EFFECTS OF A NURSE RESIDENCY PROGRAM ON COMPETENCE, JOB SATISFACTION, AND RETENTION

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Abstract

Newly graduated nurses' attrition is higher than attrition of more experienced nurses, resulting in higher costs to the healthcare system. Transition-to-practice programs, such as nurse residency programs, ease the stress of newly graduated nurses' transition to practicing nurses through additional support and education. The nursing shortage due to attrition raises the research question in patient, intervention, comparison, outcome, time format: For newly graduated registered nurses (P), do nurse residency programs (I) improve nurse retention, competence, and job satisfaction (O) when compared with traditional orientation programs (C) six months after the initiation of the residency program for the sample (T)? Based on Benner's novice to expert theory and Bandura's self-efficacy model, a mires residency program was developed and implemented to answer the question. For the mixed-methods study, nurse residents provided reflective journals and Casey Fink Graduate Nurse Experience Surveys to assess competence and job satisfaction. Also collected was retention data. Post-implementation, retention increased, and job satisfaction was trending up and consistent with benchmarks. Reflective journals demonstrated resident growth through the timeframe. A nurse residency program effectively improves retention and job satisfaction and promotes growth among newly graduated nurses.

Table of Contents

Chapter I: Introduction

As healthcare evolves, newly graduated nurses (NGNs) are increasingly unprepared for clinical practice (Kavanagh & Sharpnack, 2021), resulting in nurse managers and preceptors reporting poor performance in technical skills, critical thinking, communication, and professionalism (Gregg, 2020). When NGNs are unprepared, attrition rates increase, causing further stress and decreased job satisfaction (Bong, 2019). Additionally, the high attrition rates and unpreparedness of NGNs place a financial burden on medical facilities due to medical errors, hiring, and training (Pillai et al., 2018).

A significant challenge facing NGNs is the changes associated with moving from student to registered nurse, leading to significant growth and role development (Charette et al., 2020). Many NGNs experience transition stress during this time. Researchers emphasize the importance of extra support and education to ease the adverse effects of transition stress (Chant & Westendorf, 2019; Cochran, 2017). A proven method to assist newly graduated nurses in transition is nurse residency programs (NRPs), one form of transition-to-practice program. These programs incorporate support and education, resulting in noticeable stress reduction, improved job satisfaction, and increased retention rates (Blackburn, 2021; Brennen, 2021; Chant & Westendorf, 2019; Chesak et al., 2019).

Statement of Problem

In 2020, the national staff registered nurse (RN) turnover rate averaged 18.7% (NSI Nursing Solutions, Inc., 2021). Since the COVID-19 pandemic, the turnover rate at the selected Midwestern hospital increased to 44% (C. Futrell, personal communication, November 18, 2021). High nurse turnover resulted in prohibitive costs to the organization

and decreased patient safety (Ellison, 2020). The attrition-associated nursing shortage raised the research question in patient, intervention, comparison, outcome, time (PICOT) format: For newly graduated registered nurses (P), do nurse residency programs (I) improve nurse retention, competence, and job satisfaction (O) when compared with traditional orientation programs (C) six months after the initiation of the residency program for the sample (T)? The project manager sought to answer the PICOT question by developing, implementing, and evaluating an NRP for the chosen facility.

To determine the program's effectiveness, the project manager analyzed the selected cohort's job satisfaction, competence, and retention at various times throughout the program. A validated survey measured job satisfaction, while reflective journals helped identify competence.

Purpose/Aim of the Project

The quality improvement (QI) project aimed to improve job satisfaction, competence, and retention in NGNs at a small midwestern hospital. To achieve this goal, an NRP was developed and implemented.

Background/Problem of Interest Supported by the Literature

NGNs (within 1-2 years of graduation) experience significant stress while transitioning from student nurse to practicing nurse, causing some to leave their initial positions or quit nursing entirely (Bong, 2019). Moral distress, the inability to provide the desired care quality (Bong, 2019), may be a contributing factor since over 30% of newly licensed nurses leave the initial nursing job within the first two practice years (Bong, 2019; Chant & Westendorf, 2019; Silvestre et al., 2017). Decreased patient safety and increased costs accompany high nurse turnover rates (Bong, 2019). At the same time,

NRPs targeted at NGNs improve job satisfaction, competence, and retention (Blackburn, 2021; Brennen, 2021; Chant & Westendorf, 2019).

Significance of the Project

America suffers from a nursing shortage due to an aging workforce and increasingly complex patients (American Association of Colleges in Nursing [AACN], 2020). Even prior to the pandemic, poorly staffed units resulted in a 6% higher mortality risk than well-staffed units (AACN, 2020). Additionally concerning for facilities is the high financial cost of nurse attrition. Hiring an NGN costs a facility approximately five times as much as hiring an experienced nurse, and the investment is not recouped for a year (Pillai et al., 2018). The facility receives no return on the significant financial investment if the NGN leaves within the first year. Conversely, facilities with NRPs showed substantial savings compared to facilities with only traditional orientation programs (Walsh, 2018).

The nursing profession must safeguard against poor staffing conditions by better preparing nurses. Bong (2019) suggests that preparing NGNs well enhances job satisfaction and raises nurse retention rates, while the AACN (2020) claims that patient safety improves with intentional training. Therefore, extra intentional preparation, found in NRPs, enhances job satisfaction and reduces nurse attrition.

Impact of the Project

Decreased nurse retention leads to reduced patient safety (Ellison, 2020). NRPs are one method to optimize nurse retention, specifically among new nurses, and subsequently improve patient safety and reduce costs. Chief nursing officers, healthcare facility education departments, and other NRPs can use project findings to develop,

implement, and evaluate their residency programs. Implementing an NRP can improve confidence and job satisfaction, increasing the chances of new nurses staying in their initial jobs.

Chapter II: Literature and Theory Review

NRPs are one response to the nationwide nursing shortage (Brennen, 2021; Cadmus & Wurmser, 2019). NRPs provide additional support and education to prepare NGNs better for competent practice (Chant & Westendorf, 2019; Cochran, 2017). NGNs often struggle with transition shock and moral distress during this time (Bong, 2019; Chen et al., 2021). Established nursing theories, such as Benner's novice to expert theory and Bandura's self-efficacy theory, provide a foundational framework for NRPs to advance nurses' competence through intentional education and tailored support (Chant & Westendorf, 2019; Graf et al., 2020; Metcalf & Wiener, 2018). A nurse residency built on these strong, foundational theories can lead to well-prepared nurses who are less likely to leave their initial jobs and improves nursing care while offsetting the nursing shortage.

Literature Review

The literature search for the QI project involved multiple databases, including MEDLINE, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), and the Elton Bryson Stephens Company Information Services (EBSCO). Search terms included *newly graduated nurs*, nurse residency, nurse residency program,* and *transition to practice.* Inclusion criteria were peer-reviewed publications from 2017 discussing nurses' transition to practice in hospitals worldwide printed in English. Exclusion criteria were nurse transitions in locations other than hospitals, programs involving nursing students rather than nurses, and programs focused on one-on-one precepting rather than cohorts of residency participants, commonly called residents.

In 2003, The Joint Commission (TJC) recognized the nursing shortage as a state of crisis. TJC recommended several strategies to mitigate the crisis, including

establishing “structured postgraduate training programs” to strengthen nursing competence (TJC, 2003, p. 41). In 2011, the Institute of Medicine (IOM), now called the National Academy of Medicine (NAM), formally recommended all NGNs participate in an NRP (IOM, 2011). Since then, organizations have created NRPs and packaged the programs for sale, while specific facilities have created individual programs. Programs may seek accreditation to demonstrate consistency with recognized standards (American Nurses Credentialing Center [ANCC], 2020; Commission on Collegiate Nursing Education [CCNE], 2021).

Authors often interchange the terms *transition-to-practice program* and *nurse residency program*. However, an NRP is an example of a transition-to-practice program. Transition-to-practice programs include NRPs, internships, and preceptorships (Hampton et al., 2020). Participation in structured, evidence-based training programs, such as NRPs, helps NGNs transition to becoming competent nurses (Charette et al., 2020; Rush et al., 2019; Szarejko et al., 2021; Trepanier et al., 2021).

An NRP aims to ease the transition from nursing student to practicing nurse (CCNE, 2021; Walsh, 2018). Individual NRP goals vary. Many programs focus on nurse satisfaction and retention, but other goals include competence, confidence, critical thinking, safety, and cost savings (Chant & Westendorf, 2019; Cochran, 2017; Rush et al., 2019; Szarejko et al., 2021). Standard NRP components include didactic teaching, preceptorship, simulations, and peer support opportunities (Chant & Westendorf, 2019; Rush et al., 2019). Suggested strategies to employ in an NRP are evidence-based practice projects to encourage lifelong learning and research application to practice and collaboration with a nursing school to bridge the gap between student and nurse (ANCC,

2020; CCNE, 2021; Cochran, 2017; Doughty et al., 2018; Eckerson, 2018; Perron et al., 2020; Smith, 2021; Walsh, 2018) The project manager's goal for the literature review is to uncover NRPs value in improving retention, job satisfaction, and competence among NGNs.

Results of Poor Transitioning

Transition shock describes the physical, emotional, and intellectual exhaustion that occurs due to fears, such as failure, disappointing peers, and accidentally harming a patient, and generally happens in the first few months of NGN practice (Wakefield, 2018). NGNs often experience transition shock as expectations clash with new experiences. Transition shock decreases patient safety and nurse satisfaction as NGNs seek to reconcile theory and practice, manage workplace relationships, and improve nursing skills to meet expectations (Chen et al., 2021; Green & Kinchen, 2021; Kim & Shin, 2020).

Initially, NGNs struggle to think holistically, focusing on task performance over patient care (Murray et al., 2019). To overcome the struggle, NGNs need more personal experience to bridge the theory to practice gap (Benner, 2001). The gap often leads to moral distress, defined as a nurse knowing the right action but feeling paralyzed to act, primarily due to the work environment (Bong, 2019). Work environment constraints include inadequate resources, insufficient time due to staffing or patient acuity, and lack of support from coworkers or supervisors (Bong, 2019).

When asked to evaluate NGNs, nurse leaders and other experienced nurses rated the NGNs lowest on critical thinking, problem-solving, and communication (Gregg, 2020; Missen et al., 2016). NGNs struggle with problem-solving and critical thinking,

attempting to apply theoretical knowledge to practice (Baker, 2020; Cochran, 2017; Crimlisk et al., 2017; Gregg, 2020). The struggle indicates that NGNs need intentional training in these areas to overcome the gap between expected practice and actual NGN abilities.

Nurses are healthcare team members and must collaborate interprofessionally to provide optimal care (Hayton et al., 2021). NGNs are particularly vulnerable to workplace incivility and bullying from peers and superiors due to a lack of experience and confidence (Crimlisk et al., 2017; Halpin et al., 2017; Kim & Shin, 2020). Reviewing 15 articles, Cochran (2017) found that NGNs frequently feel unsupported and experience disproportionate workplace incivility. Additional communication and conflict resolution support provided by an NRP reduces the stress of managing workplace relationships, which is highest among younger nurses and those without previous healthcare experience (Cochran, 2017; Halpin et al., 2017).

According to Szarejko et al. (2021), nurse residents rated role expectations as one of the most challenging transition areas, requiring more confidence in prioritizing, communicating, delegating, and thinking critically. NGNs often feel overwhelmed by transitioning to practicing nurses and need help meeting expectations (Baker, 2020; Cochran, 2017; Eckerson, 2018; Szarejko et al., 2021). Nursing students require close supervision, causing a lack of learning that only independent experience can offer. Therefore, NGNs feel unprepared for the responsibility and necessary autonomy of nursing practice (Baker, 2020; Gregg, 2020; Halpin et al., 2017; Kim & Shin, 2020; Szarejko et al., 2021).

The chronic stress associated with transition shock negatively affects personal

health, increasing the risk of anxiety, hypertension, substance abuse, and poor patient outcomes through decreased care quality (Green & Kinchen, 2021). Surveyed nurse leaders believed NRPs ease the transition into practice by increasing confidence and competence and improving retention (Trepanier et al., 2021). NRPs often provide emotional support and cohort socialization to help manage transition shock's adverse effects. When attempting to reduce the adverse effects of transition shock, Chesak et al. (2019) discovered that additional targeted education that teaches stress management tends to be more effective than interventions focused on changing the environment (Chesak et al., 2019).

Value of Support

Due to increased transition stress, NGNs require additional social and emotional support. Chant & Westendorf (2019) reviewed 18 articles regarding NRPs in place for at least three years to determine vital components for sustainability and found support from leadership and a healthy work environment critical. Besides training in stress management, most NRPs provide a dedicated preceptor or mentor for support and socialization within the cohort (Chant & Westendorf, 2019; Eckerson, 2018; Perron et al., 2020; Rush et al., 2019).

Quality preceptors may be the most significant new nurse success indicator, though a supportive unit environment can mitigate the lack of a strong preceptor (Perron et al., 2020; Rush et al., 2019). Eckerson (2018) found that the most critical job satisfaction indicators were adequate peer support and positive interactions with coworkers. Written reflections demonstrated the importance of teamwork as a safety net and source of confidence (Fowler et al., 2018). Furthermore, NGNs handle the transition

to practicing nurses better with support from a cohort (Kim & Shin, 2020).

NGNs want personable, helpful, nurturing preceptors willing to provide constructive feedback and continuous support (Chen et al., 2021; Halpin et al., 2017; Kim & Shin, 2020; Rush et al., 2019). Preceptors should allow questions and use mistakes as learning rather than punitive opportunities (Fowler et al., 2018; Rush et al., 2019). Nurse residents must trust the facility's facilitators, preceptors, and mentors, as confidentiality breaches damage the trust relationship, decreasing satisfaction and NRP effectiveness (Blackburn, 2021).

An effective preceptor decreases transition shock and improves patient outcomes for the NGN (Chen et al., 2021). To be effective, preceptors require adequate education. Preceptor preparation should involve adult learning styles, conflict resolution, and a framework such as Benner's novice to expert theory (Chant & Westendorf, 2019; Rush et al., 2019). Rush et al. (2019) found that formal preceptor training improves preceptor satisfaction and NGN critical thinking. Preceptor training may occur through case studies, in-person training, or online resources (Perron et al., 2020).

Besides effective preceptors, the ethical climate impacts NGN competence and patient safety (Charette et al., 2020; Silvestre et al., 2017). Ethical climate is how a work environment manages ethical issues or the group consensus on what is morally correct (Dziurka et al., 2021; Hou et al., 2021). An affirmational ethical climate can decrease the perceived stress level of the nurses and improve job satisfaction, while a hostile ethical climate can increase moral distress (Bong, 2019; Dziurka et al., 2021; Hou et al., 2021).

In addition to the importance of healthy work environments, NRPs provide the opportunity for cohorting NGNs, allowing concurrent transition. Cohorts learn together

and reflect on experiences to support each other and find commonalities with the transition process. Effective residency sessions require quality debriefing and adequate socialization time among the cohort to promote solidarity (Chant & Westendorf, 2019; Perron et al., 2020). Debriefing, reflection, and peer discussion promote learning from others' experiences and demand a strong facilitator who provides professional and emotional support (Cochran, 2017; Eckerson, 2018; Hayton et al., 2021).

In summary, adequately training preceptors improves preceptor retention and NGN critical thinking, resulting in safer patient care. Additional social and emotional support besides precepting enhances job satisfaction and retention among NGNs. Moreover, NRPs provide opportunities for NGNs to receive necessary socialization and support from the facility.

