2017

Perioperative Preceptor Education in an Agency Preceptor Workshop

Kimberly N. Crawford
Eastern Kentucky University, k.crawfordrn@yahoo.com

Perioperative Preceptor Education in an Agency Preceptor Workshop

Submitted in partial fulfillment of the requirements for the degree of Doctor of Nursing Practice at Eastern Kentucky University

By

Kimberly N. Crawford, MSN, RN, CNOR

Richmond, Kentucky

November 1, 2017

Abstract

There is a critical shortage of perioperative nurses and the demand in the United States (US) is growing steadily by 1% to 2% each year. It is estimated that nearly 20% of registered nurses (RNs) currently working in the perioperative area will retire in the next five years. In the perioperative area, when using the 6 to 12-month orientation time frame, as outlined in the Association of PeriOperative Registered Nurses (AORN) orientation calculator, the cost of orienting a new RN can exceed $100,000. A preceptorship workshop is one strategy that has been shown as an evidence-based intervention to decrease RN turnover rates, increase job satisfaction, and have a positive effect on new nurse role transition and intent to stay. Perioperative preceptor education as a component of an agency-wide workshop was developed and implemented with the purpose to improve RN preceptor performance and proficiency, and increase perioperative RN orientee satisfaction and intent to stay. A pre- and post-intervention design was implemented in a 391-bed Magnet designated facility to evaluate these outcomes. Using eta square, mean preceptor performance and proficiency scores indicated a moderate effect size, which demonstrated clinical significance and a positive impact on the nurse practice environment.

Keywords: RN retention, perioperative preceptor, turnover, preceptor performance, preceptor proficiency

Perioperative Preceptor Education in an Agency
Preceptor Workshop

By

Kimberly N. Crawford, MSN, RN, CNOR

Capstone Advisor	Date
Capstone Project Committee Member	Date
Capstone Project Committee Member	Date
DNP Coordinator	Date
Dept. of Baccalaureate & Graduate Nursing Chair	Date

Acknowledgements

It is with sincere gratitude that I would like to acknowledge my Doctor of Nursing Practice (DNP) Capstone Committee, Dr. Donna Corley, Dr. Gina Purdue, and Dr. Preston Lewis, for all of their support and guidance. Additionally, I would like to acknowledge the DNP faculty at Eastern Kentucky University for such a rigorous program. I would like to acknowledge Karen Hill, DNP, RN, NEA-BC, FACHE, FAAN, Kathleen Blair, MSN, RN, CNOR, NE-BC, and Margaret Kramer, MSN, RN-BC for their permission and support of my DNP project at Baptist Health Lexington. I would also like to acknowledge my family and close friends for all your support and tolerance as I embarked on this challenging journey.

Table of Contents

Perioperative Preceptor Education in an Agency Preceptor Workshop

Background and Significance

Problem Identification

The current global shortage of registered nurses (RNs) across all specialties has implications not only for patient care, but for the provision of education for the nurses of the future. These shortages are a world-wide concern with noticeable reductions in the nursing workforce in the United States (US), as well as other countries (Zilembo & Monterosso, 2008). In the US, a national survey of RNs documented that an estimated 56% of working RNs were employed in hospitals, representing a decrease from 59% four years earlier Health Resource and Services Administration. Bureau of Health Professions, 2008). A shortfall of 340,000 RNs is projected in the US by 2020, which is three times larger than the 2001 shortage (Lee, Tzeng, Lin, & Yeh, 2009). The shortage of nurses is a global problem; thus, it is important to understand factors that promote the retention of newly licensed RNs in the workplace particularly in critical service lines such as perioperative services.

For new RNs who lack mature clinical skills and experience, the nature of beginning a new role and transitioning to professional practice presents serious challenges. Individual inexperience and inability to deal with complicated situations has been reported in the literature to result in a turnover rate of 55-61% of new nurses in the first year of employment (Lee et al., 2009). Assisting RNs engaged in a formal preceptorship to overcome these common challenges through professional development could lead to reduced turnover and vacancy rates in perioperative services.

Retention of new RNs has been an important issue in nursing in recent years. Orientation and training costs continually increase as vacancies occur and hospitals prepare each group of

new RN orientees to fill the void. Financial expenses have increased continuously from 1987, when costs associated with recruitment and training of RNs ranged from $1000-$3000 to 1995 with costs at $20,000-$50,000 (Lee et al., 2009). Current literature supports that a well-designed preceptorship workshop that includes an evidence-based curriculum targeting the professional challenges faced by onboarding RNs is one effective strategy to decrease RN turnover rates, increase job satisfaction, and have a positive effect on new RN role transition (Lee et al., 2009).

Context of the Problem

The perioperative area is a very specialized area. While many hospitals have preceptor programs, the curriculum is often geared toward RNs employed on inpatient units, not specialty areas. Therefore, not meeting the individualized development needs of the perioperative RN. Orientation for a new RN employee is a very costly undertaking for the hospital. If an employee becomes dissatisfied and leaves the area during or soon after his/her orientation process, a financial burden can incur and be counterproductive to maintaining adequate staffing. The perioperative environment tends to have a high turnover rate because it can be a very challenging workplace for new nurses (AORN, n.d.); thus, precipitating the need for the provision of evidence-based education that supports the effective transition of RNs into the practice environment.

Scope of the Problem

According to Pellico, Djukic, Kovner, & Brewer (2009), more than 40% of RNs in the workforce approach retirement age in the next ten years. Retaining new RNs in nursing is vital to help improve the projected shortage of 340,000 in US by 2020 (Lee et al., 2009). At the organizational level, RN retention is important for maintaining adequate staffing which is critical for ensuring quality patient outcomes. Improved retention reduces turnover costs that range from

$82,000 to $88,000 per RN (Pellico, et al., 2009). Average yearly turnover rates of all RNs range from about 5- 21%, while turnover rates for RNs in their first year of practice range from about 18- 50% samples (Pellico, et al., 2009).

