PREDICTORS OF POSITIVE CLINICAL PERFORMANCE EVALUATIONS

OF NEW GRADUATE NURSES PARTICIPATING IN

PRECEPTOR ORIENTATION PROGRAMS

by

Mary L. Brasler

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APPROVED:

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H. W. Stubblefield, Co-Chairperson

_____

G. Belli, Co-Chairperson

_____   _____

M. Boucouvalas   S. Jarecki

_____

B. Wiswell

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Mary L. Everett Brasler

Committee Chairpersons: Harold W. Stubblefield
Adult and Continuing Education
Gabriella Belli
Educational Research and Evaluation

(ABSTRACT)

The purpose of this study was to assess relationships in clinical performance evaluations by new graduate nurses participating in six orientation programs with program components and new graduate characteristics. Some orientation programs offered formal support groups while others offered no support groups. Orientation programs providing designated preceptors for graduate nurses are used widely, but few research studies support their success in assisting graduates to assume staff nurse positions. This study addressed the research question: What variables are related to positive evaluations of clinical performance by new graduate nurses?

A sample of 65 new graduate nurses, participating in six preceptor orientation programs in the Baltimore, Md. and Washington, D. C. metropolitan areas, completed pre- and post-orientation questionnaires. Demographic information, self-evaluations of clinical performance using the Six Dimension Scale of Nursing

Performance (6D Scale), and preceptor evaluations using the Preceptor Characteristics (PC) Tool were collected. The 6D Scale measured six areas of nursing performance. The PC Tool provided a rating of teaching, nursing, and interpersonal skills of preceptors.

Variables, correlating highly with the six individual scores of the 6D Scale, were entered into multiple regression analyses. A total of 11 variables were identified as predictors of clinical performance evaluation scores. The most useful predictor for all six independent variables was support provided by other nurse friends, or classmates. Preceptor skills and emotional support provided by the preceptor were predictors for five areas. Participation in formal support groups, however, was not found to be a predictor.

Major implications for practice included 1) viewing support groups as a bridge to assist graduates in developing new support systems within the work setting, 2) developing objective measures of preceptors' skills, and 3) requiring preparation courses of all primary and alternate preceptors. Major recommendations for future study included 1) investigating the relationship of preceptor education and experience with graduates' evaluation scores, and 2) further exploring the negative relationship of support group participation and evaluation scores.

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CHAPTER I

INTRODUCTION

Technological advances, increased knowledge generated by research, and new

treatment modalities developed within the health care field in recent years have

resulted in an increase of the knowledge base and skills expected of the new graduate

in nursing (Schempp & Rompre, 1986). The transition from nursing student to

graduate nurse is a difficult and stressful time. Although new graduate nurses have

successfully completed their education program designed to prepare them for the

work-place and have passed their State Board Examinations, self-doubt occurs. New

graduates report feeling lost, overwhelmed, and afraid they will miss something

significant. They at times report feelings of being unprepared for the realities of the

work-place and of being clinically incompetent (Andrews, 1987). Results of

interviews with 30 recent nursing graduates by Andrews include reported difficulties

with performing technical skills, providing nursing care for large numbers of patients,

making decisions, functioning in a leadership role, and delegating tasks.

The shocklike reaction experienced by new graduates when they realize they

are not adequately prepared for the realities of the first job in nursing has been termed

"reality shock" by Marlene Kramer (1974). New graduates experience discrepancies

between ideals and values developed and internalized within the academic

environment and those encountered in the work-place. Responses to this often include

either rejecting the value system of the school, the work-place, or rejecting oneself

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and expressing feelings of failure. These negative results of reality shock impact immediately upon the new graduate but also affect the morale of others within the work-place, the quality of nursing care provided to clients in that setting, and ultimately the profession of nursing (Friesen & Conahan, 1980; Schempp & Rompre, 1986).

Nursing staff report that new graduates have difficulties with making decisions, setting priorities, performing technical procedures, and with identifying their weaknesses and gaps in knowledge (Goldsberry, 1977). Nurse administrators indicate that new graduates lack basic skills, are not aware of nor are they prepared to deal with the realities of a staff nurse position and in general, are not prepared to practice nursing (Wagner, 1980).

All new graduates approach their first job with beginning level clinical skills. The fact that their superiors, such as head nurses, directors of nursing, and physicians often expect a higher level of competence creates a conflict. Those associated with nursing service tend to find fault with the educational preparation of new graduates (McGrath & Koewing, 1978; Stull, 1987). Some suggest that nursing faculty are not adequately prepared clinically, are not good role models for students, and are unable to assist students in working through actual, real life clinical problems (Wagner, 1980; Werner, 1980).

Many nursing educators point out that the difficulties encountered by new graduates are a consequence of moving nursing education programs from hospitals to colleges and universities. The emphasis has shifted from a technical and service orientation with training in apprentice-type programs to a theoretical and professional orientation. Cognitive skills including application of theories and problem solving abilities are valued and taught (Schempp & Rompre, 1986; Stull, 1987).

Nursing educators insist that new graduates are prepared to function at a beginning level and not as experienced staff nurses. They point out that the problem is that they are not being utilized appropriately (McGrath & Koewing, 1978; Stull, 1987). Each side--service and education--tends to blame the other and the new graduates caught in the middle of this controversy often blame themselves for their perceived inadequate preparation (Schempp & Rompre, 1986).

There are various types of transitional programs currently being used in orienting new graduate nurses. These structured programs are specifically designed to assist the new graduate in making the transition from student to beginning practitioner. Preceptor programs are the most widely used program in the Northern Virginia area according to Reed (1987). Preceptorships are educational programs that involve the one-to-one guidance of an experienced nurse and the new graduate in a clinical setting. Preceptors are staff nurses who are willing to serve as role models or teachers to the new graduate (Cox, 1988; May, 1980).

Precepting is based on modeling theory in that the experienced nurses model professional behavior for the neophyte nurse. Modeling as defined by Bandura (1987) refers to learning by observation or example and encompasses observing, imitating and copying. It is a process during which the model's behavior is a stimulus for the observer's thoughts, attitudes, and/or behavior. Learning, therefore, occurs as a result of the observer observing and imitating the behavior of the model.

Precepting is also based on the mentor concept. Mentoring generally involves a long-term, personal relationship between a successful, experienced individual and a neophyte. Mentors serve as counselors, guides, and teachers. In nursing, they assist the younger nurse in learning about the profession of nursing and in dealing with the realities of the work place (Atwood, 1979; Vance, 1982). Precepting is similar in that the preceptor also assumes the role of counselor, guide, and teacher in the process of professional socialization, but the relationship is short term, is less intense emotionally, and is established for a specific purpose.

The assumption underlying the use of preceptors is that an intense one-to-one relationship will enhance learning (Shamian & Inhaber, 1985). Allen Tough (1979) notes that individuals already successful in a field such as nursing would best know what skills and knowledge are needed. They could more easily adapt the teaching process to the learner's needs, answer questions, and guide the learner in the appropriate responses and skills. This approach is also assumed to support role

adaptation and socialization of the new graduate as well as to lower the costs of orientation (May, 1980; Shamian & Inhaber, 1985).

Statement of the Problem

The results of a survey taken in 1981 of over 1200 hospitals indicated that the average annual cost of recruiting and orienting a staff nurse is $874 and $1563, respectively (Beyers, Mullner, Byre, & Whitehead, 1983). The current nursing shortage has compounded the problems experienced by health care institutions in recruiting, orienting and retaining new graduates. There are fewer new graduates entering the job market forcing the agencies to spend more in this increasingly competitive market. An additional concern is that many new graduates resign within the first year of employment. Resignation rates for new graduates have been reported to be as high as 60% during the first year of employment (Friesen & Conahan, 1980; McLean, 1987).

This high rate of turnover causes an additional financial impact upon the employing agency faced with higher costs of hiring and orienting new staff. There is a need to orient new graduates and prepare them for full job assignment as quickly as possible to alleviate staff shortages.

Preceptor programs are reported to be the most common type of orientation program currently being utilized in the Northern Virginia area (Reed, 1987). Benefits such as improved clinical competence, increased job satisfaction, and increased self-

confidence are reported based on subjective evaluations. The research on the effectiveness of preceptor programs for new graduates, however, is inconclusive. Many authors point out the need for additional research on the effects of preceptor programs (Everson, Panoc, Pratt, & King, 1981; Myrick, 1988; Shamian & Inhaber, 1985).

In two research studies where different types of preceptor programs were compared, the low numbers of participants were problematic (Peitchinis, 1978; Hamilton, Murray, Lindholm, & Myers, 1989). Two variables considered in a few research studies were length of time (Giles & Moran, 1989; Peitchinis, 1978) and the skills of the preceptor (Giles & Moran, 1989). No studies were located that looked at other components related to the preceptor orientation program such as support groups, clinical rotations, classroom and skill laboratory experience and number of preceptors.

There is a need for research involving adequate numbers of subjects and designed to compare different types of preceptor orientation programs. Various components of the programs in relation to preparing the new graduate for full work load assignment need to be considered.

Purpose Statement

The general purpose of the study was to determine differences in clinical performance evaluations of new graduate nurses participating in two types of preceptor orientation programs in the metropolitan Washington,

D. C. and Baltimore, Md. area. Preceptor orientation programs providing planned didactic and clinical experience for the new graduate assigned to a designated preceptor as well as programs additionally providing formal support groups. The focus of the study was on specified components of the preceptor programs such as the skills of the preceptor and support groups.

<div align="center">Research Questions</div>

The original question of interest was:

Is there a difference in the self-evaluation of clinical performance by new graduates who participated in a preceptor orientation program with formal support groups and those who participated in a program without formal support groups?

Due to changes occuring during the data collection period (see Chapter III), explicit comparisons between programs were not possible. The focus of the study was maintained by rephasing the question: What variables are related to positive new graduate nurse clinical performance self-evaluation scores?

Recognizing that there may be various distinctions that may account for interaction with new graduate self-evaluation of clinical performance, the relationship between self perception of clinical performance and components of the programs as well as new graduate characteristics were studied. The variables that were studied include length of time spent in the clinical portion of the preceptor program, amount

of time spent with preceptor, preceptor's skills, time spent in clinical rotations, number of formal support group sessions, and other sources of support.

Programs offered by university teaching hospitals may differ from those offered by community hospitals. The acuity level of patients cared for by the new graduates may differ as well as availability of resources. Hospital type, therefore, was included as a blocking variable to enable an assessment of potential differences across hospitals.

Significance of the Study

It is important to determine what components of preceptor orientation programs best assist in the preparation of new graduates to assume the role of staff nurse and a full work load assignment because many agencies in this geographic area have invested time and money to provide such programs. Preceptor skills and support as well as the role of formal support groups in orientation programs for new graduates were the focus of the study. Results from this study could be applied in designing preceptor programs in order to better prepare new graduates.

Educators in clinical agencies responsible for designing and providing preceptor programs for new graduates would be particularly interested in the results of this study. It might also be useful to educators designing preceptor programs for other groups, such as nursing students or staff nurses orienting to new agencies or to specialty units. Those involved in the process of selecting and preparing preceptors

may find the study useful. Educators in basic nursing programs might be interested in the findings in relation to the basic educational preparation of graduates.

Definition of Terms

The following terms were used in this study:

New graduate nurse. Individuals beginning their first job after graduating from a diploma, associate degree, or basic baccalaureate nursing education program which prepared them for licensure as registered nurses.

Clinical performance evaluation. Scores obtained from completion of the instrument, Six-Dimension Scale of Nursing Performance. The six areas of nursing practice tested on the instrument are Leadership, Critical Care, Teaching/Collaboration, Planning/Evaluation, Interpersonal Relations/Communication, and Professional Development.

Preceptor. An experienced nurse designated to work one-on-one with a new graduate in the clinical setting. This nurse serves as a role model, resource person, and teacher.

Preceptor orientation program. A structured orientation program that is specifically designed to assist new graduates in making the transition to beginning practitioner. Graduate nurses participate in planned didactic and clinical experiences under the guidance of their designated preceptor.

Formal support group. A group experience designed especially for new graduates, scheduled at designated times during the orientation period and led by an experienced group leader. Support groups provide an opportunity for new graduates to discuss concerns related to the orientation process, receive feedback and develop problem solving skills.

Delimitations

This study was limited to an investigation of the following:

1. New graduate nurses entering their first job experience on medical-surgical, maternity, pediatric, or psychiatric units. Those hired for positions in specialty or critical care units requiring acquisition of knowledge not presented in basic nursing education programs were not included.

2. New graduates participating in selected preceptor orientation programs in the metropolitan Baltimore, Md. and Washington, D. C. area which includes Northern Virginia.

Limitations

1.   The subjects were self-selected.

2.   There were lower response rates on the post-orientation questionnaires from participants in one of the teaching hospital programs.

3.   There were fewer participants from the teaching hospitals than the community hospitals.

Organization

Chapter one consists of an introduction, background and conceptual framework for the study, statement of the problem and the purpose statement. The research questions, significance of the study, definitions, delimitations, and limitations are also included.

Chapter two provides a review of the literature on support groups and preceptor orientation programs. Chapter three describes the research design and methods to be used. Chapter four presents the results and the data analyses. Chapter five presents a summary, the conclusions and recommendations.

CHAPTER II

REVIEW OF THE LITERATURE

The general purpose of this study was to determine relationships in clinical

performance evaluations by new graduate nurses participating in preceptor orientation

programs in the metropolitan Washington, D. C. and Baltimore, Md. areas with

program components and new graduate characteristics. The orientation programs

provided planned didactic and clinical experience for the new graduates assigned to

designated preceptors. The focus of the study was on specified components of the

preceptor programs such as preceptor skills and support groups.

This chapter is divided into two sections. The first section presents a

theoretical foundation for precepting. The parameters of precepting are presented in

relation to role modeling and mentoring. In addition to the one-to-one relationship a

preceptor establishes with the preceptee, the use of support groups as an additional

source of feedback and support is discussed as well.

The second section presents a review of the literature including research

studies related to preceptor orientation programs and their components for new

graduate nurses.

Theoretical Foundation

Relationships between experienced nurses and neophyte nurse may be viewed

as a continuum. On one end is the relationship of role modeling, a passive process.

On the other end is the mentoring relationship which is an active process occurring

over a long period of time. Preceptor relationships are located in the middle and reflect characteristics of the other two types. The relationship is generally well defined such as a preceptor assigned to assist in the orientation of a new graduate nurse to a staff nurse position for a designated period of time (Campbell-Heider, 1986; Puetz, 1985).

Modeling Theory

Modeling as defined by Bandura (1987) refers to learning by observation or example. It is a process during which the model's behavior is a stimulus for the observer's thoughts, attitudes, and/or behavior. Learning, therefore, occurs as a result of the observer observing and imitating the behavior of the model (Bandura, 1987).

Modeling has been employed to establish new response patterns including eliminating unwarranted fears, modifying responses to frustration and anxiety, and increasing the assertiveness of inhibited children. It has been used primarily in promoting social behavior but cognitive behavior as well (Bandura, 1963).

There are three possible effects that may occur after exposure to a model. The first is an observational learning effect that involves the acquisition of a new behavior pattern after watching a model's performance. This is exhibited most clearly when the response is one the observer has not previously learned. The second is an inhibitory or disinhibitory effect on the observer's previously learned responses.

Observing the model receive punishment for a specific behavior, such as aggression will result in a decrease in that behavior by the observer. A disinhibiting effect is evident when observers see the model engage in prohibited or threatening activities without adverse consequences. This effect is illustrated when modeling is used with phobic individuals. The third effect is that of response facilitation when the model's behavior serves as a cue in releasing similar responses. This is illustrated by a group applauding when one individual starts to clap or looking up when observing another gazing at the sky (Bandura, 1963).

The modeling effect is enhanced if the model is perceived as similar to the observer in certain attributes, thus allowing for identification. Models who are viewed as competent and possessing intelligence, power, and prestige are generally emulated to a higher degree (Bandura, 1987). It has been reported that modeling is most effective when used with individuals who are dependent, feel incompetent, or lack self-esteem (Bandura, 1963).

One of the major components of social learning theory is that individuals tend to imitate the behavior of a model when they expect reinforcement and do not imitate when they anticipate punishment. By observing the model receive reinforcement or punishment for behaviors, the observer can avoid trial-and-error experience with the direct consequences. Vicarious consequences obtained through observation and imitation serves the same function (Bandura, 1963).

This theory of modeling is relevant to a study of graduate nurses orienting to their first position as a staff nurse. Ideally, neophyte nurses observe competent and experienced nurses in the work setting which provides an opportunity to learn appropriate professional nursing behavior. The experienced nurses or preceptors serve as the primary source of modeling stimuli to the new graduate nurses. They demonstrate the expected behavior and performance norm of a professional nurse. Preceptors demonstrate technical procedures, problem solving techniques, and relational skills (Edmunds, 1983).

Preceptors also provide corrective guidance through feedback which diminishes the likelihood of trial-and-error performance by the neophyte and promotes acquisition of professional skills and behavior. New nurses, for example, may observe the preceptor receiving praise for a particular accomplishment. The observation of the consequences may encourage the neophyte nurse to perform in a similar manner (Kramer, 1972).

One problem with role modeling is that the imitator may only achieve the level of skill demonstrated by the model (Smoyak, 1978). The emphasis is on imitation rather than self-development and perhaps should be limited in use to the early stages of professional development (Hamilton, 1981). Preceptors, however, often go beyond passive modeling of desired behavior and make the learning process more active. Discussion of desired skills and appropriate behavior promotes critical thinking related

to professional behavior and encourages development to one's potential (Hamilton, 1981; Lopez, 1983).

Mentoring

Precepting is also based on the concept of mentoring. Unlike role modeling, which is primarily a passive process, mentoring is long-term, active involvement within a close, personal relationship. Mentors serve as counselors, teachers, sponsors, and guides. They assist the neophyte in learning about the profession, and in dealing with the realities of the work place and the political scene. Mentors serve as role models, but their function goes beyond that to actively encouraging professional socialization and promoting career advancement (Atwood, 1979; Campbell-Heider, 1986; Vance, 1982).

