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## The Meaning of being a primary nurse preceptor for newly graduated nurses

Jennifer Richards

*University of Nevada Las Vegas*

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THE MEANING OF BEING A PRIMARY NURSE PRECEPTOR FOR NEWLY  
GRADUATED NURSES

by

Jennifer Richards

Bachelor of Science in Nursing  
University of Nevada, Reno  
1999

Master of Science in Nursing  
University of Nevada, Reno  
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## ABSTRACT

### **The Meaning of Being a Primary Nurse Preceptor for Newly Graduated Nurses**

by

Jennifer Richards

Dr. Cheryl Bowles, Examination Committee Chair  
Professor of Nursing  
University of Nevada, Las Vegas

Preceptorship is a vital component of the transition experience of newly graduated nurses into clinical practice. Preceptors teach, supervise, and evaluate newly graduated nurses, and also help them socialize into their roles as registered nurses. In the presence of an ever-growing nursing shortage and evidence that many new nurses are leaving their first positions, it is of paramount importance that we make every attempt to ease the transition of newly graduated nurses into clinical practice. Additionally important is the need to understand the experience of all involved in the process.

The primary purpose of this study was to achieve a better understanding, from the perspective of the preceptor, of the experience of being the primary nurse preceptor for newly graduated nurses during their transition into clinical practice. A qualitative research design with a phenomenological method of inquiry guided by the work of Max van Manen and Patricia Munhall was used. Following Colaizzi's seven stages of data analysis, an overall essence, three main themes, and nine sub-themes revealed the meaning of being a primary nurse preceptor for newly graduated nurses during their transition into clinical practice, as an altruistic responsibility to the greater good of the profession.



Understanding the meaning of being the primary preceptor for newly graduated nurses during their transition into clinical practice has significant implications for hospital administrators, nursing leaders, and nurses involved in staff development roles. Organizations should pay particular attention to whether preceptors are being expected to fulfill other roles, such as that of charge nurse, while they are precepting newly graduated nurses. Also important is the need for preceptors to be involved in the entire orientation process and the use of a systematic approach to match preceptors with preceptees. Preceptors should have opportunities to share their perspectives of preceptee characteristics that both contribute to and interfere with optimal transition experiences. Finally, time should be invested in the professional development of preceptors and mechanisms should be put in place to support them in their day-to-day preceptor practice.

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## CHAPTER ONE

### INTRODUCTION

#### *Phenomenon of Interest*

The United States is in the midst of one of the most significant nursing shortages it has ever encountered, one that is only expected to worsen over the next several years. Certain areas of the country are impacted more drastically by this shortage, which is characterized by fewer nurses entering the workforce and fewer nurses who are adequately prepared to meet the needs of patients in a constantly evolving healthcare environment (Tri-Council members for Nursing, 2001). As the nursing shortage has intensified, newly graduated nurses have assumed an important role in the recruitment and staffing strategies of hospitals (Casey, Fink, Krugman & Propst, 2004). Unfortunately, coupled with a decrease in the number of nurses entering the workforce is a particularly alarming trend of new nurses leaving their first jobs within two years and many leaving the nursing profession altogether (Bowles & Candela, 2005; Delaney, 2003).

The transition experience of newly graduated nurses into clinical practice is often fraught with stress and disillusionment. Research on this transition shows that newly graduated nurses feel anxious, overwhelmed, insecure, and puzzled by a disconnection between what they learned in nursing school and real-world nursing (Casey et al., 2004; Delaney, 2003; Oermann & Moffitt-Wolf, 1997). The difficulty of their transition is compounded by the fact that newly graduated nurses assuming staff nurse roles in acute care hospitals are expected to start their first jobs with the skills and expertise to care for acutely ill patients with increasingly complex needs (Goode & Williams, 2004).

Gone are the days when lower acuity patients could be assigned to new graduates while they transitioned into their roles. In today's healthcare environment, those lower acuity patients simply do not receive care within the acute care setting. Furthermore, because of the dire need to fill vacant positions, employers are expecting newly graduated nurses to quickly function as competent professionals (Grochow, 2008).

Preceptorship is a vital component of the transition experience of newly graduated nurses into clinical practice. As stated by Nicol and Young (2007), "an empathetic preceptor who is aware of the graduate's needs can make the difference between the graduate nurse enjoying their professional role, surviving the first year, and leaving the profession" (p. 298). Research from the perspective of newly graduated nurses has illuminated the importance of the role of the nurse preceptor in orientation programs (Oermann & Moffitt-Wolf, 1997; Orsini, 2005; Schumacher, 2007). In addition to their teaching, supervising, and evaluating responsibilities, preceptors help newly graduated nurses socialize into their professional roles (Baltimore, 2004; Casey, et al., 2004).

### *Relevance for Nursing*

In the presence of an ever-growing nursing shortage, and evidence that many new nurses are leaving their first positions, it is of paramount importance that every attempt is made to ease the transition of newly graduated nurses into clinical practice. Additionally important is the need to understand the experience of all participants involved in the transition process. Because the majority of the nursing literature has addressed preceptorship from the perspective of the newly graduated nurse, at this point, just one side of the story is more fully known. Understanding the perspective of the nurse

preceptor might help provide a better understanding of how to prepare, support, recognize and reward them for their service.

### *Focus: Specific Context*

The focus of this study was on preceptorship, specifically the experience of the nurse preceptor in the transition experience of a newly graduated nurse. Preceptors often guide newly graduated nurses through their first formal passage into real-world nursing through teaching, supervising, evaluating and supporting them. In addition, preceptors promote socialization by acquainting newly graduated nurses with unit routines, introducing them to members of the healthcare team, and role modeling professional nursing practice. Despite the seemingly important role of the preceptor during transition into clinical practice, there is a paucity of research that has sought to understand the role as it is perceived and experienced by the preceptors themselves.

### *Operational Definitions*

Preceptorship	The assigned one-to-one teaching-learning relationship between a more experienced role model and a novice transitioning into practice (Kaviani & Stillwell, 2000).
Primary Nurse Preceptor	Registered nurse (RN) assigned to provide one-to-one guidance to a newly graduated nurse during at least 75% of their total clinical orientation time. Primary Nurse Preceptors are staff nurses who provide direct patient care and have nursing

experience on the specific unit to which the newly graduated nurse has been hired.

Newly graduated nurse Graduate nurse (pre-licensure) or Registered Nurse (post-licensure) who has completed either a Bachelor's of Science in Nursing (BSN) or an Associate's Degree in Nursing (ADN) nursing program within the previous 3 months and has passed the National Council Licensure Examination for Registered Nurses (NCLEX-RN) or plans to take it within 3 months of graduation date.

### *Study Purpose*

The purpose of this study was to achieve a better understanding, from the perspective of the preceptor, of the experience of being the primary nurse preceptor for newly graduated nurses during their transition into clinical practice.

### *Research Questions*

The main question used to guide this study was:

- What is the experience of being a primary nurse preceptor for a newly graduated nurse during their transition into clinical practice?

Subsequent questions used to guide the interviews included:

- How do preceptors perceive their role in the transition experience of newly graduated nurses?
- What motivates RNs to serve in preceptor roles?

- How are preceptors prepared for and supported in their roles?
- How are preceptors recognized and rewarded for their work?
- What are the challenges associated with precepting?
- What do preceptors describe as their worst and best experiences in their roles?
- How is the experience of being a preceptor impacted by an individual's own experience as a newly graduated nurse?

### *Summary*

The United States continues to face one of the most critical nursing shortages in its history. In response to this crisis, many states have mandated nursing programs to double their enrollments and subsequently, hospitals have employed significant numbers of newly graduated nurses to fill their vacancies. The reality of their transition into clinical practice is often inconsistent with their expectations of their first nursing jobs. Preceptors play a key role in guiding and supporting newly graduated nurses during their transition into practice. Despite this key role, there is little literature that has sought to gain an understanding of the experience of the preceptors who are such an important part of this transition. Thus, this study was aimed at better understanding the preceptor's experiences of precepting newly graduated nurses.



## CHAPTER TWO

### EVOLUTION OF THE STUDY

#### *Historical Context*

##### *Differentiation Between Preceptor and Mentor*

While the concepts of preceptor and mentor overlap to some degree, there is consensus in the literature that there are distinct differences between the two (Armitage & Burnard, 1991; Billay & Yonge, 2004; Kaviani & Stillwell, 2000; Yonge, Billay, Myrick, & Luhanga, 2007). Though preceptorship only appeared in the nursing literature within the last three decades, the concept actually originated sometime during the 15<sup>th</sup> century in the form of tutoring (Ryan-Nicholls, 2004). Preceptorship describes the one-to-one teaching-learning relationship between a more experienced role model and a novice transitioning into practice (Kaviani & Stillwell). In nursing, preceptors teach, supervise, evaluate, and serve as role models for student nurses or newly graduated nurses entering practice (Billay & Yonge).

In many of the health sciences professions, preceptors are the links that connect what is learned in the academic environment with what is practiced in the clinical environment (Council of University Teaching Hospitals [COUTH], 2001). According to Armitage and Burnard (1991), the fundamental differences between mentorship and preceptorship are the clinical and role-modeling components of preceptorship. Additionally, the relationship between a preceptor and preceptee is usually assigned rather than voluntarily sought and generally lasts for a defined period of time.

The concept of mentorship dates back to Greek mythology where Mentor was a friend of Odysseus who was assigned to watch the king's son Telemachus while

Odysseus was fighting in the Trojan War. The myth portrays a mentor as a wise advisor who provides guidance (Carroll, 2004). Mentorship is a means of supporting, inspiring, and guiding an individual in their learning and personal and professional development (Council of University Teaching Hospitals [COUTH], 2001). Different from the relationship between a preceptor and preceptee, the relationship between a mentor and mentee is generally initiated by, or tends to evolve between, two professionals. Mentorship usually has no defined time limit and is unstructured in the sense that there are no specific goals to be accomplished (Yonge et al., 2007).

### *History and Significance of Preceptorship in Nursing*

Preceptorship in nursing evolved during the 1970s and 1980s when nursing schools were removed from hospital settings (Shamian & Inhaber, 1985). At this time, the need arose for a more comprehensive initial hospital orientation for new nurses entering clinical practice. Centralized orientation programs were developed in order to instruct new employees about hospital-wide policies and procedures and also to familiarize them with organizational culture.

Upon completion of the centralized programs, new nurses were sent to their units to be informally acquainted with the practical aspects of their new roles. They might be paired with a variety of nurses assigned to help them learn different aspects of the unit routine. The lack of structure sometimes associated with their unit-based orientations led to increased turnover, reality shock for new nurses, burnout, and diminished satisfaction among all of the nursing staff. (Shamian & Inhaber, 1985). As a result of the turmoil associated with the transition of new nurses into clinical practice, the preceptor model emerged.

Over the last several years, the preceptor model has been an effective method for reducing the theory-practice gap that purportedly continues to exist in nursing (Kaviani & Stillwell, 2000). As nursing programs have increased enrollments to keep up with the workforce demands for more nurses, hospitals have struggled with limited space to accommodate the clinical training experience for an increasing number of students thus contributing to a growing number of graduates who have completed their programs with limited clinical exposure (Nicol & Young, 2007). Additionally, the role of the preceptor has become increasingly important for graduate nurses from baccalaureate programs where the primary focus is on learning theory and less time is spent in the clinical environment (Yonge et al., 2007). According to Schumacher (2007), preceptors support new nurses from a clinical, social, and emotional perspective and also impact retention.

#### *Preceptor Experiences in Other Professions*

Preceptorship is a teaching method used in other health sciences professions as well as in teacher preparation programs as a means of supporting and easing transition into the practice environment. Different terms have been used to describe this one-to-one teaching-learning relationship between a more experienced role model and a novice transitioning into practice. For example, the terms traineeship, fellowship, and clinical clerkship have been used to describe the concept of preceptorship in the medical and pharmacy literature. In education the terms cooperating teacher, internship, and mentor have been used.

For the purposes of examining preceptorship-related literature in nursing and other professions, the following databases were searched in EBSCOhost (EBSCO Industries, Inc., 2008): Academic Search Premier, CINAHL, ERIC, Health Source:

Nursing/Academic Edition, and Professional Development Collection. The following search terms were used: preceptorship, preceptor experiences, mentor experiences, experiences of preceptors, experiences of mentors, being a preceptor, being a mentor, preceptors *and* new employees, cooperating teachers, preceptors *and* medicine, preceptors *and* healthcare, preceptors *and* nursing, preceptors *and* newly graduated nurses. The majority of literature that resulted from this search addressed preceptorship in nursing and more specifically, nursing education. This is consistent with findings from Billay and Myrick's (2008) integrative review of preceptorship-related literature which revealed that the bulk of their sampled articles addressed nursing education.

Though the terminology may differ slightly, the concept of preceptorship, especially as it is experienced from the perspective of the preceptee, has been well-documented in the health sciences and education literature. While the health sciences literature, as it pertains to the perspective of the preceptor, is somewhat limited, educational research related to preceptorship and/or mentorship has addressed the perspective of the preceptors and mentors from a qualitative or combination qualitative/quantitative perspective (Roehrig, Bohn, Turner, & Pressley, 2007; Sudzina & Coolican, 1994;). As is the case in the nursing literature, the health sciences and education literature has focused primarily on preceptorship as it pertains to the concept in undergraduate or graduate education and not necessarily as it relates to novices transitioning into the practice environment.

Findings from Marriott et al's (2006) study to determine the attitudes of rural pharmacists toward precepting students revealed that the pharmacist preceptors received personal satisfaction from their roles as preceptors. One of the main benefits they

identified was the reciprocal teaching and learning that occurred during their precepting experiences. They also felt rewarded by the opportunity they had to give back to their profession by supporting enthusiastic students. Having enough time for both their work and their preceptee contributed to successful experiences and insufficient time was reported as the biggest challenge to being an effective preceptor. Another factor identified as contributing to a successful experience and subsequently reported as a challenge was the preceptee's level of motivation and commitment to the experience. Preceptors had difficulties dealing with students who were uninterested in learning.

In teacher education, the concepts of cooperating teacher and mentor are very similar to that of preceptor in nursing. Cooperating teachers and mentors are the supportive guides who help teacher candidates as they transition between theory and practice (Sudzina & Coolican, 1994). In their qualitative study of the expectations of mentoring relationships between cooperating teachers and student teachers, Sudzina and Coolican found that the student teacher participants defined mentors as supportive role models and attributed success in student teaching to a positive relationship with their cooperating teacher. Some cooperating teacher participants viewed mentoring from a hierarchical perspective and believed that student teachers needed to "follow their lead in the classroom" (Sudzina & Coolican, p. 5) and others believed mentoring was a mutual relationship between the cooperating teacher and the student teacher. Findings also revealed challenges associated with the arbitrary pairing of cooperating teachers with students and drew attention to the need for formal preparation for cooperating teachers for their roles as mentors.

Roehrig et al's (2007) qualitative/quantitative case study approach to identify factors that influenced beginning teacher's effective teaching practices revealed key characteristics of both the mentor and the beginning teacher which influenced success. The mentors of more effective beginning teachers had experience as mentors and were effective teachers themselves. The characteristics of more effective beginning teachers included a realistic perceptive of their abilities and an openness to feedback and communication from their mentors. These findings pointed to the need to develop and support competent mentors and to ensure that beginning teachers make the most of the expertise offered by their mentors.

Findings from these studies that address the experiences of preceptors, cooperating teachers, and mentors working with pharmacy students and student and beginning teachers are consistent with the nursing literature as it pertains to the experiences of preceptors working with student nurses and novice nurses transitioning into practice. Personal learning and professional development have been cited as benefits to the preceptor role in both the nursing and health sciences literature (Dibert & Goldenberg, 1995; Marriott et al., 2006). Insufficient time is consistently cited as the biggest challenge to being able to precept effectively (Atkins & Williams, 1995; Henderson, Fox, & Malkonyhan, 2006; Kaviani & Stillwell, 2000; Marriott et al., 2006; Yonge, Krahn, Trojan, Reid, & Haase, 2002). Finally, the need for formal preparation for the preceptor/mentor role has been identified in the nursing and education literature (Atkins & Williams, 1995; Henderson et al., 2006; Kaviani & Stillwell, 2000; Öhrling & Hallberg, 2001; Roehrig, Bohn, Turner, & Pressley, 2007; Sudzina & Coolican, 1994).

### *Perspectives of Newly Graduated Nurses*

The bulk of nursing literature that has addressed the role of the preceptor in the transition experience of newly graduated nurses has focused primarily on the perspective of preceptees. Though this explains only one side of the story, the perspective of preceptees helps illustrate the significance of the role of the preceptor. Several studies have concluded that preceptors play a key role in the transition experience of newly graduated nurses during their entry into nursing practice (Delaney, 2003; Oermann & Moffitt-Wolf, 1997; Schumacher, 2007). Preceptors are not only responsible for role modeling and educating newly graduated nurses and but also for helping them socialize into their new roles (Baltimore, 2004). To this end, studies have established the impact preceptors have on socializing newly graduated nurses into their professional roles (Casey, et al., 2004; Godinez, Schweiger, Gruver, & Ryan, 1999; Schumacher, 2007).

Oermann and Moffitt-Wolf's (1997) descriptive, exploratory study identified the stresses, challenges, and threats experienced by newly graduated nurses during their orientation programs and the relationship of these experiences to social support. New graduates acknowledged multiple factors which inhibited their learning including criticism from the staff and a lack of needed guidance from their preceptors. Factors identified as facilitating the experience included consistent preceptors who provided positive reinforcement and guided their learning. These factors demonstrate the need for support from preceptors and reinforce the significant impact of the role of the preceptor in potentially "making or breaking" the newly graduated nurses' transition experience. Limitations to the generalizability of the results of this study include a small sample size ( $n = 35$ ) and use of only three hospitals in a narrow geographical region.

