripshover, 2016; IOM, 2012; Monaghan, 2015; Stinson, 2017). Benner (1982) and Stinson emphasized that prior RN experience grounds the decision-making skills of new APRNs and makes transitional performance successful. However, Kanter (1977, 1993) and Mota (2015) attributed employee distress, poor performance, and attrition to the organizational structure and empowerment. Poghosyan, Norful, and Martsolf (2017) also inferred that organizations are responsible for the problematic RN-APRN transitions. However, none of these scholars researched which factors (prior experience or organizational support

most impact APRN transition. According to Stinson, “experience, intuition, education, and environment all influence the overall decision-making process” of a nurse (p. 52).

Subsequently, the degree that prior RN experience and organizational support influence RN-APRN transitional performance remains unknown data crucial to developing sound public policy. Also, consider Twine’s (2018), Schwartz and Gambescia’s (2017), and Barnes’ (2015) admonishments calling for further study to fill the information gaps. Twine recommended a study quantifying how many years prior nursing experience is necessary to enter APRN programs. Schwartz and Gambescia recorded the lack of existing research on the performance of non-nurse graduates. Barnes (2015) asked for research to delineate factors affecting APRNs’ role transition.

Through this study, I explored how prior RN experiences impacted new APRN transitions in Chicago to begin filling this gap in information and help facilitate less turbulent APRN transitional experiences to increase public access to healthcare. According to the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, & Education (2008), an “APRN is a nurse whose practice builds on the competencies of registered nurses (RNs) by demonstrating a greater depth and breadth of knowledge…” (p. 7). Even though some study exists about prior RN experience and APRN transitional performance within the last decade, clearly those results are conflicting, and only minimal current research exists. Using Kanter’s (1977, 1993) theory of organizational structural empowerment and Benner’s (1982) novice to expert nursing model, I began filling this gap in information about how prior RN experiences impacted the transitional performance of new APRNs.

Summary

APRNs are critical components in healthcare services providing essential diagnostic, treatment, prescription, preventative, and curative services to the public (AANP, 2019a; IOM, 2012), yet a fundamental part of the APRN SOP remains unknown: How prior RN-APRN experiences impact APRN transitional performance. The U.S. underperforms other OECD nations in healthcare access (Squires & Anderson, 2015); however, APRNs can positively impact this trend through training and transition to the role of a PCP (AANP, 2013; NCSBN, 2008). Because APRNs practice both nursing and medicine to provide holistic healthcare, it is essential to ensure that their transitional experiences are sufficient to fill this role, yet research demonstrates that these transitional experiences remain unclear (Barnes, 2015; Herron, 2017). APRN transitional experiences include a combination of prior RN experience and organizational support (Poghosyan, Norful, & Martsolf, 2017; Stinson, 2017). Through this study, I explored how RN-APRN transitional experiences impacted new APRNs practicing in primary care in the Chicago area.

My findings inform policymakers, organizations, and educators about potential interventions necessary to improve APRNs' transition reducing attrition and increasing public access to primary care. I analyzed participants' prior RN experience and the organizational support they received that impacted their APRN practice. Chapter 2, the literature review discussed the (a) literature search strategy, (b) theoretical foundation, (c) APRN history, (d) APRN practice model, (e) APRN transition, (f) role development, (g) public policy concerns, and (h) information deficiencies.

Chapter 3 details the (a) research design and rationale, (b) role of the researcher, (c) ethical issues, (d) methodology, (e) instrumentation, (f) data collection procedures, (g) data analyses plan, (h) issues of trustworthiness, and (f) ethical procedures. Chapter 4 covers the results, and Chapter 5 presents a further discussion.

Chapter 3: Research Method

RN experience impacts APRN transitional performance (Farr, 2018). The IOM (2011) supported APRNs' full practice but noted that high APRN attrition hampered such practice. With so many HPSAs lacking healthcare providers, APRNs' readiness to practice at full capacity has never been more cogent. In 2019, more than 290,000 APRNs were practicing in the United States, and 89% of them worked in primary care (AANP, 2019a). According to the Illinois' Nurse Practice Act (2007/2018), APRN certification rests on "knowledge and skills acquired throughout an APRN's nursing education, training, and experience" (para. 1). Under Illinois' Nurse Practice Act, APRNs must maintain a current RN license, APRN license, and national certification. The Act also mandates that APRNs incorporate RN SOP skills, training, and education into their practice. Clearly, experience is a characteristic listed in Illinois' Nurse Practice Act and attributed to APRN SOP; however, it is unclear how that experience impacts transition from an RN to an APRN.

The purpose of this research was to explore how previous experience as an RN impacted a new APRN's transitional experience to begin clarifying how RN experience affects APRN transitional performance. Through this study, I inform potential policy change and begin filling that information gap to develop legislation to enhance APRN practice readiness, role transition, and reduce APRN attrition. My findings also informed nurse educators, administrators, organizations, and employers about factors influencing APRN full-capacity performance. Chapter 3 presents (a) research design and rationale, (b) role of the researcher, (c) ethical issues, (d) methodology, (e) instrumentation, (f) data

collection procedures, (g) data analyses plan, (h) issues of trustworthiness, and (f) ethical procedures.

Research Design and Rationale

Through this phenomenological study, I explored how prior RN experiences impacted the transitional performance of new APRNs to fill the current information gap and inform policymakers to develop more effective public policy considering APRNs' transitional experiences. I asked participants to relate their lived experiences in their own words and analyzed that data to explain how prior RN experience and organizational resources influenced their transitional performance. Fundamental components of this design included the RQ, central phenomenon, research tradition, and rationale for selecting this design.

Research Questions

My RQs centered on how RN-APRN transitional experience affects new APRN performance; however, transitional experience has a dual aspect: prior RN experience and experiential resources supported by the organizations wherein APRNs work. Therefore, two related RQ approaches enabled me to gather the most in-depth data on that single phenomenon. I effectively supported this dual approach through my theoretical framework combining Kanter's (1977, 1993) theory of organizational structural empowerment and Benner's (1982) novice to expert nursing model. The combination of Kanter's theory with Benner's model enabled me to gather and analyze my central RQ's phenomenological data. Thus, my two corresponding RQs were:

RQ1: How do new APRNs internalize their role transition and performance considering the availability of organizational structural empowerments necessary for their professional responsibilities and SOP analyzed using Kanter's (1977, 1993) theory of organizational structural empowerment.

RQ2: How do new APRNs view and interpret their transitional performance as an APRN relative to their RN proficiency level gaged using Benner's (1982) from novice to expert nursing model?

Central Phenomenon

This research's central phenomenon was the impact of APRN transitional experiences associated with APRN prior RN experience and organizational support during the transition. Thus, I explored the experiences and perceptions of APRNs' transitional performance considering their prior nursing experience and the organizational resources they had available for their practice. In this study, Kanter's (1977, 1993) theory of organizational structural empowerment and Benner's (1982) novice to expert nursing model were the lenses used to ground and analyze this phenomenon.

How the transition from RN-APRN affected new APRNs was attributable to organizational structures. Organizational resources available to employees impact employees' performance (Kanter, 1977, 1993); thus, I used Kanter's theory to identify organizational support factors participants attributed to their transitional performance. Participants self-reported their prior nursing experience according to Benner's (1982) five proficiency levels: novice, advanced beginner, competent, proficiency, and expert. Summarizing Benner's model levels:

- rules guide a novice;
- an advanced beginner has little experience, performs stated tasks, but is unable to prioritize care;
- a competent nurse is organized and plans ahead;
- the proficient nurse renders holistic care and has future patient insight; and
- the expert nurse recognizes patterns and uses intuition to make decisions.

Benner noted that education and experience enhance a nurse's proficiency level and that it takes 2 - 3 years to get to the competent level. Using Benner's model, I examined how new APRNs perceived and described their transitional performance considering their nursing proficiency. Using this framework, I explored the phenomenon of how APRNs' transitional experiences affected their performance by inquiring about new APRNs' perceptions and descriptions of how their transitional experiences impacted their performance.

Research Tradition

Researchers use quantitative and qualitative studies to research various phenomena; however, qualitative research is notably helpful for studying and comprehending the meaning that people ascribe to events or phenomena (Creswell, 2009; Moustakas, 1994). According to Creswell, qualitative research involves studying participants in their setting, collecting data, and generating themes and meaning. Qualitative research uses open-ended questions allowing participants' free presentation of their views, understandings, and experiences about the study phenomenon, which is not possible with quantitative research designs (Creswell 2009; Moustakas, 1994).

Qualitative research traditions are relevant to explore the depths and breadth of a given phenomenon (Ravitch & Carl, 2016). Creswell (2009) described five significant qualitative research designs:

- The grounded theory involves inductive reasoning derived from data gathered from participants.
- Case studies examine a single process, event, or individual within a specified time and threshold.
- Ethnographers study a group of people and their culture within that group's setting over time.
- Narrative research design centers on participant story-telling and timely researcher interpretation.
- Phenomenological philosophy revolves around participants' lived experiences regarding a phenomenon by gathering data through intense, exhaustive interviews.

Additionally, other forms of qualitative inquiry, such as action research, involve acting during research to study the effects on the phenomenon (Ravitch & Carl, 2016). For example, participatory action research encourages participation and community engagement while the researcher examines how to design interventions by answering practice questions. Similarly, evaluation analyzes the efficacy and efficiency of human endeavors. I explored how transitional experiences affected APRN role transition and performance from the APRN participants' perspectives, thus, phenomenology.

I deemed phenomenological research design the most suitable method to study my participants' lived experiences for multiple reasons: Phenomenologists gather and examine data from participants regarding their perspectives about a phenomenon or event (Creswell 2009; Moustakas, 1994). Phenomenology is a process wherein the participants freely explain and express their understandings and interpretations of the phenomenon under study (Creswell 2009; Moustakas, 1994). According to Rudestam and Newton (2015), phenomenology helps the researcher identify and understand the human experience as explained in participants' own words concerning the phenomenon and their perceptions. Phenomenology stemmed from Husserl in 1913 (1954/1970), who posited that understanding an event is better accomplished through gathering information from people who lived that experience and presenting an unbiased report (Beyer, 2016). Moustakas (1994) posited that "all experience holds within it essential meanings" (p. 69); thus, phenomenology explores the meaning participants attach to their experiences.

Phenomenological research is either empirical (descriptive) or interpretative (Moustakas, 1994). According to Moustakas, van Kaam (1966) conducted empirical phenomenological research about the experience of being understood by gathering information on their participants' feelings. According to Rudestam and Newton (2015), in descriptive phenomenology, the researcher organizes the data obtained from participants into patterns and themes, whereas, in interpretative phenomenology, the researcher seeks to find out how different participants understand and interpret similar events. In my research, I aggregated and coded data from participants into themes and patterns to represent new APRNs' meanings attributed to their transitional experiences.

Design Rationale

I used a descriptive phenomenological approach in this research study because I organized data from the participants' demographics and self-reported proficiency levels to identify themes and patterns. According to Moustakas (1994), an authentic phenomenological study arrives at findings "through descriptions that make possible an understanding of the meanings and essences of experience" (p. 84). Since phenomenology explores the meaning, perception, or concern people attach to experienced events, incorporating the broadest communication range is critical.

Therefore, to understand the meanings and essences of the lived experiences of new APRNs, I included demographic surveys and the participants' responses about their experiences before and during their APRN transitions. I conducted a one-on-one interview with each participant; I gathered vocal data for in-depth analyses. Due to the COVID-19 pandemic, I followed the Centers for Disease Control and Prevention (2019) recommendations and conducted recorded telephone and Zoom interviews. Thus, allowing me to capture as much data as possible while maintaining social distancing and ethical standards.

Role of the Researcher

I was the sole researcher where, after IRB approval, I gathered data by conducting participant interviews; I analyzed that data, and I reported my findings. According to Moustakas (1994), evaluating the researcher's preconceived professional and personal research-related ideologies, answering study topic questions, and verifying and

triangulating data minimize researcher bias in a phenomenological study. To minimize researcher bias, I

- ensured I had no personal or professional relationships with the participants,
- bracketed my preexisting beliefs about the study phenomenon,
- only interviewed participants who signed informed consent and consented to their interview being audio recorded,
- recorded and conducted all interviews using theoretical constructs, adhered to the IRB approved interview protocol, and
- employed member checking for transcript validity.

Preexisting Relationships

I have been an RN for over 30 years. My experience with the phenomenon under study helped me better understand APRNs' perceptions; however, my experience may be jaded due to age and outdated working conditions. Therefore, I documented my thoughts in my reflexivity journal and continually reminded myself that people see and experience things differently. Researchers recognize and document their personal biases, values, influencing backgrounds, ethical issues, and any other personal influence that could affect any study aspect in a reflexivity journal (Ravitch & Carl, 2016). Although all participants shared the same profession with me, I did not knowingly recruit personal friends. Therefore, being an APRN did not hurt the study; instead, my APRN experience assisted in interpreting and explaining participants’ perceptions through bracketing.

Bracketing

Due to personal and professional experiences, social interactions, and research preparations, I possessed several preconceived beliefs about the phenomenon I was studying. Throughout my career and during my study preparation and research, I conducted extensive and in-depth reviews of scholarly literature about this and similar contexts, which also influenced my preconceived beliefs. To minimize these potentially biasing influences, I utilized bracketing to ensure that my perceptions and beliefs did not interfere with the participant's views and experiences. According to Ravitch and Carl (2016), bracketing is an intentional act by the researcher to keep personal thoughts and opinions from influencing the study. During interviews, I listened attentively to each participant, kept a reflexivity journal to keep my emotions in check, and provided self-reflection to minimize my potential interpretation bias.

A qualitative researcher collects data through interviews, observations, and documents (Creswell, 2009); thus, as the sole researcher, I conducted all semistructured interviews, data collection, follow up, analyses, data organization, and interpretation. During the process, I minimized my personal biases. According to Ravitch and Carl (2016), it is pertinent to know the researcher's positionality, which means the researcher’s relationship with the study's context and the research setting.

I am an APRN with prior nursing experience, and I belong to APRN professional associations. Furthermore, I recruited participants through open solicitation and snowballing. Because I am an NP association member, some participants may have known me, but I did not work, nor have I ever worked, with anyone from these

associations; thus, a minimal chance existed that I had any working relationships with participants. I conducted purposeful sampling. Recorded interviews and bracketing revealed any personal influences I might extend to the participants (discussed further in Chapter 4).

Theoretical Constructs to Minimize Interview Bias

To further minimize bias, I used audio recordings of all interviews, used my reflexivity journal to recognize any personal bias and influences, adhered to my IRB-approved interview protocol (see Appendix B), and transcribed recordings within 96 hours. Recorded interviews, verbatim transcripts, and my reflexivity journal helped me recognize any instances wherein my interactions or interpretations leaned toward personal bias and enabled me to detach that bias and analyze data neutrally (discussed further in Chapter 4). However, the first step in minimizing researcher bias was to avoid all leading questions and gestures.

Thus, to control and avoid biases, I presented only unbiased questions and avoided all leading questions and gestures by adhering to my IRB-approved interview protocol, which contained carefully developed semistructured interview questions. I derived the study questions from scholarly articles related to my study that used either Kanter's (1977, 1993) theory of organizational structural empowerment or Benner's (1982) novice to expert model. Additionally, my expert content committee member and four APRNs currently practicing primary care reviewed and refined my research questions.

I further reduced potential researcher bias by using Kanter's (1977, 1993) theory of organizational structural empowerment and Benner's (1982) novice to expert nursing model to interpret and explain participants' experiences. According to Ravitch and Carl (2016), a researcher reflects on all aspects of tacit theories to minimize biases. Although phenomenology contains obvious theoretical leaning (Moustakas, 1984), I reduced potential researcher bias by explaining my findings through the lenses of Kanter's theory and Benner's model, thereby establishing data triangulation and rigorous research. Additionally, collecting, analyzing, and interpreting data using Kanter's and Benner's models helped me control my personal biases and establish that the participants were the sole owners of their experiences representing their views. Therefore, I used theoretical constructs to interpret, explain, and validate data and findings, which provided several supports to my analyses, adding to the validation and confirmability that member checking provided.

Member Checking

To ensure that all interview transcriptions were verbatim, I scrutinized the transcript with the audio-recorded version of the interview within 24- to 96-hours of the interview. I requested each participant to member check the accuracy of their transcript. Member checking (participant validation) is a process wherein each participant receives a copy of their transcript for vetting (Ravitch & Carl, 2016). I informed all participants that they could change or alter their transcripts and send any altered version back to me within 96-hours of emailing to them and that no response indicated their transcript acceptance. Ravitch and Carl emphasized that alterations resulting from member checking must be

"recorded systematically in the same ways as all other forms of data" (p. 199); therefore, I incorporated any participant validation changes into the original data set.

In addition to member checking, I used my dissertation committee for peer debriefing to ensure that personal biases did not interfere with the participants' expressed experiences. My dissertation committee consisted of experts and professionals who challenged all aspects of my study, providing feedback and highlighting missing, misinterpreted, or misrepresented areas. I then adjusted and aligned my study efficiently and factually until my committee deemed it acceptable, bias-free, and ethical.

Ethical Issues

Researchers must consider ethical issues that may arise because of the research inquiry (Creswell, 2009) and ensure that potential study benefits outweigh possible participant discomforts (U.S. Department of Human & Health Services, 2020). In keeping with ethical principles, I attended and completed the National Institute of Health NIH), Office of Extramural Research's online course, *Protecting Human Research Participants*, to ensure I addressed all potential ethical concerns. Accordingly, I succinctly explained to all participants the nature, purpose, and requirements of the study, ensured confidentiality, and gained voluntary informed consent. Specifically,

- I did not coerce any participant.
- Each participant was voluntary and participated on their own accord.
- I obtained IRB approval before solicitation and study progression.
- All participants received details about the procedures, the nature, purpose, and requirements of the research.

- I obtained informed consent from each volunteer before the interviews.
- Participants were free to withdraw from the research at any time.
- I ensured the participants' confidentiality.
- All participants received a fictitious name to preserve their privacy.
- I bracketed myself from interfering in this study.
- I used member checking to vet all data transcripts.
- Participants were free to seek study clarification and ask questions.
- There were no conflicts of interest.

Methodology

This methodology section describes the study modalities, ontology, and epistemology that guided the research and answered the RQ by dictating the study's specific methods that ensured all aspects of the study remained ethical. The methodology described the systemic approach of the research and analyses so that the study is transferable to a similar context as recommended by Sundler et al. (2019). Sundler et al. criticized the phenomenological tradition attributing a lack of lucidity. Sundler et al. also noted that "in the ontological and epistemological foundations of descriptive phenomenology, some methodological principles can be recognized" and managed throughout the research process (p.734). Thus, I employed openness, reviewed my understanding of the phenomenon, and kept a reflective journal to ensure my findings' reliability.

Since a phenomenological study employs the qualitative ontological stance of multiple realities and different people (Ravitch & Carl, 2016), I strove to explore,

understand, and present those various realities. I based my findings on the context-bound lived transitional experiences of new APRNs according to their self-stated RN proficiency levels. According to Ravitch and Carl, there are multiple realities of truth, and "knowledge is developed through the subjective experiences of people" (p. 6); thus, I interviewed participants with lived experiences of the research phenomenon to organize that information. Sundler et al. (2019) and Ravitch and Carl noted that each participant's perceptions are context-bound by their lived experiences; thus, the transitional performance data is transferable to similar contexts. In this section, I describe the research methodology in replaceable detail, thus establishing my study's rigorous nature.

I grounded the study with Kanter's (1977, 1993) theory of organizational structural empowerment and used Kanter's theory and Benner's (1982) novice to expert nursing model to extract and analyze data from the lived experiences of new APRNs. The meaning that APRNs attributed to this experience was relatable to both theories and transferable to similar contexts. After IRB approval, I selected the first 10 interested participants meeting the study criterion; thus, this process delimited the required purposeful sample. I recruited new APRNs with 0 to 5 years' experience in primary care who experienced RN-APRN transition. I then conducted semistructured, one-on-one, in-depth interviews with each participant using 10 open-ended questions until I achieved saturation. I audio-recorded each participant's interview, exploring participants' APRN performance according to their perceptions of their prior nursing and transitional experiences.

Following the in-depth interviews, I used NVivo transcription software to transcribe the data. I vetted and corrected the transcript with audio recording and then sent a copy of each participant's transcript to that participant for member checking. Once I completed member checking, I cross-checked the transcripts with the audio recordings and my reflexivity journal. During cross-checking and triangulation, I used NVivo software and immersed myself in the data commencing manual coding by highlighting recurring phases and codes that fit Kanter's (1977, 1993) and Benner's (1982) constructs, thereby categorizing themes and patterns.

After that, I allocated keywords and phrases to the categories of Kanter's (1977, 1993) and Benner's (1982) constructs, wherein I used thematic analyses, as recommended by Sundler et al. (2019), to organize themes into a meaningful whole. Finally, I interpreted findings and plan to disseminate them to various fora of interest, including policymakers and other APRN stakeholders, through scholarly journals and presentations. While the theoretical foundation was stable, study limitations influenced the overall credibility, transferability, dependability, and confirmability of the research. Therefore, I elaborate on critical components beginning with the participants.