Mentors must be willing to establish an active, long-term relationship. They must be secure, confident individuals with a healthy self-concept. They should be accepting and willing to give to others. Competence as clinicians and as teachers is an important component of mentoring. Mentors should be experts in their specialty area and demonstrate leadership. Most importantly, they must be able to work with the protege in a close emotional relationship (Atwood, 1979; Vance, 1982).

Benefits of mentoring include facilitating the adjustment of the neophyte nurse to the realities of the work place and professional socialization (Atwood, 1979; Campbell-Heider, 1986; Hamilton, 1981). The mentoring relationship has also been

found to assist in preparation for leadership roles, in career advancement, and in increased self-esteem and self-confidence (Hamilton, 1981; Puetz, 1985; Vance, 1982.

While the terms role model, preceptor and mentor refer to three different types of one-to-one relationships, their everyday use in practice is often blurred or overlapping. A few articles describing the short-term relationship of experienced nurses working with neophyte nurses refer to the nurses as mentors while the more appropriate term is preceptor (Atwood, 1979; Hamilton et al, 1989).

Both of the terms, mentor and preceptor, are used by various orientation programs in the metropolitan Washington, D. C. area to refer to designated experienced nurses working with new graduates in short term relationships. This confusion about the terms, therefore, appears both in the literature and in practice.

In addition to providing designated preceptors or mentors, several orientation programs also provide formal support groups. The preceptor enhances learning within the framework of a one-to-one relationship with the new graduate while the support group provides for supplemental learning and guidance from peers and an experienced leader.

Support Groups

Support groups are generally formed to provide an opportunity for members to share problems with others experiencing the same stress. They are viewed as a powerful tool for alleviating that stress (Caplan and Killilea, 1976).

Support groups are only recently becoming recognized as a specific type of group different from therapy groups and self-help groups but with similar concerns and dynamics (Jacobs & Goodman, 1989; Rosenberg, 1984). All three types are recognized as social support systems which serve to improve coping with short-term as well as long-term stresses and life transitions (Caplan and Killilea, 1976).

The three types of groups differ primarily in the focus of the group and role of the leader. Group therapy focuses on self-analysis of the individual with a purposeful attempt at personality change. The focus of a support group is on developing group cohesiveness and enhancing self-esteem which lead to better coping patterns. Self-help groups generally form around a specific concern such as alcoholism, divorce, or similar problems. Their focus is similar to that of support groups but the leader is often experiencing the same stress as the members. The leaders of therapy groups and support groups generally have special training and expertise in groups and/or human development (Rosenberg, 1984).

Five characteristics of support groups have been identified by Rosenberg (1984). Support group members are generally healthy individuals who are experiencing a transitory yet definable stress. They share a common problem and feel stigmatized by this problem. Group members speak a common language or jargon and seek comfort and acceptance within the group. Homogeneous groups, such as a

group of nurses dealing with a similar work-related problem, tend to be more effective.

The basic goal of support groups is to increase the coping abilities of the members. Positive reinforcement is provided within the group structure for successful coping attempts. Support from the group serves to increase the self-image and self-esteem of the members. The group has an educational purpose in that it serves as a feedback guidance system. Advice, feedback, and reality testing take place in the safety of the group (Rosenberg, 1984). Guidance, education, and problem-solving are emphasized rather than counseling (Riordan & Beggs, 1988).

The most significant curative factors within support groups has been identified by Rosenberg (1984) as decreasing the feeling of alienation by the development of group cohesion. Other factors include believing that the group will make a difference and that one is not alone, sharing feelings and anxieties, sharing facts and information about resources, practicing new coping patterns, and learning how others view their behavior.

The use of support groups have been suggested as an important component in orientation programs for new graduate nurses. New graduates encounter work-related stress which is often reported as a reason for nurses leaving the field. Work-related stress may be due to several factors such as providing nursing care for ill people on a daily basis in low paying positions while receiving little respect from other health

professions or society at large (Biggers, Zimmerman & Alpert, 1988). New graduate nurses entering the field experience the stress of learning a new job and are at risk for burnout, a decreased ability to adapt to stress (Ceslowitz, 1989).

In a study by Freeman, Logan and McCoy (1987), support groups were utilized in helping groups of working women at high risk for dysfunctional stress. While nurses were not included in the sample, this type of stress could easily apply to nurses in general and specifically to nurses in entry level positions.

Freeman, et al. (1987) report that low levels of stress tend to motivate people. High levels of accumulated stress, however, often combined with some type of barrier to problem-solving such as limited resources leads to dysfunctional stress and an decreased ability to cope. The profiles of women at high risk included factors such as limited experience with low-paying and difficult jobs, lack of external support, lack of models for handling multiple work roles, and lack of support at work.

Interventions employed in the study by Freeman et al. (1987) included support groups along with other assigned exercises such as role playing and homework assignments. The support groups were reported to be helpful in assisting with role transitions and in teaching problem-solving techniques. Other results reported were a decrease in feelings of anger, confusion, and stress as measured on pre- and post-test questionnaires. Participants reported increased ability to share feelings, identify barriers such as guilt and lack of problem-solving skills and discuss strategies to

decrease their stress levels such as using resources for support. An increased sense of competence and satisfaction with work as well as other aspects of their lives was also reported.

Bicultural training programs, which utilize a type of support group, were developed to assist in the role transition of new graduate nurses. These programs included three components. The graduate nurses attended conflict resolution workshops and group seminars and read assigned instructional materials dealing with the concept of reality shock. The focus of the group seminars, generally scheduled on a weekly basis, was to foster a climate of trust, encourage discussion on issues of concern to the new graduates, and to promote self-awareness and self-acceptance (Holloran, Mishkin, & Hanson, 1980; May, Minehan, & Deluty, 1981)). Based on these stated purposes, the group seminars apparently functioned as support groups.

Research studies evaluating bicultural training programs report decreased turnover rates and support their cost effectiveness (Holloran et al., 1980; Schmalenberg & Kramer, 1979). No bicultural training programs were located in the Washington, D. C. metropolitan area. There are fewer articles in the literature about these programs in recent years, which appears to indicate a trend in hospitals moving away from implementing that type of program.

No research studies were located which specifically focused on the benefits of support groups for new graduate nurses entering their first job.

New Graduate Nurse Transition Programs

The literature deals with various types of transitional programs for the orientation of new graduate nurse. These are structured programs that are specifically designed to assist the new graduate in making the transition from student to beginning practitioner. Reed (1987) reports that the majority (31.9%) of orientation programs in Virginia are preceptor programs, while internships account for 15.3%. This is based on the results of a questionnaire sent to 97 selected hospitals in the Commonwealth of Virginia that administer nursing orientation programs.

Preceptorships are programs that involve the one-to-one guidance of an experienced nurse and the new graduate in a clinical setting. Length of preceptor programs varies from six weeks to nine months (Schempp & Rompre, 1986). Reed's study (1987) revealed that six to nine weeks was the most common length of time for preceptor programs in Virginia.

Programs that allow the new graduate to rotate into various clinical areas to obtain a variety of experiences are called nursing internships. These programs may or may not provide a preceptor. Internship programs are generally longer than regular orientation programs with the length of time varying from three months (Cramer, 1979) to one year (Fleming, Woodcock, & Boyd, 1975) with the majority lasting six months (Aspy, 1978; Burrell, Lally, & Wiklinski, 1977; Kasprisin & Young, 1985). The primary goal of the nursing internship is to provide new

graduates with additional clinical learning experiences (Lewison & Gibbons, 1980). Other goals such as assisting with the professional socialization of the new graduate and enhancing self-confidence have been reported (Dear, 1983, Lewison & Gibbons, 1980).

Another type of transition programs are the bicultural training programs which assist the new graduate in dealing with the conflict between values taught in school and those encountered in the work place. Cognitive, affective and behavioral techniques along with structured group experiences are included (Schempp & Rompre, 1986). Seminars and workshops on a variety of topics including conflict resolution are offered on a weekly or monthly basis. Peer groups formed in the program are encouraged to share feelings and offer emotional support (Holloran et al., 1980; Kramer & Schmalenberg, 1978).

This section of the review will deal with articles and research studies related to nursing preceptorships which are the most common type of program in this geographic area and the focus of this study.

Preceptor Orientation Programs

Preceptorships are educational programs that provide a one-to-one relationship between a neophyte and an experienced nurse. A preceptor is a staff nurse with clinical expertise who is willing to serve as a role model, resource person and teacher (Cox, 1988; May, 1980). Precepting incorporates aspects of modeling theory in

that experienced nurses model professional behavior for the inexperienced new graduate nurse. Precepting also includes elements of mentoring. Precepting is similar to mentoring in that the preceptor also assumes the role of counselor, guide and teacher in the process of professional socialization, but the relationship is short term, is less intense emotionally, and is established for a specific purpose (Morrow, 1984).

The assumption underlying the use of preceptors is that an intense one-to-one relationship will enhance learning (Shamian & Inhaber, 1985). Individuals already successful in a field such as nursing would be best qualified to assess what skills and knowledge are needed (Tough, 1979). They could more easily adapt the teaching process to the learner's needs, answer questions, and guide the learner in the appropriate responses and skills. This approach is also assumed to support role adaptation and socialization of the new graduate as well as to lower the costs of orientation (May, 1980; Shamian & Inhaber, 1985).

This approach has been utilized in various settings, such as in the university setting with nursing students at the undergraduate and graduate level. Staff nurses are being utilized as preceptors for students in the clinical portion of academic courses. Clinical agencies are utilizing preceptors to assist in preparing new graduates for initial positions as well as experienced nurses entering specialty areas (Maraldo, 1977).

Historically, nursing students in this country were taught in the hospital setting by practicing nurses. This apprenticeship type of nurses' training often led to a misuse of the students to meet staffing needs of the hospital thus neglecting their educational needs. After many years of trying to correct this situation, nursing leaders were successful in moving nursing education into the collegiate setting. Nursing educators assumed control of the planning and implementing of both classroom and clinical teaching of nursing students. With the increased popularity of preceptor programs, nursing is once again turning to hospital based nurses to play a major role in the education of nursing students and graduates (Myrick, 1988).

Selection of Preceptors

There are a variety of ways in which preceptors may be selected. Preceptors may be volunteers but are more often selected by their head nurses (Begle & Willis, 1984; May, 1980; Plasse & Lederer, 1981) with input from other personnel such as clinical instructor (Hoaks, 1987), clinical director (Mooney, Diver, Schnackel, 1988), or clinical supervisor (Shogan, Prior, & Kolski, 1985). In one instance a planning committee made up of representatives from the community college and nursing service selected the preceptors (McGrath & Koewing, 1978). A committee provided guidelines for the clinical nursing coordinator to choose preceptors in another program (Murphy & Hammerstad, 1981). In the program described by Knauss (1980) the director of nursing along with the instructor made the selection. The

preceptor workshop described by Piemme, Kramer, Tack, & Evans (1987) appeared to be open to all interested nurses within that clinical agency.

Criteria for selecting preceptors varies from program to program but generally includes clinical competence, communication skills, leadership skills, ability to make decisions and resolve conflicts, interest in professional growth, and a willingness and commitment to work with new graduates (Begle & Willis, 1984; Friesen & Conahan, 1980; Hoaks, 1987; May, 1980; McGrath & Koewing, 1978; McLean, 1987; Mooney et al., 1988; Murphy & Hammerstad, 1981; Plasse & Lederer, 1981; Shogan et al., 1985).

Preparation of the Preceptors

Most of the programs offer formal preparation for the nurse preceptors which range from a one and a half hour orientation followed by weekly discussions (Friesen & Conahan, 1980) to a three day workshop (Rottet & Cervero, 1986). Workshops or conferences appear to be the most common format used in orienting the preceptors (Begle & Willis, 1984; Everson et al., 1981; Hoaks, 1987; McLean, 1987; Mooney et al., 1988; Piemme et al., 1987; Plasse & Lederer, 1981; Shogan et al., 1985).

Content of the orientation workshops as reported in the literature varied considerably. Most programs, however, included adult learning principles and learning styles (Hoaks, 1987; May, 1980; Piemme et al., 1987; Shogan et al., 1985). Other topics included needs assessment, goal setting, communication skills, reality

shock, counseling skills, values clarification, and evaluation methods (Hoaks, 1987; May, 1980; Murphy & Hammerstad, 1981; Piemme et al., 1987; Plasse & Lederer, 1981; Shogan et al., 1985).

Various types of learning experiences for the preceptors were reported in the literature. The workshop described by Shogan et al. (1985) included simulated teaching exercises. Each prospective preceptor demonstrated teaching a clinical skill in the form of a role play. Hoaks (1987) notes that the preceptor course implemented in her agency involves preparation of a videotape of a preceptor-learner teaching situation illustrating concepts presented in the program. There is also a written examination over application of the material in the course, such as adult learning principles and communication skills. A clinical component of the course is also included during which the unit instructor supervises and evaluates the new preceptor.

Role of the Preceptor

The preceptor is often described as a role model providing an opportunity for the new graduate to observe and learn while working alongside an experienced nurse. The preceptor is expected to model appropriate professional behavior, in leadership and clinical skills (Hoaks, 1987; May, 1980; Murphy & Hammerstad, 1981). Other responsibilities are in orienting the new graduate to the clinical unit, assisting with ongoing professional socialization, clinical teaching, supervision, and evaluation

(Hoaks, 1987; Mooney et al., 1988; Murphy & Hammerstad, 1981; Shogan et al., 1985).

The preceptor is often involved in assisting new graduates in assessing their learning needs (Everson et al., 1981; Goldsberry, 1977; McLean, 1987; Patton, Grace, & Rocca, 1981; Plante, Asselin, Weaver, Barber & Mannarino, 1987; Shogan et al., 1985). The new graduate may fill out a skills checklist and learning needs assessment which is then discussed with the preceptor (McLean, 1987; Plasse & Lederer, 1981). The program discussed by Shogan et al. (1985) used a form prepared by the instructor and clinical supervisor that listed nurse performance expectations specific to that clinical unit. Objectives are developed by the new graduates and preceptors which guide the clinical and didactic portions of the experience (Plante et al., 1987; Shogan et al., 1985). In one program (Everson et al., 1981) a learning contract is developed by the new graduate with the preceptors' assistance based on Malcolm Knowles' design for a learning plan. Learning needs are assessed and then appropriate objectives and strategies are developed, resources identified, and criteria for evaluation are established.

The preceptor also functions as a resource person for policies and procedures as well as in dealing with clinical problems or decision making (Harrison & Price, 1987; Murphy & Hammerstad, 1981; Plasse & Lederer, 1981). Other responsibilities of the preceptor include coordinating and facilitating the learning experiences for the

new graduate (Plante et al., 1987). Conferences are often scheduled on a regular basis between the preceptor and new graduate and in some cases the head nurse or other personnel participate. These meetings provide an opportunity to assess the progress made by the new graduate at that point and to plan for future experiences (Everson et al., 1981; Friesen & Conahan, 1980; Harrison & Price, 1987; McLean, 1987; Mooney et al., 1988; Patton et al., 1981; Shogan et al., 1985).

Preceptors also report providing counseling and support to assist new graduates in dealing with the stress that accompanies adjusting to their first job. Preceptors encourage the new graduates to share their feelings and frustrations and provide guidance in dealing with their anxieties (McLean, 1987; Murphy & Hammerstad, 1981).

Supervision and Recognition of the Preceptors

Preceptors are part of a larger administrative structure and receive support and supervision in different ways in different agencies. In some hospitals, the preceptors are supervised throughout the time they are working with the new graduates. The head nurse or clinical supervisor is frequently mentioned as a resource person for the preceptor (Mooney et al., 1988; Shogan et al., 1985). Other programs utilize the unit instructor, educational coordinator, staff development instructor, or clinical specialists in that capacity (Hoaks, 1987; May, 1980; Plasse & Lederer, 1981; Shogan et al., 1985). Begle and Willis (1984) mention the need for support among preceptors as

they work with new graduates. To provide that support, their agency established a preceptor committee that met weekly or biweekly to provide preceptors with the opportunity to voice concerns and deal with problems. These meetings are used for educational purposes as well.

Preceptors report various types of recognition or rewards for the time and effort they expend in this activity. The form of recognition reflects the value the agency places on the preceptors' contribution (Turnbull, 1983). In some cases the preceptors receive additional pay (McGrath & Koewing, 1978; Mooney, et al., 1988). They may receive an official title of staff nurse preceptor (Mooney, et al., 1988), a subscription to a professional journal, or recognition in a newsletter or by a special luncheon (Begle & Willis, 1984); Murphy & Hammerstad, 1981). Rewards or recognition also encourage preceptors to continue to participate in the program (Turnbull, 1983).

Evaluation

Most programs provided an evaluation of the orientation program and new graduate participants. A few agencies reported using a post test in evaluating the new graduates (Harrison & Price, 1987; Murphy & Hammerstad, 1981). Written evaluations (Murphy & Hammerstad, 1981; Shogan et al., 1985) that in some cases were based on specific tools (McGrath & Koewing, 1978); Rottet & Cervero, 1986; Shogan et al., 1985) were commonly provided. In other cases, the preceptors, new

graduates, and head nurses were given questionnaires to facilitate evaluating the program (Everson et al., 1981; Friesen & Conahan, 1980; McLean, 1987; Shogan et al., 1985).

In all cases, the subjective evaluations as discussed above were positive. In almost all cases reported in the literature, the new graduates gained clinical competence and were able to assume leadership roles more quickly after completing a preceptor orientation program (McGrath & Koewing, 1978; McLean, 1987; Mooney et al., 1988; Rottet & Cervero, 1986; Shogan et al., 1985). Other reported benefits included increased job satisfaction, a feeling of professional growth, and opportunity to work through conflicts (Friesen & Conahan, 1980). Improved confidence (McLean, 1987) and an easier transition from student to the role of new practitioner were also mentioned (Shogan et al., 1985).

Preceptor Program Outcomes

Benefits. Several benefits identified by the preceptors were reported in the literature. These included increased job satisfaction (Friesen & Conahan, 1980; McLean, 1987) and personal and professional growth (Mooney et al., 1988; Murphy & Hammerstad, 1981; Shogan et al., 1985). Other benefits reported were that the experience was a learning experience for them and was challenging (Knauss, 1980; Rottet & Cervero, 1986). In some cases they felt that participating as a preceptor

was a recognition of their expertise which brought increased status or even clinical advancement (Mooney et al., 1988).