Delaney's (2003) phenomenological study investigated transition experiences during orientation with a purposive sample of 10 graduate nurses. One of the major themes identified from the interviews concerned preceptor variability. Participants attributed positive and negative feelings about their progression through orientation to experiences with their preceptors. Preceptors who had worked in their respective areas for several years were considered experts and positively impacted newly graduated nurse's learning while preceptors who were less experienced or multiple preceptors during the orientation period left newly graduated nurses feeling frustrated and confused. This study identified a need for training programs to prepare preceptors to meet the needs of new graduates and also the need for collaboration between academia and service to support successful transition into clinical practice.

One of the key findings in Casey et al's (2004) descriptive, comparative study was the significant impact of the preceptor role on job satisfaction and competency development for newly graduated nurses. The Casey-Fink Graduate Nurse Experience Survey<sup>®</sup> was administered to newly graduated nurses to evaluate their transition experience upon entering the workplace and throughout their first year. Similar to the findings in Delaney's study (2003), respondents felt that progression through their orientation was negatively impacted when they had multiple preceptors. Findings suggested that preceptors need formal education not only to better meet the needs of new graduates, but also to understand the significance of their role in their transition experience. Limitations to the validity of this study include attrition over the 1 year timeframe for study participation and use of a tool that was undergoing multiple revisions throughout the study period.



Schumacher's (2007) qualitative study examined the meaning of caring interactions between preceptors and preceptees during a 10 week orientation in the hospital setting. The ten newly graduated nurses who participated in the study identified both caring and non-caring interactions during the orientation period. Caring interactions were described when preceptors advocated for their preceptees, welcomed them and included them in the unit routine and social events off of the unit, took time to challenge them and afforded them autonomy, attempted to connect with them, and provided them with constructive and specific feedback about their performance. Non-caring interactions were described when preceptors did not make eye contact with or welcome their preceptees onto the unit, did not make time to check up on them or teach them, hovered over them or watched their every move, and provided unclear or non-specific feedback about their performance.

#### *Perspectives of Preceptors*

Very few nursing studies have focused entirely on the perspective of the preceptor and even fewer have looked at their experiences from a purely qualitative perspective. Some studies are not precise in terms of whether preceptors of student nurses or newly graduated nurses were included in the sample (Henderson, et al., 2006), some have included preceptors of both students and newly graduated nurses (Dibert & Goldenberg, 1995; Stevenson, Doorley, Moddeman, & Landau, 1995) and others have focused solely on preceptors of student nurses (Atkins & Williams, 1995; Kaviani & Stillwell, 2000; Yonge, et al., 2002; Luhanga, Yonge, & Myrick, 2008). One study has examined the lived experiences of preceptors of student nurses during their practical training (Öhrling & Hallberg, 2001) and one study has explored the lived experience of learning to be a preceptor for student nurses (Smedley, 2008). There have been no studies aimed

specifically at exploring the experience of being the primary preceptor for newly graduated nurses during their transition into clinical practice.

*Student nurses or newly graduated nurses not specified.* Henderson, et al's (2006) descriptive study evaluated preceptors' perceptions of educational and organizational support for their roles as preceptors. Themes of satisfaction with the educational preparation prior to undertaking their role, satisfaction with their role, and lack of satisfaction with practice support were consistent at 2-3 months and 6-9 months after their initial preceptor training. Findings revealed a perceived lack of recognition from the organization, lack of organizational structures and insufficient time to provide support and guidance. Suggestions for improvement included decreasing clinical preceptor's workloads, ensuring the same schedule for the dyad, and establishing preceptor support networks. As evidenced by the findings from this study, these preceptors did not necessarily want monetary rewards for their service, but rather organizational support and opportunities to further develop their roles.

*Preceptors of both student and newly graduated nurses.* Dibert and Goldenberg's (1995) descriptive, correlational study sought to examine the relationships among preceptors' perceptions of benefits, rewards, supports and commitment to the preceptor role. Participants were preceptors of both newly hired staff nurses and students in their final clinical rotation of their education program. Findings revealed a correlation between preceptors' perceptions of benefits and rewards associated with the preceptor role and their commitment to the role. Positive relationships were found between the total number of times an individual assumed the role of a preceptor and their commitment to the role, while number of years of nursing experience was not related. Reasons for acting as

preceptors included opportunities for assisting new staff nurses and nursing students to integrate into the unit, teaching, improving teaching skills, sharing knowledge, and increasing their own knowledge base. Participants felt that their colleagues were supportive of their roles as preceptors but did not clearly understand the goals of the preceptor program. They felt they had been adequately prepared for their roles as preceptors but also felt that they were asked to precept too often.

Stevenson et al's (1995) exploratory, descriptive study examined the benefits and disadvantages to the preceptor role from the perspective of the nurse preceptor. Participants perceived rewards for being a preceptor as sharing knowledge, stimulation of professional growth, recognition, and satisfaction from watching the preceptee grow. Disadvantages included the time-consuming nature of the role, stress related to workload and lack of time, and lack of patient contact. In terms of desired support and rewards, participants expressed that financial rewards would make the preceptor role more attractive in addition to recognition for precepting in evaluations, the hospital newsletter, and on the clinical ladder. Participants also spoke to their need for opportunities to provide feedback and for their feedback to be valued.

*Preceptors of student nurses.* Atkins and Williams' (1995) qualitative study examined nurse's experiences of mentoring undergraduate nursing students at a hospital in England. In the United Kingdom (UK) the term mentorship is used to describe the relationship with a pre-registration student nurse while preceptorship describes the same relationship with a newly registered, or post-registration, nurse. Six categories were discovered; supporting students, facilitating learning, learning through students, managing conflicting roles and responsibilities, being supported by colleagues, and working in partnership.

Researchers concluded that mentoring student nurses is time consuming and requires administrative and collegial support if it is to be done effectively. Additionally, mentors need formal preparation for their roles that should include education about adult learning principles, role modeling techniques, and coping skills.

Kaviani and Stillwell's (2000) qualitative study used focus groups and interviews to examine preceptors, preceptees, and nurse managers' perceptions of the preceptor role and factors which influenced the performance of preceptors of student nurses. Focus groups were conducted with the student and preceptor groups and individual interviews were conducted with the nurse managers. Several themes emerged during the data analysis and led to the development of an evaluative model of preceptorship, highlighting the intrinsic and extrinsic factors impacting the preceptor, preceptee, and ultimately, preceptor effectiveness. One finding related to the multiplicity of roles which preceptors are expected to assume, indicating that preceptorship is a complex, time consuming responsibility that requires preparation and support, especially peer support. Preceptors identified networking opportunities, education, case load distribution, and open dialogue with nurse managers as strategies that would support their role.

Yonge et al's (2002) descriptive, exploratory study sought to determine the sources of stress associated with precepting student nurses during their clinical placements. Findings revealed that the most common causes of stress for these preceptors were the added responsibilities of an increased workload and the time necessary to devote to the students. Another source of stress was related to students who were not motivated, lacked confidence or had poor attitudes. One recommendation from the researchers based on these findings was that workloads be readjusted for preceptors while they are working

with students. Additionally, it was suggested that both students and preceptors be screened to determine the readiness of the student and the willingness of the preceptor to participate in the experience.

Luhanga et al's (2008) grounded theory study explored how nurse preceptors deal with unsafe students. Behaviors or "red flags" that led to the potential for unsafe practice were described and categorized into four groupings related to knowledge and skills, attitude, professionalism, and communication. Findings revealed the significance of the role of the preceptor in identifying and intervening when these potential unsafe practices occur and suggested the need for preparing preceptors who are able to do this effectively.

#### *Preceptor Experience from a Phenomenological Perspective*

Öhrling and Hallberg's (2001) phenomenological study was "aimed at illuminating nurses' lived experience of the process of preceptoring and the meaning of preceptorship in a Swedish context" (p. 530). Their focus on the perspectives of the preceptors was part of a larger study that also examined the meaning of preceptorship from the perspective of the preceptee. The researchers came to understand the meaning of preceptorship as reducing the risk of the students learning helplessness and empowering the students while they were learning in the practice setting. Findings highlighted the need for further preceptor support and development of the role of the preceptor.

Smedley's (2008) phenomenological study sought to examine the experience of learning to be a preceptor for student nurses. Participants had taken a preceptor course as postgraduate students and through interviews, shared their perspectives of that learning experience and how they had applied what they learned in the workplace. Themes revealed an increased awareness of different learning styles, changed approaches to

teaching and learning, experiences with diverse learners, and differences in approaches for precepting registered nurses and students. Limitations included use of volunteers as participants and sampling from only one hospital.

The bulk of nursing literature that has addressed the role of the preceptor in the transition experience of newly graduated nurses has focused primarily on the perspectives and experiences of preceptees. While this explains only one side of the story, the experiences of preceptees are important in exemplifying the role of the preceptor. Of the few nursing studies focused entirely on the perspective of the preceptor, even fewer have looked at preceptor experiences from a purely qualitative perspective. One study has examined the lived experiences of preceptors of student nurses during their practical training (Öhring & Hallberg, 2001) and one study has explored the lived experience of learning to be a preceptor for student nurses (Smedley, 2008). There have been no studies aimed at exploring the experience of being the primary preceptor for newly graduated nurses during their transition into clinical practice.

### *Experiential Context*

This researcher's interest in the concept of preceptorship, as it pertains to the transition experience of newly graduated nurses, is three-fold. First, an interest stems from her own experiences as a newly graduated nurse 10 years ago. This researcher was hired as a graduate nurse into a medical-surgical internship program. Spending 3 month rotations on each of five medical-surgical units over the course of a year, this researcher worked with multiple preceptors and attributes a successful first year of nursing practice to the relationships that were developed with those preceptors.

Secondly, shortly after completing the internship program, this researcher was asked to be the primary nurse preceptor for a newly graduated nurse. At that time there was no formal preparation for new preceptors which meant that she would have to emulate what she learned from her own preceptors in order to be effective. Several times during the experience she wondered how she was doing however at that time there was also no mechanism in place for feedback to or evaluation of the preceptor.

Finally, her recent interest in the topic has been peaked by her role as the facilitator of the preceptorship portion of the orientation program for newly graduated nurses on the unit where she works as a clinical nurse specialist. This researcher is responsible for selecting preceptors, pairing preceptors and preceptees, and meeting with the dyad on a regular basis for the duration of the orientation. In this role, the researcher has heard a great deal of anecdotal feedback from both preceptors and preceptees that has prompted her to want to formally study certain aspects of the experience.

Because of the researcher's personal and professional experience with preceptorship, her own ideas and assumptions about what it is like to be a preceptor were acknowledged and bracketed in a reflective journal and on data analysis documents. These pre-understandings were revisited throughout all phases of the data collection and analysis process. Additionally, before conducting interviews with the participants, the researcher was interviewed by a member of her dissertation committee as part of the bracketing process.

### *Research Context*

A phenomenological method of inquiry, guided by the work of Max van Manen (1990) and Patricia Munhall (2001, 2007), was used to discover what it is like to be the primary nurse preceptor of a newly graduated nurse during their transition into clinical practice in an acute hospital setting. The focus of phenomenology is on gaining a deeper understanding of the meaning of the experience of a particular phenomenon (Creswell, 1998, p. 65). The methods employed by both van Manen and Munhall incorporate components of descriptive and interpretive phenomenology. One of the potential strengths of this method is that if it is carried out effectively, what is learned from the participants about their experiences as preceptors and the meanings they attach to those experiences, may allow us to “derive directions, interventions, and education” (Munhall, 2001, p. 162)

### *Summary*

Preceptorship is a teaching method used in nursing, other health sciences professions, and teacher preparation programs as a means of supporting and easing transition into clinical practice. It is important to note that while different terms have been used in other professions, for the purposes of this study, preceptorship is defined as the one-to-one teaching-learning relationship between a more experienced role-model and a novice transitioning into practice (Kaviani & Stillwell, 2000). Though the terminology may differ slightly, the concept of preceptorship, especially as it is experienced from the perspective of the preceptee, has been well-documented in the nursing, health sciences,



and education literature. Research that has focused on the perspectives or experiences of preceptors in these areas, especially from a qualitative approach, is limited.

## CHAPTER THREE

### GENERAL METHOD OF INQUIRY

#### *Background of Phenomenology*

According to Dowling (2007) phenomenology is not just a qualitative research method but also a philosophy. Phenomenology surfaced as a philosophy in Germany in the early nineteenth century; one that challenged contemporary perspectives of the origins of knowledge and truth. As one of the founding fathers of phenomenology as a philosophy, Husserl believed experience to be the fundamental source of knowledge (Dowling). A key component of Husserl's philosophy was his proposal of phenomenologic reduction which requires that the researcher "meet the phenomenon as free and as unprejudiced as possible in order that the phenomenon present itself as free and as unprejudiced way as possible so that it can be precisely described and understood" (Dowling, p. 132).

Heidegger's philosophy challenged Husserl's in the sense that his focus was on understanding rather than just description and he believed in the interpretation of phenomena (Maggs-Rapport, 2001). In interpretive phenomenology the researcher is the data collection instrument, research is returned to the participants for validation, and a self-conscious approach to the process is encouraged (Maggs-Rapport). Interpretive phenomenology differs from descriptive phenomenology in the sense that "descriptive phenomenology presents the 'essential' features of the phenomena. Interpretive phenomenology uncovers concealed meanings embedded in the words of the participant narrative..." (Maggs-Rapport, p. 379).

Over time, other phenomenologists have built upon and revised the earlier writings of phenomenology as a philosophy. Additionally, in recent years there has been a movement to define and describe what has been termed new phenomenology, also termed American and/or scientific phenomenology. The premise, although debated, is that new phenomenology is an appropriate method if the focus of the research is on the subjective experience of the participants while European, or philosophical phenomenology, is an appropriate choice if the purpose of the research is to gain a deeper understanding of the phenomenon itself (Dowling, 2007).

### *Methodology and Rationale*

A phenomenological method of inquiry, guided by the work of Canadian phenomenologist Max van Manen (1990) and Patricia Munhall (2001, 2007), was used to discover what it is like to be the primary nurse preceptor of a newly graduated nurse during their transition into clinical practice in an acute hospital setting. Though some of their perspectives could be considered congruent with new phenomenology, the methods employed by both van Manen and Munhall are influenced by European or philosophical phenomenology and incorporate components of descriptive and interpretive phenomenology.

According to Munhall, van Manen's human science approach has been particularly helpful to nurse researchers because of his perspective of phenomenology as both a philosophy of being and a practice (Munhall, 2001, p. 125). According to van Manen (1990), the "essence or nature of an experience has been adequately described in language if the description reawakens or shows us the lived quality and significance of

the experience in a fuller or deeper manner” (p. 10). To the extent that the research question should determine the method, van Manen’s method is appropriate for this study in which the research question was about the experience of being a primary nurse preceptor for a newly graduated nurse during their transition into clinical practice.

Patricia Munhall’s phenomenological method is strongly linked to nursing and thus appropriate for those studies with a nursing orientation. Munhall (2007) diverges from van Manen in her perspective that phenomenologic research has the potential to be “problem solving and illuminate needed changes in many areas, whether policy or practice” (p. 149). This particular aspect of her approach is consistent with this researcher’s belief that understanding the perspective of the nurse preceptor might help us to determine how to better prepare, support, recognize and reward them for their service and also make necessary changes to preceptorship programs based on this heightened awareness.

### *Method of Data Analysis*

Colaizzi’s method was used to guide the data analysis process during this study. Colaizzi developed the seven stages of his method as a psychology student doing his doctoral dissertation in 1973 (Dowling, 2007). The two primary reasons Colaizzi’s method was used in this study are 1) it is inductive in the sense that it includes an abstraction of the participant’s words to formulate meanings in their experiences (Munhall, 2001), and 2) it requires that the data be returned to the participants for validation of the description (Speziale & Carpenter, 2007).

The steps involved in Colaizzi's method involve becoming immersed in the data by listening to the audio-tapes and reading the transcripts several times, extracting significant statements from the transcripts, formulating broad statements and meanings that describe the phenomenon, organizing meanings into clusters of themes, writing an exhaustive description of the phenomenon, defining the fundamental structure of the phenomenon, and returning the data to the participants for validation (Colaizzi, 1978; Sanders, 2003). Colaizzi advocates that when the description is returned to the participants, they are asked how it compares with their experiences thus signifying that it is an appropriate method for studies utilizing both a descriptive and interpretive approach (Dowling, 2007).

### *Methodological Rigor*

Guba and Lincoln identified the following four terms to describe the specific processes that sustain rigor or trustworthiness in qualitative research: credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Consistent with Colaizzi's method for data analysis, Lincoln and Guba state one way to establish credibility is to return the findings to the participants, through member checks, to validate that they accurately reflect their experiences. Shenton (2004) states that "thick description of the phenomenon under scrutiny" also furthers the credibility of qualitative research (p. 69). Thick description from the perspective of Geertz (n.d.), moves beyond merely recounting and act or an event to a description of the perceptions and interpretations of the act or event "without which they would not... in fact exist." (Geertz, n.d.).

Transferability refers to the potential for research findings to have meaning in similar situations (Speziale & Carpenter, 2007). Similarly, van Manen (1990) suggests that a good description of the research findings represents “something that we can nod to, recognizing it as an experience that we have had or could have had” (p. 27).