Importance of Additional Educational Preparation

With increasing patient complexity, nurses require additional training and education to provide safe, effective care (D'Ambrosio, 2021). Completing an accredited nursing program and the National Council Licensure Examination for Registered Nurses (NCLEX-RN) indicates only basic preparedness for an entry-level nurse (National Council of State Boards of Nursing, 2016). However, many facilities expect NGNs to perform at a higher practice level early in a nurse's career to meet clients' complex needs and the expanded demands created by the nursing shortage (Baker, 2020; Halpin et al., 2017; Kim & Shin, 2020; Szarejko et al., 2021). NRPs provide an opportunity for dedicated time and targeted education to prepare NGNs for the higher expectations of entry-level practice. Targeted educational training for NGNs should include delegation, prioritization, conflict resolution, autonomous decision-making, and developing

collaborative relationships with the healthcare team (Cochran, 2017). Developing these competencies requires multiple modalities, such as didactic teaching, simulations, active learning strategies, and group debriefing (Eckerson, 2018; Perron et al., 2020; Rush et al., 2019; Walsh, 2018).

Using didactic sessions with case studies improves critical thinking, clinical decision-making, and clinical leadership by allowing for active engagement and reflection, although there is no robust body of evidence for these improvements (Crimlisk et al., 2017; Perron et al., 2020; Walsh, 2018). Moreover, Rush et al. (2019) found no significant difference in dedicated education days directly after hospital orientation or spread throughout the first practice year, indicating that the timing of the dedicated education can vary without significant detriment.

Charette et al. (2020) and Walsh (2018) reviewed the literature and found NRPs improve overall performance. Some studies found nurses struggled with some physical skills even after completing a residency program, though these studies also indicated limited dedicated time towards practicing physical skills (Alghamdi & Baker, 2020; Crimlisk et al., 2017). The proposed program attempted to overcome the skills-associated challenges by regularly reviewing unfamiliar skills through the first year.

One means of providing skills review is simulation, another pedagogy commonly used in NRPs. Simulations improved residents' critical thinking, clinical judgment, confidence, and communication (Cantrell et al., 2020; Graf et al., 2020; Perron et al., 2020; Rush et al., 2019). Simulation allows NGNs to practice clinical decision-making in a safe environment while reinforcing task performance. The NRPs with quality simulation experiences help residents connect theoretical knowledge and actual patient

care while improving clinical competence, knowledge, and skills (Szarejko et al., 2021).

Nursing Shortage

The United States and Canada continue to face a nurse shortage due to aging nurses and insufficient new nurses to keep up with attrition and growing demands (Cochran, 2017). As NGN attrition rates are high, a solution to this challenge may be a transition-to-practice model such as NRPs for graduating nurses (Brennen, 2021; Cadmus & Wurmser, 2019).

NGNs have a higher attrition rate than more experienced nurses. Although reports vary on specific numbers, NGN attrition rates during the first practice year range from 30% to 61% (Bong, 2019; Cochran, 2017; Eckerson, 2018; Graf et al., 2020;). Many report attrition numbers increase in the second practice year (Bong, 2019; Chant & Westendorf, 2019; Pillai et al., 2018). Ulupinar & Aydogan (2021) found the most compelling reasons for leaving were a high workload, poor communication, and inadequate skills and knowledge, causing dissatisfaction with the work, the environment, and personal abilities.

In NRPs assessed, job satisfaction scores show decreased satisfaction around six months but trend back up by 12 months, indicating a potential NRP benefit (Eckerson, 2018; Rush et al., 2019). Crimlisk et al. (2017) reported NGN retention at 91% after the first year of an NRP. Most research did not examine retention data past the first year, though Pillai et al. (2018) found attrition increased in the second year of the NRP compared to the first year.

In addition to patient safety, the financial costs of low nurse retention are a concerning consequence. Hiring an NGN is approximately five times more expensive for

a facility than hiring an experienced nurse (Pillai et al., 2018). Facilities can recoup the investment into an NGN in about one year compared to six months for an experienced nurse (Pillai et al., 2018). A cost-benefit analysis assessing over 15 sites with NRPs compared to 34 sites with only traditional orientations demonstrated savings of $10-50 per patient day (Walsh, 2018). Silvestre et al.'s (2017) randomized, controlled, multisite study exhibited early facility cost savings using NRPs, and multiple other programs demonstrated NRPs' significant return on investment (Agosto et al., 2017; Perron et al., 2020).

In reviewing 12 articles, Eckerson (2018) found most researchers reported increased retention through implementing an NRP, and some showed significant cost savings. Cochran (2017) also found lower attrition rates and cost savings after implementing an NRP.

Review of Theory

Nursing theory promotes the advancement of nursing as a science and profession (Yu & Song, 2021). Theories allow nurses to distill and extrapolate nursing's essential aspects and a foundational theoretical framework is crucial for an NRP (ANCC, 2020; Chant & Westendorf, 2019; Graf et al., 2020). The theoretical framework for the implemented NRP centered around Patricia Benner's novice to expert model and Bandura's self-efficacy theory.

Benner's Novice to Expert Theory

In the 1980s, Dr. Patricia Benner developed a nursing experiential model to express how nurses develop critical thinking while gaining the ability to reason clinically (Chant & Westendorf, 2019). The development starts with novice nurses, who have yet to

gain experience and base care solely on the theories and rules learned. Between novice and expert, nurses progress from advanced beginner to competent, then proficient. Ideally, the end goal on the spectrum is an expert nurse with vast knowledge and experience, allowing expert nurses to provide nursing care intuitively (Benner, 2001). Each stage requires different support and understanding to progress.

Dreyfus' skill acquisition model was the foundation for Benner's nursing theory. The Dreyfus model posits how people learn new skills: moving from mere observation and reliance on abstracts to active involvement and the ability to recognize significant findings as they relate to the whole through experience (Benner, 2001). These theories are situational because gaining expertise in one area may not translate to expertise in another. For example, an expert nurse in a neonatal intensive care unit could be an advanced beginner when transitioning to a nursing home (Benner, 2001).

Bandura's Self-efficacy Theory

Self-efficacy is the belief that personal efforts lead to successfully completing a task or goal (Bandura, 1997). Low self-efficacy is a limiting factor, as the person is unlikely to make significant efforts, making them less likely to persist or succeed (Metcalf & Wiener, 2018). According to Bandura's theory, the four methods of developing self-efficacy are succeeding at tasks, observing peers succeeding, receiving genuine positive feedback, and experiencing less stress during execution (Metcalf & Wiener, 2018). Personal success is the most definitive factor for self-efficacy, with early success reducing the effects of later failures, while observing a peer's success leads to the feeling that the observer can also accomplish the task (Laurencelle & Scanlan, 2018). Positive feedback must be genuine and believable to influence self-efficacy positively

(Metcalf & Wiener, 2018). Conversely, experiencing a stress or fear reaction while performing a task can cause excessive anxiety related to the task and decrease self-efficacy (Metcalf & Wiener, 2018). Ideally, NRPs provide NGNs opportunities to develop increased self-efficacy through positive experiences and supportive practice with constructive feedback.

Alignment of Theory

According to Benner's (2001) theory, NGNs tend to join the workforce after graduation as advanced beginners (Graf et al., 2020). After clinical rotations during school, NGNs have some experience in patient care and theoretical knowledge through education. However, NGNs must use significant brain space to focus on remembering the rules and algorithms taught in school (Benner, 2001). Advanced beginners, or NGNs, struggle with prioritization because relying on protocols makes adapting to evolving situations or changing plans or patient conditions difficult (Benner, 2001).

Many NRPs use Benner's novice to expert model as the theoretical framework (Chant & Westendorf, 2019; Kukkonen et al., 2020). The model provides a lens to view experiential growth with NGNs starting as advanced beginners after graduation and progressing toward competent nurses by completing the NRP (Benner, 2001; Chant & Westendorf, 2019). Rather than focusing on specific tasks, the model provides seven nursing domains. Each domain requires the development of critical nursing aspects to progress to the next level and eventually reach expert nurse status (Benner, 2001). Intentionally created and positioned lessons, tasks, and activities throughout the program move students toward competent nurse status. The advanced beginner nurse needs time and positive experiential learning to acquire clinical reasoning skills and develop the

confidence necessary to perform at a competent level (Graf et al., 2020).

Building confidence is essential for NRPs to expand a nurse's readiness that meets the demands and expectations of an independent nurse. Incorporating Bandura's self-efficacy theory into the NRP is one way to develop confidence in new nurses, as self-confidence requires self-efficacy. Self-efficacy is one's belief that an outcome is attainable and is a concept one can apply to skills and knowledge under ideal or challenging circumstances (Metcalf & Wiener, 2018). Competence fits into self-efficacy because it is the ability to complete a task or understand a situation. Bandura argues that having a strong sense of self-efficacy allows one to improve and grow by putting forth effort based on the assertion that the task or gain is achievable (Metcalf & Wiener, 2018).

Structuring NRPs to support and form self-efficacy in NGNs is crucial to the program's success. Experiences and discussions surrounding quality simulations and practice situations provide opportunities for NGNs to develop self-efficacy in practice, leading to increased effort when learning new concepts and increased resilience (Laurencelle & Scanlan, 2018). According to Bandura's theory, there are four methods for developing self-efficacy: personal success, observing peers succeed, genuine positive feedback, and personal feelings during the event, such as a stress reaction or lack thereof (Laurencelle & Scanlan, 2018; Metcalf & Wiener, 2018). Providing opportunities to practice nursing skills and behaviors using these methods in reduced-stress environments with adequate support allows NGNs to perform better while increasing self-efficacy. NGNs will perform better with an increased sense of well-being and resilience (Laurencelle & Scanlan, 2018).

Adequate support and educational preparation can stabilize the common effects of

poor transitioning and offset the nursing shortage. In alignment with Benner's and Bandura's theories, NGNs require help learning to prioritize and adapt as they gain self-efficacy. The targeted nature of NRPs provides the support and education that help NGNs gain self-efficacy to ease the transition to practice.

Chapter III: Method

The QI project employed a mixed-method design to assess the effectiveness of the NRP by measuring retention, job satisfaction, and competence. The quantitative research assessed retention data before and after implementation and analyzed Casey-Fink Graduate Nurse Experience Survey (CFGNES) results. Residents completed the CFGNES (Appendix A) at various times throughout the residency to evaluate job satisfaction (Crimlisk, 2017; Szarejko et al., 2021). Retention rates from the hospital's human resources department determined the program's effect on attrition. The qualitative research involved a longitudinal thematic analysis of nurse residents' reflective journal entries. Analysis of reflective journals (Appendix B) demonstrated progression from advanced beginners toward competent nurses.

Design of the Project

The Institutional Review Board at the implementation facility and primary educational facility exempted the mixed-methods study (Appendices C & D). The mixed-methods approach provided depth and breadth of information regarding the effects of an NRP. Concurrent quantitative and qualitative data collection occurred throughout the project.

The NRP, intended to last one year, onboarded all NGNs (graduation date within one year of hire), with a focus on education, peer support, and socialization to the role (Bong 2019; Chant & Westendorf, 2019; Crimlisk, 2017). The development and implementation of the new NRP aimed to improve job satisfaction, competence, and retention for NGNs. After completing the hospital's orientation program, the project required at least one dedicated week with the residency facilitator for all NGNs near the

beginning of their employment. The dedicated residency week focused on skills, socialization, prioritization, and time management through education, case studies, and simulations (Chant & Westendorf, 2019; Crimlisk, 2017) (Appendix E). Subsequent monthly debriefing sessions with the facilitator included education on evidence-based practice and cohort-specific skills training (Appendix F). Additionally, the curriculum of the residency meetings included critical thinking activities, active learning strategies, and guest speakers to develop the knowledge base, critical thinking, and clinical judgment of NGNs (Crimlisk, 2017). The program concluded with an evidence-based practice improvement project.

The CFGNES, updated several times since its creation in 1996, is commonly used to assess job satisfaction, confidence, stress, and demographics among NGNs. Expert nurse directors and educators validated the survey with content derived from the literature. The CFGNES consists of five sections. Section I asks NGNs to choose the top three skills they feel uncomfortable performing from a provided list. Section II contains a Likert scale with questions covering five satisfaction factors: stress, support, patient safety, communication/leadership, and professional satisfaction. Section III further defines satisfaction through nine common job satisfaction indicators. Section IV asks about different factors affecting the transition to practicing nurse. The final section includes demographic information, including age, sex, degree, and past and current experience. The internal consistency estimates $\alpha = .89$ (Fink et al., 2008). The survey authors permitted the survey's use in the newly-created residency program (Appendix G). Nurse residents took the CFGNES at the beginning of the project, then periodically throughout the program to assess job satisfaction.

As part of the NRP, residents provided reflective journals. Reflective journaling is a means of self-reflection that promotes growth and develops clinical judgment, allowing readers to discern growth in the writer (Wright & Scardaville, 2021). The primary investigator developed the reflective prompts, and two expert nurse educators reviewed and validated the prompts. The reflective journals included three primary questions: 1) Describe a recent significant situation and how you felt and responded, 2) What does it mean to be a nurse?, and 3) Do you feel like a nurse? (Appendix B). Residents submitted reflective journals during the initial residency week and periodically throughout the program. The reflective journals provide a deeper understanding of the residents' competence and confidence in their abilities through telling stories about personal experiences.

Additional education and assistance support NGNs' transition to practicing nurses to retain new nurses, one goal of the NRP (Perron et al., 2020). The project manager collected retention data throughout the program compared to previous years at the facility and national averages. The timeframe of the Doctor of Nursing Practice project required an initial evaluation of the program at six months. Moving forward, reflective journal and CFGNES submissions will continue throughout the 12-month residency.

Setting

The project took place at a small, independent, rural hospital in the Midwest that did not have an established residency program. The 99-bed facility encompasses emergency and surgical services along with inpatient units and is the sole hospital in its county. The chief nursing officer and clinical nurse educator provided hospital support for implementing and continuing the project.

Population

Consecutive sampling recruited all members of the residency cohorts during the project timeframe. The inclusion criteria for participation were RNs who passed boards within one year of hire and were working in their first nurse job. The facility required all such nurses to participate in the NRP. Before inclusion in the study, the project manager explained the expectations and risks of participation, including the voluntary nature of the study, and obtained informed consent (Appendix H). The facility encouraged but did not require participation in the study. Exclusion criteria included non-nurse residents or residents who refused participation in the study. The study included data from each consenting resident.

A total of 17 NGNs participated in the NRP. Sixteen residents provided at least one CFGNES, and 11 provided more than one survey. Five residents provided reflective journals, with two providing more than one journal. The participating residents were predominantly female (81%) and exclusively Caucasian. Ten residents reported earning a Bachelor of Science in Nursing, while six earned an Associate Degree in Nursing (62.5% vs 37.5%) (Table 1).

Data Collection

Quantitative data collection involved administering the CFGNES at the beginning and at least every three months throughout the program. The project manager used the CFGNES to collect data on demographics, job and life satisfaction, confidence, and stressors related to the transition to practicing nurse. Residents had access to the CFGNES on their residency website and through QR codes provided at each residency session. CFGNES results were anonymous. The project manager stored all CFGNES

results in a password-protected cloud drive.

The primary satisfaction section of the survey consisted of 23 questions divided into five subscales (support, patient safety, stress, communication/leadership, and professional satisfaction), of which one subscale (stress) is not amenable to Cronbach's alpha. Cronbach's alpha established survey validity at project initiation for the overall scale (α=.871) as well as for each applicable subscale (support: α=.916; patient safety; α=.840; communication/leadership: α=.740; professional satisfaction: α=.916).

Unpaired t-tests compared means and standard deviations for each subscale to benchmark values. Paired t-tests, calculated at the beginning and at least every three months after that, examined any changes across time in means and standard deviations of each subscale. Bivariate correlation produced Pearson's r values to assess whether the overall or subscale scores correlated with age, degree, previous experience, and time in the program. Linear regression was unnecessary due to few, isolated correlations. Questions regarding specific workplace strengths and stressors required frequencies.

Quantitative data analysis also involved retention rates specific to NGNs at the facility. The hospital's human resources department tracked hiring and attrition data. Simple percentages determined changes in NGN retention before and after project initiation.

Qualitative data collection involved reflective journals, either written or video, provided by participants at initiation and at least every three months throughout the program. Residents accessed journal directions and submissions through the residency website. A password-protected cloud drive secured all journals. The reflection directions asked residents not to include names or other identifiers in the submission.