There is a critical shortage of perioperative nurses, and the demand in the US is growing steadily by 1% to 2% each year. It is estimated that nearly 20% of RNs currently working in the perioperative area will retire in the next five years (Ball, Doyle, & Oocumma, 2015). In the perioperative setting, the nursing shortage is made more difficult by a limited group of experienced perioperative RNs from which to hire, coupled with the ever-changing technological advances that create a very demanding practice environment. Perioperative areas are significantly affected by nursing shortages because of the one- to five-year development cycle of a perioperative nurse (Zinn, Guglielmi, Davis, & Moses, 2012). Typically, it takes one year to fully orient a new perioperative RN to function independently in multiple service lines, and it takes two to five years for the same RN to be ready to assume a leadership role. When using the 6- to 12-month timeframe of providing a comprehensive orientation to all service lines, as outlined in the Association of periOperative Registered Nurses (AORN) orientation calculator, the cost of orienting a new perioperative RN can exceed $100,000. As RN turnover occurs, the financial burden is further increased as it may require 60 to 90 days to recruit a new RN to the health care setting (Zinn, Guglielmi, Davis, & Moses, 2012); often resulting in overtime to fill the vacancy. Therefore, operational expenses related to orienting new perioperative employees and high attrition have led to the desire for an evidence-based preceptor workshop as requested by the supporting agency for this IRB-approved study (K. Blair, personal communication, March, 16, 2016).

Consequences of the Problem

There are several consequences of a high nursing turnover rate. These include increased cost for the department and the facility, decreased job satisfaction, decreased patient satisfaction, increased error rate/decreased patient safety, and increased complication rate (Ball, Doyle, Oocumma, 2015; Jones, 2005; O'Brien-Pallas, Griffin, Shamian, Buchan, Duffield, Hughes, et al., 2006; Waldman, Kelly, Sanjeev, & Smith, 2004).

Proposed Evidence-Based Intervention

The proposed intervention was to develop perioperative preceptor education supported by evidence in the literature for an agency preceptor workshop. The preceptor program will include defined roles and responsibilities of preceptors for orienting RNs newly assigned to the perioperative area.

Purpose of the Proposed Project

The purpose of this project was to develop, implement, and evaluate an evidence-based perioperative program as a component of the agency's formal preceptor workshop. Specific aims were to:

1. Improve RN preceptor performance and proficiency and
2. Increase perioperative RN orientee satisfaction and intent to stay.

Theoretical Framework

Patricia Benner's theory, *From Novice to* Expert, is an appropriate framework for guiding a preceptor workshop. Benner (1984) adapted the Dreyfus Model of Skill Acquisition to clinical nursing practice. By following the model's logical sequence, Benner was able to identify the performance characteristics and teaching-learning needs inherent at each level of skill. Benner's

approach has been used in the development of new graduate orientation programs, clinical promotion ladders, and clinical knowledge development seminars (Alligood & Tomey, 2006).

There are five key concepts to Benner's philosophy: novice, advanced beginner, competent, proficient, and expert. In the novice stage of skill acquisition, the nurse lacks background experience of the situation in which they are expected to perform tasks. Context-free rules and objective attributes must be given to guide their performance. These attributes are features of the task that can be recognized without situational experience. At the novice skill level, there is difficulty discerning between relevant and irrelevant aspects of a situation (Benner, 1982; Benner, 1984).

The advanced beginner stage develops when the nurse can demonstrate marginally acceptable performance (Benner, 1984). This nurse is one who has encountered enough real situations to note the recurrent meaningful components of a situation. Nurses at this stage are guided by rules and are oriented by task completion. They have difficulty grasping the current patient situation in terms of the larger perspective (Benner, 1982).

The competent stage is characterized by considerable conscious and deliberate planning that determines which aspects of a situation are important and which can be ignored. It develops when the nurse begins to see her actions in terms of long-range goals. Consistency, predictability, and time management are important in competent performance (Benner, 1982; Benner, 1984; Benner et al., 1992).

In the proficient stage, the nurse perceives the situation as a whole (Benner, 1984). Experience teaches the proficient nurse what typical events to expect in a given situation and how to modify plans in response to these events (Benner, 1982). The nurse no longer relies on preset goals for organization (Benner et al., 1992).

The expert stage is achieved when the nurse no longer relies on rules, guidelines, or maxims to connect her understanding of the situation to an appropriate action. The expert nurse has an enormous background of experience and has an intuitive grasp of the situation (Benner, 1982; Benner, Tanner, & Chesla, 1996).

Benner's philosophical framework, Novice to Expert, can guide the development of a preceptor workshop. Application of Benner's framework is illustrated in Table 1. Nurses who are new perioperative employees, whether new graduates or experienced clinicians, are at the novice level within this service line, while nurses who serve as preceptors are at the proficient or expert level of perioperative care. Novice nurses are best taught in terms of objective attributes and context-free rules; needing concepts and direction that can be recognized without situational experience (Benner, 1982). Recognizing this about the novice nurse helps the educator structure the preceptorship program, and helps the preceptors deliver the program. The educator focuses on the very basic of perioperative care, while the preceptor serves as a role model and the new nurse is more of an observer than a participant. As new nurses gain experience of each perioperative service line (e.g. general, plastics, urology, gynecology, neurosurgery, vascular, and cardiothoracic), the new nurse should progress to the advanced beginner stage.

Table 1

Application of Benner's Model to Perioperative Preceptor Workshop

Stage of development	Nurse	Preceptor	Educator
Novice	• Observer • Rotating through all perioperative areas	• Role model • Answering questions • Demonstrations	• Basic perioperative concepts
Advanced Beginner	• Actively working with preceptor in a variety of areas	• Partnering with orientees for assignments.	• Service line-specific education

Competent	• Independent assignments with preceptor back-up	• Available for support, but allowing more independence	• Decision-making skills • Complex care
Proficient	• Independent	• Minimal supervision of nurse • Terminate formal preceptor relationship	• Incorporate nurses into professional development available for all staff.
Expert	• Serve as Preceptor		

Advanced beginners demonstrate marginally acceptable operating room nursing performance, but are not ready to be independent. At this level, the nurse is one who has coped with enough practical operating room situations to note meaningful situation components, but still focuses much of his/her practice on rules that have been taught (Benner, 1982). Here the educator structures didactic or clinical educational experiences at a higher level, the preceptor begins to provide the advanced beginner with increasingly complex assignments, all the while providing support, and the new nurse becomes an active participant in care delivery.

A competent nurse is one who is able to take independent assignments in the perioperative area with the support of preceptor back-up, and sees nursing actions in terms of long-range goals or plans (Benner, 1982). The preceptor should keep in mind that the competent nurse may lack the speed and flexibility of one at the proficient level, and that the competency stage is characterized by a feeling of mastery and the ability to cope with and manage the many contingencies of clinical operating room nursing. The competent nurse's conscious, purposeful planning helps the nurse to achieve a level of efficiency and organization. The educator uses decision-making games and simulations that give nurses practice in planning and coordinating multiple, complex, intra-operative patient care demands (Benner, 1982). The preceptor should

support to help nurses with critical thinking skills, but give the nurses increasingly more independence.