Other benefits reported by nursing service and the agencies included an increase in retention of new staff nurses (Friesen & Conahan, 1980; McLean, 1987; Shogan, et al., 1985) and a decrease in the costs for orienting new staff (McLean, 1987; Mooney et al., 1988). Mooney et al. (1988) viewed preceptorships as a valuable recruitment tool which is significant in this period of nursing shortage. An unanticipated benefit reported by this program was an increase in commitment of the staff to new graduates and improved use of personnel and resources. Friesen and Conahan (1980) reported that their program enhanced the development of other staff nurses and allowed the introduction of the concept of peer review. Offering preceptorship programs also provided an opportunity for staff development and in some cases nursing faculty from the academic setting to collaborate with nursing service. This may lead to a greater appreciation of the other's role and the complexities of the job setting (Maraldo, 1977; Mooney et al., 1988).

The primary benefit to patients that was reported was a perceived increase in the quality of nursing care provided. Not only was the clinical competence of the new graduates enhanced, but the skills of the preceptors and other staff members were improved as well (Friesen & Conahan, 1980; Goldenberg, 1987/88; Turnbull, 1983).

Problems. There were several problems associated with preceptorships

identified in the literature. The most common one involved scheduling difficulties.

There was agreement that preceptors need to be available to the new graduates, but in

some cases it was difficult to arrange for them to work on the same shift consistently

(Begle & Willis, 1984; Friesen & Conahan, 1980; Shogan et al., 1985).

A second problem pointed out by Goldenberg (1987/88) is that monetary

constraints may result in orientation programs for preceptors that are too brief to be

effective. Providing release time to enable preceptors to fully participate in

workshops and other aspects of the programs may present financial difficulties as well

as interfere with continuity of care on the clinical unit.

A third area of problems relates to the relationship between the new graduates

and their preceptors. Shogan et al. (1985) report difficulties with assigning more than

one orientee to a preceptor. Another difficulty identified was that some new

graduates tend to rely too much on the preceptor for solving problems. There is also

a possibility that assigning preceptors to new graduates may result in a mismatch in

personality and communication creating more stress (Goldenberg, 1987/88). Lucke

(1980) reported that new graduates felt pressured to learn and smothered by the

preceptor's presence. They also indicated that preceptors with good clinical skills

may not necessarily be the best teachers. Some reported feeling a sense of

abandonment at the completion of the program. Preceptors reported feeling

personally accountable for the performance of the new graduate. Begle and Willis (1984) state that problems that do occur need to be addressed as soon as possible.

Overall, the articles reviewed indicated that, based on subjective evaluations, preceptor programs for new graduates are an effective way to prepare new graduates for the realities of the work place. Assumptions are made that these programs are more cost effective, result in increased job satisfaction and lower turnover rates. It is also assumed that clients receive higher quality care as a result of new graduates and nursing staff participation. In spite of these positive impressionistic reports, many authors point out the need for research on the issue of effectiveness of preceptor programs (Everson et al., 1981; Myrick, 1988; Shamian & Inhaber, 1985).

Effectiveness of Preceptorships

Research studies dealing with the topic of effectiveness of preceptorships have produced mixed results. Two studies involving nursing students reported by Olson, Gresley, and Heater (1984) and Myrick (1986, cited in Myrick, 1988) indicate that there was no significant difference in the clinical performance between students who were precepted and those who were not. A third study involving new graduates was done by Huber (1981) to determine if there was a difference in the clinical performance of new graduate nurses participating in a preceptorship program as compared to those participating in an internship program. Although both groups

demonstrated improvement in their performance after completing the orientation programs, there was no significant difference between the groups.

In contrast to the studies mentioned above indicating no significant results, three studies investigating the effectiveness of preceptorship programs for nursing students did demonstrate significant results. Scheetz (1989) reports that nursing students participating in a summer preceptorship program demonstrated a greater increase in clinical competence as compared to students working as nursing assistants. The students who did not participate in a structured preceptor program, however, reported working in a buddy relationship with a staff nurse. Scheetz questions whether variables other than the presence of a preceptor may account for the differences.

In the second study, Vigen (1987) reports that senior nursing students participating in an preceptored clinical experience scored significantly higher on perceived readiness for beginning professional practice and perceived clinical competence specifically in the areas of collaboration, communication, critical care, and professional development.

The third study, which was undertaken by Clayton, Broome, and Ellis (1989), indicated that nursing students participating in a preceptorship demonstrated a greater increase in professional socialization as compared to students in a traditional course. The precepted students scored significantly higher on four of six subscales on

Schwirian's Scale of Nursing Performance, the same instrument used by Vigen (1987). The results indicated that there was an increase in professional socialization over time. The author speculated that six months might be too early to demonstrate a significant difference in the two areas of critical care skills and professional development. The results of Vigen's study, however, did demonstrate a difference in those two areas at the completion of the clinical preceptorship experience.

Shamian and Lemieux (1984) compared the preceptor teaching model to the formal teaching model in order to determine which was more effective. Although this study did not use new nursing graduates as subjects, the results reflect that the preceptor model is effective as a teaching method. There was no significant difference between the preceptored and formal teaching group on measurements taken immediately after the teaching sessions. When tested three months later, however, the preceptored nurses scored significantly higher in knowledge and attendance at educational programs. Benefits from using a preceptor teaching model emerged after a three month time period, perhaps indicating more effective internalization of material.

Two research studies dealing exclusively with preceptorships for new graduates were reviewed. McGrath and Princeton (1987) used an exploratory research design including both qualitative and quantitative data collection methods such as interviews and review of documents. Their findings included reports from

new graduates indicating that their weakest area was technical skills, that the availability of the preceptor program was a major factor in recruitment, and that the program helped build their confidence in leadership skills. Findings based on data collected from other sources indicated that the program only minimally assisted in developing leadership skills.

Hamilton et al. (1989) used a quasi-experimental design to study the effects of using mentors in orienting new graduate nurses. Factors studied included length of time and ratio of mentors to graduates. They report increased job satisfaction and leadership behavior and a higher retention of nurses who had received a longer orientation period.

Two research studies were reviewed that dealt with preceptor orientation programs for newly employed nurses. These were not limited to new graduate nurses but included experienced nurses as well.

Giles and Moran (1989) conducted a quasi-experimental research study comparing the buddy method with the preceptor method utilized in orienting newly employed nurses. Both new graduates and other experienced nurses participated in the orientation. Buddies were staff nurses paired off to work with the new staff orientees. Typically the staff assigned as buddies varied from day to day and they did not participate in formal training to prepare them for this assignment as did the preceptors. Greater satisfaction was reported with the preceptor method. Other

findings include a decrease in nursing turnover from 20% to 16% and a decrease from 32% to 18% in resignations occurring in the first year of employment. Decreases in these areas can result in substantial financial savings for an institution. Even though the precepted group required a longer orientation, they were viewed as better prepared to assume full work responsibilities at the completion of the program than the nurses who had been buddied.

Peitchinis (1978) evaluated the performance of newly hired nurses participating in three different types of orientation programs. Results indicated no significant difference in the clinical performance among participants of a one week regular orientation program, of a ten day precepted experience on a special orientation unit, or of a three day precepted experience on a special orientation unit. Nursing competency scores gradually increased over a period of six months with significant increases at each of the five measurement periods. Highest scores were reported in the three-year diploma graduates. Significant differences in quality of patient care given by staff participating in the two precepted programs were also reported.

The majority of the research studies that were reviewed evaluated the effectiveness of preceptor programs designed for nursing students. Only three studies examined programs designed for new graduates. The findings from Huber's (1981) study did not demonstrate any difference in performance of new graduates participating in a preceptor program compared to those in an internship program.

Both groups did, however, have significant performance gains. Her study would have been more meaningful if she had included a control group to determine if new graduates participating in either type of transition program experience a greater gain in performance skills than those receiving a traditional orientation.

The findings of three studies (Giles & Moran, 1989; Hamilton et al., 1989; McGrath & Princeton, 1987) did demonstrate that preceptor programs assist the new graduate in making the transition from student to beginning practitioner. Their findings support the assertions that preceptorships are effective in recruitment and in reducing turnover and resignations in the first year of employment. The study by Shamian and Lemieux (1984) on the preceptor teaching model lent further support to the view that precepting is an effective teaching method. Further research is needed to more fully evaluate the effectiveness of preceptorship with new graduates and to determine the program components that will best assist the new graduate in making the transition to staff nurse.

Conclusion

There is a vast number of articles in the literature dealing with the transition period new graduates experience when they begin the practice of nursing and the various programs developed to assist the new graduate during this stressful time. Many of these articles describe a specific program that has been established. A few provide helpful conceptual information and fewer still propose possible solutions to

the overall problem of lack of clinical competence and inadequate preparation of the new graduate.

Various claims as to the effectiveness of nursing preceptorships have been made, but few are supported by data based studies. The few studies included in this literature review present varying results.

In general the literature reflects that there is a wide variation in the types of nursing preceptorship programs offered across the country. These programs vary in length, content presented, methods of presentation, clinical component, supervision and evaluation. It is difficult to compare one program with another because of these differences and perhaps unwise to compare participants from one program with another program unless this variation is somehow controlled.

Another criticism is that although the definition of a preceptorship is generally clear, the essence of what is present within those programs that is assumed to be making the difference in preparing the new graduate is not clearly conceptualized. Huber's (1981) study looked at role modeling as a conceptual framework but her findings did not support the claim that preceptors as role models of professional behavior made a significant difference. Most of the studies did not clearly identify their conceptual framework. Scheetz (1989) reported that students participating in a summer preceptor program demonstrated significant gains in clinical competence over students working as nursing assistants. Even though the precepted students had

greater gains, both groups did experience gains. The nonprecepted students reported that they had established a close relationship with a staff nurse who assisted them throughout their experience. The author indicated that other variables associated with the precepting experience or the organization itself should be identified and studied.

There may indeed be other variables as alluded to by Scheetz (1989) that have not been identified or controlled that are affecting research results. Variations in programs, organizational environment, responses of staff and supervisory personnel, and events from the subject's personal life were not discussed in the studies reviewed.

In two of the studies reviewed where different types of preceptor programs were compared, the low numbers of participants were problematic (Hamilton et al, 1989; Peitchinis, 1978;). Two variables considered in a few research studies were length of time (Giles & Moran, 1989; Peitchinis, 1978) and skills of the preceptor (Giles & Moran, 1989). No studies were located that looked at other components related to the preceptor orientation program such as support groups, clinical rotations, classroom and skill laboratory experience and number of preceptors.

<u>Summary</u>

A large body of literature was located regarding various types of new graduate orientation programs including preceptorships. Very few data based research studies on preceptor programs for new graduate nurses were located.

This chapter included the theoretical foundation for precepting, a one-on-one relationship between an experienced nurse and a neophyte nurse, as it differs from and is similar to role modeling and mentoring. Support groups supplement the role of the preceptor by providing guidance and feedback to the new graduate orientee in a group setting with peers and an experienced leader.

Numerous articles describing successful preceptor orientation programs cited benefits to the new graduate of improved clinical performance, ability to assume leadership roles more quickly, and easier transition from nursing student to staff nurse. Other benefits mentioned include decreased turnover, decreased orientation costs and increased job satisfaction for all participants.

There were relatively few studies devoted to cost effectiveness, recruitment or retention. Only three research studies dealing exclusively with preceptor orientation programs for new graduates were located.

Very few studies have considered preceptor skills and length of time and none were located that looked at other program components such as support groups, clinical rotations, and number of preceptors. The gap in the literature this study will address is the contribution of various components of orientation programs, such as preceptor skills and support groups, in assisting new graduate nurses in assuming the role of staff nurse.

CHAPTER III

METHOD

The general purpose of the study was to determine differences in clinical

performance evaluations of new graduate nurses participating in preceptor orientation

programs offering formal support groups and programs without support groups. The

focus of the study was on specified components of the preceptor orientation programs

including the skills of the preceptor and participation in support groups and other

clinical activities. Originally the plan was to compare new graduates participating in

preceptor orientation programs from sets of teaching and community hospitals that

either provided formal support groups or did not. Due to unanticipated changes

within one of the orientation programs which added formal support groups which

were not originally planned, the original design was altered. The main purpose of the

study was addressed from a different perspective using regression analyses.

Design

Six preceptor orientation programs offered by hospitals in the Baltimore, Md.

and Washington, D.C. metropolitan areas, including Northern Virginia, provided the

setting for this study. Preceptor programs were selected based on the formal support

group component of their orientation programs for new graduates. These hospitals

were matched for size, teaching affiliation, and geographical location. Information

gathered from a preliminary survey of area hospitals assisted in a tentative selection

of six preceptor programs.

Within each group of three hospitals, one is a University teaching hospital affiliated with a medical school, one is a community hospital in the Northern Virginia suburban area and one is a community hospital in the District of Columbia.

The independent variables were type of preceptor orientation program along with type of hospital. Hospital type was included as a blocking variable to control for potential differences between teaching and community hospitals and to enable an assessment of potential differences across hospitals.

The design was, therefore, three hospitals offering support groups and three hospitals not offering support groups (see Figure 1).

Preceptor Orientation Programs Without Support Groups

Three of the hospitals selected offered preceptor orientation programs with classroom sessions and clinical experience on medical-surgical, maternity, pediatric or psychiatric units with a preceptor. One of the programs had a designated starting date in June and completion time 8-10 weeks later. Starting dates for the other two programs ranged from every two weeks to once a month. The length of time in the clinical portion in those two programs varied between six to eight weeks and in some cases extended beyond twelve weeks depending upon the individual needs of the participants.

Hospitals	Preceptor Orientation Programs	
	With Support Groups	Without Support Groups
University Teaching Hospitals	N = 1	N = 1
Community Hospitals	N = 2	N = 2

Figure 1. Research Design

Preceptor Orientation Program With Support Groups

The other three hospitals selected offered preceptor orientation programs with formal support groups led by a psychiatric clinical specialist or experienced nurse educator. Two of the hospitals offered programs starting in June and again at the end of the summer. The third program started a new group each month for a total of four groups. The length of these programs varied from eight to twelve weeks. Classroom sessions and clinical experience on medical-surgical, maternity, pediatric, or psychiatric units with a preceptor were included.

Subjects

New graduate nurses hired to fill vacancies on medical-surgical, maternity, pediatric, or psychiatric units within the participating hospitals and who participated in the formal preceptor orientation programs from the end of May to early September, 1990 were asked to participate in the study. New graduates from diploma, associate degree (A.D.) and bachelor of science in nursing (B.S.N.) degree programs that prepare their graduates for licensure as registered nurses were included.

In addition to the new graduates who were the focus of the study, other participants included the designated preceptors of the new graduates. The preceptors were registered nurse employees of the respective hospitals.

All of the new graduates and preceptors were asked to voluntarily participate in the study.

Variables

The primary dependent variable was the clinical performance evaluations of the new graduate. Six dimensions of nursing performance were evaluated by the new graduates and their preceptors. The new graduates provided an assessment of their own skills at the beginning and end of the orientation program. The assessment of the new graduates' clinical performance by the preceptors at the end of the orientation program was obtained as an external validity check on the new graduates' self-evaluation.

The preceptor's skills, a potential confounding variable, was evaluated by both the new graduate and the appropriate preceptor.

Additional variables that were included are demographic variables related to the new graduates. These were their age and sex, type of basic nursing education program, type and length of previous hospital work experience, previous experience with preceptors, and previous experience at the orientation hospital. Sources of emotional support for the new graduates were also included.

Variables related to the program components that were included are the length of the classroom portion, length of the clinical portion, time spent in clinical rotations, time spent in support groups, participation in state board course during orientation period, number of preceptors during orientation, and length of time spent with primary and alternate preceptors.

Instruments

Six-Dimension Scale of Nursing Performance

The Six-Dimension Scale of Nursing Performance (Six-D Scale), a self-report instrument developed by the Ohio State University Research Foundation, was used to evaluate the clinical performance of the new graduates. The instrument is found in Appendix A. This questionnaire consists of 52 items grouped into six performance subscales: Leadership, Critical Care, Teaching/Collaboration, Planning/Evaluation, Interpersonal Relations (IPR)/Communications, and Professional Development. The instrument assesses the frequency of nursing behaviors on the Professional Development subscale and the quality of nursing activities on the other five subscales. As reported by Schwirian (1978), the instrument is designed for both self-appraisal and employer appraisal reporting of nursing performance.

Reliability. Reliability has been assessed for each of the subscales using Cronbach's alpha. Scores ranged from a low of .84 on the Leadership employer appraisal subscale to .98 for the Professional Development self-appraisal subscale (Schwirian, 1978). Reliability for this study has been determined on both the pre-orientation and post-orientation instruments using Cronbach's alpha. Pre-orientation reliabilities for new graduates' data ranged from .62 on the Leadership subscale to .75 on the Teaching/Collaboration subscale. Scores obtained from the post-orientation instrument ranged from .52 on the Critical Care subscale to .69 on Professional

Development with the exception of the Leadership scale which was .38. A table summarizing scores obtained on both pre-orientation and post-orientation instruments used by the new graduates and the instrument used by preceptors is found in Appendix B.

Validity. Construct and content validity have been confirmed (Schwirian, 1978). A factor analysis of the criterion behaviors conducted following responses by nurse graduates and supervisors demonstrated high congruence. External validity was strengthened when additional data analyses indicated that data scoring differentiated between graduates previously identified as most promising and those who had not been so identified.

Preceptor Characteristics

The Clinical Instructor Characteristics Ranking Scale (CICRS), developed by Rauen (1974), was modified for this study to provide an evaluation tool for assessing the skills of the preceptor. The instrument is found in Appendix C. The original instrument consisted of eighteen behaviors using a six-point ranking scale. The behaviors were divided into three groups and categorized as nurse role, teacher role, or person (interpersonal) role. Nurse role characteristics include knowledge, nursing skills, and attitudes toward nursing. Teacher role characteristics relate to instructor-student relations such as providing learning opportunities, feedback, and resources.

