THE EFFECT OF PRECEPTORSHIP ON ROLE TRANSITION

OF NOVICE STAFF NURSES

By

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Abstract

This study investigated the effect of a preceptorship program on role transition of novice staff nurses. A quasi-experimental, control group pretest post-test, design was used. Thirty-four novice staff nurses participated in the study; 20 in the preceptorship (experimental) group, and 14 in the traditional orientation (control) group. Three research hypotheses were investigated to determine whether novice staff nurses who participated in a preceptorship orientation program would: (1) demonstrate easier role transition, (2) report a higher level of job performance, and (3) demonstrate less role deprivation, than those novice staff nurses who participated in a traditional orientation program. Role transition was measured using the Six Dimension Scale of Nursing Performance (Schwirian, 1978) and the Nursing Role Conception Scale (Corwin, 1961). Participants completed the two scales during the first week of the orientation or preceptorship programs and again one-month later. Results indicated no significant differences (p<0.05) between the groups on either the Nursing Role Conception Scale or the Six Dimension Scale of Nursing Performance.

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CHAPTER ONE

INTRODUCTION

Background to the Problem

Nurse leaders in education and practice settings have long been concerned about the role transition required for the beginning nurse practitioner (Goldenberg, 1987/1988; Talarczyk & Milbrant, 1988). While Benner and Benner (1979) described the change from student to practitioner as "a troubled passage at best" (p. 15), Meir-Hamilton and Keifer (1986) depicted it as "one of life's most challenging role transitions" (p. 3). In essence, beginning practice in nursing can be the best of times or the worst of times.

Varied approaches have been utilized in an effort to ease the problem of troubled transitions (Goldenberg, 1987/1988; Talarczyk & Milbrant, 1988). The most prevalent is the use of preceptorship programs (Morrow, 1984). In a preceptorship progam, a preceptor is "a person, generally a staff nurse, who teaches, counsels, inspires, role models and supports the growth and development of an individual (the novice) for a fixed and limited amount of time with the specific purpose of socialization into a new role" (Morrow, 1984, p. 4).

While the literature provides abundant anecdotal descriptions of the benefits of preceptorship programs (Chickerella & Lutz, 1981; Davis & Barham, 1989; Donius, 1988; Goldenberg, 1987/1988; Jennings, Costello, Durkin, & Rotkovitch, 1986; Metzger, 1986; Spears, 1986; Stull 1987) there is an obvious scarcity of research studies confirming the effectiveness of preceptorships in easing role transition experiences of novice staff nurses.

Studies of preceptorships have been conducted, (Allanach & Jennings, 1990; Clayton, Broome, & Ellis, 1989; Dobbs, 1988; Giles & Moran, 1989; Huber, 1981; Itano, Warren & Ishida, 1987; McLean, 1987; Sheetz, 1989; Shogan, Prior & Kolski, 1985). Among these, studies by Giles and Moran; McLean; and Shogan, Prior, and Kolski; essentially have been program evaluation, satisfaction surveys. Studies by Clayton et al.; Dobbs; and Itano et al.; investigated transition in terms of the effects of preceptorship on role mastery and role conceptions when preceptorship programs were used as part of student preparatory education. Studies by Huber (1981) and Allanach and Jennings (1990), examined the effect of preceptorship programs on the role transition of novice staff nurse orientees; however, only Huber's study compared the effects of different types of orientations

(internship versus preceptorship) on the role transition of novice staff nurses.

Spears (1986) has called for research on the effect of preceptorship programs on newly graduated nurses. Particularly, for pre- and post-preceptorship measurements of novice nurse performance and selfconcept, to determine if changes actually do occur as a result of the preceptorship experience. Myrick (1988) concurs that research in this area is required. "While the underlying assumption for the use of preceptorship programs is that one-to-one learning furnishes an effective method of learning, there is limited empirical evidence to substantiate its effectiveness" (Myrick, 1988, p. 136).

Problem Statement

It is presumed that preceptorship is indeed a useful orientation strategy which eases the role transition of novice staff nurses; however, evidence necessary to substantiate this belief is lacking. Research is needed to examine the actual effect of preceptorships on the role transition of novice staff nurses. Specifically, research is needed comparing the transition which occurs in orientations without preceptorships to the transition that occurs with preceptorships. This comparison is

needed in order to determine whether differences in role transition of novice staff nurses can be attributed to preceptorship programs.

Purpose

The purpose of this study was to examine the effect of preceptorship programs, used in hospital-based orientations, on the role transition of novice staff nurses.

Theoretical Framework

Kramer's (1974) theory of reality shock provided the theoretical framework for this study. The reality shock concept is borrowed from the literature and the experience of culture shock. Culture shock is the surprise and imbalance felt when one moves from his/her accustomed culture to an unfamiliar culture that has different meanings and requires adjustment to previously familiar events (Kramer & Schmalenberg, 1977a). Moving from school to practice is comparable to moving into a new cultural system in which ideals, rewards, and sanctions differ from those received in school.

The term reality shock is used predominantly in relation to the response of neophytes upon entry into a professional field (Kramer and Schmalenberg, 1977a). It characterizes the shock-like response of neophytes when confronted with work experiences for which they presumed they would be prepared, but, find they are not prepared. The typical shock-like response occurs when the novice senses professional ideals acquired at school are not appreciated in the work setting. The discrepancy in values of the work and school cultures, which neophytes confront upon work entry, leaves them in a state of values conflict, and thus, susceptible to reality shock.

In the theory of reality shock, Kramer (1974) suggested the transition from student to novice nurse will follow a predictable pattern. This transition process consists of four phases: (1) honeymoon, (2) shock, (3) recovery, and (4) resolution.

During the honeymoon phase, the novice usually perceives the world through rose-colored glasses. In this phase, one focuses on two primary concerns: (1) mastery of skills, and (2) social integration into the work group (Kramer, 1974). Since neophytes during this phase are so absorbed with the novel features of their work, they are likely to be inefficient in accurately appraising the work situation. "The sudden realization that nursing isn't what one thought it would be and the dissatisfying feeling that this evokes is the precursor to the shock phase" (Kramer & Schmalenberg,

1977a, p. 10). When the novice experiences obstacles to goal achievement, either due to lack of personal competency or due to system restrictions, the shock phase begins (Kramer, 1974).

Characteristic features of the shock phase are: (1) moral outrage, (2) rejection, (3) fatigue, and (4) perceptual distortion (Kramer, 1974). Moral outrage is the anger experienced at finding out things are not as they ought to be (Kramer & Schmalenberg, 1977a). The rejection component can either be a rejection of values acquired in school or a rejection of workforce norms/expectations. Moral outrage and rejection are draining and result in physical symptoms. Often, depression is the first indication that one is experiencing the shock phase. In contrast to the honeymoon phase, perception is distorted in the shock phase to the extent that everything has a globally negative outlook. The shock phase is depleting and fortunately, it is time limited. Eventually, recovery or resolution must occur.

The recovery phase is identified by the return of a more realistic appraisal of the work situation and by a return of one's sense of humor. Tension and anxiety levels decrease and there is a new sense of balance.

Accompanying this new balance is an initial ability to competently predict actions and reactions of others and an ability to see more than one's own perspective. "The recovery phase is crucial to constructive conflict resolution, because in this phase the newcomer realizes that previous perspectives and strategies probably will not work and that new ones are called for" (Kramer & Schmalenberg, 1977a, P. 17).

In the resolution phase, there are various ways in which reality shock may be resolved; some are constructive, while others are more detrimental. Examples of various less functional means of resolving reality shock include: (1) restricting involvement by performing at a minimally acceptable level; (2) transferring jobs frequently in an effort to find the elusive perfect job; or (3) withdrawing completely from the profession to start a new career, or withdrawing temporarily from the profession only to return years later.

The most constructive resolution is a bicultural adaptation, in which the neophyte reevaluates school learned values, maintaining those that are beneficial and meshing them with the realities of the work situation. Constructive resolutions are growth producing and enable

the person to integrate work values with school values. The interweaving of the two perspectives is more functional than either perspective independently (Kramer, 1974).

Kramer's (1974) description of reality shock brought the difficulties, that new graduates have in making the adjustment to practice, to the attention of the nursing profession. Kramer found the first year in a hospital setting is often marked by dramatically conflicting value systems, specifically, the idealism of education and the reality of nursing practice. Studies by Stewart-Dedmon (1988) and Horsburgh (1989) concur with Kramer's finding that the discrepancy between the ideal mode learned in their education program and the reality of the bureaucratic mode practiced and enforced in the work setting is the primary cause of reality shock for new graduates.

Kramer and Schmalenberg (1977a) identified that students are usually presented with the "front-stage" reality of the nursing unit. This front-stage reality is the appearance that the unit staff portrays for specific audiences (students, faculty, and administration). "Following employment the new graduate discovers or uncovers the "back-stage" reality, the things that go on

everyday when everyone's guard is down and they are not putting their best foot forward. It causes a great deal of anger because these new graduate nurses had not been prepared for the back-stage reality" (p. 11).

The manner in which a neophyte reconciles this conflict greatly determines whether the person will remain in the profession (Ahmadi, Speedling & Kuhn-Weissman, 1987; Kinney, 1985; Kramer, 1974). Many new graduates, dissatisfied and frustrated, opt to leave the profession within the first year of graduation (Fisher & Connelly, 1989; Jennings et al., 1986; McLean, 1987). Experiencing reality shock, the novice staff nurse has difficulty in practicing nursing in the work environment.

Health care organizations have established the need for the nursing role and have instituted demands about activities that ought to occur in the role (Rubin, 1988). The nurse must perform activities demanded by the organization to successfully fulfill the nursing role. The novice staff nurse's failure to function immediately as a seasoned and competent professional nurse has been attributed to inadequate socialization to the realities of the professional role, rather than to inadequate theoretical knowledge (Benner & Benner, 1979).

According to Watson (1983) professional socialization is the complex process by which a person acquires the knowledge, skills, and the sense of identity that are characteristic of a member of that profession. Socialization is aimed at learning new values, beliefs, attitudes, and behaviours; and in resynthesizing previously learned material in resolving conflicts between and among various role expectations which comprise the role complex (total roles a person occupies).

Socialization and Reality Shock

Socialization into an occupational role entails: shifting focus from broad professional goals to specific work tasks, internalizing values of the occupational group, and adopting prescribed behaviours (Leddy & Pepper, 1985). The latter refers to the behaviors one must display according to the norms of the reference group. Professional role expectations are transmitted and maintained through education and regulatory processes (Corwin & Taves, 1962). Thus, through socialization experiences one learns the expectations of a particular role.

Prior to entering practice, much of the knowledge nurses acquire in terms of the professional nursing role

is provided by the faculty of their preparatory education program (Conway, 1983). Frequently, however, the role expectations of educators are incongruent with those of practitioners. Yet, "it is the culture of the practicing nurse whose role expectations" novice nurses will encounter and have to reconcile when they begin practice (Clayton, Broome & Ellis, 1989, p. 72).

Deficient role socialization can lead to role conflicts (Hardy & Conway, 1988). According to Rendon (1988) role incongruence creates role conflicts which interfere with efficient role performance. Beginning nurses are inexperienced in dealing with role conflicts created by the clashing of bureaucratic goals with the professional ideals learned at school.

Dobbs (1988) identified that successful role transition, from student to practitioner in nursing, requires an integration of the three nursing role conceptions (professional, bureaucratic, and service). This integration is necessary in order that the novice nurse may "accomplish bureaucratic goals while maintaining professional standards and quality care" (Dobbs, 1988, p. 167). The orientation process is an important factor affecting role development and role transition (DiMauro & Mack, 1989).

According to Itano et al. (1987) novice nurses need guidance in developing competence in practice while preserving professional conceptions emphasized in education. Several authors suggest preceptorship programs provide such guidance (Clayton et al., 1989; Dobbs, 1988; Goldenberg, 1987/1988; Itano et al., 1987; Patton, Grace & Rocca, 1981). These programs assist neophytes to reconcile conflicts between values acquired in school with those of the clinical practice environment.

Preceptorship Programs and Socialization

The primary goals of preceptorship programs are (1) to assist novice nurses with socialization to professional and bureaucratic nursing roles and (2) to assist with skill acquisition needed for successful role performance.

Preceptors serve as role models and resource persons for novice nurses. Preceptors are oriented to the roles and functions of the preceptor. Their orientation covers such topics as: objectives of the preceptorship program, functions of the preceptor role, adult learning principles, stages of adjustment of novice staff nurses, and methods of formative and summative evaluation (Modic & Bowman, 1989). The preparation of preceptors for the role and the preceptorship program's one-to-one

arrangement distinguishes it from a traditional orientation program. The latter is a "buddy system" where various experienced nurses, none of whom receive preparation for the role, are "buddied with" the neophyte during the orientation period (Morrow, 1984).

Preceptors provide guidance to neophytes in role socialization and in gaining competence in role performance in the practice setting (Clayton, 1989; Dobbs, 1988). The preceptor provides the neophyte with a model of performance to emulate in order to fulfill the performance expectations of practice. In turn, the neophyte internalizes role conceptions that are congruent with the role of practicing professional nurses. Thus, preceptors facilitate role transition of novice nurses by promoting role socialization and role performance.

Dobbs (1988) contends when new graduates are not assisted with the transition into the work role they frequently resolve the conflict of reality shock in negative rather than constructive ways. For example, (1) values associated with professional practice are diminished or rejected, or (2) values appreciating attainment of bureaucratic goals are discarded and active practice is abandoned. Orientation programs and preceptorship programs have been used in facilitating the

preceptorship programs are the most effective vehicles to facilitate role socialization of novice nurses.

In summary, preceptorship programs offer a means of easing the transition from student to novice staff nurse practitioner. This is accomplished through assistance provided to the neophyte in the areas of skill mastery and social integration. In addition, preceptorships are believed to reduce the effects of reality shock experienced by novice nurses.

Definition of Terms.

For the purpose of this study the following definitions were used:

<u>Novice Staff Nurse</u> is an individual beginning his/her first employment as a staff nurse.

<u>Preceptor</u> is an experienced registered nurse with a particular area of nursing expertise who can teach and guide the preceptee (novice staff nurse) and who has received preparation prior to assuming the function of preceptor.