According to Benner (1982), many nurses stay at the competent level because it is perceived as the ideal level by their supervisors and is supported and reinforced institutionally. The standardization of procedures, geared to manage the high turnover in nursing, most often reflect the competent level of performance (Benner, 1982). According to Benner (1982), most in-service education is also aimed at the competent level of achievement. Thus, this is a period when preceptors end the formal preceptor relationship, providing total independence for the new nurse. Educators now include the newer nurse in the larger cadre of staff when planning professional development.

Review of Literature

The terms "preceptor and mentor" are many times used interchangeably in the literature. For the purpose of this literature review, the term "preceptor" was the primary term used to search for literature. Although there are role overlaps between preceptors and mentors, clear differences in role and function have been identified by many authors. Mentoring is seen as more of a relationship that facilitates professional and personal growth than a functional role (Ashurst, 2008; Butler & Felts, 2006; Persaud, 2008; Haggerty, Holloway, & Wilson, 2013). In contrast, precepting is mostly short-term and well defined within the clinical practice area (Firtko, Stewart, & Knox, 2005; Haggerty et al., 2013). A preceptor is a practicing nurse who provides individual clinical supervision and teaching, primarily on a one-on-one basis, while still carrying a normal clinical workload. Preceptors facilitate professional socialization and act as role models with the goal of assisting beginning level practitioners into their new role transition (Ford, Fitzgerald, & Courtney-Pratt, 2013; Haggerty et al., 2013; Omansky, 2010).

Preceptor Program Outcomes

Many investigators evaluating preceptorship workshops have measured multiple outcomes. As early as 2004, Almada, Carafoli, Flattery, French, and McNamara evaluated the impact of a preceptor workshop that offered newly graduated nurses' (NGNs) adequate education, improved preparation during education, and a support system as a measure to reduce rising retention rates. The mixed methods study involved a convenience sample of NGNs (N=40) entering practice in a small, 150-bed, nonteaching community hospital in eastern Massachusetts. A coded survey tool, along with a written consent form was sent to each NGN after completion of the preceptor program and three months of working independently (approximately six months from the start date). The survey included yes/no questions, visual analogue scales (VAS), and open-ended questions. The survey evaluated nurse satisfaction, reasons the NGNs may have considered for leaving, and feedback for possible improvements in the program. All members of professional development staff were competent on the correct use of the VAS to maintain validity and were available to assist the preceptors with the surveys. A VAS was used to answer three questions regarding overall satisfaction with the experience in the program. The overall response rate was 89% (n=40). The baseline data reflected nurses hired during a 14-month period (April 2000 to May 2001 inclusive) prior to implementation. The results indicated a high satisfaction rate overall as the average VAS mean score for this area was 93.7%. Retention rate of NGNs was 93% compared to a 25% baseline rate.

Hallin & Danielson (2009) compared RNs' experiences of acting as personal preceptors for nursing students and explored relationships between preceptors' experiences and personal/clinical characteristics. A descriptive cross-sectional design was adopted for this study. Data were collected by means of self-administrated questionnaires from two independent

preceptor groups in a hospital in Sweden before (n=113) and six years after introduction of a preceptor model (n=109). The questionnaire was examined for face and content validity. Items were generated from a literature review and content validity were assessed by means of the known-groups technique. Internal consistency Cronbach's alphas ranged from .83 to .95 for the different subscales (mean .87). Data were analyzed with descriptive and correlational statistics using parametric and non-parametric methods. Statistically significant improvements were noted in preceptors' experiences. Significantly more preceptors reported that they felt prepared for their role following the intervention; a high proportion reported that they were confident in their ability to offer guidance (84.4%) and felt secure in the preceptor role (78.0%).

The purpose of a quasi-experimental study by Lee et al. (2009) was to design a preceptorship program and evaluate its effects on turnover rate, turnover cost, quality of care, and professional development. Lee and colleagues implemented a preceptor program at an 1,800-bed teaching medical center and collected extensive data. Turnover rate was calculated as the percentage of new nurses who resigned from their jobs. These data were extracted from the personnel databank of the study hospital. Turnover cost included advertising, vacancy, hiring, orientation, and training. It was estimated to be 1.2 - 1.3 times the employee's salary. The total turnover cost was $2,954 per person per month, based on an employee salary of $2,272 per month. The indicators of quality of nursing care included medication error rate data, the number of falls, and the incident rate. Figures were adopted from the Committee of Quality Improvement. Patient satisfaction was measured by the Patient's Satisfaction towards Nursing Care instrument, which included 10 questions using a five-point Likert scale. Cronbach's alpha was 0.86 for internal consistency reliability; Content Validity Index (CVI) was 0.92. Satisfaction of the preceptor's teaching behavior was measured with a scale the investigators modified from

Kernan, Holmboe, & O'Connor's (2004) Teaching Encounter Card and Santucci's (2004) Residency Program Evaluation Tool. This 20-item questionnaire allowed new nurses to evaluate preceptors' performance and whether they succeeded in understanding the new nurses' merits and difficulties. Cronbach's alpha was 0.9 for internal consistency reliability; CVI was 0.86. Preceptor's perception was measured with a scale modified from Dilbert & Dolly's (1995) the Preceptor's Perception of Benefits and Rewards Scale, the preceptor's Perception of Support Scale, and the Commitment to the Preceptor Role. This 20-item preceptor's perception questionnaire included benefits, rewards, support, and commitment. A four-point Likert scale was used; higher scores indicated greater understanding of the evaluator for the clinical preceptor's benefits, rewards, support, and commitment. Cronbach's alpha was 0.89; CVI was 0.87 for content validity (Lee et al., 2009, p. 1219-1220). Lee and colleagues demonstrated that after initiating the preceptor program, the turnover rate was 46.5% less than the previous year, the turnover cost was decreased by $186,102, medication error rates made by new nurses dropped from 50% to 0%, and incidents of adverse events and falls decreased. All nurses expressed satisfaction with their preceptor guidance.