At each residency session, the facilitator reminded residents of the expectation of confidentiality among the cohort with any shared personal information or experiences, but that confidentiality was not guaranteed. A locked drawer in a locked office secured all signed informed consent forms, separately from collected data, to limit the risk of personally-identifiable data.

The mixed-methods design allowed breadth and depth of data, collected concurrently, for more comprehensive understanding. Multiple submissions of the CFGNES and reflective journals enabled tracking residents over time for change and growth.

Chapter IV: Results

The overarching goal of the QI project was to implement an effective NRP. A mixed methods research design evaluated the program's effectiveness by determining NGN competence, job satisfaction, and retention. Mixed methods designs use qualitative and quantitative data interpretation to answer the research question (Merriam & Tisdell, 2016). Quantitative and qualitative data collection was concurrent to answer different aspects of the research question. Chapter four discusses the evaluative data for the QI project, the implications for practice, project limitations, and recommendations for the facility.

Results of Data Collection and Analysis

Quantitative analysis of retention data and CFGNES results assessed retention and job satisfaction. Human resources provided NGN retention data for analysis. Residents provided information about satisfaction, stressors, and support through the CFGNES. Qualitative analysis of reflective journals investigated the NGNs' growth and change over time. Qualitative descriptions of residents' actions and perceptions provided a better understanding of lived experience. Opportunities for evaluative data collection occurred often, as the residency program facilitator encouraged residents to submit reflective journals and CFGNESs at deliberate intervals.

Quantitative Analysis

The CFGNES provided quantitative data on nurse residents' job satisfaction. Data collected by the CGFNES included demographics, comfort with skills, nursing safety, communication/leadership, perceived support, stressors, professional satisfaction, job satisfaction, and perceived difficulties and needs. The project manager chose the

CFGNES due to its widespread use in assessing NRPs and the graduate nurse experience (Alghamdi & Baker, 2020; Baker, 2020; Cadmus & Wurmser, 2019; Fowler et al., 2018; Kim & Shin, 2020; Nash et al., 2018; Pillai et al., 2018; Szarejko et al., 2021). Residents completed the survey every one to three months throughout the residency program. Surveys completed at months zero and three yielded sufficient data for analysis. Few residents completed surveys at month one (n=4) and months five to seven (n=3), so the monthly analysis did not include those months due to low numbers.

The NRP also aimed to improve NGN retention. The facility's human resources department provided NGN retention data for the three years before the NRP's initiation. The project manager examined the data for post-implementation changes.

Casey Fink Graduate Nurse Experience Survey

The CFGNES has five sections. Section II comprises five factors: support, patient safety, stress, communication/leadership, and professional satisfaction (Casey et al., 2021).

Table 2

CF Subsection Averages over Time

	Month 0	Month 3
Overall	3.18	3.00*
Support	3.54	3.17*
Safety	2.70	2.75
Communication/Leadership	3.02	2.79
Professional Satisfaction	3.55	3.36

*=p<.05

Each of the five factors contains various queries whose scores, when averaged together, provide a score for each subscale, with a score of 'one' being an undesirable finding and a score of 'four' being a desirable finding. Overall and subscale averages ranged from 2.70 to 3.67 (Table 2, Figure 1). Casey et al. (2021) provided benchmarks for each area through analysis of CFGNES from 71,919 NGNs completed at six months post-graduation over ten years (Table 3). According to an unpaired t-test, the residents' support (t_{71947}=.18, p=.860) and professional satisfaction (t_{71947}=.28, p=.78) subscales were slightly higher than but not significantly different from the benchmarks. Residents' overall (t_{71944}=.64, p=.5213) and communication/leadership (t_{71947}=1.46, p=.1409) subscale were below the benchmark, but not significantly. The only statistically significant difference was in the patient safety subscale, in which residents scored lower than the benchmark (t_{71947}=2.17, p=.0297) (Figure 2).

Table 3

Comparison of Overall and Subsection Means to Benchmarks

	Participants	Benchmark
Overall	3.08	3.16
Support	3.33	3.31
Safety	2.75	3.01*
Communication/Leadership	2.93	3.09
Professional Satisfaction	3.39	3.36

*=p<.05

For the overall scale and each subscale, mean resident scores decreased from month zero to month three, although only the changes in overall score (t_6=2.79, p=.032)

and support (t_7=3.86, p=.006) were statistically significant. Notably, scores for the overall scale and all subscales trended up by months five to seven. However, insufficient residents submitted surveys past month three (n=3) for valid statistical analysis.

Section III of the CFGNES asks residents about satisfaction with nine aspects of working as a nurse. From month zero to month three, satisfaction with all nine aspects decreased, although only three dropped significantly: satisfaction with vacation (t_6=2.121, p=.078), benefits packages (t_7=2.049, p=.080), and weekends off (t_7=2.049, p=.080). An insufficient number of residents submitted surveys past three months (n=3) to perform valid statistical analysis. Of note, the overall and all subscale scores trended upward at months five to seven but lacked power for inclusion in results.

Section IV of the CFGNES queries NGNs about factors affecting their transition (Table 4). Residents rated a lack of confidence as the most significant and common difficulty, with increases from month zero to month three. The workload, fears, and orientation problems were also rated difficult, although workload increased slightly in the third month, while fears and orientation problems decreased (Figure 3). In response to what would make residents feel more supported or integrated, residents first selected an improved work environment, although the desire for improved orientation increased noticeably by month three (Figure 4). Residents rated peer support as the most consistently satisfying aspect of their work environment, with ongoing learning and the professional nursing role also rated high at month zero but decreasing by month three (Figure 5). Residents rated system issues as the least satisfying aspect of their work

Table 4

Responses to CFGNES Section IV

	Month 0	Month 3
Current Difficulties		
Role expectations	18.2%	18.2%
Lack of confidence	45.5%	72.7%
Workload	36.4%	45.5%
Fears	45.5%	27.3%
Orientation issues	54.6%	18.2%
Help feel more supported		
Improved orientation	10%	45.5%
Increased support	30%	27.3%
Unit socialization	20%	27.3%
Improved work environment	60%	72.7%
Most satisfying aspects		
Peer support	72.7%	72.7%
Patients and families	45.5%	36.4%
Ongoing learning	100%	36.4%
Professional nursing role	72.7%	36.4%
Positive work environment	27.3%	27.3%
Least satisfying aspects		
Nursing work environment	9.1%	25%
System	100%	58.3%
Interpersonal relationships	0.0%	33.3%
Orientation	0.0%	33.3%

environment (Figure 6). Of note, all three other assessed areas increased noticeably at the three-month mark: the nursing work environment, interpersonal relationships, and orientation.

Pearson's *r* determined possible correlations between the overall scale and subscale scores with resident age, degree, and previous experience (Table 5). Only one correlation was statistically significant: degree earned with stress level at three months

(r_{10}=-.642, *p*=.024). Degree and stress level achieved a moderate to strong negative correlation. At three months of practice, residents with a higher degree felt lower stress than those with a lower degree. This correlation did not exist at month 0 (r_8=-.063, *p*=.863).

Several correlational trends emerged through analysis. At a single point in time, two trends existed. At month zero, the level of previous experience was trending toward a moderate positive relationship with feelings of support (r_9=.520, *p*=.101), although the trend stops at month three (r_{10}=.134, *p*=.678). At month three, the earned degree trended toward a moderate negative relationship with feelings toward maintaining patient safety (r_{10}=-.544, *p*=.067).

Three more trends emerged. Residents with previous work experience resembling the nursing role trended toward a positive correlation with overall satisfaction (r_{25}=.290, *p*=.142), feeling supported (r_{28}=.269, *p* =.150), and higher comfort levels in communicating and delegating (r_{28}=.294, *p*=.155). Each of these trends may have achieved significance with increased data.

Retention

The facility's human resources department provided NGN retention data for the three years before program implementation. Due to program time restrictions, the project manager could only assess the first six months of retention. Numbers vary, but national NGN retention rates for the first year range from 30-61% (Bong, 2019; Cochran, 2017;

Table 6

Retention Rates

	6-month retention	12-month retention

2020	88% (22/25)	80% (20/25)
2021	86.7% (13/15)	80% (12/15)
2022	85% (17/20)	85% (17/20)
Post-Implementation	94.1% (16/17)	----

Eckerson, 2018; Graf et al., 2020). The facility was on the high end of retention among NGNs pre-implementation and increased at the six-month mark after implementation (Table 6). Rising retention rates demonstrated a potential benefit of the NRP.

The quantitative data obtained from the CFGNES revealed some fluctuation in job satisfaction throughout the QI project. All subscale averages trended up by five to seven months. Other significant findings included residents lacking confidence and desiring additional and continued support. Residents found coworker support to be the most satisfying. Additionally, the analysis of NGN retention rates demonstrated a potential benefit of the NRP.

Qualitative Analysis

Residents received reflective journal prompts to guide journal responses throughout the residency program to assess growth and competence. The journal prompts included three basic questions, asking residents to reflect on a significant nursing situation, their thoughts on nursing, and themselves as nurses (Appendix B). Due to the submitted journal formatting and similarities in answers, researchers analyzed question one separately, while questions two and three were analyzed together.

The aim of the reflective journals was to explore resident competence. The journals displayed residents' growth and transition, especially regarding self-efficacy or the resident's belief that goals were achievable.

Two researchers independently reviewed the reflective journals for theme validation to identify significant statements and themes. The researchers then discussed individual findings until both agreed on the proposed themes. Triangulation means using multiple data sources, methods, investigators, or theories to support findings, thereby increasing the findings' credibility (Merriam & Tisdell, 2016). To improve credibility through triangulation, NVivo 12 then analyzed the reflective journals to validate the discovered themes further. Researchers finalized themes on reaching a consensus between the researchers and NVivo 12. To further validate the results, researchers returned the results to the residents for a member check. Member checks reduce the risk of researchers misinterpreting data when researchers share preliminary results with respondents for feedback and clarification (Merriam & Tisdell, 2016).

Researchers first analyzed journals by month to identify changes in the group over time. Residents submitted journals for analysis at months one, two, and five. Analyzing the group as a whole allows for identifying general themes applicable to the group over time. Two residents submitted multiple journals during the timeframe. Researchers analyzed these journals for individual changes over the project's course.

Monthly Analysis

Every person has a unique story. Despite the similarity of all residents in transitioning from nursing student to practicing nurse, each resident has a unique history, education, and personality. Researchers analyzed the journals together across time,

Table 7

Themes by Month

	Theme 1	Theme 2

Description of Significant Experience

Month 1 Question 1	Affective State	Learning
Month 2 Question 1	Stress Reaction	Self-Discovery
Month 5 Question 1	Stress Reaction	Autonomy

Do you feel like a nurse?

Month 1 Questions 2-3	Becoming	Caregiving
Month 2 Questions 2-3	Transition	Art of Nursing
Month 5 Questions 2-3	Growth	Identity

attempting to identify changing themes in the group as a representation of the whole. Of the two cohorts included in the analysis, four residents submitted journals at month one, two at month two, and two at month five.

Month 1, Question 1. During the first residency month, resident journals described a situation significant to the resident in some way, from practice as either a student or a new nurse. Answering the first reflective prompt, residents described the experience and how the resident felt and responded to the situation. Through those stories, two themes arose: affective state and learning (Table 7).

Affective State. Bandura (1997) describes four means for affecting self-efficacy, including through physiological and affective states. When a person experiences a significant physical or emotional reaction to stress, the person often interprets the reaction as a deficit in themselves (Bandura, 1997). Suppose a person believes feelings or reactions related to an event indicate some failure on the person's part. In such cases, the person is less likely to desire to repeat the experience or feel confident in achieving the goal (Bandura, 1997). While fear is an expected response to an unfamiliar situation and

can even heighten senses and improve reaction times, feeling overwhelmed is counterproductive (Bandura, 1997). NGNs, as anyone gaining new skills and confidence, need adequate support to correctly interpret emotions and physical responses to allow learning and growth from the experiences instead of becoming overwhelmed and unable to deal with the situation or associated feelings.

Each resident described a situation involving a time when the resident felt nervous, afraid, overwhelmed, or otherwise out of control. The patient situations described were tense and often life-threatening, requiring the resident to depend heavily on the preceptor for direction. Lack of education and experience increase fear, exacerbated by the fact that facilities often expect new nurses to perform with the competence of more experienced nurses (Sterner et al., 2021). In this way, a resident explained her fears and inadequacies in the significant situation she experienced. “I will admit that when I first saw the state of the patient, I was scared. I wasn’t sure what was going on with him.”

NGNs often feel overwhelmed after finishing nursing school and starting to practice as independent nurses. This season of life is full of new experiences and potentially unforeseen changes in thought patterns. One resident described attempting to establish a therapeutic relationship with a patient’s spouse who “couldn’t wrap his head around” his wife’s current health state. Another resident felt “thrown into the whole system” with coworkers who “make you feel stupid.” Without adequate support and outside recognition of the experiences’ newness, the new nurses have difficulty managing those feelings.

Within the affective state, a subtheme of communication emerged. During times

of stress, it is natural to rely on previously-developed habits (Fiorella, 2020). According to Benner (2001), communication is essential to the nursing role, both with the patient/family and the interprofessional team. In the helping role, nurses communicate verbally and nonverbally with patients to help patients understand and heal, provide comfort and reassurance, and build therapeutic relationships (Benner, 2001). Communication is also part of monitoring and ensuring the quality of healthcare practices (Benner, 2001). By coordinating care within the interdisciplinary team, nurses ensure quality care by reducing the risk of errors and prioritizing patients' needs (Benner, 2001). At a basic level, residents understand the importance of communicating with the healthcare team and patients to achieve optimal health outcomes. As novices without the knowledge or experience to perform other nursing skills, nursing students spend significant time practicing communication during clinical experiences. Having formed the habit of communication during nursing school, many residents depended on that habit when faced with stressful situations.

Resident journals demonstrated a strong emphasis on communication. Most residents described communication as a positive factor. Residents described utilizing therapeutic communication with a patient family or effective delegation and teamwork with coworkers. However, not all communication was positive. One resident felt an unlicensed personnel was "bossing me around," which the resident was unsure how to handle. Another described an ethical dilemma in communication, where the resident feared accidentally breaking patient confidentiality, as the resident knew the patient well. The pervasiveness of communication topics throughout the journals supports the residents' recognition of its importance.

Learning. Bandura (1997) identifies other means for achieving self-efficacy, including personal success and observing peers succeed. By succeeding at goals the person deems difficult or observing peers do the same, people feel a stronger sense of capability and belief in future success (Bandura, 1997). A small amount of struggle is helpful, as completing tasks too easily can make the person give up at the first sign of difficulty (Bandura, 1997). Allowing the NGNs opportunities to experience and observe new things allows NGNs to build a sense of self-efficacy for long-term success.

Nurses must be lifelong learners. Residents' responses demonstrated a desire to learn from others and their own experiences. Residents sought opportunities to grow and become better nurses. Often, learning occurred through observation and discussion, as the residents "[felt] very comfortable asking questions" or had another nurse "help explain things in simpler terms." Other times, the residents learned through trial and error, having the autonomy to "[figure] out what way works best for me" or "[figure] out what are things I should prioritize over others." Sometimes, residents learned simply by being in new experiences. "This is not something you see on a daily basis as a student nurse, but it was a day that I learned what it meant to be a nurse." Through experiences and relationships, residents learned more about themselves and what it means to be a nurse.

Benner (2001) describes advanced beginners as those with enough real-life experience to perform at a basic level. At the NGN stage, residents have some real-life experience through clinical rotations. As advanced beginners, residents must learn to combine the learned rules with personal experience to generate and apply guidelines. Advanced beginners evolve from a complete dependence on rules in the novice stage to a reliance on guidelines (Benner, 2001). With limited experience, advanced beginners need

help prioritizing the guidelines or experiences (Benner, 2001). The residents focused on following the learned guidelines, including what to do if a patient is in distress or how to maintain patient confidentiality, based on personal experiences.