Participant Selection Logic

Participant selection requires RQ consideration relative to the context and inquiry population (Ravitch & Carl, 2016); thus, my target participants for this study were new APRNs currently licensed in Illinois, working for 0 to 5 years in primary care in the Chicago area. CNPs, CNSs, CRNAs, and CNMs all practice as APRNs (AANP, 2013; NCSBN, 2008); however, not all APRNs are PCPs (Dubree et al., 2015). For instance,

according to NCSBN (2008), CRNAs are trained to provide a full spectrum of anesthesia-related care for individuals across all levels of acuity throughout the patient's life span; thus, CRNAs do not practice as PCPs. Since I explored ARPNs practicing as PCPs, I excluded CRNAs from my participant sample.

My RQ centered on APRNs working in primary care, and I phenomenologically explored people who experienced the transition to APRN. I limited their tenure to 0 - 5 years to decrease potential recall problems. I delimited participant language fluency to English to avoid communication barriers and misrepresentation of information because I speak English. I selected Chicago because I lived in Chicago and needed an accessible purposeful sample. APRN SOP varies from state-to-state imposing the limitation of state-specific licensing on APRNs practicing in Chicago. Illinois' Nurse Practice Act (2007/2018) requires APRNs to maintain national certification. Hence, participants had a CNP or CNS certification; the only CNM participant dropped out at the last minute due to unforeseen circumstances. The differing specialty certifications presented different transitional challenges and perceptions; therefore, including CNP and CNS participants created an even distribution of those specialties, increasing the validity and transferability of findings through data triangulation.

Sampling Strategy

Sampling is the researcher's choice regarding who may participate in the study (Ravitch & Carl (2016). After obtaining IRB approval [# 12-16-20-0560467], I distributed recruitment fliers directed toward APRNs meeting the study criterion (see Appendix C) to generate a representative participant pool. I emailed recruitment fliers to

the two IRB-approved selected APRN professional organizations to distribute and direct interested participants to contact me. I also posted those fliers on WhatsApp social media. Because recruitment fliers did not generate eligible participants based on the study criterion, I used a snowballing recruitment measure to increase participants.

The recruitment flier encouraged readers to notify others who met the study criterion: snowballing. Snowballing is a sampling method that engages research participants to enlist other participants (Glen, 2014). A snowball sampling method is proper where the recruitment of participants is limited (Glen, 2014); in this case, my ability to reach the entire potential Chicago area APRN participant pool was limited. Since APRNs often know new APRNs matching the study criterion, the snowballing strategy allowed me to reach a wider APRN population that did not otherwise hear about the study.

Within two weeks of a potential participant's expressed interest, I emailed that participant a demographic survey and an informed consent form (see Appendix A). That consent form included the study details. That email and informed consent explained the audio-recorded, one-on-one interviews and requested willing volunteers to complete both forms and return them to me via email within 72 hours. When I did not receive the forms within 48 hours, I conducted a reminder phone call after 72 hours when needed.

I selected the first 10 responses meeting the study criterion to participate in this study: purposeful sampling from the sample pool. Purposeful sampling is used in a qualitative study to draw participants with the qualification, knowledge, and lived experience of the inquiry subject (Creswell, 2009; Ravitch & Carl, 2016). Therefore,

purposeful sampling best enabled in-depth and contextual information answering the RQ, specifically related to new APRN transitional experiences and performance. After participant selection, I called all interested parties, informing them of their selection. I informed those selected that they have met the study criterion, were then considered participants, and advised them of the subsequent step procedures.

Participant Selection Criterion

The criterion is crucial in a study to certify that the sampling represents the intended study population and that the chosen criterion helps me answer the RQ (Ravitch & Carl, 2016). The recruitment flier specified the study criterion to ensure that each participant met the minimum criterion to participate in this study. All participants in the purposeful participant pool met each of the following criteria:

- Fluent in the English language
- Illinois licensed and board-certified
- ARPN with 0 to 5 years' experience
- APRN working in primary care
- APRN working in the Chicago, Illinois area.

Number of Participants and Rationale

I selected the first 10 interested respondents returning the demographic survey and signed consent form that met the study criterion for interviews; I based the number of participants on qualitative saturation. Qualitative studies do not require many participants; instead, qualitative research incorporates in-depth interviews to understand the participant's experience (Creswell, 2009). According to Rudestam and Newton

(2015), phenomenological research typically uses a sample of 10 or fewer as the initial foundation to reach data saturation.

Data saturation occurs when interviews are not yielding any new information (Fusch & Ness, 2015). For my study, data saturation occurred after seven interviews, but I interviewed two additional participants to ensure comprehensive data collection from various primary care settings. Fusch and Ness contended that data saturation is crucial for the validity of phenomenological studies that use rich, thick interview data. Fusch and Ness posited that phenomenological data collection should continue until the point when data saturation has been reached rather than relying on the number of recruited participants. However, saturation depends on research questions (Ravitch & Carl, 2016); hence, saturation differs from one study to another. For example, Paul (2015) conducted a qualitative study of the transition from novice adjunct to experienced educator; 14 novices were interviewed for an average of 50 minutes to reach saturation. However, Paul noted that experienced educators attained saturation after seven 58-minute interviews. Paul conducted an additional three interviews to ensure that no sites and assignments were left out to ensure saturation. Paul's sample (n = 10) aligned with Rudestam and Newton's (2015) assertion that phenomenological research typically uses 10 or fewer participants as the initial foundation to reach data saturation. While I planned to interview 10 new APRNs, I had only nine that met the study criteria and four that did not meet the study criteria.

Recruitment Procedures

After obtaining IRB approval for this study, I distributed recruitment fliers (Appendix C) to professional organizations and WhatsApp NP groups with my contact information. I invited all respondents to complete the demographic survey and informed consent, subsequently selecting participants on a first-come, first-served basis limited to those meeting the study criterion (see Appendix A). I reminded unresponsive inquirers of study deadlines. I accepted interested participants for 8 weeks. I notified interested participants of their participation status. I arranged interviews and collected data via audio-recorded interviews (see Appendix B). Through each of these interactions, I adhered to the NIH's standards for protecting human participants.

Initial recruitment extended from the professional groups from which I secured agreement for flier distribution. Additionally, to reach the extended APRN population throughout the Chicago, Illinois area, I posted a copy of the flier to appropriate Chicago area NP groups' social media pages on WhatsApp according to the group's bylaws. The flier met WhatsApp site requirements for public posting. Recruitment fliers indicated the research subject (APRN transitional performance), the study type, location, time, and length of interviews. Recruitment fliers delineated participant criterion (APRN licensed and practicing in primary care in Chicago, Illinois, for 5 years or less). Recruitment fliers also noted participation on a first-come-first-served basis. Recruitment fliers directed interested participants to contact me at the email address or phone number provided on the flier.

I emailed a demographic survey and informed consent form to all interested volunteers who contacted me. For those interested applicants who contacted me by phone, I explained the study, answered any questions, obtained their email, and sent them the same email as the other interested respondents. The email also explained informed consent and stipulated that participation was contingent on signing and returning the informed consent and completing the demographic survey within 72 hours. The email introduced me, my dissertation chair, explained the research, set participation expectations, and established selection criteria. The email requested a response within 72 hours and included stipulations that, by completing and returning the demographic questionnaire and the informed consent, the respondent provided informed consent to participate in the study.

If inquirers did not return the demographic questionnaire and informed consent within the proscribed 72 hours, I contacted them and reminded them to complete and return the questionnaire. I made applicant reminders at the 48- and 72-hour marks via email and phone call, respectively, resulting in a 96-hour final submission cutoff. Any phone contacts were polite, compassionate, and informative, answering questions and explaining the need for the demographic questionnaire's timely return. I notified any interested participants not meeting the study criterion or not returning the signed consent form that they did not qualify for study participation. I ceased sending demographic questionnaires and informed consent eight-weeks after initial flier distribution. I informed all participants of their participation status through a phone call and scheduled an interview date for those selected to participate.

Within 96 hours of the selection, I called each participant in the sample pool (n = 9) to arrange a mutually agreeable interview forum (telephone or Zoom), date, and time for the interview. I scheduled all interviews within two weeks of selecting the participant. Due to the ongoing COVID-19 pandemic, I arranged all interviews via telephone or Zoom. I ensured the chosen technology adequately functioned to conduct the audio-recorded interviews in as quiet and undisturbed a manner as possible. I conducted no more than one interview per day to avoid researcher fatigue.

I called participants the day before the interview to remind them of the interview appointment. I set-up and checked that recording instruments were working correctly. To ensure anonymity, I asked each participant to select an unidentifiable pseudonym and, henceforward, referred to that participant in all ways via only that pseudonym. I explained the study at the start of each interview session (see Appendix B) as follows:

1. I greeted and thanked the participant for their time and participation.
2. I introduced myself as the researcher.
3. I informed participants of their freedom to withdraw from the study and ask questions at any time.
4. Lastly, before I commenced the interview questions, I
    a. explained the study purpose,
    b. described the interview procedures,
    c. outlined the participant's role in the interview,
    d. explained any risk involved in the study,
    e. explained steps I will take to ensure participants confidentiality, and

f. clarified the use of data gathered during the interview.

A moment of debriefing occurred following the interview to review the interview and enable participants to share their views about the interview and offer suggestions. I asked the participants if they would like to read the final study.

Instrumentation

Instrumentation refers to the procedure involved in gathering research data, whereas research instruments are the means a researcher uses to collect data for the study (Ravitch & Carl, 2016) and is a cornerstone of the content validity of this study. According to Moustakas (1984), content validity is a means of establishing that a study is rigorous and representative of participants' lived experiences. Data triangulation, member checking, and peer debriefing are other methods of ensuring content validity (Ravitch & Carl, 2016). Thus, the instruments I used incorporated these techniques to ensure that my instrumentation was sufficient to answer the RQ.

I represented the data with thick descriptions to enable transferability; I achieved data triangulation using multiple sources and theories; member checking and peer vetting ensured correct representation and support findings. To accomplish this level of rigorous reliability, I used several instruments, including (a) my personal computer and Walden email; (b) participant demographic surveys; (c) an IRB interview protocol and questions; (d) tested audio-recording instruments via telephone and Zoom (e) reflexivity journal; (f) NVivo transcription and qualitative analysis software; (g) member checking; (h) Kanter's (1977, 1993) theory of organizational structural empowerment; and (i) Benner's (1982) novice to expert nursing model.

Personal Computer and Walden Email

One of the instruments for this study was my personal MS word computer system. My computer was accessible to only me and was password-secured; thus, the computer was secure for data storage. I used my computer to store and transfer interview data to NVivo for transcription and data organization. My Walden email was password secured and only known to me. I used my email to recruit and communicate with research applicants and participants. My personal computer and my Walden email were valuable instruments for data triangulation and member-checking, which authenticated my study's content validity and, therefore, the sufficiency of these instruments to answer RQ.

Participant Demographic Surveys

I used demographic questionnaires to gather, organize, and analyze data. According to Ravitch and Carl (2016), demographic questions “focus on people’s social location, identities, and positionalities as they conceptualize and describe them” (p. 153). I presented participant demographics as descriptive statistics generated from the demographic questionnaires. I used demographic data during coding, pattern, theme identification, and data analyses and discussion.

Because my RQ focused on the influence of RN-APRN transitional experiences considering their performance, participants’ demographic data was critical to answering that RQ. The demographic questionnaires' questions generated information about participants’ licensure, residence, prior RN experience, RN practice, APRN specialty, APRN experience, proficiency levels, and practice environment (see Appendix A). These

were the demographic data that I needed to answer the RQ; therefore, the demographic survey was sufficient to answer that RQ.

IRB Interview Protocol and Questions

I used an IRB-approved interview protocol (see Appendix B), which included the interview questions, to ensure that human participants were protected, and that the data collected was sufficient to answer the RQ. I adhered to that interview protocol to ensure that I consistently incorporated all NIH requirements, participants understood the study and were comfortably able to give informed consent to participate, and collected all data needed to answer the RQ for each participant. Therefore, the interview protocol was essential to ensure data collection validity, reliability, and sufficiency to answer the RQ.

The interview protocol started with preparing the interview environment and ended after the participant has exited the interview. Accordingly, inclusive to the protocol was (a) the environment preparation, (b) greetings, (c) explanations, (d) reviewing informed consent in detail, (e) the interview format and questions, (f) addressing participant questions, (g) setting next-step expectations, and (h) thanking the participant and bidding them farewell. While the central portion of the interview protocol that generated the data needed to answer the RQ was the interview format and questions, the other instruments were critical to ensuring reliability, validity, confirmability, transferability, and participant well-being. Lennon and Fallon (2017) studied nurse prescribers' experience in an acute care setting using semistructured, one-on-one interviews, which followed a study guide (interview protocol). Lennon and Fallon also incorporated two open-ended questions with five subprompts; consequently, I utilized an

interview protocol with open-ended questions, multiple follow-up questions, and prompts that helped elicit the meaning of the participant's experiences.

Accordingly, after verified informed consent, I conducted a semistructured, one-on-one, in-depth interview with each participant incorporating Moustakas' (1994) recommendation to ask broad questions when seeking to understand participants' experiences regarding a phenomenon. According to Ravitch and Carl (2016), researchers use semistructured interview instruments, the most common qualitative question type, "to organize and guide the interview but can also include specific, tailored follow-up questions within and across interviews" (p.154). The interview consisted of 10 interview questions, with related subsections, exploring participants' lived experiences during their role transition from RN-APRN. Data aggregated from the interview questions encompassed (a) APRN practice experiential resources, (b) RN proficiency levels, and (c) structural empowerments that could have impacted participants' performance. I asked probing questions and follow-up questions to stimulate additional detail as needed.

My development of the interview questions followed a rigorous analysis and passed an expert review that ensured sufficiency to answer the RQ and support validity, credibility, and confirmability. I derived the questions from a combination of my in-depth literature review, Kanter's (1977, 1993) theory of organizational structural empowerment to examine structural resources, and Benner's (1982) novice to expert nursing model to assess proficiency levels. The interview questions were reviewed and sanctioned by four practicing APRNs with doctoral degrees and deemed sufficient to answer the RQs.

Before each interview, I set up the interview space and ensured the environment was quiet and free from distractions. Interviews lasted approximately 60 minutes, and I audio-recorded all interviews to ensure rich, detailed data collection. Interviews took place via telephone or Zoom.

Audio-Recording Instruments

I prepared early to set-up and tested the recording devices. I audio-recorded the interviews and used my reflexivity journal to document my thoughts as they occurred. I used recordings for (a) cross-checking and validation, (b) expanding my reflexivity notes, (c) verbatim transcription, (d) and increased understanding to increase validity, confirmability, reliability, and sufficiency of data collection to answer the RQ. I conducted and audio-record the Zoom interviews using the software's built-in recording capabilities, and I recorded the telephone interviews with Sony digital recorder. Additionally, I recorded all interviews with my personal computer's recording tools as a backup.

I set up the recording equipment and tested the recording devices early to ensure they were working correctly. After re-explaining the interview protocol, I reviewed informed consent and asked participants if they had any questions. I asked the participant if they were ready to begin and turned-on recording equipment. At the end of the interview, I asked participants if they had additional information; after that, I thanked the participant and turned off the recorder. I referred to each participant by their chosen pseudonym, and I labeled the recordings with the assigned fictitious name; thus, securing participants' confidentiality in the recordings and transcriptions thereof.

I transcribed each interview within 24- to 96-hours of that interview using NVivo transcription and MS Word to maintain content validity, which is essential for rigorous research sufficiency to answer my RQ. I vetted the transcribed copies for accuracy and, after that, emailed a copy to the participant for member checking. I scrutinized a copy of the transcript with the audio-recording to ensure every transcription word was verbatim. I immersed myself in the data. Considering my reflexivity journal to reduce potential researcher bias, I highlighted words and phrases that matched nurses' proficiency levels and empowered organizational structures.

Reflexivity Journal

My reflexivity journal contained annotations that I made to document thoughts and observations throughout the study and during the interviews. For data triangulation and to control researcher bias, I took notes during the interviews and while listening to the interview audio-recordings. The inherent issues of transferability and reliability of researcher notes did not occur because I incorporated multiple data collection sources, as suggested by Ravitch and Carl (2016), that I combined to increase my findings' validity.

I transcribed and coded all researcher notes within 24-96 hours of the associated interview to increase the reliability of my interpretations; after that, I incorporated the data into categorization and patterns for data analyses. According to Ravitch and Carl (2016), recording researcher observations may help the researcher gather and interpret data that they could not gain otherwise. Thus, my notes added to my understanding and interpretation of participants' lived experiences, providing sufficient data to answer my RQ. I identified participants using their chosen pseudonym; thus, securing participants'

confidentiality in my notes. I will destroy all notes at the end of five years following completion of the research using a professional shredding company.

NVivo Transcription and Qualitative Analysis Software

Initially conceptualized in 1981, social science researchers have used NVivo qualitative data analysis software reliably for over 20 years (Richards, 2002). I uploaded the data into NVivo software for transcription and manually reviewed transcripts with MS Word within 24- to 96-hours of each interview to obtain as close to real-time data as possible, which was crucial for content validity, confirmability, transferability, and sufficiency to answer my RQs. This process established a rigorous research audit trail wherein I transcribed, compared, coded, and analyzed data for patterns and themes to answer my RQs.

Member Checking

Member checking is a process wherein the participants authenticate their interview transcript and make alterations as they deem necessary to verify their interviews' accurate accounting (Ravitch & Carl, 2016). I emailed a copy of their transcript to each participant within 24-96-hours of the associated interview and asked that participant to review the transcript for accuracy. I informed participants to add or delete if necessary and return the vetted copy within 96 hours. I included a statement informing participants that responses not received with 96 hours confirmed that the transcripts were correct, and no alterations were needed. Member checking validates the study's content and increases confirmability, validity, and the sufficiency to aggregate

data that can answer the RQ (Ravitch & Carl, 2016). I incorporated all reviews into NVivo within 24-96-hours of receiving them.

Kanter's Theory of Organizational Structural Empowerment: Resources

Similarly, I used Kanter's (1977, 1993) theory of organizational structural empowerment as a tool to gather data about APRNs' available transitional resources. During interviews, participants described various aspects of organizational empowerment, support, and resources available for their SOP during the transition from RN-APRN. I used Kanter's construct to identify data associated with transitional resources and linked them with APRN performance. Aggregating these data answered the portion of the RQ about how resources impact transitional performance. Because Kanter's construct details how various resources influence performance, Kanter's theory was sufficient for collecting and analyzing data associated with that phenomenon. Additionally, using an established theory like Kanter's increased the reliability and confirmability of findings.

Benner's Novice to Expert Nursing Model: Self-reported Proficiency

Benner's (1982) novice to expert nursing model is not just a framework for this study; it is also a fundamental tool for data collection and analysis. I used Benner's model in several ways:

a. The self-reported proficiency level of participants on the demographic questionnaire;

b. based on participants' during interview descriptions of their prior nursing experience, its impact on role transition, and their performance, established their level of nursing proficiency according to Benner's five levels; and
c. I used these two diagnostic data sets during coding, analyses, and interpretation of APRNs' experiences during role transition to link transitional experiences to prior RN experience or the concomitant practice infrastructure.

The self-reported proficiency levels for all participants were identical to their interview proficiency levels; one participant noticed a mistake in her self-reported proficiency level during the interview and corrected that pruriency ranking to reflect the accurate proficiency level. Identifying participants' RN skill levels was crucial to answering the RQ and establishing validity. Because Benner's model is structured and specific, it was sufficient to gather the data needed to answer the RQ.

Zoom Communication Tool

Due to the COVID-19 pandemic, I used Zoom recorded interviews as an alternative interview tool wherein social distancing was maintained while still allowing opportunities to observe participants' non-verbal cues. Zoom communication platform supported real-time audio communication and built-in audio-recording functions (Zoom, n.d.). To reliably and sufficiently answer my RQ, interviews must capture both verbal and non-verbal communications and be recordable. Zoom communication platform was sufficient to capture the data needed and included the recordings needed for additional data collection and analyses. Furthermore, my personal computer functioned as a back-up recorder during the interviews.

Data Collection Procedures

Data collection procedures describe the specifics of data collection, such as who will collect data, where it will be collected, the frequency and duration of data collection, how data will be stored, and any follow up involved. I alone collected data via the instrumentation and techniques outlined in the Instrumentation section of this Chapter. While participants chose the setting for the interview convenient for them, such as their home, I made sure that I conducted the interviews in a quiet space away from any distractions. To maintain social distancing, I gave participants a choice of Zoom or telephone interviews.

I interviewed each participant once, and each interview lasted approximately 60 minutes. Due to the pandemic, I could not generate enough interested participants within two-weeks after flier distribution as planned; it took an additional six weeks to recruit 10 participants, and one dropped out at the last minute. All demographic surveys and informed consent were completed within 96 hours, I conducted all interviews within 1 month, and participants completed all member-checking within 96 hours; thus, the entire data collection event did not exceed 2 months. Data analyses took longer.