Romp and Kiehl (2009) evaluated new nurse satisfaction and effectiveness following a preceptor program at one large metropolitan tertiary medical center. The program was evaluated by three methods: summative evaluation of each class, changes in job satisfaction, and RN turnover rates. Prior to implementation of the program, one group of orientee nurses (N=49) completed an Orientation Evaluation Survey. After program implementation, a different group of 34 orientee nurses completed the same survey. The survey contained five Likert-style questions and five open-ended questions about their experience with their preceptors. These surveys were administered after approximately six to eight weeks of orientation. In a Preceptor

Survey, preceptors provided their feedback about topics for additional preceptor education, preferred length of a class, level of satisfaction and suggestions for improvement of the Preceptor Program. Of the 230 preceptors who received the survey, 82 responded for a 36% return rate.

The overall Orientation Evaluation Survey had a mean nonsignificant rating improvement from 4.36 to 4.50. However, satisfaction with the preceptors was statistically significant and increased from 4.40 to 4.69 (p = .016). The 12-month RN turnover rate before implementation of the program was 13.9%, and reduced to 10.1% post-implementation. Consequently, outcomes further demonstrated a 29% reduction in turnover rate for the medical center, which averaged 760 nurses and an estimated training cost of $67,100 per new nurse. Estimated savings during this timeframe from new nurses alone was estimated to be $1.8 million, even after accounting for other indirect costs of the program: the preceptor salaries for attending classes, educator salary for providing the education; and other expenses secondary to learning space, food, educational materials/handouts, and flyers.

Fox (2010) evaluated an acute care mentor program for retaining new nurses in their positions, improving satisfaction, and encouraging more experienced nurses to make a fresh commitment to professionalism. In 2004, the turnover rate among first-year acute care RNs was 31%. In 2006, the hospital initiated a pilot RN mentor program, including 12 RN mentors and 12 RN protégés from select nursing units. Data were collected with pre- and post-evaluation surveys completed at the end of the 4- to 6-month and the 6- to 9-month periods. The results showed a 0% turnover rate during the one-year pilot program. On initiation of the mentor program in 2006, the turnover rate (remaining on the same nursing unit) improved to 16.6%. In 2007, the turnover rate was 13.8, and in 2008, the year-to-date turnover rate was 10.3% at the conclusion of the first successful year. The program led to a 67% decrease in turnover for

registered nurses. Satisfaction scores improved by one level in 75% of participants surveyed, moving from agree to strongly agree or from tend to disagree to agree. Based on these findings, the mentor program was expanded to include RNs working in inpatient nursing units, surgery, and emergency departments. Each year, the RN turnover rate has decreased. In 2009, the turnover rate was 10.3%. Due to the success of the program, it has been expanded in scope to include other professionals experiencing high turnover in targeted departments.

Smedley, Morey, & Race (2010) evaluated RN preceptors who had completed a specially designed program in a health care facility intended prepare them for their role. The investigators wanted to see if the RN preceptors believed that the program had such effects as: increasing their knowledge of teaching and learning process, increasing their knowledge, understanding and use of generic preceptor skills, increased their preceptor self-efficacy, and positively changing their attitude toward student nurses. The investigators used an anonymous survey technique to collect data from RNs who had successfully completed the preceptor program over a three-year period. Respondents completed the Preceptor Program Educational Outcomes (PPEO) scale. The overall scale had reliability (Cronbach's alpha = .95), as were each of the subscales: Change in Knowledge of Teaching and Learning (KTL) (a=.91), Change in Generic Preceptor Skills (GPS) (a=.91), and Change in Preceptor Self-efficacy (PSE) (a=.88), and for the Change in Preceptor Attitude Toward Student Nurses (PATSN) subscale it was not applicable. Independent group *t* test and one-way between group analysis of variance with post hoc comparisons showed no significant differences in any of the PPEO subscale scores based on the demographic variables, including age group, initial nursing qualification, experience, language background, previous postgraduate study, or reason for enrollment in the preceptor program. Multiple regression analysis, using backward regression analysis, explored the potential relationships between

various outcome measures and identified independent variables, including PPEO subscales and preceptor demographic features. The ratio of cases to independent variables for the respective data sets were low, but still within acceptable levels. The study data suggested that most of the RNs participating in the preceptor program believed that the program had achieved its proposed learning outcomes. The PPEO KTL subscale had a mean of 3.1 and a lower quartile of 3.0, demonstrating that more than three-fourths of the respondents perceived that their knowledge of teaching and learning processes had increased as a result of the preceptor program. The PPEO GPS subscale had a mean of 3.1, indicating that most who completed the preceptor course believed that their knowledge and understanding of generic preceptor skills had increased. Further, because only 8.5% of participants indicated that the preceptor course did not increase or influence the way they perceived themselves and their abilities as a preceptor (self-efficacy), the data strongly suggested that the preceptor program had fulfilled another of its objectives. Finally, a mean of 3.1 for the PPEO PATSN subscale indicated that most of the RNs in the preceptor program perceived that they had undergone a positive change in this area. The data also indicated that, to a large extent, PPEO subscales were independent of background variables of the RN preceptor, and thus, related to the actual preceptor program experience.

Sandau, Cheng, Pan, Gaillard, and Hammer (2011), examined the hospital-wide effects of a mandatory eight-hour preceptor workshop on preceptors and orientees on self-reported confidence and comfort (pre- to post-workshop). To establish construct validity, survey items related to the workshop curriculum and were based on theories of adult learning and the framework for novice to expert. Content validity was established by a panel of three experts: the hospital orientation specialist at the study site, a master's prepared clinical nurse specialist involved in critical care education, and a doctorally-prepared clinical nurse specialist. For the

orientee survey, the correlation coefficient for the seven Likert-type scale items (Cronbach's alpha) was .95. For the five Likert-type scale items on the preceptor baseline survey, Cronbach's alpha was .82. Paired *t*-tests revealed that preceptors (n=131) reported significantly improved results for mean confidence and comfort scores. One-year post intervention, significantly more orientees were retained (95%) than in the previous year (87%) (chi-square, p<.05).

Figueroa, Bulos, Forges, and Judkins-Cohn (2013) evaluated a study that explored first-year turnover rates of new graduate RNs and new graduate RNs' and preceptors' perceptions of the Married State Preceptorship Model (MSPM). The investigators used a combined qualitative and quantitative approach to collect survey and focus group data. First-year turnover rates were evaluated for two years before (Cohorts 1 and 2) and one year after (Cohort 10) the MSPM implementation. Overall, 91% (n=91) of the preceptors perceived the MSPM to be beneficial to new graduate RNs and 90% (n=90) recommended its use in the orientation process. The preceptors reported that the MSPM influenced the retention of new graduate RNs (86%, n=86), and increased the confidence of new graduate RNs (89%, (n=89). The Cohort 10 turnover rate of 2.6% was a significant decrease from Cohort 1 (12.0%; x^2=7.47; p<.05) and Cohort 2 (25.7%; x^2=19.84; p<.05).