In the first journal, residents focused on nursing's task-oriented and legalistic aspects. Journals included in-depth descriptions of the residents' actions in each situation. In one journal, the resident described each action performed: "I quickly grabbed a wheelchair," "I took him back to a room," "I then started to take his vitals," "I applied EKG pads," "I rolled him onto his side," "I stayed with the patient," "I jumped into action," and "I grabbed the provider." As an advanced beginner, the resident used previous experience with a patient in unidentified distress and knowledge of associated learned rules to respond to the situation. There was minimal discussion of higher-level thinking or decision-making; the resident focused on completing tasks.

Another resident focused almost wholly on nursing's legal aspects, worried about inadvertently violating patient confidentiality through her actions. The resident described previously knowing the patient personally and was able to process how to apply the learned rules to the unfolding situation. At the earliest stage of nursing practice, residents know the rules and formulas learned in school and learn to apply them to practice based on personal experience.

Month 1, Questions 2-3. In questions two and three, residents reflected on their current view of what it means to be a nurse and their current view of themselves as a nurse. The different but related questions allowed for a better understanding of the residents' perception of personal growth and change. Researchers also considered the residents' answers for question one when analyzing questions two and three, as the

response to significant situations also influences how the residents think and feel about nursing and themselves. Through these reflections, two themes emerged: becoming and caregiving (Table 7).

Becoming. Worth (2009) defines becoming as a process producing a shift in identity, unlimited by linear time. In part, the term becoming denotes a fundamental shift in a person's self-perception, occurring intermittently rather than constantly, on an unpredictable schedule. Individuals undergo their unique process of becoming at their own pace and timing. For study purposes, residents are becoming nurses. Although each resident graduated from an accredited nursing school and earned a registered nurse license, these accomplishments do not always lead to a person identifying as a nurse. As Worth (2009) describes, becoming a nurse is more of a process than a singular moment.

Residents described their current state as becoming nurses, recognizing their abilities and the need for continued growth. "I knew what [being a nurse] was, but it wasn't until I started to learn and do that I realized exactly what it meant." Residents recognize the need for additional knowledge and experience to truly feel like a nurse and respond how a nurse should, based on their perceptions.

- "I feel like nursing school teaches you how to be a nurse through books and exams and floor nursing is very different" (Resident #5)
- "I am still trying to understand why certain things affect others and trying to figure out what is going on with the patient" (Resident #2)
- "I am very proud to be able to call myself a registered nurse, but I also do not yet feel like a nurse" (Resident #1)
- "Right now, I do not feel like a nurse. I feel between a nursing student and

a nurse" (Resident #3)

Each of the four residents described their current state as not feeling like a nurse, but all expressed the belief that they are growing toward being a nurse. One resident expressed the hope of "[becoming] the great nurse that I know I am capable of becoming," while another, referring to the decision to become a nurse, stated, "everyday…I know I made the right decision."

Beyond the particular situations in their reflections, residents acknowledged the inherent aspect of nursing which involves embracing the pressure and responsibility associated with the profession, and expressed concerns about their ability to excel as competent nurses. As stated, physiological and affective states can positively and negatively influence a person's self-efficacy (Bandura, 1997). NGNs are under significant stress as they slowly learn to think and act independently (Benner, 2001). Residents' interpretation of physical and emotional stress responses can impact self-efficacy or the belief in eventual success (Bandura, 1997).

At this stage, residents found nursing overwhelming: "My current view of nursing is overwhelming at times" and "it can be intimidating and overwhelming." Residents recognized "we have a great deal of responsibility…I take my role as a nurse very seriously." Worrying about being able to care for patients safely or accidentally harming someone was a common thought. One resident stated, "I feel as though I will be in situations that are critical, and I will freeze or cause the patient harm because I don't know what to do." Another felt there was still "a lot to learn…I'm missing the crucial elements an experienced nurse knows." Alternatively, overconfidence can increase errors. Therefore, residents' concern about their ability to provide safe care is no reason for

censure (Bengtsson et al., 2021). Supportive and well-trained preceptors or NRP facilitators can help NGNs maintain healthy confidence.

At month one, residents' affective states and overwhelming feelings did not bolster their self-efficacy. When a person associates an intense physical or emotional response as a sign of a deficit in the effort toward a goal, the person can fear continuing in the attempt (Bandura, 1997). One resident stated experiencing "imposter syndrome." Another felt that nursing is "not always a positive career," while a third stated, "sometimes I question if I enjoy being a nurse." Despite the overall negativity of the overwhelming feelings, one resident declared, "the love I have for nursing has not wavered." If the residents can learn to see these overwhelming feelings as an expected and temporary facet of transition, the residents can increase their self-efficacy and *become* nurses.

Caregiving. The role of a nurse has many interpretations. Benner (2001) describes seven essential roles or functions of nursing, referred to as domains. These domains include the helping role, the teaching-coaching function, the diagnostic and monitoring function, effective management of rapidly changing situations, administering and monitoring therapeutic interventions and regimens, monitoring and ensuring the quality of health care practices, and organizational and work-role competencies (Benner, 2001). Each of the seven domains encompasses the caring aspects of nursing, including providing comfort measures, preserving personhood, anticipating patient care needs, administering medications accurately and safely, setting priorities, and ensuring safe medical and nursing care (Benner, 2001).

Residents consistently included caregiving functions when describing what it

means to be a nurse. In defining nurses, residents included a variety of responses on what nursing is, including communication, relationships, tasks, education, and personal support. “I think being a nurse is mostly knowing how to perform interventions at the appropriate times while also maintaining a good relationship and communication with my coworkers and patients.” Another resident listed several roles without explanation: “caregiver, advocate, communicator, leader, and teacher.” Residents in the first month of residency recognized nursing roles without the ability to describe the roles completely; residents provided short descriptions without explanation or examples.

Month 2, Question 1. Only two residents submitted reflective journals at month two. The two residents had very different experiences. Both residents were similar in age and educational background. One resident worked as an intern before graduation, while the other worked as a nursing aide. One resident, a previous nursing aid, missed several nursing experience opportunities due to illness shortly after licensure. Presumably, the vastly different experiences were due to the amount of experience as a nurse since on-boarding.

At month two, the two residents answered the same questions as at month one. For question one, both residents described a critical, potentially life-threatening situation from practice, with differing responses from the residents. The differences in experience and response made determining themes more difficult. Two themes emerged from the analysis: stress reaction and self-discovery (Table 7).

Stress Reaction. Bandura’s (1997) description of self-efficacy through physiological and affective responses explains the importance of the person’s interpretation of their physical and emotional state. A person’s existing sense of self-

efficacy and past experiences determine the stress reaction (Bandura, 1997). If a person views the stress response as a challenge and motivator, the stress response can improve performance and attention (Bandura, 1997). Conversely, when an individual perceives a stress response as debilitating, this reaction may consequently manifest as such (Bandura, 1997).

Both residents described a serious situation in which the resident experienced significant stress. When the residents recognized the presence of a critical patient, one described the stress response as "my adrenaline was high," while the other described "I was in shock." Both residents identified their own physical reactions to the stress of the situation but reacted differently.

Due to a stressful situation, resident #3 felt increased adrenaline and used that adrenaline to improve care. "I was able to see or perform these skills [intubation and NG tube placement], improving my nursing skills and critical thinking." Once the situation concluded, the resident reflected on personal performance and the patient's status. The resident recognized personal growth and stated, "if I was put in this situation again, I would want less assistance with this skill."

A stressful situation for resident #4 resulted in a feeling of shock. The resident panicked and the stress decreased performance. "I had no idea what to do…I didn't know how to suction. I felt like everything was absolute chaos." Presumably having learned to suction during nursing school, resident #4 felt unable to do so due to the stress reaction. Once the situation concluded, the resident "[wished] I was given more instruction." The diverse experiences and self-efficacy of the residents resulted in significantly different reactions to their stressful situations.

Self-Discovery. Reflection facilitates a deeper understanding of one's learning, personal growth, and self-awareness (Tanner, 2006). Knowing oneself well enables achieving one's potential (Joshi et al., 2023). Without self-knowledge, experiences and actions cannot be fully understood. Reflection for understanding occurs in conjunction with situations of uncertainty often occurring in NGN practice (Tanner, 2006).

Both residents could reflect on their performance and discover personality traits and personal growth. Resident #3 reflected on the situation and personal performance when the situation concluded. "Once things calmed down, I realized the poor outcome for this patient.' As part of the reflection, resident #3 recognized personal growth as a nurse, describing the situation as "improving my nursing skills and critical thinking" and stating that "if I was put in this situation again, I would want less assistance with this skill…I want to be able to stand on my feet more." The resident recognized progress and sought increased autonomy in nursing.

Resident #4 also reflected on personal strengths and abilities. "I felt like everything was absolute chaos…I learned that I like controlled situations." The resident was uncomfortable in the described situation and did not approve of personal performance. Rather than seeking autonomy, resident #4 wanted more direction. "I wish we had gone through what to do…I wish I was given more instruction." On reflection, resident #4 discovered a preference for control and direction that did not match the experience on the floor.

Month 2, Questions 2-3. The same two residents described their current perceptions of nursing and of themselves as nurses. Through analysis, two themes emerged: transition and the art of nursing (Table 7).

Transition. Adjusting from student nurse to registered nurse is a significant transition. Duchscher's stages of transition theory describes transition shock as a time of emotional, physical, sociocultural, and intellectual stress as a person attempts to transition to a new role or state (Graf et al., 2020). According to Duchscher, transition shock is most commonly associated with the doing phase of transition, which occurs in the first several months of nursing practice and is highly task-oriented and rule-focused (Graf et al., 2020). Duchscher's second stage is the being stage, which involves increased confidence and familiarity with the role and early acceptance of responsibility (Graf et al., 2020).

Resident #3 exemplified transitioning toward Duchscher's being stage. Not wholly confident nor familiar with the nurse role, resident #3 gained confidence and familiarity. "I am…processing patient situations differently than when I was a student." The resident recognized the differences in her thinking and responses based on her increased knowledge and comfort with the role. As evidenced by the answer to Question 1, the resident was more confident in her role and sought additional autonomy, "as I progress…I want to be able to stand on my feet more." Despite the stress experienced, resident #3 was able to process the situation, take some responsibility, and develop self-confidence. At this point, resident #3 was transitioning to the being stage, though not fully achieved yet, as evidenced by their statement, "introducing myself as a nurse feels unusual."

In contrast, resident #4 is firmly rooted in the transition shock aspect of the doing stage. As part of the doing stage, the resident is focused on what she should be doing (Graf et al., 2020). "I had no idea what to do." "Next time, I will know what to do."

Transition shock is evident in the situation described, as the resident describes distress in three of the four aspects of transition shock:

- Emotional: “I was in shock.”
- Sociocultural: “We hadn’t had time to go over what the nurses do.”
- Intellectual: “I wish that I was given more instruction” and “I didn’t know how to suction.”

Resident #4 had yet to develop the confidence and familiarity indicative of the being stage. The resident needs additional support, education, and confidence because “I don’t feel like a real … nurse yet.”

Art of Nursing. In their qualitative analysis of nurse residents’ reflective journals, Fowler et al. (2018) discovered a theme the authors referred to as the ‘art of nursing.’ Fowler et al. (2018) described the art of nursing as compassion, advocacy, empathy, kindness, and holistic care. The art of nursing recognizes that nursing is more than performing nursing tasks. It holistically uses nursing knowledge to care for a patient, family, or community (Fowler et al., 2018).

Both residents recognized the differences in expectations or previous experience compared to the current experiences. Resident #4 recognized the art of nursing as the goal. The resident stated that “processing is very different,” recognizing that experienced nurses were processing situations on a different level than she was. “I am … learning to think about a lot of different factors all at once.” Resident #4 recognized the need for growth and a change in thinking to move past a student's thought processes and was “learning to be okay with not being amazing at things.”

Resident #3 also described the differences in processing. “When I was a student, I

could only process snapshots of patients and not the whole picture…now I have a better grasp of situations and what the patient needs." The resident recognized that the thought processes used as a student nurse were inadequate and was developing new understandings through experience. With the recognition of personal growth came the knowledge of more to learn. "I don't have the … mindset the other nurses on the floor have." Resident #3 recognized the need to practice the art of nursing and was working towards that goal.

As part of the art of nursing, both residents referenced the need for nurses to advocate for their patients. "The role of the nurse is ambiguous, but one of the biggest is patient advocator." "The nurses are there…to try different things to help…[and] are also the advocates." However, neither resident described what it meant to be an advocate. As part of the reflective story describing a memorable experience, resident #3 described the preceptor advocating for the patient but did not necessarily recognize or identify the situation as such.

Month 5, Question 1. Only two residents submitted reflective journals at month five. The two residents' experiences were very different. One was younger and earned a bachelor's degree (resident #3). The other was nearly ten years older and had earned an associate degree (resident #1). Resident #3 worked as an intern before graduation, while resident #1 worked as a radiology tech. Due to circumstances outside the resident's control, resident #1 could not work as a nurse at the time of the journal. The differences in the residents' experiences may have impacted their provided responses.

At month five, the two residents answered the same questions as in months one and two. For question one, both residents described a significant situation from practice,

both potentially life-threatening, with varied responses from the residents. Differences in experience and situational response made themes more challenging to determine. Two themes emerged from the analysis: autonomy and stress reaction (Table 7).

Autonomy. Kurt & Gurdogan (2023) describe *autonomy* as the ability to perform responsibilities independently, within the confines of rules and governing principles. Autonomy is a requirement of nursing care because nurses are responsible for patients' lives and are expected to practice safely without unnecessary oversight (Benner, 2001). Autonomously practicing safe care enforces self-efficacy through achieved mastery experience (Bandura, 1997). Nevertheless, this autonomy is largely missing in nursing education, forcing healthcare facilities to provide it while providing constructive feedback.

At month five, resident #3 was able to practice autonomously. Resident #3 returned to the floor from a break to discover that a new patient was in significant distress and needed to transfer to a higher level of care. The resident stabilized and managed the patient until the time for the transfer. Management trusted the resident to care for a critical patient, and the resident managed care with minimal assistance or oversight.

At month five, resident #1's journal did not reflect autonomous practice. The reflection of resident #1 on a critical situation illustrated that she received low-level responsibilities from the preceptor. Other nurses treated the resident like a tech or a student, expecting her to perform compressions and observe medication administration and transport. Consequently, the resident primarily engaged in a tech or student role, which limited her opportunities for autonomous nursing practice and deprived her of valuable experiential learning.

Autonomous, practicing nurses are expected to lead interdisciplinary teams. Benner (2001) posits that building and maintaining therapeutic teams optimizes patient care. To be therapeutic, the team must continuously share all relevant perspectives (Benner, 2001). Such teams improve morale and care coordination for improved outcomes (Benner, 2001). Additionally, one means of improving self-efficacy is through vicarious experience or watching peers succeed (Bandura, 1997). Being part of a team that succeeds, even with minimal involvement, can improve a team member's belief in future successes.

Both residents talked extensively about their team, how well everyone worked together, and the importance of teamwork. Resident #3 was a team leader. The resident was the primary nurse for the described patient and took charge of the situation, delegating other patients to available nurses "so I was able to focus on this patient." The resident coordinated with other nurses and departments to ensure optimal outcomes for the patient.

Resident #1 was part of a team working on a cardiac arrest but had no leadership role. The resident was a supportive member of the team. "The …techs and I performed CPR." "I was able to put in an OG for the first time and helped the other nurse organize lines." The resident was impressed by the teamwork and recognized that each team member had specific roles but could not see her role. "It was intimidating to be in the situation with all of the moving parts and everyone with their job laid out. Everyone worked very well together and seemed to just know what to do."

Stress Reaction. Stressful situations cause physical and emotional responses (Bandura, 1997). Stress can be a motivating factor, heightening senses and sharpening

focus, or a detrimental factor, inducing a fight-or-flight response that decreases productivity (Bandura, 1997). A person's stress level and previous experience influence the stress reaction, whether positive or negative (Bandura, 1997).