Person role characteristics include behaviors that reflect interpersonal relationship skills such as honesty, empathy, and kindness.

The original instrument asked respondents to rank the characteristics in order of importance. The modified tool used in this study contains the original items with changes in wording to facilitate its use in evaluating preceptor skills and to accommodate the use of a five-point scale on each item.

Reliability. The reliability of the original instrument was established by Rauen (cited in Cooper, 1982) using the test-retest method. Spearman Rank-Order Correlation Coefficient was used to determine the subtest reliability. Results were as follows: Teacher Role Rho = 0.47, Nurse Role Rho = 0.75, and Person Role Rho = 0.53. The Spearman-Brown Prophecy Formula, used to test the CICRS instrument as a whole, yielded a .75 reliability coefficient.

Reliability of the modified instrument used in this study was established using Cronbach's alpha. Scores obtained on the instrument used by the new graduates are .78 for Teacher, .65 for Nurse, and .85 for Person Role Characteristics. Scores obtained on the instrument used by the preceptors are .46 for Teacher, .62 for Nurse, and .70 for Person Role Characteristics.

Validity. Content validity was established by Rauen. Twenty-five experts were asked to categorize each characteristic on a consultation instrument as to nurse role, teacher role, or person role. Each item meeting with 80 percent or greater

agreement between the experts and Rauen's categorization was retained (cited in

Cooper, 1982).

Demographic Information

Questionnaires were designed to obtain information about the new graduates

and the orientation program. These were pilot tested on a group of new graduates

during the spring of 1990.

New Graduate. A pre-orientation questionnaire was developed to collect

information about the new graduates and their orientation program. New graduates

were asked to indicate their age, sex, education background, type and length of

previous work experience in a hospital, previous experience working with preceptors

and clinical experience in the orientation hospital.

A post-orientation questionnaire asked them to indicate number of preceptors,

length of time with their primary preceptor, length of time with alternate preceptors,

and sources of support that assisted them in assuming the role of staff nurse.

Questionnaires that were used for the new graduates are found in Appendix D.

Preceptor orientation program. Additional information about each preceptor

program was collected by interviewing the directors of the six programs. This

information included length of time of orientation, length of time of the classroom

portion, availability and time spent in state board review course, availability and time

spent in technical skills practice laboratory, length of time in the clinical portion,

availability and time spent in clinical rotations, availability and time spent in support

groups. The interview guide is found in Appendix E.

<div align="center">Procedure</div>

Written permission to use the two research instruments was obtained from the

respective authors, Patricia Schwirian and Karen Rauen (See Appendix F for letters

granting permission). A copy of the research proposal was submitted to the research

committees of the hospitals participating in the study and their approval obtained

either by telephone or by letter.

The instruments were pilot tested in the spring of 1990 on new graduate nurses

and preceptors participating in preceptor orientation programs in area hospitals.

Appropriate changes in the tools were made before formal data collection.

Data collection took place from May 21, 1990 through December 30, 1990.

All questionnaires were color-coded to facilitate distribution and tabulation of the

data.

Pre-orientation questionnaires composed of the Six-Dimension Scale of

Nursing Performance and a demographic section were distributed to the new

graduates and collected at a scheduled classroom session during the first week of

orientation. The post-orientation questionnaires composed of a demographic section

and the two research instruments, the Six-Dimension Scale of Nursing Performance

and Preceptor Characteristics Rating Scale, were mailed to the new graduates at the

end of twelve weeks. They were asked to indicate on a detachable form the name of their preceptor who would evaluate their clinical performance. They were also asked to return the forms by mail.

On completion of the orientation programs, questionnaires were mailed on an individual basis to the preceptors designated by the graduates. These questionnaires consisted of the two research instruments, the Six-Dimension Scale of Nursing Performance and the Preceptor Characteristics Rating Scale. Preceptors were asked to return the forms by mail.

Stamped, pre-addressed envelopes were provided to all respondents. Follow-up contact by mail was made to encourage completion and return of the questionnaires.

Confidentiality was maintained throughout the data collection process. All questionnaires were personally distributed to avoid potential problems with perceptions of either positive or negative effects from the involvement of hospital personnel. Each form was given an assigned number and the master list of names and case numbers was available only to myself and was destroyed after completion of the study. The preceptors were given the name of the person they were to evaluate on a top sheet which they were instructed to detach from their questionnaire before mailing to avoid placing names on the forms.

<u>Analyses</u>

Descriptive statistics were used to provide information about the six orientation programs, including classroom topics, educators, and components of the clinical portion as well as a profile of the new graduates including age, educational preparation and past hospital experience.

In the original 2 x 2 design, the groups were to be compared using multivariate analysis of variance on evaluation of the preceptors by the new graduates. This was to be done for the purpose of determining if perceived preceptors' skills were comparable across both types of preceptor programs and types of hospitals. Depending on these results, either MANOVA or MANCOVA was to be used on the six dependent subscales of the new graduates' post-orientation clinical performance self-evaluations.

Unexpected changes within one of the community hospitals during the orientation program involving the addition of support groups that were not originally planned violated the quasi-experimental design. Additionally, low completion rates, particularly from one of the teaching hospitals, would have produced a dramatically unbalanced design. The MANOVA analyses consistent with the original design, therefore, were no longer viable.

The main purpose of the study could still be addressed, but from a different perspective, using regression analyses. Dependent variables for these analyses were

the six post-orientation new graduate clinical performance evaluation scores. Subsets

of relevant independent variables were determined for each analysis from two

perspectives: (1) variables that correlated with the dependents, and (2) variables that

were theoretically logical for inclusion. In order to acknowledge the potential

differences between teaching and community hospitals, hospital type was included as a

dummy variable in the regressions. Participation in support groups, the main variable

of interest, was changed from a two-level factor to a continuous variable reflecting

time spent in support groups. In retrospect, this was a more reasonable approach

because time in support groups varied dramatically across programs in the original

"with support group" level of this factor.

Preliminary analyses. New graduates in teaching hospital orientation programs

were compared on all demographic variables with those in community hospital

programs using chi-square and t-test analyses. Because of the different nature of

teaching and community hospitals, all descriptive information was presented

separately. New graduates were also compared on all demographic variables between

the two teaching hospitals and among the four community hospitals.

Those completing both pre- and post-orientation questionnaires were compared

with those completing only the pre-orientation questionnaires on all demographic

variables using chi-square and t-test analyses. The t-test was also used to compare the

mean clinical performance evaluation scores on the 6-D Scale to determine any

possible differences between those who completed both questionnaires and those who completed only the pre-orientation questionnaire.

The two groups were compared on evaluation of the preceptors by the new graduates and on the self-evaluation of the preceptors to determine if preceptors' skills were comparable across types of hospitals.

Variables selected as potentially useful based on theoretical considerations were correlated with the six clinical performance scores. Those variables correlating highly with the six independent scores were identified and selected for inclusion in the regression analyses.

<u>Predictors of Clinical Performance</u>. Regression analyses was performed on all significant variables identified in the preliminary analyses. Scatter plots were examined for potential outliers. Based on an evaluation of Cook's Distance values, it was determined that there were no significant outliers that might affect the regression results. Stepwise regression as well as manual regression analyses that first introduced those variables considered to be valuable based on theory were performed. Six regression models of predictors of clinical performance were obtained.

<div align="center">Summary</div>

This chapter described the method of study implemented for this research, including the design, instruments used in the study, procedure for data collection and the statistical procedures that were utilized. Alterations in the original design and

analyses that were necessary due to unexpected changes occurring in the middle of the data collection period were described.

CHAPTER IV

RESULTS

The general purpose of this study was to assess relationships in clinical performance evaluations of new graduate nurses participating in six preceptor orientation programs with program components and new graduate characteristics. All of the orientation programs provided classroom and clinical experience for graduate nurses assigned to designated preceptors. Some of the orientation programs offered various amounts of support through formal support groups while others offered no formal support groups. The focus of the study was on preceptor orientation program components including preceptor skills and participation in formal support groups.

All statistical procedures were performed utilizing the Number Cruncher Statistical System (Hintze, 1988).

Setting

Six preceptor orientation programs for new graduate nurses offered by hospitals in the Baltimore, Md. and Washington, D.C. metropolitan areas including Northern Virginia provided the setting for this study. Three of the hospitals offered programs with formal support groups and the other three programs did not initially offer support groups for the graduate nurses.

Each group of three hospitals was composed of one University teaching hospital affiliated with a medical school, a community hospital in the Northern

Virginia area, and a second community hospital in the District of Columbia. In the middle of the data collection period, one of the community hospitals, Hospital F, instituted a special internship program for new graduate nurses on designated units within the hospital. This program consisted of additional classroom sessions and formal support groups sessions. Two instructors were assigned to implement this special program and conduct the support group sessions. Four of the ten respondents from this hospital participated in support group sessions, therefore confounding the original design of the study. For descriptive comparison purposes the orientation programs were grouped under the categories of teaching hospitals and community hospitals.

Program Components

Each of the six orientation programs included a classroom and clinical component. Table 1 summarizes the components of the six orientation programs. Each program provided a general orientation to the hospital attended by new employees in various categories. Topics included hospital policies, policies of nursing service and interdepartmental services. Each of the six programs provided additional class sessions on intravenous therapy, cardio-pulmonary resuscitation, planning patient care and medical records. Class sessions related to the nature of the particular clinical units for which the nurses were employed were covered in most of the

Table 1

Orientation Program Components

Orientation Program Components		
	Teaching Hospitals	
Components	A N = 16	D N = 13
Number of Programs	2	2
Total Weeks	10	6
Class Days	3 initially, then 1 day week for all (total of 9 more)	5 + 1½ days in independent activity
State Board Review Course (SBRC)	Yes, 3 days	No
Time off for Outside SBRC	No	Possible
Clinical Rotations	Yes, 10 days +	No, but possible on individual basis
Skills Lab	No	Yes
Support Group Sessions (SGS)	9	No
Length of SGS	1 hour	NA
Leader of SCS	Nursing Education Coordinator	NA

Table 1 Continued

Orientation Program Components				
Components	Community Hospitals			
	B N = 20	C N = 14	E N = 34	F N = 21
Number of Programs	4	2	1	4
Total Weeks	12	8	8	12
Class Days	5, plus 10 additional classes on some units	5	4, plus 1-8 classes on some units	4, plus 2 days per week on some units for 4 weeks
State Board Review Course (SBRC)	No	No	Yes, 4 ½ days	Yes, 5 days
Time off for Outside SBRC	Possible	Yes	No	Yes
Clinical Rotations	No; available on some units	Yes, 3½ days	Yes, time varies	No; available on some units
Skills Lab	No	No; on individual basis	Yes, 2 days	Yes, time varies
Support Group Sessions (SGS)	12	2, plus others as needed	No	4 sessions for nurses on some units
Length of SGS	1 hour	2 hours	NA	2 hours for some nurses
Leader of SGS	Psychiatric Liaison Nurse	Orientation Coordinator	NA	Instructor

programs. Nursing care of certain types of patients, such as those with cardiac or respiratory problems, was included when appropriate to the clinical unit.

Three of the programs offered a state board review course as a part of the orientation. The other three indicated that arrangements could be made in work schedules to allow the graduate nurses to attend review courses outside the hospital. Graduate nurses beginning orientation after mid-July had already taken the State Board Examination and therefore attendance at review courses was no longer applicable.

Three of the programs provided scheduled clinical rotations related to the nature of their clinical unit as part of the orientation. Generally these were observational experiences in areas that included the operating room, endoscopy unit, nuclear medicine, cardiac catheterization laboratory, physical therapy, or clinics. In some cases, the graduate nurses spent part of a day with nurse specialists such as diabetic nurse specialists or enterostomal therapist. None of the six programs provided for extended clinical experience caring for patients on other specialty units as a scheduled component of the orientation.

Scheduled sessions for the graduate nurses to practice various clinical skills were provided in three of the programs. Proficiency in cardio-pulmonary resuscitation was required in all programs and assistance with other skills was provided on the units on an individual basis.

Three of the programs provided regularly scheduled support group sessions as part of the orientation. They were led by experienced nurses such as a psychiatric liaison nurse or a nurse from the nursing education department. Although the number of scheduled support group sessions varied from two to 12 across the three programs, attendance by the graduate nurses was affected by work schedules and varied widely. Hospital F established a special program for graduate nurses working on medical units starting in July which included four support group sessions. Four of the ten graduate nurses from this hospital reported attending support group sessions that were not part of the initial program schedule.

Subjects

All new graduates hired for staff nurse positions on medical-surgical, maternity, pediatric, or psychiatric units and who participated in the formal orientation programs within the participating hospitals were invited to participate in this study. All 118 new graduates present at the designated orientation sessions completed the pre-orientation questionnaire. Of these, 107 completed the orientation programs and 65 graduate nurses returned the post-orientation questionnaire for a 61% completion rate. Table 2 summarizes the numbers of the new graduate nurse participants from the orientation programs.

Two of the respondents completed their orientation program but did not pass the State Board Examinations. Because they did not receive licensure as R. N.'s,

Table 2

Pre- and Post-Orientation Respondents

	Teaching Hospital	Community Hospital	Total
Pre-Orientation Respondents	N = 29	N = 89	N = 118
Completing Orientation Programs	N = 24	N = 83	N = 107
Post-Orientation Respondents	N = 15	N = 50	N = 65
Completion Rate	62%	60%	61%

they were unable to assume the position of staff nurse at the completion of their orientation program. Their post-orientation questionnaires were included in the analyses related to the orientation program and the various program components.

Potential Bias due to Subject Loss

Out of the 118 pre-orientation participants, 107 completed their orientation programs and 65 of those returned their post-orientation questionnaire. Due to such a large group of non-respondents to the follow-up questionnaire, comparisons on all demographic variables were made between this group and those who did respond. A summary of the results including the t test and chi-square analyses are found in Appendices G and H. No significant differences were found between those who completed the pre-orientation questionnaire and those who completed both the pre- and post-orientation questionnaires at the .01 alpha level on any of the demographic variables.

These two groups were also compared on their pre-orientation scores on the Six-Dimension Scale of Nursing Performance. Results of the t test analyses are found in Appendix I. Scores on each of the six dimensions of nursing performance including Leadership, Critical Care, Teaching/Collaboration, Planning/Evaluation, IPR/Communications, and Professional Development were included. No significant differences were found between these two groups at the .01 alpha level on their six pre-orientation nursing performance scores.

Since no significant differences were found on demographic variables or on the six nursing performance scores, it was determined that the 65 new graduates completing both the pre- and post-orientation questionnaires were comparable to the original 118 participants and no bias due to subject loss was present.

Sample of Interest

The demographic characteristics of the 65 graduate nurses responding to the post-orientation questionnaire are summarized in Table 3. Appendix J contains an additional table summarizing the demographic characteristics of the graduate nurses completing the post-orientation questionnaire by individual hospitals.

Graduate nurses who completed the post-orientation questionnaire from the teaching hospitals (N = 15) were compared on all demographic variables with post-orientation respondents from the community hospitals (N = 50). Results of the Chi-square and t-test analyses are summarized in a table in Appendix K. No significant differences were evident between the two groups on any of the demographic variables (α = .01).

Three males were included in the study accounting for 4.6% of the total sample as shown in Table 3. Ages of the new graduates ranged from 21-40 with a mean age of 26.2. Slight differences in the mean age of those in the teaching hospital group (24.3) compared to those in the community hospital group (26.8) could be considered significant at the .05 level (t = -2.02) but not at the .01 level.

Table 3

Demographic Characteristics of New Graduates

Graduate Nurse Characteristics N = 65			
Characteristic	Teaching Hospitals N = 15	Community Hospitals N = 50	Total Sample N = 65
	N %	N %	N %

Sex
  Male
  Female
	1 6.7
	14 93.3
		2 4
		48 96
			3 4.6
			62 95.4

Nursing Education
  Diploma
  ADN
  BSN
	0 0
	4 26.7
	11 73.3
		1 2
		22 44
		27 54
			1 1.5
			26 40.0
			38 58.5

Age
  Range
  Mean
  St. Dev.
	21-32
	24.3
	3.7
		21-40
		26.8
		5.2
			21-40
			26.2
			5.0

Past Hospital Experience
  Mean
  St. Dev.
	1.4
	1.6
		1.5
		1.7
			1.4
			1.7

Exp. at Orient. Hospital
  Mean
  St. Dev.
	.4
	.7
		.3
		.6
			.3
			.6

Exp. at Orient. Hosp.
  None
  Nu Student
  Employee
  Both
	N %
	8 53.3
	0 0
	6 40.0
	1 6.7
		N %
		24 48
		10 20
		13 26
		3 6
			N %
			32 49.2
			10 15.4
			19 29.2
			4 6.2

Only one of the graduate nurses was from a diploma program, while 40%
were from associate degree (A.D.) and 58% were from baccalaureate (B.S.N.)
programs. Close to three quarters of the new graduates in the teaching hospitals had
B.S.N. degrees, while those in the community hospitals were almost evenly divided
between B.S.N. (54%) and A.D. (44%) programs.

About half of the graduates from both the teaching and community hospital
group reported previous work experience at their orientation hospital. Only one of
the graduates from the teaching hospital group, however, reported experience as a
nursing student in that hospital compared to 13 from the community hospital group.

The majority of the participants who have previous hospital experience worked
as nurse aides or nurse externs (see Appendix L). A smaller percentage worked as
nurse technicians, Licensed Practical Nurses (L. P. N.), and ward secretaries. A few
of the participants reported work experience in more than one category. Although
distinctions may be made between the terms and job descriptions of nurse aide, nurse
extern and nurse technician, in each case the individual is working under the
supervision of a registered nurse in giving care to patients. The differences are
primarily in the amount and type of preparation for the job. These three positions
might best be viewed as one category for purposes of this study.

Other positions mentioned by those in the teaching hospital group were
housekeeper, medical specialist in the Army, and medical research technician. Other

positions listed by those in the community hospital group included respiratory therapist, medical technician in the Air Force Reserve, monitor technician, emergency room registrar, nurse's aide in nursing home, attendant for physically handicapped adults, and program assistant.