Hu et al. (2015) conducted a repeated-measures design to evaluate the effects of a 10-minute preceptor (10MP) model for assisting new graduate nurses (NGNs) in their professional development and increasing their retention in hospitals. Based on a self-administered questionnaire, the preceptorship program showed significant differences between groups (p=0.001) for work stress at months 2 and 3 and work experience at months 1, 2, and 3. The 10MP group reported lower turnover intention and higher satisfaction with the preceptors than the traditional preceptor model (TPM) group.

Preceptor Best Practice

According to Haggerty, Holloway, & Wilson (2012), content identified as integral to the education of preceptors is knowledge of adult learning, the development of expertise through the concept of novice to expert, precepting phases, facilitation of critical thinking, evaluating performance, conflict resolution, communication skills, and giving feedback. According to the Association of PeriOperative Registered Nurses (AORN, n.d., p.37), nurses selected to serve as preceptors should have the following characteristics and competencies: (a) knowledge and ability to apply adult learning principles; (b) the ability to articulate perioperative nursing practice; (c) knowledge of AORN's standards, recommended practices, and guidelines; (d) demonstrated application of the nursing process and critical pathways; and (e) a willingness to work one-on-one with an orientee. Other ideal preceptor attributes include a positive attitude, patience, and supportiveness, the desire to motivate and inspire, and a passion for the professional role.

Synthesis

It is imperative for the preceptorship and orientation process of the perioperative area to be designed to recruit high quality RNs, improve the nurse retention rate, ensure patient safety practices, and support the perioperative area with a positive learning environment (Wilson, 2012). This can be accomplished by reviewing the literature and developing an evidence-based program. In this literature review, the investigators who evaluated preceptorship programs measured multiple outcomes. These include turnover rate, cost, job satisfaction, orientee or students' satisfaction with preceptor, preceptors' feelings of preparedness, and clinical competence in students or orientees. Almada et al. (2004); Figueroa et al. (2013); Fox (2010); Hu et al. (2015); Lee et al. (2009); Romp & Kiehl (2009); and Sandau et al. (2011) demonstrated a decrease in turnover rate. Lee et al. (2009) and Romp & Kiehl (2009) reported a decrease in

cost. Almada et al. (2004) and Fox (2010) reported an increase in overall nurse satisfaction. Hu et al. (2015); Lee et al. (2009); Romp & Kiehl (2009) reported an increase in satisfaction with preceptors. Hallin & Danielson (2009) and Smedley, Morey, & Race (2010) reported an increase in the preceptors' feelings of preparedness. Each of the studies provide evidence for the proposed perioperative preceptorship program. The outcomes most relevant to the current proposal include preceptor performance, nurse satisfaction, and orientees' intent to stay.

Agency Description

Setting

The DNP project was implemented at Baptist Health Lexington (BHL), a non-profit, three-time Magnet-designated community hospital located in Lexington, Kentucky. BHL, a 391-bed tertiary care facility, is also a major medical research and education center. Established in May 1954, BHL continues to receive formal recognition for the delivery of excellence in cardiovascular and oncology care. The hospital's Clinical Research Center conducts groundbreaking medical research in both fields. The organization continues to lead in maternity care, having delivered nearly 150,000 babies since opening of the facility. The hospital manages and operates six outlying outpatient centers including locations in Georgetown, Nicholasville, and Richmond, Kentucky. Specialized comprehensive patient services include, but are not limited to: cardiovascular services, oncology care, women's health, neuroscience (stroke care), emergency care, CyberKnife treatment, genetic counseling, orthopedics, home care, weight-loss surgery, rehabilitation services, sleep disorders center, and occupational health (Baptist Health Lexington [BHL], 2017). BHL has been providing care to the local community for over 60 years. It is one of the few hospitals in the nation to be designated a Magnet facility based on

nursing excellence and exemplary patient outcomes by the American Nurses Credentialing Center (BHL, 2017).

The DNP project was implemented in the perioperative area of BHL. The perioperative area has 20 OR suites, one of which is an endovascular suite. Surgeons in seven service lines perform a wide variety of surgical procedures including open-heart, vascular, neurosurgery, orthopaedics, general/bariatric, gynecological, and urologic/ENT/plastics/oral surgeries. The perioperative area also has two Robotic Surgical Systems, which are utilized in heart, general, gynecological, urologic, and bariatric robotic procedures. In 2015, BHL OR performed 9,679 surgeries. Of these, 5,233 were inpatient and 4,446 were outpatient.

The need for a Perioperative Preceptor Workshop was identified by the perioperative unit director and educator, as well as other hospital educators and personnel (K. Blair, personal communication, March, 2017) to address high attrition and nurse satisfaction. Administration and clinical nursing staff were seeking a solution to address the preceptorship education gap specific to the perioperative area and were ready and willing to adopt a modified program. A dedicated, evidence-based preceptor workshop was identified as a need in the perioperative area because it is a highly-specialized area. While the hospital currently has a preceptor workshop offered to all hospital employees, this professional development activity has historically been geared toward nurses working on a multi-bed inpatient care unit, and did not address specialized procedural departments such as the perioperative area. New employee orientation is a very costly undertaking for the hospital. In the perioperative area, when using the 6- to 12-month timeframe of providing orientation, as outlined in the AORN orientation calculator, the cost of orienting a new perioperative nurse can exceed $100,000 (Zinn, Guglielmi, Davis, & Moses, 2012). If an employee becomes dissatisfied and terminates employment during or after the

orientation process, the result is an increased financial burden to the agency and potential staffing and patient safety issues.

Target Population

Preceptors (*N*=5) meeting the following inclusion criteria were selected to attend the BHL Preceptor Journey Workshop Update with the evidence-based perioperative component: 1) minimum of one year experience in the perioperative area, and 2) documented attendance to an initial BHL Preceptor Journey Workshop within the last two to three years. BHL perioperative orientees were perioperative RNs hired within the last 6 months.