Both residents experienced highly stressful situations. On recognizing the severity of the patient's condition, resident #3 stated, "my stress level skyrocketed." Despite the elevated stress level, resident #3 could care safely for the patient and coordinate the care team to ensure patient stabilization and readiness for transfer. After safely transferring the patient, the resident assessed personal performance and recognized areas for growth and improvement in a similar situation.

Resident #1 also experienced significant stress. Like resident #3, resident #1 did not panic or freeze due to stress. Instead, the resident supported the team and helped the patient. Unlike resident #3, resident #1 did not manage the situation or coordinate care. Instead, the resident took on an assistive role. Resident #1's preceptor debriefed the situation following the experience and helped her identify areas of improvement.

Month 5, Questions 2-3. The same two residents expressed different perceptions of nursing and themselves as a nurse within the same journal entry. A potential common influencing factor for these differences is varying experiences and responsibilities. Through analysis, two themes emerged: growth and identity (Table 7).

Growth. According to Benner (2001), during the advanced beginner stage, the preceptor or instructor should help the advanced beginner recognize significant findings and prioritize care as the advanced beginner gains increased independence. Successfully identifying and prioritizing findings and receiving genuine positive feedback from preceptors improves self-efficacy (Bandura, 1997). Residents must have opportunities for

personal success and verbal encouragement to develop self-efficacy and growth. According to Duchscher's transition model, residents should be in the being phase at five months, having developed some confidence and responsibility in practice (Duchscher & Windey, 2018). Development of skills, confidence, and self-efficacy allow for growth.

Resident #3's reflective writing represented the being stage. Resident #3 showed self-confidence in her abilities. "I…feel like I can stand on my own two legs for the majority of the time." The resident no longer depended on a preceptor to verify priorities but independently recognized concerning findings and priorities. Resident #3 took responsibility for a critical patient and provided safe, autonomous care, increasing self-efficacy through personal success.

Alternatively, the answers resident #1 provided regarding the nurse's role and how she sees herself as a nurse illustrated the doing stage. In the doing stage, often occurring in the first three to four months of practice, the NGN focuses on completing tasks rather than higher-level thinking. Unfortunately, due to circumstances outside the resident's control, resident #1 continued to work in the pre-graduation role until this journal entry and did not receive sufficient growth opportunities. Therefore, despite being a nurse for five months, the resident did not experience notable growth, as actions, thoughts, and views did not change significantly. "I am still processing situations the same as before."

Identity. A professional identity is the group of thoughts, feelings, and expectations a person has about being a member of a profession (DiBenigno, 2022). Professional identity develops over time, starting during the education phase and developing through socialization to the role from other members of the profession

(DiBenigno, 2022). On hiring, the view of professional identity may be romanticized and will adjust based on experiences and encounters with others (DiBenigno, 2022). Nursing has a professional identity strongly influenced by the nurse's expectations and interactions with coworkers and patients.

Resident #3 was "starting to feel like a 'real nurse'" at five months. The resident cared safely for critical patients and developed a sense of autonomy and confidence. Resident #3 views being a nurse as "the caregiver of patients and [coordinator of] care from many different specialties in healthcare." The resident could think beyond the nursing tasks to consider the nurse's holistic identity.

Resident #1 needed more opportunities to progress toward a professional identity. Due to a lack of changes in role and responsibility, resident #1 still felt "imposter syndrome." "I do not feel like a real nurse still." The lack of growth opportunities shapes the resident's identity. "I…basically do the same things I did prior to getting the RN behind my name."

Nurses develop at different rates. While some commonalities exist between residents, growth does not exist on a predictable timetable. Prior experience, personality, and experiential opportunities influence change and growth. Generalities combine with individual differences to develop an NGN's mind and experience.

Individual Analysis

Only two residents submitted more than one journal. Resident #3 submitted three journals, and resident #1 submitted two. The same two residents submitted journals at month five. Due to the different experiences of the residents, each resident had widely different outcomes. Both residents described high-stress situations in question one before

explaining an understanding of nursing and the view of self as a nurse.

Resident #3. Resident #3 provided three reflective journals at months one, two, and five. The first journal described a situation from the final semester of clinicals, the second journal described a situation during orientation, and the third journal described a situation from independent practice after orientation. Each situation was highly stressful, involving a patient in critical condition and the resident's actions and reactions during and after. The resident reflected on personal performance and growth opportunities in each situation. The resident then detailed perceptions of nursing and self as a nurse. The overarching theme of becoming emerged through resident #3's stories and perceptions.

Worth (2009) defines the concept of *becoming* as a process that shifts one's identity over an undefined length of time. For QI project purposes, the resident was *becoming* a nurse. In becoming a nurse, the resident grew in understanding of what it means to be a nurse, incorporated *nurse* into personal identity, and gained competence in thinking and acting like a nurse.

In resident #3's month one journal, the resident described interacting with and speaking to the patient but did not provide any nursing care. There is no mention of nursing tasks, clinical judgment, or critical thinking. In this situation, the resident focuses solely on not accidentally breaking a rule by compromising patient confidentiality. Despite the danger to the patient, the resident mentioned personal emotional turmoil without referencing the patient's emotional state.

At this stage, the resident described nursing as "giving medications or educating about the importance of lowering blood pressure." As a nursing student and novice nurse, the resident focused on following the rules and understanding nursing tasks, such as

administering medication or educating the patient (Benner, 2001). At the time of the first journal, being a nurse was not integral to the resident's identity, despite being a registered nurse. "I do not feel like a nurse. I feel between a nursing student and a nurse…I'm missing the crucial elements an experienced nurse knows to care for patients."

Resident #3 was in orientation as a nurse at the time of the second journal. Again, the resident described a situation with a critical patient but with a more active role. Observation and participation "[improved] my nursing skills and critical thinking." Confidence and self-efficacy increased as the resident successfully completed nursing skills and "would want less assistance with this skill" in the future and wanted "to be able to stand on my feet more" (Bandura, 1997). Being in the advanced beginner stage, the resident sought increasing autonomy due to learning to apply learned rules to experience (Benner, 2001). The resident no longer focused primarily on tasks and rules but could think about the patient more holistically, recognizing the patient's and family's emotional state. "Once things calmed down, I realized the poor outcome for this patient. I felt sad for the patient and his family."

Resident #3 recognized limited personal growth at month two. "When I was a student, I could only process snapshots of patients and not the whole picture. Now I have a better grasp of situations and what the patient needs." The resident recognized the personal changes and growth that allowed a deeper understanding of patient situations that rarely occur as a nursing student. "I still don't view myself as a 'real' nurse…I am, however, processing patient situations differently than when I was a nursing student." By month two, nursing was becoming a part of the resident's identity.

In the month five journal, the resident was no longer on orientation but practicing

independently as a nurse. Again, the resident described a critical patient. Unlike previous journals, the resident was now the primary nurse caring for the patient. Despite significant stress, the resident assessed the patient's condition, recognized the risks for further deterioration, and responded appropriately to the situation. The resident went beyond focusing on tasks and rules to understanding the patient's situation and coordinating care. “I had to start an esmolol drip while the EMTs were getting her ready to get on the truck…I was on a conference call with the ER and OR nurses.” The resident’s confidence to take charge, delegate, and communicate effectively evidenced growth. The growth demonstrated progress toward a competent nurse, at which stage the nurse has a long-term view and can prioritize care appropriately (Benner, 2001). As part of the progress, the resident also exemplified Duchscher’s being stage, with increasing comfort and responsibility in the nursing role (Duchscher & Windey, 2018). Although the resident recognized personal growth, they acknowledged having more to learn to fit their idea of being a nurse. “If I was in a similar situation, I would have…there is still a steep learning curve ahead of me.”

At month five, the resident practiced independently, no longer dependent on a preceptor to make decisions. Management trusted the resident to care for a critical patient, and the resident proved worthy of the trust. At this stage, the resident was incorporating nursing into her personal identity. “I am starting to feel like a ‘real nurse.’ I have a better grasp of nursing…I definitely don’t feel like a student anymore and feel like I can stand on my own two legs for the majority of the time.” Resident #3 was confident in personal ability without overconfidence.

Resident #1. Resident #1 submitted two reflective journals for the residency

program at months one and five. In both journals, the resident described responses to critical patients, followed by views of nursing and self as nurse. Both situations occurred after the resident became a nurse. However, due to extenuating circumstances, the resident was not working as a nurse until after the month five journal. The resident worked at the facility before and during nursing school and stayed in the same role for the first six months of the residency program. Through the resident's stories and perceptions, the theme emerged that lack of opportunity stunts growth.

In both journals, coworkers did not treat the resident as a nurse but acted as if the resident was still in the former role, so the resident did not attempt to grow past the former role. At month one, the resident describes each task completed for the patient. While each described task was within the purview of a nurse, each task was also in the purview of unlicensed personnel: transfer to a wheelchair, reposition in bed, take vitals, and apply telemetry pads. The resident acted independently but not to the full scope of nursing practice. Focus on tasks is common for an advanced beginner who is aware of the rules and has limited experience in applying the rules to actual patients (Benner, 2001).

Ideally, as the NGN gains experience, there is movement past simple focus on tasks to prioritization of tasks. Resident #1 did not occupy the nursing role by the month five journal. Therefore, the resident's reflective writing did not show growth in identity, ability, or confidence. At month five, the resident describes another critical patient. During the month five situation, the resident worked as part of a team without being treated like a nurse. The resident helped the techs perform compression and observed medication administration, with evidence of learning but not critical thinking or independence. "It was interesting to see [another nurse] cross-checking compatibility and

I learned a lot about how to confirm and check med compatibility." Learning to check drug compatibility after five months as a nurse implies that the resident did not do so at a time when other residents practiced independently.

Despite participating in the team at month five, the resident did not truly feel part of the team. "It was intimidating to be in the situation with all of the moving parts and everyone with their job laid out. Everyone worked very well together and seemed to just know what to do." The resident recognized the benefits of teamwork but could not visualize a personal role as part of the team.

Overall, the resident had stunted growth due to a lack of opportunity. At month one, the resident stated, "I am very proud to be able to call myself a registered nurse, but I also do not yet feel like a nurse…I will hopefully overcome what I feel is 'imposter syndrome.'" The resident recognized the difference between the label of nurse and developing a sense of personal, professional identity as a nurse (DiBenigno, 2022). However, the resident indicated at month five, "I do not feel like a real nurse still…I believe imposter syndrome will be quite real for a while…I am still processing situations the same as before." Resident #1 realized the lack of expected personal growth and attributed it to "basically [doing] the same things I did prior to getting the RN behind my name."

Residents #1 and #3 were chronologically at the same place in their nursing careers. However, each resident presented as significantly different by month five. Resident #3 grew in confidence, competence, and autonomy while developing a professional identity as a nurse. Conversely, resident #1 needed more growth opportunities and remained stunted, acting and thinking the same as in month one.

Coworkers challenged resident #3 and expected competence, so the resident rose to meet those expectations. Coworkers treated resident #1 like before becoming a nurse, so the resident remained stagnant.

Residents' experiences varied throughout the program. Personal self-efficacy and opportunities affected growth and transition. Throughout the journals, residents experienced stressful situations. Differences in stress response implied the resident's confidence level, and the resident's actions demonstrated coworkers' confidence in the resident.

Discussion

Attrition is high in nursing, especially among NGNs who experience additional stress due to transitioning to practicing nurses (Charette et al., 2020; NSI Nursing Solutions, Inc., 2021). The QI project aimed to improve job satisfaction, retention, and competence in NGNs at a small midwestern hospital by developing and implementing an NRP. The CFGNES assessed job satisfaction, human resources data evaluated retention, and reflective journals examined competence and transition.

Job Satisfaction

In 2021, the CFGNES survey authors reassessed its validity by collecting 71,919 survey results over ten years (Casey et al., 2021). The author's data provide a benchmark for NGN responses to CFGNES's Likert scale. Participant scores are statistically consistent with the benchmark. Participant scores were averages of 0-7 months, while benchmark scores were exclusively from the six-month mark. Most QI participant data collection involved residents with less experience than NGNs in the benchmark study,

accounting for some discrepancies. However, the results demonstrate that residents' job satisfaction was similar to other NGNs.

Changes in nursing could account for the lower safety score, as the benchmark scores represented ten years of data before the pandemic. Patient acuity and staffing loads changed following the onset of the pandemic, causing increased workload and added responsibilities. NGNs must learn to handle these changes, but inadequate preparation to meet these expectations makes them feel less confident in prioritizing and organizing time and care (Brennen, 2021).

The CFGNES measured satisfaction through multiple avenues. Section II used a Likert scale to assess five factors of satisfaction: support, patient safety, stress, communication/leadership, and professional satisfaction, as well as providing an overall score. There was a significant drop in the support subscale from month 0 to month 3. At month 0, most residents had just started orientation. At the beginning of orientation, NGN expectations are low, and support is high in supervision, feedback, and more controlled exposure to new experiences. By month 3, most residents had either finished orientation or were soon to finish. When residents are off orientation, expectations are high, with minimal support. Managers and coworkers expect NGNs to practice safely and independently (Kim & Shin, 2020). However, residents felt they needed more support, especially from other nurses on the unit who could help them develop realistic expectations and confidence. A mentor or ongoing preceptorship past the traditional orientation is a method to provide this extended support (Kim & Shin, 2020).

The mean for each subscale of the CFGNES dropped slightly between month 0 and month 3, although none were statistically significant other than the support subscale.

However, the overall score did drop significantly between month 0 and month 3. The decrease in each subscale explains the overall decrease in score. According to the literature, job satisfaction scores for NGNs tend to decrease around six months, then trend back up by 12 months (Eckerson, 2018; Rush et al., 2019). Due to project time constraints, data was not available at 12 months. An insufficient number of residents submitted surveys past three months (n=3) to perform valid statistical analysis. Of note, overall and all subscale scores were trending up at months five to seven but lacked power for inclusion in results.

Another section of the CGNES asks how satisfied NGNs are with nine aspects of the job: salary, working hours, encouragement/feedback, and responsibility (Table 8). Satisfaction trends basically stayed the same, with a slight downward trend for encouragement/feedback and choosing shifts. Although both aspects averaged at least ‘moderately satisfied’ at month 0, there were no subsequent increases in the scores. The slight decrease in satisfaction with encouragement/feedback could be attributed to advancement within the orientation process, as preceptors and coworkers feel less need to praise someone as experience increases. Staffing changes at the hospital could substantiate the slight decrease in satisfaction with choosing shifts. Near the beginning of the second cohort, the facility lost many travel nurses, requiring staff nurses to work mandated overtime shifts. Throughout the assessed timeframe, no average dropped to the ‘dissatisfied’ level. All scores remained between ‘neither satisfied nor dissatisfied’ and ‘very satisfied’ for all assessed aspects.

Table 8

Average Satisfaction Rating by Month

	Month 0	**Month 3**
Salary	*4.27*	*3.83*
Vacation	*4.09*	*3.64*
Benefits	*3.82*	*3.42*
Working Hours	*4.09*	*3.67*
Weekends Off	*4.09*	*3.50*
Advancement Opportunities	*3.82*	*3.58*
Responsibility	*3.64*	*3.50*
Encouragement/ Feedback	*4.36*	*3.83*
Choosing Shifts	*4.00*	*3.83*

Note. Ratings range from 0=very dissatisfied to 5=very satisfied

The survey also assessed NGN satisfaction with various occupational factors. While residents rated no factor mean as 'dissatisfied,' satisfaction with each factor decreased from month 0 to month 3. Most decreases were not statistically significant; however, three factors did decrease significantly. Resident satisfaction with vacations (t_6=2.121, p=.078), benefits packages (t_7=2.049, p=.080), and weekends off per month (t_7=2.049, p=.080) decreased significantly by month 3 (Figure 7). Residents submitted insufficient data at months one, five, or seven to include in the analysis.

Of submissions at month three, 70% were submitted around the holiday season, which likely reinforced the knowledge that nursing staff are required to work holidays. Around the same time, the facility made some changes in staffing, including multiple travel nurses leaving, which led to staff picking up extra shifts, including on the

weekends. Staffing changes, in conjunction with working holidays, could account for decreased resident satisfaction.