Dependability and confirmability are established through the use of an audit trail defined as a clear description of each step in the research process that the reader can easily follow and could even repeat. The audit trail should be transparent enough that there is no ambiguity on the part of the reader about the choices made or how interpretations are arrived at during the data analysis phase (Whitehead, 2004).

Other activities done before and during the qualitative research process also contribute to the rigor or trustworthiness of the study. Bracketing refers to the deliberate identification and setting aside of the researcher’s own preconceived thoughts and ideas about the phenomenon under investigation (Speziale & Carpenter, 2007). Horsburgh (2003) acknowledges that even if it is advantageous, total detachment on the part of the researcher is not possible. van Manen (1990) espoused his belief that objectivity in phenomenological research allows the researcher to remain true to the object of study “while avoiding the danger of becoming arbitrary, self-indulgent, or of getting captivated and carried away by our unreflected preconceptions” (p. 20). In other words, though it may not be advantageous to become completely detached from the interview and analysis process, bracketing and reflecting on our own presuppositions helps us be objective and thus allows us to hear what the participants tell us about their experiences without hearing what we want to or think we should hear. Reflective journaling at all phases of the study is one way to accomplish bracketing.

Another activity that contributes to methodological rigor is sampling. Purposive sampling is a means of selecting participants on the basis of their ability to provide relevant data on the phenomenon of interest (Horsburgh, 2003). While this approach may not yield findings that are geographically or even demographically generalizable, the goal is to achieve situational and/or contextual representativeness. In order to ensure that each participant included in the sample was a good fit for this study, the researcher utilized pre-interview screening questions to determine whether or not the participant should be included in the sample.

Sampling for saturation describes a process in which new participants are added until no new information emerges during data collection and analysis. Saturation is defined as repetition of data and signifies the completion of data collection about a particular phenomenon (Speziale & Carpenter, 2007). Saturation occurs when the researcher has learned enough information from the participants to tell a synthesized story combining detail from all of the interviews (Morse, 2007). Sampling for saturation requires that throughout the data collection process, the researcher pays particular attention to the amount of information being collected in each category and continues sampling in those areas where data is limited in order to build up that data (Morse, 2007).

### *Summary*

Both a philosophy and a method, phenomenology is appropriate when the focus of the research is on gaining a deeper understanding of the meaning of the experience of a particular phenomenon (Creswell, 1998). This chapter has provided an overview of the origins of phenomenology and the rationale for using this method to achieve a better

understanding, from the perspective of the preceptor, of the experience of being the primary nurse preceptor for a newly graduated nurse during their transition into clinical practice. Additionally, this chapter has outlined Colaizzi's method for data analysis and the rationale for using his approach to guide the analysis phase of this particular study. Finally, this chapter has provided an overview of some of the activities utilized to uphold rigor and trustworthiness in phenomenological research.



## CHAPTER FOUR

### APPLIED METHOD OF INQUIRY

#### *Sample and Setting*

Purposive sampling was used with a goal of recruiting between 4 and 8 participants from a large, urban hospital in the Western United States. This type of sampling was necessary for this study in order to recruit participants with varying numbers of precepting experiences, as an even distribution of preceptors with different numbers of experiences precepting newly graduated nurses was sought. Congruent with sampling for saturation of the data as described by Morse (2007), throughout the data collection process the amount of information being collected in each area, from each individual participant, was evaluated and subsequently helped determine the need for continued sampling.

Inclusion criteria were (1) registered nurses who worked a minimum of 24 hours a week at the bedside at the study hospital, and (2) registered nurses who were primary preceptors for at least one newly graduated nurse during the year prior to their participation in the study. The hospital hires approximately 120 newly graduated nurses each year thus there were potentially 120 primary nurse preceptors who met the inclusion criteria. For the purpose of human subject's protection, nurses who worked on the researcher's home unit were excluded from participating because of her recent position as the clinical nurse specialist for that particular unit.

## *Gaining Access*

### *Recruitment*

Upon agreement from the facility and permission from both the university and hospital institutional review boards, the researcher met with nurse managers, clinical nurse specialists, and clinical nurse educators to identify the preceptors on their units (see Appendix A for facility agreement, see Appendixes B and C for institutional review board approvals). With permission to do so, flyers were distributed in each potential participant's mailbox at their place of employment and also posted in areas on each unit identified by the nurse managers, clinical nurse specialists, and clinical nurse educators. The flyer briefly described the study and directed interested parties to contact the researcher to enroll and obtain additional information about the study (see Appendix D for flyer). When the researcher distributed the flyers to potential participant's mailboxes, it was noticed that many mailboxes appeared not to be checked on a regular basis and an amendment was requested and granted by both the university and hospital institutional review boards to attend staff meetings to announce the study and distribute flyers (See Appendixes E and F for amendments).

Scripting was used when potential participants contacted the researcher to describe the purpose of the study and the processes for informed consent, data collection, and maintenance of confidentiality (see Appendix G for script). During this initial phone conversation the participants were asked the screening question related to their years of experience precepting newly graduated nurses.

### *Confidentiality*

Participant identity was protected at all times. No person, including but not limited to, any employee of the study hospital, has been or will be notified by the researcher of a participant's involvement in the study. No personal identifiers or portions of personal identifiers will be used on any data analysis documentation or publications that may result from the study. Participants were given letters (i.e. Participant A) for the taped interviews and these same letters were used (i.e. P-A) for the presentation of study results. Participant demographic data was collected prior to the taped interviews and will not be linked to the taped interviews. Institutional Review Board (IRB) protocols for both the university and the hospital were followed for storage of demographic data, interview data and consents. Confidentiality agreements were signed by appropriate individuals at the transcription and the qualitative data analysis training companies who had access to the interview data (see Appendixes H and I for confidentiality agreements).

### *Consent*

Informed consent forms were developed to comply with the university and hospital institutional review boards (see Appendixes J and K for consent forms). The consent forms explained the voluntary nature of participation in the study and the right of the participant to withdraw from the study at any time without explanation and without penalty. Individuals who volunteered to participate signed their consent prior to the beginning of the first interview and were given a copy of their consent form. Participants were reminded of their right to withdraw at the beginning of each subsequent interview.

### *Data Collection*

Demographic information was collected from each participant prior to beginning the first interview (see Appendix L for demographic information). Participants were reminded at the beginning of the first interview that the purpose of this study was to achieve a better understanding, from the perspective of the preceptor, of the experience of being the primary nurse preceptor for a newly graduated nurse during their transition into clinical practice. The opening question for each interview was “Tell me about your experiences as the primary preceptor for a newly graduated nurse during their transition into clinical practice.” Subsequent questions were used to guide the interviews and depended on what was learned from the participant from the opening question. Examples of subsequent questions included

- How do you perceive your role in the transition experience of a newly graduated nurse?
- What motivates you to be a preceptor?
- How were you prepared for your role as a preceptor?
- How are you supported in your role as a preceptor?
- How are you recognized and rewarded for your work?
- What are the challenges associated with precepting?
- What would you describe as your worst and best experiences in this role?
- How is the experience of being a preceptor impacted by your own experience as a newly graduated nurse?

### *Data Analysis*

Each interview was transcribed and imported into NVivo8, a qualitative data analysis software package (QSR International, 2007). Data were analyzed using Colaizzi's framework as described by Sanders (2003). The following stages of data analysis occurred; immersion in the data, extraction of significant statements at the individual level, movement from significant statements to formulated meanings at the individual level, movement from formulated meanings to theme clusters and emerging themes at the individual level, returning to the participants for validation of both verbatim transcripts and researcher's interpretation of meanings and themes at the individual level, movement from themes at the individual level to theme clusters at the collective level, movement from them clusters to essences at the collective level, presentation of audit trails at the individual and collective levels to qualitative expert, and writing the exhaustive description and fundamental structure of the phenomenon.

### *Methodological Considerations*

Before and during the interview process and at all steps of the data collection and analysis process, the researcher's own ideas and presuppositions about what it is like to be a preceptor were acknowledged and bracketed through reflective journaling on data analysis documents. According to Sword (1999), "reflection on the influence of self not only creates personal awareness of how the research is shaped by one's own biography, but also provides a context within which audiences can more fully understand the researcher's interpretation of text data" (p. 270). Additionally, before conducting interviews with the participants, the researcher was interviewed by a member of her

dissertation committee as part of the bracketing process. According to Fleming, Gaidys, and Robb (2003), one way to provoke one's pre-understandings is through conversation with a colleague. The researcher's thoughts and pre-understandings that were elicited during the bracketing interview were revisited throughout the data collection and analysis process.

One of the ways in which credibility was established is through the use of direct quotes to help ensure that the perspectives of the participants were represented as clearly as possible in the presentation of study results. There were both similarities and differences in the stories told by the participants, reflected in the presentation of themes and sub-themes. However, consistent with Munhall's recommendations (2001), rather than homogenizing all of the interviews into one final narrative, every attempt has been made to tell the different stories of meaning for each participant in the exhaustive description (p. 151). Additionally, the return of data to the participants for validation of their stories lends to the credibility of the collected data.

Establishing trustworthiness in qualitative research is parallel to establishing validity and reliability in quantitative research. The trustworthiness of this study, including dependability and confirmability, has been established in two ways. First, the interpreted meanings and emerging themes were returned to the participants in order for them to validate that the descriptions accurately reflected their experiences. The participants were informed that if any part of the description was inaccurate or misinterpreted, the researcher would return to the data and revise the description. Secondly, an audit trail developed and maintained by the researcher and shared with two members of the committee with qualitative expertise, provided a clear description of each step in the

research process. Detailed examples were provided to illustrate the movement from raw data to significant statements and meanings and subsequently to clusters of sub-themes, themes, and the overall essence of the phenomenon. Additionally, decisions related to meanings, themes, essences, and the exhaustive description were presented to and confirmed by a member of the dissertation committee who is an experienced phenomenological researcher and her input was integrated into the presentation of study findings.

### *Strengths and Limitations*

First and foremost, the researcher's interest in understanding the experience of primary preceptors of newly graduated nurses lent itself to a qualitative approach thus adding strength to this particular study. Additionally, a strength of using the phenomenological method is that what we learn from the participants about their experiences as preceptors and the meanings they attach to those experiences, may allow us to "derive directions, interventions, and education" (Munhall, 2001, p. 162). More specifically, understanding the experience of being a primary nurse preceptor from their own perspectives has provided better understanding about how to prepare, support, recognize and reward them for their service.

Though it could be viewed by some as a potential limitation, the researcher's personal and professional experience with preceptorship likely facilitated the rich descriptions provided by the participants about their experiences as preceptors. The researcher has worked in the acute care environment for 10 years in positions as a staff nurse, nurse educator, and clinical nurse specialist and during that time been a preceptee, a preceptor,

and the orientation coordinator for the preceptorship program on her home unit. Because of this experience, there was inherently a degree of pre-understanding and potentially bias on the part of the researcher, which may have influenced the study in terms of interview content and data analysis, however every effort was made to limit this bias through the use of bracketing before and during the interview process and at all stages of data analysis.

Another possible limitation of this study is selection bias in the sense that the registered nurses who participated self-selected into the study and by doing so, could be assumed to have had strong feelings, either positive or negative, about being preceptors, thus influencing them to participate. It is less likely that this actually occurred as evidenced by a distinct balance between both positive and negative descriptions of precepting experiences in the study findings.

### *Summary*

This chapter has provided a detailed description of how a phenomenological method of inquiry was actually applied in this research study. Two methods of sampling, purposive sampling and sampling for saturation, had significance for this particular study. Issues related to accessing and selecting participants and human subject's protection considerations have been discussed. This chapter has also provided an illustration of the specific steps that were taken during the data collection and ongoing analysis phases and describes important methodological considerations that were made to ensure the rigor and trustworthiness of the study. Finally, the potential strengths and limitations of this study are outlined.



## CHAPTER FIVE

### FINDINGS

The purpose of this study was to achieve a better understanding, from the perspective of the preceptor, of the experience of being the primary nurse preceptor for newly graduated nurses during their transition into clinical practice. The main question used to guide this study was:

- What is the experience of being a primary nurse preceptor for newly graduated nurses during their transition into clinical practice?

This chapter illustrates the meaning of the primary preceptor's experience through a description of and introduction to the participants, a detailed description of the data collection and analysis process, and the presentation of an overall essence, three main themes, and nine sub-themes.

#### *Description of the Participants*

A total of 6 registered nurses participated in this study. Five of the participants were female, one was male. The highest level of education reported by 5 participants was a bachelor's degree; one participant had a master's degree. Their years of experience as registered nurses ranged from 1 to 26 years and the number of experiences they had as primary preceptors for newly graduated nurses ranged from 1 to 6. It is important to note that one participant had 26 years of nursing experience and the range for the other 5 participants was between 2 to 3 years. It is also important to note that despite her 26 years of experience as a registered nurse, this participant only had 5 precepting experiences with newly graduated nurses. The number of classes that each participant took that

included preceptor-related education ranged from 0 to more than 5. One participant took no preceptor-related classes, two took 1 class, 1 took 3 classes, and 2 took 5 or more classes.

### *Introduction to the Individual Participants*

Stories shared by the six primary preceptors who participated in this study collectively contributed to the emergence of an overall essence, three themes, and nine sub-themes. As the participants shared these stories, meanings and themes emerged at the individual level as well. The participant's own words will be used to illustrate the theme that stood out most for each them.

#### Participant A: Motivated by Commitment to the Unit

What I'm going for is...I love the unit that I'm working in, and I love seeing nurses that are very competent and very much belong in the unit. I don't want to see task doing...I feel that great nursing care is so beneficial for the patient, because if you know how to orchestrate everything, all the team together, all the doctors from different disciplines, to come together, to communicate between all of that– you are like a conductor for the patient. And I feel like my job is rewarding when I can look back and see that the nurses I precepted are able to do that.

#### Participant B: Impacted by Own Experience as a Preceptee

I love educating fellow nurses, especially someone who's scared. I've been in their shoes, I know what it feels like to be kind of let loose, and you're always afraid of what's my preceptor going to be like...my experience as a new grad was not the best...I did not get a positive interaction with her, and I didn't want to same thing to happen with my preceptee.

#### Participant C: Motivated by Commitment to the Unit and the Profession

Mostly for me I want to make a difference in the people that are coming up to be nurses. I want to try to get my two bits in there and see if I can make a difference... I'm not trying to make clones of me, but I think certain things, if you teach people how to prioritize so that they can have a better day, and they can also have a better working relationship with their colleagues, then it's a plus for everybody.

#### Participant D: Wearing Multiple Hats

And when we were there, we would still have to be charge nurse, we would still have to be taking an assignment, and we would still have to be precepting. So that was really hard. Going a few times to say this is a lot of hats to wear in one day, and if you want our preceptees to get a good education out of this, and get something out of this, we need to take one of those hats away...in terms of doing your project from a preceptor point of view, they need to be only wearing one hat...you're a preceptor and that's it. You need to be dedicated to that person in order to make that a very good moment.

#### Participant E: Having a Good Match

...really making a good match. Because even though there were a lot of things that didn't work out, our personalities— it's like he felt supported by me, and I felt like he was trying his hardest. Just having that ability to say it was a very good match, it was a good connection, I felt I could teach him everything I knew and nothing somebody else could have done would have made a difference in changing any of the stuff that he was having problems with.

#### Participant F: Watching the New Nurse Grow

I think a preceptor you're spending so much time just teaching them how to be a nurse, and then teaching them like how to survive, and just how to do their job. And there are so many tasks that you're teaching them, that it's nice when they're able to do things on their own. But then they come to you when they have a concern, or they come to you— and you're more like a counselor, and they're coming to you with problems and concerns, and you can actually see them growing.

### *Data Collection*

Each participant took part in two interviews, lasting from 30-60 minutes. Though no interviews were conducted during participant's work time, for their first interviews, 5 participants chose to be interviewed in the researcher's office at the study hospital and 1 participant chose to be interviewed at a picnic table just outside the hospital because the weather was so pleasant that day. One participant initially chose to be interviewed at a coffee shop at the hospital however when it was discovered that there was loud music

playing and no area for privacy, the participant chose to move the interview to the researcher's office.

Many of the participants were coming in to the hospital on their day off for other meetings thus the researcher's office was a convenient location for their interviews. The researcher's office was private and quiet, with two chairs and a wrap-around desk. The style of the desk allowed the researcher and participants to sit facing each other with no physical barriers between them. The researcher's phone was unplugged and a "Do Not Disturb" sign was placed on the door so that the interview would not be interrupted.

The six registered nurses who volunteered to participate in the study were consented prior to the beginning of the first interview. They were given two separate consents; one for the university and one for the hospital, and were given an opportunity to read, ask questions about, and sign both consents. It was necessary to have two separate consents to comply with the university's and hospital's institutional review boards and the rationale for this was explained to each participant. The consent forms explained the voluntary nature of participation in the study and the right of the participant to withdraw from the study at any time without explanation and without penalty. Participants were given copies of both of their consents and were reminded of their right to withdraw at the beginning of each subsequent interview.

Five of the follow up interviews were conducted in the researcher's office at the study hospital, again based on the choice of the participants. One follow up interview was conducted via a conference call because the participant moved out of the area between the first and second interviews. For this particular follow up interview, the verbatim transcription document and the meanings/themes document, both specific to the

individual participant, were sent to the participant's private email address and both the researcher and the participant had hard copies of the documents in front of them during the phone interview.

Because the researcher has held various nursing positions within the study institution over the past 10 years, it was possible that she would know some or all of the nurses who volunteered to participate in this study, on a personal and/or professional level. As it turned out, the researcher had not previously met 3 of the 6 nurses who volunteered to participate in the study, 2 participants were known to her very casually within the workplace, and only one participant was well-known to the researcher on a professional level.