I securely stored all collected data and study analyses and will continue to securely store such for 5 years, after which I would destroy it according to Walden University IRB policy. I stored all nondigital data, including audio tapes, in a secure locked cabinet in my private office accessible only to me and will professionally shred it after 5 years. I stored all encrypted digital data on my password-protected personal computer located in my private office, will reformat the storage drive after 5 years, and

then destroy the storage device, rending it inoperable. Additionally, NVivo software has internal security processes providing additional file safety (QSR International, n.d.). For added participant security and confidentiality, all transcripts are identifiable only via each participant's pseudonym.

Follow-up procedures commenced after data collection, included verification inquiries, and will include dissemination of findings. Verification inquiries included (a) asking participants if they have suggestions about how to improve the interview process, (b) confirming my understanding of participants' meanings, and (c) verifying if participants would like to receive a final copy of my findings. Dissemination will be to interested participants, scholarly journals, public policymakers, APRN educators, and organizational administrators.

Data Analyses Plan

Data analyses start during the interview stage as the researcher makes observations toward examining information collected (Creswell, 2009); however, in this study, some data analyses began when applicants returned their demographic questionnaires. I collected data from (a) demographic questionnaires, (b) interviews, (c) my reflexivity journal, (d) member checking, and (e) Kanter's (1977, 1993) and Benner's (1982) constructs. All four data collection sources provided data for both aspects of my central RQ.

1. I established Benner's five proficiency levels as codes/categories in NVivo.
    a. Provided proficiency identification: descriptive statistics.
    b. Provided organization tools for analyses and interpretation.

c. Established pre-set codes associated with proficiency.
    i. Set codes for words indicating proficiency.
    ii. Set codes for phrases indicating proficiency.
        1. Novice
        2. Advanced beginner
        3. Competent nurse
        4. Proficient nurse
        5. Expert nurse

2. I established Kanter's organizational support and empowerment factors as codes/categories in NVivo.
    a. Provided resources support identification.
    b. Provided organization tools for analyses and interpretation.
    c. Established pre-set codes associated with resources.
        i. Set codes for words indicating resources.
        ii. Set codes for phrases indicating resources.
            1. Empowerment
            2. Support
            3. SOP supplies
            4. Structure
3. I uploaded demographic surveys into NVivo.
4. I connected participant proficiency level using demographic data and Benner's model.

   a. Assigned proficiency categories (1 – 5).
   b. Assigned experience categories (0 – 5)
   c. Assigned certification categories (CNS, CNP, CNM)

5. I transcribed and uploaded interviews into NVivo using participants' fictitious names.
   a. Interview data was the primary data source.
   b. Uploaded the audio record into NVivo transcription software for Windows.
   c. Reviewed the transcribed copy.
   d. Listened to the recording and compared the recorded audio with the transcription copy for accuracy.
   e. Ensured that I transcribed every recorded word verbatim and correctly by the software.
   f. Corrected any errors.
   g. Increased research validity and rigor.
   h. Noted any emerging codes and themes while scrutinizing.
6. I connected interview transcripts with participant demographics.
   a. Adjusted all previous participant identifiers to correlate with participants' fictitious names.
   b. Henceforward, used only participants' fictitious names when connecting participant data with any coding or analysis process.
7. I uploaded researcher notes from my reflexivity journal into NVivo.

   a. Researcher notes added researcher interpretation to unspoken communication.
   b. Connected researcher notes to participants.

8. I uploaded all member-checked alterations received into NVivo.
   a. Added validity and confirmability.
   b. Added understanding enhancing interpretation.
   c. Ensured I connect alterations with the correct participant.
9. I coded
   a. Maintained an open mind.
   b. Reread data several times to elicit meaning (Sundler et al., 2019).
   c. Applied a code, a word or sentence that ascribes meaning to the data allocating meaning summarizing implications (Saldana, 2016).
   d. Related to proficiency, if possible.
   e. Related to resources, if possible.
   f. Coded data to generate patterns, categories, and analyses (Saldana, 2016).
   g. Used color-coding to link emerging themes to RQs and participant narratives to represent the recurring participant's perceptions.
10. I analyzed
   a. Organized coded data into patterns.
   b. Using thematic analyses, explored the coded data (Sundler et al., 2019).

c. Remained reflective.

d. Used descriptive terminology.

e. Tabulated emerging themes.

f. Tabulate thematic frequency to identify essential and recurring themes.

g. Related themes to proficiency.

h. Related themes to resources.

11. I associated participant quotes with findings.

    a. Used participant quotes to add comprehension.

    b. Used participant quotes to add validity and confirmability.

12. I used phrases to give data meaning.

    a. Described the participants' lived experiences.

    b. Sundler et al. (2019) noted that "faithful descriptions of meanings usually need more than a single word" (p. 736).

    c. Compared and contrasted phrases.

13. I analyzed discrepant cases.

    a. Carefully analyzed all statements that stand out from the rest (see Creswell, 2009).

    b. Discerned why the case was discrepant.

    c. Reported discrepant cases.

        i. Noted how each is different.

        ii. Explained interpretations of discrepancies.

        iii. Reflected on any other considerations for discrepancies.

Issues of Trustworthiness

Trustworthiness, otherwise known as validity, is a way to show that the research findings represent the participants' lived experience (Ravitch & Carl, 2016). Ravitch and Carl noted that the idea of validity/trustworthiness is complex because different authors use different terms to explain the same concept. Validity is representative of the positivist paradigm of quantitative research (Ravitch & Carl, 2016). To distinguish between the naturalistic/constructivist paradigm from the positivist, Lincoln and Guba (1985) established the criteria for trustworthiness: credibility, transferability, dependability, and conformability.

The validity of a study denotes how well the study captures the essence of the phenomenon of study. (Ravitch & Carl, 2016). My interview questions targeted new APRNs' RN-APRN transitional experiences using Benner's (1982) novice to expert nursing model and Kanter's (1977, 1993) theory of organizational structural empowerment to ensure research validity relates to the study phenomenon. The interview questions evolved after in-depth literature review articles exploring similar contexts and frameworks. Four practicing APRN faculty and my Walden dissertation committee validated the questions. Because I was the only coder during this study, there were no intra- and intercoder reliability issues; however, credibility, transferability, dependability, and confirmability were applicable.

Credibility

Credibility is the researcher's ability to represent all information gathered from the participants accurately and is the equivalent of quantitative internal validity (Ravitch &

Carl, 2016). Ravitch and Carl recommended achieving credibility through triangulation, member checking, and using rich, thick descriptions to represent the data, whereas Guba (1985) suggested triangulation through prolonged engagement. While I did not conduct a prolonged engagement with participants, I did triangulate multiple data sources, member checking, saturation, reflexivity, peer-review, and in-depth discussion using rich, thick descriptions and participant quotations.

Triangulation. Triangulation is the process of obtaining data from various sources such as interviews, observation, and document analyses (Creswell, 2009). I collected data from new APRNs working in primary care within various settings and documented my thoughts during the interviews creating a secondary data source for triangulation. As another means of triangulation, I used multiple theories to explore the lived experience of new APRNs during the transition from RN-APRN. Ravitch and Carl (2016) noted that using two theories helps obtain data through multiple sources, thereby achieving data triangulation.

Member Checking. Also known as participant validation (Ravitch & Carl, 2016), member checking entails the researcher cross-checking the data with participants to ensure an accurate representation of their thoughts, allowing participants to correct or authenticate their study findings at will (Creswell, 2009). I emailed each participant a copy of their verbatim transcript, requesting that they review and authenticate or correct it within 96-hours. I also indicated that I would consider responses not received within 96-hours as authenticated.

Saturation. Data saturation is crucial for the validity of phenomenological studies, and rich, thick interview data should determine when data saturation has been reached (Fusch & Ness, 2015). Rudestam and Newton (2015) posited that phenomenological research typically uses 10 or fewer participants to reach data saturation. While I planned to interview 10 new APRNs, one dropped from the study leaving only nine.

Reflexivity. Reflexivity is a means to explain the researcher's role and influence in the research process and findings (Ravitch & Carl, 2016). As the researcher, my position and experience as an RN and APRN impacted how I organized, conducted, and understood this study. Before I undertook the interviews, I reflected on my views, experiences, biases, and research process choices to minimize bias. I bracketed those reflections and revised them from time to time to keep my views from influencing the participants. To avoid jeopardizing the data, I did not use any leading questions, nor did I give my opinions. I used NVivo software for transcription and analyses of the interview data, which minimized bias during transcription. I used a journal to note my thoughts with each interview to help identify bias and deal with reflexivity.

Peer Review. Peer review entails inviting someone who has no part in the study to review the study and bring to light any biases or elements of the research that the researcher may have ignored (Guba,1985). I incorporated my committee chairperson to review my study, and I addressed any feedback findings. This peer-review further enhanced the rigor and validity of my research.

Transferability

While quantitative researchers generalize their studies (Guba, 1985), qualitative studies establish findings transferability to similar circumstances (Ravitch & Carl, 2016). I achieved transferability by using audit trails, data triangulation, and thick, rich descriptions to present the study phenomenon to be transferable to similar settings, people, and contexts. Thus, transferability extends to policymakers, nurse educators, administrators, and organizations that influence APRNs public policy, training, and practice in Chicago, Illinois, and similar areas with APRNs working in like settings with equivalent years of experience.

Dependability

Dependability, comparable to reliability in a quantitative study, is how a study establishes how data is collected and that the data will accurately answer the RQs (Ravitch & Carl, 2016). Ravitch and Carl recommended using triangulation and audit trails to establish dependability. Rigorous triangulation that included multiple data sources and theoretical foundations was built into this study to increase credibility, enhancing dependability.

I interviewed new APRNs who work with different populations in different primary care settings and grounded the study using two theories enabling me to triangulate various perspectives. I also maintained and documented my thoughts in my reflexivity journal, which created a detailed accounting of the data collection, analyses, and audit trail. Thus, to increase study dependability and conformability, I followed

Guba's (1985) recommendations using audit trails, documentation, a thorough description of every research step, and reporting all findings.

Confirmability

Confirmability, referred to as objectivity in a quantitative study, is a way to show that the data correctly represents participants' perceptions (Guba, 1985). Guba recommended achieving confirmability through reflexivity, triangulation, and external audits which, I built into this study design. External audits are akin to audit trails (Guba, 1985); thus, my reflexivity journal, combined with the detailed study design, provided a complete audit trail. Triangulation of interview data, reflexivity notes, process notes, transcripts, and analyses are all raw study documents that supported triangulation and enhanced study duplication. Member checking and peer review provided an additional external review, thus, increasing confirmability.

Ethical Procedures

I designed this study to be highly ethical in every aspect: (a) Human participants, (b) associated institutions, (c) recruitment materials, (d) data collection and analyses activities, (e) data security and storage, and (f) participant confidentiality, among other considerations. As I was the only researcher, there were no issues related to interrater reliability, and I presented a sound methodology to control potential researcher bias. While I thoroughly outlined the design and methodology of this study, I also detailed ethical specifics associated with any study aspect that may affect my human participants, beginning with the most critical: the participant agreements.

Participant Agreements: Informed Consent

I emailed demographic surveys and consent forms to volunteers (see Appendix A). I thoroughly reviewed the informed consent details with each participant at the start of each interview and verified informed consent before commencing data collection. Participant agreements, in the form of informed consent, included introductions and explanations; criterion, purpose, and procedures; participant expectations and responsibilities; risks, benefits, confidentiality, audio-recording, and data treatment; and contact information and verification.

Treatment of Human Participants

I completed the online course, *Protecting Human Research Participants*, through the NIH, Office of Extramural Research. Following that training and the recommendations of Ravitch and Carl (2016), I engaged in relational ethics by accepting criticisms from participants, remaining reflective, making changes according to member checking, and accepting real collaboration. Ravitch and Carl emphasized that researchers should engage in "respectful and mutually beneficial research relationships" with every participant at every stage of the study (p. 350).

My first interaction with potential participants stemmed from their response to my recruitment flier (see Appendix C), followed by an emailed demographic survey and informed consent process, and finally, one-on-one interviews. I then email all interested applicants an introduction to myself, the study, and an invitation to complete the enclosed demographic questionnaire and informed consent should they wish to apply (see Appendix A). That invitation, questionnaire, and informed consent included (a) study

details, (b) privacy considerations, (c) risks and benefits, and (d) a statement whereby the applicant provided informed consent. When needed, I conducted two polite reminders expanding the importance of timely response, an email at 48 hours and a phone call at 72 hours. The phone call echoed the email.

After applicant selection, I notified all applicants of their selection status and schedule 60-minute interview sessions at a date, time, and in a forum (telephone or Zoom) convenient for each participant. I called each participant a day before their scheduled interview to remind them of the interview, date, and time. I prepared for the interview 30-minutes before the scheduled start time to ensure audio-recording equipment was functioning and the interviews remained undisturbed.

At the start of each interview, I introduced myself, explained the study, went over informed consent details, turned on audio-recording devices, and then proceeded with the interview questions, respectively. While going over informed consent, I

a) ensured the participants knew that they could respond or refuse to respond to any interview question without any harassment or coercion from myself or the university,
b) that they were free to withdraw from the study at any time, and
c) could make changes to their interview transcripts during the member checking process.

All participants selected a pseudonym to maintain their data's confidentiality and anonymity, and I addressed them by that pseudonym henceforward. If a participant selected a pseudonym already chosen, I asked them to select a different one. Participants

were free to ask any questions at any time during the research. I adhered to the interview protocol (see Appendix B) and asked follow-up questions whenever necessary. At the end of the interview, I debriefed participants, asked if they had any further questions, inquired if they had any concerns, set expectations for member-checking, and verified if they wanted a copy of my study findings. I thanked the participants for their time and invited them to contact me if they had any additional questions or concerns.

In all interactions with the participants, I applied the seven ethical research principles I learned from NIH to ensure (a) social and clinical value, (b) validity, (c) fair and respectful participant treatment, (d) favorable participant risk-benefit ratios, (e) independent review, (f) informed consent, and (g) respect for potential and enrolled participants. This research did not have any significant risk or side effects, except for daily life activities such as tiredness following an in-depth interview. I masked any information linked to the participants and maintained participants' confidentiality by using each participant's fictitious pseudonym.

Institutional Permissions

I obtained organizational approval from the two selected APRN professional groups to forward the recruitment flier and obtained Walden IRB approval before commencing recruitment for this study. I gained an agreement to distribute the recruitment fliers before applying for IRB approval so that IRB could review my recruitment procedures. I did not commence actual flier distribution or recruitment of any kind until after I had IRB approval to proceed with the study.

Recruitment Materials

Recruitment materials included a recruitment flier (see Appendix C) to solicit volunteers, an invitation to apply, a demographic questionnaire (see Appendix A), and informed consent to ensure participants met the study criterion. Potential participants initiated contact with me by responding to the recruitment flier. I emailed all interested applicants an invitation to participate, explaining the study details along with the demographic questionnaire and informed consent, asking them to return the completed questionnaire and informed consent within 72 hours. In the invitation to apply, I let all participants know that they were free to accept or decline the invitation to participate. Once accepted, they could withdraw from the study at any time.

Collection Activities

I collected data via the demographic questionnaires, interview questions, audio-video recordings, and my reflexivity journal, in conjunction with Benner's (1982) novice to expert nursing model and Kanter's (1977, 1993) theory of organizational structural empowerment. The primary data source was from semistructured interviews with nine new APRNs who had experienced the transition from RN-APRN; however, my presence during the interview may have influenced participants' responses. Therefore, I practiced self-bracketing and began the interview by setting a calming environment and encouraging discussion about becoming an APRN. As the participant relaxed, I shifted focus to their transitional experiences and asked the probing RQs listed on my interview protocol (see Appendix B). I asked follow-up questions based on participants' responses and clarified my understandings with participants for accuracy.

Throughout the study, I kept a reflexivity journal to help bracket and minimize potential researcher bias and influence. I also took notes, recorded my observations during the interviews, and listened to the interviews' audio-recordings in my reflexivity journal. To minimize potential misinterpretation, researcher misinterpretation, and bias, I frequently cross-checked my data analyses against my reflexivity journal and adjusted data interpretation as needed.

Treatment of Data

I securely stored all data in my private office, either on my password-protected personal computer or in a locked file cabinet throughout the study. I will continue to do so for five years, as required by Walden University. After the study, all data were digitized, encrypted, and stored on a single password-protected USB and safely stored in my private office in a locked file cabinet. Five years after the study is published, I will reformat the USB storage device and then destroy the device rendering it inoperable. I will also send any undigitized data to a professional shredding company for destruction. Digitized data will include:

a) reflexivity journal
b) interview transcripts
c) audio-video recordings
d) member checking results

I alone had, and will continue to have, access to the data but will provide the data to legal authorities should I be legally mandated to make the data available; however, I will only reference the participants’ assigned fictitious pseudonyms.

Participant Confidentiality

Throughout the study, I masked any information linked to any participant connecting data with participant demographics only via each participant's assigned fictitious pseudonym. When each interview commences, I asked the participant to select a fictitious pseudonym, explained that the pseudonym was to ensure confidentiality, and, henceforward, referred to that participant solely by their pseudonym. If the selected pseudonym was in use by another participant, I asked the participant to select another until they select a unique name. One participant had selected their name but changed to a pseudonym upon my request; no other pseudonyms had to be changed. After the interview, I connected the participant's demographic data with their interview data and adjusted all references to that participant to reflect only their pseudonym. Therefore, there is no way to connect a participant's legal name to their pseudo-identity, and all data were analyzed and stored using only that pseudonym. While data will be disseminated widely to interested participants, scholarly journals, public policymakers, APRN educators, and organizational administrators, I will only reference participants' pseudonyms.

Other Ethical Concerns

Other ethical concerns included participant incentives and conducting the study within my professional environment; however, neither applied to this study. I gave each participant a $10 Amazon gift certificate as a thank you for their time, and all participants were free to choose the communication forum most convenient for them. I am a professional APRN and, thus, possess knowledge, personal experience, and bias about the study phenomenon, which are jaded by time. Therefore, I kept my recalls in my

reflexivity journal to bracket and minimize my potential influence on data collection and analyses. I recruited participants practicing my profession in the same city I live in, and my participant selection sample was purposeful. Therefore, I prepared to eliminate any applicant names that I recognized from the representative sample pool. However, I recognized no names and did not have to eliminate anyone for that reason. I did not select participants from my workplace.

Summary

Through this phenomenological study, I explored how RN-APRN transitional experiences impacted new APRNs' performance using Benner's (1982) novice to expert nursing model and Kanter's (1977, 1993) theory of organizational structural empowerment. My design's rigor included multiple processes to strengthen the credibility, transferability, dependability, and confirmability of my findings and followed ethical procedures for both human and data treatment in line with the NIH. Upon IRB approval, I commenced participant recruitment; collected, coded, and analyzed data; interpreted results; and discussed my findings correlating the impact of APRN transitional experiences on their performance corresponding to proficiency levels and organizational supports.

Chapter 3 detailed the study (a) research design and rationale, (b) role of the researcher, (c) ethical issues, (d) methodology, e) instrumentation, (f) data collection procedures, (g) data analyses plan, (h) issues of trustworthiness, and (f) ethical procedures. Chapter 4, the study results, include (a) study setting, (b) demographics, (c)

data collection, (d) data analyses, (e) evidence of trustworthiness, and (f) study results. Chapter 5 presents further discussion and recommendations.

Chapter 4: Results

With this phenomenological research, I explored how prior RN experiences influenced APRNs' transitional performances in primary care in the Chicago area. Using semistructured interviews, I explored APRNs' perceptions about how prior nursing experience impacted their transitional performances and internalized their available SOP resources. Through the central research question, I sought to learn how the nursing experience shaped primary care nurse practitioner's transitional performance; it contained two subquestions to garner the answer.

This chapter covers (a) the research setting, (b) participant demographics, (c) data collection, (d) data analyses, (e) evidence of trustworthiness, and (f) study results. It details findings on participants' experiences during their transition from RN-APRN through identifying the major themes revealed during data analyses. This chapter begins with a detailed examination of the study setting to introduce the ontology of the study.

Study Setting

Throughout the time of the study, including the interviews, , the environment in Chicago was tense. Three major extenuating factors occurred in Chicago and throughout the country: the COVID-19 pandemic, the hostile presidential election, and the violent race-related riots. Nevertheless, the participants were eager to share their perceptions of their experiences transitioning from RN-APRN. Many hoped that an effective policy would emanate from their experiences to help new APRNs. One participant pointed out that "this study was overdue."

Throughout the interviews, I did my best to put them at ease them as they recounted their transitions; no participant seemed burdened during the interview. Though participant recruitment continued longer than anticipated, I accepted only qualified participants (see Chapter 3). Thus, all participants were classified as new APRNs who had worked in primary care for less than 5 years. No personal or organizational conditions seemed to influence the participants during the interviews. Still, the pandemic, the election, and the riots could have influenced some of them.

COVID-19 Pandemic

Due to the pandemic, recruiting and interviewing qualified participants were difficult, and all communications used Zoom or telephone. Some candidates dropped out of the study, and I rescheduled several appointments due to COVID-19. Some participants suffered COVID-19 related illnesses; some were frontline workers; others helped their children with online school; a few balanced all three challenges. The increased workload due to COVID-19 caused the only CNM in the participant pool to drop out of the study.