<u>Preceptorship program</u> is a formal type of hospital orientation in which novice staff nurses are assigned to designated nurse preceptors. Novice staff nurses receive individual guidance from their preceptors with whom they rotate shifts over the course of the preceptorship program.

<u>Traditional Orientation Program</u> is a formal period in which the novice staff nurse receives teaching and guidance in unit routine from a variety of experienced staff nurses. These staff nurses who provide guidance do not receive educational preparation to assume this teaching role.

<u>Role</u> "is a set of expectations about how a person in a given position in a particular social system should act and how others in reciprocal positions should act" (Kramer, 1974, p. 52).

<u>Role Transition</u> is the alteration in expectations related to actions and reactions demanded by a change in role from student to novice staff nurse. Role transition was measured by Schwirian's Six Dimension Scale of Nursing Performance and Corwin's Nursing Role Conception Scale. <u>Role Conception</u> is the internal representation of role expectations held by an individual at a specific time (Corwin, 1961). Role conception is a measure of social integration. Corwin categorized nursing role conceptions into three categories: (1) professional role conception (PRC) which indicates prime loyalty to the nursing profession; (2) bureaucratic role conception (BRC) which

indicates prime loyalty to hospital administration; and (3) service role conception (SRC) which indicates prime loyalty to the patient.

<u>Role Deprivation</u> is the internal response felt by a nurse when circumstances in the work environment restrict role portrayal such that the nurse perceives an ideal role conception to be non-functional in practice (Itano et al., 1987; Dobbs, 1988).

<u>Job Performance</u> is the ability to competently carry out nursing actions while in the practice setting. An important component of job performance is skill mastery. Job performance was measured using Schwirian's Six Dimension Scale of Nursing Performance.

Research Hypotheses

The research hypotheses examined in this study were: 1. Role transition will be perceived to be easier by novice staff nurses who participate in a preceptorship program than by novice staff nurses who participate in a traditional orientation program.

2. Job performance levels reported by novice staff nurses who participate in a preceptorship program will be higher than those reported by novice staff nurses who participate in a traditional orientation program.

3. Perceived role deprivation reported by novice staff nurses who participate in a preceptorship program will be less than that reported by novice staff nurses who participate in a traditional orientation program.

Based on the hypotheses of this study, a diagram of the hypothesized role transition process occurring post workentry with preceptorship versus traditional oreintation programs is presented in Figure 1. Upon leaving educational programs, neophyes have particular role conceptions and skill levels. When they enter the work setting, neophytes recognize that their role conceptions and skill levels must be adjusted to the demands of the work environment. This adjustment creates the values conflict associated with reality shock. Two possible strategies to ease reality shock (traditional orientation programs and preceptorship programs) with the proposed impact of each on role transition are presented.



Figure 1. Hypothesized Role Transition Process Occurring Post Work-entry with Preceptorship versus Traditional Orientation Programs.

Assumptions

In this study the following assumptions were accepted: 1. Beginning practice as a novice staff nurse requires a successful role transition.

2. Participants will provide frank and honest ratings of their self-perceived performance and role conception on pre and post-tests.

Role transition can be assessed using Corwin's
 Nursing Role Conception Scale and Schwirian's 6-D Scale.
 Preceptors in the preceptorship program have received preparation prior to assuming the preceptor role.

Limitations and Delimitations

The recognized limitations and delimitation of this study were:

Limitations

 Random selection or random assignment into the traditional orientation and preceptorship groups was not feasible.

There are some factors that could not controlled.
 These included: (a) hospital staffing needs,
 (b) assignments of orientees and preceptees, and (c)

multiple unit and hospital variations.

Delimitation

1. The length of time to complete the study was circumscribed, so it was not possible to measure longterm role adjustment. The adjustment during the first month of orientation was examined.

Significance of the Study

In the present climate of economic restraints and nursing shortages, the orientation of nurses is a significant aspect of a nursing department's program and budget (Flewellyn & Gosnell, 1987; Hoffman, 1985; Mooney, Diver, & Schnackel, 1988). According to Flewellyn and Gosnell the cost of orientating one nurse is estimated to be between 1500 and 3000 dollars. Flewellyn and Gosnell note that to justify the investment in orientation programs, nursing departments must be able to identify outcomes. That is, the relationship among the orientation method, performance in the clinical area, and retention of nurses. Increasingly, nursing departments will be called on to justify expenditures such as those associated with preceptorship programs used to orient novice staff nurses. To be able to justify the need for, and the appropriateness of such resource allocation, research on the effect of preceptorship programs is essential.

Furthermore, given the problems associated with retaining nurses in the profession, and the contention that preceptorship programs ease role transition difficulties, it is important that their effectiveness in this area be substantiated through research.

Scope of the Study

This thesis is organized into six chapters. Included in Chapter One are the study problem, the purpose, its significance and the research hypotheses. In addition, the theoretical framework is explained and its link to socialization and role transition is illustrated. In Chapter Two selected literature on preceptorships is

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reviewed. In Chapter Three research methods and procedures are described. In Chapter Four findings are presented. In Chapter Five analysis of findings is discussed. In Chapter Six the summary, conclusions, and implications are presented.

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CHAPTER TWO

REVIEW OF THE LITERATURE

Selected literature relevant to preceptorships is reviewed in this chapter. Factors instrumental in motivating nurse administrators to use preceptorship programs for orientation of novice nurses are discussed. Review of literature on preceptorships covers anecdotal and research literature, but focuses on the latter.

Development of Preceptorship Programs Historically, a standard orientation has been provided by the inservice education department. It usually lasted anywhere from one to two weeks. This general hospital orientation focused on global topics such as hospital philosophy, policies and procedures. Subsequent to the hospital-wide orientation, the new employee participated in an informal orientation to the nursing unit. Different nurses were buddied with the novice nurse to advise her/him in the unit routine, and to provide informal help and guidance (Shamian & Inhaber, 1985).

However, these orientation programs were inadequate in providing structured learning of the unit routine, and in assisting with socialization to the staff nurse role. This deficit resulted in increased anxiety levels in new graduates. The deficiencies of this buddy system for

orientation of novice nurses, raised concern among nurse managers. Its inefficiency in orienting neophytes to the unit routine, and in assisting them with role socialization, was associated with high staff turnover, reality shock, early burnout, and low morale among both novice and experienced nurses (Shamian & Inhaber, 1985). In order to reduce the anxiety resulting from adjustment to the new work milieu, preceptorship programs were developed. These programs range from two weeks to four months in duration (Shamian & Inhaber, 1985).

According to Shamian and Inhaber (1985) implementation of the preceptorship model appears to be in response to the identified needs of both nursing service and nursing education personnel. However, Backenstose (1983) contends preceptorship is not a totally new concept in nursing; from its inception nursing has used a type of apprenticeship or preceptorship model in which practicing nurses educated students and novice nurses. Although preceptorships take advantage of apprenticing neophytes with experienced nurses, there is an important distinction between apprenticeship and preceptorship. The difference is that, while apprenticeship is synonmous with an informal buddy system; preceptorship, is apprenticeship but with an "enlightened guide" who is

prepared for the formal and informal teaching function. The underlying assumption of preceptorship programs is that the one-to-one learning experience with an seasoned role model, (1) eases transition of neophytes into the staff nurse role; and (2) facilitates integration of neophytes into the work group. This is based on the assumption that the experienced preceptor orients the neophyte to norms and expectations of the reference peer work group to which the novice wishes to become an accepted member. In the preceptorship model "integration of the new employee into the unit is facilitated by someone who is close to the scene of activity and there is good reason to believe that a peer relationship is better able to affect the required learning" (Shamian & Inhaber, 1985, p. 80). In this model, the preceptor provides an immediate resource person for the novice nurse during the transition period (Metzger, 1986).

Benefits of Preceptorship

Many anecdotal articles have been written on the benefits of preceptorship programs for anticipatory socialization whereby students, as part of their education program, work with hospital preceptors (Chickerella & Lutz, 1981; Davis & Barham, 1989; Donius, 1988; Estey & Ferguson, 1985; Fisher & Connolly, 1989;

Jennings et al., 1986; Limon, Bargagliotti, & Spencer, 1982; Rodzwick, 1984; Spears, 1986; Wheeler, 1984). In addition, many anecdotal articles have also been written on the benefits of preceptorship programs for orientation of new employees, particularly new graduates (Friesen & Conohan, 1980; Goldenberg, 1987/1988; Marchette, 1985; McGrath & Koewing, 1978; Modic & Bowman, 1989; Patton, Grace & Rocca, 1981; Schempp & Rompre, 1985; Shogan et al., 1985). The use of preceptorship programs both in education and practice settings is strongly endorsed by all cited authors. Benefits of preceptorship programs can be summarized to include the following:

(1) helping novice staff nurses to develop skill mastery;
(2) facilitating the role transition of novice staff
nurses by assisting them to link educational and practice
experience; (3) reducing problems associated with reality
shock; (4) socializing and integrating the novice staff
nurse within the unit; and (5) enhancing professional
growth and job satisfaction for staff nurses who function
as preceptors (Shamian & Inhaber, 1985).

Research on Preceptorship

Despite the evident interest in preceptorship, there has been limited research on the effect of preceptorship programs on novice staff nurses in terms of role

transition or performance outcomes. Huber (1981) conducted a study to investigate the effect of preceptorship and internship orientation programs on graduate nurse performance. According to Huber (1981) internship orientation programs, differ from preceptorship programs in that they are less individually monitored and rely on various non-designated nurses to guide the novice. The internship orientation in Huber's study is synonymous to the orientation provided by the traditional orientation programs of the present study. The focus of Huber's study was to determine if graduate nurses completing a hospital-based preceptorship orientation perceived their performance more positively than graduate nurses completing a hospital-based internship orientation program. Participants in the preceptorship orientation program group each had a designated nurse preceptor to guide them and to act as a role model. The internship orientation group did not have designated preceptors. Study participants evaluated their performance ability before and after their respective orientations. Performance ability was measured using the Six Dimension Scale of Nursing Performance (6-D Scale) at pre and post orientation. Analysis of the differences between the groups failed to

show any significant differences.

Olsen, Gresley, and Heater (1984) examined an eight week undergraduate clinical course to determine if it would strengthen nursing students' perception of competence and self-concept. The study sample was composed of 48 students which included eight interns, five non-interns, and 36 control. A pretest, post-test design was employed. Instruments used in the study were the Tennessee Self-Concept Scale and the 6-D Scale. Data analysis using ANOVA with a 0.05 significance level found no significant difference between the groups. Since however, the numbers in the intern and non-intern groups were so small, power to detect significant differences between the groups was low.

A study conducted in Canada by Shamian and Lemieux (1984) evaluated whether there was any difference in the effectiveness of two teaching methods in enhancing the knowledge base of participating nurses. The two teaching models that were evaluated were the preceptor teaching model and the formal teaching model. The study sample was composed of all nurses (registered nurses and nursing assistants) who worked on 14 designated units within a 600-bed hospital. The participants completed two scales: the first, immediately following teaching sessions; and

the second, after a three month time interval. The findings of this study were that the preceptorship model of teaching resulted in better outcomes in terms of knowledge attainment, skills, educational program attendance, and assessment capabilities when compared to the traditional teaching method. Despite the fact that this study concluded that the preceptorship model of teaching was superior to the traditional methods, its findings cannot be generalized as the study was limited to one hospital in eastern Canada, and potential for bias arises out of the heterogeneous sample used in the study.

Itano et al. (1987) studied whether there was a difference in role conceptions and role deprivation in students who participated in a preceptorship program and those students who did not. The study included 118 students of a baccalaureate nursing program. Role conceptions and role deprivation were measured using Corwin's Nursing Role Conception Scale. Results of this study demonstrated no differences between the groups in role conceptions or role deprivation.

In 1988 Dobbs conducted a study to investigate the effect of a preceptorship program used in the senior year of baccalaureate nursing education program as a method of providing students with anticipatory socialization to the
work role of professional nurses. The study measured role conceptions and role deprivation immediately before and after a preceptorship program using Corwin's Nursing Role Conception Scale. The study sample consisted of 103 generic baccalaureate students. Results of this study indicated a significant difference at p <.01 in perceived role deprivation. The author suggests that this result supports the effectiveness of a preceptorship program in promoting anticipatory socialization to the work role of professional nursing. However, since all subjects in four different groups received the same treatment (preceptorship) one needs to question the degree to which preceptorship, as opposed to another teaching strategy, accounts for the change in the measures over the two testing periods.

Clayton et al. (1989) examined the effect of a preceptorship experience on role socialization of graduate nurses. The sample consisted of two groups, one having a preceptorship experience in the final quarter of the baccalaureate program (n=33) and one group having a faculty member providing a "traditional" clinical learning experience (n=33). Schwirian's 6-D Scale was completed by each group three times: prior to the course, immediately following the course, and six months after

graduation. Results of the study only partially supported the hypothesis that there would be significant differences between the groups on the six subscales. At six months follow-up there was a significant difference between the groups with the preceptor group scoring higher on the: (a) leadership (p.004); (b) teaching/collaboration (p.01); (c) interpersonal relations /communications (p.008); and (d) planning/ evaluation (p.009) subscales. However there was no significant difference between the groups on the professional development (p.11) and critical care (p.21) subscales.

Sheetz (1989) investigated the effect of nursing student preceptorship programs on the development of nursing student competence among 72 senior baccalaureate students. A non-equivalent comparison group, pretest, post-test design was used. The sample consisted of a treatment group of 36 students who participated in nursing student preceptorship programs and a comparison group of 36 students who worked as nursing assistants in a non-instructional clinical setting. Head nurses on the units to which the subjects were assigned observed the subjects on each of the first three days of the second (pretest) and tenth (post-test) weeks of the

preceptorship or nursing assistant experience. At the end of the third day of observation, head nurses rated the student's clinical competence using the Clinical Competence Rating Scale. Results indicated students who participated in summer preceptorship programs gained greater levels of clinical competence, than did students who worked as nursing assistants in non-instructional clinical settings.

Giles and Moran (1989) compared the orientation satisfaction outcomes of nurses oriented by a buddy system with those nurses oriented by the preceptorship program. Results indicated nurses oriented by the preceptorship program method were more satisfied than those nurses who were oriented by the buddy system (p<0.01). However, caution must be used since concurrent and retrospective comparisons of subject experiences with orientation may have biased results.