Congruence of Capstone Project to Selected Organization's Missions, Goals, and Strategic Plan

The mission of Baptist Health (2016, p. 10) is to "demonstrate the love of Christ by providing and coordinating care and improving health in our communities". This project was based on the goal and mission of providing quality healthcare services via staff development in the perioperative area; therefore, ensuring the provision of optimal patient care

Stakeholders

The perioperative preceptor intervention was implemented through collaboration and support of many within the organization. Stakeholders included the BHL Human Resources Department, Chief Operating Officer/Chief Nursing Officer (COO/CNO), Surgical Services Director, Director of Education, Surgical Services Assistant Director, Surgical Services Nurse Manager, Surgical Services Educator, and the Professional Development Specialist who leads the hospital-wide preceptor program.

Statement of Mutual Agreement with Agency

See Appendix A

Project Design

A quasi experiment, pre-test/post-test design was used to evaluate primary outcomes of this project. Descriptive and inferential statistics were calculated to evaluate and compare preceptor performance and proficiency, as assessed by the preceptor, pre- and post-intervention. Descriptive and inferential statistics were used to evaluate preceptor performance and proficiency, nurse satisfaction, and intent to stay by the orientee post-intervention. Data were entered into the Statistical Package for Social Sciences (SPSS v. 24) and analyzed by the project leader (primary investigator).

Project Methods

Description of Evidence-based Intervention

The perioperative preceptor intervention included five major components: preceptor selection, agency preceptor workshop with perioperative components, perioperative preceptor booster session, selected preceptors actively precepting orientees, and evaluation of preceptor performance and proficiency (via preceptor and orientee), orientee satisfaction, and orientee intent to stay. Perioperative components during the agency preceptor workshop included OR Orientation Progression Examples (Appendix B) and OR Teaching Scenarios (Appendix C). The booster session was a thirty-minute OR Lunch & Learn session which included a preceptor study guide (Appendix D). After participants attended the preceptor workshop, the preceptor participants were placed with the orientees as much as possible during their orientation. Evaluation of preceptors took place pre- and post-intervention, and evaluation of orientees took place post-intervention only.

Measures and Instruments

Preceptor performance and proficiency. The Baptist Health Lexington Preceptor Performance and Proficiency Assessment (BHLPPPA; Bradley et al., 2015, Appendix E) was developed previously by the agency to assess preceptor performance and proficiency. The BHLPPPA is individualized to reflect the roles of respondents (preceptor and new nurse versions). Each version of the BHLPPPA contains 28 items: 1) 12 items related to preceptor performance (Subscale 1); and 2) 16 item related to preceptor proficiency (Subscale 2). Using a 4-point Likert scale (4 = strongly agree;1 = strongly disagree) respondents rate each item. A mean score is obtained for each subscale. Content validity was established with an average item-level content validity index (I-CVI) = 0 .99. Strong test-retest (r = 0.79-0.99) and internal consistency correlations (Cronbach's alpha = 0.90-0.97) were found for both subscales for preceptor and new nurse versions (Bradley, et al, 2015). Permission was granted by the author to use this instrument (Appendix F). Reliability of the BHLPPPA for the proposed sample of preceptors and orientees was determined using Cronbach's alpha. The respondent burden for the BHLPPA is approximately 5 minutes. This instrument was the outcome of a previous study conducted by BHL, and has been used to evaluate the preceptor workshop at BHL in the past.

Nurse satisfaction. The McCloskey/Mueller Job Satisfaction Survey (MMSS; McCloskey, 1974; McCloskey & McCain, 1987; Mueller, and McCloskey, 1990, Appendix G) was used to measure participants' (RN orientees') job satisfaction. The MMSS is a 31-item survey with a 5-point Likert scale (1 = very dissatisfied; 5 = very satisfied). Higher scores indicate higher levels of satisfaction. The survey captures eight types of satisfaction including: 1) satisfaction with extrinsic rewards; 2) scheduling; 3) family/work balance; 4) co-workers; 5) interaction; 6) professional opportunities; 7) praise/recognition; and 8) control/responsibility.

Cronbach's alpha for the global scale internal consistency was 0.89 (McCloskey, 1974; McCloskey & McCain, 1987; Mueller, and McCloskey, 1990). Permission to use the scale was granted by the University of Iowa (Appendix H). Reliability of the MMSS for the proposed sample of orientees was determined using Cronbach's alpha. Respondent burden for this instrument is approximately 5 minutes.

Intent to stay. The Intent to Stay/Leave Job Diagnostic Survey (Appendix I) (Grindel & Hagerstrom, 2009; Hackman & Oldham, 1980) was used to measure orientees' intent to stay. The survey is comprised of 15-items with a 7-point Likert scale (1 = strongly disagree; 7 = strongly agree). This survey evaluates personal feelings about the job, therefore, intent to leave/stay with the organization by measuring three components: 1) meaningfulness of the work; 2) responsibility for the work; and 3) knowledge of the results. Cronbach's alpha for internal consistency is 0.77 (Grindel & Hagerstrom, 2009; Hackman & Oldham, 1980). Reliability of the Intent to Stay/Leave Job Diagnostic Survey for the proposed sample of orientees was determined using Cronbach's alpha. The respondent burden for this instrument is approximately 5 minutes.

Implementation Plan (March – November 2017)

Collaboration with BHL Surgical Services Director and BHL Education Department (March).

The topic of perioperative preceptorship education for an evidence-based project was initially suggested by the BHL Surgical Services Director. An exhaustive literature review was done by the project leader it was found to be an appropriate intervention for the desired outcomes of improving preceptor performance & proficiency, increasing perioperative RN satisfaction, and intent to stay. Multiple meetings and collaboration ensued with the BHL Education Department to determine how to best meet the needs of perioperative preceptor education. The education department had been in the process of modifying the agency-wide

preceptor workshop based on recent research, and suggested the project leader develop specific perioperative content to be utilized with perioperative RNs during the interactive portion of the agency-wide workshop.

Institutional Review Board Approval (May). BHL served as the IRB of record. Permission to conduct the intervention was obtained from BHL CNO/COO and BHL Surgical Services Director. IRB approval was granted under expedited review by BHL, on May 30th, 2017 with an authorization agreement from the Eastern Kentucky University Office of Sponsored Programs (Appendix J). An IRB amendment was also submitted to the BHL IRB and permission granted on July 20th (Appendix K).

Recruited RN participants (preceptors in May/orientees in September). Preceptors meeting the inclusion criteria were selected to attend the BHL Preceptor Update workshop with the perioperative component. This led to only 5 qualified participants. For these RNs participation was mandatory; however, data collection was voluntary. Perioperative RN orientees were a convenience sample of perioperative RNs hired within the last 6 months. During their orientation process, orientees worked day shift, 5 days per week, 8 hour days.