Presidential Election Year

The presidential election in 2020 in the United States was contentious and unsettling. The environment was fraught with fear and anxiety; safety was a significant concern for most people. My study participants were an embodiment of the whole nation's state, but they were concerned about patient care and safety; thus, many felt obliged to share their lived experience as they transitioned from RN-APRN duties. All

participants were happy to share their experiences, hopeful that RN experiences and practice environments improve APRN resources.

Ongoing Riots and Violence

The year 2020 also marked a long stretch of riots and violence following the deaths of unarmed black men at police's hands. The Black Lives Matter peaceful protests sometimes became marred by looting and violence. People did not feel safe leaving their homes sometimes. These prevailing circumstances complicated people's lives and often resulted in unstable environments. The participants did not show any evidence of influence due to the prevailing environment.

Demographics

I interviewed nine Illinois licensed, new APRNs working for less than 5 years in Chicago's primary care settings. I attained data saturation after seven interviews but interviewed two more participants to ensure inclusion of more than just CNP certifications resulting in eight CNPs and one CNS participant. All participants were females because the only qualified male dropped out due to unforeseen circumstances.

Participants' average RN and APRN experience were 13.2 and 1.4 years, respectively. Two APRNs had less than 10 years of RN experience, while seven had greater than 10 years of RN experience. Participants worked in multiple clinical practice areas as RNs, five in intensive care units (ICU), and four had long-term care experience. All the APRNs' highest nursing degree was MSN. More than 50% of participants rated themselves as expert nurses before transitioning to new APRN roles, 33% proficient, and 11% only competent (see Table 1). Thus, by Benner's (1982) novice to expert nursing

model, 11% of the participants felt they lacked speed and flexibility when they transitioned from RN-APRN.

Table 1

Demographic Characteristics of Study Participants

Pseudonym	Length of RN service before APRN role (years)	APRN Certification	APRN specialty	PCP setting	Length of APRN service	Proficiency level at transition
Jane	10	CNP	FNP	Ambulatory/ hospitalist	3	Expert
Jessica	7	CNP	FNP	Long term	2	Expert
Lizzy	22	CNP	FNP	Ambulatory	4	Proficient
Love	21	CNP	Adult NP	Ambulatory	4	Expert
Lucy	17	CNS	CNS	Ambulatory/ hospitalist	4	Expert
Mati	12	CNP	FNP	Long term	2	Proficient
Oby	9	CNP	FNP	Long term	1	Competent
Olivia	5	CNP	FNP	Subacute	2	Expert
Rose	16	CNP	FNP	Ambulatory	2	Expert

Data Collection

After receiving Walden IRB approval, I commenced data collection by emailing invitations to two APRN professional groups and posting study recruitment fliers to appropriate WhatsApp groups as stated in Chapter 3. I emailed recruitment fliers to potential participants daily through WhatsApp social media messaging. I followed up with the presidents of the professional groups through email to ascertain my invitation flier's status. I recruited only three volunteers after 2 weeks. Thus, I employed a snowball recruiting technique by engaging the first three participants to recruit additional qualified volunteers over 8 weeks.

Within that 8 weeks, I rejected four volunteers that did not meet the study criteria and recruited 10 interview participants to cover the three groups of APRNs outlined in Chapter 3. However, a last-minute withdrawal of the only CNM left me with nine participants and excluded one APRN category. Thus, after vigorous recruiting efforts, I recruited nine new APRNs meeting the study criteria, including eight CNPs and one CNS.

All participants read and confirmed consent by replying I consent to the consent form. I conducted all interviews through either Zoom or telephone and audio-recorded each. Interviews occurred in a quiet space away from any distractions. I set up and tested the recording and equipment 30 minutes before the interview. I conducted one interview per day. I greeted and thanked participants for their participation and time. I introduced myself and explained the research protocol. I asked the participant to select a pseudonym and henceforth identified that participant with their chosen pseudonym.

I asked if participants had any questions. I explained to the participants that the study was voluntary, and they could withdraw consent at any time up to the study submission. I informed the participants that the study did not have any inherent risk to them except for usual tiredness following a daily activity. I explained the purpose of the interview, the interview procedures, how the data gathered would be used, participants' roles, confidentiality, and steps taken to ensure their confidentiality. I explained the audio recording and turned the recording equipment on, stated my name and participants' pseudonym. I interviewed each participant one-time for an average of 60 minutes.

During the first interview, the participant suggested I bunch the questions together because some were similar. After that, I placed the questions that seemed similar together but did not eliminate them. I determined that the questions seemed similar because the study explored the lived experiences during transition related to prior nursing experience and organizational structural empowerment using two lenses. Furthermore, the questions enabled participants to reinforce areas that were most important to them.

After each interview, I removed information that could link participants to their workplaces from the data and did not refer to their specialty when discussing their views to maintain confidentiality. Data collection was smooth except for two short-lived Zoom temporary bandwidth problems that resolved with repositioning of the computer closer to the WIFI router. There were a few minutes of data collection disruption because sound froze due to the bandwidth problems; after that, data collection proceeded well. There were no unusual circumstances encountered during data collection.

I attained data saturation after seven interviews. I conducted two more interviews to ensure a CNP participant's inclusion and coverage of the samples outlined in Chapter 3. Although I planned on interviewing 10 participants, I only interviewed nine because of difficulty with participant recruitment due to the COVID-19 pandemic. Thereby, exceeding data saturation, I collected comprehensive data to answer the research questions.

During each interview, I wrote down words or phrases that aligned with proficiency and structural empowerments. I asked follow-up questions to dig deep into the meaning of the experiences expressed by the participants. I confirmed my

understanding of participants' meaning during interviews and verified if participants wanted a final copy of my research findings. I used my personal computer and Sony digital recorder for the interviews. I asked participants if they had additional information before ending each interview and requested feedback about the interview process. I stored and continue to store all data securely in a locked cabinet and on a password-protected computer. I will destroy all data after 5 years of research completion.

Data Analyses

This section discusses how I analyzed the data and the procedure I used to discover emerging patterns and themes. I adopted Sundler et al.'s (2019) three steps of thematic analyses. I commenced the data analysis process soon after receiving the demographic data. Data analyzed included the demographic questionnaire, semistructured audio-recorded interviews, handwritten notes, Kanter's (1977, 1993) theory, and Benner's (1982) model. The demographic data provided context for analyses and participant descriptions.

Transcript Scrutinization

I uploaded the interview recordings, electronically transcribed them with NVivo transcription software, and manually reviewed them using MS Word to reflect only the participants' pseudonyms. After that, I reviewed the transcription copy against the audio recording for verbatim comparison. I corrected all errors to ensure that I transcribed every word verbatim and correctly. I ran into a technical problem during NVivo transcript correction; thus, I exported Microsoft Word files to continue. I listened to the audio while correcting the transcript in Microsoft word to ensure accuracy.

While scrutinizing the transcripts, I used the comment section in MS Word to note codes and patterns. I noted emerging codes and themes and made some handwritten notes. I connected all participant identifiers with their pseudonym and uploaded them into NVivo software for data organization and analyses. I uploaded my reflexivity journal and handwritten notes under memo in the NVivo software. I established Benner's (1982) five proficiency levels and Kanter's (1977, 1993) organizational structural empowerment codes in NVivo.

Thematic Overview

To garner a quick theme overview, I used NVivo functionality to generate a word cloud highlighting and emphasizing word frequency (see Figure 1). According to QRS International (n.d.), word frequency queries itemize frequently articulated words or phrases, represented via a word cloud depiction that is helpful for theme recognition. Word clouds display the most frequently spoken word by the participants in different fonts, with bigger fonts representing what the participants expressed most (QRS International, n.d.). Thus, from the word cloud, the most prominent words participants uttered were experience, nurse, know, get, like, and patients, followed by training, role, help, transition, need, things, make, APRN, and the other similarly bolded words. I inferred from the word cloud and interview transcripts that participants frequently spoke about their RN experience, their patients, and their knowledge. The participants voiced the role prior nursing experience played in their transitional performance and the patients' population. The inference from the word cloud aligned with patterns that emanated from the interviews, minimizing any bias.

Figure 1

Participant word frequency

Coding Organization

I ran into technical problems using NVivo to analyze and organize all the data, so I resorted to manual coding for the rest of the data analyses. Manual coding helps small studies entrench the study's domination and ownership (Saldaña, 2016). I compared the themes emanating from my manual coding to the word cloud and noted that they were similar, limiting bias. I used thematic analyses based on the descriptive phenomenology approach by Sundler et al. (2019) to analyze the interview data. The goal was to understand the participants' descriptions of their lived experiences related to the research question. Sundler et al. summarized thematic analyses in three steps (a) achieve familiarity with data through open-minded reading, (b) search for meanings and themes,

(c) organizing themes into a meaningful wholeness. I followed these three steps to analyze my data.

The first step in data analyses was to my familiarization with the data and keep an open mind as I immersed myself in the data. I read the transcript for each interview several times and examined the lived experiences of participants. I pondered on the meanings of the participants' lived experiences all through the day for some time. I sometimes woke up pondering the meaning participants attached to their experiences and how they related to each other. All participants had similar experiences with SOP resources and maintained that prior nursing experience was integral to their transitional performance. Each participant discussed their experiences with ease and used strong words to describe their experiences, such as tough, shocking, intimidating, and challenging. All participants had similar suggestions of entrenching orientation and role transition in APRN policy and training.

The second step was searching for meanings in the data, new information, and relating such to my research question. While reading the whole text, I went back and forth to some parts of the text to deepen my understanding of the text's meaning and themes. I assigned phrases and words to meanings relating to experience in red and meanings relating to structural resources in blue ink. I compared meanings that related to each other for each RQ to elicit similarities and differences. According to Sundler et al. (2019), “meanings need to be related to each other to get a sense of patterns” (p.736). I slowly allowed meaning patterns to emerge as I went back and forth between similar codes. I maintained an open mind to garner new information rather than what was known.

The last step in my thematic analyses was organizing themes into a meaningful wholeness. Once I determined the similar phrases, I grouped them to establish a meaningful pattern. After that, I used a statement to formulate a significant theme emanating from the pattern's meaning that would answer the specific RQ. For RQ 1, six major themes emanated from the participants' perceptions of organizational structural empowerment and transitional performance: (a) workplace orientation, (b) workplace resources, (c) support from the organization, (d) empowering information, (e) sense of being overwhelmed, and (f) communication difficulty. For RQ2, I noted six major themes: (a) knowledge-seeking, (b) experience crucial, (c) environment familiarity, (d) advocacy and holistic care, (e) overcoming stress and anxiety, and (f) cheap labor.

All participants agreed that, after a long time at bedside nursing, they believed they could do more for the patients and provide better holistic care independent of physicians. I also found that the need to advance patient care rendered, coupled with their RN experience, motivated participants to go into an APRN program. One of the participants noted her love for nursing education motivated her to become a CNS. All APRNs in this study noted they were poorly paid for their job, and credit for patient care goes to the physician. The most prevalent theme was workplace orientation, followed by workplace resources, and prior nursing experience.

Evidence of Trustworthiness

As an integral part of my data analyses, I analyzed the process and results for trustworthiness using several methods. I meticulously checked for credibility, transferability, dependability, and confirmability using the techniques I outlined in

Chapter 3. Subsequently, I found ample evidence of trustworthiness demonstrating the validity of my results.

Credibility

To establish credibility, I ensured that I represented all information gathered through member checking and my committee review. All participants received a copy of their transcript. All participants reviewed their transcripts for a correct and accurate representation of their lived experiences, and no participants requested or made any changes to transcripts. My dissertation committee at Walden University conducted a peer review of my study. To triangulate my data, I interviewed new APRNs from different settings of primary care. I bracketed myself from my opinions, biases, and experiences by reflecting on them to avoid influencing participants many times. For example, when one participant discussed provider language and communication, I noted my memories of a similar situation in my reflexivity journal. Thus, I reviewed that data multiple times, intentionally separating and dismissing my personal feelings. No participant asked for my opinion and offered none. My study attained saturation after seven interviews, and I interviewed two more participants for data triangulation.

Transferability

I determined that my findings can be transferred to new APRNs in primary care in other parts of Illinois beyond the Chicago area. I used data triangulation and thick, rich descriptions to present the study phenomenon, rendering findings transferable to similar settings, people, and contexts. To further generalize my findings to inform causal relationships, the aggregated data could add depth and insight to a quantitative study.

Dependability

I followed the procedure outlined in Chapter 3 for data collection and analyses to ensure dependability. I interviewed new APRNs who work with different populations in different primary care settings. I used two theories to enable me to triangulate various perspectives of my study. I documented my thoughts in my reflexivity journal and kept a detailed accounting of the data collection, analyses, and audit trail. I will keep all documents related to this study for five years after publication so that anyone interested in replicating my study can review and confirm them.

Confirmability

I used my reflexivity journal and detailed study design to provide a complete audit trail. I achieved data triangulation by interviewing new APRNs in different primary care settings. During the interviews, I clarified and verified participants' responses to ensure information reliability. Participants vetted and confirmed their transcripts. I kept reflexivity notes, handwritten notes, transcripts, and analyses of all raw study documents to support triangulation and enhance study duplication. Member checking and peer review provided additional review, thus, increasing confirmability.

Study Results

I paired participants' demographic information with their proficiency levels, length of RN service, and prior practice sites (see Table 2). I found that most new APRNs who worked in ICU rated themselves as expert RNs. New APRNs attributed their proficiency levels to their positions wherein they attended more than regular bedside nurse duties. APRNs reported that they attended and interpreted laboratory results and

sometimes held a full MD position to expedite patient care. For example, Lizzy noted that some physicians who trusted her judgment allowed her to prescribe and that that physician signed such prescriptions as a verbal order. Even so, participants noted that, when they attained APRN status, they experienced the anxiety of facing a new role with uncertainty. Participants also reported that when anxious, they were comforted by acknowledging that they were carrying on with some aspect of what they had been doing as an RN like patient education, teaching, advocacy, and collaboration. However, most of their new APRN role was in unfamiliar territory with a less than friendly environment. I determined that the hostile environment impacted their transitional performance and confidence, but prior nursing experience assuaged it to some extent. Several themes emerged from the interviews, which I present according to each RQ individually.

Table 2

Participant Proficiency Comparison

Participant	Proficiency level	Years of RN tenure	Prior RN practice	Certification	Practice site
Jane	Expert	10	Intensive care unit (ICU), medical/surgical (Med/surg), Telemetry (TELE)	CNP	Ambulatory, hospitalist
Jessica	Expert	7	ICU, Med/surg	CNP	long-term care
Lizzy	Proficient	22	ICU, Med/surg, Emergency room (ER), Labor & delivery, psychiatry	CNP	Ambulatory care
Love	Expert	21	ICU, tele, med/surg	CNP	Ambulatory care
Lucy	Expert	17	ICU	CNS	hospitalist, Ambulatory care
Mati	Proficient	12	Acute care, long term care	CNP	Home care
Oby	Competent	9	Home health	CNP	Home health
Olivia	Proficient	5	Adult medical unit, TELE.	CNP	Sub-acute
Rose	Expert	16	Med/surg, long-term care	CNP	Correctional center

RQ1: Organizational Structural Empowerment

Six themes emerged from the participants' perceptions of organizational structural empowerment and transitional performance (see Table 3).

Table 3

Thematic Analyses of Organizational Structural Empowerment

Patterns	Themes	Theme descriptions
New APRNs received less than 1-week orientation; three new APRNs reported no orientation; one reported six weeks. High attrition rate. Most new APRNs shadowed physicians, were uncomfortable, not relaxed.	*Workplace orientation*	Participants reported being thrown into the job without adequate orientation. Only one new APRN was oriented by APRN and was preferred. Sink or swim. Thrown out there. Shown an office space. One day to familiarize with electronic health records.
Insufficient or nonexistent resources. Technology challenges. Colleagues as resources. Educational materials and up-to-date software such as journals. Reliance on outside providers. Learning on the job. Time issues. Resources favor physicians.	*Workplace resource*	Participants reported lacking equipment, resources, and a resource person. They must get outside coaching. New APRNs were conversant with listening, talking to patients and family, and counseling; these take up their time, resulting in less output and good patient outcomes. Lacked back up.
Unsatisfactory relationship with physicians, administrators, and other providers. Poor wages. High workload. High expectation. Not appreciated. Unyielding physicians.	*Organizational support*	Push back, conflicting relationships; patients caught in the middle. Physicians get credit for APRN job. New APRNs share similar responsibilities as physicians but not compensated as physicians. Physicians too busy to help.
Poor role visibility. Physicians not accepting. Experienced RNs push back. No formal feedback	*Empowering information*	New APRNs reported poor role recognition, patients not understanding their role. Some physicians did not understand new APRN roles, refused APRN care, thought competition, not collegiality, Lacking performance reviews.
The expectation to know it. Time management. Medication real world. Unyielding physicians. No prior RN experience.	*Sense of being overwhelmed*	Due to prior experience as RN, new APRNs were expected to know what to do; therefore, they received little or no orientation, lack of prior nursing experience.
New role, new communication style. Needs provider language. Lack confidence.	*Communication difficulty*	New APRNs reported not having the appropriate language to communicate with patients and providers; they lacked provider communication skills. Imposter syndrome

Workplace Orientation

Orientation in a workplace allows new employees to acclimate to the company processes, procedures, protocols, and personnel. Kanter (1977, 1993) posited that employees do well when the organization furnishes essential employee performance resources. Seven out of the nine research participants received inadequate orientation (0 to 2 days) in the workplace, while two reported that they received orientation for about 2 to 6 weeks. Kanter demonstrated that workplace orientation ensures that an employee is acquainted with the organization and is a fundamental groundwork needed for success. According to Oregon state university (n.d.), orientation provides new employees contentment, confidence, a better chance of staying on the job, and better interaction with superiors.

Additionally, anxiety, lack of confidence, and lack of support were predominant features reported by my study participants. Barnes (2015) noted that high attrition in new APRNs often occurs in the first year of work life. A good and durable orientation with a visible resource person provides a milieu conducive to new role transition (Kanter, 1977, 1993), thus retaining APRNs. For example, Lucy reported that “when I got the job of the coordinator, I was just shown to my office and told, this is your office, and that was the only orientation and empowerment.” Likewise, Lizzy stated that “they just hire you, they throw you out there, you are a provider, so they assume you should know what to do, you are on your own. They just show you the office and show you the patients.”

On the other hand, Jessica was onboarded by an experienced APRN for two weeks, thereby increasing her confidence and ensuring she was ready to work on her own after that orientation. Jessica said,

> The role that I'm at is more of a sink or swim type of place and, you know, most people run away and leave, I would say that a good policy to put in place to help the transition with new nurse practitioners…, of course orientation, orientation is important everywhere.

Thus, I found that familiarizing new APRNs with organizational cultures, and not merely introducing them to an empty space and department heads, augurs well for transitional performance.

Workplace Resources/Employee Empowerment.

Participants noted workplace resource deficiencies ranging from technology challenges, translators, salary, and staffing, which impacted their performances and confidence. Rose described inadequate patient information emanating from the organization's limited technology advancement: According to Rose, "what you know about the patient is what is handed over to you." This information lack is dangerous to patient safety because, as Moustakas (1984) demonstrated, people have an imperfect recollection of events. Additionally, IOM (2012) recommended HIT for safe health care delivery. According to IOM, HIT facilitates error reduction in healthcare. Rose conveyed that,

> Because we are not fully electronic for a lot of patients' data, they are faxed over to you, as a medical provider you don't have access to them, the nurses hand it

> over to you. So, since I work with the same group of people, you know who do what and who do not do what. Even when you have new patients, the information handed to you is what you know about the patient, so that is a sticky situation.

One participant enunciated the importance of having access to a patient's medical record. Jane noted that the patient's past medical record helped her provide holistic care to her patients stating that,

> I got support from a lot of my mentors in my group, I got help from the depths of medical records, yes, because it is there for you just to kind of go back and see what, you know, what people did and search for more information.

Therefore, providers rely on documentation of patients' past circumstances to deliver holistic care; lack of it limits the benefit that would accrue to a patient.

All participants complained about expectations to see patients within a limited time, reporting that as a source of anxiety and burden for new APRNs. Participants noted that new APRNs needed time to adjust to the new role before they must adhere to time guidelines. Lizzy said she did not earn any bonus in the first three years because the bonuses depended on the number of patients she saw, and she was slow at the beginning. Lizzy emphasized that she improved overtime because she learned to use the electronic health record system efficiently:

> Sometimes you find out that you need more than they actually provided for you to be successful. Sometimes having this nursing background, you seem to talk to patients more and forget the time. So, by the time you know it, you are racing with time. So, time was my greatest enemy then. So, I was struggling, especially

> for some days. They'll double book the patients. And you're looking at the time my patients are waiting. So, it was very tough initially until I was able to find a way to handle it.