Allanach and Jennings (1990) investigated whether an eight week preceptorship program at one military medical center eased the transition process of new graduates (N=44). A repeated measures design was used to assess changes in preceptees affective states over time. Participants completed the Multiple Adjective Affect Checklist and the I-E Scale (which measures

internal/external locus of control) at: one week prior to the preceptorship program; at the end of the program; and at five, and 16 weeks after completion of the preceptorship program. Although the results failed to support the contention that the transition from student to staff nurse did generate anxiety, participants did verbalize feelings of psychological tension. Allanach and Jennings suggest a possible explanation for this result is that the preceptorship program itself resulted in the more positive affective states of participants. They identify that a control comparison group who had not had a preceptorship experience would have been beneficial in terms of interpreting the effect of preceptorship on transition experiences.

Summary

In summary, the various studies on preceptorship have resulted in inconsistent findings. More research on preceptorship is needed to substantiate the belief that preceptorship is a useful orientation strategy. This study investigated the effect of preceptorship on role transition of novice staff nurses when preceptorship was used as an orientation strategy.

CHAPTER THREE

METHODS AND PROCEDURES

Reseach design, methods and procedures are presented in this chapter.

Design

A quasi-experimental, control group pretest post-test design was used. This design was appropriate in that random selection and assignment were not feasible. Whether novice staff nurses participated in a preceptorship program depended completely on the type of orientation program used by the employing agency.

Setting

The study was conducted in three tertiary hospitals in lower mainland British Columbia, one of which uses a preceptorship program and two others which do not use preceptorship programs for orientation of new nursing staff. These hospitals range in size from 575 to 875 beds.

The preceptorship program consisted of a three day central nursing orientation and one-half day general hospital-wide orientation (Appendix A). Subsequent to this central orientation, novice staff nurses were assigned to designated preceptors by the head nurse of their respective wards. Novice staff nurses were preceptored for two to three weeks.

Head nurses of the respective units are responsible for assigning the preceptors to work with novice staff nurses. Experienced nurses who are selected to be preceptors participate in a four-hour Preceptor Development Program prior to assuming the preceptor role (Appendix B).

One of the traditional orientation programs consisted of three and one-half days central nursing orientation followed by up to a maximum of 11.5 shifts in which novice staff nurses are buddied with various experienced staff nurses on their respective wards (Appendix C). The other traditional orientation program included four days of central orientation, one-half day central hospital-wide orientation, and one day unit specific orientation (Appendix D). Following this central orientation, novice nurses on average received an additional two days of unit specific orientation.

A convenience sample (N=34) of novice staff nurses in their first-time employment as staff nurses was obtained from three tertiary hospitals in lower mainland British Columbia. Although role transition is required with all role changes, this study focused on the role transition

Sample Criteria and Selection

of novice nurses. Accordingly, the sample selected was limited to novice staff nurses in their first-time employment as staff nurses, all of whom, were undergoing a similar role change; student to novice staff nurse.

Initial contact with three potential participating agencies was made to determine the feasibility of obtaining the needed study sample. Because limited statistics were kept on the preceptorship and orientation progams, it was not always possible to extrapolate the number of participants who were novice staff nurses in their first-time employment. However, one hospital that used a traditional orientation program indicated on average over the last two years it had six new graduates per month on orientation. This same hospital indicated that 42 percent of the nurses they employ annually are new graduates. In descending order, this hospital had the greatest numbers in orientation during the months of September, January, and June.

Another hospital that used a traditional orientation program orientated 177 nurses during the previous year, but was unable to determine of that number how many were novice staff nurses. The months with the highest proportion in orientation were January, October, September, and June respectively.

The third hospital used a preceptorship program and employed 240 novice staff nurses during the previous year. The months with the largest proportion of new graduates in orientation were January, September, and June. Based on initial contact and discussion with these three agencies, it appeared feasible to obtain the needed study sample. Agency approval to conduct the study was obtained from the three institutions.

A letter (Appendix E) which explained the study and requested participation was distributed to potential study participants (novice staff nurses in their first time employment in nursing). The sample was selected from volunteers contacted through visits by the researcher to the participating agencies' orientation or preceptorship program during the first week of the respective programs. The researcher explained the study, addressed any questions from potential participants and requested their participation.

Persons who met the sample criteria and those agreeing to participate completed three scales: a Demographic Data Sheet (Appendix F), Schwirian's Six Dimension Scale of Nursing Performance (Appendix G), and Corwin's Nursing Role Conception Scale (Appendix H). Completion of these scales required approximately 20

minutes. Participants supplied their names and addresses to the researcher to use for the mailout of questionnaires for the second data collection.

One month later, the 6-D Scale and the Nursing Role Conception Scale with an accompanying letter, were sent to participants for completion. Two weeks after the second set of questionnaires were mailed, reminder letters encouraging reply to the follow-up scales were sent to participants who had not to date returned questionnaires. Data were collected from October, 1989 until February, 1990.

Protection of Human Subjects

Ethical approval to conduct this study was granted by the University of British Columbia Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects and by Ethical Review Committees in participating agencies.

Participants in the study were given a letter explaining the purpose of the study and the requirements involved in participation. In addition, they were given an opportunity to question the researcher about the study. They were informed that individual responses to the study would be kept confidential, that they could withdraw from the study at any time, and completion of

the questionnaires implied consent by the respondent to participation in the study.

To maintain confidentiality, each participant was assigned a code number so that names of subjects did not appear on the completed questionnaires. Previously assigned code numbers with an added "A" were affixed to the follow-up scales to maintain confidentiality and to allow comparison of subject's pretest and post-test scores.

Measurement of Variables

The independent variable was the type of orientation. Subjects in the experimental group were those in the hospital where the preceptorship program was in effect and, thus, were assigned to a designated preceptor(s) for the duration of the preceptorship program and the study. The assignment of the preceptor was part of that agency's preceptorship program and under the direction of the agency not the investigator. The treatment effect was the presence of designated nurse preceptors in the preceptorship group and a lack of designated preceptors in the traditional orientation group. The dependent variable studied was role transition. This variable was measured by two scales: Schwirian's Six Dimension Scale of Nursing Performance (1978) and Corwin's Nursing Role Conception Scale (1961).

Instruments

Data were collected using two instruments: Schwirian's Six Dimension Scale of Nursing Performance (6-Scale) and Corwin's Nursing Role Conception Scale.

Six Dimension Scale of Nursing Performance

The Six Dimension Scale of Nursing Performance (6-D Scale) consists of 52 items categorized into six dimensions of nursing performance: teaching/ collaboration, critical care, planning/evaluation, interpersonal relations /communications, professional development, and leadership (Appendix G). Subscale items in the interpersonal relations/communications dimension relate to nurse's behavior in the realm of communication and interpersonal realtionships with clients and colleagues. This subscale included such items as helping a patient communicate with others, and contributing to productive working relationships with other health team members. Leadership subscale dimensions relate to actions that the nurse would employ in enacting a leadership function. This subscale included such items as the ability to guide other health team members and to delegate effectively. The critical care subscale taps into nursing activities associated with care of

critically ill patients. It includes such items as functioning calmly in emergency situations, and recognizing and meeting the emotional needs of a dying patient. The teaching and collaboration subscale depicts behaviors in which the nurse teaches the client/family, as well as, behaviors indicative of the collaborative role of nurses with patients, families, and other health professionals. It includes such items as teaching preventive health measures and encouraging the family to participate in the client's care. The planning and evaluation subscale comprises behaviors involved in planning and evaluating the client's nursing care. The professional development subscale describes characteristics of professionalism, such as, using learning opportunities for ongoing personal and professional growth.

The Six Dimension Scale of Nursing Performance was designed to be used for self-appraisal of performance, supervisor evaluation of performance and/or for nurse graduates' ranking of the adequacy of their nursing education program (Schwirian, 1978). Approval to use this scale was obtained from the copyright holder.

Respondents use a four point Likert type rating scale .

described behaviours. On the first 42 items, subjects rate how well they perform on the identified activities (1=not very well, 2=satisfactorily, 3=well, 4=very well, X=not expected in my current job). On the final 10 items on professional development, subjects rate the frquency with which they engage in specified behaviors (1=seldom, 2=occasionally, 3=frequently, 4=consistently). Each of the six subscales of the Six Dimension Scale of Nursing Performance is comprised of a different number of items: leadership (5); critical care (5); teaching/ collaboration (11); planning/evaluation (7); interpersonal relationships/communication (12); and professional development (10). Because of this difference in number of subscale items the scoring formula was: X...Xn

n – m

where X...Xn = the numerical rating for each behavior in the subscale; n= the total number of items in the subscale; m= the total number of items in the subscale for which the subject rated "not expected in my current job". Use of this formula ensured the elimination of any scoring penalty for those items which were not expected in the current job (Schwirian, 1978).

Content and construct validity of this scale was established during its development. Following an

extensive literature review of concepts, constructs, and measures to describe nursing performance, deans and directors of 151 schools of nursing were asked to provide operational definitions of effective nursing performance. These same individuals, along with experienced nurse educators, researchers, and administrators served as pilot respondents to review and critique the developing scale. Respondents were consistently asked to consider whether any of the items were biased in favour of, or against, any of the three types of nursing programs. No bias was evident (Schwirian, 1978). From an initial pool of 76 nursing behaviours, following factor analysis, 52 items loading on the six sub-scales were retained.

Reliability was calculated using Chronbach's alpha for each of the subscales. The alpha coefficients ranged in value from 0.84 for the leadership subscale to 0.98 for professional development subscale (Schwirian, 1978). In a study by Clayton et al (1989) reliability measures for this scale using a sample of 66, ranged from a low of 0.73 for the leadership subscale to a high of 0.96 for the professional development subscale.

Nursing Role Conception Scale

Corwin's (1961) Nursing Role Conception Scale (Appendix H) was developed to measure role conceptions and role

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deprivation. It assesses respondents' allegiance to hospital bureaucracy, the nursing profession, and the patient. The scale consists of 22 hypothetical nursing situations. Using a Likert-type rating, (5=strongly agree, 1=strongly disagree), respondents indicate the way the situation ought to be and also the way it actually is. Six items make up the bureaucratic subscale, and eight items comprise each of the professional and the service subscales.

Professional role conception refers to occupational principles that suggest primary loyalty to the nursing profession. Bureaucratic role conception refers to the administrative rules and regulations which depict the nurse's job in a specific organization and suggests primary allegiance to nursing administration. The service role conception refers to nursing as a calling and suggests a primary loyalty to the patient. Differences between the "actual" and "ideal" scores for each item are added to yield the total role deprivation score. Permission to use this scale was granted by the copyright holder.

Content validity was established by Corwin (1961) during the development of the scale. Kramer (1970) demonstrated construct and predictive validity at the

0.01 level of confidence. The test-retest reliability coefficients for the role conception subscale were: (a) 0.86 service, (b) 0.89 bureaucratic, and (c) 0.88 professional. Other nurse researchers have used this scale in recent studies but have not reported any new information in terms of the reliability of this scale (Dobbs, 1988; Itano et al., 1987).

In a series of studies utilizing Corwin's Nursing Role Conception Scale (1961), it has been found that the mean role deprivation score of graduate nurses working for at least one year is 23. The shock phase of reality shock is associated with scores greater than 30 (Kramer, 1974, p.102).

Data Analysis

Descriptive statistics were used to describe the groups in terms of such demographics as: sex, age, academic preparation, and previous clinical experience in the employing agency prior to employment as staff nurses. Because these demographic data were of a nominal level, chi-square analysis was conducted. The chi-square statistic tests whether observed proportions differ significantly from expected (Glass & Hopkins, 1984).

In addition, groups were compared on pretest scores of the Nursing Role Conception Scale and the Six Dimension

Scale of Nursing Performance to assess for homogeneity of variance between the groups. The overall change within the groups from pre-test to post-test in each dimension of the 6-D Scale were analyzed using paired t-tests. Using the same statistical test, the overall change within the groups from pre-test to post-test on the Nursing Role Conception Scale was also analyzed.

Differences between the groups on post-test scores of each of the scales was assessed using pooled t-tests. The significane level for the study was set at p <0.05. The SPSS-X (Statistical Packages for the Social Sciences) a computer analysis system package was used for data analysis.

Summary

In this chapter, the methods and procedures for the study were outlined. A quasi-experimental, control group, pretest post-test design was used. Sample criteria and selection procedures were presented. Instruments used in the study were discussed and procedures for data analysis were explained. Ethical considerations in conducting the study were addressed.

CHAPTER FOUR

PRESENTATION OF DATA

The results from the data analysis procedures are provided in this chapter. Findings in relation to the research hypotheses and supplemental findings are presented.

Descriptive Characteristics of the Sample

Thirty four novice staff nurses comprised the final study sample. Initially, 50 novice staff nurses completed the pretest; 30 in the preceptorship (experimental) group and 20 in the traditional orientation (control) group. Since the purpose of this study was to investigate the effect of a preceptorship program on role transition of novice staff nurses, the study design required that role transition from pretest to post-test be compared. Thus, 13 participants, who completed the pretest but did not complete the one-month follow-up portion of the study, were eliminated from the final study sample. One participant in the traditional orientation group had to withdraw from the study due to resigning from the hospital prior to the one month follow-up portion of the study. Two participants returned their one-month follow-up questionnaires after the cut-off date for inclusion in the study, and were

therefore not included in the final study sample. The one month follow-up response rate was 70% for the experimental group and was 75% for the control group. The overall response rate was 72.5%.

All participants were female. The sample ranged in age from 21 to 34 years with the mean age 24.5 years. The majority of the study sample (94 %) were diploma graduates. Participant's previous experience in the employing agency ranged from zero weeks to three years (those with three years experience were graduates of the school of nursing of the hospital to which they were employed). The experimental group's clinical experience in the employing agency prior to employment ranged from zero to three years with a mean of 63.3 weeks. The control group's experience in the employing agency ranged from zero to 64 weeks with a mean of 21.8 weeks. Additional demographic characteristics of the sample are presented in Table 1.