Residents rated lack of confidence as their most difficult challenge. NGNs struggle to transition to independent nurses due to a sudden change from minimal responsibilities as student nurses to complete responsibility for their patient care as a nurse. Hence, NGNs need ample opportunities for successful experiential learning and honest, positive feedback to increase self-efficacy (Bandura, 1997).

An increase in workload is expected from month zero to month three. The resident has finished orientation or is nearing completion of orientation and must take a full load of patients. The transition off orientation could concern NGNs, resulting in increased responsibility and decreased support.

Concerns about fear of harming a patient and orientation issues decreased at month three. With more experience, the resident becomes comfortable, causing less concern about accidentally harming a patient. Additionally, the experience is a tool to gain familiarity with the unit, technology, and staff. The greater awareness of the work environment and coworkers eases stress and decreases the concern of harming patients.

Requests for an improved work environment involve gradual ratio changes, increased assistance from unlicensed personnel, and schedule or committee work involvement. Each unit at the facility manages orientation for staff. The nurse-to-patient load may suddenly change for residents toward the middle to end of orientation, or a heavier patient load may be necessary to offset poor staffing and lack of unlicensed personnel. When this happens, an NGN may feel alone and without support (Fowler et al., 2018).

The desire for improved orientation increased noticeably at month three. At month three, orientation was over or would soon end. This finding suggests that NGNs may require extended orientation compared to experienced new hires, as NGNs must also orient to the nursing role rather than just the hospital or unit (Kim & Shin, 2020).

Most residents (72.7%) found the unit staff helpful and supportive at months zero and three. Peer support is one of nurses' most vital indicators of intent to stay and job satisfaction (Eckerson, 2018). NGNs must feel they belong to the unit and can count on help when needed.

At month zero, residents rated ongoing learning from preceptors and mentors and the professional nursing role, with the challenges and empowerment, as common satisfiers. At month zero, NGNs felt accomplished when completing nursing school and becoming a nurse, making the inherent challenges more satisfying. The initial orientation period is also a time of high mentoring or precepting, with significant support from more experienced nurses.

Residents consistently found only system issues to be the least satisfying. System issues include outdated facilities and equipment, lack of space, and paperwork. However, by month three, the other three areas assessed for least satisfying had increased noticeably. The change could indicate a growing dissatisfaction with the facility or nursing, which the researchers suggest occurs within six months of practice and is associated with the high attrition rate of NGNs (Eckerson, 2018; Pillai et al., 2018; Rush et al., 2019).

Multiple factors influence an NGN’s experience and satisfaction. The strongest and only significant correlation was between degree earned and stress. Residents who

earned a bachelor's degree, as opposed to an associate's degree, felt significantly less stress at month three than month zero. Traditional bachelor programs consist of four years of study, whereas associate programs are generally two years. The additional time may give bachelor-prepared NGNs additional experience and confidence in practice and increase resilience (Wu et al., 2022).

Several trends emerged in relationships. At month zero, those with experience that closely resembled an RN tended to feel supported. Most nurse-related experiences were from student externships. Presumably, many student externships occurred at the facility, allowing the NGNs to feel more comfortable with the staff at the practice initiation. By month three, residents with less experience in roles like nurses had time to gain comfort with coworkers and feel more supported.

At month three, residents with higher degrees perceived patient safety as lower. The trend is surprising, as nurses with higher education levels tend to provide safer care with better patient outcomes (Harrison et al., 2019). The trend could be attributed to stress levels as the scale assesses the NGN's perception of the safety of patient care, not the actual care given.

The overarching job satisfaction findings revealed that residents with more nurse-related experience have slightly increased overall satisfaction, feelings of support, and comfort in communicating and delegating. While experience as a nurse extern is not equivalent to nursing experience, there are correlations. Nurse extern programs increase confidence, skills, and comfort in the nursing environment (Rugs et al., 2020).

Overall, job satisfaction scores stayed within acceptable levels throughout the project timeframe. While precipitating factors varied in strength throughout the project,

residents never expressed significant dissatisfaction with any aspect of the job except for system issues. Satisfaction was consistent with national benchmarks and trended upward at the project's conclusion.

Retention

The facility's annual NGN retention rates for the three years pre-implementation were consistently higher than reported national averages, although trending down. The trend could be partially attributed to the pandemic and its subsequent effects on staffing, including the rise in travel nursing and the increased stress on nurses. Post-implementation retention rates for NGNs rose significantly from pre-implementation rates. A potential contributing factor to the improved retention rate is the amount and quality of ongoing support provided through the NRP, although the relationship is not necessarily causational.

Another factor that potentially influenced the retention rate was staffing at the facility. Around the beginning of the second cohort, the facility made significant changes, including closing travel nurse contracts, closing some units, and restructuring others. One restructuring combined two units into one space. Per debriefing sessions, at least two residents, previously unhappy in their primary unit and considering a change, appreciated the change with the additional staff and support that occurred when the units merged. The change increased satisfaction with the facility and the unit for those residents.

Before implementation, the facility's overall nurse retention rate was lower than the NGN retention rate. During the pandemic, many experienced nurses left staff nurse jobs to become travel nurses. NGNs did not have enough experience to become travel nurses, potentially contributing to the difference in retention rates.

Overall, NGN retention rates increased after project implementation, although a direct causational relationship is unclear. Increased support provided through the NRP and facility staffing changes may contribute to the increased retention rate. However, too many confounding factors hinder defining correlational relationships for NGN retention rates.

Competence

Benner's novice to expert theory provides a framework for assessing the increasing competence of nurses (Benner, 2001). Benner expects NGNs to begin as advanced beginners, having enough knowledge and experience to provide basic care without the ability to prioritize that care or comprehend the long-term plan (Benner, 2001). Reflective journal analysis supports that residents were advanced beginners at month one. At month one, residents experienced significant fear and stress while focusing on learning from other nurses and understanding what it means to be a nurse.

According to Benner (2001), a nurse should reach a competent level after two to three years of consistent practice in the same area. As such, facilities should not expect residents to achieve competence within six months of graduation. Instead, the aim of the NRP was to foster growth toward competence in residents and assist in the transition. Unfortunately, few residents submitted journals after month one, making it challenging to assess growth. One resident, resident #3, showed distinct signs of growth toward competence. Resident #3 demonstrated increasing autonomy and responsibility with time. By month five, resident #3 could look past the immediate situation toward the future and prioritize current needs based on that view.

The other resident with more than one journal, resident #1, lacked growth

opportunities. At month five, resident #1 was still an advanced beginner, with some knowledge and experience, but primarily learning from other nurses rather than acting as a nurse. The difference between the two residents highlights the need for the NRP to partner with resident units to ensure adequate support and opportunity on the floor.

With minimal data past month one, there was insufficient data to conclude whether or not the residency program promoted growth toward competence among NGNs. However, the reflective writings did illustrate that differences in resident experience at the bedside significantly impacted growth.

Implications for Practice

An NRP supports NGNs transitioning from student nurses to practicing nurses. Transition is stressful, with NGNs requiring additional support to transition to a state of competence and satisfaction. Preceptors and nurse leaders can use themes drawn from reflective journals to guide orientation procedures. NGNs want to grow into good nurses but need assistance. NGNs need guidance and opportunities to manage stress and should feel free to express that stress to peers without fear of condemnation. Management should incorporate time for debriefing and building relationships. As one resident stated in a journal, “I think the residency program has been good to see where everyone else is at and to form relationships.”

Fortunately, the facility plans to continue the NRP past the Doctor of Nursing Practice project. The data indicates increases in NGN retention at six months, resulting in benefits to the facility’s financial status and the respective units' culture. For sustainability, the NRP will need a residency facilitator willing to invest in the lives and careers of NGNs.

Limitations

The QI project had several limitations, potentially affecting the validity or generalizability of results. Due to the time constraints of the Doctor of Nursing Practice project, there was a small sample size with only two cohorts included. Additionally, residents did not fully participate in data collection, with many not submitting the CFGNES and more not submitting reflective journals. Moreover, lack of financial and time investment by the facility limited the residents' engagement in the program.

Nominally, the facility supported the NRP. In practice, many residents worked during preplanned residency activities because the staffing pattern did not account for the resident’s extended break from the unit, forcing NGNs to remain on the unit to care for their patients. Furthermore, managers and charge nurses were reluctant to release needed nurses from patient care for residency activities. Consequently, monthly meetings experienced low attendance, diminishing the benefits of the NRP.

The facility collected NGN employment information for approximately three years before project implementation. Facility data collection began near the onset of the pandemic, with the first residency cohort starting toward the end of the pandemic. The pandemic may have affected retention numbers, especially during the pandemic, with the draw of travel and agency nursing. Around the start of the second residency cohort, the facility did not renew the contracts of travel nurses, affecting available patient beds and staffing ratios, which could have influenced retention in the residency cohorts.

Recommendations

The NRP succeeded in improving NGN retention and managing job satisfaction. However, there is always room for growth and improvement. Since the institution intends

to continue the residency program, several changes could improve the program's impact on retention, job satisfaction, and NGN growth toward a safe, confident, independent nurse.

During the QI project, monthly residency meetings consisted of two hours once per month, divided between debriefing and evidence-based practice projects. Ideally, monthly residency days would be longer, preferably eight-hour days. Adding additional time to the monthly residency meetings would have several benefits. Additional time would ensure residents were not working during the residency meetings. The residency facilitator could incorporate simulations or case studies specific to the residents' areas of interest into the residency days to assess and stimulate critical thinking. With additional time, residents would have more time for debriefing and forming relationships in and among cohorts for support on the unit. The added time would also allow residents to provide formal and informal feedback by completing the CFGNES and writing reflective journal entries while verbally discussing the NRP during residency meetings. The feedback could help the residency facilitator understand the residents' mindset and recognize concerns that the facilitator, preceptor, or manager may need to address. Reflective journals also allow the resident to close the learning loop, reflecting on personal performance and growth. Writing reflective journal entries routinely through two years of practice will foster self-discovery and supply evidence of growth toward becoming a competent nurse based on Benner's (2001) theory.

During the project's planning stage, the facility planned to concurrently restructure and improve the preceptor program, providing additional education and training to all preceptors. One reason for the intended changes was to support NGNs

better in their transition. However, before project implementation, the professional development nurse in charge of the preceptor project left the position and was not immediately replaced. As a result, the preceptor program did not change and had little to no interaction with the NRP. Ideally, NGN's preceptors should be aware of what is happening in the NRP and share resident progress with the residency facilitator, allowing the preceptor and residency programs to partner in developing the NGN.

The facility could also consider a mentorship program on the floor past the traditional orientation. A mentorship program could include the preceptor continuing to mentor the resident, a separate mentor assigned to the resident to provide support and encouragement, or simply partnering the resident with an experienced nurse during each shift so the resident has someone to ask questions and advice.

Statistical analysis of demographics and CFGNES results did not show a statistical correlation between nurse-related experiences, such as nurse intern programs, before becoming an NGN and feelings of satisfaction, support, and comfort with communication and delegation due to limited sample size. However, the results trended toward this correlation. This trending correlation suggests that facility administrators should continue or consider expanding the existing nurse intern program as a pipeline for nursing staff that also benefits the NGN.

A nurse residency exists to support NGNs but can only provide some needed support. Preceptors and nurse leaders should know each resident's growth trajectory and recognize their need for better or additional support. Regular interaction between the preceptors, manager, and residency program facilitator could provide a united front to meet the individual needs of each resident.

The NRP also requires a dedicated facilitator to coordinate program meetings and needs, support residents, and collaborate with other facility areas to achieve regular interaction. The facilitator should be passionate about helping NGNs grow and providing a mentorship relationship.

The aim of the QI project was to improve retention, job satisfaction, and competence among NGNs through participation in an NRP. Retention data, CFGNES, and reflective journals provided insight into residents' growth and changing perceptions of nursing and themselves throughout the program. Data collected from the CFGNES indicated that the residents' job satisfaction was consistent with benchmarks, human resources data revealed that retention rates increased post-implementation, and residents illustrated growth towards competence in their reflective journaling when given adequate opportunity. The evaluative data did not show conclusive evidence that the NRP caused the intended improvements. Yet, if the program remains in place and employs the suggested recommendations, the NRP could be an opportunity for the facility to retain competent, confident, reflective nurses with a desire for lifelong learning.

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Appendices

Appendix A

Casey-Fink Graduate Nurse Experience Survey (Revised)

CASEY-FINK GRADUATE NURSE EXPERIENCE SURVEY (REVISED)

I. List the top three skills/procedures you are *uncomfortable performing* independently at this time? (please select from the drop down list) list is at the end of this document.

1. _____

2. _____

3. _____

4. _____**I am independent in all skills**

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
1. I feel confident communicating with physicians.	☐	☐	☐	☐
2. I am comfortable knowing what to do for a dying patient.	☐	☐	☐	☐
3. I feel comfortable delegating tasks to the Nursing Assistant.	☐	☐	☐	☐
4. I feel at ease asking for help from other RNs on the unit.	☐	☐	☐	☐
5. I am having difficulty prioritizing patient care needs.	☐	☐	☐	☐
6. I feel my preceptor provides feedback and encouragement about my work.	☐	☐	☐	☐
7. I feel staff is available to me during new situations and procedures.	☐	☐	☐	☐
8. I feel overwhelmed by my patient care responsibilities and workload.	☐	☐	☐	☐
9. feel supported by the nurses on my unit.	☐	☐	☐	☐

10. I have opportunities to practice skills and procedures more than once. ☐ ☐ ☐ ☐

11. I feel comfortable communicating with patients and their families. ☐ ☐ ☐ ☐

II. Please answer each of the following questions by placing a mark inside the circles:

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
12. I am able to complete my patient care assignment on time.	☐	☐	☐	☐
13. I feel the expectations of me in this job are realistic.	☐	☐	☐	☐
14. I feel prepared to complete my job responsibilities.	☐	☐	☐	☐
15. I feel comfortable making suggestions for changes to the nursing plan of care.	☐	☐	☐	☐
16. I am having difficulty organizing patient care needs.	☐	☐	☐	☐
17. I feel I may harm a patient due to my lack of knowledge and experience.	☐	☐	☐	☐
18. There are positive role models for me to observe on my unit.	☐	☐	☐	☐
19. My preceptor is helping me to develop confidence in my practice.	☐	☐	☐	☐
20. I am supported by my family/friends.	☐	☐	☐	☐
21. I am satisfied with my chosen nursing specialty.	☐	☐	☐	☐
22. I feel my work is exciting and challenging.	☐	☐	☐	☐

23. I feel my manager provides encouragement and feedback about my work. ☐ ☐ ☐ ☐

24. I am experiencing stress in my personal life. ☐ ☐ ☐ ☐

25. If you chose agree or strongly agree, to #24, please indicate what is causing your stress. (You may circle more than once choice.)

    a. Finances
    b. Child care
    c. Student loans
    d. Living situation
    e. Personal relationships
    f. Job performance
    g. Other _____

III. How *satisfied* are you with the following aspects of your job:

	VERY DISSATISFIED	MODERATELY DISSATISFIED	NEITHER SATISFIED NOR DISSATISFIED	MODERATELY SATISFIED	S.
Salary	☐	☐	☐	☐	
Vacation	☐	☐	☐	☐	
Benefits package	☐	☐	☐	☐	
Hours that you work	☐	☐	☐	☐	
Weekends off per month	☐	☐	☐	☐	
Your amount of responsibility	☐	☐	☐	☐	
Opportunities for career advancement	☐	☐	☐	☐	
Amount of encouragement and feedback	☐	☐	☐	☐	
Opportunity for choosing shifts worked	☐	☐	☐	☐	