I also determined remuneration was empowering to the new APRNs. Participants felt management did not appreciate their roles because their income did not represent their productivity. Love reported:

> But the system as a whole does not appreciate the role of APRNs. It is so because the system still believes that the doctor is all in all in the system, so they still do not think that for the role that we are playing, that we deserve to be paid more…, we deserve the benefits that doctors get, because we do the same thing that doctors do, so it becomes so disheartening when…, I see 20 patients, but some of the doctors are seeing only 16…, who is being paid more, is the doctors.

New APRNs also feel empowered through organizational and colleague appreciation. Jane noted that,

> Some days I don't feel appreciated. I think some days…, I feel like I do too much that the pay doesn't cut what I do. Some days I feel appreciated because I helped somebody, and I made a difference in somebody's life. Some days I feel appreciated because the registered nurses that have you as their backup openly appreciate you being there.

Jane's lack of appreciation due to poor wages and appreciation from colleagues lends credence to Kanter's (1977,1993) theory of organizational structural empowerment. For example, a commiserate wage and recognition for work done will empower Jane and

confer a sense of worthiness. According to Kanter, recognition and rewards confer dignity to employees. New APRNs would feel the gravity of their role and performance if the organization recognizes their impact.

New APRNs also noted that staffing was a problem during their transitional period. Matti reported that,

> Staffing is a problem because we don't only need staffing, we need bilingual employees, so employees that can deal with patients of different cultural backgrounds and race especially Spanish speaking. So, we saw challenges in that area, so staffing is a problem.

Therefore, language barriers and lacking translators obliterated communication and impeded safe healthcare delivery by new APRNs. Olivia also noted that available resources were directed to the physicians but not for APRN use:

> The nurses always go in with the physicians…, and they explain the patient care and all that stuff [patient status] but when it comes to a person like myself, it's different…, It's just like we're going to figure it out …, on our own or look it up in the computer.

Organizational Support

All participants reported poor role recognition among the patients and physicians. Furthermore, poor role identification resulted in lost services with patients walking out on the new APRN, and some physicians refusing to share knowledge with the attitude of competition, not collegiality. Lizzy noted that about three patients walked out and said, “no, I don't want to see an NP; I want to see the physician” and added that “it will be

better if the person who is scheduling the patients is telling them that they will be seeing NPs.” Lizzy further indicated that,

> The physicians need to know that the NPs are there to help with the patients and not competing with them; you know, some of them see NPs as competitors instead of seeing them as colleagues here to help.

Thus, patients were not well informed about APRN roles, so much so that they requested the physician consultation after APRN's consultation. One of the patients asked one of the participants if she was learning to become a doctor. Lizzy reported that a patient asked her,

> When are going to go back to school to be a doctor? They don't understand that you are a clinician just like the doctors, so, yeah, it was a challenge, especially for some of the patients that, would think that, oh, are you going to call the doctor after you have seen me or are you seeing me, and then you go and call the doctor.

According to Kanter (1977, 1993), organizations well informed about employee roles will extend that information to all employees and the environment. Organizations must provide a milieu for every healthcare provider's collaboration. Andregård and Jangland (2015) noted that APRN roles are viewed differently within an organization; therefore, the organization must educate employees and clients about new APRNs' roles. Jane’s experience is that the patients did not understand her role and would not accept her instructions:

> Because you are a nurse practitioner, they think you're just a nurse, so that's especially with the geriatrics; no matter how many times you tell them who you

> are, they still call you a nurse, so, with the geriatrics, sometimes we just let them call everybody who is a provider doctor, just for them to have confidence in who is treating them, to take instructions because sometimes they are very resistant to taking instruction from you.

Role recognition and visibility are essential to an employee's dignity (Kanter, 1977, 1993). One of Kanter's theory's assumptions is that some employers bestow dignity to some of their employees and inhibit others; expressions of dignity include "recognition, reward, status, autonomy, and control" (p.251). Lack of role recognition of APRN status could impact their confidence and performance.

Participants noted a lack of empowering resources such as technology. Rose explained that her prior knowledge of the environment and patients as an RN helped her deliver safe care. As a new APRN, Rose noted that was limited:

> Because we are not fully electronic for a lot of patients' data, they are faxed over to you, as a medical provider you don't have access to them, the nurses hand it over to you. So, since I work with the same group of people, you know who do what and who do not do what. Even when you have new patients, the information handed to you is what you know about the pt., so that is a sticky situation.

Information Availability

Information and resource availability enhances new APRN performance. Like other participants' organizations, Rose's organization did not offer much support for the new APRNs. Several participants echoed Rose's feelings describing transition as "sink or swim, you are on your own, or you are a provider, so you should know everything."

Some participants resorted to outside assistance and coaching from other experienced providers and physicians willing to help.

According to Lucy, there was another hospital close with a seasoned APRN program. Lucy stated that she "needed to know about how to run this program; I had to go over there every day almost to sit with her for one hour to see what was going on." New APRNs resorted to self-help, outside tutorials, educational materials, and software like *Up to Date*. Nurses envision themselves as lifelong learners (Jensen,2007), and nurses learn as they work (Benner, 1982; & Skår, 2010). *Up to Date* is an example of such software. All research participants noted that they engaged in on-the-job learning to gain educational resources and stated that prior RN experience shaped this culture for them.

Feedback is also crucial for successful transitional performance (Kanter, 1977, 1993). Some participants reported that the feedback they received came six months to one year from the time of transition, and they wished they received that information earlier. Jane reported that she did not receive formal feedback during her transition:

> At the end of every year, we are reviewed by all the physicians and all the APRNs. So, you have your mates, APRNs reviewing you, and the physician you've ever worked with reviewing you; I just think that, you know, they shouldn't wait for one year to get you to correct something. But like I said, it takes a year to get the feedback.

Kanter (1977, 1993) noted that feedback evokes employees' reactions and is pertinent for their performance. Most participants did not receive any formal feedback during their transitions, and information sharing was not optimal. Mati said,

> We should have like a meeting quarterly, or annually, where everybody comes on the table and say the challenges they have, and not wait until something happens. For now, it is until something happens; that's when we share.

Sense of Being Overwhelmed

Participants reported feeling like they were overwhelmed. One participant told the story of a colleague, a new APRN who cried a lot at work due to a sense of being overwhelmed and frustrated; that participant's colleague resigned within three months of employment. Another participant cried on the first day of transition because the organization sent her to run a clinic without workplace orientation. The medical director told her she was known to be a seasoned nurse and expected to know what to do. Participants explained that there was a tendency for their organizations to equate an experienced RN to a competent APRN because the RN was transitioning to APRN within the same organization. Love reported that,

> I told the medical director this was the first day I'm seeing patients in this system, and I started with twenty-six patients; tears just started running down my eyes; he came and held me like calm down, Love calm down, they told me you're a seasoned APN, you've been in the system for 20 years. I said yes, I've been in this system for 20 years but as a regular RN.

Love also noted that the experience of seeking help from some of the physicians was difficult and undesirable:

> I find it difficult at that time to go to my collaborative physician because he is one of those people that thinks that, oh, you're an APRN, and you know it all, figure it out. The physician's disposition is dangerous to the safety of the patients; backup is a very important organizational support that could impact transitional performance of APRNs. A new APRN would need onboarding in order to transition into the new role.

Love explained that she surmounted these challenges due to her prior RN experience; however, she still felt highly overwhelmed even given 21 years of RN experience.

Communication Difficulty

All the APRNs decried the distinct lack of adequate provider communication skills during training, conveying that they needed to learn how to communicate with patients and colleagues as an APRN during their APRN training or orientation. Jane explained that,

> When you are a registered nurse, you already know how to talk to your patients, but now you are talking to them with a different hat, we are talking to them as a provider… especially for us to learn how to talk to our patient as a provider, instead of like as a registered nurse, because it is a different hat.

An experienced APRN oriented Jessica. Jessica noted, "I was able to learn just seeing our preceptors, other providers, seeing how they interact with patients or how they think or just gaining their knowledge from their hands." Hence, communicating with patients and

colleagues as a PCP provider instead of an RN could be learned during orientation under an experienced APRN's supervision instead of a busy physician.

Participants indicated that appropriate communication skills convey confidence and inspire trust in an APRN's care. According to Jane,

> The challenge was, I think initially I got a lot of pushback from the registered nurses, but looking back, I think in the beginning, they may also detect that you don't have much confidence when you talk to them, you know the tone.

All the participants wished they learned how to speak like a PCP provider during their APRN training. According to Jane, the push back a new APRN encountered in the transitional period was relatable to poor provider communication skills. Jane noted that patients detected a lack of confidence through lacking provider-level communication skills. This finding was surprising because I did not discover it during my literature review.

RQ2: APRN Transitional Performance

Six themes emerged from participants' perceptions of their proficiencies relative to their transitional performances (see Table 4). My analyses of this data considered that participants had five to 22 years of prior RN experience. All participants said their prior nursing experience was the foundation of their APRN role for most of their responsibilities, excluding the medical aspect. They each relied on the skills they learned during their prior RN practice to seek knowledge, advocate for patients, and provide impactful patient education.

Table 4

Thematic Analyses of APRNs' Transitional Performance

Patterns	Themes	Theme description
Advancement, advocacy, wanted to do more for patients, on the job training. Exposure to information-seeking resources as an RN. Autonomy.	*Prior RN experience critical for knowledge-seeking*	New APRNs knew they could do more by advancing their education. Experience with information and RN knowledge seeking. The ability to source resources was learned as an RN.
Performing beyond RN role. Good assessment, observation. Disease/medication knowledge and teaching skills. Educating skill. Liaison, some level of autonomy as an experienced RN. Job termination due to lack of RN experience.	*RN experience was everything*	Performing beyond RN SOP. Confident, good assessment skills ensured safe care. Knowledgeable about the patients, disease process, medications, experienced educator, advocate, liaison for patients and family. Trusted by physicians. Survived, not succumb; coped, not crumble.
Familiar environment. Experience with disease processes. Prior medication knowledge. Prior experience, familiar setting.	*Familiar environment; safe care*	Familiarity with clinical environment, disease presentation, and management, knew what to do, knew the staff and their capability: good communication skills, conflict resolution, team building. Familiar setting. Similar patient population. Resourceful.
Spend time listening to the patient, hands-on, educator, liaison between patient /family, and providers. Empathetic, compassionate, preferred provider due to hands-on, listening, teaching, educating.	*Sense of advocacy, compassion, and holistic care*	RNs spend time teaching and educating. Communication skills developed as an RN, listening to patients, empathic, counseling, teaching patient and family, advocates for the patient. Knows what to do, resourceful. Preferred provider due to hands-on, listening, teaching, educating. Patient education and teaching skills.
New role challenges, imposter syndrome, sense of uncertainty, unsure of themselves, still thinking like an RN, someone needs to supervise.	*Overcoming stress and anxiety.*	Coping due to prior RN experience, knew what to do. APRN higher level of competency but a part of nursing carried over. Holistic care. A new experience. Prior RN experience helped build confidence.
Wearing two hats, assigned RN role as well as APRN plus provider role as physicians.	*New APRNs as cheap labor*	Prior RN experience a reason for the dual role. New APRNs are used as providers and at the same time assigned RN duties, role confusion by patients, impacted role visibility.

Prior Foundational Nursing Experience

While all the participants stated that they lacked empowering resources from their organization, they also emphasized that their prior RN experience provided a foundation for knowledge-seeking and leveraged their RN skills to benefit the patient. RNs engage in professional development training and see their job environment as a learning environment (Skår, 2010). With the ever-changing health care environment and new technology, RNs must constantly upgrade their knowledge (Benner, 1982). For example, Jessica explained that prior experience as an RN spurred her journey for knowledge acquisition, becoming a provider, diagnosing, and impactfully educating patients to better outcomes. Oby explained that "prior RN experience is a foundation and helps to facilitate the transition to the NP role" According to Oby, prior RN experience helped her assessment during the transition from RN-APRN:

> So I would say that the first time I went to in to see a patient, it was like I was nervous, you know, because as a registered nurse, I do home visit, it's not that I'm not conversant with making assessments or something like that but this time, It is a higher degree of difficulty, that the patient depends on you or your assessment or whatever you find out with the disease process to be able to do the right thing to help your patient, so the first day I was kind of nervous, you know, it really wasn't like everything is new to me, but I think it's just natural to have that. But soon after, I begin to relax and feel confident.

Lucy noted that,

> At the RN level, I knew what it was like to be doing things, and you don't have the proper education, and you are not equipped to do it. So that kind of shaped what I was into when I transitioned into this APRN role. I knew there was a lot of education needed. I knew that education had to be given because I know that there are things in critical care that we are doing, and we don't have enough knowledge or education of why we are doing it and how we have to learn to do it.

Prior RN experience also exposed RNs to educational resources for knowledge advancement. Lizzy told a story of a new APRN who could not source out information because she had only one to two years of RN experience and was unable to cope, frustrated, overwhelmed, and resigned. Lizzy shared that that new APRN,

> Was struggling with medications, to treat patients, you know, when she has to treat like pharyngitis, she knew it at the back of her mind, but she was not sure of the dosage and I was encouraging her to use the apps to help her with the dosage. she had a hard time doing that, and she did not stay. So, it was very frustrating several times for her.

Transitioning into the new APRN was challenging in many ways for all the participants but was especially challenging in their knowledge quest. All participants noted that their years of RN experience helped new APRNs source out avenues and materials to assist their SOP. Olivia added that prior RN experience made it easier for her to discover care resources.

Prior RN Experience was Everything

All participants expressed their long-standing experience of taking care of patients and knowing that they could have done more to motivate and advance to APRN roles. All the participants who rated themselves "expert" reported performing above RN SOP, and that experience motivated them to enter the APRN program. Rose reported that she was "kind of doing things beyond your scope of practice as an RN, so I decided to go to school for APRN status."

The confidence to apply RN practice and experience was also a significant factor in participants' advancement to APRN roles. Jessica noted that her transitional experience related to her expert RN level because she confidently relayed pertinent information to patients because she had been doing that as a bedside nurse. Most participants rated their transitional performance as either advanced beginner or competent APRN; thus, prior RN experience did not translate entirely to experienced APRN. These skill levels lend credence to Benner's theory that nurses acquire skills through practice and experience, shaping a nurse's performance. For example, Mati noted that prior RN experience helped her prioritize care, handle the social aspect of patients' needs, collaborate with other providers, and interpret laboratory values. Olivia reported that skills learned at the RN level, including assessment skills, advocacy, effective communication, observance, and vigilance, were instrumental to her transitional performance. On the other hand, Olivia also noted that having RN experience did not preclude her from anxiety associated with the new role. According to Olivia, "when

transitioning from an RN to an APRN, the practitioner is essentially so once again, they are stepping into new territory."

Because APRN is a new role requiring a higher competence level with more responsibility, all new APRNs admitted to some anxiety level. Olivia stated that "I became nervous again as an APRN." Olivia rated herself as an expert RN and was one of the two new APRNs who rated themselves as novice APRNs. The two new APRNs had the least length of years as RNs, and Olivia admitted to not incorporating much intuition in her APRN practice. According to Benner (1982), expert-level RNs use intuition for judgement. Olivia emphasized the difference she felt like a new APRN:

> It's using a higher level of learning; now you're using more interpretation skills, using more not much so intuition, but more so much that you learned from school to make adequate decisions regarding your patient's care. I went from calling the physician for labs that are abnormal to me now, being the one interpreting the labs and writing the orders and treating appropriately.

Mati said her RN SOP exposed her to a heavy patient load; thus, her experience enabled her to adapt to expectations during the transition. Oby stated:

> Having acquired this wealth of experience as an RN, it actually backs you up and gives you confidence in what you are doing, except that this is a new role to you, and so it feels like you are lacking or something like that, but because of the experience that I have acquired, it gives you a kind of a smooth transition into your new role as an APRN.

Rose, on the other hand, started with a familiar patient load like when she was an RN:

> When I transitioned, I had a caseload of my own, the patients I was managing as a case manager. When I became their provider, I already have a good rapport with them and their family; first week, I did not feel like I am starting from the scratch; I have a foundation to build on. That really helped.

Familiar Practice a Facilitator of Transitional Performance

More than half of the study participants were working in environments like where their RN. They cherished it and emphasized that the familiar environment made the new role less arduous. Jane summarized:

> The RN-APRN transitional performance was great in the sense that I had experience when I was a registered nurse, so it's pretty much like before you think about stuff, you already know what to do actually, because you have been doing it, except now you are doing it with somebody not telling you to do it. You're doing it because you know what to do and then you are, not waiting for somebody to tell you to do it. So, in that area, I really know what to do for my patient most of the times.

Rose noted that she was familiar with her patients' medications as an RN and therefore could safely prescribe them:

> Yes, before I transitioned in this role, I had an idea about the medications, first line, second line, and what to do when medications are not working. It helped to guide the treatment; you already know these meds at the RN role. That really helped to build the trust level; knowing how the medications worked helped to keep watch over my patients. Prior RN role really helped.

Mati noted that she was working with a similar population to the population she took care of as an RN because she had learned a lot about that population as an RN. Mati related the impact of that on her APRN performance:

> My performance, I would say, was moderate or competent as an APRN because I had so much experience with the nursing skills in geriatric population, so I stayed with this group of patients, so there wasn't much to learn about the geriatrics and their transition or their disease condition.

Rose related that the advantage of transitioning to a familiar practice environment:

> I was here before, and I worked few years as an RN; when I transitioned to APRN role, I knew what needed to be done. I knew what needed to be done at the medical level and what needed to be done at the nursing level; it improved the patient safety a lot because you knew both sides. While I was transitioning, I was kind of doing both roles to make sure things are followed up well. Like I call pt. to make sure all questions are asked, labs drawn, etc. Since I work with the same patients and place, I know who will or will not do what they are supposed to do. That was one of the benefits of starting at the same site because you know people, this.

This finding was corroborated with Farr's (2018) findings that "being able to have a clinical practice and then transition to the NP role in the same clinical setting helped to ease the transition to NP practice" (p. 58). Jane also reported that she found her prior clinical setting easier to navigate during transition than the ambulatory site with no prior

clinical experience. Therefore, a familiar RN practice environment positively influences APRN performance in similar environments.

Sense of Advocacy, Compassion, Patient Education and Teaching

All participants were motivated to transition to an APRN role because they felt they could do more for their patients. Mati noted that "cares were fragmented [during their RN tenure] and sometimes it took a long term to reach the physician and obtain orders. Such delays had resulted in re-hospitalization of patients from long term care." Mati became an APRN to provide holistic care to patients and advocate for all the patients' needs. As an RN, Mati's SOP limited her:

> Working as a nurse on the floor and sometimes, especially with the long-term care setting, you are the only one and you spend most of the time with the patient and I thought if I could provide more help to these patients, and I could be able to make decisions that were waiting for the doctors to make and sometimes the facility. The communication between the long-term care patients and the doctors is kind of slow.

All participants shared similar data indicating that their prior nursing experience facilitated APRNs' capability to educate and instruct their patients. All participants expressed that educating and empowering patients to take care of their health is a skill they learned from their RN experience; Jessica termed this behavior as "bedside manner." Although there were initial rejections from patients due to poor APRN role visibility, all the participants claimed that educating patients caused some patients to switch from physician-provided PCP to APRN-provided PCP services. The teaching and instruction

skills were carried over from RN responsibility to new APRN role and helped cushion their fears and anxiety. Mati noted,

> I'm surprised most of my patients do compare me with their primary care physicians and prefer me just because you have that other piece of nursing attached to the part that they want [from their PCP], and they keep saying, I can get what they give me, and I get this part too.

Overcoming Anxiety, Stress, and Fear

All participants stated that the transition from RN-APRN presented anxiety, fear, and stress because it was something new requiring a higher level of competency. They also noted that having prior RN experience and working in a familiar environment reduced stress and anxiety. Olivia noted the impact of RN SOP on her stress level "as an RN, you are a patient advocate, so it relieved the stress level in terms of when it comes down to being able to talk to the patients and their family effectively. Oby shared that,

> It is the experiences that we acquire during the RN period that position us as an APRN; it helps with what you are seeing, or what is coming, it's not that you are not competent enough to carry out the APRN [role], you already have the competency.

According to Hart and Bowen (2016), nursing experience mitigated overwhelming feelings and the associated incompetence felt by new APRNs. Thus, requiring some years of experience for APRN programs could mitigate burnout and job termination. Cherniss (1995) reported that lack of experience was antecedent to burnout due to a new role's stress. According to Benner (1982), incremental experience secured

through working helps nurses see a presenting situation holistically, thus, enabling them to identify more significant aspects. My participants noted that they have confidence and, therefore, less stress because of prior RN attributes of good assessment and education skills that enhanced their ability to impact patients' wellbeing and safety. When I asked Mati how the SOP of RN impacted her stress level, Mati stated,

> Firstly, as a nurse, I worked in long term care where the nurse-patient ratio was overwhelming, so it prepared me to see more patients in a shorter period of time if need be, it prepared me to prioritize, it prepared me to be able to deal with the social aspect that could impact their care and could impact their treatment.

Prior RN experience made Mati's stress level manageable because she is well prepared to handle her workload.