Table 1

Demographic Characteristics of Sample (N=34)

	Experimental	Control
Characteristic	(n=14)	(n=20)
	* # / %	# / %
Basic Nursing Education		
Diploma (2 year)	5/ 25	12/ 86
Diploma (3 year)	14/ 70	1/ 7
Baccalaureate	1/ 5	1/7
Other Post Secondary		
Education		
Yes	12/ 60	9/ 64
No	8/ 40	5/ 36
Clinical Experience	· · ·	
in Employing Agency *		
yes	12/ 60	11/ 79
no	8/40	3/ 21
Duration	10/ 50	
< three years	10/ 50	14/ 100
3 years	1/ 35	0/ 0
Hospital Employment		
Prior to Education Prog	ram	
none	10/ 50	7/ 50
nurse's aide	4/ 20	4/ 29
other	6/ 30	3/ 21
Work_Experience *		
(Non-hospital)		
yes	18/ 90	13/ 93
no	2/ 10	0/ 0

* demographic characteristics with less than total sample size because some subjects did not respond to all items.

Chi-square analysis was used to compare the groups in terms of particular demographic charateristics. This analysis is used to determine whether observed proportions differ significantly from expected proportions (Glass & Hopkins, 1984). Demographic charateristics subjected to chi-square analysis were: (1) basic nursing education; (2) post-secondary education; (3) clinical experience in employing agency; (4) length of clinical experience in employing agency; (5) hospital work experience other than during education program; (6) past non-hospital work experience; and (7) age.

Results of chi-square analysis on demographic characteristics demonstrated significant differences in expected and observed proportions on basic nursing education and clinical experience in the employing agency prior to employment. In terms of basic nursing education, 86% of the traditional orientation group were from a two year diploma program; while 70 % of the preceptorship group were from a three year diploma The chi-square statistic on basic education was program. significant at 0.0012. This highly significant finding illustrates that the groups were skewed such that the preceptorship group consisted predominantly of three year diploma graduates, whereas the control group consisted predominantly of two year diploma graduates. This significant discrepancy in observed and expected

porportions could be an important factor in role transition experiences of the groups.

In relation to length of clincal experience in the employing agency, there was a significnt difference in group proportions analysed using chi-square. The significance of the chi-square statistic on this characteristic was 0.0216. The experimental group had a large porportion of members who had substantially more clinical experience in the employing agency prior to employment as novice staff nurses than did the control group. The significant difference in observed and expected porportions of this demographic variable may be an influential factor in the transition experiences of the two groups.

Results in Relation to Research Hypotheses Three research hypotheses were evaluated statistically in this study. For clarity, results in relation to research hypothesis two are presented first, followed by results in relation to hypothesis three, and then results in relation to hypothesis one are presented. HYPOTHESIS TWO: JOB PERFORMANCE LEVELS REPORTED BY NOVICE STAFF NURSES WHO PARTICIPATE IN A PRECEPTORSHIP PROGRAM WILL BE SIGNIFICANTLY MORE IMPROVED THAN THOSE REPORTED BY NOVICE STAFF NURSES WHO PARTICIPATE IN A TRADITIONAL

ORIENTATION PROGRAM.

Hypothesis two was measured by the Six Dimension Scale of Nursing Preformance. Pretest scores were compared to evaluate whether the two groups were similar in terms of job performance levels at the beginning of the study, and therefore, whether making comparisons over time to assess the treatment effect were appropriate. Pretest scores of the experimental and control groups on the Six Dimension Scale of Nursing Performance are presented in Table 2.

On the four point scale, the mean scores for the control group on the Six Dimension Scale of Nursing Performance ranged from a low of 2.41 on the teaching/ collaboration subscale to a high of 3.37 on the professional development subscale. The means scores for the experimental group ranged from 2.55 on the teaching/ collaboration subscale to 3.46 on the professional development subscale. However, with the exception of the leadership subscale, at pretest the experimental group scored themselves higher in all other subscales of the Six Dimension Scale of Nursing Performance than did the control group.

Group pretest mean scores were compared using pooled t-tests, and results indicate no statistically significant differences between the groups in any of the

six subscales of the Six Dimension Scale of Nursing Performance. Group variances were also compared and demonstrated homogeneity of variance. In addition, since the control group consisted of participants from two separate sites, pretest scores for respondents within the control group who were from separate sites, were analysed separately. Pooled t-tests yielded no significant differences in means. There was also homogeneity of variance. These results supported combining responses from subjects at the two separate sites and treating them as one control group.

The statistical analysis thus indicates that since the groups were not significantly different on pretest scores, it is reasonable to compare the experimental group's performance outcomes associated with the treatment effect (presence of a preceptor) to those of the control group.

Table 2

Pretest Scores on the Six Dimension Scale of Nursing Performance for Experimental and Control Groups (N=34)

	Exper (n=20	Experimental (n=20)		rol 4)		<u>.</u>
	x	S.D.	x	s.D.	t- value	₽
LEADERSHIP	2.74	0.51	2.84	0.50	0.54	0.59
CRITICAL CARE	2.71	0.47	2.49	0.47	-1.35	0.19
TEACHING/						
COLLABORATION	2.55	0.40	2.41	0.53	-0.88	0.39
PLANNING/						
EVALUATION	2.81	0.52	2.76	0.37	-0.25	0.81
INTERPERSONAL						
RELATIONSHIPS	/					
COMMUNICATION	3.23	0.39	3.16	0.32	-0.52	0.61
PROFESSIONAL			·	• •		
DEVELOPMENT	3.46	0.32	3.37	0.35	-0.79	0.44

p<0.05

The within-group change from pretest to post-test on the Six Dimension Scale of Nursing Performance was assessed for each group using paired t-tests. A comparison of pretest to post-test scores for the experimental group on the Six dimension Scale of Nursing Performance is presented in Table 3. The within-group change from pretest to post-test for the experimental group was significant in the planning/evaluation subscale. Although the mean scores of the experimental group on all the other subscales increased from pretest to post-test, the change was not significant.

Table 3

Comparison of H	retes	t to Pos	st-test	: Score	es on the	Six		
Dimension Scale	e of N	ursing B	Perform	nance f	Eor the			
<u>Experimental G</u> (n=20)	coup.				-			
Pretest Post-test								
• •	x	S.D.	x	S.D.	t-values	₽		
LEADERSHIP	2.77	0.51	2.84	0.53	-0.55	0.59		
CRITICAL CARE	2.71	0.47	2.77	0.55	-0.71	0.49		
TEACHING/ COLLABORATION	2.55	0.40	2.60	0.52	-0.37	0.72		
PLANNING/ EVALUATION	2.81	0.52	2.98	0.43	-2.26	0.04*		
INTERPERSONAL RELATIONSHIPS/ COMMUNICATION	3.23	0.39	3.33	0.38	-1.03	0.32		
PROFESSIONAL DEVELOPMENT	3.46	0.32	3.49	0.33	-0.77	0.45		

* indicates significant difference at p<.05.

A comparison of scores on the Six Dimension Scale of Nursing Performance from pre-test to post-test for the control group is presented in Table 4. Results demonstrate that the mean scores of the control group consistently increased in all subscales, from pretest to post-test, with these changes differing significantly in only the critical care, teaching/collaboration, and interpersonal relationships/communication subscales.

Thus, performance ratings reported by both groups revealed discrepancies in the dimensions of performance in which each group exhibited significant improvement from pretest to post-test. The question is whether these discrepancies are due to orientation program differences. Table 4

<u>Comparis</u>	<u>son of</u>	Pret	<u>est to</u>	Post-tes	t Score	es on	the Six
Dimensio	on Sca	le of	Nursin	g Perform	mance :	for th	ne Control
Group ((n=14)						

1							
	Pre	test	Post	-test	· · · ·		
	x	S.D.	x	S.D.	t-val	ues p	
LEADERSHIP	2.84	0.50	2.93	0.53	-1.07	0.30	
CRITICAL							
CARE	2.49	0.47	2.93	0.31	-5.09	0.00***	
TEACHING/			· .	· .			
COLLABORATION	2.41	0.53	2.72	0.55	-2.55	0.02*	
PLANNING/		·	• · · · · · · · · · · · · · · · · · · ·				
EVALUATION	2.76	0.37	2.98	0.55	-1.87	0.08	
INTERPERSONAL							
REALATIONSHIP	S/			•			
COMMUNICATION	3.16	0.32	3.41	0.43	-3.52	0.004**	
PROFESSIONAL					· * *		
DEVELOPMENT	3.37	0.35	3.36	0.,40.	0.15	0.88	
* indicates	signi	ficant d	lifference	at p<	.05.		
A		C 1			0.1		

** indicates significant difference at p<.01.</pre>

*** indicates significant difference at p<.001.

Performance ratings of the two groups at post-test as measured by the Six Dimension Scale of Nursing Performance were compared using pooled t-tests. Scores on the Six Dimension Scale of Nursing Performance at the one month follow-up for the experimental and control groups are presented in Table 5. Results indicate no significant differences between the groups. Thus, since there were no significant differences between the groups! scores on the Six Dimension Scale of Nursing Performance, the second research hypothesis; that job performance levels reported by novice staff nurses who participate in a preceptorship program will be significantly more improved than those reported by novice staff nurses who participate in a traditional orientation program, was not supported. In other words, in comparing the performance of the two groups, as reported on the Six Dimension Scale of Nursing Performance, analysis shows that the preceptorship experience with the presence of a designated preceptor did not have the identified effect on performance outcomes that was anticipated.

Table 5

Comparison	of Post-test	t Sco	res on	the	Six	Dimension	Scale
of Nursing	Performance	for	Experim	nenta	l an	d Control	
<u>Groups</u> (n=:	34)						

<u></u>	Experimental (n=20)		Control (n=14)			
	x	S.D.	x	S.D.	t-value	es p
LEADERSHIP	2.84	0.53	2.93	0.53	0.48	0.63
CRITICAL CARE	2.77	0.55	2.93	0.31	0.95	0.35
TEACHING/ COLLABORATION	2.60	0.52	2.72	0.55	0.69	0.50
Planning/ EVALUATION	2.98	0.43	2.98	0.55	-0.04	0.97
INTERPERSONAL RELATIONSHIPS						
COMMUNICATION	3.33	0.38	3.41	0.43	0.61	0.54
PROFESSIONAL DEVELOPMENT	3.49	0.33	3.36	0.40	-1.04	0.30
			·		 	·

p<0.05

HYPOTHESIS THREE: PERCEIVED ROLE DEPRIVATION REPORTED BY NOVICE STAFF NURSES WHO PARTICIPATE IN A PRECEPTORSHIP PROGRAM WILL BE LESS THAN THAT REPORTED BY NOVICE STAFF NURSES WHO PARTICIPATE IN A TRADITIONAL ORIENTATION PROGRAM.

The Nursing Role Conception Scale was used to evaluate the third research hypothesis. In completing this scale subjects were asked to rate 22 hypothetical nursing a second

situations in terms of how the situation ideally ought to be in nursing, and also how the situation actually is in nursing. Scores for both the responses (ideal versus actual) are given.

Pretest mean scores of the control and experimental groups on the Nursing Role Conception Scale were compared using pooled t-tests. This analysis was carried out to establish whether groups were similar at the beginning of the study in relation to role conceptions/role deprivation, and thus, whether comparisons of role conception/deprivation outcomes in relation to the treatment effect were appropriate. Group variances were compared to determine whether there was homogeneity of variance between the groups. Results of both these comparisons indicate no significant differences between the groups. In addition, since the control group was drawn from two separate sites, responses of participants from these two sites were compared separately. Results indicated no significant differences in means and also indicated homogeneity of variance within the responses of participants from the two separate sites. This supported joining these subject's responses to be considered as one control group. This overall analysis of pretest scores demonstrated that the groups were not significantly

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different in relation to role conceptions/ deprivation at the start of the study, and thus, supported the appropriateness of making comparisons in light of the treatment effect at the one-month post-test.

A comparison of pretest to post-test Nursing Role Conception Scale scores for the experimental (preceptorship) group, using paired t-tests, is presented in Table 6. Results demonstrate that the within-group change, from pretest to post-test on the Nursing Role Conception Scale, was significant only on the professional role conception subscale. While mean scores decreased from pretest to post-test on all the subcales (BRC, PRC, SRC, RD), only on the professional role conception (ideal) subscale was this decrease significant. This result suggests that for the experimental group there was a decrease in PRC (ideal) following a preceptored orientation. There was not however an accompanying increase in BRC as one might expect.

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Table 6

· · · ·	Pretes	st	Post-t	est		
	x	S.D.	x	S.D.	t-value	s p
BRC (ideal)	17.50	3.90	17.10	2.75	0.60	0.56
(actual)	18.80	2.75	19.15	2.48	-0.49	0.63
PRC (ideal)	26.80	3.43	25.10	4.39	2.72	0.01*
(actual)	23.70	2.54	22.75	3.14	1.32	0.20
SRC (ideal)	27.90	3.24	27.70	2.64	0.36	0.73
(actual)	24.30	2.76	23.10	3.96	1.35	0.19
RD	5.40	6.35	4.80	6.96	0.38	0.71
· .						
	eianiti/	ant dit	terence	at $p<.0$	5.	•

COMPARISON OF PRETEST TO POST-TEST NURSING ROLE

A comparison of Nursing Role Conception Scale scores from pretest to post-test for the control (traditional orientaion) group, using paired t-tests, is presented in Table 7. While the control group's mean scores stayed the same or decreased slightly from pretest to post-test, the within group change from pretest to post-test was not significant on any of the subscales (BRC, PRC, SRC, RD). Analysis indicates for the control group the traditional orientation program at one month did not show a significant impact on role conceptions/role deprivation.

Table 7

COMPARISON OF PRETEST TO POST-TEST NURSING ROLE CONCEPTION SCALE SCORES FOR CONTROL (TRADITIONAL ORIENTATION) GROUP.