It was especially important for the researcher to build a rapport with the participants whom she had not met previously but this was something she focused on with the participants she knew as well. Building rapport involved talking about things that did not involve the study to open up dialogue and establish a comfortable environment at first. Additionally, this involved asking participants about their awareness of qualitative research, giving them background about qualitative research as necessary, and talking to them about open-ended questions.

At the closure of the interviews, after the audio-recorder was turned off, the researcher engaged in conversation with each participant. In some cases, the researcher answered participant's questions about her plans for what she would do with this research and when she would be finished with her dissertation.

Each participant was made aware when they consented to participate in the study that they may be asked to participate in more than two interviews. Repetition of information

across participants began to occur during the first interview with the second participant. During the first interviews with both the fifth and sixth participants, it was determined that not a significant amount of new information was being discovered and at this point, no new participants were recruited.

It is important to recognize that no significant differences were noted between the interview with the preceptor with 26 years of nursing experience and the 5 other participants. This was likely due to the fact that despite her many years of nursing experience, the number of experiences she had as the primary preceptor for a newly graduated nurse was similar to, and in one case less than, the other participants. No participant attrition occurred in this study, as the 6 participants who were initially interviewed also participated in the final interviews.

The primary purpose of the final interview with each participant was to return the verbatim transcriptions of their individual responses in the initial interviews and the researcher's interpretations of the descriptions of their experiences for their validation. Additionally, participants were given an opportunity to add any additional information to the existing data from their first interviews.

Some participants had additional precepting experiences with newly graduated nurses between the first and second interviews, and during the final interviews, were able to share how their experiences were similar or different than what they described during the initial interviews. Returning to the participants after some time had passed allowed the researcher to account for changing social realities though it is important to note that while their experiences may have been different, those participants who had new opportunities

to precept reflected that their views and thoughts had not changed since their first interviews.

### *Data Analysis*

Each interview was transcribed and imported into NVivo8 (QSR International, 2007) during a series of three sessions with an NVivo8 training consultant. During the training, the researcher learned to use the software to organize and begin coding the transcribed data. The researcher discovered throughout this process that, as a novice qualitative researcher, it was also important to supplement her work in NVivo8 with a manual organizing and coding process and as such, several tables were created in Microsoft Word 2003. Data were then analyzed using Colaizzi's framework as outlined below.

#### *Immersion in the Data*

During this phase, the researcher listened to each audio-tape a minimum of 3 times. A printed copy of each transcription was used for jotting down thoughts and memos while listening to the interviews. Additionally, each transcribed interview was read 4 times, at least twice while listening to the words on tape, and significant statements were highlighted using a yellow highlighter. During the reading and re-reading of each of the transcripts, thoughts and memos were also jotted down on the actual documents.

#### *Extracting Significant Statements*

The six transcribed interviews comprised a total of 30,341 words. From the 6 transcripts, 264 significant phrases and statements, related to what it is like to be a primary nurse preceptor for newly graduated nurses, were extracted. Each significant statement was typed on one column of a two-column table.

### *Formulating Meanings*

Next, the formulated meanings of each significant statement and phrase were typed on the second column of the two-column table. From the 264 significant statements and phrases, 296 meanings were formulated.

### *Organizing Clusters of Themes/Emerging Themes*

During this phase of the analysis, the formulated meanings column of the two-column table was cut and pasted into the first column of a new three-column table. From the 296 meanings, clusters of themes developed, reflecting what each meaning revealed about being a primary nurse preceptor. Emerging themes were captured at both the individual and collective levels.

### *Returning to the Participants for Validation*

Their verbatim transcripts, emerging themes, and outliers at the individual level were returned to the participants during follow-up interviews to validate that the descriptions actually depicted their lived experiences as primary preceptors for newly graduated nurses. The outliers were explained to the participants as formulated meanings that did not emerge as themes at the individual level, but may contribute to themes at the collective level. Participants were given an opportunity to both corroborate and negate the researcher's interpretations of their experiences.

During the follow up interview, participants were asked to read through both the transcribed interviews and make comments if necessary, adding to the credibility of the study. With the exception of one participant asking for a theme to be called something that he felt more accurately described his experience and also asking for one of the meanings to be changed for the same purpose, all 6 participants validated that the



researcher's interpretations effectively captured the meanings of their experiences as the primary preceptors for newly graduated nurses. Their substantiation of the findings is illuminated in the following comments:

Honestly, I don't think I have any...you kind of summarized how I feel regarding my role as a preceptor, you captured almost everything. (P-A)

Hmm, yeah, that was really good. I don't really have any...you nailed it on the head based upon reading this. (P-B)

That's good. I really believe that you – I'm like, yeah, that's exactly what I was trying to say in one sentence. (P-D)

Yeah, I remember most of it though, like at least the important parts, which I think you captured very well. (P-E)

#### *Writing the Exhaustive Description and Defining the Overall Essence*

During this phase, a document was created containing all of the themes and the outliers that emerged at the individual level. Beginning with the section for participant A, each unique theme and outlier was given a number, starting with the number one. Similar themes and outliers throughout the remainder of the document were given the same number. For example, the theme *Balance between Autonomy and Safe Nursing Care* emerged at the individual level for Participant A and was assigned the number one. A similar theme, *Balance between Letting Go of Responsibility and Providing a Safe Zone* emerged at the individual level for Participant B, and was also assigned the number one. In order for a theme or outlier to be assigned a unique number, it had to be found at least once for a minimum of two participants. A total of 17 theme clusters were created using this process.

Next, a two-column table was created with the emergent themes at the collective level placed in the left column and space designated in the right column for essences and

themes at the collective level. Themes at the collective level were read and re-read along with the thoughts and memos that the researcher had bracketed throughout the data analysis process. In order to arrive at the overall essence, the researcher examined each emerging theme with the following question in mind

- What makes being the primary nurse preceptor for a newly graduated nurse what it is, without which it would not be?

Subsequently, the 17 theme clusters at the collective level were connected under an overall essence, three main themes and nine sub-themes that together, embody the meaning of being the primary preceptor for newly graduated nurses during their transition into clinical practice.

### *Audit Trail Results*

An audit trail for each individual participant was created and maintained by the researcher. The first several pages of each audit trail consisted of a two column table with significant statements in the left column and formulated meanings in the right column. Next, a four column table showed formulated meanings, theme clusters, emergent themes, and validation statements specific to the meanings, theme clusters, and emergent themes. Finally, other comments from the follow up interviews were displayed using free text after the tables. All of the audit trails were shared with two committee members with qualitative research expertise. These committee members provided feedback related to the audit trails which was integrated as the data analysis continued (see Appendix M for an abbreviated example of an audit trail).

### *Themes and Sub-Themes*

The overall essence of being the primary preceptor for newly graduated nurses during their transition into clinical practice was understood as an altruistic responsibility to the greater good of the profession. The experiences of the primary preceptors who participated in this study will be described in the context of three main themes and nine sub-themes; each sub-theme will be illustrated along with the main theme to which it most closely linked (see Figure 1).



*Figure 1.* Overall essence, themes, and sub-themes.

*Main Theme: Professional Commitment*

The first main theme “professional commitment” involved the sub-themes (1) internal motivation, (2) wearing multiple hats, (3) sharing ownership of the experience, and (4) beyond being a preceptor. The six primary preceptors who participated in this study shared stories that illuminated the selfless ways in which they embraced their roles, beginning with their own internal motivation to be preceptors.

*Sub-theme: internal motivation.* The sub-theme “internal motivation” emerged when participants talked about what motivated them to be preceptors and how they were recognized and rewarded for their work. Before elaborating on this sub-theme, it is important to point out that not all of the preceptors in this study independently sought out the opportunity to precept; rather they were asked to do it by their supervisors and managers, sometimes after only being a nurse for a year. This was not something they felt negatively about, but a fact that they understood as necessary given the large number of newly graduated nurses being hired on their units. Even though becoming a preceptor might have been a response to a request or even an expectation of them, it was clear that these six preceptors were very positive about and genuinely committed to their roles.

Collectively, the primary motivating factors for the six preceptors in this study were commitment to their individual nursing units, love of teaching, appreciation of the mutual learning opportunities provided by the preceptor role, and opportunity to make a difference in the development of a new nurse and for nursing as a whole. The following examples illustrate the perspectives of the preceptors:

I always seek new opportunities to orient new grads into the unit because I like the unit I am working in... because I am very detail oriented- I want to make sure the new grads are well equipped to go out and be safe in the field. (P-A)

I love educating fellow nurses, especially someone who's scared. I've been in their shoes, I know what it feels like to kind of be let loose...that's what I want to do when I get older is to be an educator, so that way, the nurses can perceive what it's like to be a bedside nurse and not just what they read in the textbooks. (P-B)

I love teaching, really...I feel at home when I'm teaching people. I actually feel like I'm a better nurse when I'm teaching people, because it makes me put myself in check every once in awhile. (P-D)

...it's a lot more work because you can't just do your own little thing and take care of your patients, but it's also like you're always learning from them...if you have to teach, then you have to think about it, you need to become better at what you are doing. So by teaching, you become a better nurse at the same time. (P-E)

Mostly for me I want to make a difference in the people that are coming up to be nurses. I want to try to get my two bits in there and see if I can make a difference...It motivates me because it makes the unit I work on run better. I'm not trying to make clones of me, but I think certain things, if you teach people how to prioritize so they can have a better day, and they can also have a better working relationship with their colleagues, then it's a plus for everybody. (P-C)

Some preceptors in this study were also impacted and motivated by their own experiences as preceptees, learning both what they wanted to take away and also what they might change. Those preceptors who were only a year or two out of school themselves brought a certain degree of empathy to their roles as evidenced by comments such as "I try to understand that this is their first job out of school," "I've been in their shoes, I know what it feels like to kind of be let loose," "...it was kind of nice starting off as a preceptor having not been that far out of nursing school because I was able to think about when I was a student, or when I was a new nurse," and "Those moments remembering I was here, I remember when this was all brand new."

Two participants had very positive experiences as preceptees, remembering their preceptors as role models and talking about what they carried with them when they became preceptors themselves. Following is an example of the way in which one preceptor emulated her own preceptor with her preceptee:

My experiences literally were from my experiences as being a preceptee... I was an apprentice nurse and so I was paired up with one. I saw how she reacted, or worked with me, and then when I became a new grad as well. I just kind of learned from them, and how they approached me. And that was how I was able to go forth with her (my preceptee). (P-D)

On the other hand, some of the preceptors had neutral and even negative experiences with their own preceptors but also learned significant lessons from those experiences:

Okay, I learned what not to do. If there is a personal conflict with other disciplinary personnel, and there's some verbal exchange, I don't do that. I try to solve problems, so I learned what not to do...but I don't label that person as a bad preceptor, I tend to take what I can take, if I feel I can benefit from it. (P-A)

My preceptor was a very strong nurse on the floor...but I was pretty much left on my own, where she was off doing other things. And so therefore we never really go to talk until the end of the shift, and she was always like let's go, let's go...so I didn't want the same thing to happen. (P-B)

I had a good relationship with my preceptor as well but I didn't feel like they were available as long. So I try to be more available to my preceptee than my preceptor was, because they were just so busy with their case loads. (P-E)

It was also apparent that their ambition to precept came more from their own internal motivation than anything external, when the participants discussed the recognition and reward they receive for their work. Collectively, their primary source of recognition came from their preceptees in the form of gratitude for the preceptor's contributions to their success:

Once in awhile I hear, thanks to \*...I saved somebody's life because I feel really good about what I am doing, that I'm competent and I know how to ask questions, I know how to approach doctors. (P-A)

Thank you is pretty much the recognition I have gotten, from my preceptee, she took me to lunch and gave me a thank you card...I've definitely been rewarded and recognized from her. (P-D)

...the new nurses this year recognized us...it was really nice, they had a party for us. (P-F)

Three of the participants discussed that they were recognized verbally with compliments for their abilities to precept well and also felt recognized just by being asked to serve as preceptors. They had varying responses when asked whether it would be meaningful to receive some type of reward and recognition outside of their own units, though for the most part, they agreed that while it might be helpful, it was not what they were seeking as evidenced by the following examples:

I don't know if it would really make a difference. I mean, it is just part of being a nurse. You train students, you train new nurses that come in. You have that provided, so it's kind of like almost an automatic- to me it seems like a natural part of what your job is. (P-E)

...I think it's like all the jobs that you do in your life. Most of the time we do the jobs we love, not because of the paycheck, it's because we want to do it. (P-C)

I haven't really thought about it, like what it's worth to me...I don't really expect anything or need anything for it. I enjoy doing it so it's its own reward. (P-F)

Preceptors in this study felt most rewarded as they watched their preceptees grow into competent, critically thinking nurses. Some described satisfaction, and in certain cases relief, when the orientation period was over and they knew that their peers felt comfortable working alongside their former preceptees. The following examples exemplify the pride these preceptors felt as they realized the difference they made for their preceptees and ultimately the patients that would be impacted through the care provided by these new nurses:

I feel that great nursing care is so beneficial for the patient because if you know how to orchestrate everything, all the team together...you are like a conductor for the patient. And I feel that my job is rewarding when I can look back and see that the nurse I precepted is able to do that. (P-A)

It's rewarding to see and know that my graduate nurse who is now on her own is capable- she does really well on her own. She steps in to help me all the time when I need it. That's rewarding, to see how well she's done since she started. (P-D)

My last nurse I oriented is just wonderful...and seeing how well she's doing, and seeing her when her patient starts going downhill, how she immediately catches it and does the right thing- is just really rewarding. (P-F)

*Sub-theme: wearing multiple hats.* The sub-theme “wearing multiple hats” surfaced when preceptor's discussed the challenges they face in their roles. Though their perspectives stemmed from different experiences, all six participants shared views that collectively contributed to the emergence of this sub-theme. For one preceptor, the issue of “wearing multiple hats” led to having to put aside the structure and process related to the preceptorship in order to take care of patients:

...for those who are clinicians, which most preceptors are, your love is taking care of the patient, so you're always going to jump into that first...when people get busy and people are taking care of the patients...all the structure around the preceptor and mentor care maps and checklists and stuff like that- it just falls through the cracks. (P-C)

At times, some preceptors were torn between their responsibilities to their patients and their preceptees, feeling like they were not as available to their preceptees as they should be. For one preceptor, she felt at times as if she was abandoning her preceptee:

...we were really short staffed, and so there were times when I had to take more patients than I should have had to take...I'd have my person that I was precepting, they would take four patients and I'd have to take three patients and I felt like that took me away from being available to the person I was precepting. I think that was hard. I felt like I abandoned them at times, and I didn't feel like I was really able to be available to them. (P-F)

Wearing multiple hats was also understood in the more literal sense when preceptors actually had to do multiple roles within the course of the day, leaving them unable to focus their undivided attention on their preceptees. As described in the example above, it seemed common for the preceptors to have their own patient assignments in addition to being responsible for their preceptees and their preceptee's patients. On occasion though,



some preceptors were also assigned to the charge nurse role, in addition to having their own patients and their preceptee:

My precepting experience was very challenging because at the same time I was in charge for four days out of the four weeks that we were together. So that presented a whole new challenge for me, in being comfortable with her taking care of patients, as well as me trying to take care of two floors and 78 patients. (P-B)

...we would still have to be the charge nurse, we would still be having to take a (patient) assignment, and we would still have to be precepting. So that was really hard. Going a few times (to the supervisor) to say, this is a lot of hats to wear in one day, and if you want our preceptees to get a good education out of this, and get something out of this, we need to take one of those hats away. (P-D)

...time-wise you're having to balance them, sometimes being charge nurse, your preceptee and your full case load. And then if they're not able to carry their case load, having to pick up that work too and trying to figure out how to balance so they're not overwhelmed, but not overwhelming yourself at the same point. (P-E)

Wearing multiple hats was such a strong sentiment for one preceptor that during the follow-up interview when she read this theme, she wanted to reiterate how important this finding was to the study. She had an opportunity to precept another newly graduated nurse between the first and second interviews and her recollection of what she experienced was very vivid:

I think this is the big point, and I just don't know – granted, I'm not writing your paper, but the wearing of multiple hats is a key issue. I don't know if anyone else you've interviewed made comments to that or not. But just in remembering – because this is very recent to me now – remembering those moments when I was the charge nurse, I was the preceptor, I was the only person, like, not even the charge nurse, we didn't even have a manager or supervisor. I'm like running, you know what I mean. I just remember those moments where you really felt like you had so many roles, and you couldn't truly give that preceptee that ability to learn. I can't say ability to learn because it doesn't make sense, but to devote your time to them because you're so focused on okay, I'm in charge, I've got to make sure everybody is okay. I have to make sure the unit is running correctly, have to make sure the preceptee is doing good...but that's a big key that I think things would be so much better off if the preceptor does not have to have, they only have that one...that one task. (P-D)

*Sub-theme: shared ownership.* The sub-theme “shared ownership” transpired when preceptors talked about their feelings of accountability for the actions of their preceptees and the outcomes of the preceptorship and also when they discussed their roles in providing feedback about the progress of the preceptorship. Preceptors described their feelings of accountability and responsibility for the actions of their preceptees both when they were successful and also when they weren’t making progress as quickly as they were expected to:

Yes, I do (take personal accountability for the preceptee’s success). And I would take personal accountability if they weren’t successful either. Because then I would have to figure out why, what happened and what can I do differently. (P-D)