The majority of the new graduate participants were employed full time (92.3%) on medical-surgical units (86.1%). Five were working on maternity units and four on pediatric units. Most of the graduate nurses reported some previous experience with preceptors (62.6%) with nine of these indicating extensive experience. Extensive experience was described working with a staff nurse designated as a preceptor during virtually every clinical rotation experience in their nursing program rather than with a nursing faculty member.

Other findings related to program components as reported by the new graduates are found in Appendix M. Many of the new graduates reported working with more than one preceptor. The mean number of preceptors in the community hospital programs was slightly more (3.14) than those in the teaching hospitals (2.60). The number of days the new graduates reported spending with preceptors other than their primary preceptor ranged from 1 to 24 days overall with a slightly higher mean (3.92) for those in the community hospitals than those in teaching hospitals (2.26).

Other program components varied widely among the various programs including the number of group sessions attended by the new graduates. The mean

number of sessions attended in Hospital A was 6.9 compared with a mean of 0.8 for graduates in Hospitals C and F. Number of class days ranged from 1 to 50, number of times the graduates were given full work assignments during orientation ranged from 0 to 32, and the length of orientation ranged from 24 to 98 days for all participants.

<div align="center">Preliminary Analyses</div>

New Graduate and Preceptor Evaluations

Potential differences between preceptors in teaching hospitals and those in community hospitals were evaluated. Comparisons were made on the preceptor characteristic evaluation scores obtained from the graduate nurses from teaching hospitals and those in community hospitals. No significant differences were found between the two groups ($\alpha = .05$) (see Appendix N). Comparisons were also made on the preceptor characteristic self-evaluation scores obtained from the preceptors from teaching hospitals and those in community hospitals. Results, found in Appendix N, show no significant differences between the two groups of preceptors ($\alpha = .05$).

Preceptors from teaching hospitals and community hospitals, therefore, were considered to be comparable on teaching, nursing and interpersonal relationship characteristics.

Comparisons were then made on the new graduates' clinical performance

evaluation scores obtained from the preceptors from teaching hospitals and those in

community hospitals. Results, found in Appendix O show no significant differences

between the two groups ($\alpha = .05$).

Pearson's Correlation Coefficients were determined for the paired preceptor

and graduate nurse post-orientation clinical performance scores. There were no

significant correlations in any of the six dimensions of nursing performance (see

Appendix P).

Relationships among Demographic Variables and Clinical Performance

A total of 21 variables selected as potentially useful based on theoretical

considerations were correlated with the six clinical performance scores. Sixteen of

the 21 variables were found to correlate with the dependent variables. These 16

independent variables and the six dependent variables, the post-orientation clinical

evaluation scores by the new graduates, with descriptions are listed in Table 4.

Intercorrelations of all variables are found in Appendix Q.

Correlations of the independent variables with the dependents ranged from .19

to .47. The three variables relating to preceptor skills as measured by the preceptor

evaluation tool (PC1, PC2, and PC3) were found to be highly correlated with one

another and with SUP2 which is a rating of support provided by the preceptor and

Table 4

List of Variables

Dependent Variables

S1   Leadership
S2   Critical Care
S3   Teaching/ Collaboration
S4   Planning/ Evaluation
S5   IPR/ Communication
S6   Professional Development

Independent Variables

SUP 2   Rating of emotional support from primary preceptor
SUP 3   Rating of support from staff nurses
SUP 4   Rating of support from family
SUP 5   Rating of support from non-nurse friends
SUP 6   Rating of support from other new grads
SUP 7   Rating of support from other nurse friends
DAYS P2   Number of days with alternate preceptor
GRPSESS   Number of group sessions attended
HOSP 2   Teaching vs community hospital
NED2   Nursing education preparation
NWRKTIME   Time previously worked in hospital
PC 1   Preceptor skills as Teacher
PC 2   Preceptor skills as Nurse
PC 3   Preceptor skills as Person
PROLE   Combined rating scale of preceptor helping roles
TIMENUST   Time worked in orientation hospital as nursing
             student

PROLE which reflects ways in which the preceptor provided assistance to the new graduate. The r's for these five variables ranged from .66 to .87.

Relationships among Clinical Performance Variables

Correlations were made among the six clinical performance variables obtained from the post-orientation clinical evaluation by the new graduates. Although highly correlated, considering them in separate individual analysis is consistent with the original intent of the instrument (P. M. Schwirian, personal communication, March 6, 1990).

Predictors of Clinical Performance

Preliminary analyses were conducted to assess the data for potential outliers. Scatter plots for all variables and Cook's distance values were evaluated. It was determined that there were no significant outliers that might influence the results of the regression analyses. Multicollinearity was assessed by regressing each group of independent variables associated with each of the six dependents on the remaining predictors. The R^2 values ranged from .0004 to .167.

Manual forced entry regression procedures were performed initially which allowed variables considered to be useful based on theory to be entered first. The results were consistent with automatic stepwise regression analyses performed by the computer which were also performed.

Variables for inclusion in each model were selected based on two criteria: 1) they made theoretical sense, and 2) they correlated with the dependent variable. Additionally, in order to acknowledge the fact that the new graduates had differential entry levels on these clinical performance measures, pre-orientation scores were included first in each model. In this way, any variables additionally contributing to the models can be attributed to program components or other external support variables. Table 5 shows the relevant variables in each model, along with the beta-weights and R^2 values.

In two cases, Leadership and Planning/Evaluation, the pre-orientation scores accounted for a non-significant 1% and 9%, respectively, of post-orientation scores. In the former case, the relevant model included three additional variables to account for 46% of S1, Leadership. In the latter case, four additional variables accounted for 47% of variability in S4, Planning/Evaluation.

SUP7, reflecting support the new graduates received from other nurse friends, and PC2, the rating of preceptor's nursing skills, were in both these models. NWRKTIME, also entered the Leadership model while DAYSP2 and TIMENUST were relevant for the Planning/Evaluation model.

Pre-orientation scores did enter the remaining four models with a significant R^2 ranging from 19% for the Critical Care Scale to 30% for Professional Development.

Table 5
Multiple Regression Report

VARIABLE	r	beta	R^2	ΔR^2	p value
S1: Leadership					
*S1-Pre	.11	.13	.01	.01	.210
SUP 7	.47	.37	.24	.23	.001
PC2	.45	.33	.38	.14	.003
NWRKTIME	-.40	-.29	.46	.08	.009
S2: Critical Care					
S2-Pre	.43	.44	.19	.19	.001
SUP 7	.37	.38	.33	.14	.001
S3: Teaching / Collaboration					
S3-Pre	.50	.35	.25	.25	.003
SUP 7	.34	.31	.36	.11	.005
**TIMENUST	.36	.21	.41	.05	.057
**SUP 2	.42	.21	.44	.03	.060
S4: Planning / Evaluation					
*S4-Pre	.31	.15	.09	.09	.160
PC2	.47	.37	.29	.20	.001
SUP 7	.41	.34	.39	.10	.002
DaysP2	.29	.21	.43	.04	.047
TIMENUST	.24	.21	.47	.04	.040
S5: IPR / Communications					
S5-Pre	.50	.31	.25	.25	.004
SUP 7	.46	.31	.39	.14	.002
SUP 2	.45	.27	.45	.06	.011
NED2	.26	.21	.48	.03	.033
**HOSP2	-.23	-.17	.51	.03	.090
S6: Professional Development					
S6-Pre	.55	.35	.30	.30	.001
PC1	.42	.27	.36	.06	.009
SUP 7	.42	.24	.45	.09	.015
DaysP2	.22	.23	.50	.05	.021
SUP 4	.37	.22	.54	.04	.026

* p > .10 (NS)   ** p < .10   Remaining Variables p < .05

SUP7 proved to be a relevant variable in each of these cases, as in the first two models, but PC2 was not.

In all but S2, Critical Care, these models accounted for about 50% of the variability in the dependents. For S2, only SUP7 entered the model after the pretest for a total R^2 of 33%.

Subscales S3, S5, and S6

The R^2 values ranged from .44 to .54 for the remaining subscales. Support from other nurse friends, SUP7, was found to be the most useful variable overall, appearing in all six models.

Other useful variables for subscales S3, S5, and S6 were SUP2 and PC1. Both of these variables relate to the primary preceptor. PC1 is the rating on teaching skills as measured by the Preceptor Characteristics Tool while SUP2 reflects a rating of the emotional support the preceptor gave the graduate nurse during the orientation period.

In all the regression models, substituting PC1, PC2 and/or SUP2 only changed the total R^2 slightly. This indicates that these three variables, all related to the preceptors' skills or support, were very similar in their ability to explain the dependent variables.

Other Useful Predictors

TIMENUST, which indicates the total amount of time the graduate nurse spent as a nursing student at that orientation hospital before graduation, was a useful predictor for both the Teaching/Collaboration and Planning/Evaluation models.

The variable, NWRKTIME, reflected the total amount of time the new graduate previously worked in a hospital in roles such as nursing assistants or L. P. N.'s. This variable, however, had a negative correlation, indicating that the longer the work experience, the lower the graduate rated their clinical performance in the area of Leadership.

The variable, DAYSP2, indicates the number of days the graduates spent with one or more alternate preceptors. The positive correlation indicates that those who worked more days with an alternate preceptor rated themselves higher in the areas of Planning/Evaluation and Professional Development.

NED2 indicates that basic nursing educational preparation the graduate nurse received. Since this variable was dummy coded, the positive correlation indicates that the baccalaureate graduates rated themselves higher on the IPR/Communications subscale. This subscale was the only one in which this variable was found to be useful.

HOSP2 reflects whether the new graduate participated in an orientation program in a teaching or community hospital. Those in the community hospital programs rated themselves higher on the IPR/Communications subscale.

The variable, SUP4, reflects the emotional support received from the family. It was only found in the model for Professional Development, which measures personal responsibility, being self-directed, having a positive attitude, as well as knowledge of ethical and legal aspects of nursing.

The variable, GRPSESS, which reflects the number of support group sessions attended, while correlating ($r = -.27$) with S5, IPR/Communications dimension, did not prove to be a useful predictor. This variable was found to have a negative correlation with all performance dimensions except Leadership. The negative correlation indicates that those graduate nurses attending a higher number of group sessions rated themselves lower in all areas of clinical performance except Leadership.

Additional Findings

The graduate nurses were asked to indicate how their preceptor was most helpful in making the transition from student to staff nurse. The responses covered all aspects of the teaching, nursing, and interpersonal relationship skills of the preceptor. The largest number of new graduates (38%) responded that the excellent

nursing skills of their preceptor were helpful while 25% indicated a combination of excellent teaching and interpersonal relationship skills.

The graduate nurses additionally indicated whether they intended to continue working at that hospital for less than a year or more than a year. They were also asked to indicate whether this intention was based on their orientation experiences or other reasons, such as returning for further education or plans to move. The majority (86%) indicated that they planned to continue working for more than a year, 11% planned to work less than a year at that hospital, and 3% were undecided. Of those indicating they would likely work less than a year, two individuals identified orientation experiences and one identified experiences occurring after orientation as the reason for leaving. The other four cited personal reasons for their decision to work less than a year at that hospital.

Summary

Descriptive and inferential statistical findings were presented in this chapter. Although the original research question was no longer appropriate due to changes in the design, the primary focus of the study was addressed. Relationships between new graduates' self evaluation of clinical performance, demographics and components of the orientation programs were explored.

No significant differences were found in preliminary analyses comparing new graduates in teaching hospital and community hospital orientation programs on

demographic variables. Regression analyses were then performed on all pertinent independent variables for each of the six dependent variables. Results of the multiple regression analyses were presented and useful predictors for all six dimensions on nursing performance were identified. Preceptor skills and emotional support provided by the preceptor were included in the useful predictors, while attendance at formal group support sessions was not.

Additional findings indicated that excellent skills of the preceptor in teaching and interpersonal relationships were identified by a majority of graduates as most helpful. A large majority of graduate nurses also indicated their intention to continue working at their orientation hospital.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The problem addressed in this study was related to the need to provide

orientation programs that assist new graduate nurses in assuming the role of staff

nurse as quickly and effectively as possible to alleviate staff shortages. Currently,

programs providing preceptors for the graduate nurses are most commonly used in the

Northern Virginia area. The purpose of this study was to determine relationships in

self-evaluations of clinical performance by new graduate nurses participating in six

preceptor orientation programs with program components and new graduate

characteristics. Some of the orientation programs offered various amounts of support

through formal support groups while the others offered no formal support groups.

The focus of the study was on specified components of the programs including

preceptor skills and participation in formal support groups. The main research

question addressed was

What variables are related to positive evaluations of clinical performance

by new graduate nurses?

Summary

Six preceptor orientation programs offered by hospitals in the Baltimore, Md.

and Washington, D.C. metropolitan areas, including Northern Virginia, provided the

setting for this study. Classroom and clinical experiences with a preceptor were

provided for the new graduates. Regularly scheduled support group sessions were

also provided for some of the participants. A total of 118 new graduates participating in these six programs completed the pre-orientation questionnaire. Of these, 107 completed the full orientation program while 65 graduates returned the post-orientation questionnaires.

The 65 new graduate nurses provided demographic information and also evaluated their post-orientation clinical performance using the Schwirian 6 Dimension Scale of Nursing Performance. This tool measured nursing skills in six different areas; Leadership, Critical Care, Teaching/Collaboration, Planning /Evaluation, IPR/Communications, and Professional Development. The new graduates and their preceptors completed the Preceptor Characteristics Evaluation Tool which rated the preceptors on teaching, nursing, and interpersonal skills.

Preliminary analyses on all demographic variables revealed no significant differences between the new graduates in teaching hospital and community hospital orientation programs. The two groups were, therefore, combined into one group for further analyses.

Variables that correlated highly with the six individual subscales of the Schwirian 6 Dimension Scale were entered into multiple regression analyses. A total of 11 variables were identified as useful predictors of post-orientation clinical performance scores beyond the explanation provided by the corresponding pre-

orientation scores. The pre-orientation scores for the Leadership and Planning/Evaluation dimensions were found to be non-significant.

The most useful variable, a rating of the support provided by other nurse friends, ranked as either the first or second most powerful predictor for all six dimensions of clinical performance.

Another group of useful predictors for all dimensions of clinical performance except Critical Care were related to the primary preceptor. These variables reflect the emotional support provided by the preceptor as well as preceptors' nursing skills and teaching skills. Graduate nurses giving their preceptors high ratings in these three areas in turn rated their own clinical performances higher. Those new graduates reporting greater amounts of time spent with an alternate preceptor rated themselves higher in the areas of Planning/Evaluation and Professional Development.

Another useful predictor for the nursing dimension Planning/Evaluation was the total amount of time the graduate nurse spent as a nursing student at that orientation hospital before graduation. It also was marginally useful as a predictor for Teaching/Collaboration.

The variable reflecting the basic nursing educational preparation the graduate received was a useful predictor for the nursing dimension of IPR/Communications. Baccalaureate graduates rated themselves higher on this nursing dimension than the associate degree graduates.

The variable reflecting type of hospital was marginally useful as a predictor on only one dimension of nursing performance. Graduates from the community hospital programs rated themselves higher on the IPR/Communications subscale than those from teaching hospitals.

New graduates indicating helpful support from the family rated themselves higher on Professional Development. This dimension of nursing performance is concerned with personal responsibility, being self-directed, having a positive attitude, as well as knowledge of ethical and legal aspects of nursing.

The total amount of time new graduates previously worked in a hospital, as nursing assistants or L. P. N.'s was useful as a predictor for Leadership. This variable, however, had a negative correlation, indicating that the longer the work experience, the lower the graduate rated their clinical performance in that area.

While three variables were identified as predictors for Leadership, the low reliability score for this subscale makes their usefulness questionable. Similarly, while one variable was identified as a predictor for Critical Care, which deals with technical skills, emergency care, and working with dying patients, its usefulness is limited as the predictive power is very low.

Significant by their absence are the many other variables that were considered to be potentially important prior to the multiple regression analyses. These variables included age, number of days in the classroom, length of time in orientation, previous

experience with preceptors and the number of group sessions attended. These variables did not correlate highly with the six independent variables and therefore were not useful as predictors.

The variable reflecting the number of group sessions attended was found to correlate negatively with all the subscales of the dependent variable except Leadership. Graduate nurses attending a higher number of group sessions, therefore, rated themselves lower in all areas of clinical performance except Leadership.

Conclusions

The emotional support new graduates received from their nurse friends other than preceptor or staff nurses they work with or other new graduates in that orientation program was strong. These nurse friends are most likely classmates from their nursing education program. The new graduates enter their new job with these relationships in place which then apparently serve as a major source of emotional support for the graduates as they move through their orientation period. The findings indicate that support from these friends is perhaps stronger and certainly more pervasive than the support from their preceptor or other individuals.

The three variables related to emotional support received from the preceptor and their teaching and nursing skills were comparable in their usefulness as predictors. Substituting one of these variables for any of the others only slightly affected the results of the regression analyses. Whether preceptors were highly rated

on their nursing or teaching skills or on the emotional support they provided, the positive relationship they shared with the new graduate appeared to influence clinical performance scores more than any other variable related to the components of the orientation programs.

New graduates reporting greater amounts of time working with alternate preceptors rated themselves higher in the areas of Planning and Professional Development. Most programs reported an attempt to ensure that new graduates work closely with only one preceptor and have limited periods with alternate preceptors. The rationale for this practice, based on the underlying concept of precepting, is that a close one-to-one relationship with an experienced nurse will enhance learning and foster the role adaptation and socialization of the new graduate (Shamian & Inhaber, 1985). The findings reported by Giles and Moran (1989) support the practice of pairing one orientee with one preceptor for the entire orientation period. The findings in this study, however, appear to indicate that the additional experience with one or more other preceptors may provide opportunities to learn different ways to plan and evaluate their care. Graduate nurses also apparently gain from the close relationship with more than one preceptor in the area of Professional Development, which deals with personal responsibility, accepting constructive criticism and maintaining high standards of practice. Perhaps receiving feedback from more than one person assisted them in developing a more confident attitude toward their own professionalism.