APRNs as Cheap Labor Because They Wear Two Hats

Four participants noted that they were used to accomplishing the RN and APRN roles by management, a situation Love called "cheap labor." The new APRNs were sometimes assigned dual RN and APRN roles, causing the patients and other providers to find it challenging to differentiate a new APRN's role. I asked Rose if she was appreciated as an APRN during her role transition; she responded that "the problem is the management feels like, you have an RN license on top of your APRN license, so they expect you to do an RN role as well as APRN role; so that is a cheap labor." Mati stated that one of the difficulties during the transition was having to balance the role of RN and APRN, stating,

> It's very shocking in the sense that the RN are used to hands-on and listening attentively, but when you trust a patient to APRN, you expect that APRN to provide just all the patient needs, medication wise or lab wise, and move forward. And as somebody who has worked with this patient sitting by their bed and listening to them crying and stuff like that, it's just so hard to move that fast. So, we have to find a way to manage both. So, you are acting as a physician and a nurse; you find yourself in the middle; yes, it is hard [for the patient] to tell. The transition is tough. The idea of using new APRNs to cover the role of a provider as well as RN makes role visibility and recognition problematic.

Subsequently, my participants said they are helpful to RNs as a backup, but sometimes that impinges on their time for the APRN role. Mati said,

> I try to multitask in the sense that I would go to a patient's house, and if the wound VAC is leaking, I will not leave without changing the wound vac. So, while I'm doing the Doctor's role, I'm doing the nursing role.

Thus, I found that being an experienced RN made new APRNs sometimes undertake dual roles at a sitting because of inadequate coverage for other nursing roles.

Discrepant Cases/Non-confirming Data

Discrepant cases and non-confirming cases are study findings that are conflict with the rest of the research findings (Ravitch & Carl, 2016). In this study, I found one slightly discrepant case. The eight CNPs agreed that prior RN experience and available SOP resources impacted their professional experience. However, the CNS stated that prior RN experience did not impact her role as a program coordinator. According to the

CNS, she loved to teach, and she was educating and following up on patients for compliance already. The CNS agreed that prior RN experience shaped her knowledge culture, information acquisition, and confidence.

I determined that this difference stood out because the CNS was not engaged in hands-on projects and had no need to prescribe medications. The CNS was engaged in gathering statistical data and learned that during her role transition. Lucy reported:

> We know that even in nursing at the bedside, you are really not proficient in statistics, plotting [graphs], and all that. But with this program, I just needed to do it. I even had to go out and do some courses that would give me an edge over getting all these numbers right and how to use Excel to generate graphs and data.

Although she prescribed care, she was more involved with the statistics of care rendered. I found no other discrepancies or non-confirming data.

Summary

APRN SOP includes RN SOP (Nurse Practice Act, 2007/2018), but how prior RN practice impacted new APRNs' transitional experiences remained shrouded. I used Kanter's (1977, 1993) theory of organizational structural empowerment and Benner's (1982) novice to expert nursing model to ground my study and analyze the data. I found that new APRNs' resource availability impacted their performance, and according to Jessica, the "lack of resources affected quality of service and also impacted my performance." There was a deficiency in empowering resource and information availability resulting in APRNs not receiving adequate orientation, no backup, and poor

role visibility, which all caused job terminations and increased stress levels leading to unsafe practices.

On the other hand, participants noted that having prior nursing experience conferred confidence, ability to interpret laboratory results, familiarity with patient population, disease management, and medications, leading to safe health care services. All APRNs were motivated to transition from RN-APRN because of long-standing RN experience and confidence to do more to help their patients. All participants that rated themselves at the expert level reported less stress.

Chapter 4 included the (a) study setting, (b) demographics, (c) data collection, (d) data analyses, (e) evidence of trustworthiness, and (f) study results. Chapter 5, the discussion, conclusion, and recommendations, includes (a) interpretation of findings, (b) study limitations, (c) recommendations, and (d) implications.

Chapter 5: Discussion, Conclusion, and Recommendations

The purpose of this phenomenological study was to explore how the nursing experience shaped primary care APRNs' transitional performance in the Chicago, Illinois, area. Using Benner's (1982) novice to expert nursing model and Kanter's (1993, 1997) theory of organizational structural empowerment as guiding lenses, I interviewed nine new APRNs and analyzed the data for themes. I found that organizational structural empowerment factors and prior RN experience impacted APRN transitional performance. My findings begin to explain the current high attrition rate of APRNs, and the safety concerns noted in the literature review. This chapter includes (a) interpretation of findings, (b) study limitations, (c) recommendations, and (d) implications.

Interpretation of Findings

I determined that prior nursing experience was instrumental in how new APRNs rendered safe and effective healthcare services in the face of inadequate organizational structural resources. Some of the participants reported job terminations by new APRNs in their first year of APRN practice stemming from lack of RN experience. Those new APRNs who terminated their jobs had less than 3 years of prior RN experience. Benner (1982) noted that experience accrues as nurses gain in skill acquisition, and experience gained over time enhances performance. According to Abel (2018), attrition rates were high due to a lack of confidence in one's capability during RN-APRN transition, which my findings corroborated. Lizzy noted:

> We'll see her crying, and some of the MAs [medical assistants] would say, oh, she's crying again, she will lock herself behind the door as if it was too much for

> her, she was just barely RN for 2 years, then because you can just get into the NP program, she went, and she didn't know where to start. You have to teach her. She had extra weeks [of orientation], but it wasn't still enough because her clinical background wasn't much.

Not having much clinical background in nursing affected the nurse's ability to utilize resources. Lizzy noted that "she was struggling with medications, like pharyngitis, she knows it at the back of her mind, but she's not sure of the dosage and I was encouraging her to use the apps, she had a hard time and was very frustrated." Rose captured the sentiment well:

> Before I transitioned in this role, I had an idea about the medications, what to do when medications are not working. It helped to guide the treatment; you already know these meds at the RN role. That really helped to build the trust level; knowing how the medications worked helped to keep watch over my patients. Prior RN role really helped.

I determined these results from analyses of each of the two RQs, with RQ1 indicating organizational structural empowerment deficiencies and RQ2 correlating prior RN experience.

Organizational Structural Empowerment Findings (RQ1)

I found that the lack of resources such as workplace orientation, workplace resources, organizational support, employee empowerment, and information availability hindered new APRN transitional performance. I asked participants their perception of

organizational structural empowerment and all participants identified empowering resources as described by Kanter (1977, 1993). Rose said,

> Organizational structural empowerment to me is that we have a nice nursing department kind of giving you a platform to go to, bring ideas about quality improvement, outcome improvement, but nobody wants to hear anything about it, what they want to know is how many patients you can see, how much you can generate, that is just it. So, it is not really empowering anybody. This depends on organizational structure.

Rose highlighted the communication problems, including idea sharing, visibility, encouragement, and integration into the organizational hierarchy. Kanter demonstrated that each of these impact employee performances. Lizzy noted that having a good support staff was crucial for safe care, “for instance, in our community, we have a lot of Hispanics that don't understand English. So, sometimes it's a big challenge to get somebody to translate.”

I also found that prior nursing experience enhanced utilization of the limited resources available. I asked Olivia how prior RN experience helped her transitional performance, and she responded:

> I would say pretty much collaborating with the physician…, or collaborating with other team, team players, prior nursing kind of help with that whole transition into my APRN work life, also going through evidence-based practice, reading articles, or reading journals and things like that.

I also found provider communication deficiency not previously listed in the topic's prior literature. Most of the new APRNs reported that they did not know how to speak as a provider, which was a cause of anxiety, often portending the observer's lack of confidence. Jane reported that as an RN:

> You are a registered nurse, you already know how to talk to your patients, but now you are talking to them with a different hat, we are talking to them as a provider, especially for us to learn how to talk to our patient as a provider, instead of like as a registered nurse, because it is a different hat.

Additionally, participants lacked orientation resources and empowerments; as Love put it, "We were thrown out there." All APRNs noted that on-the-job orientation was an empowering resource paramount to the successful transition to the new role of PCP. Of the few participants who received orientation, only one was oriented by an experienced APRN. Subsequently, only that participant found her role transition smooth, resulting in confidence on her own. During her orientation, she had an onboarding experience, worked with the experienced NP for one week, and the second week she worked independently under the watchful eyes of the experienced APRN. She had the freedom to interact with the APRN, asked any questions, and adapt to the new role. She was ready to go after the second week of onboarding with the experienced APRN; thus, that participant experienced organizational structural empowerment.

Conversely, the new APRNs oriented only by physicians said they were uncomfortable and did not get the opportunity to perform an assessment or make decisions since the physician did it all. Furthermore, with physician-provided orientation,

there was no trusting relationship. Love described her relationship with a collaborating physician as “intimidating,” and Olivia said, ‘it was demeaning, you never seemed to do enough.” A relationship devoid of trust will hinder collegiality (Kanter, 1977, 1993). One participant noted that the medical director assigned her a full patient load on her first day without orientation at an unfamiliar clinic. That participant did not know the clinic hours for that clinic and showed up 1 hour late.

Correlations to Kanter’s Theory

My findings supported Kanter’s (1977, 1993) theory of organizational structural empowerment in several ways. Kanter demonstrated that employees’ performance depends mainly on organizational resources available to them for their jobs and that communication is an integral part of employee empowerment. Seven of the new APRNs reckoned with the lack of orientation during their transitions from RN-APRN. As a result, they described their role transition as shocking and challenging, reported resulting job resignation. Love recommended, “every organization should have a structure where, just like the doctors gets orientation when they start in an establishment, APRNs should also get that orientation.” I also determined that those missing organizational structural empowerments exasperated RN-APRN transitional performance challenges. Kanter asserted that empowering resources are those factors that enhance employees’ performance. Workplace resources such as assistance availability were not available to 5 out of 9 study participants; thus, they resorted to outside help from other providers.

Transitional Performance Findings (RQ2)

Participants noted that prior nursing experience was everything to them. RN experience helped them diagnose and deliver care that sometimes resulted in patients choosing the APRN as their PCP over the physician. Mati explained:

> So, I was on the bedside [RN] from the day I had my license to the day I left. So, I able to isolate and identify these conditions and their stages, just like what I saw in the RN role; I'm surprised most of my patients do compare me with their primary physicians and prefer me just because you have that other piece of nursing attached to the part that they want and they keep saying, I can get what they [physicians] give me, and I get this part, you touch my legs [assessment], I think I prefer you.

I determined that prior RN skills crucial to new APRNs include assessment, diagnosing, collaboration, laboratory results interpretation, teaching, advocacy, counseling, and resourcefulness. Participants reported that each of these skills helped them transition from RN-APRN and provide effective and efficient safe care.

Additionally, participants reported that their RN experience skills essentially aided their RN-APRN transitional performance. For example, participants who did not receive orientation had worked many years as an RN; therefore, their RN experience and performance equated to new APRN performance. However, this presumptive equation is dangerous because APRN performance responsibility embodies both the nursing and medical aspects as a PCP (Shuler & Davis, 1993), a new responsibility for a new APRN. Interestingly, these APRNs fared well because their prior RN experience laid a

foundation for them to obtain the knowledge, information, and resources needed to discharge their responsibilities safely.

All participants in this study noted that RN experience was the foundation for their APRN SOP. The new APRNs who had more years of experience reported doing more than their RN SOP at the RN level, which motivated advancement to APRN status. Furthermore, the new APRNs with more RN experience that did not receive any orientation during transition reported the orientation lack was because management assumed that they were knowledgeable enough and are familiar with the system. Thus, those new APRNs with more RN experience received office space and assignments but no orientations. Since the new APRNs with greater than 10 years of RN experience had multiple RN specialty experiences, they could comfortably care for anyone, especially the population they cared for as RN.

I also found that new APRNs transitioned easier and more comfortable to practices in similar environments as their RN experiences. One participant who was an ICU RN noted that it was easier for her to handle her hospitalist assignment in ICU than her ambulatory care assignment because she was familiar with ICU nursing. Six out of nine study participants reported that transitioning to similar areas of prior nursing experience reduced their anxiety and stress associated with the new APRN role.

Correlations to Benner's Model

I found that new APRNs with prior RN experience developed skills as an RN through clinical practice and education, which corroborated Benner's (1982) novice to expert nursing model. As the RNs engaged in clinical practice, they moved from lacking

experience and judgment about presenting clinical situations to competent, proficient, and expert skill levels, as indicated by Benner. They perceived themselves moving from advanced beginner nurses to expert nurses.

I found that it was easier for more experienced RNs to transition than those who were less experienced. For example, to obtain the information and necessary resources for their SOP, new APRNs resorted to creative software use and medical journals, among other inventive methods, to gain the empowerment and resources they needed. It was not the same for new APRNs who had limited RN experience. Lizzy noted that her colleague, who only had two years of RN experience before transitioning to APRN, resigned because she could not get answers and could not use resources to ground her new role. That APRN became very frustrated with the workload and how quickly the organization thrust complex medical cases on her. Gauging by Benner's (1982) novice to expert model, at two years of RN experience, that new APRN had not attained a competent RN skill level. Benner reported that it takes 2-3 years of clinical practice to attain a competent skill level; however, this new APRN had not accumulated enough clinical experience and skill for the information seeking and resource utilization needed to fulfill APRN responsibilities.

Study Limitations

This descriptive phenomenological research's limitations included participant-provided data, technical challenges, sample size, and generalization potential. Data was limited by what participants were willing to share during the interview. Technical challenges resulted in manual coding, data organization, and analyses, thereby increasing

study timeframe due to manual entry and multiple redundant trustworthiness processes (discussed in Chapter 4). Localized snowball recruitment and purposeful sampling limited my sample. Thus, the generalization of findings is limited accordingly.

Recommendations

My findings lend credence to a needed policy change regarding organizational support for APRNs, APRN training, and prior RN practice. By analyzing organizational structural empowerment and transitional performance themes, I recommend evolving APRN-related public policy to address organizational support, training, and prior practice issues. While such policy pertains specifically to the Chicago area due to this study's limitations, further analyses could extend that generalizability beyond local and state agencies to federal levels for national public safety.

Policy Recommendations

Based on my findings, I recommend public policy related to APRN licensing address the following issues:

a) Organizational support
    a. APRN provided orientation minimum, not less than one week
    b. APRN role recognition and support

b) Transitional training
    a. Provider communication skills
    b. Coping accommodations

c) Prior RN experience
    a. A minimum number of years RN tenure, not less than three

b. Experience in a similar medical environment

I base these recommendations on my findings to address existing inexperience issues and inadequate support, resulting in unsafe patient care and APRN attrition. Illinois' current Nurse Practice Act (2007/2018) does not address these three elements. Thus, new APRNs gain PCP licensing before they can thoroughly and safely provide PCP services, causing unreliable public health services and high APRN attrition rates.

Organizational Recommendations

I found that orientation onboarding for new APRNs provided by experienced APRNs made transitional performance less daunting and provided superior organizational support. I suggest that experienced APRNs interact and direct all new APRNs through an onboarding experience wherein the new APRNs would benefit from the experienced APRN's ideas and discuss fears openly without judgement. I recommend that every organization assess the skill level of the APRN to determine orientation needs and reassess those skills after orientation to ensure the new APRN is well equipped to succeed. I also recommend that organizations embrace organization-wide dissemination of APRN roles before hiring APRNs and inform all potential clients of APRN roles. All APRN professional organizations should embark on APRN role public education to enhance APRN recognition.

Training Recommendations

I discovered that new APRNs lack the PCP-level communication skills needed to inculcate APRN transitional training. I suggest that experienced NPs from different population foci and specialties have face-to-face meetings with new APRNs to explain

expectations, roles, resources, provider languages, and coping mechanisms. Based on my findings, a mandatory shadow rotation with an experienced APRN from a similar environment would add much-needed role awareness for the new APRNs.

Prior RN Practice Recommendations

I determined that prior RN experience and practice similarity contributed to successful RN-APRN transition and performance. Based on study observations and participants' suggestions, APRN programs should require at least three years of prior RN practice. I found that APRNs practicing in environments like their prior RN practices experienced smoother RN-APRN transitions, better performance, and happier patients. I also determined that RN experienced APRNs were more resourceful, confident, and provided superior patient care. Additionally, I found higher attrition rates in new APRNs with fewer than three years prior RN experience.

Recommendations for Future Study

I further recommend that researchers engage in additional research using various methodologies and designs to explore and increase my findings' generalizability. For example:

- Quantitative research to study the length of RN experience acceptable for APRN program and practice.
- Mixed method study to determine the relationship of type of RN clinical experience and transitional performance.
- Mixed method study identifying the length of APRN orientation commensurate to a smooth transition.

- Quantitative study identifying the specific attrition rates in correlation to years of prior RN experience to identify at what point prior experience stops significantly contributing to APRN attrition.
- Several qualitative studies to identify factors that enhance APRNs practice environments, performance, and physician perceptions of APRNs with and without prior RN experience.

This list comprises only a handful of further studies to understand better how RN-APRN transitional experiences affect APRN performance.

Implications

My findings contribute to social change at community, organizational, and policy levels through implications to public policy, social change, and theory. New APRN workplace orientations at the organizational level coupled with prior RN practice would help increase APRN retention, minimize public safety concerns, increase primary care service availability, and, thus, increase community health. For example, providing empowering resources at the organizational level would provide a healthy environment so that new APRNs would thrive, reducing the attrition rate and attendant cost, which would subsequently increase PCP services availability. Additionally, public policy addressing APRN training and prior RN practice would similarly increase public healthcare availability and quality.

Implications for Public Policy

Adopting policy recommendations addressing (a) organizational support, (b) RN-APRN transition training, and (c) prior RN experience would close current gaps in

Illinois' existing Nurse Practice Act (2007/2018), thereby increasing community health and public safety while reducing APRN attrition rates. Policy addressing new APRN organizational supports would reduce the alarming APRN attrition rates and public safety concerns reported by IOM (2011). Likewise, policy addressing APRN transitional training would address these concerns, help close current NCSBN (2008) APRN training gaps, and enhance RN-APRN transitions, thereby promoting superior PCP services. Finally, public policy addressing prior RN experience would address the AANP and NCSBN issues. Policy addressing prior RN experience would help minimize the drug-related deaths reported by the IOM (2012). Thus, the implications of my findings could significantly impact public health.

Implications for Social Change

Implications for positive social change influenced by my study findings include (a) reduced APRN attrition, thereby increasing PCP services to the public, (b) increased APRN performance, thereby improving the PCP services available to the public, and (c) improved APRN visibility thereby expediting PCP services due to increased public awareness of APRN skills. At an organizational level, organizations could experience improved customer satisfaction while reducing overall organizational costs due to lower APRN attrition, improved APRN performance, and confident stakeholders. At a local level, individuals, families, and communities would increase their quality of life (QOL) because they and their loved ones would be healthier more quickly, reducing healthcare costs and increasing productivity. Illinois would experience the same increased QOL and economic improvements and smoother public administration due to those improvements.

Furthermore, Illinois might positively influence other states similarly, which could carry over to a national level. If the entire nation were to experience these positive social changes, the overall economy would significantly improve and the QOL of all citizens, thereby freeing up resources to address other vital issues.

Theoretical Implications

My findings support and confirm both Kanter's (1977, 1993) theory of organizational structural empowerment and Benner's (1982) novice to expert nursing model, thus providing further evidence of both constructs' trustworthiness. Furthermore, using Kanter's theory, I noted a previously undocumented empowering element correlated with Benner's model: provider communication skills. While Kanter firmly discussed employer-employee communication, Kanter did not include discussion of provider-level communication skills. However, those communication skills distinctly align with Kanter's theory in communication and performance since provider-level communication skills involve both the communication aspect and the APRN communicating as the provider. Likewise, I correlated RN provider level skill to Benner's competent skill level hence all participants in this study saw effective communication with their patients as a skill carried forward from their bedside nursing experience. According to Benner, RN provider-level communication skills are part of nursing skills, which accrue as the RN continues in practice. As APRNs, they need the medical provider language at the APRN level.

Conclusion

When empowering resources are not available for new APRNs, transitional performance is turbulent, shocking, and disabling. I discovered that while new APRNs may be certified to practice, they often do not practice because of a lack of organizational support. Additionally, I found that prior nursing experience does not equate to an experienced APRN. Therefore, workplace orientation and prior RN experience are crucial for new APRNs. Prior nursing experience enhances orientation and confidence for new APRNs while decreasing attrition rates; therefore, there should be public policy considering the minimal RN experience tenure necessary for APRN programs and organizational support expectations. There should be aggressive APRN role marketing in all healthcare settings to increase role visibility and service utilization.