And then if they’re not at a point where you’re expecting them to be, then it kind of feels like you failed them because they’re not where they’re supposed to be in a certain timeframe or they’re not as fast a learner as some of the other preceptees. It’s kind of hard. I felt like, okay, what am I doing wrong. (P-E)

Eventually someday they’re (the newly graduated nurse) going to fall, and they’re going to make that silly phone call to the doctor, they’re going to be the one who gives the wrong medication. It happens, but the accountability factor is, you know, ultimately they are my responsibility at the end of the day. (P-B)

In addition to their own feelings of personal accountability for the actions of their preceptees, some preceptors discussed feeling that their supervisors and managers held them primarily accountable for the actions of the preceptees. This was an issue discussed with a level of frustration and perplexity:

...I think maybe they forget that we can’t teach everything. There are some things that people have to learn on their own, like time management. I have a new grad that I precepted on night shift and now she’s on day shift and struggles to manage an assignment. This was two years ago and people still make comments about how she could have been taught to manage time better. (P-F)

Along the same lines, another preceptor described a situation where there was a complaint made to a supervisor about her preceptee and instead of providing the feedback

directly to the preceptee, the supervisor implied that it was the responsibility of the preceptor to give the feedback because she was “personally responsible for how she behaved”:

...there’s no reason why she couldn’t have given her that feedback as opposed to me. Why am I the persistent buffer, it’s not that that’s a bad thing, but eventually she’s going to get feedback from everybody. How about I be the person who helps them handle the feedback as opposed to the one always giving it. (P-C)

In some cases, preceptors felt it was their responsibility to continue their work outside of the hospital environment in order to cultivate optimal learning experiences for their preceptees. One preceptor described her unique approach to meeting with her preceptee outside of the hospital setting in order to discuss the progression of the preceptorship. She came up with this idea on her own and explained the reason behind it:

Just because the hospital setting is so stressful, that if you can meet with someone in just street clothes, it seems to lighten the whole environment and we were able to work on our weaknesses a heck of a lot more...it’s a better environment and you’re going to accomplish more. (P-B)

Another preceptor talked about going home and doing research in order to ensure he taught his preceptees current and evidence-based information:

I really feel that when you precept somebody, you have a lot of accountability on hand, meaning the information I give to the preceptee has to be correct, has to be evidence-based, has to be up to date. So I constantly go to research. I feel that I have a lot of accountability when I precept people for how they turn out, and it’s a reflection of my work...I think that’s my accountability when I precept somebody is to go home and do extra homework myself. (P-A)

This preceptor reflected on the meaning of personal accountability during the follow up interview and asked to change this emerging theme at the individual level from personal accountability to personal pride. He discussed that while he has some accountability to promote a successful preceptorship experience, “it’s also up to the individual and how they take their experience and try to grow themselves” and “sometimes it’s not like a

measure of how you precept, like if the person is not successful as a preceptee on your unit, it doesn't mean you fail as a preceptor."

Despite the level of accountability, personally felt by preceptors and also expected by their supervisors and managers, there were inconsistencies related to their roles in providing feedback related to the progress of the preceptorship. This variability was related to lack of a formal process for providing feedback, insufficient time for feedback, and in some cases, providing feedback and feeling like it was not heard.

As the individuals who work most closely with newly graduated nurses during their transition into clinical practice, preceptors have invaluable insight related to their preceptees and want to be given an opportunity to share their feedback as evidenced in the following examples:

...as a preceptor, we tend to have a feeling of who is going to make it, or who's going to fly by, who's going to improve, and who's just not going to make it. (P-A)

we should all sit down, me, the preceptee and them (the supervisor, manager, and nurse educator), and say okay, these are the things that I see you still need to work on...I think it would make the person being precepted a lot more comfortable, because they're just kind of scared, period. And they're wondering what the heck's going on. (P-C)

Some preceptors discussed situations in which they provided feedback related to their preceptees and felt that it was not heard by their supervisors and managers. Their feedback concerned the need for their preceptee's to have more orientation time in order to feel confident and safe and they attributed the lack of regard for their feedback as being related to budgetary constraints and a need to have the newly graduated nurses functioning independently as quickly as possible. Two preceptors shared these concerns

in the follow up interviews when they were asked if there was anything they wanted to add to the data:

The only other thing, because it's been frustrating for me lately...I'm having issues with the length of orientation that they're allowing these new graduate nurses to receive, with money issues, they're rushing them way too fast. I think it's scary, and not fair for them to not give them a good orientation time... You don't want to do that to a new grad. We could end up losing them quick. They can just be too overwhelmed and not want to be there anymore. I feel like we'll probably lose more money out of it than saving money. (P-D)

It's frustrating as a preceptor when you're telling management that you don't feel they're ready but you're told that they don't get any more time. I do (feel there is an opportunity to give feedback), but I don't feel that anything's done with it. I think that it's...I know part of it's a budget thing... (P-F)

*Sub-theme: beyond being a preceptor.* The sub-theme “beyond being a preceptor” surfaced as the participants discussed their perceptions of their role in the transition experience of newly graduated nurses. The term mentor came up in the first interview with the first participant when he was asked about his role in the socialization of newly graduated nurses. He responded:

I do keep in touch with all my preceptees afterwards, I try to act more as a mentor and not a preceptor...I think that's how I support them through their transition, is to go back and check up and offer advice, or just for them to talk or vent. (P-A)

He went on to share his perspective on the difference between being a preceptor and being a mentor:

...precepting, it's just like when you go to a new job you have someone who you're assigned to learn the job with. Mentoring is to allow them to grow, and empower their learning experience. (P-A)

The concept of mentorship and the difference between precepting and mentoring came up again in the first interviews with other participants as they talked about their roles:

...a preceptor is there for guidance and providing the education, where a mentor is more of a role model type situation where you also have a more bonding type relationship, and they can ask you questions when they're unsure, or even when they run into a situation with the manager, how do they go about taking care of that situation. (P-B)

I feel like they're almost like the big sister/little sister kind of thing where the person, even though you're precepting them for a short period of time, later on they'll still almost always come back to you with their questions that they never could really ask another person...I think the preceptor is meant to be, you know, teach me how to do this job in this period of – be this like resource person for information and stuff like that. And then later if they come to you, is it still that or have they moved to a level where they... I think that maybe only one or two of them I would say I've actually become a mentor to... (P-C)

Definitely a mentor, I believe...I hope and I feel like I am, like that one person that they had that connection with that they feel okay to go to any time, even though she's on her own now. (P-D)

I feel like I'm that confidant- like we're friends and she feels comfortable to come to me, like I'm a safe person to come to and ask a question. She doesn't feel like she's asking me a dumb question. Not that I would think anybody else would think that's a dumb question, but definitely I feel like I'm her mentor. (P-D)

I think as a preceptor you're spending so much time just teaching them how to be a nurse, and then teaching them like how to survive, and just how to do their job. And there are so many tasks that you're teaching them, that it's nice when they're able to do things on their own. But then they come to you when they have a concern, or they come to you – and you're more like a counselor, and they're coming to you with problems and concerns, and you can actually see them growing. (P-F)

Beyond being a preceptor was also embedded in some participants' accounts of the support that they provided beyond the initial orientation period, after the "official" preceptorship was over. Some met with their former preceptees outside of the work environment, specifically to follow up on how they were doing now that they were "on their own." Others made themselves available to their former preceptees when they worked together on their units, or during shift changes if they were working opposite

shifts, and made it a point to check on them frequently to ensure that they were doing okay.

While they acknowledged the differences between being a preceptor and being a mentor, there was a clear sense that most of the preceptors saw themselves as being both to their preceptees. They described themselves as friends, confidants, and counselors. They perceived that their former preceptees felt comfortable coming to them after their orientation was over, and continued to foster the connections they made beyond the preceptorship.

*Summary.* The first main theme “professional commitment” involved the sub-themes (1) internal motivation, (2) wearing multiple hats, (3) shared ownership, and (4) beyond being a preceptor. The six primary preceptors who participated in this study shared stories that illuminated the ways in which, despite substantial challenges at times, they graciously embraced their roles. This theme exemplifies their commitment to the greater good of the nursing profession.

#### *Main Theme: Raising our Young*

The second main theme “raising our young” involved the sub-themes (1) need for support (2) balancing autonomous nursing practice and safe patient care, and (3) recognizing the individual. During a follow up interview with one of the participants, she reflected on an experience she had between the first and second interviews, as the primary preceptor for an experienced nurse. She noted that because her recent preceptee had been a nurse for a year, it wasn’t necessary for her to teach her skills but more of an orientation to the flow of the unit and policies and procedures that might be new to her. Her approach was much different with her newly graduated nurse where she was

responsible for really educating and being there for the preceptee. She made the analogy that being the primary preceptor for a newly graduated nurse was like being a parent:

...it's kind of like you're their parent, whereas there's all of these people in a child's life, you have grandparents, school teachers, you have all of these people who influence them but the parents are primary, I guess would be the best analogy. (P-E)

When asked if there was anything she wanted to add to the data, she talked about being proud of how her former preceptee had progressed in the time that had passed and made another reference to the relationship between the preceptor and the newly graduated nurse preceptee being similar to the relationship between a parent and a child:

Just looking back now, where my preceptee is now, it's kind of nice to know that he's finally getting the hang of things and being independent and taking on things when he needs to be. So everybody's just takes their own time to get to where they need to be. So it makes you feel a little bit better where it's like okay, it's not the month after where you're still a little concerned, now it's like okay, they're doing fine...like with a child, you're just happy that they are doing well, that they are succeeding, not struggling as much. (P-E)

*Sub-theme: need for support.* The sub-theme “need for support” emerged when participants talked about how they were supported and in some cases, not supported in their preceptor roles. Just as the parents needed the help of grandparents and school teachers in raising their children in the parenting analogy, these preceptors identified that they needed external support in order to be successful in their roles. Support and lack of support came from various sources including their peers, supervisors, managers, nurse educators, and clinical nurse specialists.

Some participants described being supported by the nurse educators and clinical nurse specialists on their units. Most commonly, support came as advice and assistance in challenging situations and sharing of knowledge with both the preceptor and preceptees. One participant described his nurse educator as his “preceptor to precepting:”



I do have a nurse educator in my unit that acts as my preceptor to precepting. Because I will go back with challenges I encounter. I will go back to her with personality conflicts. (P-A)

This preceptor's impetus to seek advice from others was discussed previously in his observation that negative consequences can occur when preceptors do not encourage growth in their preceptees by belittling them or not being supportive. Not wanting to repeat the mistakes he witnessed, he acknowledged looking for guidance from people who had been preceptors for a long time.

Support from the supervisors and managers was shown through allowing preceptors to voice concerns, matching preceptors and preceptees based on learning styles, and assuming the charge nurse role for the preceptor when possible. While thoughtfulness related to matching preceptors and preceptees was viewed as support from supervisors and managers, not matching preceptors and preceptees was perceived as a lack of support by two of the participants in this study:

...unfortunately, when you're assigned to a new grad, she (the manager) really doesn't base it upon personalities, she just places them with someone that's a strong nurse...there's been some that I wish she really would have gotten to know the person and matched them more appropriately...Because we've had a lot of quarrels and ended up switching people, and so for them it's been a very negative aspect. (P-B)

...in the situations that I've been placed as a preceptor, there wasn't a lot of ground work done about whether you two would be a good fit personality wise, or whether you had sort of the same kind of style... sometimes two people are like oil and water, and if you don't know that from the beginning and you're all the way into it, three weeks into it, and it's like you're not getting what I'm saying, and I'm not liking what you're saying. (P-C)

*Sub-theme: balancing autonomous nursing practice and safe patient care.* The sub-theme "balancing autonomous nursing practice and safe patient care" transpired as some of the preceptors spoke about the fine line between pushing their preceptees too hard and

sheltering them too much and also about letting go of their own responsibilities in order to nurture independence in their preceptees. At the same time, the preceptors felt ultimately responsible for the safe care of their patients and in some cases, this balance was difficult to maintain.

One preceptor described a time-management teaching strategy he learned from his “preceptor to precepting” in which he gave his preceptee a timeline for completing certain tasks throughout the day. He would ask that the medications be passed by a certain time and the charting be completed by a certain time and then he’d leave them alone, having empowered them to have control over the tasks. He reflected on this strategy:

I think that a really good way to orient someone is to empower them to make them feel they can take care of their own patient, while the patient care is not suffering because of late medication or late charting. (P-A)

Another preceptor described the stressful feeling of wondering if she was pushing her preceptees enough so they would be able to handle their own patient assignments when the orientation period was over or if she should intervene to help them when they were struggling:

It’s like trying to figure out those times when I should just let them try it themselves, and pick up the pieces later. There’s no patient safety involved...or do I need to sweep in there and get them together because they’re losing it... (P-C)

The term “letting go” was used by two preceptors to describe what they had to do in order to promote self-reliance in their preceptees. This was not an easy task for these preceptors and was actually something they had to learn to do.

...my experience, being the role model, was having to let go of responsibility and training someone else that responsibility and how to balance the day...that was

the hardest thing was learning how to transition someone to think like I do and keep their organization at the same time. (P-B)

She further clarified what letting go meant to her:

...letting them go is just letting them be out on their own and experiencing things, but still trying to keep them within a safe comfort zone. Letting go to me is letting them be around the patients and interacting with the patients, and just being a behind the scenes person. I engage a lot with my patients, so that was very challenging to just step back and let someone else take my shoes. That was difficult in terms of letting go. (P-B)

In one case, the preceptee had to encourage the preceptor to let go:

That was the other challenge in terms of sit back, don't do everything for them because they'll never learn. It got down to the point where she (the preceptee) had about two weeks left and said "I need you to sit right there. This is your area in the nurse's station and I will come to you when it's time"...that was my other challenge, letting go and letting her- I knew she was good at what she was doing, but letting it go and sitting at my post essentially. (P-D)

This preceptor attributed her reluctance to let go to not knowing all of the facts about who is ultimately responsible for the patients from a legal or licensure perspective, when a preceptor is working with a preceptee. She investigated this with her supervisor and manager and her peers on the unit, but received varying responses and was still unclear about it. Not knowing the facts was a source of frustration and concern for this preceptor and significantly contributed to her hesitancy to completely step back and let her preceptee work autonomously.

*Sub-theme: recognizing the individual.* The sub-theme "recognizing the individual" emerged as the preceptors talked about adapting to the learning styles of their preceptees and constantly questioning the effectiveness of their teaching and what they could do differently. Some preceptors were prepared for their roles with unit-based education on learning styles and also by their previous roles in education. Through their illustrations,

these preceptors exhibited a strong sense of self-awareness of their own abilities to be flexible and in some cases, their difficulty adapting.

Some preceptors talked about adapting and individualizing the focus of teaching and learning to their individual preceptees after assessing their learning styles:

...because it's not a cookie cutter, I found out. I've had six different cookies so far, no experience is the same. And I don't expect precepting to be a cookie cutter at all...it has to be individualized. (P-A)

In terms of strategies, I just kind of learned how she learned. We actually had talked right before she started, like "How do you best learn? Reading materials, doing it, or hearing it?" So that was that whole kinesthetic learning versus auditory versus visual. It was kind of good because we both learn the same way, which is kinesthetic, which is doing it. So I was able to take that kind of strategy and goal it towards her. (P-D)

As evidenced in the example above, similarity in learning styles between the preceptor and preceptee was seen as a benefit and in contrast, an inability for the preceptor to identify the preceptee's learning style or differences in learning styles caused frustration for some preceptors:

...when these people are coming into their second or third career, these are adults who should be able to speak their needs about something, you know "I'm a visual learner" or "I need to see it in writing"...I'm not really good about picking that up about people. (P-C)

...it's really hard for me to adapt my- because I'm kind of a creature of habit and I always do things a certain way, but I really have to think about how am I going to do this so it works for me because they're still my patients, but also for her so she has a good learning experience too. I usually will go home and think about how I could have done something better, and then I make a new plan for the next day. (P-F)

The preceptor who described herself as a creature of habit, attributed her worst experience as a preceptor to a possible personality or learning style conflict in the dialogue that follows:

I think I get frustrated when people don't get things the way I think they should get things, and I get kind of impatient...it was just so frustrating for me because this person was kind of a negative person anyways, and it was very draining on me. I think that was my worst experience...maybe personalities, maybe I didn't recognize that she learned differently than me. (P-F)

*Summary.* The second main theme “raising our young” involved the sub-themes (1) need for support (2) balancing autonomous nursing practice and safe patient care, and (3) recognizing the individual. Returning to the parenting analogy provided during a follow up interview with one participant, the meaning of being the primary preceptor for newly graduated nurses is understood as a commitment to cultivate independence in the preceptee requiring external support for the preceptor, preservation of a balance between letting go while maintaining safety, and an effort to adapt to the learning needs of the preceptee. Much like parents who encounter challenges as they raise their children, the six primary preceptors who participated in this study shared stories that explained the struggles they faced in supporting the growth and development of their preceptees, and their attempts to overcome these.

*Main Theme: Bridge between the Book and the Bedside*

The third main theme “bridge between the book and the bedside” involved the sub-themes (1) setting the stage for success, and (2) connection to clinical practice. Preceptors in this study shared their perspectives about the characteristics and factors that contributed to positive as well as negative transition experiences for preceptees. They also acknowledged the importance of their role in linking what their preceptees learned in nursing school with what they experienced at the bedside.

*Sub-theme: setting the stage for success.* The sub-theme “setting the stage for success” became apparent when preceptors talked about the importance of matching

criteria in preceptor-preceptee pairing. This sub-theme was also recognized when preceptors described the preceptee characteristics and external factors that contributed to a successful or non-successful experience for the preceptee and subsequently, the preceptor.