New graduates with longer previous clinical experience as nursing students at the hospital where they are now employed as an R. N. rated themselves higher in the areas of Teaching, Planning and Evaluation. Skills in teaching, planning, and evaluation may require a period of time for graduate nurses to develop. Their previous clinical experience as nursing students at that hospital, therefore, may have allowed them to feel more confident about the policies, procedures, and expectations of the work place so that they in turn rated themselves higher on their performance in those areas of nursing practice. They may have been able to progress faster than those without previous experience at this point. It is possible that other graduates may soon catch up and perhaps will even surpass those with experience as nursing students in the orientation hospital.

New graduates reporting longer periods of previous hospital work experience rated themselves lower in the area of Leadership. This negative correlation might indicate that the longer period of time they worked as a nursing assistant or L.P.N.'s somehow led them to develop negative perceptions of their skills and question their ability to move up in the system. They may have sensed higher expectations by the head nurse or other staff nurses based on their previous work experience. When in the new role as a graduate nurse, perhaps it was more difficult to feel confidant that they could assume the responsibilities and function as a professional nurse and leader.

The baccalaureate graduates rated themselves higher in the area of

IPR/Communications than the associate degree graduates. Some aspect of the baccalaureate nursing programs may account for a higher degree of confidence in their communication skills. The specialized communication skills utilized by nurses tend to be more abstract than others such as technical skills, therefore, requiring time and practice to develop. Four years of education including both nursing and general courses as opposed to two years provides more opportunities to assume the role of professional nurse as a communicator.

Another predictor for the IPR/Communications dimension was type of hospital program. Those in the community hospital programs rated themselves higher on this subscale. Perhaps the personality type of the graduate nurses who seek employment in a community hospital as opposed to a teaching hospital accounts for this difference. Those graduates with more positive skills or greater confidence in their communication skills may be attracted to the community hospital setting. Another possibility is that there may be factors in the work environment in community hospitals that account for this difference. The new graduates may receive more positive feedback and respect as nurses and members of the health team, and possibly more nurturing in their new role by other staff members.

There is also a possibility that factors related to the work environment in the teaching hospital may account for this finding. The graduates in the teaching hospitals may have had more difficulty with this skill because of the complexities and

frustrations associated with the system of health care delivery in that setting. Nurses communicate daily not only with patients and other nurses but also with various levels of medical personnel with new graduate nurses assuming a low position within that hierarchy. Communication with physicians about patient's needs and medical treatment is particularly complex and frustrating in a teaching hospital setting. If they had difficulties in managing this complex system it might have affected their view of their ability to communicate effectively with others.

New graduates indicating strong support from their family rated themselves higher in Professional Development. This dimension is concerned with personal responsibility, being self-directed, having a positive attitude, as well as knowledge of ethical and legal aspects of nursing. Perhaps the family, recognized by many as important in the development of personal values, has an important impact on these areas of professional behavior and prepares the new nurse for the expectations of the work environment.

The Critical Care section of the tool dealt with technical skills, emergency care, and working with dying patients. Only one variable considered in this study showed evidence of any relationship with the Critical Care dimension of nursing. Attendance at special classes and skills lab provided in the orientation programs to assist new graduates with technical skills and in caring for critically ill patients did not correlate with this subscale. Perhaps the new graduates had few or no

opportunities during the orientation period to develop these skills and thus were not confident in their abilities.

The pre-orientation clinical performance scores provided additional explanatory information about four of the six nursing dimensions. The scores for Leadership and Planning/Evaluation, however, were not significant. It is possible that the new graduates were not confident in their skills in these areas at the beginning of the orientation program. The other variables related to these two dimensions did provide useful predictive information about the post-orientation scores. This may indicate that the orientation program components and outside support had more impact on the leadership, planning and evaluation skills of the new graduates than those in any of the other dimensions.

Graduates reporting a greater number of group sessions attended rated themselves lower on all dimensions of nursing. This negative correlation indicates that for some reason the group did not function in the way that theory would lead us to anticipate. Support groups are formed to help the participants in identifying their difficulties, alleviating anxieties, recognizing that others are experiencing similar problems, and developing new ways of coping (Caplan and Killilea, 1976; Rosenberg, 1984,).

The group sessions may have become problem focused rather than solution focused. Perhaps the more sessions the participants attended led only to further

discussion of problems with no movement toward solutions. It may have been that with more knowledge and awareness of problems in practice, the graduates became more conscious of their own lack of knowledge leading to doubts that they would be able to make a difference, make changes, or even be effective.

Groups are generally voluntary in nature and emphasis is placed on development of group cohesiveness which requires regular attendance of all members (Rosenberg, 1984). The varying number of sessions attended as reported by the new graduates and several comments as to work schedule conflicts interfering with attendance may provide an explanation for this finding. The erratic attendance patterns and widely varying number of sessions reported may have influenced the development and progress of the different groups.

The participants may not have fully invested their energy into the group. They may not have viewed the group sessions as helpful in meeting their particular needs. Perhaps the agenda or goals presented by the leader were perceived as different from those of the group members. They may not have had time to feel comfortable with the other new graduates in the group which is essential to group cohesiveness.

Another possibility is that the new graduates had strong support systems already in place, from other nurse friends, and had no strong need to contribute to the group. Attending required group sessions with strangers may have been perceived as another meeting to attend that kept them from activities considered more important.

They may have decided that their energies were best spent in developing relationships with their preceptor and other personnel on the unit where they were working.

The findings reported in available research studies on the effectiveness of preceptor programs for new graduates or nursing students are inconclusive. Some of the studies report significant differences in clinical performance by those working with a preceptor while others report no differences. Scheetz (1989) suggests that factors other than the preceptor may be accounting for some of the differences. This study found that preceptor skills and support from the preceptor were useful predictors of new graduates' positive clinical performance scores. Variables other than the preceptor were found to be useful predictors as suggested by Scheetz. These included outside support from other nurse friends and family as well as various program components and new graduate characteristics.

<u>Recommendations for Practice</u>

The following recommendations were developed based on the findings and conclusions of this study.

Hospitals offering orientation programs for new graduates should recognize that relationships providing emotional support are most likely in place before they enter an orientation program. Offering formal support groups, therefore, may not necessarily provide strong support to some individuals but should serve as a bridge to developing new support systems within the work setting. While not based on findings

from this study, it may be helpful for hospitals to consider the following if a decision is made to continue offering formal support groups. The focus and goals of support groups should be examined and clearly stated. Group sessions should be scheduled so that all members are able to attend. Leaders should be carefully selected and experienced in group work. Offering support groups that are unit based might be more helpful so that the new graduates are forming relationships with nurses with whom they will be working.

Educators in nursing education programs also need to be aware of the findings related to support from other nurse friends. Some nursing students may need encouragement and assistance in developing relationships with classmates.

The support provided by the preceptor as well as the preceptor's skills are important components of the orientation program. The selection process of preceptors should include objective measures of their teaching, nursing and interpersonal relationship skills. Preceptor preparation courses should be required and should include topics designed to assist the experienced R. N.'s in working with new graduates. Potential alternate preceptors should undergo the same selection process and receive the same preparation as the primary preceptors.

Because prior experience as a nursing student in the workplace was found to have been helpful, the hospitals should consider increasing their efforts to recruit nursing students who have their clinical experiences in their agency. They should

also monitor all aspects of the educational experiences nursing students receive in their institution and make every effort to ensure these experiences are positive.

Based on the finding that new graduates with longer periods of previous hospital work experience rated themselves lower in several areas of clinical performance, these individuals should be identified early in the orientation period. They should undergo an assessment of their individual needs and receive special assistance during the orientation period regarding socialization to their new role as staff nurse when indicated.

Recommendations for Future Research

Two major recommendations for future research are:

The relationship of other aspects associated with preceptors and new graduates' clinical performance evaluations should be further investigated. Variables such as preceptors' education, age, years of work experience, years of experience as a preceptor, participation in a preceptor preparation course among others should be considered.

The negative relationship between participation in support groups and clinical performance self-evaluation scores found in this study should be further explored.

Other recommendations for future research include assessing the relationship of self-esteem on new graduate nurses' self-evaluation of nursing performance.

Identifying those new graduates with high self-esteem may provide additional predictive information about clinical performance evaluation scores.

Further study of the possible lack of preparation of new graduates in the areas of leadership, planning and evaluation should be undertaken. Assessing the amount and type of experiences in these areas the graduates experienced in formal education programs as well as during the orientation programs is suggested.

Further investigation of the relationship between previous experience at the orientation hospital as nursing students with clinical performance scores is suggested as well as determining whether any differences persist over a period of time.

Additional information about the negative relationship between previous hospital work experience and clinical performance scores is needed in further understanding this finding.

Further investigation of the effects on graduate nurse clinical performance evaluations of working with more than one preceptor during the orientation period is recommended.

The relationship between hospital setting and clinical performance, particularly the IPR/Communications dimension, should be investigated further. Variables including the type of agency, goals, and factors in the work environment are suggested for further study.

Other factors that may be related to skills in the Critical Care dimension such as measures of manual dexterity and experiences as a nursing student as well as during the orientation period with critically ill or dying patients should be investigated in future studies.

In summary, these recommendations for future research would help to further define the major findings from this study. The most useful predictor for all six dimensions of nursing performance was the support provided by other nurse friends. Preceptor skills and emotional support from the preceptor were also useful predictors. Participation in formal support group sessions, however, was not found to be a useful predictor.

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Appendix A

Six-Dimension Scale of Nursing Performance

Pre-Orientation by New Graduate

Post-Orientation by New Graduate

Post-Orientation by Preceptor

INSTRUCTIONS

Please fill in the information requested below.

After assigning a participant number to your forms, this sheet will be detached and kept in a separate file accessible only to me. All of the forms you complete as part of this study as well as the forms returned by other nurse participants will be identified by that number only.

New Graduate Name: _____

Hospital Name:_____

Unit where you are working: _____
(during orientation period)

Pre-Orientation
New Graduate
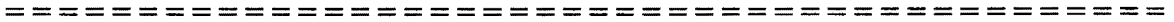
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Six Dimension Scale of Nursing Performance

Section I: Performance of Nursing Behaviors

Instructions: This section contains a list of activities in which nurses engage with varying degrees of frequency and skill.

Please circle the number that best indicates how well you feel you can perform these activities as you begin this orientation program using the following scale:

Scale:
0 Not applicable
1 Minimal
2 Limited
3 Fair
4 Good
5 Excellent

1. Teach a patient's family member about the patients' needs.   0 1 2 3 4 5

2. Coordinate the plan of nursing care with the medical plan of care.   0 1 2 3 4 5

3. Give praise and recognition for achievement to those under your direction.   0 1 2 3 4 5

4. Teach preventive health measures to patients and their families.   0 1 2 3 4 5

5. Identify and use community resources in developing a plan of care for a patient and his/her family.   0 1 2 3 4 5

6. Identify and include in nursing care plans anticipated changes in patient's condition.   0 1 2 3 4 5

7. Evaluate results of nursing care.   0 1 2 3 4 5

Scale:
0 Not applicable
1 Minimal
2 Limited
3 Fair
4 Good
5 Excellent

8. Promote the inclusion of the patient's decisions
    and desires concerning his/her care.   0 1 2 3 4 5

9. Develop plan of nursing care for a patient.   0 1 2 3 4 5

10. Initiate planning and evaluation of nursing care
    with others.   0 1 2 3 4 5

11. Perform technical procedures:
    e.g. oral suctioning, tracheostomy care,
    intravenous therapy, catheter care, dressing
    changes, etc.   0 1 2 3 4 5

12. Adapt teaching methods and materials to the
    understanding of the particular audience;
    e.g., age of patient, educational background,
    and sensory deprivation.   0 1 2 3 4 5

13. Identify and include immediate patient needs
    in the plan of nursing care.   0 1 2 3 4 5

14. Develop innovative methods and materials for
    teaching patients.   0 1 2 3 4 5

15. Communicate a feeling of acceptance of each
    patient and a concern for the patient's welfare.   0 1 2 3 4 5

16. Seek assistance when necessary.   0 1 2 3 4 5

17. Help a patient communicate with others.   0 1 2 3 4 5

18. Use mechanical devices: e.g., suction machine,
    Gomco, cardiac monitor,respirator, etc.   0 1 2 3 4 5

19. Give emotional support to family of dying patient.   0 1 2 3 4 5

Scale:
0 Not applicable
1 Minimal
2 Limited
3 Fair
4 Good
5 Excellent

20. Verbally communicate facts, ideas, and feelings
    to other health team members.   0 1 2 3 4 5

21. Promote the patient's right to privacy.   0 1 2 3 4 5

22. Contribute to an atmosphere of mutual trust,
    acceptance, and respect among other health
    team members.   0 1 2 3 4 5

23. Delegate responsibility for care based on
    assessment of priorities of nursing care needs
    and the abilities and limitations of available
    health care personnel.   0 1 2 3 4 5

24. Explain nursing procedures to a patient prior
    to performing them.   0 1 2 3 4 5

25. Guide other health team members in planning
    for nursing care.   0 1 2 3 4 5

26. Accept responsibility for the level of care
    provided by those under your direction.   0 1 2 3 4 5

27. Perform appropriate measures in emergency
    situations.   0 1 2 3 4 5

28. Promote use of interdisciplinary resource persons.   0 1 2 3 4 5

29. Use teaching aids and resource materials in
    teaching patients and their families.   0 1 2 3 4 5

30. Perform nursing care required by critically
    ill patients.   0 1 2 3 4 5

31. Encourage the family to participate in the
    care of the patient.   0 1 2 3 4 5

32. Identify and use resources within your health
care agency in developing a plan of care for
a patient and his/her family.   0 1 2 3 4 5

33. Use nursing procedures as opportunities for
interaction with patients.   0 1 2 3 4 5

34. Contribute to productive working relationships
with other health team members.   0 1 2 3 4 5

35. Help a patient meet his/her emotional needs.   0 1 2 3 4 5

36. Contribute to the plan of nursing care for
the patient.   0 1 2 3 4 5

37. Recognize and meet the emotional needs of a
dying patient.   0 1 2 3 4 5

38. Communicate facts, ideas, and professional
opinions in writing to patients and their
families.   0 1 2 3 4 5

39. Plan for the integration of patient needs with
family needs.   0 1 2 3 4 5

40. Function calmly and competently in emergency
situations.   0 1 2 3 4 5

41. Remain open to the suggestions of those under
your direction and use them when appropriate.   0 1 2 3 4 5

42. Use opportunities for patient teaching when
they arise.   0 1 2 3 4 5

Section II. <u>Performance of Professional Development Behaviors</u>

Instructions: Please circle the number that best describes the frequency with which you have engaged in the following behaviors before beginning this orientation.

Scale:
0 Not applicable
1 Never
2 Seldom
3 Occasionally
4 Frequently
5 Consistently

1.	Use learning opportunities for on-going personal and professional growth.	0 1 2 3 4 5
2.	Display self-direction.	0 1 2 3 4 5
3.	Accept responsibility for own actions.	0 1 2 3 4 5
4.	Assume new responsibilities within the limits of capabilities.	0 1 2 3 4 5
5.	Maintain high standards of self-performance.	0 1 2 3 4 5
6.	Demonstrate self-confidence.	0 1 2 3 4 5
7.	Display a generally positive attitude.	0 1 2 3 4 5
8.	Demonstrate knowledge of the legal boundaries of nursing.	0 1 2 3 4 5
9.	Demonstrate knowledge of the ethics of nursing.	0 1 2 3 4 5
10.	Accept and use constructive criticism.	0 1 2 3 4 5

INSTRUCTIONS

PLEASE FILL IN THE INFORMATION REQUESTED BELOW.

After assigning a participant number to your forms, this sheet will be detached and kept in a separate file accessible only to me. All of the forms you complete as part of this study as well as the forms returned by other nurse participants will be identified by that number only.

New Graduate Name: _____

Hospital Name: _____ Unit: _____

<u>Date</u> you started working as graduate nurse: _____

Please identify the <u>preceptor</u> with whom you have been working and your <u>head nurse</u> who are best able to evaluate your performance at this time and the <u>unit</u> on which they are currently working.

Preceptor:_____

Unit:_____

Head Nurse:_____

Unit:_____

PLEASE FILL OUT ENCLOSED FORMS AND RETURN IN ENVELOPE PROVIDED:

1. New Graduate Post Orientation Data Sheet
2. <u>Six Dimension Scale of Nursing Performance</u>
3. <u>Preceptor Characteristics</u> (this tool relates to your preceptor)

Number _____

Post-Orientation
New Graduate
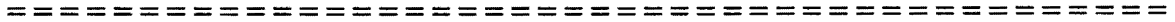
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Six Dimension Scale of Nursing Performance

Section I: Performance of Nursing Behaviors

Instructions: This section contains a list of activities in which nurses engage with varying degrees of frequency and skill.