References

Abel, L. (2018). Transition: The road to becoming a nurse practitioner. *The Nurse Practitioner, 43*(6), 8. http://doi.org/10.1097/01.NPR.0000532769.99003.ba

Adams, E., K., & Markowitz, S. (2018). *Improving efficiency in the health-care system: Removing anticompetitive barriers for advanced practice registered nurses and physician assistants* [Policy proposal]. The Hamilton Project. https://www.hamiltonproject.org/assets/files/AdamsandMarkowitz_20180611.pdf

Al-Ghabeesh, S. H., Abu-Moghli, F., Salsali, M., & Saleh, M. (2013). Exploring sources of knowledge utilized in practice among Jordanian registered nurses. *Journal of Evaluation in Clinical Practice, 19*(5), 889-894. https://doi.org/10.1111/j.1365-2753.2012.01869.x

American Academy of Family Physicians. (n.d.). *Primary Care*. Retrieved July 6, 2020, from https://www.aafp.org/about/policies/all/primary-care.html

American Association of Nurse Practitioners. (n.d.a). *Historical Timeline*. Retrieved July 7, 2020, from https://www.aanp.org/about/about-the-american-association-of-nurse-practitioners-aanp/historical-timeline

American Association of Nurse Practitioners. (n.d.b). *Starting your nurse practitioner (NP) career*. Retrieved July 7, 2020, from https://www.aanp.org/student-resources/starting-your-np-career

American Association of Nurse Practitioners. (2013). *Nurse practitioner curriculum*. Retrieved July 7, 2020, from https://www.aanp.org/advocacy/advocacy-resource/position-statements/nurse-practitioner-curriculum

American Association of Nurse Practitioners. (2019a, November 13). *National nurse practitioner week: NPs are key to providing better rural care*. https://www.aanp.org/news-feed/national-nurse-practitioner-week-nps-are-key-to-providing-better-rural-care

American Association of Nurse Practitioners. (2019b). *Scope of practice for nurse practitioners*. Retrieved July 7, 2020, from https://www.aanp.org/advocacy/advocacy-resource/position-statements/scope-of-practice-for-nurse-practitioners

American Association of Nurse Practitioners. (2020, February). *NP fact sheet*. Retrieved July 7, 2020, from https://www.aanp.org/about/all-about-nps/np-fact-sheet

American Nurses Association. (n.d.). *Scope of practice*. Retrieved July 7, 2020, from https://www.nursingworld.org/practice-policy/scope-of-practice/

Andregård, A.-C., & Jangland, E. (2015). The tortuous journey of introducing the nurse practitioner as a new member of the healthcare team: A meta-synthesis. *Scandinavian Journal of Caring Sciences*, *29*(1), 3-14. http://doi.org/10.1111/scs.12120

APRN Consensus Work Group, & National Council of State Boards of Nursing APRN Advisory Committee. (2008, July 7). *Consensus Model for APRN Regulation: Licensure, Accreditation & Education Regulation: licensure, accreditation & education*. https://www.ncsbn.org/Consensus_Model_Report.pdf

Arrowsmith, V., Lau-Walker, M., Norman, I., & Maben, J. (2016). Nurses' perceptions and experiences of work role transitions: A mixed methods systemic review of the

literature. *The Journal of Advanced Nursing*, *72*(8), 1735-1750 http://doi.org/10.1111/jan.12912

Barnes, H. (2015). Exploring the factors that influence nurse practitioner role transition. *The Journal for Nurse Practitioners*, *11*(2), 178–183. http://doi.org/10.1016/j.nurpra.2014.11.004

Bazzell, A. F., & Dains, J. E. (2017). Supporting nurse practitioner preceptor development. *The Journal of Nurse Practitioners*, *13*(8), E375-E382. http://doi.org/10.1016/j.nurpra.2017.04.013

Benner, P. (1982). From novice to expert. *The American Journal of Nursing, 82*(3), 402-407. https://www.medicalcenter.virginia.edu/therapy-services/3%20-%20Benner%20-%20Novice%20to%20Expert-1.pdf

Benner, P. (2004). Using the Dreyfus model of skill acquisition to describe and interpret skill acquisition and clinical judgment in nursing practice and education. *Bulletin of Science, Technology & Society*, *24*(3), 188-199 http://doi.101177/0270467604265061

Beyer, C. (2016). Edmund Husserl. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy* (Winter ed.). Stanford University. https://plato.stanford.edu/entries/husserl/

Blanck, S., & Engström, M. (2015). District nurses' prescribing practice and its link to structural conditions. *Journal of the American Association of Nurse Practitioners*, *27*(10), 568-575. http://doi.org/10.1002/2327-6924.12234

Bobay, K., Gentile, D. L., & Hagle, M. E. (2009). The relationship of nurses'

professional characteristics to levels of clinical nursing expertise. *Applied Nursing Research*, *22*(1), 48-53. http://doi.org/10.1016/j.apnr.2007.03.005

Brown, M.-A., & Olshansky, E. (1997). From limbo to legitimacy: A theoretical model of the transition to the primary care nurse practitioner role. *Nursing Research*, *46*(1), 46-51. http://doi.org/10.1097/00006199-199701000-00008

Budryk, Z. (2016, January 26). Malpractice claims against nurses on the rise. *Fierce Healthcare*. https://www.fiercehealthcare.com/healthcare/malpractice-claims-against-nurses-rise

Buerhaus, P. I., DesRoches, C., M., Dittus, R., & Donelan, K. (2015). Practice characteristics of primary nurse practitioners and physicians. *Journal of Nursing Outlook*, *63*(2), 144-153. http://doi.org/10.1016/j.outlook.2014.08.008

Calabrese, R. L. (2012). *Getting it right: The essential elements of a dissertation*. Rowman & Littlefield Education.

Cantlay A., Salamanca, J., Golaw, C., Wolf, D., Maas, C.et al. (2017). Self-perception for clinical practice: A survey of accelerated Masters program graduate registered nurses. *Nurse Education in Practice*, 24, 34-42 https://doi.org/10.1016/j.nepr.2017.03.005

Centers for Disease Control and Prevention (2019). Coronavirus diseases (COVID-19). Retrieved on August 3, 2020, from cdc.gov/coronavirus/2019-ncov-ncov/prevent-getting-sick/social-distancing.html

Chavez, K. S., Dwyer, A. A., & Ramelet, A.-S. (2018). International practice settings, interventions, and outcomes of nurse practitioners in geriatric care: A scoping

review. *International Journal of Nursing Studies*, *78*, 61-75. http://dx.doi.org/10.1016/j.ijnurstu.2017.09.010

Cherniss, C. (1995). *Beyond burnout: Helping teachers, nurses, therapists, & lawyers recover from stress & disillusionment*. Routledge.

Chesney, M., L. & Duderstadt, K., G. (2017). States' progress toward nurse practitioner full practice authority: Contemporary challenges and strategies. *Journal of Pediatric. Health Care,31*(6), 724-728. https://doi.org/10.1016/j.pedhc.2017.09.002

Codier, E. E., Kofoed, N. A., & Peters, J. M. (2015). Graduate-entry non-nursing students: Is emotional intelligence the difference. *Nursing Education Perspectives*, *36*(1), 46-47. http://doi.org/10.5480/12-874.1

Cormier, M. E., & Whyte, J., IV. (2016). Comparison of second-degree and traditional baccalaureate nursing students' performance in managing acute patient deterioration events. *Journal of Nursing Education and Practice, 6*(8), 138-144 http://doi.org/10.5430/jnep.v6n8p138

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). SAGE Publications.

Croke, E. M. (2003). Nurses, negligence, and malpractice: An analysis based on more than 250 cases against nurses. *American Journal of Nursing*, *103*(9), 54-63. http://doi.org/10.1097/00000446-200309000-00017

Cummings, C. L., & Connelly, L. K. (2016). Can nursing students' confidence levels increase with repeated simulation activities? *Nurse Education Today, 36*, 419-

421. http://doi.org/10.1016/j.nedt.2015.11.004

Dalen, J. E., Ryan, K. J., & Alpert, J. S. (2017). Where have the generalists gone? They became specialists, then subspecialists. *The American Journal of Medicine, 130*(7), 766-768. https://doi.org/10.1016/j.amjmed.2017.01.026

Dubree, M., Jones, P., Kapu, A., & Parmley, C. L. (2015). APRN practice: Challenges, empowerment, and outcomes. *Nurse Leader, 13*(2), 43-49. https://doi.org/10.1016/j.mnl.2015.01.007

Dillon, D. L., Dolansky, M. A., Casey, K., & Kelley, C. (2016). Factors related to successful transition to practice for acute care nurse practitioners. *Advanced Critical Care, 27*(2), 173-182. http://doi.org/10.4037/aacnacc2016619

Dlamini, C. P., Mtshali, N. G., Dlamini, C. H., Mahanya, S., Shabangu, T., & Tsabedze, Z. (2014). New graduates' readiness for practice in Swaziland: An exploration of stakeholders' perspective. *Journal of Nursing Education and Practice, 4*(5), 148-158. http://doi.org/10.5430/jnep.v4n5p148

Dreyfus, S. E., & Dreyfus, H. L. (1980). *A five-stage model of the mental activities involved in directed skill acquisition*. Storming Media.

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

El-Banna, M. M., Briggs, L. A., Leslie, M. S., Athey, E. K., Pericak, A., Falk, N.L., & Greene, J. (2015). Does prior clinical experience predict academic success in graduate nurse practitioner programs? *Journal of Nursing Education, 54*(5), 276-

280. https://doi.org/10.3928/01484834-20150417-05

Faraz, A. (2016). Novice nurse practitioner workforce transition into primary care: A literature review. *Western Journal of Nursing Research, 38*(11), 1531-1545. http://doi.org/10.1177/0193945916649587

Faraz, A. (2017). Novice nurse practitioner workforce transition and turnover intention in primary care. *Journal of the American Association of Nurse Practitioners*, *29*(1), 26-34. http://doi.org/10.1002/2327-6924.12381

Farr, S. M. (2018). *A Qualitative study using phenomenology: Investigation of the lived experience of second-degree master's entry nurses as they transition to their advanced practice role* [Dissertation, University of Hawaii at Mānoa]. University of Hawaii at Mānoa digital archives. https://scholarspace.manoa.hawaii.edu/bitstream/10125/62612/2018-08-phd-farr.pdf

Fitzpatrick, S., & Gripshover, J. (2016). Expert nurse to novice practitioner: The journey and how to improve the process. *The Journal for Nurse Practitioners*, *12*(10), E419-E421. https://doi.org/10.1016/j.nurpra.2016.05.012

Fodeman, J., & Factor, P. (2015). Solutions to the primary care physician shortage. *The American Journal of Medicine, 128*(8), P800-P801. http://doi.org/10.1016/j.amjmed.2015.02.023

Fougère, B., Lagourdette, C., Abele P., Resnick, B., Rantz, M., Lai, C. K. Y., Chen, Q., Moyle, W., Vellas, B., & Morley, J. E. (2018). Involvement of advanced practice nurses in the management of geriatric conditions: Examples from different

countries. *The Journal of Nutrition, Health & Aging*, *22*(4), 463-470 http://doi.org/10.1007/s12603-018-1008-6

Freeling, M., & Parker, S. (2015). Exploring experienced nurses' attitudes, views, and expectations of new graduate nurses: A critical review. *Nurse Education Today*, *35*(2), e42-e49. http://doi.org/10.1016/j.nedt.2014.11.011

Fulton, C. R., Clark, C., & Dickinson, S. (2017). Clinical hours in nurse practitioner programs equals clinical competence. Facts or misnomer? *Nurse Educator*, *42*(4), 195-198. http://doi.org/10.1097/NNE.0000000000000346

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report*, *20*(9), 1408-1416. https://cpb-us-e1.wpmucdn.com/sites.nova.edu/dist/a/4/files/2015/09/fusch1.pdf

Gardenier, D. (Ed.) (2015). Should supervision be required for early-career nurse practitioners? *The Journal for Nurse Practitioners*, *11*(2), 168-169. http://doi.org/10.1016/j-nurpra.2014.11.006

graduatenursingedu. (n.d.). *What is a Registered Nurse?* Retrieved July 6, 2020, from www.graduatenursingedu.org/what-is-a-registered-nurse/

Garland, G. A. (1996) Self-report of competence: A tool for the staff development specialist. *Journal of Nursing Staff Development*, *12*(4), 191-197. Retrieved from July 3, 2020, from https://pubmed.ncbi.nlm.nih.gov/8936163/

Glen, S. (2014). Snowball sampling: Definition, advantages, and disadvantages. Retrieved August 11, 2020, from https://www.statisticshowto.com/snowball-sampling/

Hart, A., M., & Bowen, A. (2016). New nurse practitioners' perceptions of preparedness for and transition into practice. *The Journal for Nurse Practitioners, 12*(8), P545-P552. http://doi.org/10.1016/j.nurpra.2016.04.018

Herron, E. K. (2017). New graduate nurses' preparation for recognition and prevention of failure to rescue: A qualitative study. *Journal of Clinical Nursing, 27*(1-2), E390-E401. http://doi.org/10.1111/jocn.14016

Hennessy, L. (2017). The lived experience of registered nurses educated in accelerated second degree of science in nursing programs: A hermeneutic research study [Special issue]. *Nurse Education in Practice, 28,* 264-269. http://doi.org/10.1016/j.nepr.2017.09.010

Hooker, R. S., Brock, D. M., & Cook, M. L. (2016). Characteristics of nurse practitioners and physician assistants in the United States. *Journal of the American Association of Nurse Practitioners, 28*(1), 39-46. https://doi.org/10.1002/2327-6924.12293

Husserl, E. (1970). *Crises of European sciences and transcendental phenomenology*. Evanston, IL: (D. Carr, Trans.). Northwestern University Press. (Original work published in 1954)

Iglehart, J. K. (2014, October). *Meeting the demand for primary care: Nurse practitioners answer the call*. National Institute for Health Care Management https://www.nihcm.org/pdf/Meeting-the-demand-for-primary-care-nurse-practitioners-answer-the-call-John-Iglehart-Expert-Voices-10-2014.pdf

Illinois Nurse Practice Act, IL. Act, IL. C.S. § Section 65-5-65 (2007 & rev. 2018). http://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=1312&ChapterID=24

Institute of Medicine (U.S.) Committee on Patient Safety and Health Information Technology. (2012). *Health IT and patient safety: Building safer systems for better care*. National Academies Press. http://doi.org/10.17226/13269

Institute of Medicine (U.S.) Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine. (2011). *The future of nursing: Leading change, advancing health*. National Academies Press. http://doi.org/10.17226/12956

Institute of Medicine (U.S.) Committee on Quality of Health Care in America. (2001). *Crossing the quality chasm: A new health system for the 21st century*. National Academies Press. http://doi.org/10.17226/10027

Jensen, K. (2007). The desire to learn: An analysis of knowledge-seeking practices among professionals. *Oxford Review of Education, 33*(4), 489–502. https://doi.org/10.1080/03054980701476055

Jakimowicz, M., Williams, D., & Stankiewicz, G. (2017). A systematic review of experiences of advanced practice nursing in general practice. *BioMed Central Nursing*, *16*(6), 1-12. https://doi.org/10.1186/s12912-016-0198-7

Jokiniemi, K., Haatainen, K., & Pietilä, A.-M. (2015). From challenges to advanced practice registered nursing role development: Qualitative interview study. *International Journal of Nursing Practice*, *21*(6), 896-903. http://doi.org/10.1111/ijn.12334

Jones, J., Kotthoff-Burrell, E., Kass-Wolff, J., & Brownrigg, V. (2014). Nurse practitioner graduates “speak out” about the adequacy of their educational

preparation to care for older adults: A qualitative study. *Journal of the American Association of Nurse Practitioners*, *27*(12), 698-706. http://doi.org/10.1002/2327-6924.12230

Kanter, R. M. (1977). *Men and women of the corporation*. Basic Books.

Kanter, R. M. (1993). *Men and women of the corporation* (2nd ed.). Basic Books.

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. http://doi.org/10.1097/01.NEP.0000000000000112

Keeling, A. W. (2015). Historical perspectives on an expanded role for nursing. *The Online Journal of Issues in Nursing*, *20*(2). http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-20-2015/No2-May-2015/Historical-Perspectives-Expanded-Role-Nursing.html

Kelly, N. R., & Mathews, M. (2001). The transition to first position as nurse practitioner. *Journal of Nursing Education*, *40*(4), 156-162. https://doi.org/10.3928/0148-4834-20010401-05

Kim, M.-J., & Kim, Y.-J. (2015). Variables affecting nursing competency of clinical nurses. *Indian Journal of Science and Technology*, *8*(26), 1-9. http://doi.org/10.17485/ijst/2015/v8i26/80758

Kleinpell, R., & Kapu, A., N. (2017). Quality measures for nurse practitioner evaluation. *Journal of the American Association of Nurse Practitioners*, *29*(8), 446-451.

http://doi.org/10.1002/2327-6924.12474

Kohtz, C. (2016). Stack the odds in favor of newly licensed RNs. *Nursing Management*, *47*(3), 22-28. http://doi.org/10.1097/01.NUMA.0000480756.46180.4b

Kolb, D. A. (1984). *Experiential learning: Experience as the source of learning and development.* Prentice-Hall.

Korte, A. (2017, September 28). *Rauner signs bill expanding practice authority for certain nurses*. Illinois Policy. Retrieved July 21, 2020, from https://www.illinoispolicy.org/rauner-signs-bill-expanding-practice-authority-for-certain-nurses/

Laschinger, S., Almost, H. K., & Tuer-Hodes, D. (2003).Workplace empowerment and magnet hospital characteristics: Making the link. *Journal of Nursing Administration*, *33*(7/8), 410-422. Retrieved on July 16, 2020, from https://journals.lww.com/jonajournal/Abstract/2003/07000/Workplace_Empowerment_and_Magnet_Hospital.11.aspx

Ligenza, 2015, July 23). *Loretta Ford: The "mother of the nurse practitioner movement*. Retrieved from: https://www.bartonassociates.com/blog/throwback-thursday-loretta-ford-the-mother-of-the-nurse-practitioner-movement-2

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. SAGE Publications.

Litchman, M. L., Schlepko, T., Rowley, T., McFarland, M., & Fiander, M. (2018). A scoping review of Advanced Practice Registered Nurse Consensus Model outcomes: Part four of a four-part series on critical topics identified by the 2015 Nurse Practitioner Research Agenda. *Journal of the American Association of*

Nurse Practitioners, *30*, 170), 710-723. http://doi.org/10.1097/JXX.0000000000000111

Lowe, G., Jennings, N., Tregaskis, P., Kenneally, A., & Bucknall, T. (2017). Profiling nurse practitioner practice patterns at a major urban acute health service. *Collegian*, *25*(3), P277-P283. http://doi.org/10.1016/j.colegn.2017.07.002

MacLellan, L., Levett-Jones, T., & Higgins, H. (2015). Nurse practitioner role transition: A concept analysis. *Journal of the American Association of Nurse Practitioners*, *27*(7), 389-397. http://doi.org/10.1002/2327-6924.12165

Maruthappu, M., Ologunde, R., & Gunarajasingam, A. (2013). Is health care a right? Health reforms in the USA and their impact upon the concept of care. *Annals of Medicine & Surgery*, *2*(1), 15-17. http://doi.org/10.1016/s2049-0801(13)70021-9

Mcandrew, R. M., Grabowski, D. C., Dangi, A., & Young, G. J. (2016). Prevalence and patterns of potentially avoidable hospitalizations in the US long-term care setting. *International Journal for Quality in Health Care*, *28*(1), 104-109. http://doi.org/10.1093/intqhc/mzv110

Merriam-Webster. (n.d.a). *Feedback*. Retrieved June 26, 2020, from https://www.merriam-webster.com/dictionary/feedback

Merriam-Webster. (n.d.b). *Performance*. Retrieved June 26, 2020, from https://www.merriam-webster.com/dictionary/performance

Miller, E. M., & Hill, P. D. (2018). Intuition in clinical decision making. Differences among practicing nurses. *Journal of Holistic Nursing*, *36*(4), 318-329. http://doi.org/10.1177/0898010117725428

Monaghan, T. (2015). A critical analysis of the literature and theoretical perspectives on theory-practice gap amongst newly qualified nurses within the United Kingdom. *Nurse Education Today*, *35*(8), e1-e7. http://doi.org/10.1016/j.nedt.2015.03.006

Moran, G. M., & N. (2017). How does role transition affect the experience of trainee advanced clinical practitioners: Qualitative synthesis. *Journal of Advanced Nursing*, *74*(2), 251-262. http://doi.org/10.1111/jan.13446

Morilla-Herrera, J. C., Garcia-Mayor, S., Martín-Santos, F. J., Uttumchandani, S. K., Campos, Á. L., Bautista, J. C., & Morales-Asencio, J. M. (2016). A systematic review of the effectiveness and roles of advanced practice nursing in older people. *International Journal of Nursing Studies*, *53*, 290-307. http://doi.org/10.1016/j.ijnurstu.2015.10.010

Mota, A. (2015). *Structural Empowerment: A qualitative inquiry into the work-life of the oncology nurse* [Doctoral dissertation, St. John Fisher College]. https://fisherpub.sjfc.edu/education_etd/214

Moustakas, K. (1994). *Phenomenological research methods.* SAGE Publications.