As discussed previously, supervisors and managers who deliberately matched preceptors and preceptees were viewed as supportive, while not matching based on some sort of criteria was viewed as a lack of support by some preceptors. Preceptors who were pre-matched with their preceptees based on personalities and learning styles attributed their positive experiences to being well-matched. Quite the contrary, as remembered by one preceptor, personality and learning style conflicts were a factor in her worst precepting experience. One preceptor described the way that her supervisor was helpful in her development of a relationship with her preceptee because she used a learning style inventory to match them:

She's done those studies with learning styles and she does this learning style inventory. We did that this go around with trying to match up preceptors with preceptees who have similar learning styles. It was actually really interesting...It worked in my case, that's how I got my preceptee who worked kind of like I do and learned like I do. (P-F)

Setting the stage for success was also understood as recognition by the preceptors of preceptee characteristics that both contributed to and interfered with successful preceptorship experiences. The language used to describe positive preceptee characteristics included motivated, knowledgeable, being proactive about learning, takes criticism well and improves from it, direct, straightforward, quick at organizing, big picture thinking, very organized, and trusted. Preceptor's experiences working with

preceptees who exhibited these positive characteristics are portrayed in the following examples:

She's knowledgeable, she had basic nursing knowledge from school, she's proactive in her learning, she's motivated, she takes criticism well, and she improves from it. She uses it as a building block for her to grow, and I could really see that. (P-A)

She's a lot like me, she's very direct, very straightforward, she just wants you to cut to the chase and tell her what the problem is. (P-C)

She was quick at organizing and she was really big picture from the beginning. The small details, she was still good at, but they didn't overwhelm her. (P-C)

...we already had a pretty good relationship going into it, and we trusted each other, and I trusted her as a very good apprentice nurse. (P-D)

...she was one of those that was extremely motivated and very, very organized...I think she was really aware of being able to stay on task. (P-F)

By the same token, preceptors identified characteristics that interfered with successful preceptorship experiences for the both the preceptor and the preceptee. The words used to describe unconstructive preceptee characteristics included expect spoon-fed information, sitting down/sitting back, does not take advice very well, so far out there, not very insightful, and negative person. The following example illustrates one preceptor's observation of the passiveness of some preceptees:

I feel that nurses that are coming on are younger and expect spoon-fed information...expect to be taught everything in three months. That's the biggest challenge. I don't find a lot of proactive learning from the preceptee. (P-A)

In addition to acknowledging the preceptee characteristics that hindered the preceptorship experience, some preceptors also recognized that sometimes there may be external factors impacting the preceptee that they were not always acutely aware of. These preceptors felt there needed to be a mechanism in place for understanding what

might be going on in preceptee's lives, outside of the work environment and recognized that this kind of support might be lacking.

In some cases, the solution to a less than optimal preceptorship experience was to switch preceptors in the middle or toward the end of the orientation period. This led to frustration for the preceptors who were taking over in the middle or at the end of preceptorships that were not going well. It was also a source of concern for them in the sense that they wondered why there was no structure for identifying that things were not working out earlier in the process. It is important to note that switching preceptors was not necessary for the preceptors who had been matched with their preceptees. Three participants described situations where multiple preceptors were used and in two cases, these preceptors were the last preceptors to be utilized:

Come to find out, the preceptee had about five different preceptors due to personality conflicts...she went through multiple preceptors- no one wanted to precept her anymore. I brought my concern to the manager, and I said "I really don't feel that this would work for her in this unit." (P-A)

I also think it was one of those oh, so and so's tried it, you're like the last straw person kind of thing. I don't know- when someone gets put into that situation, both myself and the person- how well that could ever happen. It's almost to me like a set up not to work...At that point I don't think it's about the people, it's about this is just not the place for you to work. (P-C)

*Sub-theme: connection to clinical practice.* The sub-theme "connection to clinical practice surfaced as preceptors acknowledged that the reality of a nurse's first job may be different from school, recognized that teaching and learning must evolve throughout the preceptorship from basic to more complex, and identified the importance of helping their preceptees transition their textbook knowledge to their practice at the bedside and move away from the tasks toward the bigger picture. Some of their sentiments are reflected in the following examples:



I try to be understanding that this is their first job out of school, that sometimes things that are obvious to me may not be obvious to them. (P-A)

when you're first starting in the preceptorship, it's more just basically getting people used to the way, it's more like, it's almost like an orientation thing...like the basics of this is what this piece of paper looks like, this is where you sign the dot here...So it starts out with that little vagueness, this is where the paperwork goes...It moves into more complex things like okay, what's going on with this patient, what's the next step you want to do, what would you possibly think if this happens. It's all trying to be the "what if" person as much as you can. (P-C)

...as students, they know how to take really good care of the patient and what the nurse does for them, but they don't often get a big feel about where the other people are and how much they can tap into them. (P-C)

I think a preceptor you're spending so much time just teaching them how to be a nurse, and then teaching them like how to survive, and just how to do their job...they get so caught up in their tasks that they need to do...I think that's the biggest thing about survival, is getting over that first mindset of how am I going to do this? (P-F)

Some preceptors conveyed that a substantial part of their role was to foster their preceptee's development of critical thinking skills. The following examples illustrate some of the strategies used by these preceptors in teaching their preceptees how to critically think:

I think that the primary role for me is to be able to sort of guide them into a critical thinker...And I try to not just give them the answer, but stimulate other questions. I think that's how I lead them to be a critical thinker. (P-A)

that (critical thinking) was really something I had to push and think. You can see the way she was trained from school. You had to get her to think out of the textbook and get her to see the big picture more. (P-D)

It was really hard for me in terms of challenging her, to get her to think what was the priority at that moment. Where medicating a patient for pain or nausea was more of a priority than finishing a progress note. Or taking out a PICC line before they're transferred to a skilled nursing facility, before transport showed up, was more of a priority than taking a break...Sometimes I would ask open-ended questions and say like "so, tell me about this" or "what do you think about this?" or "so what are you going to do now?" or "why would you do this?" (P-D)

Though it was something they appreciated as crucial to the preceptorship, most perceived that teaching critical thinking was extremely challenging. For one preceptor, it was one of the biggest things she struggled with:

I have no clue (how to attempt to teach someone critical thinking). That's one of the biggest things I think I struggle with. My big thing, because time management is so important, and part of that is critical thinking. What do you need to do first? That's just something that's so hard to teach. I think a class on that or more guidance would be so helpful, because I haven't figured out how to teach that yet. (P-F)

*Summary.* The third main theme “bridge between the book and the bedside” involved the sub-themes (1) setting the stage for success, and (2) connection to clinical practice. The preceptors in this study shared insights that illuminated the critical role they play in the transition of newly graduated nurses into clinical practice. They pointed out the characteristics and factors that they perceived contributed to positive as well as less than optimal transition experiences for preceptees. They also acknowledged their role in linking what their preceptees learned in nursing school with what they experienced at the bedside as they helped them move away from the tasks associated with nursing, toward the bigger picture.

### *Summary*

The meaning of being the primary preceptor for newly graduated nurses during their transition into clinical practice has been described context of three main themes and nine sub-themes. These three themes and nine sub-themes are interconnected, and collectively contribute to the overall essence of being the primary preceptor for newly graduated nurses during their transition into clinical practice, understood as an altruistic responsibility to the greater good of the profession.

## CHAPTER SIX

### DISCUSSION AND INTERPRETATION

#### *Discussion and Return to Literature*

In this study, three main themes and nine sub-themes revealed the meaning of being the primary preceptor for newly graduated nurses during their transition into clinical practice, understood as an altruistic responsibility to the greater good of the profession. The first main theme “professional commitment” encompassed the sub-themes internal motivation, wearing multiple hats, shared ownership, and beyond being a preceptor. This main theme illuminated the ways in which the preceptors in this study selflessly embraced their roles, even in the face of challenges such as being torn between their responsibilities to their patients and their preceptees. This theme also highlighted the preceptor’s commitment and accountability to the success of their preceptees and the inconsistencies related to their roles in providing feedback. Finally, this main theme provided insight into the preceptor’s perceived differences between being a preceptor and being a mentor and the ways in which they assumed the role of mentor to their newly graduated nurse preceptees at some point during or after the orientation period.

Preceptors in this study were motivated by their commitment to their individual nursing units, love of teaching, appreciation of the mutual learning opportunities provided by the preceptor role, and the opportunity to make a difference in the development of a new nurse and for nursing as a whole. Their primary source of recognition and reward came from their preceptees and most agreed that while external reward or recognition might be helpful, it was not something they actively sought. These

preceptors felt both gratified and rewarded as they watched their preceptees grow into competent, critically thinking nurses.

The internal motivation and reward described by the preceptors in this study is consistent with findings in the nursing and health sciences literature. Dibert and Goldenberg (1995) reported the most important reasons for being preceptors as opportunities to assist new nurses to integrate into the unit, teach, improve teaching skills, share knowledge, gain personal satisfaction, and increase their own knowledge base. Stevenson et al. (1995) found that preceptors perceived the rewards of their roles as sharing knowledge, stimulation of professional growth, recognition, and satisfaction from watching the preceptee grow. Similarly, Marriot et al. (2006) reported that one of the main benefits identified by pharmacist preceptors was the reciprocal teaching and learning that occurred and the opportunity to give back to their profession by supporting enthusiastic students.

In terms of the need for external rewards, the findings from this study are inconsistent with the findings in Stevenson et al.'s (2006) study in which preceptors expressed that financial reward would make the preceptor role more attractive. It is possible that the preceptors in this study were not seeking external or financial reward because they were already receiving it in the form of pay differential while they were precepting and also had the opportunity to obtain points on the clinical ladder for doing so. Despite the fact that they all worked at the same hospital, their perceptions about the financial rewards available to them varied. Two preceptors mentioned pay differential, although one did not mention it initially and remembered it later in the interview. Two other preceptors

mentioned points on the clinical ladder, and two did not discuss any form of financial reward.

Preceptors in this study were often torn between their responsibilities to their patients and their preceptees, and in some cases to other duties like being assigned as the charge nurse for their units. Wearing multiple hats was a source of stress for these preceptors, primarily because it left them unable to focus their undivided attention on their preceptees. Insufficient time and increased workload have been described in the nursing and health sciences literature as challenges associated with being a preceptor (Henderson, et al., 2006; Stevenson et al., 1995; Yonge, et al., 2002; Young, Theriault, & Collins, 1989) however the depth with which this issue was articulated in this study has not been reported previously.

While the nursing literature has pointed to the need for preceptors to balance their responsibilities to both their patients and preceptees (Atkins & Williams, 1995; Henderson, et al., 2006; Kaviani & Stillwell, 2000; Öhrling & Hallberg, 2000), this particular study shed light on the extra responsibility some of these preceptors were expected to assume, as charge nurses for their units, while they were precepting,. This finding may be unique to the preceptors in the study hospital, however it is worthy of further exploration as it relates to the outcome of the transition experience for the newly graduated nurse and also the preceptor's satisfaction with their role.

Preceptors in this study identified their role in the shared ownership of the transition experience. They expressed feelings of pride when their preceptees were successful and mutual accountability when they were not progressing as quickly as they were expected to. Clearly, these preceptors had valuable insight related to their preceptees and they

wanted an opportunity to share their feedback with their leadership teams. Preceptors also wanted their feedback, particularly as it related to the need for their preceptees to have enough orientation time to feel confident and safe, to be respected and followed through by their supervisors and manager. Stevenson et al. (1995) identified a similar need for preceptors to be more involved in the orientation process, beginning with hiring, and also for their input related to preceptees to be valued.

It is possible that supervisors and managers do solicit and value feedback from preceptors but are faced with competing demands such as budgetary constraints and the need to fill open positions quickly. Nevertheless, there should be a venue for preceptors to provide feedback and this feedback should be earnestly considered especially as it relates to patient safety and the retention of new nurses. When the tremendous costs associated with orienting newly graduated nurses are considered, it would seem counter-productive to withhold an additional week or two of orientation if in the end these new nurses leave the unit, hospital, or even profession because they never feel safe or confident in their nursing practice.

Preceptors in this study acknowledged that there were differences between being a preceptor and being a mentor. They perceived that preceptors provided guidance and taught newly graduated nurses how to do their jobs, while mentors were friends, confidants, and counselors who empowered newly graduated nurses to grow. Some of the preceptors in this study viewed themselves as preceptors and mentors simultaneously during the orientation period, while others believed that they moved into the role of a mentor after the orientation period was over. This concept of moving beyond being a preceptor, either during or after the orientation period, has not been reported previously

in the literature that was reviewed. This finding raises questions about whether newly graduated nurses should be paired with both a preceptor and a mentor and also whether there is a natural transition from preceptor to mentor when a nurturing, supportive relationship evolves between the newly graduated nurse and the preceptor.

The main theme “raising our young” involved the sub-themes need for support, balancing autonomous nursing practice and safe patient care, and recognizing the individual. This main theme highlighted the need for preceptors to be supported in their roles in order to ensure optimal transition experiences for their preceptees. This theme also illustrated the fine line that preceptors must balance between pushing preceptees too hard and sheltering them too much. Finally, this main theme provided insight into the way in which these preceptors recognized the individual learning needs of their preceptees and in many cases, adapted their teaching in order to meet those needs.

Preceptors discussed support in this study mainly in the context of their supervisors and managers matching preceptors with preceptees. Thoughtfulness related to matching preceptors and preceptees was viewed as support from supervisors and managers, while randomly pairing preceptors and preceptees was viewed as a lack of support. Challenges associated with the arbitrary pairing of cooperating teachers and student teachers were also discovered in Sudzina and Coolican’s (1994) study of the expectations of mentoring relationships between cooperating teachers and student teachers. Recommendations from Hickey’s (2009) study included matching preceptors and orientees based on learning styles.

Some of the preceptors in the current study spoke about situations where changes were made to preceptor-preceptee pairings when conflicts surfaced during the orientation

period. In these situations, the preceptors and preceptees had been randomly paired. The preceptors recognized that switching between multiple preceptors would potentially create a negative experience for both the preceptors and the preceptees. Delaney (2003) found similarly that switching back and forth between multiple preceptors contributed to a frustrating and confusing transition experience for preceptees.

The sometimes difficult balance that preceptors in this study maintained between nurturing independence in their preceptees and ensuring the safe care of their patients is consistent with findings in the nursing literature. Bourbonnais and Kerr (2007) explored preceptor's views of their experiences with students in their final clinical rotation. Their findings revealed an overriding theme called "safe passage", the role of the preceptor was to promote the safe passage, and the meaning of safe passage was both for the patient and the student. Öhring and Hallberg (2000) also found that the preceptors of student nurses in their study maintained this same kind of balance in a theme in their study entitled "being responsible for nursing care and creating space for learning." It is interesting to think about how provision of safe nursing care by new nurses is ensured in the absence of structured orientation programs and without preceptors.

The main theme "bridge between the book and the bedside" involved the sub-themes setting the stage for success and connection to clinical practice. This main theme illuminated the invaluable perspectives shared by these preceptors about the characteristics and factors that contributed to positive, as well as less than optimal transition experiences for preceptees. This theme also exemplified the ways in which the preceptors helped link what the newly graduated nurses learned in school, to their clinical



practice at the bedside. One of the most important ways they did this was by fostering their preceptee's development of critical thinking skills.

The preceptors in this study identified preceptee characteristics that both contributed to and impeded successful preceptorship experiences for both the preceptors and the preceptees. Words used to describe positive preceptee characteristics included motivated, knowledgeable, being proactive about learning, takes criticism well and improves from it, direct, straightforward, quick at organizing, big picture thinking, very organized, and trusted. Words used to describe unconstructive preceptee characteristics included expect spoon-fed information, sitting down/sitting back, does not take advice very well, so far out there, not very insightful, and negative person.

Both positive and obstructive preceptee characteristics were reported in the nursing, education, and health sciences literature. Specifically, Roehrig et al. (2007) found that the characteristics of more effective beginning teachers included a realistic perceptive of their abilities and an openness to feedback and communication from their mentors. Kaviani and Stillwell (2000) reported that the preceptee's motivation level contributed to the effectiveness of the relationship between the preceptor and the preceptee. Marriott et al. (2006) found that pharmacist preceptors felt rewarded by the opportunity they had to give back to their profession by supporting enthusiastic students and also challenged when dealing with students who were uninterested in learning. Yonge et al. (2002) found that student characteristics such as laziness, lack of confidence, and poor attitude contributed to stress for the preceptors. Luhanga et al. (2008) found that students with attitude problems such as overconfidence, lack of receptiveness to feedback, and indifference, were the most difficult for preceptors to work with. In their study, students

who had an unreceptive attitude to receiving feedback were not trusted by their preceptors.

Preceptors in this study were empathetic to the fact that the reality of their preceptee's first nursing jobs was different from school and recognized that teaching and learning would evolve throughout the preceptorship from basic to more complex. Hickey (2009) found similarly that preceptors recognized the orientation process as a learning process in which the preceptee's skills would improve over time. Additionally, Hickey reported preceptors' awareness of the learning curve of newly graduated nurses. Preceptors in the current study also expressed that one of their main roles was to help their preceptee's develop critical thinking skills. Though they acknowledged the importance of this function, it was something that they found challenging and sometimes struggled with. This finding is consistent with a recent study by Sorenson and Yankech (2008) which found that even preceptors with many years of nursing experience struggled with how to teach critical thinking until they took a specific course that prepared them to do so.