(n=14)			· · ·			
,	Pretest		Post	-test		
	x	S.D.	x	S.D.	t-values	P
BRC (ideal)	16.36	2.98	16.36	1.99	0.00	1.00
(actual)	18.71	2.59	18.93	2.17	-0.24	0.17
PRC (ideal)	28.36	2.10	27.21	3.19	1.45	0.89
(actual)	22.86	2.35	23.86	3.76	-1.16	0.27
SRC (ideal)	28.43	3.52	28.29	2.05	0.14	0.89
(actual)	24.57	2.21	23.93	2.70	1.09	0.30
RD	7.00	5.88	5.14	6.49	0.99	0.34

BRC=bureaucratic role conception. PRC= professional role conception. SRC= service role conception. RD= role deprivation.

p<0.05

A comparison of pretest to post-test Nursing Role Conception Scale scores for both groups using pooled ttests is presented in Table 8. Results indicate no significant difference between the groups from pretest to post-test on any subscales of the Nursing Role Conception Scale. Thus, research hypothesis three was not supported. This analysis suggests that despite a significant within-group decrease in PRC (ideal) for the experimental group; this difference was not enough to cause a significant difference in overall post-test scores on the Nursing Role Conception Scale. In other words, despite some discrepancy in within-group role conception scores from pre-test to post-test, the groups' post-test role conception and role deprivation scores were not significantly different even though they participated in different types of orientation programs.

Table 8

	Experimental (n=20)		Cont (n=1	Control (n=14)		
	x	S.D.	x	S.D.	t-value	s p
<u>Pretest</u>						
BRC (ideal)	17.50	3.90	16.36	2.98	-0.92	0.36
(actual)	18.80	2.75	18.71	2.59	-0.09	0.93
PRC (ideal)	26.80	3.43	28.36	2.10	1.51	0.14
(actual)	23.70	2.54	22.86	2.35	-0.98	0.33
SRC (ideal)	27.90	3.24	28.43	3.52	0.45	0.66
(actual)	24.30	2.76	24.57	2.21	0.31	0.76
RD	5.40	6.35	7.00	5.88	0.74	0.46
Post-test						
BRC (ideal)	17.10	2.75	16.36	1.99	-0.86	0.39
(actual)	19.15	2.48	18.93	2.17	-0.27	0.79
PRC (ideal)	25.10	4.39	27.21	3.19	1.54	0.13
(actual)	22.75	3.14	23.86	3.76	0.93	0.36
SRC (ideal)	27.70	2.64	28.29	2.05	0.70	0.49
(actual)	23.10	3.96	23.93	2.70	0.68	0.50
RD	4.80	6.96	5.14	6.49	0.15	0.89

<u>COMPARISON OF PRETEST TO POST-TEST NURSING ROLE</u> <u>CONCEPTION SCALE SCORES FOR BOTH GROUPS</u>

BRC= bureaucratic role conception. PRC= professional role conception. SRC= service role conception. RD= role deprivation scale.

p<0.05

HYPOTHESIS 1. ROLE TRANSITION WILL BE PERCEIVED TO BE EASIER BY NOVICE STAFF NURSES WHO PARTICIPATE IN A PRECEPTORSHIP PROGRAM THAN BY NOVICE STAFF NURSE WHO PARTICIPATE IN A TRADITIONAL ORIENTATION PROGRAM.

Role transition is the alteration in expectations related to actions and reactions demanded by a change in . role. Role transition from student to novice staff nurse requires adjustments in skill mastery and role conceptions/role deprivation. In order for hypothesis one to be supported, pretest to post-test scores reported by the experimental (preceptorship) group, had to reveal significantly less role deprivation on the Nursing Role Conception Scale and significantly higher performance ratings on the Six Dimension Scale of Nursing Performance than those reported by the control (traditional orientation) group. Comparisons of group scores at posttest on both instruments using pooled t-tests (Table 5 and Table 8) demonstrate no significant differences between group post-test scores. Since this was the result, the first research hypothesis was not supported.

Summary

Results of of the data analysis were presented in this chapter. Demographic charateristics of the sample were evaluated using chi-square analysis and showed that the
groups differed on two variables: basic nursing education and amount of clinical experience in the employing agency prior to beginning employment as staff nurses. These differences may have been influential factors in the role transition experiences of participants.

Pretest scores in relation to performance levels as measured by the Six Dimension Scale of Nursing Performance, and role conception/role deprivation scores as measured by the Nursing Role Conception Scale were compared. Results indicate no significant differences between the groups at the start of the study. This finding supported the suitability of comparing performance ratings and role conceptions/role deprivation over the time of the study to assess the effect of treatment (presence of a designated preceptor for the experimental group, and lack of a designated preceptor for the control group) on these outcomes.

Within-group changes in performance ratings from pretest to post-test for each group were assessed. Results of this analysis revealed discrepancies in the dimensions of performance in which each group showed significantly improved performance ratings. The experimental group showed significant improvement in only the planning/evaluation dimension, while the control

group exhibited improved performance in the critical care, teaching/collaboration, and interpersonal relationships/communication dimensions of performance. A question is whether these discrepancies are due to orientation program differences or other factors.

Post-test performance ratings of both groups were compared. Analysis indicated no significant differences between the groups on any dimensions of performance measured by the Six Dimension Scale of Nursing Performance. Thus, despite discrepancies in the dimensions of performance in which each group exhibited performance gains from pretest to post-test; these discrepancies were not enough to result in significantly different performance ratings between the groups at posttest.

Within-group changes in role conception/role deprivation scores were compared. Analysis showed that the experimental group had a significant decrease in PRC (ideal) from pretest to post test, but it did not have an accompanying increse in BRC (ideal) as one might expect. The control group did not exhibit any significant differences in role conceptions/role deprivation at posttest.

Results indicate that there were no significant differences between the groups on either the Nursing Role Conception Scale or the Six Dimension Scale of Nursing Performance. Thus, neither group's role transition experiences differed significantly over the other. Consequently, none of the three research hypotheses of this study was supported.

CHAPTER FIVE

DISCUSSION OF FINDINGS

In this chapter study findings and interpretation of statistical data presented in the preceding chapter are discussed. Study results in relation to each of the research hypotheses and factors that may have influenced these results are discussed. Results of this study are compared to the findings of other studies of preceptorships.

Discussion in Relation to Research Hypotheses For clarity, discussion of results in relation to each of the research hypothesis will deal first with hypothesis two, followed by discussion of results of hypothesis three, and will conclude with discussion of results related to hypothesis one.

<u>HYPOTHESIS TWO</u>: JOB PERFORMANCE LEVELS REPORTED BY NOVICE STAFF NURSES WHO PARTICIPATE IN A PRECEPTORSHIP PROGRAM WILL BE HIGHER THAN THOSE REPORTED BY NOVICE STAFF NURSES WHO PARTICIPATE IN A TRADITIONAL ORIENTATION PROGRAM.

Pretest performance scores reported by the experimental group were consistently higher than those of the control group in all subscales of the Six Dimension Scale of Nursing Performance, but the leadership subscale. This

suggests that subjects in the experimental group began their preceptorship program with a predominantly more positive self-perception of their performance ability. In comparing the within-group change in performance ratings, the control group had a significant improvement from pretest to post-test in three dimensions of performance (critical care, interpersonal relationships /communication, and teaching/collaboration). The experimental group from pretest to post-test had a significant improvement in only the planning/evaluation dimension of performance. However, at post-test there was no significant differences in the post-test performance scores between the groups. It is possible that the higher pretest performance ratings of the experimental group were balanced out by the control group's improved performance in more dimensions of performance than that of the experimental group. This balancing effect may explain why there were no significant differences between the groups in post-test performance outcomes. One must question what factors might explain the unexpected discrepancy in within-group performance outcomes? Possible explanations relate to demographic variables of study participants, program factors, and study design limitations.

Demographic Variables

Analysis of demographic variables using chi-square analysis revealed that the group proportions were significantly different on two demographic variables: (1) basic nursing education and (2) clinical experience in the employing agency prior to their present employment as novice staff nurses. The experimental group had a significantly higher porportion of subjects, who were educated in a three year diploma program (70%), as compared to the traditional orientation group, who had a significantly higher porportion of participants who were educated in a two year diploma program (85.7%).

The experimental group had a greater proportion of subjects who had been graduates of the hospital school of nursing of the employing agency. They therefore had substantially more clinical experience in the employing agency prior to this employment than did the control group (Table 2).

Participants in the experimental group at pretest already had more clinical experience by virtue of the longer educational program. They also has significantly more clinical experience in the practice setting where they are now employed. With the combination of these factors, in addition to the preceptorship program, one

might expect that their performance would continue to improve and be significantly higher than that of the control group. Despite the apparently favorable advantages in demographic variables, the experimental group post-test performance ratings did not differ significantly from that of the control group. Probable explanations for this relate to program factors or study design limitations.

Program Factors

The difference in focus of the central nursing orientation aspects of the preceptorship and traditional orientation programs is one program factor that may have contributed to this study not finding any statistically significant difference in performance outcomes between the groups. The traditional orientation program at both sites was guite skill oriented as compared to the preceptorship program (Appendices B, C, and D). This factor may have been instrumental in the performance improvement exhibited by the control (traditional orientation) group on the Six Dimension Scale of Nursing Performance. This group had a significant performance improvement in three subscales (critical care, teaching/collaboration, and interpersonal relationships /communication), (Table 4); while the preceptorship group

had significant improvement in performance on only one subscale (planning/evaluation), (Table 5).

Study Design Limitations

A study limitation which made it impossible for the researcher to randomly assign participants to the experimental and control groups is another factor that may have influenced the performance results. Since subjects could not be randomly assigned to the experimental or control groups, subjects may have differed in areas of self perception, and/or in their ability to accurately appreciate changes in their nursing performance. Whether individuals were in the experimental or control group was beyond the investigator's control since this was under the agency's control. Without random assignment of subjects to the control and experimental groups there is no means to control factors such as individual participants having: (1) unequal actual performance ability at the beginning of the study, and (2) unequal ability to accurately recognize performance gains within their own performance over time. Although pretest mean scores and variances were assessed and were not found to be significantly different, this does not mean that differences were not present. Neither, do these assessments address potential differences in participants' abilities to recognize performance gains over time.

HYPOTHESIS THREE: PERCEIVED ROLE DEPRIVATION REPORTED BY NOVICE STAFF NURSES WHO PARTICIPATE IN A PRECEPTORSHIP PROGRAM WILL BE LESS THAN THAT REPORTED BY NOVICE STAFF NURSES WHO PARTICIPATE IN A TRADITIONAL ORIENTATION PROGRAM.

Results indicate that there were no significant differences between the groups in pretest role conceptions and role deprivation scores. In comparing the within-group change in role conceptions/ role deprivation, the experimental group had a significant decrease in professional role conception (ideal) but there was no accompanying increase in bureaucratic role cojnception as one might expect. Possible reasons that may be posed for this result are:

(1) The experimental group who were precepted may have received increased pressure from preceptors to conform to bureaucratic rules. Based on their experience, they may have perceived it necessary, in order to gain approval from their peer preceptors, to adjust downward their ideal professional role conception ratings. However, despite decreasing their PRC (ideal), post-test scores

indicate they were not yet ready to significantly increase their BRC. Kramer and Schmalenberg (1977b) identified that certain testing takes place when novice nurses are attempting to become accepted members of the unit work group. In essence the first job for novice nurses is a proving ground where the novice must prove her/himself in the staff nurse role. Participants in the preceptorship group may have perceived that their PRC needed to be adjusted to more closely match the PRC of the reference group to which they aspired to become accepted members. This may account for the decrease in PRC (ideal) at post-test measurement. Given the fact that the control group had various experienced nurses who buddied with them, subjects in the control group may not have identified as closely with the reference group towhich they desired membership. Thus, unlike the experimental group, the control group did not report a decrease in PRC (ideal) at post-test.

(2) A second possibility is that the experimental group may have received negative feedback (sanctions) for holding such high ideal PRC and for attempts to live up to these ideal professional role conceptions in professional practice. If this were the case, at posttest they may have adjusted their ratings (decreased PRC-

ideal) in light of such feedback.

(3) Another possibility is that this decrease in PRC ideal may reflect a realistic positive adjustment to the demands of practice. Perhaps the level of professionalism that neophytes acquire in school is too high for the demands of the practice setting. Corwin (1961) identified that role conceptions acquired in school do not grasp the full complexities of the work experience. Consequently, the refining and adjusting of these ideal standards is almost an inescapable adjunct to beginning professional practice. Kramer and Schmalenberg (1977a) identified that the most successful resolution of reality shock is a bicultural adaptation, in which the neophyte reevaluates school learned values, maintaining those that are beneficial, and meshing them with the realities of the work situation. As such, this decrease in PRC (ideal) reported by the experimental group may indicate a positive movement toward realism necessary for successful role transition.

Despite the differences in within-group changes from pretest to post-test in the PRC (ideal), there were no statistically significant differences between the groups in post-test role conception/role deprivation scores. A possible explanation for this might be that during this first one month both programs may have concentrated more on mastery of skills and organizational abilities, as opposed to dealing with social integration. If this were the situation, this would account for the study results failing to find any differences between the groups on role conceptions and role deprivation.

<u>HYPOTHESIS ONE</u>: ROLE TRANSITION WILL BE PERCEIVED TO BE EASIER BY NOVICE STAFF NURSES WHO PARTICIPATE IN A PRECEPTORSHIP PROGRAM THAN BY NOVICE STAFF NURSES WHO PARTICIPATE IN A TRADITIONAL ORIENTATION PROGRAM.

In order for this hypothesis to be supported the experimental group had to report higher performance scores and lower role deprivation scores at post-test than those reported by the control group. Since this was not the result this hypothesis was not supported. Several possible reasons may account for this result.

Program Factors

The assignment of preceptors for the experimental group is a program factor that may have influenced the performance and role deprivation results of this study. Head nurses of the respective wards to which novice staff nurses were hired were responsible for assigning preceptors to work with novice nurses. On occasions, nurses assigned to function as preceptors with the novice

nurses, had not attended the Preceptor Development Program which prepares preceptors to function in this role. In these situations, these staff nurses who are called preceptors, were really more like the "buddy" of the traditional orientation program. Moreover, novice staff nurses in the preceptorship program were frequently assigned more than one preceptor. In essence, these practices dilute the expected overall treatment effect of a preceptorship program, and may have been instrumental factors in there being no significant differences between the groups on performance ratings; role conceptions/ deprivation; or role transition experiences.