Collected preceptor pre-intervention data & implemented intervention (May 30th and July 5th). The intervention included attendance to the agency preceptor update workshop with the perioperative component. Prior to the start of the workshop, the project leader distributed to the perioperative RN participants the BHLPPPA as a pre-intervention assessment. The top document of the survey was a cover letter which reinforced that completion of the survey was voluntary. Participant confidentiality was maintained through coding; each participant was asked to code their pre-test with a four-digit code using their mother's birthday (2 digits for the month and 2 digits for the day). The pre-intervention survey required less than five

minutes to complete. RNs placed the survey in an envelope marked "pre-test" to help preserve confidentiality. Once each had completed the survey, the intervention (mandatory education workshop) was implemented. This included powerpoint content presented by the preceptor workshop facilitator and the DNP Project Leader. The powerpoint was part of the original BHL preceptor workshop curriculum and is not part of the project per se. The second half of the class incorporated content created by the Project Leader specifically for the education of the perioperative RNs. This educational content included OR Teaching Scenarios and OR Orientation Progression Examples. The entire workshop took approximately four hours.

Provided booster session supported by literature (Sept 19th). Approximately 2.5 to 3.5 months after attending the preceptor workshop, each selected perioperative preceptor (participant) also attended a 30-minute “OR Lunch and Learn” session conducted by the Project Leader. During this session, a preceptor study guide composed by the Project Leader, based on the preceptor class content, was reviewed and discussed with the perioperative preceptors. The literature supported booster session was implemented for a solid content review between the time the perioperative preceptors attended the workshop and were assigned an orientee.

A study by Bry and Krinsley (1992) reported positive booster session effects. Four systematic single case replications supported the idea that booster sessions promoted temporal generalization of behavioral family therapy effects. Adolescent substance abuse decreased and academic performance increased during 8 – 18 months of follow-up when there were booster sessions following treatment; whereas, substance abuse increased and academic performance decreased when there was no booster session. These booster session effects on adolescent substance use and academic performance parallel some effects found in related problem areas, where booster sessions were also assumed to promote resistance to extinction of knowledge

(Whisman, 1990). Guerney, Vogelsong, and Coufal (1983) and MacDonald and Budd (1983) increased temporal generalization of parent training programs through booster sessions. Lando (1982) found that booster sessions improved generalization across time of a smoking cessation program. Kingsley and Wilson (1977) and Perri et al. (1986) improved generalization over time with booster sessions following weight reduction programs.

Collected preceptor's post-intervention data using BHL Preceptor Performance and Proficiency Assessment (Oct 18th). Following the perioperative preceptor education, OR management and the OR educator assigned the orientees to be with the selected participants (preceptors) during their orientation, as much as the OR schedule would allow. Collection of preceptor post-intervention data utilizing the BHLPPPA was conducted in October giving the participants time to utilize the knowledge from the educational sessions with their orientees. Confidentiality was maintained through the use of coding; each participant was asked to code their pre-test with a four-digit code of their mother's birthday (2 digits for the month and 2 digits for the day). A cover letter was included with the surveys to ensure participation was voluntarily and each could contact the Project Leader with any questions. Cover letter and surveys were placed in an envelope and taped to the preceptors' Surgical Services locker. Once they completed the surveys, the participants were instructed to return the surveys to an appropriate marked, confidential, secure box at the OR front desk.

Collected orientee data using multiple surveys (Nov. 6th). Collection of orientee data utilizing the BHLPPPA, the MMSS, and the Intent to Stay Job Diagnostic Survey was conducted in November, after at least seven weeks of orientation, to allow the orientees adequate exposure to the preceptors and the perioperative area practice environment. Again, a cover letter was included with the surveys to reinforce volunteer participation and provide contact information for

the Project Leader. Cover letters and surveys were placed in an envelope and taped to the orientees' Surgical Services locker. Once each completed the surveys, participants were instructed to return the surveys to an appropriate marked, confidential, secure box at the OR front desk.

Results

All data was analyzed using IBM SPSS version 24. Demographic data were used to describe the preceptor and orientee samples. Participants included five preceptors and five orientees. Participant preceptor RN experience ranged from 4 - 40 years and RN experience at BHL ranged from 2 - 9 years. Participant orientee age ranged from 24 - 34 years, orientation length, which is often based on experience and performance, ranged from 8 - 24 weeks, and number of preceptors worked with ranged from 5 - 10.

A paired-samples t-test was conducted to evaluate the impact of the perioperative preceptor intervention on preceptors' performance and proficiency, as assessed by the preceptors. There was not a significant difference in mean scores for preceptor performance from pre-intervention (M=36.80, SD=5.119) to post-intervention (M=39.00, SD=3.674), t (4) = -.732, p *(.505)* >.05. The mean increase in scores was 2.20 with a 95% confidence interval ranging from -10.55 to 6.15. The eta squared (.12) indicated a moderate effect size.

Table 2

Paired t-test Comparing Preceptor Performance Pre- and Post-Intervention

Performance	***M (SD)***	***t***	***df***	***p***	**Eta squared**
Pre-intervention	36.80 (5.1)	-.732	4	.505	.12
Post-intervention	39.00 (3.7)				

There was not a significant difference in scores for preceptor proficiency from pre-intervention (*M*=56.00, *SD*=8.000) to post-intervention (*M*=55.60, *SD*=8.173), *t* (4) = .535, *p (.621)* >.05. The mean decrease in scores was .40 with a 95% confidence interval ranging from -1.68 to 2.45. The eta squared (.07) indicated moderate effect size.

Table 3

Paired t-test Comparing Preceptor Proficiency Pre- and Post-Intervention

Proficiency	***M (SD)***	***t***	***df***	***p***	**Eta squared**
Pre-intervention	56.00 (8.0)	.535	4	.621	.07
Post-intervention	55.60 (8.2)				

The eta squared indicates clinical significance (.01=small, .06=moderate, .14=large effect size)

Descriptive statistics were ran for orientee data since it was collected post-intervention only. Based on mean scores derived from the BHLPPPA, 100% (n= 5) of the orientee participants agreed that during their orientation their preceptors' performance met appropriate standards. Also 80% (n=4) agreed, while 20% (n=1) disagreed that during their orientation, their preceptor ensured they were proficient. According to frequencies ran on orientee data from the BHLPPPA performance subscale, 100% (n=5) of orientees agreed that during their orientation the preceptor helped them to develop confidence in their nursing role, assessed their learning needs, built on their previous learning experiences, provided meaningful feedback, and assisted them to feel comfortable with the unit. According to the BHLPPPA proficiency subscale, 100% (n=5) of orientees agreed that during their orientation their preceptor ensured that they were proficient in required skills, documentation, communicating with patients, setting priorities relative to patient care, and transitioning to independent practice.