IV. Transition (please circle any or all that apply)

1. **What difficulties, if any, are you currently experiencing with the transition from the *"student"* role to the *"RN"* role?**
    a. role expectations (e.g. autonomy, more responsibility, being a preceptor or in charge)
    b. lack of confidence (e.g. MD/PT communication skills, delegation, knowledge deficit, critical thinking)
    c. workload (e.g. organizing, prioritizing, feeling overwhelmed, ratios, patient acuity)
    d. fears (e.g. patient safety)
    e. orientation issues (e.g. unit familiarization, learning technology, relationship with multiple preceptors, information overload)
2. **What could be done to help you feel more supported or integrated into the unit?**
    a. improved orientation (e.g. preceptor support and consistency, orientation extension, unit specific skills practice)
    b. increased support (e.g. manager, RN, and educator feedback and support, mentorship)
    c. unit socialization (e.g. being introduced to staff and MDs, opportunities for staff socialization)
    d. improved work environment (e.g. gradual ratio changes, more assistance from unlicensed personnel, involvement in schedule and committee work)
3. **What aspects of your work environment are most satisfying?**
    a. peer support (e.g. belonging, team approach, helpful and friendly staff)
    b. patients and families (e.g. making a difference, positive feedback, patient satisfaction, patient interaction)
    c. ongoing learning (e.g. preceptors, unit role models, mentorship)
    d. professional nursing role (e.g. challenge, benefits, fast pace, critical thinking, empowerment)
    e. positive work environment (e.g. good ratios, available resources, great facility, up-to-date technology)
4. **What aspects of your work environment are least satisfying?**
    a. nursing work environment (e.g. unrealistic ratios, tough schedule, futility of care)
    b. system (e.g. outdated facilities and equipment, small workspace, charting, paperwork)
    c. interpersonal relationships (e.g.gossip, lack of recognition, lack of teamwork, politics)
    d. orientation (inconsistent preceptors, lack of feedback)

5. **Please share any comments or concerns you have about your residency program:**

V. ***Demographics:*** **Circle the response that represents the most accurate description of your individual professional profile.**

1. **Gender**
   a. Female
   b. Male
2. **Ethnicity:**
   a. Caucasian (white)
   b. Black
   c. Hispanic
   d. Asian
   e. Other
   f. I do not wish to include this information

3. **Area of specialty:**
   a. Adult Medical/Surgical
   b. Adult Critical Care
   c. OB/Post Partum
   d. NICU
   e. Pediatrics
   f. Emergency Department
   g. Oncology
   h. Transplant
   i. Rehabilitation
   j. OR/PACU
   k. Psychiatry
   l. Ambulatory Clinic
   m. Other: _____

4. **School of Nursing Attended** (name, city, state located): _____

5. **Date of Graduation: _____**
6. **Degree Received:** AD: _____Diploma: _____BSN: _____ND:___

7. **Other Non-Nursing Degree (if applicable):**

8. **Date of Hire** *(as a Graduate Nurse)***:**

9. **What previous health care work experience have you had:**
   a. Volunteer
   b. Nursing Assistant
   c. Medical Assistant
   d. Unit Secretary
   e. EMT
   f. Student Externship
   g. Other *(please specify)*:

10. **Have you functioned as a charge nurse?**
    a. Yes
    b. No

11. **Have you functioned as a preceptor?**
    a. Yes
    b. No

12. **What is your scheduled work pattern?**
    a. Straight days
    b. Straight evenings
    c. Straight nights
    d. Rotating days/evenings
    e. Rotating days/nights
    f. Other *(please specify)*:

13. **How long was your unit orientation?**
    a. Still ongoing
    b. ≤ 8 weeks
    c. 9 – 12 weeks
    d. 13 – 16 weeks
    e. 17 - 23 weeks
    f. ≥ 24 weeks

14. **How many** *primary* **preceptors have you had during your orientation?**

_____number of preceptors

15. Today's date: _____

Drop down list of skills

Assessment skills
Bladder catheter insertion/irrigation
Blood draw/venipuncture
Blood product administration/transfusion
Central line care (dressing change, blood draws, discontinuing)
Charting/documentation
Chest tube care (placement, pleurovac)
Code/Emergency Response
Death/Dying/End-of-Life Care
Nasogastric tube management
ECG/EKG/Telemetry care
Intravenous (IV) medication administration/pumps/PCAs
Intravenous (IV) starts
Medication administration
MD communication
Patient/family communication and teaching
Prioritization/time management
Tracheostomy care
Vent care/management
Wound care/dressing change/wound vac
Unit specific skills _____

Appendix B

Reflective Journal Questions

Please answer the following prompts in your journal:

1. Describe, in detail, a significant situation you were involved in as a nursing student over the last three months. This situation may be positive or negative. It should be memorable and personally significant to you. Please describe what happened, how you responded, if anyone else was involved (please do NOT use any personally identifying information for other staff, patients, or visitors), etc.
    a. As you describe this situation, please consider the following questions. Do NOT answer individually or in order. Answer them as part of your story.
        i. In that situation, how did you feel? What emotions were you experiencing during and/or after the situation?
        ii. What, if anything, did you learn from the situation? (About yourself? About nursing? About life?)
        iii. What did you perform well during the situation? (Communication? Skills? Critical thinking? Ethical decision-making? Prioritization? Delegation? Leadership? Time management?)
        iv. If you were in a similar situation again, is there anything you would do differently? (Would you want to respond differently? Do you wish you had additional information or training? Did you need additional support?)
    b. Please indicate if you would be willing to discuss this situation at a residency meeting.
2. Describe your current view of nursing. (What does it mean to be a nurse? What is the role of nurses?)
3. Describe your current view of yourself as a nurse. (Do you feel like a ‘real’ nurse? In general, do you think you act and respond the way you think a nurse should? Are you satisfied with your decision to become a nurse?)

Appendix C

IRB Exemptions: Facility

From: Stucky,Sally <Sally.Stucky@marionhealth.com>
Sent: Thursday, July 14, 2022 3:50:19 PM
To: Renna,Denise <Denise.Renna@marionhealth.com>
Cc: Greentree, Megan <megan.greentree@indwes.edu>; Crawford,Kathryn <Kathryn.Crawford@marionhealth.com>; Seward,Sarah <Sarah.Seward@marionhealth.com>
Subject: RE: Project for IRB

We have reviewed your proposed project and it was determined that IRB approval is not required since the project will not involve any human subjects.

Appendix D

IRB Exemption: Educational Facility

Institutional Review Board
4201 South Washington Street
Marion, IN 46953

Tel: 765-677-2090
Fax: 765-677-6647

Notice of Exemption

Effects of a Nurse Residency Program on Competence, Job Satisfaction, and Retention
Title of Research Topic

Megan Greentree, Angela Bailey
Investigator(s)

1769.22
IRB ID Number

The IWU Institutional Review Board (IRB) has reviewed your proposal and has determined that your proposal is exempt from further review by the IRB because the proposed project does not constitute human subjects research. Federal regulations that establish the authority of the IRB provide a specific definition of human subjects research which defines the scope of IRB authority. Your project falls outside the federal definition of human subjects research and is therefore not subject to IRB review.

Please note that this exemption regards only the oversight of human subjects research by the IRB. The IRB has not reviewed any other aspects of the research project and makes no judgement on the merits of the project or its methodologies. All research executed at IWU must conform to all applicable state and federal laws and regulations and to all applicable IWU policies.

Comments:

Ph.D.
Chair, Institutional Review Board

September 14, 2022
Date

Appendix E

Outline of Nurse Residency Program Topics

Nurse Residency Program Included Topics

Topics were included based on accreditation standards and input from hospital stakeholders

- Hospital-specific policies
  - Nurse roles/responsibilities
  - Dress code
  - Social media
  - Etc.
- Hospital-specific resources
  - Continuing education
  - Certification
  - Different departments and clinics
  - Just culture
- Documentation
  - Charting system
  - Incident reports
  - Narrative notes
- Communication
  - Report
  - Provider communication
  - Service recovery
- Diversity, Equity, Inclusion
  - Recognizing preconceptions
  - Strategies for inclusion
  - Case studies
- Time Management, Prioritization, & Delegation
  - Including case studies
- Self-Care and Resiliency
- Patient Care
  - Skin care/wound care
  - Fall prevention
  - Infection control
  - Narcotics
  - Patient teaching
- Therapies
  - Physical
  - Occupational
  - Speech

    - Respiratory
- Recognizing and intervening for heart dysrhythmias
- Ethics
    - Making ethical decisions
    - Indiana Donor Network
    - End of life care
    - Hospice vs palliative care

Simulation Topics
Topics were chosen based on input from hospital stakeholders

- Medication administration
- Post op care
- Fall prevention/post fall care
- Caring for atrial fibrillation, congestive heart failure, and angina
- Stroke care
- Post-partum hypertension
- Rapid response/emergencies (sepsis, respiratory distress, post-partum hemorrhage)
- Code Blue/Pink (PALS and ACLS)

Appendix F

Evidence-Based Practice Curriculum Overview

1. How to choose an idea
2. Writing a PICOT question
3. Completing a SWOT analysis
4. Searching and evaluating literature
5. Creating a plan for implementation
    a. Relevant stakeholders
    b. Generating buy-in
    c. Types of data
6. Obtaining IRB approval
7. Analyzing data
8. Determining effectiveness
9. Disseminating findings

Appendix G

Permission to Use Casey-Fink Graduate Nurse Experience Survey

June 2015

Dear Colleague:

Thank you for the inquiry regarding the *Casey-Fink Graduate Nurse Experience* **S*urvey*□ (revised, 2006) instrument.**

The survey was originally developed in the spring of 1999, initially revised in June 2002, and revised a second time in 2006. Since that time, it has been used to survey over 250 nurses in hospital settings in the Denver metropolitan area, and has been further validated by over 10,000 graduate nurse residents participating in the University Health System Consortium/AACN Post Baccalaureate Residency program and elsewhere nationally and internationally. Psychometric analysis has been done using these data and is reported in the summary included with this letter. We have published a report of the research we conducted in the development of this instrument:

Casey K, Fink R, Krugman M, Propst J: The graduate nurse experience. *Journal of Nursing Administration.* 2004; 34(6):303-311.

Fink RM, Krugman ME, Casey K, Goode CM. The Graduate Nurse Experience: Qualitative Residency Program Outcomes. *Journal of Nursing Administration*. 2008;38(7/8):341-348.

We are granting you permission to use this tool to assess the graduate nurse experience in your setting. Please note that this tool is copyrighted and should not be changed in any way. We have enclosed a copy for you to use for reproduction of the instrument.

We hope that our tool will be useful in your efforts to enhance the retention, professional development, and support of graduate nurses in your practice setting. Please email us if you have further questions. We would be interested in being informed as to your results or publications related to the use of our instrument.

Sincerely,

Kathy Casey, RN, MSN
Manager, Clinical Education Programs, Exempla Lutheran Medical Center Adjunct Faculty, University of Colorado, College of Nursing
kathy.casey@sclhs.net

Regina Fink, RN, PhD, AOCN, FAAN
Associate Professor, University of Colorado College of Nursing
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Appendix H

Informed Consent Form

Title of Study: Effects of a Nurse Residency Program on Competence, Job Satisfaction, and Retention

Principal Investigator
Megan Greentree
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megan.greentree@indwes.edu

Purpose of Study
You are being asked to take part in a research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. Please read the following information carefully. Please ask the researcher if there is anything that is not clear or if you need more information.

The *purpose of this study* is to assess effects of a nurse residency program on job satisfaction, competence, and retention.

Study Procedures
As a participant in this research study, you will be asked to:

- Complete the Casey-Fink Graduate Nurse Experience Survey at the beginning of the program and every three months throughout the program
- Provide a reflective journal submission (either handwritten, typed, or video) at one month then every third month of the program

Risks
There are minimal risks associated with this research study. Your anonymity may not be maintained if you choose to provide video reflective journals, rather than handwritten or typed.
You may decline to answer any or all questions and you may terminate your involvement at any time if you choose.

Benefits
The goal of the project is to improve onboarding and transition to practice for new graduate nurses. You will benefit directly from access to the residency program and improvements to the residency program based on feedback, and indirectly, in the future, through improved preparation of yourself and future coworkers. Society will benefit through improved preparation of newly graduated nurses.

Confidentiality
Your responses to the Casey-Fink Graduate Nurse Experience Survey will be

anonymous. Please do not write any identifying information on your survey. Every effort will be made by the researcher to preserve your confidentiality regarding your reflective journals including the following:

- Assigning code names/numbers for participants that will be used on all research notes and documents
- Keeping notes and any other identifying participant information in a locked file cabinet and/or dedicated flash drive in the personal possession of the researcher.

Participant data will be kept confidential except in cases where the researcher is legally obligated to report specific incidents. These incidents include, but may not be limited to, incidents of abuse and suicide risk.

Contact Information
If you have questions at any time about this study, or you experience adverse effects as the result of participating in this study, you may contact the researcher whose contact information is provided on the first page. If you have questions regarding your rights as a research participant, or if problems arise which you do not feel you can discuss with the Primary Investigator, please contact the Hospital's Institutional Review Board (research@marionhealth.com).

Voluntary Participation
Your participation in this study is voluntary. It is up to you to decide whether or not to take part in this study. If you decide to take part in this study, you will be asked to sign a consent form. After you sign the consent form, you are still free to withdraw at any time and without giving a reason. Withdrawing from this study will not affect the relationship you have, if any, with the researcher. If you withdraw from the study before data collection is completed, your data will be returned to you or destroyed.

Consent
I have read and I understand the provided information and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost. I understand that I will be given a copy of this consent form. I voluntarily agree to take part in this study.

Participant's signature _____ Date _____

Investigator's signature _____ Date _____

Tables

Table 1

Demographics

	Cohort 1		Cohort 2		Total	
Total Number	*8*		*8*		*16*	
	#	*%*	*#*	*%*	*#*	*%*
Age						
20-29	*6*	*75%*	*5*	*62.5%*	*11*	*68.75%*
30-39	*1*	*12.5%*	*2*	*25%*	*3*	*18.75%*
40-49	*1*	*12.5%*	*1*	*12.5%*	*2*	*12.5%*
Gender						
Female	*6*	*75%*	*7*	*87.5%*	*13*	*81.25%*
Male	*2*	*25%*	*1*	*12.5%*	*3*	*18.75%*
Ethnicity						
Caucasian (White)	*8*	*100%*	*8*	*100%*	*16*	*100%*
Specialty						
Adult Medical/Surgical	*1*	*12.5%*	*0*	*0%*	*1*	*6.25%*
Adult Critical Care	*1*	*12.5%*	*1*	*12.5%*	*2*	*12.5%*
OB/Postpartum	*0*		*1*	*12.5%*	*1*	*6.25%*
Emergency Department	*4*	*50%*	*6*	*75%*	*10*	*62.5%*
OR/PACU	*1*	*12.5%*	*0*	*0%*	*1*	*6.25%*
Other	*1*	*12.5%*	*0*	*0%*	*1*	*6.25%*
Degree						
ADN	*3*	*37.5%*	*3*	*37.5%*	*6*	*37.5%*
BSN	*5*	*62.5%*	*5*	*62.5%*	*10*	*62.5%*
Previous Experience						
Nursing Assistant	*0*	*0%*	*4*	*50%*	*4*	*25%*
Unit Secretary	*0*	*0%*	*1*	*12.5%*	*1*	*6.25%*
Student Extern	*2*	*25%*	*1*	*12.5%*	*3*	*18.75%*
Volunteer	*1*	*12.5%*	*0*	*0%*	*1*	*6.25%*
EMT	*0*	*0%*	*1*	*12.5%*	*1*	*6.25%*
Other	*5*	*62.5%*	*1*	*12.5%*	*6*	*37.5%*
CFGNES Completed						
One	*2*	*25%*	*3*	*37.5%*	*5*	*31.25%*
Two	*3*	*37.5%*	*5*	*62.5%*	*8*	*50%*
Three	*3*	*37.5%*	*0*	*0%*	*3*	*18.75%*