Nevertheless, one needs to recognize the difficulties, with the nursing shortage, of having enough experienced nurses prepared to function in the preceptor role. Recent literature has identified this problem (Cantwell, Kahn, Lacey & McLaughlin, 1989; Griepp, 1989; Hamilton, Murray, Lindholm, & Myers, 1989; Lewis, 1990). Griepp (1989) noted several instances of nurses with limited experience (less than one year) being assigned "by default" to function as preceptors because units did not have enough experienced staff nurses for its preceptor requirements.

Job factors and individual characteristics of the preceptors selected for the preceptor role, may influence the quality of the feedback, supervision, and guidance given to the novice staff nurse by preceptors (Sheetz, 1988). These factors may also have influenced the study findings. One needs to question whether "the preceptor truly act[s] as a preceptor or do other job responsibilities make this impossible" (Cantwell, et al., 1989, p.229). This is particularly a problem with the nursing shortage. When problems and practices such as these exist, they neutralize the expected positive influence of preceptors for novice nurse transition to practice.

Another consideration was identified by Sheetz (1989). She found that registered nurses who buddied with students who were not in a preceptorship program assumed the informal role of preceptor to students, even though the role was not formally recognized by the organization. If staff nurses in the control (traditional orientation) program followed this practice, even though they had not received preparation for the role, they may have provided guidance to the novice staff nurses of the control group, similar to that which was provided by the preceptors to novice staff nurses in the preceptorship (experimental)

group. As such, the expected difference in treatment between the experimental and control group would not have occurred. If this were the case, it would account for the lack of significant differences between the groups in terms of transition experiences.

Study Design Limitations

Whether novice staff nurses in the study had participated in a preceptorship program as part of their educational program is a factor that was not assessed, and which might have contributed to the results. These programs are included in some curricula as a means to provide students with anticipatory socialization to the novice staff nurse role (Chickerella & Lutz, 1981). One could surmise, if subjects had such an experience, they might be sensitized to the issues surrounding the transition from student to beginning pratitioner, and this may influence their adjustment to practice. As such, consideration of this factor in the study design would have helped in interpreting possible reasons for study results.

The time frame for the study is another factor that may have affected the results of this study. Participants may not have moved beyond the honeymoon phase of reality shock. During the honeymoon phase, the new nurse's

appraisal of her/his job is typically very positive. There is a tendancy to view situations through rosecolored glasses (Kramer, 1974), and as such, during this stage "problems are not recognized, they're not even perceived" (Kramer & Schmalenberg, 1977a, p. 6). Accordingly, if subjects in this study had not moved beyond the honeymoon phase, conflicts which new nurses are expected to have to face, may not have yet surfaced from their perspectives. As such, it would be useful to study the groups over a longer time frame, and investigate whether changes in any of these parameters (performance ratings, role conceptions/ deprivation, role transition) will be exhibited with time.

A third study design factor that may have contributed to the unexpected results of this study was the small sample size. When sample size is small this limits the power to detect significant differences should differences actually exist (Burns & Grove, 1987).

Individual Factors

Many individual factors may have been influential in the role transition outcomes of the two groups. According to Spickerman (1988) many factors mediate the severity of reality shock. Skills, knowledge levels,

and attitudes associated with clinical practice are influential. Other factors such as self concept, interpersonal relationship skills, organizational abilities, and compatability between personal and professional goals also contribute to one's adjustment when entering professional practice. Accordingly, if the groups had persons who were confident, had solid knowledge bases, strong interpersonal relationship and organizational skills; these factors alone, as opposed to the particular orientation program that the individuals received, may have made these individuals more likely to be accepted into the reference work group of experienced nurses. This is likely to be the case since these are the types of skills that experienced nurses tend to highly value. Kramer and Schmalenberg (1977b) noted that experienced nurses are continually testing the neophyte with informal tests and judging the neophyte's performance based on their own standards of performance, without consideration of the neophyte's lack of experience. Given this, it is reasonable to suggest that if participants possessed characteristics such as these described, they would be more likely to be accepted as full members of the unit work group of professional nurses.

Comparison of Present Study Results to Other Studies

It had been expected that the preceptorship group, as a result of the preceptorship program, would demonstrate significantly greater performance gains than the traditional orientation group. This study failed to support the hypothesis that job performance levels reported by novice staff nurses who participate in a preceptorship orientation program will be higher than those reported by novice staff nurses who participate in a traditional orientation program. This is similar to the findings of Clayton, Broome and Ellis (1989); Huber (1981); and Olsen, Gresley, and Heater, 1984. Huber (1981) found that graduate nurses who completed a hospital-based preceptorship orientation program preceived their performance to be no different than graduate nurses completing a hospital-based internship orientation program. Huber also used the Six Dimension Scale of Nursing Performance to measure self-perceived performance by graduate nurses.

Olsen, Gresely and Heater (1984) found that nursing students who completed an eight week undergraduate clinical course did not perceive their performance, as rated on the Six Dimension Scale of Nursing Performance, to be different from that of students who had not

completed the course.

Clayton et al. (1989) used measures of performance, as self-evaluated by participants on the Six Dimension Scale of Nursing Performance, to determine the effect of a preceptorship experience on role socialization of graduate nurses. The study only partially supported the hypothesis that there would be significant differences between the groups on the six subscales of the Six Dimension Scale of Nursing Performance. There were significant differences between the groups on the leadership, teaching/collaboration, interpersonal relationships/communication and planning/evaluation subscales, but not on the professional development and critical care subscales.

Like other studies that have investigated role conceptions/role deprivation (Dobbs, 1988; Itano et al., 1987), results of this study did not find any significant effect of a preceptorship program on role conception or role deprivation as compared to a traditional orientation program. At post-test measurement there were no significant differences between the preceptorship and traditional orientation groups' role conception and role deprivation scores. Thus, the study hypothesis, that participants in the preceptorship program would report

less role deprivation than participants in the traditional orientation program was not supported.

Participants in this study did not have significant differences in performance ratings or role conceptions/role deprivation at post-test measurement. Thus, novice staff nurses' role transition experiences were not found to be significantly different whether they participated in the preceptorship or the traditional orientation program. As such, the treatment effect of presence of a preceptor for the preceptorship group was not as strong an influence on role transition of novice staff nurses as had been expected.

Summary

The results of this study failed to support any of the study hypotheses that suggested novice staff nurses who participated in a preceptorship program would (1) report higher performance ratings, (2) less role deprivation, and (3) easier role transition than novice staff nurses who participate in a traditional orientation program. Results of the study and factors that may be posed to explain the study findings were discussed. Results of this study were compared to results of other studies on preceptorship.

CHAPTER SIX

SUMMARY, CONCLUSIONS, AND IMPLICATIONS

A summary of study findings and conclusions are presented in this chapter. In addition, limitations of the study, study implications, and recommendations for future study are provided.

Summary

The transition from student to beginning practitioner in nursing has been identified as a particularly difficult transition. Preceptorship programs have been used as orientation strategies in a effort to ease this transition from student to practitioner in nursing. The purpose of this study was to investigate the effect of a preceptorship program on the role transition of novice staff nurses. The three research hypotheses that were tested in this study were:

1. Role transition will be perceived to be easier by novice staff nurses who participate in a preceptorship program than by novice staff nurses who participate in a traditional orientation program.

2. Job performance levels reported by novice staff nurses who participate in a preceptorship program will be higher than those reported by novice staff nurses who participate in a traditional orientation program.

3. Perceived role deprivation reported by novice staff nurses who participate in a preceptorship program will be less than that reported by novice staff nurses who participate in a traditional orientation program.

Demographic characteristics of the groups were assessed using chi-square analysis. Results revealed that the experimental and control groups differed significantly on two variables: (1) basic nursing education, and (2) amount of clinical experience in the employing agency prior to their present employment as novice staff nurses. These differences in proportions may have been important influencing factors on the role transition experiences reported by the groups.

In relation to hypothesis two, results indicated no significant differences between the groups in post-test performance outcomes. There were discrepancies from pretest to post-test in the areas of performance in which the groups reported statistically significant withingroup performance gains. The control group reported improvements in three dimensions of performance (critical care, teaching/collaboration, and interpersonal relationships/communication). The experimental group reported improved performance in only the planning/ evaluation dimension of performance. Despite these

within-group differences, comparison of overall post-test scores revealed no significant differences between the groups in any dimensions of performance as measured by the Six Dimension Scale of Nursing Performance. Many possible reasons were presented for these results (demographic variables, program factors, and study design limitations).

Role conception and role deprivation scores, as measured by the Nursing Role Conception Scale, were tested to evaluate hypothesis three. Analysis of results in relation to hypothesis three revealed a significant within-group decrease in PRC (ideal) from pretest to post-test for the experimental group; but not an accompanying increase in BRC as one might expect. Several possible explanations for this result were introduced. On the remaining subscales of the Nursing Role Conception Scale (BRC, SRC, RD), the experimental group exhibited no significant within-group differences between pretest and post-test scores. By comparison, the control group reported no significant within-group differences from pretest to post-test in any subscales of the Nursing Role Conception Scale (PRC, BRC, SRC, RD).

Post-test role conception and role deprivation scores of both groups were compared. Results indicated no statistically significant differences between the groups on these scores. Thus, at one month the preceptorship program had less of an affect on role deprivation than had been anticipated.

Since the experimental group did not report higher performance ratings or lower role deprivation scores than those reported by the control group, the first research hypothesis, that suggested role transition would be easier for the experimental group, was not supported. Role transition experiences of the groups were not found to be significantly different. Results suggest that at one month there was no difference exhibited in either program assisting novice staff nurses to make the transition from student to beginning practitioner.

Conclusions

Conclusions which can be drawn from analysis of the study data are:

1. Participants in both programs (preceptorship and traditional orientation) showed significant performance gains in distinctly different aspects of performance as measured by the Six Dimension Scale of Nursing Performance. While the control (traditional orientation) group exhibited performance gains on three dimensions of performance (critical care, teaching/collaboration, and

interpersonal relationships/communication); the experimental group reported improved performance on only one dimension of performance (planning/evaluation). However, participants in neither group gained significantly in terms of overall performance ability over the other. Thus, it can be concluded that both programs provide benefits, but in different directions, with different areas of focus.

2. Role conception scores of the groups at post-test were not significantly different. However, the experimental (preceptorship) group reported a significant within-group decrease in PRC (ideal). The control group reported no significant within-group differences in any role conceptions from pretest to post-test. It can be concluded that the within-group change in role conceptions reported by the groups demonstrates that the groups had different experiences in their orientation programs.

3. Participants in the preceptorship program did not demonstrate less role deprivation than participants in the traditional orientation program. Thus, it can be concluded that preceptorship program participants did not perceive themselves as having less conflict in resolving dilemmas about how situations ideally ought to be in

nursing versus how they actually are in practice. The preceptorship program had less of an effect on role deprivation than was anticipated.

4. Overall, the findings suggest that, at one-month postemployment, no difference was shown in either program assisting novice staff nurses to make the transition from student to beginning practice in professional nursing. Thus it can be concluded that the presence of preceptors was less of a factor in influencing novice staff nurse role transition than had been anticipated.

Limitations

Recognized limitations of this study include: 1. Random selection or random assignment of subjects into experimental (preceptorship) and control (traditional orientation) groups was precluded. This depended entirely on the employing agency, and therefore, was out of the investigators's control.

2. Because of time constraints, the post-test was administered at one month. This may have been too short a time interval in which to detect significant role transition differences between the groups.

3. In practice novice staff nurses in the preceptorship program were often assigned more than one preceptor. In addition, there were several occasions when experienced

nurses, who had not had the educational program to prepare them for the preceptor role, were assigned as preceptors to novice staff nurses. These factors may have limited the effectiveness of this preceptorship program. Particularly, in offsetting benefits attributed to preceptorship programs, such as, one-to-one learning, with an "enlightened guide" who is prepared for the preceptor role.

4. The sample size was small, thus limiting the power to detect differences should differences actually exist.
5. Factors such as staffing needs, assignments given to novice staff nurses, and work milieu in participating agencies were factors that were not controlled in this study.

Implications

Findings of the study have implications for nursing practice, education, and research. Each of these is presented individually in the following sections. Nursing Practice

The period of beginning employment as novice staff nurses is critical to the professional development and long term adjustment of nurses. The socialization experienced during this time establishes the basis for their satisfaction and later loyalty to bureaucratic and

professional standards (Ahmadi et al., 1987). Practice settings need to foster positive environments that facilitate novice nurses' transition from school to practice.

The ability of nursing practice settings to provide a supportive environment to beginning staff nurses is becoming more difficult given today's changing health care environment. According to Talarczyk and Milbrant (1988) the present health care environment, with emphasis on "high tech" and cost containment, places increased demands on nurses. It requires nurses who are able to provide competent and sensitive nursing care to patients with increased acuity. Moreover, it requires that they deliver this care in a fast paced manner. These factors add to the pressures experienced by novice nurses in making the transition from school to practice.

According to Hamilton et al. (1989) hospital orientation programs have essentially focused on the familiarizing new nurses to the policies and protocols of the institution; and have usually failed to attend to providing guidance to the novice in role development, that is, in acquisition of attributes that are characteristic of the professional nursing role.

Kramer and Schmalenberg (1977b) described how the first job of novice nurses is a proving ground. In this proving period the novice is put through many formal and informal tests by the referent work group. The problem for neophytes with these tests is that they are ambiguous, and the criteria for passing the tests are not clear. Another problem with these tests is that members of the referent work group tend to judge neophytes' performance from the level of performance they have attained by experience without regard for the neophyes lack of experience. It would be worthwhile for practice settings to appraise the testing, particularly informal testing, that takes place and to discuss the impact of this testing on transition experiences of neophytes. Clearly, when such practices are discussed there is a greater likelihood that testing, if it is to continue, could be adjusted so that expectations in testing could reflect the different experience levels between novice and seasoned professionals. Consequently, expert levels of performance would not be expected from beginning practitioners.

Based on the present study findings, both of the orientation programs (preceptorship and traditional orientation) were equal in that there were no significant differences in role transition experiences, whether novice staff nurses participated in a preceptorship or a traditional orientation program. This suggests that the benefits of preceptorship programs over traditional orientation programs, that have been cited in the literature, may not be borne out as strongly as was anticipated. If preceptorship programs are to be of greater benefit in assisting novice staff nurses to make the transition from students to beginning practitioners, attention needs to be given to preceptorship program development and monitoring of their effectiveness.