### *Implications for Nursing*

Understanding the meaning of being the primary preceptor for newly graduated nurses during their transition into clinical practice has significant implications for hospital administrators, nursing leaders, and nurses involved in staff development roles. The findings from this study should prompt organizations to evaluate whether preceptors are being expected to fulfill other roles, such as charge nurse for their units, while they are precepting newly graduated nurses. As evidenced by the vivid descriptions provided by preceptors in this study who "wore multiple hats," these circumstances have the

potential to lead to frustration and even burnout for preceptors and may also bring about a perception that precepting is an extra burden. Additionally, these situations lead to less than optimal learning experiences for preceptees and under certain circumstances, may even jeopardize patient safety. Preceptors play a crucial role in the transition experiences of newly graduated nurses. While budgetary and staffing constraints must be considered, if the goal is to nurture new graduates through their transition experience and ultimately retain them in their new positions and in our profession, provisions must be put in place that allow preceptors to be successful in their roles.

Similarly important is the need for nursing leaders and nurses in staff development roles to involve preceptors in the entire orientation process and to utilize a systematic approach, based on learning styles, to match preceptors with preceptees. Preceptors have indispensable insight related to their preceptees and they want opportunities to provide feedback related to the progress of their orientation. More importantly, preceptors want their feedback, especially as it relates to their preceptees ability to function safely and independently, to be valued. Understandably, nursing leaders are faced with competing demands such as budgetary constraints and the need to fill open positions quickly. On the other hand, when the tremendous costs associated with orienting newly graduated nurses are considered, the short-term benefits of quickly filling an open position must be weighed against the risk of losing newly graduated nurses from the unit, the organization, and even the profession because they never feel safe or confident in their nursing practice. Ultimately, these losses continue to contribute to the nursing shortage and subsequently impact quality patient care.

Nursing leaders and nurses in staff development roles can also learn from the preceptor's articulate descriptions of preceptee characteristics that both contribute to and interfere with optimal transition experiences. Positive preceptee characteristics could contribute to a template for the ideal candidate for graduate nurse positions. Interview questions could be designed to elicit responses that demonstrate these characteristics in newly graduated nurses and those who tend to be unmotivated, unreceptive, lacking insight, and generally negative could be identified before they are ever hired. Additionally, an understanding of these issues by nursing instructors in the academic setting could help them cultivate these positive characteristics from the time students enter their nursing programs.

Nurses in staff development roles should invest time in the professional development of preceptors and support them in their day-to-day preceptor practice. Preceptors should be provided with all of the facts related to their roles and responsibilities from a legal and licensure perspective. Learning how to foster the development of critical thinking and time management skills should be a key component of ongoing advancement in their roles. To this end, one strategy may be to involve preceptors in simulation experiences with their preceptees as a means of helping them teach and evaluate critical thinking and prioritization skills. Preceptors could also benefit from education related to learning and personality styles and about how to work effectively with preceptees whose learning and personality styles may be different than their own. The same type of education might be beneficial in the beginning of and throughout undergraduate nursing programs in order to prepare nursing students to work effectively with different personalities. Finally,

preceptors might benefit from their own preceptor or mentor, to assist and support them in their development of their preceptor role.

### *Limitations*

Because of the researcher's personal and professional experience with preceptorship, there was inherently a degree of pre-understanding and potentially bias on the part of the researcher, which may have influenced the study in terms of interview content and data analysis. Every effort was made to limit this bias through the use of bracketing before and during the interview process and at all stages of data analysis. Another possible limitation is selection bias in the sense that the registered nurses who participated self-selected into the study and by doing so, could be assumed to have had strong feelings, either positive or negative, about being preceptors, thus persuading them to participate. It seems less likely that this actually occurred as evidenced by a distinct balance between both positive and negative descriptions of precepting experiences in the study findings. The 3-6 month time period between the initial and follow up interviews is a potential limitation since some of the participants had subsequent preceptor experiences. However, even those participants who had been preceptors again in the time that passed confirmed what they stated in their initial interviews and validated that the researcher's interpretations captured their experiences.

### *Recommendations*

Findings from this study are based on the experiences of six primary preceptors for newly graduated nurses from one hospital and as such, these findings may be unique to

these preceptors and to the study hospital. One particularly concerning finding was related to the additional roles that some preceptors were expected to assume while they were precepting, particularly the role charge nurse for their units. This issue could be explored further to determine its prevalence elsewhere and could also be examined in the context of how fulfilling multiple roles impacts satisfaction and outcomes related to the preceptorship from both the perspectives of the preceptor and preceptee.

Findings related to the preceptor's views of themselves as mentors both during and after the orientation period could also be researched. Further investigation of this concept could be aimed at whether there is a natural transition from being a preceptor to becoming a mentor to newly graduated nurses and under what circumstances this kind of evolution occurs. It might also be interesting to pair newly graduated nurses with both a preceptor and a mentor as they transition into clinical practice and then study the impact of those relationships over time.

Preceptors in this study identified their need for support and discussed the various ways in which they were both supported and not adequately supported in their roles. One preceptor described being supported by a "preceptor to precepting." This approach to supporting preceptors, especially new preceptors, could be implemented in a structured manner and evaluated related to outcomes of the preceptorship for both the newly graduated nurse and the preceptor.

The importance of matching preceptors and preceptees based on their personalities and learning styles cannot be overlooked. Personality and learning style inventories should be evaluated for their applicability in pairing primary preceptors with newly graduated nurse preceptees. If an appropriate tool does not exist, one that is nursing-

specific should be developed and tested. Additionally, further research should be conducted to examine the impact of matching preceptors with preceptees on the outcome of the preceptorship from the perspectives of the preceptor and preceptee.

Finally, the number of years of nursing experience for the preceptors in this study ranged from 1 to 26 years and the number of experiences they had as primary preceptors for newly graduated nurses ranged from 1 to 6. Though there were no significant differences in the interviews among participants with varying years of nursing experience, the range of nursing experience brings up an important question related to the amount of nursing experience necessary and appropriate for being a preceptor. Research should be conducted to evaluate whether there is a relationship between a preceptor's years of nursing experience and their success as a preceptor. In addition, this type of study may help to determine whether there is a level of either novice or advanced experience of the preceptor that is ineffective or even detrimental to their preceptor role.

### *Summary*

Some of the findings from this study corroborate findings in the preceptor-related literature that was reviewed. This study also adds new information that has not been reported previously and has significant implications for hospital administrators, nursing leaders, and nurses involved in staff development roles. With regard to the issue of "wearing multiple hats," organizations should pay particular attention to whether preceptors are being expected to fulfill other roles, such as that of charge nurse, while they are precepting newly graduated nurses. Also exemplified in this study, is the importance of preceptors' involvement in the entire orientation process and the use of a

systematic approach to match preceptors with preceptees. Finally, the findings highlighted the importance of time invested in the professional development of preceptors and their need for support in their day-to-day preceptor practice.



APPENDIX A  
FACILITY AGREEMENT

Brenda Durosinmi, MPA, CIP, CIM -Director  
Office for the Protection of Research Subjects  
University of Nevada Las Vegas  
4505 Maryland Parkway Box 451047  
Las Vegas, NV 89154-1047

Subject: Letter of Authorization to Conduct Research at Renown Regional Medical Center.


Dear Ms. Durosinmi:

This letter will serve as authorization for the University of Nevada, Las Vegas (UNLV) research team; Cheryl Bowles PhD, EdD, RN and Jennifer Richards, MSN, RN, to conduct the research project entitled *The Experience of Precepting a Newly Graduated Nurse* at Renown Regional Medical Center (Facility).

The Facility acknowledges that it has reviewed the protocol presented by the researcher, as well as the associated risks to the Facility. The Facility accepts the protocol and the associated risks to the Facility, and authorizes the research project to proceed. The research project may be implemented at the Facility upon approval from the UNLV and Renown Health's Institutional Review Boards.

If we have any concerns or require additional information, we will contact the researcher and/or the UNLV Office for the Protection of Research Subjects.

Sincerely,

  
Facility's Authorized Signatory

8/5/08  
Date

MICHAEL A. RASINGER, CHIEF NURSING OFFICER  
Printed Name and Title of Authorized Signatory

## APPENDIX B

### IRB APPROVAL, UNIVERSITY OF NEVADA, LAS VEGAS



### Biomedical IRB – Expedited Review Approval Notice

#### NOTICE TO ALL RESEARCHERS:

*Please be aware that a protocol violation (e.g., failure to submit a modification for any change) of an IRB approved protocol may result in mandatory remedial education, additional audits, re-consenting subjects, researcher probation suspension of any research protocol at issue, suspension of additional existing research protocols, invalidation of all research conducted under the research protocol at issue, and further appropriate consequences as determined by the IRB and the Institutional Officer.*

**DATE:** September 26, 2008  
**TO:** Dr. Cheryl Bowles, Physiological Nursing  
**FROM:** Office for the Protection of Research Subjects  
**RE:** Notification of IRB Action by Dr. John Mercer, Chair *DM/c*  
Protocol Title: **The Experience of Precepting a Newly Graduated Nurse**  
Protocol #: 0808-2825

This memorandum is notification that the project referenced above has been reviewed by the UNLV Biomedical Institutional Review Board (IRB) as indicated in regulatory statutes 45 CFR 46. The protocol has been reviewed and approved.

The protocol is approved for a period of one year from the date of IRB approval. The expiration date of this protocol is September 25, 2009. Work on the project may begin as soon as you receive written notification from the Office for the Protection of Research Subjects (OPRS).

#### PLEASE NOTE:

Attached to this approval notice is the **official Informed Consent/Assent (IC/IA) Form** for this study. The IC/IA contains an official approval stamp. Only copies of this official IC/IA form may be used when obtaining consent. Please keep the original for your records.

Should there be *any* change to the protocol, it will be necessary to submit a **Modification Form** through OPRS. No changes may be made to the existing protocol until modifications have been approved by the IRB.

Should the use of human subjects described in this protocol continue beyond September 25, 2009 it would be necessary to submit a **Continuing Review Request Form** 60 days before the expiration date.

If you have questions or require any assistance, please contact the Office for the Protection of Research Subjects at [OPRSHumanSubjects@unlv.edu](mailto:OPRSHumanSubjects@unlv.edu) or call 895-2794.

Office for the Protection of Research Subjects  
4505 Maryland Parkway • Box 451047 • Las Vegas, Nevada 89154-1047

## APPENDIX C

### IRB APPROVAL, RENOWN REGIONAL MEDICAL CENTER

Renown Regional Medical Center  
Institutional Review Board  
1155 Mill St., X-19  
Reno, NV 89502

September 5, 2008

Cheryl Bowles, PhD, EdD, RN  
4505 Maryland Parkway Box 453018  
School of Nursing/Bigelow Health Sciences, 419  
Las Vegas, NV 89514

RE: IRB # 2008-025

Dear Dr. Bowles and Ms. Richards

Michele Pelter, RN, PhD, a designee of William McHugh, MD, reviewed your protocol:

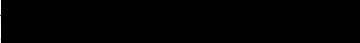
*The Experience of Precepting a Newly Graduated Nurse*

on **September 5, 2008** and granted expedited approval. The Institutional Review Board of Renown Regional Medical Center will meet on **November 6, 2008** at which time he will inform them of this decision.

IRB Approval necessitates the following:

- ◆ It is required that you notify the IRB (and as appropriate; the FDA, institutional officials and sponsors), within 10 days, of the following:
  - Any changes in their research activities, including study completion, (amendments must be submitted in consecutive order).
  - Any unanticipated problems involving risk to human subjects.
  - Any adverse reactions, morbidity or mortality.
  - (This timely reporting to the IRB is not limited to local occurrences/findings but also includes multisite discoveries as well)
- ◆ It is required that a progress report be reviewed by the IRB within **one year** of your approval date, **September 4, 2009**. This report will need to include the number of patients included in the protocol and any complications or adverse reactions. If you do not have a form for such reporting, one can be obtained from the IRB.
- ◆ If your study is completed prior to the expiration date, please submit a progress report indicating closure to the IRB.
- ◆ All revisions to the protocol and consent form are to be approved by the IRB prior to implementation.

Sincerely,

  
Sally Sue Broili, MT(ASCP)  
Administrative Coordinator, Institutional Review Board

H:\IRB 07-00\Correspondence - Pls\Graduate Studies\Bowles-Richards\Expedited Approval 090508.doc

## APPENDIX D

### FLYER

# **Research Study:** ***The Experiences of Precepting a Newly Graduated Nurse***

- **Are you a Registered Nurse working at the bedside a minimum of 24 hours a week?**
- **Have you been the primary preceptor for at least one newly graduated nurse in the past year?**

If you can answer YES to the questions above, you are invited to join this research study. Your participation may contribute to a better understanding, from your perspective, of the experience of being the primary preceptor for a newly graduated nurse during their transition into clinical practice.

Should you volunteer to participate, you will be asked to commit to a minimum of two interviews, lasting approximately one hour each, at the location of your choice.

Your participation is entirely voluntary. You can decide to withdraw from the study at any time and for any reason. Your employment at Renown Regional Medical Center will not be affected in any way based on your participation in or withdrawal from this study.

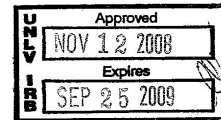
Complete confidentiality will be maintained at all times during and after your participation in this study. Your name and/or any other personal identifiers will not be used to associate you with this study.

**If you are interested in participating or would like more information regarding this study please contact:**

**Jen Richards, MSN, RN of Cheryl Bowles, EdD, RN  
(775) 224-0494 (Leave Message)**

## APPENDIX E

### IRB APPROVAL, AMENDMENT, UNIVERSITY OF NEVADA, LAS VEGAS



### Biomedical IRB – Expedited Review Modification Approved

#### NOTICE TO ALL RESEARCHERS:

*Please be aware that a protocol violation (e.g., failure to submit a modification for any change) of an IRB approved protocol may result in mandatory remedial education, additional audits, re-consenting subjects, researcher probation suspension of any research protocol at issue, suspension of additional existing research protocols, invalidation of all research conducted under the research protocol at issue, and further appropriate consequences as determined by the IRB and the Institutional Officer.*

**DATE:** November 14, 2008  
**TO:** Dr. Cheryl Bowles, Physiological Nursing  
**FROM:** Office for the Protection of Research Subjects  
**RE:** Notification of IRB Action by Dr. John Mercer, Chair *omice*  
Protocol Title: **The Experience of Precepting a Newly Graduated Nurse**  
Protocol #: 0808-2825

---

The modification of the protocol named above has been reviewed and approved.

Modifications reviewed for this action include:

- The student investigator will attend staff meetings to announce the research study and distribute flyers.

This IRB action will not reset your expiration date for this protocol. The current expiration date for this protocol is September 25, 2009.

Should there be *any* change to the protocol, it will be necessary to submit a **Modification Form** through OPRS. No changes may be made to the existing protocol until modifications have been approved by the IRB.

Should the use of human subjects described in this protocol continue beyond September 25, 2009, it would be necessary to submit a **Continuing Review Request Form** 60 days before the expiration date.

If you have questions or require any assistance, please contact the Office for the Protection of Research Subjects at [OPRSHumanSubjects@unlv.edu](mailto:OPRSHumanSubjects@unlv.edu) or call 895-2794.

Office for the Protection of Research Subjects  
4505 Maryland Parkway • Box 451047 • Las Vegas, Nevada 89154-1047

## APPENDIX F

### IRB APPROVAL, AMENDMENT, RENOWN REGIONAL MEDICAL CENTER

**Renown Regional Medical Center  
Institutional Review Board**  
1155 Mill St., X-19  
Reno, NV 89502

October 15, 2008

Cheryl Bowles, PhD, EdD, RN  
4505 Maryland Parkway Box 453018  
School of Nursing/Bigelow Health Sciences, 419  
Las Vegas, NV 89514

RE: IRB # 2008-025

Dear Dr. Bowles and Ms. Richards

Antonio Fontelonga, MD, a designee of William McHugh MD, has reviewed your request for amendment # 1 to protocol:

*The Experience of Precepting a Newly Graduated Nurse*

on **October 2, 2008** and granted expedited approval. The Institutional Review Board of Renown Regional Medical Center will meet on **November 6, 2008** at which time Dr. McHugh will inform them of this decision.

This does not change your progress report date to this committee.

Sincerely,



Sally Sue Broili, MT(ASCP)  
Administrative Coordinator, Institutional Review Board

## APPENDIX G

### PHONE SCRIPT

Thank you for your interest in this study. Before I tell you about this study, I'd like to know how many years of experience you have precepting newly graduated nurses. The purpose of this research is to achieve a better understanding, from the perspective of the preceptor, of the experience of being the primary nurse preceptor for newly graduated nurses during their transition into clinical practice. Should you decide to participate, you will be asked to take part in a minimum of two tape-recorded interviews with the researcher lasting approximately one-hour each. The interviews will be conducted at the time and location of your choice. No interviews will be conducted during work time. I will review and have you sign a consent before your first interview begins. It is important for you to know that confidentiality will be maintained at all times and that your participation is entirely voluntary.

APPENDIX H

TRANSCRIPTION CONFIDENTIALITY AGREEMENT



**Transcriber's Confidentiality Agreement**

---

**TITLE OF STUDY:** The Experiences of Precepting a Newly Graduated Nurse

**PRINCIPAL INVESTIGATOR:** Cheryl Bowles, PhD, EdD, RN & Jennifer Richards, MSN, RN (Student Investigator)


**CONTACT PHONE NUMBER:** (702) 895-3082

---

As a transcribing typist of this research study, I understand that I will be hearing tapes of confidential interviews. The information on these tapes has been revealed by research participants who participated in this project on good faith that their interviews would remain strictly confidential. I understand that I have a responsibility to honor this confidentially agreement.