Please circle the number that best indicates how well you feel you can perform these activities upon completion of this orientation program using the following scale:

Scale:
0 Not applicable
1 Minimal
2 Limited
3 Fair
4 Good
5 Excellent

1. Teach a patient's family member about the
    patients' needs.   0 1 2 3 4 5

2. Coordinate the plan of nursing care with the
    medical plan of care.   0 1 2 3 4 5

3. Give praise and recognition for achievement to
    those under your direction.   0 1 2 3 4 5

4. Teach preventive health measures to patients
    and their families.   0 1 2 3 4 5

5. Identify and use community resources in developing
    a plan of care for a patient and his/her family.   0 1 2 3 4 5

6. Identify and include in nursing care plans
    anticipated changes in patient's condition.   0 1 2 3 4 5

7. Evaluate results of nursing care.   0 1 2 3 4 5

Scale:
0 Not applicable
1 Minimal
2 Limited
3 Fair
4 Good
5 Excellent

8.   Promote the inclusion of the patient's decisions and desires concerning his/her care.   0 1 2 3 4 5

9.   Develop plan of nursing care for a patient.   0 1 2 3 4 5

10.   Initiate planning and evaluation of nursing care with others.   0 1 2 3 4 5

11.   Perform technical procedures: e.g. oral suctioning, tracheostomy care, intravenous therapy, catheter care, dressing changes, etc.   0 1 2 3 4 5

12.   Adapt teaching methods and materials to the understanding of the particular audience; e.g., age of patient, educational background, and sensory deprivation.   0 1 2 3 4 5

13.   Identify and include immediate patient needs in the plan of nursing care.   0 1 2 3 4 5

14.   Develop innovative methods and materials for teaching patients.   0 1 2 3 4 5

15.   Communicate a feeling of acceptance of each patient and a concern for the patient's welfare.   0 1 2 3 4 5

16.   Seek assistance when necessary.   0 1 2 3 4 5

17.   Help a patient communicate with others.   0 1 2 3 4 5

18.   Use mechanical devices: e.g., suction machine, Gomco, cardiac monitor, respirator, etc.   0 1 2 3 4 5

19.   Give emotional support to family of dying patient.   0 1 2 3 4 5

Scale:
0 Not applicable
1 Minimal
2 Limited
3 Fair
4 Good
5 Excellent

20. Verbally communicate facts, ideas, and feelings
to other health team members.   0 1 2 3 4 5

21. Promote the patient's right to privacy.   0 1 2 3 4 5

22. Contribute to an atmosphere of mutual trust,
acceptance, and respect among other health
team members.   0 1 2 3 4 5

23. Delegate responsibility for care based on
assessment of priorities of nursing care
needs and the abilities and limitations of
available health care personnel.   0 1 2 3 4 5

24. Explain nursing procedures to a patient prior
to performing them.   0 1 2 3 4 5

25. Guide other health team members in planning
for nursing care.   0 1 2 3 4 5

26. Accept responsibility for the level of care
provided by those under your direction.   0 1 2 3 4 5

27. Perform appropriate measures in emergency
situations.   0 1 2 3 4 5

28. Promote use of interdisciplinary resource persons.   0 1 2 3 4 5

29. Use teaching aids and resource materials
in teaching patients and their families.   0 1 2 3 4 5

30. Perform nursing care required by critically
ill patients.   0 1 2 3 4 5

31. Encourage the family to participate in the
care of the patient.   0 1 2 3 4 5

Scale:
0 Not applicable
1 Minimal
2 Limited
3 Fair
4 Good
5 Excellent

32. Identify and use resources within your health
     care agency in developing a plan of care for a
     patient and his/her family.   0 1 2 3 4 5

33. Use nursing procedures as opportunities for
     interaction with patients.   0 1 2 3 4 5

34. Contribute to productive working relationships
     with other health team members.   0 1 2 3 4 5

35. Help a patient meet his/her emotional needs.   0 1 2 3 4 5

36. Contribute to the plan of nursing care for
     the patient.   0 1 2 3 4 5

37. Recognize and meet the emotional needs of a
     dying patient.   0 1 2 3 4 5

38. Communicate facts, ideas, and professional
     opinions in writing to patients and their families. 0 1 2 3 4 5

39. Plan for the integration of patient needs with
     family needs.   0 1 2 3 4 5

40. Function calmly and competently in emergency
     situations.   0 1 2 3 4 5

41. Remain open to the suggestions of those under
     your direction and use them when appropriate.   0 1 2 3 4 5

42. Use opportunities for patient teaching when
     they arise.   0 1 2 3 4 5

Section II. Performance of Professional Development Behaviors

Instructions: Please circle the number that best describes the frequency with which you have engaged in the following behaviors during this orientation.

Scale:
0 Not applicable
1 Never
2 Seldom
3 Occasionally
4 Frequently
5 Consistently

1.   Use learning opportunities for on-going personal
     and professional growth.   0 1 2 3 4 5

2.   Display self-direction.   0 1 2 3 4 5

3.   Accept responsibility for own actions.   0 1 2 3 4 5

4.   Assume new responsibilities within the limits
     of capabilities.   0 1 2 3 4 5

5.   Maintain high standards of self-performance.   0 1 2 3 4 5

6.   Demonstrate self-confidence.   0 1 2 3 4 5

7.   Display a generally positive attitude.   0 1 2 3 4 5

8.   Demonstrate knowledge of the legal boundaries
     of nursing.   0 1 2 3 4 5

9.   Demonstrate knowledge of the ethics of nursing.   0 1 2 3 4 5

10. Accept and use constructive criticism.   0 1 2 3 4 5

INSTRUCTIONS

Dear Preceptor,

You will be evaluating the new graduate whose name is listed below.

PLEASE NOTE: I have assigned a participant number to your forms.
You may detach this sheet after completing the forms prior to mailing them back to me if you wish. All of the forms you complete as part of this study as well as the forms returned by other nurse participants will be identified by code number.

New Graduate Name: _____

Hospital Name:_____

Unit:_____

PLEASE FILL OUT ENCLOSED FORMS AND RETURN IN ENVELOPE PROVIDED:

1. Six Dimension Scale of Nursing Peformance (this tool relates to the new graduate).

2. Preceptor Characteristics (this tool relates to your skills).

3. Preceptor Data Sheet.

4. Consent Form. (Please sign and return to me.)

Number _____

Post-Orientation
Preceptor

===

Six Dimension Scale of Nursing Performance

Section I: Performance of Nursing Behaviors

Instructions: This section contains a list of activities in which nurses engage with varying degrees of frequency and skill.

Please circle the number that best indicates how well the graduate nurse performs these activities using the following scale:

Scale:
0 Not applicable
1 Minimal
2 Limited
3 Fair
4 Good
5 Excellent

1. Teaches a patient's family member about the patients' needs.

    0 1 2 3 4 5

2. Coordinates the plan of nursing care with the medical plan of care.

    0 1 2 3 4 5

3. Gives praise and recognition for achievement to those under his/her direction.

    0 1 2 3 4 5

4. Teaches preventive health measures to patients and their families.

    0 1 2 3 4 5

5. Identifies and uses community resources in developing plan of care for patient and family.

    0 1 2 3 4 5

6. Identifies and includes in nursing care plans anticipated changes in patient's condition.

    0 1 2 3 4 5

7. Evaluates results of nursing care.

    0 1 2 3 4 5

Scale:
0 Not applicable
1 Minimal
2 Limited
3 Fair
4 Good
5 Excellent

8. Promotes the inclusion of the patient's decisions and desires concerning his care.

0 1 2 3 4 5

9. Develops a plan of nursing care for a patient.

0 1 2 3 4 5

10. Initiates planning and evaluation of nursing care with others.

0 1 2 3 4 5

11. Performs technical procedures: e.g. oral suctioning, tracheostomy care, intravenous therapy, catheter care, dressing changes, etc.

0 1 2 3 4 5

12. Adapts teaching methods and materials to the understanding of the particular audience; e.g., age of patient, educational background, and sensory deprivation.

0 1 2 3 4 5

13. Identifies and includes immediate patient needs in the plan of nursing care.

0 1 2 3 4 5

14. Develops innovative methods and materials for teaching patients.

0 1 2 3 4 5

15. Communicates a feeling of acceptance of each patient and a concern for the patient's welfare.

0 1 2 3 4 5

16. Seeks assistance when necessary.

0 1 2 3 4 5

17. Helps a patient communicate with others.

0 1 2 3 4 5

18. Uses mechanical devices: e.g., suction machine, Gomco, cardiac monitor, respirator, etc.

0 1 2 3 4 5

19. Gives emotional support to family of dying patient.

0 1 2 3 4 5

Scale:
0 Not applicable
1 Minimal
2 Limited
3 Fair
4 Good
5 Excellent

20. Verbally communicates facts, ideas, and feelings to other health team members.   0 1 2 3 4 5

21. Promotes the patient's right to privacy.   0 1 2 3 4 5

22. Contributes to an atmosphere of mutual trust, acceptance, and respect among other health team members.   0 1 2 3 4 5

23. Delegates responsibility for care based on assessment of priorities of nursing care needs and the abilities and limitations of available health care personnel.   0 1 2 3 4 5

24. Explains nursing procedures to a patient prior to performing them.   0 1 2 3 4 5

25. Guides other health team members in planning for nursing care.   0 1 2 3 4 5

26. Accepts responsibility for the level of care provided by those under his/her direction.   0 1 2 3 4 5

27. Performs appropriate measures in emergency situations.   0 1 2 3 4 5

28. Promotes use of interdisciplinary resource persons.   0 1 2 3 4 5

29. Uses teaching aids and resource materials in teaching patients and their families.   0 1 2 3 4 5

30. Performs nursing care required by critically ill patients.   0 1 2 3 4 5

31. Encourages the family to participate in the care of the patient.   0 1 2 3 4 5

Scale:
0 Not applicable
1 Minimal
2 Limited
3 Fair
4 Good
5 Excellent

32. Identifies and uses resources within your health care agency in developing a plan of care for a patient and his family.   0 1 2 3 4 5

33. Uses nursing procedures as opportunities for interaction with patients.   0 1 2 3 4 5

34. Contributes to productive working relationships with other health team members.   0 1 2 3 4 5

35. Helps a patient meet his/ her emotional needs.   0 1 2 3 4 5

36. Contributes to the plan of nursing care for the patient.   0 1 2 3 4 5

37. Recognizes and meets the emotional needs of a dying patient.   0 1 2 3 4 5

38. Communicates facts, ideas, and professional opinions in writing to patients and their families.   0 1 2 3 4 5

39. Plans for the integration of patient needs with family needs.   0 1 2 3 4 5

40. Functions calmly and competently in emergency situations.   0 1 2 3 4 5

41. Remains open to the suggestions of those under his/her direction and uses them when appropriate.   0 1 2 3 4 5

42. Uses opportunities for patient teaching when they arise.   0 1 2 3 4 5

Section II. <u>Performance of Professional Development Behaviors</u>

Instructions: Please circle the number that best describes the frequency with which the new graduate has engaged in the following behaviors.

Scale:
0 Not applicable
1 Never
2 Seldom
3 Occasionally
4 Frequently
5 Consistently

1. Uses learning opportunities for on-going personal and professional growth.   0 1 2 3 4 5

2. Displays self-direction.   0 1 2 3 4 5

3. Accepts responsibility for own actions.   0 1 2 3 4 5

4. Assumes new responsibilities within the limits of capabilities.   0 1 2 3 4 5

5. Maintains high standards of self-performance.   0 1 2 3 4 5

6. Demonstrates self-confidence.   0 1 2 3 4 5

7. Displays a generally positive attitude.   0 1 2 3 4 5

8. Demonstrates knowledge of the legal boundaries of nursing.   0 1 2 3 4 5

9. Demonstrates knowledge of the ethics of nursing.   0 1 2 3 4 5

10. Accepts and uses constructive criticism.   0 1 2 3 4 5

Appendix B

Reliability of Six Dimension Scale
of Nursing Performance

Reliability Six Dimension Scale of Nursing Performance			
Subscales	Graduate Nurses Pre-orientation	Graduate Nurses Post-orientation	Preceptors
Leadership	.62	.38	.65
Critical Care	.74	.52	.71
Teaching/ Collaboration	.75	.69	.82
Planning/ Evaluation	.74	.62	.84
IPR/ Communications	.65	.67	.85
Professional Development	.73	.69	.83

Appendix C

Preceptor Characteristics

by New Graduates

by Preceptors

Preceptor Characteristics
New Graduate

Number _____

Please indicate your level of agreement or disagreement with respect to each of the following statements about your primary preceptor.

Key:
0 Not applicable
1 Strongly disagree
2 Disagree
3 Agree
4 Strongly agree

1.	Was available for help when I needed guidance.	0 1 2 3 4
2.	Demonstrated knowledge of scientific principles relative to patient care.	0 1 2 3 4
3.	Showed genuine interest in me as an individual.	0 1 2 3 4
4.	Gave assignments that helped me transfer theoretical concepts to actual patient care.	0 1 2 3 4
5.	Demonstrated ability to do nursing skills (such as nursing procedures).	0 1 2 3 4
6.	Encouraged me to be "open" thereby respecting my opinions and feelings.	0 1 2 3 4
7.	Demonstrated honesty to me and others.	0 1 2 3 4
8.	Demonstrated ability to use scientific principles relative to patient care.	0 1 2 3 4
9.	Suggested helpful resources when I had questions.	0 1 2 3 4
10.	Demonstrated how to function in a real nursing situation.	0 1 2 3 4
11.	Avoided embarrassing me.	0 1 2 3 4

Key:
0 Not applicable
1 Strongly disagree
2 Disagree
3 Agree
4 Strongly agree

12.	Encouraged me to think for myself.	0 1 2 3 4
13.	Showed a contagious enthusiasm for giving quality patient care.	0 1 2 3 4
14.	Evaluated my progress in nursing in a fair manner.	0 1 2 3 4
15	Rewarded my efforts to give quality nursing care.	0 1 2 3 4
16.	Showed empathy to me and others.	0 1 2 3 4
17.	Demonstrated kindness during daily interactions with people.	0 1 2 3 4
18.	Showed a continued interest in applying improved methods of giving nursing care.	0 1 2 3 4
19.	My preceptor was helpful to me in making the transition from student to staff nurse	
	a. By modeling what a professional nurse does	0 1 2 3 4
	b. By modeling how a professional nurse relates to others	0 1 2 3 4
	c. By actively teaching me	0 1 2 3 4
	d. By using positive feedback and encouragement	0 1 2 3 4
	e. By being a resource person while I worked independently	0 1 2 3 4
	f. By listening to me and caring	0 1 2 3 4

20. Complete this sentence: My preceptor was <u>most helpful</u> to me in making the transition from student to staff nurse by

_____

_____

_____

Key:
0   Not applicable
1   Strongly disagree
2   Disagree
3   Agree
4   Strongly agree

21.   What was helpful in decreasing your anxiety and/or enabling you to be more comfortable in assuming your role as a staff nurse?

a. The support group provided in your orientation program.   0 1 2 3 4

b. Support from your primary preceptor.   0 1 2 3 4

c. Support from one or more staff nurses on your unit.   0 1 2 3 4

d. Support from your family (spouse, parents, children, etc.)   0 1 2 3 4

e. Support from non-nurse friends.   0 1 2 3 4

f. Support from other new graduate nurses in your orientation program.   0 1 2 3 4

g. support from other nurse friends.   0 1 2 3 4

h. other:_____   0 1 2 3 4

Preceptor Characteristics
Preceptor

Number _____

Please indicate your level of agreement or disagreement with respect to each of the following statements about yourself as a preceptor.

Key:
0 Not applicable
1 Strongly disagree
2 Disagree
3 Agree
4 Strongly agree

1.	Was available to orientee to provide guidance as needed.	0 1 2 3 4
2.	Demonstrated knowledge of scientific principles relative to patient care.	0 1 2 3 4
3.	Showed genuine interest in orientee on an individual basis.	0 1 2 3 4
4.	Provided assignments which relate theoretical concepts to actual patient care.	0 1 2 3 4
5.	Competent in nursing skills (procedures).	0 1 2 3 4
6.	Was able to promote and encourage orientee to be "open" and express opinions and feelings.	0 1 2 3 4
7.	Demonstrated honesty to orientees.	0 1 2 3 4
8.	Was able to use scientific principles relative to patient care.	0 1 2 3 4
9.	Was able to provide a variety of resources to help orientee with questions.	0 1 2 3 4
10.	Demonstrated how to function in a real nursing situation.	0 1 2 3 4
11.	Avoided embarrassing orientee.	0 1 2 3 4

Key:
0 Not applicable
1 Strongly disagree
2 Disagree
3 Agree
4 Strongly agree

12. Encouraged orientee to think for him or herself.   0 1 2 3 4

13. Showed enthusiasm for giving quality patient
care.   0 1 2 3 4

14. Evaluated orientee's progress in nursing in a
fair manner.   0 1 2 3 4

15. Rewarded orientee's efforts in giving quality
nursing care.   0 1 2 3 4

16. Demonstrated empathy towards orientee and others.   0 1 2 3 4

17. Demonstrated kindness during daily interactions
with people.   0 1 2 3 4

18. Demonstrated continued interest in applying
improved methods of giving nursing care.   0 1 2 3 4

Appendix D

Demographic Questionnaires

Pre-Orientation by New Graduates

Post-Orientation by New Graduates

Number_____

New Graduate Pre-Orientation Data Sheet

Instructions: Please complete each item by checking the appropriate response or listing the information requested.

1. What is your age?   _____

2. What is your gender?   1.____ Male
                                               2.____ Female

3. From which nursing program did   1.____ Diploma
    you graduate?   2.____ ADN
                                               3.____ BSN

4. What is your previous work   1.____ None, other than as
    experience in hospitals?   a nursing student.
    Check all that apply: 2.____ Nurse's aide _____
                                               3.____ Orderly _____
    Please indicate the length of time you   4.____ Practical Nurse ___
    were employed for each position in   5.____ Ward secretary or
    the space beside each item: clerk _____
                                               6.____ Other: Give job title
                                                       and time employed:

                                                       _____
                                                       _____

5. How much previous experience have   1.____ No experience with
    you had with a preceptor during   preceptors
    your basic nursing education program?   2.____ Minimal (one clinical
    This refers to clinical   rotation or portion of one)
    experience in which you were primarily   3.____ Moderate (two or more
    supervised by a preceptor (a designated   rotations)
    staff nurse) rather than by nursing   4.____ Extensive (virtually every
    faculty   every clinical experience in
                                                       program)

6.   What is your previous clinical clinical experience at <u>this</u> hospital?

1.____ I have never worked in this hospital before.

2.____ I have worked here as a nursing student.
Length of time:
_____

3.____ I have worked here as a paid employee.

Your job title at that time:

_____

Length of time employed:

_____

Number_____

New Graduate Post-Orientation Data Sheet

<u>Instructions</u>: Please complete each item by checking the appropriate response or listing the information requested.

1.   How many preceptors did you work with during the clinical portion of your orientation?

        _____

2.   On the average, how many days per week were you assigned to the same unit and same shift with your <u>primary preceptor</u>?

1.____ One day a week.
2.____ Two days each week.
3.____ Three days each week.
4.____ Four days each week.
5.____ Five days each week.

3.   How many <u>times</u> were you assigned to the same unit and same shift with an <u>alternate preceptor</u>?

1.____ One time.
2.____ Two times.
3.____ Three times.
4.____ Four times.
5.____ Other: Please give times_____.