Difficulties arise with preceptor programs having enough experienced staff prepared to function as preceptors. The impact of the nursing shortage, complicates the ability of practice settings to have enough experienced nurses to provide preceptors for novice nurses. Changing preceptor assignments in the middle of the program or assigning several preceptors for each novice nurse destroys the continuity for the neophyte (Goldenberg, 1987/1988). If practice settings are to reap the greatest benefits that have been ascribed to preceptorship programs, mechanisms to increase the number of preceptors prepared to fulfill that role are needed.

Attention also needs to be given to the person's selected for the preceptor role. The clinical competence; interpersonal relationship/communication skills; teaching abilities; and willingness of experienced nurses chosen for the preceptor role are all important ingredients in ensuring the quality of the teaching and guidance given to noephytes by preceptors.

In this preceptorship program studied there were no formal standards in terms of the qualities required in preceptors. As well there was no formalized ongoing follow-up with preceptors and orientees. These factors might limit the degree to which the program is operating consistent with its purpose. Nursing practice needs to address issues of commitment to the preceptorship program as a means to assist novice nurses with the transition to practice if it is to be used as it was intended to be used. If these programs are to be successful organizational commitment to the objectives of the preceptorship program is essential.

Nursing Education

Nursing education prepares practitioners for a practice discipline, and as such, must be alert to the realities of clinical practice in today's nursing practice settings. Nursing education must prepare students for

the transition to practice and the typical problems that beginning practitioners face. As such, education programs must provide content in reality shock and anticipatory socialization to the reality of the professional nursing role.

To be successful in providing adequate anticipatory socialization programs, educators must be knowledgable of the "real world" situation in nursing practice settings. Role expectations of educators and practitioners must become more congruent. Moreover, if educators are to adequately prepare students for professional practice in nursing, mechanisms are needed to ensure that educators are clinically proficient, and thus are qualified, to prepare nursing students for the real world of nursing. Thus, nursing education and nursing practice need to be closely linked in order that students begin practice with the technical, interpersonal relationship, and conceptual skills necessary to handle the realities of beginning nursing practice.

Given the pace of change in nursing, educators must have some means to maintain competence in order to provide instruction and supervision to students that will, upon graduation, provide them with the requisite skills to competently begin practice in nursing. Many issues need to be addressed particularly in the university setting. According to Myrick (1988) clinical teaching in university settings is subordinate to classroom teaching, research, and publication. Nursing ought to question what is the ideal combination, for nursing faculty in terms of clinical proficiency, and expertise in the application of sound teaching and learning principles.

Another issue that needs to be addressed is whether educational standards are appropriate, or whether nursing education is advocating and teaching perfectionism as opposed to professionalism? Nursing education and nursing service personnel should collaborate in establishing appropriate curriculum content for nursing education programs. There must be agreement between nursing education and nursing service on what constitutes appropriate basic entry-level skills of new graduates.

There have been frequent debates concerning the gap between nursing practice and nursing education personnel (Schempp & Rompre, 1986). Nursing service personnel often complain that schools of nursing fail to adequately prepare students for practice. As a result, practice settings must spend inordinate time in orienting new graduates before they are ready to assume full patient

care responsibilities. Educators defend that it is impossible to prepare a finished product ready for practice in any setting. They also contend that practice settings fail to treat the new graduate in a manner that fosters successful transition from school to practice. The novice nurse, caught in the middle of this debate between nursing education and nursing practice personnel, frequently feels personally responsible for her/his inadequate preparation for the staff nurse role (Schempp & Rompre, 1986). A resolution to this long standing blaming game is needed so that practice and education personnel work collaboratively to provide positive conditions for smoother transitions of neophytes into professional practice.

Another issue that needs to be addressed by nursing education relates to the nursing shortage and its effects. Educators, practice personnel, and professional nursing bodies need to consider the limits to which they are willing to compromise professional expectations for bureaucratic standards. Given the critical nursing shortage and the promise of increasing pressure to make compromises (i.e., decrease standards in nursing practice and nursing education), it is crucial that these issues be addressed. Nursing needs to clearly and proactively

delineate the limits to which it will submit in decreasing standards. This will ensure that contingencies with accompanying rationale are developed so that nursing education standards and not unduely jeopardized.

Clearly, nursing practice is the raison d'etre of the nursing profession. Nursing education is charged with preparing practitioners for the practice of nursing. Educators must be proficient in the practice of professional nursing, and thus, cannot be separate from nursing practice.

Nursing Research

Preceptorship programs are extensively used for orientation of novice staff nurses to nursing practice. While many benefits of preceptorship programs for this purpose are noted in the anecdotal literature on the subject, the research which has investigated the effect of preceptorship programs has found conflicting results. More research is needed to investigate the effect of preceptorship programs. It is recommended that this study be replicated with a larger sample size and that participants be followed over a longer time frame in order to determine whether changes in role transition of novice staff nurses over time can be attributed to the

effects of the preceptorship program.

In addition, future research could address: (1) Whether preceptorship programs, as opposed to traditional orientation programs, have any differences in terms of effects on job satisfaction, and retention of nurses.

(2) Whether prior clinical experience in the employing agency as part of their education program teaches neophytes the "back stage" reality and the day-to-day politics of the bureaucratic organizations in which novice nurses begin practice. (This data would be useful in determining whether this information can be deleted or condensed in orientation programs).

(3) Whether differences in novice staff nurse outcomes correlate to level of preceptor competence.

(4) Whether there are differences in effects of preceptorship programs when preceptors receive orientation to the preceptor role versus programs where preceptors do not receive preparation for the preceptor role.

(5) Whether retention of nurses is increased when they begin professional practice in a place of employment where they received substantial clinical experience during their preparatory education program.
(6) Whether orientation programs which focus on skill mastery as opposed to social integration foster positive role transition.

Clearly preceptorship programs are frequently used in nursing education programs and nursing practice settings. More study is needed to validate whether these programs are truly as effective as they have been declared to be.

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Appendix A.

Monday

0800-0830	Welcome, Introduction, Meet Instructors
0830-0915	Charting Responsibilities and Accountability
0915-0930	"Lift and Transfer Techniques" video
0930-1000	Break
1000-1030	Nursing Personnel Policies
1030-1100	"Restraint/Non Restraint" video
1100-1200	Blood Glucose Monitoring
1200-1300	Lunch
1300-1600	Clinical Area- Complete:
	Policy and Procedure Module, Pharmacy Module,
	Pre-reading Material, Search and Find and
	Lifting and Transferring Return Demonstration.

Tuesday

0800-1200	Hospital Wide Orientation (by Employee
	Relations)
1200-1300	Lunch
1300-1330	Communications Systems
1330-1345	Introduction to Competency Based Education
1345-1415	Computers in Nursing
1415-1445	Break
1445-1530	Philosophy
1530-1600	Overview of Nursing Division Organization

Wednesday

0800-0840	Education and Research
0840-0910	Quality Assurance, Standards and Protocals
0910-0930	Break
0930-1000	Pastoral Care
1000-1100	Infection Control
1100-1200	Respiratory Therapy
1200-1300	Lunch
1300-1600	Parenteral Therapy

Thursday

- 0800-1100 Code Blue (General Areas)
- 1100-1200 Lunch
- 1200-1600 Clinical Area

OR

- 0700-1100 Clinical Area
- 1100-1200 Lunch
- 1200-1500 Code Blue (General Areas)

Preceptor Development Program

Purpose:

This half day program is designed to assist participants (registered nurses who will be acting as preceptors) to develop the knowledge, skills and attitudes necessary to effectively quide a new employee through orientation.

Program Objectives:

At the end of the program the participant will be able to:

- Describe the purposes and benefits of a preceptorship program for orientation.
- Outline roles of the orientee, preceptor and head nurse or delegate in the Hospital Preceptorship Program.
- 3. Identify methods of assessing an orientee's learning needs.
- 4. Outline competency areas required of the orientees.
- 5. Develop teaching strategies to assist orientees to meet their learning needs and competencies.
- 6. Give constructive feedback in response to an observed performance or case study.

Appendix C.

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Traditional Orientation Schedule Hospital (A)

Tuesday

0800-0830	Introduction
0830-0835	Pastoral Care
0835-0840	Spiritual Aspects
0840-0900	Personnel Services
0900-0930	Union Reps: HSA HEU BCNU
0930-0945	Coffee
0945-1015	Infection Control
1015-1040	Fire Safety
1040-1100	Disaster Plan
1100-1120	Employee Health Services
1120-1200	Lunch
1200-1230	Nursing Department Philosophy & Objectives
1230-1300	Nursing Personnel Information
1300-1530	Back Care Program

Wednesday

0730-0815	Computerized Medication System
0815-0900	I.V. Therapy
0900-0915	R.N.A.B.C.
0915-0930	Coffee
0930-1045	T.P.N.
1045-1145	Unit Orientation (Complete seek and
	find, review unit orientation)
1145-1215	Lunch
1215-1245	Care of the Surgical Patient
1245-1400	Charting
1400-1415	Coffee
1415-1530	Equipment Workshop

<u>Thursday</u>

1200-1315	Emergeno	y Eq	quipment	;	
1315-1530	Care of	the	Person	with	AIDS
	Summary	anđ	Evaluat	cion	

Friday Extended Orientation (For New Graduates)

0800-0830	Introduction
0830-0900	Coffee
0900-1000	AIDS Update
1000-1100	Registered Nurse and Charge Nurse Roles
1100-1200	Lunch
1200-1315	Processing Orders
1315-1400	Physician Coverage
1400-1415	Coffee
1415-1600	Equipment Workshop

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. . Traditional Orientation Schedule Hospital (B)

Tuesday

- 0800-1200 Central Orientation (Welcome from Education Services and Administration, Slide tapes "Welcome to Hospital", "Fundamentals of Back Care", Fire Safety, Tour of Hospital, Union Reps, Benefits Presentation and Completion of Benefits Forms).
- 1200-1300 Lunch
- 1300-1330 Introduction to Acute Care Nursing Orientation
- 1300-1600 Independent Study: Respiratory Therapy, Support Services Modules, Videotape- Oxygen Delivery Systems, Demonstration and Practice: Oxygen Delivery Systems

<u>Wednesday</u>

0800-0815 0830-0845 0845-0915 0915-0945 0945-1000 1000-1045 1045-1200 1200-1300 1300-1315 1315-1415	Clinical Nurse Specialist Welcome from Nursing Department Video- "Chest Tubes" Demonstration/Practice "Pleurevac" Break Independent Study- Chest Tubes and Support Services Modules Demonstration & Return Demo "Accuchek II" Lunch Home Care Liaison Nurse Independent Study of Modules: Emergency Cart, Cardiac and Respiratory Arrest, and Catheterization
1430-1600	Demonstration/Practice: Emergency Cart, Cardiac and Respiratory Arrest, and Catheterization
Thursday	
0800-0900 0900-0930	Independent Study: Infection Control Multiple Choice Post Quiz: Emergency Cart, Cardiac and Respiratory Arrest, Support Services, Catheterization, Infection Control, Respiratory Therapy, Chest Tubes
0930-1000 1000-1015 1015-1030 1030-1045 1045-1200	Review Quiz Tour (ICU, C.S.D., Pharmacy) Break Lecture/Discussion Medicus System Independent Study- Medicus System

1200-1300 Lunch

Traditional Orientation Schedule Hospital (B)

Thursday (Con't)

 1300-1600 Return Demonstrations: Chest Tubes, Catheterization, Respiratory Therapy
 1300-1600 Independent Study: Medicus, Medications, Nursing Department, Pharmaceutical Math Questions Handout, I.V. Therapy and Direct I.V. Medications

Friday

0800-0900	Demonstration/Practice I.V. Therapy, Direct I.V. Medications
0900-0915	Break
0915-1030	Independent Study: I.V. Therapy, Direct I.V. Medications
1030-1130	Multiple Choice Quiz- Medications, I.V. Therapy, and Direct I.V. Medications
1130-1200	Review Quiz
1200-1230	Lecture/Discussion Charting Legalities
1230-1300	Lunch
1300-1600	Independent Study: Patient Chart, Equipment,
	Return Demos: I.V. Therapy, Direct I.V.
	Medications
	Quiz- Medicus
	Evaluation

Monday (all Day) Unit Orientation

Tuesday

0800-1230	CPR Basic Level 1 (only if certification
	necessary) or Unit Orientation
1300-1400	Transfer Techniques
1400-1530	Mock Arrest (Emergency Cart, Cardiac and
	Respiratory Arrest

Letter of Introduction

The University of British Columbia School of Nursing Vancouver, British Columbia

Dear Colleague:

I am a graduate student in the University of British Columbia School of Nursing. For my thesis, I am conducting a study to examine the effect of orientation programs on the role transition of new graduates in their first-time employment as registered nurses.

To date there has been limited research done which has investigated the effectiveness of orientation programs. In order for nursing departments to make decisions on particular types of programs and to justify expenditure, it is important that their effectiveness be evaluated. The purpose of this study is to compare the effectiveness of two types of orientation programs.

Your voluntary participation is requested to provide information regarding orientation. This information may be helpful in improving future orientation programs. Each participant will be asked to complete two questionnaires at the start of orientation and again one month later. These include: a self-appraisal of nursing performance using Schwirian's Six Dimension Scale of Nursing Performance and a self-appraisal of role conception using Corwin's Nursing Role Conception Scale. Completion of these scales is estimated to take approximately 15 and 20 minutes respectively. Finally, each participant will be asked to complete a Demographic Data Sheet. Follow-up scales will be mailed to participants with prepaid postal return envelopes.

All information provided will be used in confidence by this researcher. Individual responses will be kept confidential and they will not be shared with hospital personnel. In order to preserve the identity of participants in the study, each participant in the study will be assigned a code number. Only code numbers, not names of participants, will be appear on the completed questionnaires. A separate list of study participants will be kept by this researcher. All data will be maintained in safekeeping by this researcher. The completed study will not disclose the identity of individual participants. Your participation in this study would be appreciated. Participation in this study is on a voluntary basis, and you are free to withdraw from the study at any time. There is no penalty associated should you choose not to participate in the study. If the questionnaires are completed it will be assumed that consent to participate in the study has been given. Finally, whether or not you participate in this study will not influence how you are evaluated by hospital personnel during your orientation period.