National Academies of Sciences, Engineering, and Medicine. (2016). *Assessing progress on the Institute of Medicine report: The future of nursing*. National Academies Press. https://doi.org/10.17226/21838

National Council of State Boards of Nursing. (n.d.). *APRNS in the U.S.* Retrieved July 7, 2020, from https://www.ncsbn.org/aprn.htm

National Council of State Boards of Nursing. (n.d.). *APRN Consensus Model Toolkit. Consensus Model for APRN Regulation: Licensure, Accreditation, Certification &*

Education July 7, 2008. Retrieved July 29, 2020, from https://www.ncsbn.org/739.htm

National Council of State Boards of Nursing. (2012.). Campaign for APRNS Consensus *Requirements for Accrediting Agencies and Criteria for APRN Certification Programs* Retrieved July 25, 2020, from https://www.ncsbn.org/12_APRN_Certification_updated.pdf

Nugroho, S., & Afif, A. N. M. (2014). Factors affecting employee performance: A case study in marketing and trading directorate, Pertamina Ltd. World Academy of Science, Engineering, and Technology, Open Science Index 92, *International Journal of Humanities and Social Sciences*, *8*(8), 2801-2804. http://doi.org/10.5281/zenodo.1111799

Nyikuri, M., Kumar, P., English, M., & Jones, C. (2019). "I train and mentor, they take them": A qualitative study of nurses' perspectives of neonatal nursing expertise and its development in Kenyan hospitals. *Nursing Open*, *7*(3), 711-719. https://doi.org/10.1002/nop2.442

Oliver, N. (2019). The role of the advanced practice nurse. In B. Scott & M. Thompson (Eds.). *Transitioning from RN to MSN: Principles of professional role development* (pp.71-88). Springer Publishing.

Orgambídez-Ramos, A., & Borrego-Alés. (2014). Empowering employees: Structural empowerment as antecedent of job satisfaction in university settings. *Psychological Thought*, *7*(1), 28-36. https://doi.org/10.5964/psyct.v7i1.88

Ortiz, J. (2016). New graduate nurses' experiences about lack of professional confidence.

Nurse Education in Practice, 19, 19-24. http://doi.org/10.1016/j.nepr.2016.04.001

Oregon State University (n.d.). *Why is orientation important?* University Human Resources. Retrieved March 9, 2021, https://hr.oregonstate.edu/employees/administrators-supervisors/onboarding-process/why-orientation-important

Owens, R. A. (2018). Transition experiences of new rural nurse practitioners. *The Journal of Nurse Practitioners*, *14*(8), 605-612. https://doi.org/10.1016/j.nurpra.2018.05.009

Patient Protection and Affordable Care Act, 42 U.S.C. § 18031 (2010). https://www.congress.gov/111/plaws/publ148/PLAW-111publ148.pdf

Paul, P. A. (2015). Transition from novice adjunct to experienced associate degree nurse educator: A comparative qualitative approach. *Teaching and Learning in Nursing*, *10*(1), 3-11. http://doi.org/10.1016/j.teln.2014.09.001

Petterson, S. M., Liaw, W. R., Phillips, R. L., Jr., Rabin, D. L., Meyers, D. S., & Bazemore, A. W. (2012). Projecting US primary care physician workforce needs: 2010-2015. *Annals of Family Medicine, 10*(6), 503-509. http://doi.org/10.1370/afm.1431

Phillips, C., Kenny, A., Esterman, 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*(2), 106-111. http://doi.org/10.1016/j.nepr.2013.07.007

Pino-Jones, A. D., Wolfe, B., Wimmer, K., Bowden, K., Rosenthal, L., Nogar, C., Furfari, K., & Cumbler, E. (2019). Physicians' perceptions of advanced practice

providers on hospitalist teams. *Journal for Nurse practitioners*, *15*(2), E37-E40. http://doi.org/10.1016/j.nurpra.2018.08.030

Poghosyan, L., Liu, J., Shang, J., & D'Aunno, T. (2017). Practice environments and job satisfaction and turnover intentions of nurse practitioners: Implications for primary care workforce capacity. *Health Care Management Review, 42*(2), 162-171. https://doi.org/10.1097/HMR.0000000000000094

Poghosyan, L., Norful, A., A., & Martsolf, G. R. (2017). Organizational structures and outcomes of newly hired and experienced nurse practitioners in New York state. *Nursing Outlook, 65*(5), 607-614. https://doi.org/10.1016/j.outlook.2017.03.001

Poghosyan, L., Shang, J., Liu, J., Poghosyan, H., Liu, N., & Berkowitz, B. (2015). Nurse practitioners as primary care providers: Creating favorable practice environments in New York State and Massachusetts. *Health Care Management Review, 42*(1), 46-55. https://doi.org/10.1097/HMR.0000000000000010

Poore, J. A., Cullen, D. L., & Schaar, G. L. (2014). Simulation-based interprofessional education guided by Kolb's experiential learning theory. *Clinical Simulation in Nursing*, *10*(5), E241-E247. http://doi.org/10.1016/j.ecns.2014.01.004.

Pulcini, J. A., & Wagner, M. A. (2002). Nurse Practitioner Education in the United States: A success story. *Clinical Excellence for Nurse Practitioners*, *6*(2). http://international.aanp.org/Content/docs/pulciniarticle0305.pdf

QSR International. (n.d.). *NVivo transcription*. Retrieved August 21, 2020, from https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/about/nvivo/modules/transcription

Raftery, C. & Tori, K. (2015). Mentoring: Supporting NP transition to practice. *The Journal for Nurse Practitioners-JNP*. *11*(5), 560. http://dx.doi.org/10.1016/j.nurpra.2015.03.023

Rantz, M. J., Birtley, N. M., Flesner, M., Crecelius, C., & Murray, C. (2017). Call to action: APRNs in U.S. nursing homes to improve care and reduce costs. *Nursing Outlook*, *65*(6), 689-696. https://doi.org/10.1016/j.outlook.2017.08.011

Ravitch, S. M., & Carl, N. M. (2016). *Qualitative Research: Bridging the conceptual, theoretical, and methodological*. SAGE Publications.

Rich, E. R. (2005). Does RN experience relate to clinical skills? *Nurse Practitioner*, *30*(12), 53-56. http://doi.org/10.1097/00006205-200512000-00009

Rich, E. R., & Rodriquez, L. (2002). A qualitative study of perceptions regarding the non-nurse college graduate nurse practitioner. *Journal of the New York State Nurses Association*, *33*(2), 1-8. Retrieved August 12, 2020, from https://pubmed.ncbi.nlm.nih.gov/15052883/

Richards, T. (2002). An intellectual history of NUD*IST and NVivo. *International Journal of Social Research Methodology*, *5*(3), 199-214. https://doi.org/10.1080/13645570210146267

Roberts, M. E., & Goolsby, M. J. (2017). Nurse practitioner research agenda roundtable: October 2015. *Journal of the American Association of Nurse Practitioners*, *29*(1), 7-11. http://doi.org/10.1002/2327-6924.12420

Rosciano, A., Lindell, D., Bryer, J., & DiMarco, M. (2016) Nurse practitioners' use of intuition. *The Journal for Nurse Practitioners*, *12*(8), 560-565. https://doi.

org/10.1016/j.nurpra.2016.06.007

Rudestam, K. E., & Newton, R., R. (2015). *Surviving your dissertation: A comprehensive guide to content and process* (4th ed.). SAGE Publications.

Saadat, V., & Saadat, Z. (2016). Organizational learning as a key role of organizational success. *Social and Behavioral Sciences, 230*, 219-225. https://doi.org/10.1016/j.sbspro.2016.09.028

Saldaña, J. (2016). *The coding manual for qualitative researchers*. (3rd ed.). SAGE Publications.

Schneider, R. (2020, May 6). *Requirements to become a nurse practitioner*. https://nursejournal.org/nurse-practitioner/what-to-know-to-become-a-nurse-practitioner/

Schram, M., Fuentes, V., Rojas, B., Tijerino, M., Thomas, M., Williams, C., Butler, E., & Prentiss, A. (2018). Signs of severity (SOS) Ed escalation guide: Bridging the experience gap. *Journal of Emergency Nursing*, *44*(4), P353-P359. http://doi.org/10.1016/j.jen.2017.11.011

Schwartz, J., & Gambescia, S., F. (2017). A literature review of research on what has become of accelerated second-degree baccalaureate nursing graduates. *Nursing Education Perspectives*, *38*(1), 29-31. http://doi.org/10.1097/01.NEP.0000000000000100

Skår, R. (2010). How nurses experience their work environment as a learning environment. *Vocations and Learning, 3,* 1-18. http://doi.org/10.1007/S12186-009-9026-5

Smith-Barrow, D. (2016, January 7). *Change careers with an accelerated graduate*

degree in nursing. U.S. News & World Report. https://www.usnews.com/education/best-graduate-schools/top-nursing-schools/articles/2016-01-07/transition-into-nursing-with-an-accelerated-graduate-degree-program

Shuler, P. A., & Davis, J., E. (1993). The Shuler nurse practitioner practice model: A theoretical framework for nurse practitioner clinicians, educators, and researchers, part 1. *Journal of the American Academy of Nurse Practitioners*, *5*(1), 11-18. http://doi.org/10.1111/j.1745-7599.1993.tb00835.x

Squires, D., & Anderson, C. (2015). *U.S. health care from a global perspective: Spending, use of services, prices, and health in 13 countries* (Issue brief No. 15). The Commonwealth Fund. https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2015_oct_1819_squires_us_hlt_care_global_perspective_oecd_intl_brief_v3.pdf

Stinson, K. J. (2017). Benner's framework and clinical decision-making in the critical care environment. *Nursing Science Quarterly*, *30*(1), 52-57. http://doi.org/10.1177/0894318416680536

Sullivan, T. (2018, May 5). *Institute of Medicine report – the future of nursing: Leading change, advancing health*. Policy & Medicine. https://www.policymed.com/2011/02/institute-of-medicine-report-the-future-of-nursing-leading-change-advancing-health.html

Sundler, J., S., Lindberg, E., Nilsson, C., & Palmer, L. (2019). Qualitative thematic

analysis based on descriptive phenomenology. *Nursing Open*, *6*(3), 733-739. http://doi.org/10.1002/nop2.275

Teoh, Y. T. E., Pua, L. H., & Chan, M. F. (2013). Lost in transition: - A review of qualitative literature of newly qualified registered nurses' experiences in their transition to practice journey. *Nurse Education Today*, *33*(2), 143-147. http://doi.org/10.1016/j.nedt.2012.08.016

Twine, N. (2018). The first year as a nurse practitioner: An integrative literature review of the transition experience. *Journal of Nursing Education and Practice*, *8*(5), 54-62. https://doi.org/10.5430/jnep.v8n5p54

U.S. Census Bureau (2019, October 8). *Older people projected to outnumber children for the first time in U.S history*. https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html

U.S. Department of Health & Human Services. (2020). *International compilation of human research standards*. Office of Human Research Standards https://www.hhs.gov/ohrp/sites/default/files/2020-international-compilation-of-human-research-standards.pdf

Van Kaam, A. (1966). *Existential foundations of psychology*. Duquesne University Press.

Vespa, J. (2019, Oct 8). *The graying of America: More older adults than kids by 2035*. U. S. Census Bureau. https://www.census.gov/library/stories/2018/03/graying-america.html#:~:text=In%20less%20than%20two%20decades,in%202034%20(previously%202035).l

Vleet, A. V., & Paradise, J. (2015, January 20). *Tapping nurse practitioners to meet*

rising demand for primary care. https://www.kff.org/medicaid/issue-brief/tapping-nurse-practitioners-to-meet-rising-demand-for-primary-care/

Walden University, Center for Research Quality. (n.d.). Institutional Review Board (IRB): Research ethics. Retrieved on July 2, 2020, from http://academicguides.waldenu.edu/researchcenter/orec

Walker, A., Costa, B. M., Foster, A. M., & de Bruin, R. L., (2017). Transition and integration experiences of Australian graduate nurses: A qualitative systematic review. *Collegian*, *24*(5), P505-P512. http://doi.org/10.1016/j.colegn.2016.10.004

Wallace, D., & Boller, J. (2014). New nurse practitioner competencies: Skill development and reflective writing rubrics. *The Journal for Nurse Practitioners*, *10*(7), E13-E21. https://doi.org/10.1016/j.nurpra.2014.04.018

Whitlow, R. A. (2015). *Becoming a novice again: Exploring the role of transition from registered nurse to family nurse practitioners* (Publication No. 3730585) [Doctoral dissertation, Capella University]. ProQuest Dissertations and Theis Global.

Xue, Y., Zhiqiu, Y., Brewer, C., & Spetz, J. (2016). Impact of state nurse practitioner scope-of-practice regulation on health care delivery: Systemic review. *Nursing Outlook*, *64*(1), 71-85. http://doi.org/10.1016/j.outlook.2015.08.005

Zoom Video Communications, Inc. (n.d.) *Local recording*. Retrieved August 21, 2020, from https://support.zoom.us/hc/en-us/articles/201362473-Local-recording

Appendix A: Demographic Questionnaire

Thank you for volunteering to participate in my research, exploring the impact of RN-APRN transitional experiences on APRN performance. Completing this questionnaire will take about 10 minutes, and your response will help me determine if you meet the requirements to participate in this study. Your timely response is critical to the study, so I am requesting you submit your completed demographic survey within 72 hours. I will review your responses and contact you within two weeks to notify you of selection or non-selection.

You are not under any compulsion to participate, no one would think less of you if you chose not to participate, and you can opt-out of the study at any point without any breach of confidentiality.

1. How many years did you work as an RN before becoming an APRN?
2. When you practiced clinically at the RN level, what were your clinical practice areas, and approximately how many years did you practice in each of your identified practice areas before becoming an APRN?

7 What is your highest nursing degree?

8 Please rate your RN proficiency level during your transition to APRN. (Please circle one).

   a. Novice: This group of nurses has no experience. Their performance is based on rules and protocols given to them as a guide to their work.

b. Advanced Beginner: These nurses have acquired some experience but cannot distinguish between significant situational components and remain guided by rules. Thus, these nurses are unable to prioritize care.

c. Competent Nurse: It takes 2-3 years of nursing practice to attain a competent level. At this level, the nurse can determine what aspects and attributes are most essential and can establish long-term care goals and plans. However, the nurse still lacks flexibility and speed.

d. Proficient Nurse: A nurse gains the proficient level as they continue working and gaining experience. At this level, the nurse anticipates and sees the whole situation, has gained much experience, and can anticipate and plan how to solve problems.

e. Expert Nurse. The expert nurse performs without depending on rules and guidelines. Instead, the expert nurse relies on a wealth of experience to promptly reach decisions, uses intuition for decision making, and is very experienced.

10. What is your APRN certification?

a. Certified nurse-midwife (CNM)

b. Certified nurse practitioner (CNP)

c. Clinical nurse specialist (CNS)

11. How many years have you been an APRN? (Please circle one)

a. 0-1 year

b) 1-2 years

c) 2-3 years

d) 3-4 years

e) 4-5 years

12. What is your APRN primary care specialty?

13. In what primary care practice setting are you currently working?

I will securely store all documents, including your responses, and data related to this study in a locked cabinet and password-protected computer accessible to only me for 5-years; after which I will send them to a professional shredding company for destruction, and all digital data will be reformatted, and the storage device destroyed. I am available to answer any of your questions.

This concludes this survey. I will contact you within two weeks to notify you of selection to participate. If you wish to know the study results, simply email me, and ask me to send them to you upon completion.

Thank you for your participation

Appendix B: Interview Protocol and Questions

I will adhere to the following interview protocol throughout each interview.

1. I will set-up 30 minutes early to prepare the environment
    a. Ensure the area is quiet and lacks distraction.
    b. Set up and test recording and communication equipment.
2. I will greet and thank participants upon connection.
    a. Thank the participant for their time and participation.
    b. Introduce myself and explain the research protocol.
    c. Ask the participant to select a pseudonym.
    d. Review informed consent and answer any questions about it.
        i. Voluntary
        ii. Free to withdraw
        iii. Risk and benefit
        iv. Confidentiality
3. I will explain the study.
    a. Purpose
    b. Interview procedures
    c. Participant's role
    d. How the data gathered from their interviews will be used
4. I will begin the audio-recording.
    a. Explain audio-recording

   b. Explain that the participant will state, on the recording, that they consent to participate and be audio-recorded
   c. Turn on the recording equipment
   d. State my name, the participant's chosen pseudonym
5. I will commence the interview questions.

Interview Questions

1. Thinking about your prior nursing experience before becoming an APRN, how would you rate your nursing proficiency level using Benner's novice to expert nursing model identified below?
   a. Novice: This group of nurses has no experience. Their performance is based on rules and protocols given to them as a guide to their work.
   b. Advanced Beginner: These nurses have acquired some experience but cannot distinguish between significant situational components and remain guided by rules. Thus, these nurses are unable to prioritize care.
   c. Competent Nurse: It takes 2-3 years of nursing practice to attain a competent level. At this level, the nurse can determine what aspects and attributes are most essential and can establish long-term care goals and plans. However, the nurse still lacks flexibility and speed.
   d. Proficient Nurse: A nurse gains the proficient level as they continue working and gaining experience. At this level, the nurse anticipates and sees the whole situation, has gained much experience, and can anticipate and plan how to solve problems.

e. Expert Nurse. The expert nurse performs without depending on rules and guidelines. Instead, the expert nurse relies on a wealth of experience to promptly reach decisions, uses intuition for decision making, and is very experienced.

2. What motivated you to transition from an RN to an APRN?
    a. What does it mean to be an APRN for you?
    b. Do you feel any different from RN-APRN?
    c. Do you feel appreciated as an APRN?
3. How do the organization and other employees comprehend your role?
    a) Do other healthcare providers understand your role?
    b. Do patients understand your role?
    c. How were you empowered during your transition from RN-APRN?
    d. To what extent do you feel that APRN training furnished your ability to collaborate with other healthcare professionals?
    e. As an APRN, are you part of any organizational committee or hierarchy?
4. How would you describe your RN-APRN transitional performance?
    a. What performance challenges did you face during your transition from RN-APRN?
    b. What was your greatest challenge during your transition?
    c. How long did you work as an RN before transitioning to an APRN?
    d. What supports did you have during your transition?
    e. Do you feel that support facilitated your transitional performance?

5. Equating your proficiency level to Benner's novice to expert nursing model, please rate and explain your transitional performance and experiences.
    a. How would you describe your transitional performance about your prior RN experience?
    b. How did your RN experience impact your transitional experience to APRN?
    c. How did your prior RN SOP impact your transitional stress levels?
6. What is your perception of organizational structural empowerment?
    a. Did you have the organizational support necessary for you to fulfill your responsibilities during your transition?
    b. Did you have the SOP resources necessary for you to fulfill your responsibilities during your transition?
    c. Did you have the information necessary for you to fulfill your responsibilities during your transition?
    d. Did you receive the feedback necessary for you to fulfill your responsibilities during your transition?
    e. How did available resources empower you?
7. How do you perceive your role within the organization?
    a. How would you describe your relationship with your administrators?
        i. Sharing of information?
        ii. Communication between you and the administration?
        iii. Encouraging you to share ideas?

b. How would you describe your relationship with your colleagues?
    i. Do physicians understand your role?
    ii. Do other healthcare providers understand your role?
    iii. Do patients understand your role?
c. How were you integrated into organizational committees or hierarchy?
d. To what extent do you feel that APRN training informed your ability to collaborate with other healthcare professionals?

8. Do you believe that your prior nursing experience and the organizational support you received during your RN-APRN transition were useful?
    a. How did you internalize the impact of prior nursing experience with the organizational environment and transitional performance?
    b. How would you describe ancillary staff's adequacy allocated for your service in terms of quantity, quality, and sufficiency?
9. How would you describe the feedback, goals, and outcome measures you received toward your APRN SOP?
    a. Was the feedback empowering?
    b. Were the goals challenging?
    c. Where the outcome measures appropriate?
10. What policies do you think will facilitate a less stressful transitional experience for new APRNs?
    a. If there is one recommendation you would give to improve the transitional performance of RNs to APRNs, what would it be?

b. Is there any other information you would like to add that will foster improved APRN training and transitional experience?
c. Do you have any suggestions for improving my interview process?
d. Would you like to read the final study?
e. Do you have any questions?

This concludes this interview. Thanks again for taking out time for this interview. I am available to answer any new questions you may have about this study.

Appendix C: Recruitment Flier

RESEARCH STUDY ON ADVANCED REGISTERED NURSE PRACTITIONER (APRN) TRANSITIONAL PERFORMANCE

- ✓ ARE YOU AN APRN (CNM, CNP, CNS)?
  - OR DO YOU KNOW SOMEONE WHO IS?
- ✓ HAVE YOU PRACTICED FOR FIVE YEARS OR LESS?
- ✓ ARE YOU WORKING IN CHICAGO PRIMARY CARE?
- ✓ ARE YOU FLUENT IN THE ENGLISH LANGUAGE?

If so, you are invited to participate in this research study exploring APRN transitional experiences. The study involves a short survey and an approximately 60-minute, audio recorded, one-on-one interview via telephone, Zoom, or Skype on a day and time convenient to you. Participants meeting the study criteria will be selected on a first-come-first-served basis for two weeks or until 14 participant slots are filled [01/31/2021]. As a thank you for your time, each participant will receive a $10 Amazon gift certificate at the end of data collection.

Please contact Helen Okeke [redacted]
Thank you very much.