I hereby agree not to share any information on these tapes with anyone except the principal investigator of this project. Any violation of this agreement would constitute a serious breach of ethical standards, and I pledge not to do so.

This acknowledgement is governed by HIPAA as well as other applicable federal, state, university and local laws, rules and regulations.

  
Signature of Transcribing Typist

10-15-08  
Date

MARILYN MCKEEGAN  
Printed Name of Transcribing Typist



## APPENDIX I

### NVIVO8 TRAINING CONFIDENTIALITY AGREEMENT

#### Confidentiality Agreement

Trainer: DataSense, LLC

EIN 77-0486285

Address: 25101 Bear Valley Road, Ste 297, Tehachapi, CA 93561-8311

Job Title: Training

Title of Study: The Experience of Precepting a Newly Graduated Nurse

Principal Investigator: Cheryl Bowles, PhD, EdD, RN

Student Investigator: Jen Richards, MSN, RN

---

#### Confidentiality:

As an NVivo8 (Qualitative Data Analysis Software) trainer, I understand that I will have access to data obtained during confidential interviews. The information on collected during these interviews has been revealed by research participants who participated in this project on good faith that their interviews would remain strictly confidential. I understand that I have a responsibility to honor this confidentiality agreement.

I hereby agree not to share any information accessed during this training with anyone except the student investigator participating in the training, and the principal investigator of this project. Any violation of this agreement would constitute a serious breach of ethical standards, and I pledge not to do so.

This acknowledgement is governed by HIPAA as well as other applicable federal, state, university and local laws, rules, and regulations.

This agreement is binding from October 6 2008 and applies to any and all current and future work by DataSense, LLC.

Karen I. Conger, Ph.D.  
Authorized by

October 6 2008  
Date

Karen I. Conger, Ph.D.  
Trainer Acknowledgment

Signature: 

## APPENDIX J

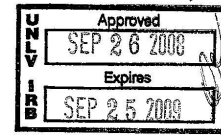
### INFORMED CONSENT, UNIVERSITY OF NEVADA, LAS VEGAS

RECEIVED

SEP 18 2008



#### INFORMED CONSENT SCHOOL of Nursing



---

**TITLE OF STUDY:** The Experience of Precepting a Newly Graduated Nurse

**INVESTIGATOR(S):** Cheryl Bowles PhD, EdD, RN and Jennifer Richards, MSN, RN

**CONTACT PHONE NUMBER:** (702) 895-3082

---

#### **Purpose of the Study**

You are invited to participate in a research study. The purpose of this study is to achieve a better understanding, from your perspective, of the experience of being the primary nurse preceptor for newly graduated nurses during their transition into clinical practice. Understanding your perspective might help us to better understand how to prepare, support, recognize and reward preceptors for their service.

#### **Participants**

You are being asked to participate in the study because you work a minimum of 24 hours a week at the bedside at the study hospital and you have been the primary preceptor for at least one newly graduated nurse in the last year.

#### **Procedures**

If you volunteer to participate in this study, you will be asked to take part in a minimum of two AUDIO-recorded interviews conducted by the student investigator, lasting approximately one-hour each. The interviews will be conducted at the time and location of your choice. No interviews will be conducted during work time. During the interviews you will be asked questions about your experiences as the primary nurse preceptor for a newly graduated nurse. It is important for you to know that confidentiality will be maintained at all times and your participation is entirely voluntary.

#### **Benefits of Participation**

You may not experience any direct benefits from participating in this study except the satisfaction of participating in research. However, we hope that learning about the experience of being a primary nurse preceptor from your perspective might help us better understand how to prepare, support, recognize and reward preceptors for their service.

#### **Risks of Participation**

There are risks involved in all research studies. This study may include only minimal risks. It is unlikely that any of the interview questions will make you uncomfortable or distressed however it is important for you to know that you will not be expected to answer any question that makes you feel this way. It is also important for you to know that you may end an interview and/or withdraw from the study at any time, for any reason, without negative consequences.

#### **Cost /Compensation**

There will not be financial cost to you to participate in this study. The study will take approximately 2 hours of your time. You will not be compensated for your time.

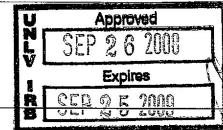
Participant Initials \_\_\_\_\_

1 of 2

RECEIVED

SEP 18 2008

TITLE OF STUDY: The Experience of Precepting a Newly Graduated Nurse  
INVESTIGATOR(S): Cheryl Bowles PhD, EdD, RN and Jennifer Richards, MSN, RN  
CONTACT PHONE NUMBER: (702) 895-3082



**Contact Information**

If you have any questions or concerns about the study, you may contact Cheryl Bowles PhD, EdD, RN or Jen Richards, MSN, RN at 702-895-3082. For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted you may contact **the UNLV Office for the Protection of Research Subjects at 702-895-2794.**

**Voluntary Participation**

Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time without prejudice to your relations with the university. You are encouraged to ask questions about this study at the beginning or any time during the research study.

**Confidentiality**

All information gathered in this study will be kept completely confidential. Interviews will be audio-recorded and transcribed by a private transcriptionist who is not affiliated with the hospital in any way. In addition, the researcher will receive data analysis training from an individual instructor who is not affiliated with the hospital in any way. Some of your transcribed data may be used during the training. All personal identifiers and portions of personal identifiers in the transcribed data will be removed by the researcher prior to using the data in the training. Both the transcriptionist and the data analysis instructor are required to sign confidentiality agreements for the protection of the interview data. No reference will be made in written or oral materials that could link you to this study. Separate files of interviews, transcripts, and demographic data will be stored on a password protected computer in a locked office at UNLV for 3 years after completion of the study. After the storage time the information gathered will be destroyed.

**Participant Consent:**

I have read the above information and agree to participate in this study. I am at least 18 years of age. A copy of this form has been given to me.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Participant Name (Please Print)

I ALSO AGREE TO HAVE MY INTERVIEWS AUDIO-RECORDED.

\_\_\_\_\_  
SIGNATURE OF PARTICIPANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PARTICIPANT NAME (PLEASE PRINT)

***Participant Note: Please do not sign this document if the Approval Stamp is missing or is expired.***

Participant Initials \_\_\_\_\_

2 of 2

## APPENDIX K

### INFORMED CONSENT, RENOWN REGIONAL MEDICAL CENTER

**Renown Regional Medical Center  
Institutional Review Board  
CONSENT TO PARTICIPATE IN A RESEARCH STUDY**

**TITLE OF STUDY:** The Experience of Precepting a Newly Graduated Nurse  
**INVESTIGATOR(S):** Cheryl Bowles, PhD, EdD, RN (702) 895-3082  
Jennifer Richards, MSN, RN (775) 224-0494  
**PROTOCOL #:**  
**SPONSOR:**

#### 1. INTRODUCTION

Before you agree to take part in this research study, it is important that you read and understand several general principles that apply to all who take part in our studies: (a) taking part in the study is entirely voluntary; (b) personal benefit may not result from taking part in the study, but knowledge may be gained that will benefit others; (c) any significant new findings that relate to your treatment will be discussed with you; (d) you may withdraw from the study at any time without penalty or loss of any benefits to which you are otherwise entitled. The nature of the study, as well as the risks, inconveniences, discomforts and other pertinent information about the study are discussed below. You are urged to discuss any questions you have about this study with the staff members who explain it to you. This consent may contain words that you do not understand. Please ask the investigator or staff to explain any words or information that you do not understand.

Renown Regional Medical Center  
INSTITUTIONAL REVIEW BOARD  
Approved: [Signature]  
Expiration Date: 12/1/19

#### 2. PURPOSE

You are invited to participate in a research study. The purpose of this study is to achieve a better understanding, from your perspective, of the experience of being the primary nurse preceptor for a newly graduated nurse during their transition into clinical practice. Understanding your perspective might help us to better understand how to prepare, support, recognize and reward you for your service. Furthermore, knowing about your experiences as a preceptor might illuminate some of the reasons why the transition experiences of newly graduated nurses are often so traumatic.

#### 3. SUBJECTS

You are being asked to participate in the study because you work a minimum of 24 hours a week at the bedside at the study hospital and you have been the primary preceptor for at least one newly graduated nurse in the last year.

#### 4. PROCEDURES

(7/30/08)

Page 1 of 4

**TITLE OF STUDY:** The Experience of Precepting a Newly Graduated Nurse  
**INVESTIGATOR(S):** Cheryl Bowles, PhD, EdD, RN (702) 895-3082  
Jennifer Richards, MSN, RN (775) 224-0494

**PROTOCOL #:**

**SPONSOR:**

---

If you volunteer to participate in this study, you will be asked to you will be asked to take part in a minimum of two audio-recorded interviews conducted by the student investigator, lasting approximately one-hour each. The interviews will be conducted at the time and location of your choice. No interviews will be conducted during work time. During the interviews you will be asked questions about your experiences as the primary nurse preceptor for a newly graduated nurse. It is important for you to know that confidentiality will be maintained at all times and your participation is entirely voluntary.

5. BENEFITS

There may be no direct benefits to you as a participant in this study. However, we hope that learning about the experience of being a primary nurse preceptor from your perspective might help us better understand how to prepare, support, recognize and reward you for your service. Additionally, knowing about your experiences as preceptors might illuminate some of the reasons why the transition experiences of newly graduated nurses are often so traumatic and subsequently provide ideas for interventions that might ease this transition.

Renown Regional Medical Center  
INSTITUTIONAL REVIEW BOARD  
Approved 12/24/08 4/16  
Expiration Date 12/1/09

6. RISKS

There are risks involved in all research studies. This study may include only minimal risks. It is unlikely that any of the interview questions will make you uncomfortable or distressed however it is important for you to know that you will not be expected to answer any question that makes you feel this way. It is also important for you to know that you may end an interview and/or withdraw from the study at any time, for any reason, without negative consequences.

7. ALTERNATIVES

Your participation in this research study is entirely voluntary. The alternative is that you choose not to participate.

**TITLE OF STUDY:** The Experience of Precepting a Newly Graduated Nurse  
**INVESTIGATOR(S):** Cheryl Bowles, PhD, EdD, RN (702) 895-3082  
Jennifer Richards, MSN, RN (775) 224-0494  
**PROTOCOL #:**  
**SPONSOR:**

---

#### 8. CONFIDENTIALITY

The investigators, Renown Regional Medical Center and the University of Nevada, Las Vegas will treat your identity with professional standards of confidentiality and protect it to the extent allowed by law. The U.S. Department of Health and Human Services (Food and Drug Administration), Renown Regional Medical Center Institutional Review Board and University of Nevada, Las Vegas have the right to inspect and/or copy your study records. All information gathered in this study will be kept completely confidential. Interviews will be audio-recorded and transcribed by a private transcriptionist who is not affiliated with the hospital in any way. In addition, the researcher will receive data analysis training from an individual instructor who is not affiliated with the hospital in any way. Some of your transcribed data may be used during the training. All personal identifiers and portions of personal identifiers will be removed by the researcher prior to using the data in the training. Both the transcriptionist and the data analysis instructor are required to sign confidentiality agreements for the protection of interview data. No reference will be made in written or oral materials that could link you to this study. Separate files of interviews, transcripts, and demographic data will be stored on a password protected computer in a locked office at UNLV for 3 years after completion of the study. After the storage time the information gathered will be destroyed.

Renown Regional Medical Center  
INSTITUTIONAL REVIEW BOARD  
Approved 10/2/08  
Expiration Date 10/1/09

#### 9. COSTS/COMPENSATION

There will not be financial cost to you to participate in this study. The study will take approximately 2 hours of your time. You will not be compensated for your time.

#### 10. RIGHT TO REFUSE OR WITHDRAW

Participation is voluntary. You may refuse to participate or withdraw from the study at any time, without negative consequences. If the study design or use of the data is to be changed, you will be so informed and your consent re-obtained. You will be told of any significant new findings developed during the course of this study which may relate to your willingness to continue participation.

#### 11. QUESTIONS

If you have any complaints, you may contact one of the investigators whose names and phone numbers are listed at the beginning (or end) of this form. You may report

**TITLE OF STUDY:** The Experience of Precepting a Newly Graduated Nurse  
**INVESTIGATOR(S):** Cheryl Bowles, PhD, EdD, RN (702) 895-3082  
Jennifer Richards, MSN, RN (775) 224-0494

**PROTOCOL #:**

**SPONSOR:**

(anonymously if you so choose) any complaints which you may have regarding: 1) treatment;  
2) response to this treatment; and 3) subject's rights as an investigational research subject to:

Chair, Renown Regional Medical Center IRB

1155 Mill St., X-19

Reno, NV, 89502

Or call: The IRB Office  
775-982-5760.

You may want to contact the UNLV Office for the Protection of Research Subjects at 702-895-2794.

#### 12. CLOSING STATEMENT

MY SIGNATURE BELOW INDICATES THAT I HAVE DECIDED TO VOLUNTEER AS  
A RESEARCH SUBJECT AND THAT I HAVE READ, UNDERSTAND, AND I HAVE  
RECEIVED A COPY OF THIS CONSENT FORM.

Renown Regional Medical Center  
INSTITUTIONAL REVIEW BOARD  
Approved 12/2/08  
Expiration Date 12/1/09

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARTICIPANT (OR LEGALLY  
RESPONSIBLE PERSON)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PERSON WHO DISCUSSED  
THE CONSENT PROCESS

I ALSO AGREE TO HAVE MY INTERVIEWS AUDIO-RECORDED.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARTICIPANT (OR LEGALLY  
RESPONSIBLE PERSON)

\_\_\_\_\_  
PARTICIPANT NAME (PLEASE PRINT)

(7/30/08)

Page 4 of 4

## APPENDIX L

### DEMOGRAPHIC INFORMATION

- 1) Gender  
Male\_\_\_\_\_
- Female\_\_\_\_\_
- 2) Highest level of education  
Diploma\_\_\_\_\_
- Associates Degree\_\_\_\_\_
- Bachelors Degree\_\_\_\_\_
- Masters Degree\_\_\_\_\_
- Doctoral Degree\_\_\_\_\_
- 3) Years of experience as a registered nurse\_\_\_\_\_
- 4) Years of experience as a preceptor for newly graduated nurses\_\_\_\_\_
- 5) Approximate number of precepting experiences (newly graduated nurses)\_\_\_\_\_
- 6) Number of classes participated in that included preceptor-related education  
0\_\_\_\_\_
- 1\_\_\_\_\_
- 2\_\_\_\_\_
- 3\_\_\_\_\_
- 4\_\_\_\_\_
- 5 or more\_\_\_\_\_



## APPENDIX M

### EXAMPLE OF AUDIT TRAIL

<b>Significant Statement</b>	<b>Formulated Meaning</b>
“I want to make sure the new grads are well equipped to go out and be safe into the field.”	Equip newly graduated nurses to practice safe nursing care.  Want to develop safe practitioners.
“I always seek new opportunity to orient new grads into the unit because I like the unit I’m working in.”	Motivated precept by a desire to make the unit better.
“I love the unit that I’m working in, and I love seeing nurses that are very competent...I don’t want to see task doing in the unit I’m working in.”	Desire to promote the development of competent nurses in the unit; motivated by a love for the unit.
“I think that my primary role of precepting is to not only orient the new grad to do the tasks that are very specific for that unit, but to make sure that they can critically think in the critical care unit. Yeah, and then I think that the primary role for me is to be able to sort of guide them into a critical thinker.”	Guide preceptees in their development of critical thinking skills.

<b>Formulated Meaning</b>	<b>Theme Cluster</b>	<b>Emergent Theme</b>	<b>Validation</b>
1) Equip newly graduated nurses to practice safe nursing care. 2) Empower newly graduated nurses to take care of their patients and at the same time, continue to ensure safe nursing care. 3) Want to develop safe practitioners. 4) The balance between autonomous nursing practice and safe patient care. 5) Desire to promote safe nursing practice.	The preceptor has to find the balance between promoting autonomy for the preceptee while continuing to ensure safe care of the patients.	Balance Between Autonomy and Safe Nursing Care	“That captures how I feel, you know, most of my concern is how are you able to precept new grads and allow them to do stuff without constantly having to watch them like a hawk. Because even though we don’t like to admit it, mistakes do happen. Like how to find the right balance is the hardest part I think. And that really captured that part.”

## REFERENCES

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## VITA

Graduate College  
University of Nevada, Las Vegas

Jennifer Richards

### Home Address:

80 Sawbuck Road  
Reno, Nevada 89519

### Degrees:

Bachelor of Science, Nursing, 1999  
University of Nevada, Reno

Master of Science, Nursing, 2005  
University of Nevada, Reno

### Special Honors and Awards:

Yaffa Dahan Nursing Dissertation Award, 2008

Jacobs Foundation Scholarship for Advanced Education in Nursing, 2008

Northern Nevada Nurse of Achievement, Advanced Practice Nursing, 2006

Outstanding Thesis, "Experiences of Expert Nurses in Caring for Patients with Postoperative Pain"

### Publications:

Richards, J. & Hubbert, A. (2007). Experiences of Expert Nurses in Caring for Patients with Postoperative Pain. *Pain Management Nursing*, 8, 17-24.

Richards, J. & Ballard, N. (2008). Colloid cyst: A case study. *Journal of Neuroscience Nursing*, 40, 103-105.

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### Dissertation Committee:

Chairperson, Cheryl Bowles, Ed.D.  
Committee Member, Lori Candela, Ed.D.  
Committee Member, Nancy York, Ph.D.  
Graduate Faculty Representative, Leann Putney, Ph.D.