This thesis study is being supervised by Dr. Sonia Acorn, Assistant Professor, University of British Columbia School of Nursing. Office phone number for Dr. Acorn is:

If you have any questions about the study please contact me at the University of British Columbia School of Nursing or at my home address: Bernadette MacDonald address Phone

Sincerely;

Bernadette MacDonald R.N. B.N. (MSN student)

Demographic Data Sheet Please use a check mark to indicate which of the following categories apply to you. 1. Sex: _____male female 2. Type of program: ____ orientation preceptorship Basic Nursing Education: 3. ____ Diploma (two year program) ____ Diploma (three year program) Baccalaureate program 4. Other post-secondary education (besides nursing) ____ yes ____ no if yes please specify_____ 5. Did you have clinical experience in employing agency your education program? during ____ yes __ no if yes please specify number of weeks 6. Past experience working in a hospital: (does not include clinical experience in question 4) ____ none ____ nurse's aide other (please specify) 7. Length of past experience working in a hospital: please specify number of months or years 8. Past work experience other than in a hospital ____ yes ____ no if yes please specify_____ 9. Age:

Code Number_____

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SIX-DIMENSION SCALE OF NURSING PERFORMANCE (6-D SCALE) (Schwirian)

PERFORMANCE OF NURSING BEHAVIORS

Instructions: This section contains a list of activities in which nurses engage with varying degrees of frequency and skill. For these activities that you do perform in your current job, please indicate how well you perform them by using numbers from the following key:

- l Not very well
- 2 Satisfactorily
- 3 Well
- 4 Very well
- X Not expected in my current job
- TC Teach a patient's family members about the patient's needs.
- PE . Coordinate the plan of nursing care with the medical plan of care.
- L ____ Give praise and recognition for achievement of those under your direction.
- TC Teach preventive health measures to patients and their families.
- TC ____ Identify and use community resources in developing a plan of care for a patient and his family.
- PE ____ Identify and include in nursing care plans anticipated changes in patient's condition.
- PE Evaluate results of nursing care.
- IPR ____ Promote the inclusion of the patient's decisions and desires concerning his care.
- PE Develop a plan of nursing care for a patient.
- PE Initiate planning and evaluation of nursing care with others.
- CC ____ Perform technical procedures: e.g., oral suctioning, tracheostomy care, intravenous therapy, catheter care, dressing changes, etc.
- TC ____ Adapt teaching methods and materials to the understanding of the particular audience: e.g., age of patient, educational background, and sensory deprivations.
- PE Identify and include immediate patient needs in the plan of nursing care.
- TC Develop innovative methods and materials for teaching patients.

IPR	 Communicate a feeling of acceptance of each patient and a concern for the patient's welfare.
IPR	 Seek assistance when necessary.
IPR	 Help a patient communicate with others.
CC	 Use mechanical devices: e.g., suction machines, Gomco, cardiac monitor, respirator, etc.
СС	 Give emotional support to family of dying patient.
IPR	 Verbally communicate facts, ideas, and feelings to other health team members.
IPR	 Promote the patient's right to privacy.
IPR	 Contribute to an atmosphere of mutual trust, acceptance, and respect among other health team members.
L	 Delegate responsibility for care based on assessment of priorities of nursing care needs and the abilities and limitation of available health care personnel.
IPR	 Explain nursing procedures to a patient prior to performing them.
L	 Guide other health team members in planning for nursing care.
L	 Accept responsibility for the level of care provided by those under your direction.
СС	 Perform appropriate measures in emergency situations.
TC	 Promote the use of interdisciplinary resource persons.
TC	 Use teaching aids and resource materials in teaching patients and their families.
CC	 Perform nursing care required by critically ill patients.
TC	 Encourage the family to participate in the care of the patient.
TC	 Identify and use resources within your health care agency in developing a plan of care for a patient and his family.
IPR	 Use nursing procedures as opportunities for interaction with patients.
IPR	 Contribute to productive working relationships with other health team members.
IPR	 Help a patient meet his emotional needs.
PE	 Contribute to the plan of nursing care for the patient.
СС	Recognize and meet the emotional needs of a dying patient.

TC _____ Communicate facts, ideas, and professional opinions in writing to patients and their families.
 TC _____ Plan for the integration of patient needs with family needs.
 CC _____ Functions calmly and competently in emergency situations.
 L _____ Remain in open to the suggestions of those under your direction and use them when appropriate.
 IPR _____ Use opportunities for patient teaching when they arise.

PERFORMANCE OF PROFESSIONAL DEVELOPMENT BEHAVIORS

Instructions: Using the following key, please indicate on the line at the left of each item the number that best describes the frequency with which you engage in the following behaviors.

- 1- Seldom or never2 Occasionally3 Frequently4 Consistently
- PD Use learning opportunities for on-going personal and professional growth.
- PD Display self-direction.
- PD Accept responsibility for own actions.
- PD Assume new responsibilities within the limit of capabilities.
- PD Maintain high standards of self-performance.
- PD Demonstrate self-confidence.
- PD Display a generally positive attitude.
- PD Demonstrate knowledge of the legal boundaries of nursing.
- PD Demonstrate knowledge of the ethics of nursing.
- PD Accept and use constructive criticism.

Key To Subscales:

- L Leadership
- CC Critical Care
- TC Teaching/Collaboration
- PE Planning/Evaluation
- IPR IPR/Communications
- PD Professional Development

Appendix H.

NURSING ROLE CONCEPTION SCALE

INSTRUCTIONS

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This consists of a list of 22 hypothetic situations in which as nurse might find herself.

You are asked to indicate both:

- A) the extent to which you think the situation should be the ideal nursing.
- B) the extent to which you have observed the situation in your hospital.

Notice the <u>two</u> (2) questions must be answered for <u>each</u> situation. Consider the questions of what ought to be the case and what is really the case separately; try not to let your answer to one question influence your anwser to the other question. Give your opinions; there are no "wrong" answers.

Indicate the <u>degree</u> to which you agree or disagree with the statement by checking one of the alternative answers, ranging from: STRONGLY AGREE, AGREE, UNDECIDED, DISAGREE, and STRONGLY DISAGREE.

STRONGLY AGREE indicates that you agree with the statement with almost no exceptions.

AGREE indicates that you agree with the statement with some exceptions.

<u>UNDECIDED</u> indicates that you could either "agree" or "disagree" with the statement with about an equal number of exceptions in either case.

DISAGREE indicates that you disagree with the statement with some exceptions.

STRONGLY DISAGREE indicates that you disagree with the statement with almost no exception.

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Here	is an ex	ample:	STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DI SAGREE
Some docto	gradua rs are n	te nurses in New York hospitals believe that nore professional than nurses.					
	Α.	On the basis of the facts graduate nurses should believe doctors are more professional.					
	8.	Graduate nurses at my hospital actually <u>do</u> believe that doctors are more professional.					
Suppo more	se that profess	, almost without exception, you agree that nurses sho sional. Then check (\checkmark) the first column (STRONGLY A	uld reg GREE)	ard doc for que	tors as estion A	•	
Suppo that d questi	se that, loctors on B.	, with some exceptions, you disagree that nurses in yo are more professional. Then check (⁄) column four (C	our hosp)ISAGRI	oital <u>do</u> EE) afte	believe er		
Be <u>sur</u>	re you p	place a check mark (\checkmark) after <u>both</u> questions A and B.					
Burea	ucratic	Items				,	
 One graduate nurse, who is an otherwise excellent nurse except that she is frequently late for work, is not being considered for promotion, even though she seems to get the important work done. 							
	Α.	Do you think this is the way it <u>should</u> be in nursing?					
	в.	Is this the way things are at your hospital?					
2.	A head nurse at one hospital insists that the rules be followed in detail at all times, even if some of them do seem impractical.						And the second
	Α.	Do you think this is the way head nurses and supervisors <u>should</u> act?					
	в.	Is this the way head nurses and supervisors at your hospital actually <u>do</u> act when the occasion arises?					
3.	A grad staff i worke import the he	duate staff nurse observes another graduate nurse, licensed practical nurse, or aide who has d in the hospital for months violating a very tant hospital rule or policy and mentions it to ad nurse or supervisor.					
	Α.	Do you think that this is what graduate nurses should do?				_	* ~ -1
·	в.	Is this what graduate nurses at your hospital actually do when the occasion arises?				·	

		· · · · · · · · · · · · · · · · · · ·	STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DI SAGREE
4.	Wher grad facto	n a supervisor at one hospital considered a uate for promotion, one of the most important ors is the length of experience on the job.					
	Α.	Do you think this is what supervisors <u>should</u> regard as important?					
	В.	Is this what supervisors at your hospital actually do regard as important?					
5.	In talking to acquaintances who aren't in nursing, a graduate nurse gives her opinions about things she disagrees with in the hospital.						
	Α.	Do you think this is what graduate nurses should do?					
	В.	Is this what graduate nurses at your hospital actually do when the occasion arises?					
6.	A graduate nurse is influenced mainly by the opinions of the hospital authorities and doctors when she considers what truly "good", nursing is.						
	Α.	Do you think this is what graduate nurses should consider in forming their opinions?					
	в.	Is this what graduate nurses at your hospital actually do consider in forming their opinions?					
PRO	FESSIC	NAL ITEMS					
7.	One ideal hospi	graduate nurses tries to put her standards and s about good nursing into practice even if ital rules and procedures prohibit it.					
	Α.	Do you think that this is what graduate nurses should do?					
	в.	<u>Is</u> this what graduate nurses at your hospital actually <u>do</u> when the occasion arises?					
8.	One told welfa	One graduate nurse does not do anything which she is told to do unless she is satisfied that it is best for the welfare of the patient.					
	Α.	Do you think that this is what graduate nurses should do?					
	В.	<u>Is</u> this what graduate nurses at your hospital actually <u>do</u> when the occasion arises?					•

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		·	STRONGLY AGREE	AGREE	UNDECIDED.	DISAGREE	STRONGLY DISAGREE
9.	All g in pr confe	raduate nurses in a hospital are active members ofessional nursing associations, attending most erences and meetings of the association.					
	Α.	Do you think this <u>should</u> be true of all nurses?					
	в.	Is this true of nurses at your hospital?					
10.	All graduate nurses in a hospital spend, on the average, at least six hours a week reading professional journals and taking refresher courses.						
	Α.	Do you think this <u>should</u> be true of all nurses?					
	8.	Is this true of nurses at your hospital?					
11.	Some nurses try to live up to what they think are the standards of their profession, even if other nurses on the ward or supervisors don't seem to like it.						
	Α.	Do you think that this is what graduate nurses <u>should</u> do?					
	8.	Is this what graduate nurses at your hospital actually do when the occasion arises?					
12.	Some graduate nurses believe that they can get along very well without a lot of formal education, such as required for a B.S., M.S., or M.A. college degree.						
	Α.	Do you think that this is what graduate nurses should believe?					
	В.	Is this what graduate nurses at your hospital actually do believe?					
13.	At so consi facto of, a proce	At some hospitals when a graduate nurse is considered for promotion, one of the most important factors considered by the supervisor is her knowledge of, and ability to use, judgement about nursing care procedures.					
	Α.	Do you think this is what supervisors <u>should</u> regard as important?					
	в.	<u>Is</u> this what supervisors at your hospital actually <u>do</u> regard as important?					·

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		· ·	STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DI SAGREE
14.	Some hospitals try to hire only graduate nurses who took their training in colleges and universities which are equipped to teach the basic theoretical knowledge of nursing science.						
	Α.	Do you think this is the way it <u>should</u> be in nursing?					
	8.	Is this the way things are at your hospital?					
SERV	ICE ITE	EMS					
15.	At one hospital graduate nurses spend more time at bedside nursing than any other nursing task.						
	Α.	Do you think this is the way it <u>should</u> be in nursing?					
	в.	Is this the way things are at your hospital?					
16.	Head nurses and doctors at one hospital allow the graduate nurse to tell patients as much about their physical and emotional condition as the nurse thinks is best for the patient.						
	Α.	Do you think this is the way it <u>should</u> be in nursing?					
	в.	Is this the way things are at your hospital?					.
17.	A doctor orders a patient to sit up in a wheel chair twice a day, but a graduate nurse believes that he is not emotionally ready to sit up; the doctor respects her opinion and changes the treatment.						
	Α.	Do you think this is the way it <u>should</u> be in nursing?					
	в.	Is this the way things are at your hospital?					
18.	Doctors and head nurses at the hospital respect and reward nurses who spend time talking with patients in an attempt to understand the hostilities, fear, and doubts which may effect the patient's recovery.						
	Α.	Do you think this is what doctors and head nurses <u>should</u> regard as important?					
	в.	Is this what doctors and head nurses at your hospital actually <u>do</u> regard as important?					·~~ -

			STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE
19.	A graduate nurse believes that a patient ought to be referred to a psychologist or a public health nurse and tries to convince the doctor of this, even though he is doubtful.						
	Α.	Do you think this is what a graduate nurse should do?					
بيومونيوني	В.	Is this what graduate nurses at your hospital actually do when the occasion arises?					
20.	At one hospital the nurse's ability to understand the psychological and social factors in the patient's background is regarded as more important then her knowledge of such other nursing skills as how to give enemas, IVs, or how to chart accurately.						
	Α.	Do you think this is the way it <u>should</u> be in nursing?					
	8.	Is this the way things are at your hospital?					
21.	Some graduate nurses believe that the professional nurses who should be rewarded most highly are the ones who regard nursing as a calling in which one's religious beliefs can be put into practice.						
	Α.	Do you think that is is what graduate nurses should believe?			·		
	8.	Is this what graduate nurses at your hospital actually do believe?					
22.	At some hospitals the graduate nurses who are most successful are the ones who are realistic and practical about their jobs, rather than the ones who attempt to live according to idealistic principles about serving humanity.						
	Α.	Do you think this is the way it <u>should</u> be in nursing?	,		r		
	в.	Is this the way things are at your hospital?					