Table 5

Pearson's R Correlations

	Over Time	Month 0	Month 3
Age	---	---	---
Age vs Overall Score	.020	-.265	.065
Age vs Support	-.014	-.279	.065
Age vs Safety	.112	.144	-.021
Age vs Stress	.012	-.311	.382
Age vs Communication/Leadership	-.142	-.319	-.213
Age vs Professional Satisfaction	.232	.058	.304
Degree	---	---	---
Degree vs Overall Score	.054	.317	.134
Degree vs Support	.123	.259	.352
Degree vs Safety	-.140	.108	-.544^
Degree vs Stress	-.226	-.063	-.642*
Degree vs Communication/Leadership	-.146	-.179	.034
Degree vs Professional Satisfaction	.139	.075	.275
Previous Experience	---	---	---
Experience vs Overall Score	.290^	.383	.228
Experience vs Support	.269^	.520^	.134
Experience vs Safety	.154	.191	.029
Experience vs Stress	.217	.182	.296
Experience vs Communication/Leadership	.294^	.233	.273
Experience vs Professional Satisfaction	.152	.257	.229

^=*trend (p=.067-.150); *=significant (p<.05)*

Figures

Figure 1

CFGNES Subsection Averages over Time, with Standard Deviations

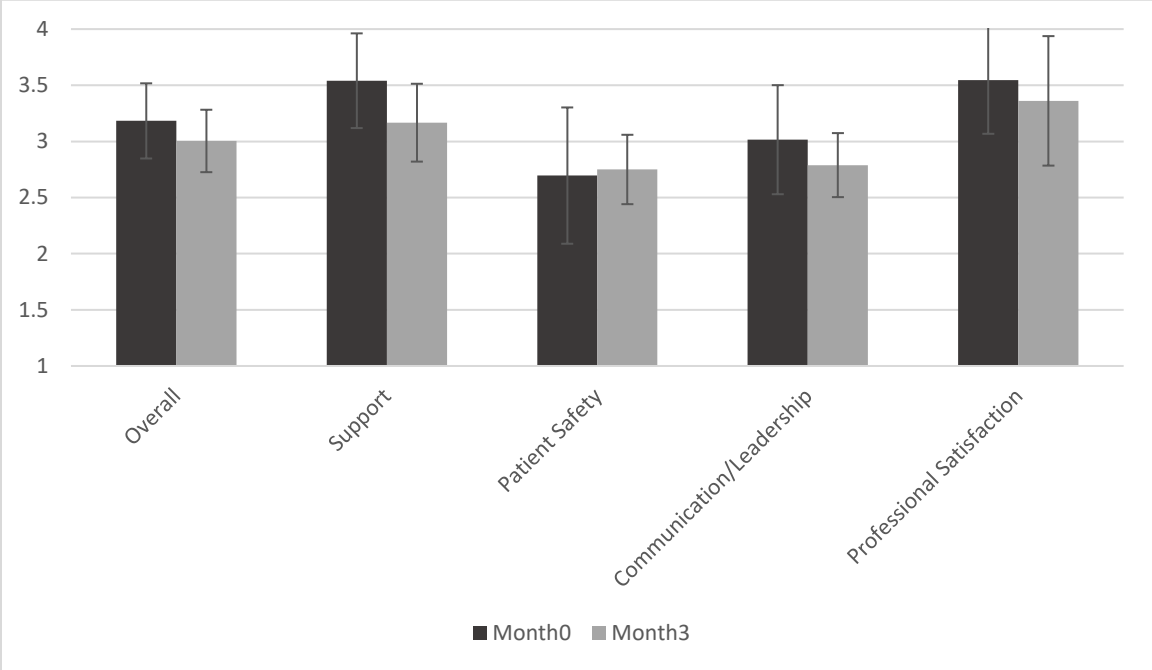

Figure 2

Comparison of Overall and Subsection Means to Benchmarks

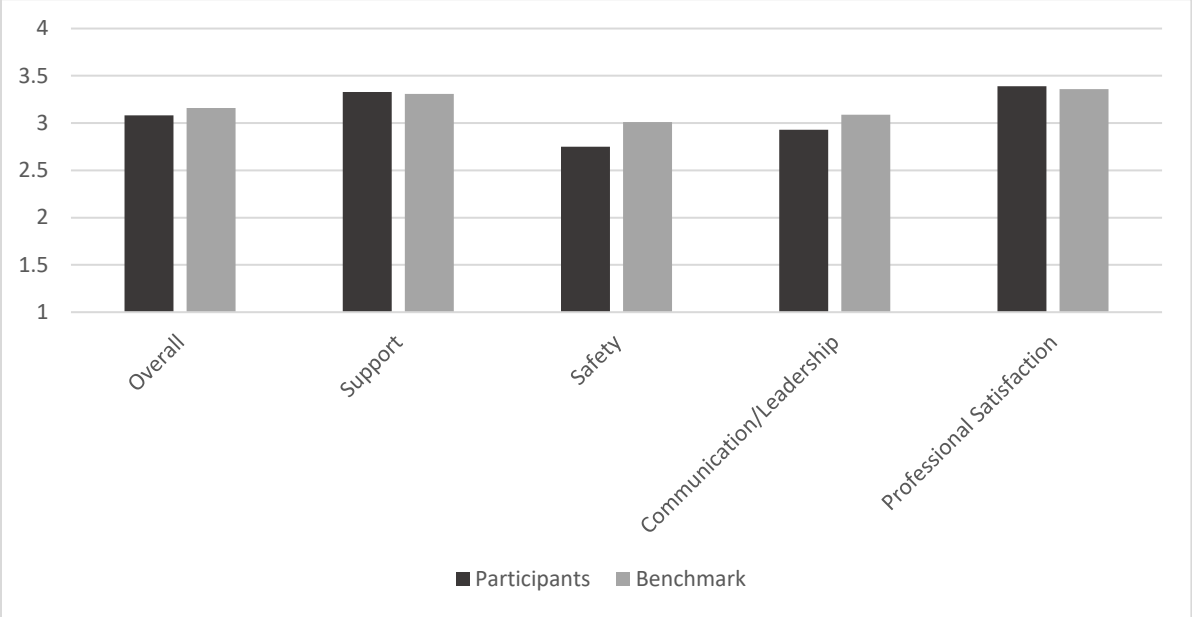

Figure 3

Reported Current Difficulties with Transition over Time

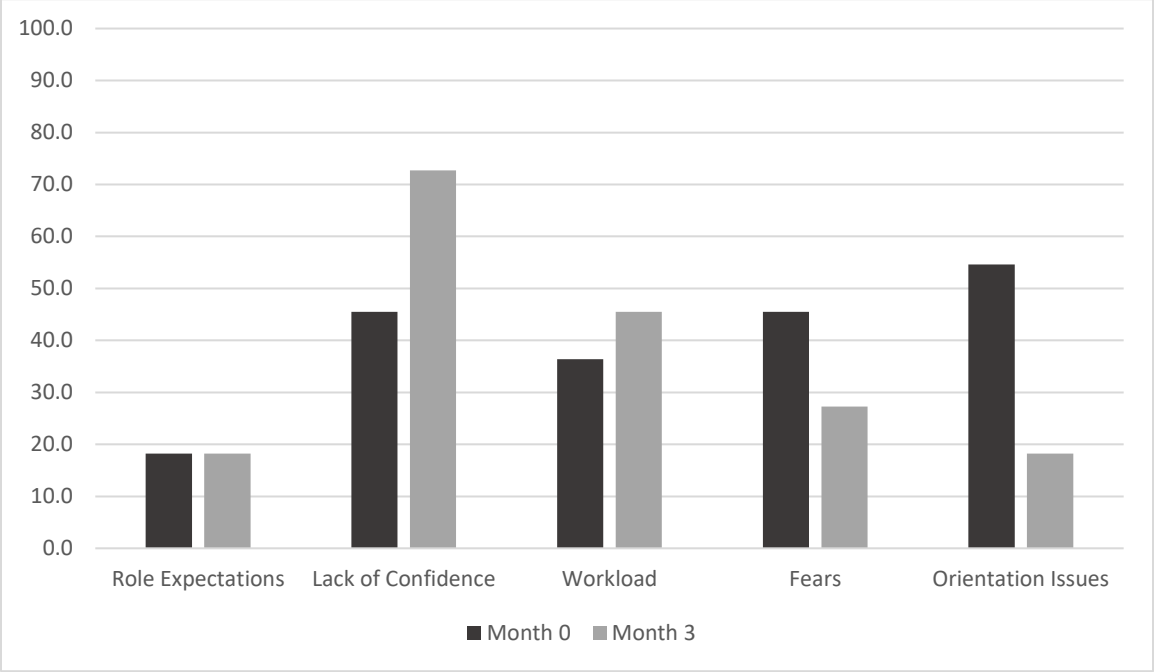

Figure 4

Factors to Make Residents Feel More Supported over Time

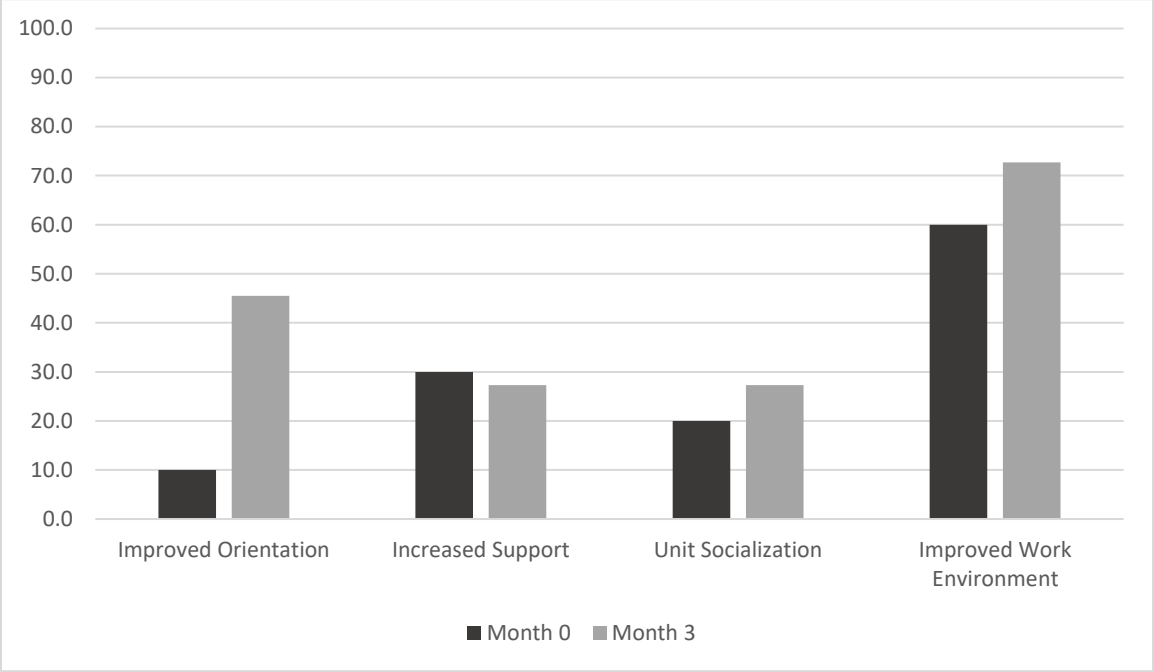

Figure 5

Most Satisfying Aspects of Job over Time

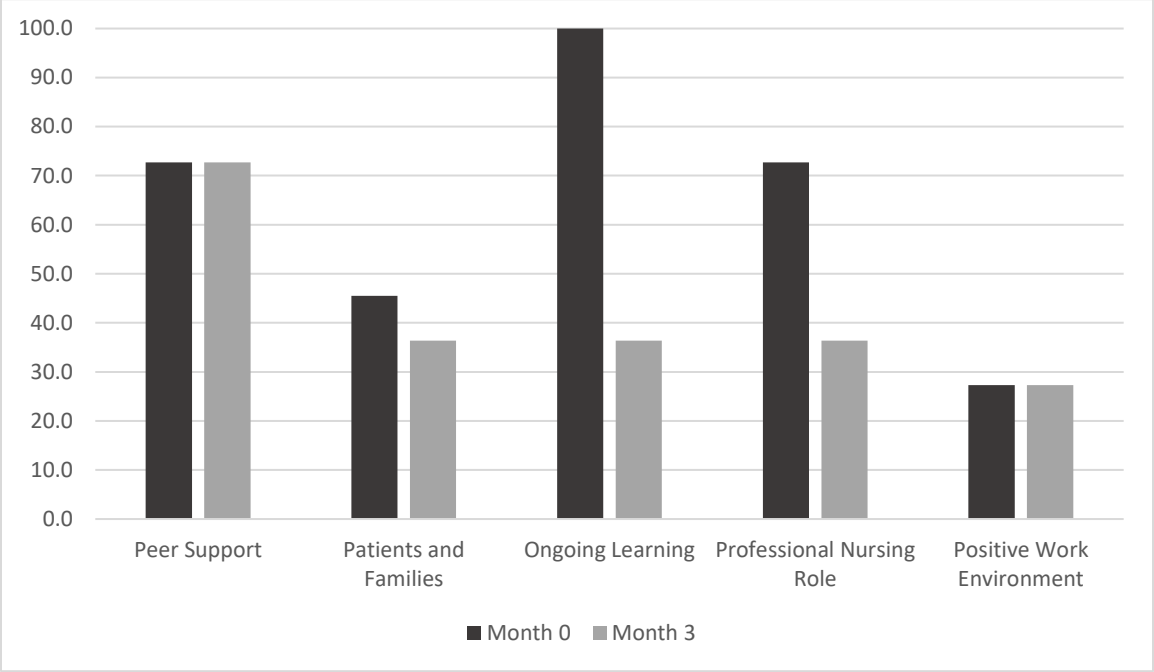

Figure 6

Least Satisfying Job Aspects over Time

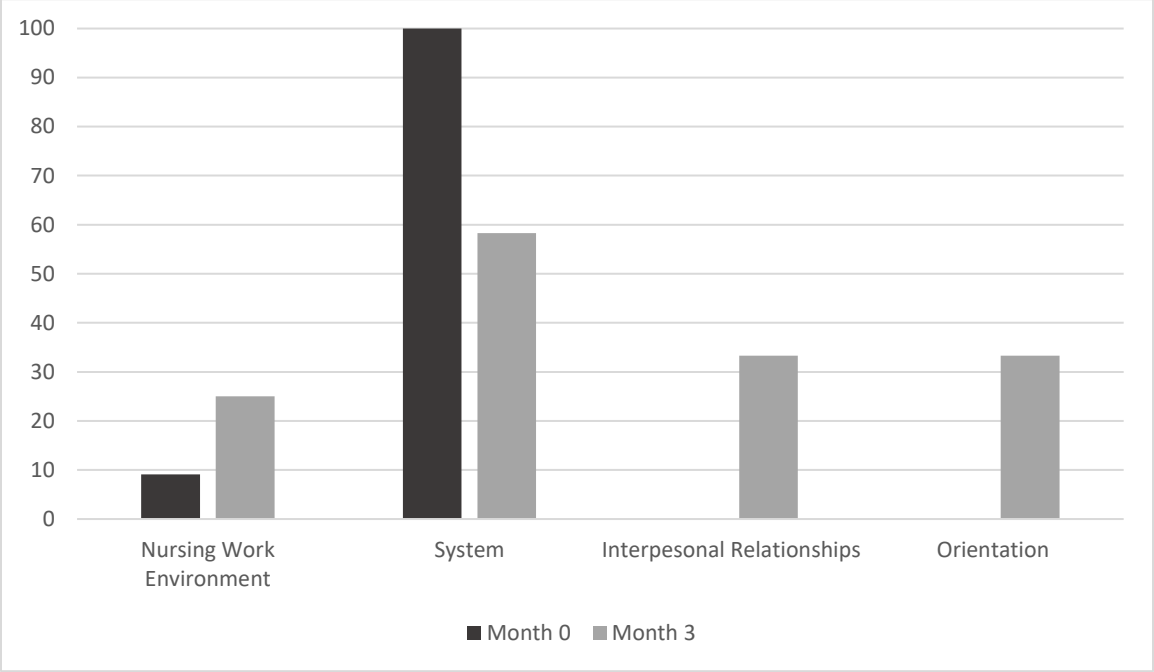

Figure 7

Satisfaction Trends over Time, Means and Standard Deviations