4.   On the average, how many orientees did your <u>primary preceptor</u> work with during the time you were being oriented?

1.____ Only myself.
2.____ Myself and one other.
3.____ Myself and two others.
4.____ Myself and three others.
5.____ More than four orientees. Please indicate how many orientees:_____

5.   How many <u>days</u> (and parts of days) of classes have you attended during your orientation program? (Include days in general orientation)

        _____

6.   How many <u>days</u> of the state board
        review course provided during your
        orientation did you <u>attend</u>?
                                                _____
                                                ____ Not provided in my
                                                orientation program.

7.   How many <u>days</u> of a state board
        review course provided by an
        <u>outside provider</u> did you <u>attend</u>?
                                                _____
                                                ____ Did not attend a review
                                                course during orientation
                                                period.

8.   How many clinical days, if any,
        have you <u>missed</u> during this
        orientation period?
                                                _____

9.   How many support group sessions
        did you <u>attend</u>?
                                                _____
                                                ____ Not available in my
                                                orientation program.

10.   Were you ever given a <u>full workload</u>   _____ No.
        <u>assignment</u>, i.e. assigned to a similiar   _____ Yes, one time.
        number of patients as other staff nurses   _____ Yes, two times.
        on your unit, at any time <u>during your</u>   _____ Yes, three or more
        <u>orientation period</u>?   Please indicate how many
                                                times: _____

11.   Please indicate your status at this time:

___   a. I assumed a full workload assignment as of_____(Please give date)
        and continue to care for a similiar number of patients as other staff nurses on my
        unit and am no longer working under the supervision of a preceptor.

___   b. I am still working with my preceptor with a reduced workload assignment.

___   c. Other. Please explain _____

12. Please check one of the following:

____   a. I am currently working full-time.

____   b. I am currently working part-time for _____ hours a week.

13. Please check one of the following:

____   a. Based on my orientation experiences, I am likely to work at this hospital for less than a year.

____   b. Based on other reasons, (ie plans to move or return to school, family or personal concerns), I am likely to work at this hospital for less than a year.

____   c. I am likely to work at this hospital for more than a year.

____   d. Other:

Appendix E

Program Directors'

Interview Guide

Number_____

Program Directors' Interview Guide

Instructions: Please complete each item by checking the appropriate response or listing the information requested

1.   What were the total number of weeks the new
        graduates spent in your orientation program?
        (Include time in classroom and clinical)   _____
        If the time varies, please give the range.

2.   How many days did the new graduates spend
        in the classroom for:
        General Orientation?   _____

        Nursing Orientaton?   _____

3.   Was a state board review course
        offered during the orientation   1. ____   Yes
        program?   2. ____   No

4.   Was time off allowed for new graduates
        to attend review courses?   1. ____   Yes
                                                2. ____   No

5.   How many days did the new graduates
        spend in the state board review   _____
        course?   ____ Not applicable

6.   Were there scheduled opportunities to practice technical skills in a laboratory or classroom setting?

1. ____ Yes
2. ____ No

If yes, give time allotted for skills lab.

_____

7.   Were rotations to other clinical areas scheduled for <u>all</u> new graduates in your orientation program? (such as the OR, clinics, dialysis unit)

1. ____ Yes
2. ____ No

8.   If yes, indicate the areas the new graduates visited and approximate time spent in each area. Check all that apply:

1. ____ Operating Room _____
2. ____ Dialysis Unit _____
3. ____ ICU _____
4. ____ CCU _____
5. ____ Endoscopy _____
6. ____ Physical therapy_____
7. ____ Radiology _____
8. ____ Laboratory _____
9. ____ Other.

Give areas & time:

_____

_____

_____

9.   Were support groups provided for new graduates at your hospital?

1. ____ Yes
2. ____ No

10.   How many sessions of the support group were scheduled?

_____

11.   How long were the sessions?

_____

12. What is the title of the individual leading the support group?   _____

13. How are the preceptors selected?   _____

14. How are the preceptors matched with orientees?   _____

15. Do they work the same shift with same days off?   _____

16. How are orientees evaluated?   _____

17. What is the orientation coordinator's role?   _____

18. Additional comments:

Appendix F

Letters of Permission

For Use of Instruments

March 6, 1990

Mrs. Karen Rauen
10406 N. Sunflower Ct.
Mequon, Wisconsin 53092

Dear Mrs. Rauen

    This letter is to confirm our earlier telephone conversation regarding permission to use the Clinical Instructor Characteristics Ranking Scale as a measurement tool in my dissertation. As we discussed, I will be using your original items but modifying the tool by adding a five-point rating scale on each item.

    I appreciate your permission to use your instrument for the purposes of my study. When completed, I will be happy to share my findings with you.

    For your convenience, I have included a form below to provide written confirmation of your consent.

Sincerely,

Mary Brasler

I give Mary Brasler permission to use the Clinical Instructor Characteristics Ranking Scale (CICRS) which I developed in her dissertation. I understand that the instrument will be modified and used as an evaluation tool for preceptors. I ask that I be credited in writing with the development of the original instrument.

Yes ✓
No _____
Date 3/20/90

Signature _____

March 6, 1990

Dr. Patricia Schwirian
1591 Grenoble Rd.
Columbus, Ohio 43221

Dear Dr. Schwirian,

This letter is to confirm our earlier telephone conversation regarding permission to use the 6-D Scale as a measurement tool in my dissertation.

I appreciate your permission to use your instrument for the purposes of my study. When completed, I will be happy to share my findings with you.

For your convenience, I have included a form below to provide written confirmation of your consent.

Sincerely,

Mary Brasler

I give Mary Brasler permission to use the 6-D Scale which I developed. I ask that I be credited in writing with the development of the scale.

Yes ✔
No _____

Date 3/31/90

Signature

Demographic Variables
New Graduates Completing Pre-Orientation
and Those Completing Pre- and Post-Orientation

New Graduate Nurse Characteristics						
	Respondents					
Characteristics	Pre Only N = 53		Pre and Post N = 65		Total N = 118	
	N	%	N	%	N	%
Sex						
Male	0	0	3	4.6	3	2.5
Female	53	100	62	95.4	115	97.5
Nursing Education						
Diploma	2	3.8	1	1.5	3	2.5
ADN	22	41.5	26	40.0	48	40.7
BSN	29	54.7	38	58.0	67	56.8
Age						
Range	21-51		21-40		21-51	
Mean	27.38		26.21		26.7	
Stand. Dev.	7.5		5.0		6.3	
Past Hospital Experience						
Mean	2.1		1.4		1.8	
Stand. Dev.	3.5		1.7		2.7	
Past Exp. at Orient. Hosp.						
Mean	.9		.3		.6	
Stand. Dev.	2.0		.6		1.5	
Prev. Position Orient Hosp	N	%	N	%	N	%
None	20	37.7	32	49.2	52	44.1
Nu Student	9	17.0	10	15.4	19	16.1
Employee	18	34.0	19	29.2	37	31.4
Both	6	11.3	4	6.2	10	8.5

Appendix H

Comparison of New Graduates Completing Pre-Orientation
and Those Completing Pre- and Post-Orientation
on Demographic Variables

Graduate Nurse Characteristics N = 118		
Characteristics	Test	p
Sex	$\chi^2 (1) = 2.51$	.11
Nursing Education	$\chi^2 (2) = .6621$	.72
Age	$t = -.9593$	.34
Past Hospital Experience	$t = -1.3008$	.20
Past Experience at Orientation Hospital	$t = -1.7628$	.08
Previous Position at Orientation Hospital	$\chi^2 (3) = 2.0497$	.56

Comparison of Graduate Nurses Completing Pre-Orientation
and Both Pre and Post-Orientation Questionnaires on
Pre-Orientation Nursing Performance

Performance Dimensions	Group	N	Mean	t	p
Leadership	Pre Both	52 64	3.46 3.46	-.040	.97
Critical Care	Pre Both	53 65	3.04 2.98	-.444	.66
Teaching/ Collaboration	Pre Both	53 65	3.24 3.25	.088	.93
Planning/ Evaluation	Pre Both	53 65	3.35 3.45	.883	.38
IPR/ Communications	Pre Both	53 65	3.94 3.92	-.197	.84
Professional Development	Pre Both	53 65	4.12 4.09	-.367	.71

Demographic Variables
by Hospital

Graduate Nurse Characteristics Teaching Hospitals						
Characteristic	Hospital A N= 10		Hospital D N = 5		Total N = 15	
	N	%	N	%	N	%
Sex Male Female	0 10	0 100	1 4	20 80	1 14	6.7 93.3
Nursing Education Diploma ADN BSN	0 4 6	0 40 60	0 0 5	0 0 100	0 4 11	0 26.7 73.3
Age Range Mean Stand. Dev.	21-32 25.0 4.3		22-26 23.0 1.7		21-32 24.3 3.7	
Past Hospital Experience Mean St. Dev.	1.0 1.5		2.2 1.6		1.4 1.6	
Past Exp. Orient. Hosp. Mean St. Dev.	.1 .3		.9 1.0		.4 .7	
Prev. Position Orient. Hosp. None Nu Student Employee Both	8 0 2 0	80 0 20 0	0 0 4 1	0 0 80 20	8 0 6 1	53.3 0 40.0 6.7

Appendix J Continued

Demographic Variables
by Hospital

Graduate Nurse Characteristics Community Hospitals										
Characteristic	Hosp. B N = 13		Hosp. C N = 10		Hosp. E N = 17		Hosp. F N = 10		Total N = 50	
	N	%	N	%	N	%	N	%	N	%
Sex										
Male	2	15.4	0	0	0	0	0	0	2	4
Female	11	84.6	10	100	17	100	10	100	48	96
Nursing Education										
Diploma	0	0	0	0	1	5.9	0	0	1	2
ADN	9	69.2	3	30	3	17.6	7	70	22	44
BSN	4	30.8	7	70	13	76.5	3	30	27	54
Age										
Range	23-40		22-32		21-38		22-32		21-40	
Mean	29.9		26.4		24.7		26.6		26.8	
St. Dev.	5.9		3.7		5.2		4.2		5.2	
Past Hosp. Experience										
Mean	1.3		1.2		1.0		2.7		1.4	
St. Dev.	1.6		.8		1.3		2.5		1.7	
Past Exp. at Orient. Hosp.										
Mean	.1		.8		.5		0		.3	
St. Dev.	.4		.6		.6		0		.6	
Prev. Pos. Orient. Hosp.	N	%	N	%	N	%	N	%	N	%
None	10	76.9	2	20	4	23.5	8	80	24	48
Nu St	2	15.4	1	10	5	29.4	2	20	10	20
Employee	1	7.7	7	70	5	29.4	0	0	13	26
Both	0	0	0	0	3	17.6	0	0	3	6

Appendix K

Comparison of New Graduates
In Teaching and Community Hospitals
on Demographic Variables

Graduate Nurse Characteristics N = 65		
Characteristics	Test	p
Sex	$\chi^2 (1) = .1864$	.67
Nursing Education	$\chi^2 (2) = 1.9044$	.39
Age	$t = -2.02$	.05
Past Hospital Experience	$t = -.0453$	.96
Past Experience at Orientation Hospital	$t = .1644$	.87
Previous Position at Orientation Hospital	$\chi^2 (2) = 3.8487$	.28

Appendix L

Past Hospital Work Experience

New Graduate Past Hospital Experience						
Past Hospital Experience	Teaching Hospitals N = 15		Community Hospitals N = 50		Total N = 65	
	N	%	N	%	N	%
Past Hospital Experience						
Nurse Aide	7	46.7	21	42.0	28	43.0
Nurse Extern	7	46.7	13	26.0	20	31.0
Nurse Technician	0	0	5	10.0	5	7.7
LPN	1	6.7	2	4.0	3	4.6
Unit Secretary	3	20.0	6	12.0	9	13.8
Other	3	20.0	8	16.0	11	16.9
Experience at Orientation Hospital						
Nursing Student	1	6.7	13	26.0	14	21.5
Nurse Aide	2	13.3	6	12.0	8	12.3
Nurse Extern	5	33.3	9	18.0	14	21.5
Nurse Technician	0	0	1	2.0	1	1.5
LPN	0	0	1	2.0	1	1.5
Unit Secretary	0	0	1	2.0	1	1.5
Other	1	6.7	1	2.0	2	3.0

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Program Components
By Hospital

Variables	Program Components Teaching Hospitals		
	Hospital A N = 10	Hospital D N = 5	Total N = 15
Number of Preceptors Range Mean	1-5 2.70	1-4 2.40	1-5 2.60
Days with Alternate Preceptor Range Mean	0-5 2.30	1-3 2.20	0-5 2.26
Class Days Range Mean	3-17 10.00	7-12 9.20	3-17 9.70
Group Sessions Range Mean	0-13 6.90	0 0	0-13 4.60
Number of Full Work Assignments Range Mean	2-7 4.10	2-30 10.60	2-30 6.27
Length of Orientation Range Mean	41-83 59.50	24-47 39.60	24-83 52.87

Program Components
By Hospital

	Program Components Community Hospitals				
Variables	Hosp B N = 13	Hosp C N = 10	Hosp E N = 17	Hosp F N = 10	Total N = 50
Number of Preceptors Range Mean	2-8 4.08	1-9 3.00	1-8 2.94	2-4 2.40	1-9 3.14
Days with Alternate Preceptor Range Mean	1-10 4.23	1-24 5.70	1-12 3.24	2-4 2.90	1-24 3.92
Class Days Range Mean	3-50 19.19	7-25 13.06	6-40 16.68	1-30 13.40	1-50 16.03
Group Sessions Range Mean	1-9 3.15	0-2 0.80	0 0	0-3 0.80	0-9 1.14
Number of Full Work Assignments Range Mean	0-15 3.77	2-20 8.10	0-32 4.44	2-15 7.40	0-32 5.61
Length of Orientation Range Mean	35-94 54.00	30-77 48.6	30-98 62.27	24-84 57.11	24-98 56.18

Appendix N

Comparison of Preceptor Evaluations
by New Graduates and Preceptors
in Teaching and Community Hospitals

Preceptor Characteristics			
	Teacher Role	Nurse Role	Person Role
New Graduates Mean: Teaching Community	3.54 3.65	3.59 3.71	3.51 3.68
t	-.781	-1.056	-1.135
p	.44	.30	.26
Preceptors Mean: Teaching Community	3.58 3.57	3.74 3.61	3.67 3.71
t	3.891	1.530	-.343
p	.97	.14	.73

Appendix O

Comparison of Clinical Performance Evaluations
by Preceptors
in Teaching and Community Hospitals

New Graduate Clinical Performance Evaluations by Preceptors N = 49				
6 D subscales	Teaching Hospital Mean	Community Hospital Mean	t	p
Leadership	3.22	3.59	-1.247	.22
Critical Care	3.21	3.57	-1.222	.23
Teaching/ Collaboration	2.89	3.34	-1.686	.10
Planning/ Evaluation	3.26	3.75	-1.454	.17
IPR/ Communications	3.67	4.04	-1.558	.13
Professional Development	3.88	4.28	-1.872	.07

Appendix P

Correlation of Clinical Performance Evaluations
by New Graduates and Preceptors

Performance Dimensions	r	p
Leadership	-0.0105	.95
Critical Care	-0.1468	.31
Teaching/ Collaboration	-0.0672	.65
Planning/ Evaluation	-0.0885	.55
IPR/ Communications	-0.0777	.60
Professional Development	-0.0424	.77

Appendix Q

Intercorrelations for Independent Variables
with Six Dimensions of Nursing Performance

S1: Leadership

VARIABLES	S1	1	2	3	4	5
1. SUP7	.47	--				
2. PC2	.45	.16	--			
3. SUP2	.41	.20	.68	--		
4. NWRKTME	-.40	-.22	-.15	-.15	--	
5. PC1	.39	.11	.84	.75	-.22	--
6. PROLE	.34	.21	.76	.83	-.24	.86

S2: Critical Care

VARIABLES	S2	1	2
1. SUP7	.39	--	
2. SUP5	.30	.46	--

S3: Teaching / Collaboration

VARIABLES	S3	1	2	3	4	5
1. SUP2	.42	--				
2. TIMENUST	.36	.21	--			
3. SUP7	.35	.20	-.09	--		
4. SUP6	.33	.32	.07	.45	--	
5. NWRKTME	-.33	-.26	.02	-.21	-.22	--
6. PC2	.29	.68	.09	.15	.27	-.14

S4: Planning / Evaluation

VARIABLES	S4	1	2	3	4	5	6
1. PC2	.47	--					
2. SUP2	.44	.68	--				
3. SUP7	.40	.15	.20	--			
4. SUP6	.38	.27	.32	.45	--		
5. PC1	.31	.84	.75	.11	.16	--	
6. DAYSP2	.28	.03	-.12	.07	.01	-.13	--
7. TIMENUST	.25	.09	.21	-.09	.07	.14	.04

S5: IPR / Communications

VARIABLES	S5	1	2	3	4	5	6	7	8
1. SUP7	.46	--							
2. SUP2	.45	.20	--						
3. SUP6	.42	.44	.31	--					
4. PROLE	.41	.20	.83	.25	--				
5. PC2	.40	.13	.68	.26	.76	--			
6. NWRKTME	-.34	-.22	-.27	-.23	-.24	-.16	--		
7. GRPSESS	-.27	-.06	-.07	-.05	-.18	.05	-.14	--	
8. NED2	.26	.06	.02	.21	.01	.09	-.08	-.09	--
9. HOSP2	-.23	-.12	-.08	-.08	-.11	-.13	-.04	.48	.15

S6: Professional Development

VARIABLES	S6	1	2	3	4	5	6	7
1. SUP2	.44	--						
2. PC2	.43	.66	--					
3. PC1	.41	.74	.85	--				
4. SUP7	.41	.20	.13	.10	--			
5. PROLE	.37	.83	.76	.86	.20	--		
6. SUP4	.36	.26	.15	.12	.21	.21	--	
7. PC3	.35	.79	.73	.87	.13	.85	.16	--
8. DAYSP2	.19	-.11	.05	-.13	.07	-.17	-.07	-.22