Based on mean scores derived from the MMSS, 40% (n=2) of orientee participants reported they were overall moderately satisfied with their job, while another 40% (n=2) were neither satisfied or dissatisfied, and 20% (n=1) were moderately dissatisfied. According to frequencies ran on orientee data from the MMSS, 80% (n=4) were satisfied with their nursing peers, while 20% (n=1) were neither satisfied or dissatisfied; 20% (n=1) were very satisfied with their immediate supervisor, 60% (n=3) were moderately satisfied, and 20% (n=1) were neither satisfied nor dissatisfied; 20% (n=1) were moderately satisfied with the amount of encouragement and positive feedback, 60% (n=3) neither satisfied nor dissatisfied, and 20% (n=1) moderately dissatisfied.

Mean scores derived from the Intent to Stay Job Diagnostic Survey revealed 80% (n=4) of orientee participants "slightly agreed" in their answers to stay in the job, while 20% (n=1) were neutral. According to frequencies ran on orientee data from the Intent to Stay survey, 20% (n=1) reported strong agreement that they were generally very satisfied with their job, whereas, 60% (n=3) agreed, and 20% (n=1) agreed slightly.

Discussion

The project demonstrated clinical significance and a positive impact on the nurse practice environment. After conducting inferential statistics on the pre-and post-intervention data submitted by the preceptors, the preceptor workshop demonstrated a positive effect on preceptor performance, but not for preceptor proficiency. While these results are not statistically significant, in part due to the small sample size, outcome data demonstrate moderate clinical significance, and therefore, have value for the perioperative clinical area.

Since the orientee participants were recently hired into their position at Baptist within the last 6 months, pre-intervention data was not collected from them, as they would have no

experience to draw from to answer the survey questions. Based on mean scores and frequencies derived from the BHLPPPA, one can infer that the orientee participants were very satisfied with their preceptors' performance during their orientation and most felt that their preceptors ensured that they were proficient as a perioperative RN during their orientation. From the mean scores and frequencies of the MMSS, evidence supports majority of orientee participants are not dissatisfied regarding their current perioperative RN job. Based on mean scores and frequencies obtained from the Intent to Stay Job Diagnostic Survey, it can be ascertained that the majority of orientee participants intend to stay in their current job as a perioperative RN. These results shine a favorable reflection on perioperative preceptor performance and proficiency in response to the intervention, as well as orientee satisfaction and intent to stay.

Limitations to this project include a very small sample size. As of August 10th, 2017, there were 31 RNs in the perioperative department, including night shift and weekends, and only five met the criteria to participate as a preceptor in this project. Also, during the time frame of this project, there were only five perioperative RN orientees in the department. While these limitations occurred, it was still important to conduct and evaluate this intervention because it would be very difficult to acquire a larger and adequate sample size to demonstrate statistical significance using inferential statistics. The time it would take to do this would be quite considerable, and out of the timeframe of a project such as this. Another limitation is that all survey data collected were collected via self-report instruments, so one must rely on participants to be objective and truthful in their responses. It is also a limitation that the orientee participant data were collected post intervention only. This occurred because the orientees were just recently hired to this position and had not worked at the agency long enough to give adequate

pre-intervention data. Given the scope of this project, there was not time to perform a 6-month reassessment of orientees.

Implications

This project opens the door for further future project expansion. Findings identified moderate clinical significance; therefore, future IRB-approved studies comprised of a larger sample size and a more extensive educational intervention are warranted. Additionally, longitudinal data should be collected with the orientees who participated in this project, to evaluate job satisfaction and retention rates at six months and one year post initial orientation.

Conclusion

Project findings were consistent with those found in the literature. The preceptor RN participants reported increased feelings of being prepared, based on their responses to preceptor performance. Perioperative RN orientees reported being overall satisfied with their job and preceptor performance & proficiency, as well as, an intent to stay. Based on discussion with the BHL Surgical Services Director, there was a strong need for this program in the perioperative department. The Education Department also agreed there was a strong need for preceptor education, especially with components for specialized areas. BHL has an established agency preceptor workshop, and this perioperative component was a needed addition. To sustain and advance this project, the education department will continue the agency preceptor workshop, as normal, and the OR educator will continue to facilitate the perioperative components when there are perioperative attendees. While the results of this project did not demonstrate statistical significance, outcome data are of value to the agency because of the demonstration of clinical significance. Clear identification of preceptors, clarity in roles for preceptors and orientees, and

demonstrable cost reduction established workable processes that are sustainable for long-term implementation and evaluation.

References

Alligood, M. R., & Tomey, A. M. (2006). *Nursing theorists and their work* (6th ed.). St. Louis, MO: Elsevier Mosby.

Almada, P., Carafoli, K., Flattery, J., French, D., and McNamara, M. (2004). Improving the retention rate of newly graduated nurses. *Journal for Nurses in Staff Development, 20*(6), 268-273.

Ashurst, A. (2008). Career Development: The preceptorship process. *Nursing & Residential Care*, *10*(6), 307-309.

Association of periOperative Registered Nurses. (n.d.). Perioperative orientation resources: Your guide to orientation, recruitment, and retention. Retrieved November 15, 2016, from http://www.aorn.org/education/facility-solutions/periop-101/perioperative-orientation-resources

Ball, K., Doyle, D., & Oocumma, N. (2015). Nursing shortages in the OR: Solutions for new models of education. *Association of Operating Room Nurses Journal, 101*(1), 115-136. doi: 10.1016/j.aorn.2014.03.015

Baptist Health (2016). *Employee handbook: An introductory guide* (Rev ed.). [Electronic version]. Retrieved from Baptist Health Portal

Baptist Health Lexington. (2017). About Baptist Health Lexington. Retrieved from http://baptisthealth.com/lexington/pages/default.aspx

Barker, E., & Pittman, O. (2010). Becoming a super preceptor: A practical guide to preceptorship in today's clinical climate. *Journal of the American Academy of Nurse Practitioners, 22,* 144-149. doi: 10.1111/j.1745-7599.2009.00487.x

Benner, P. (1982). From novice to expert. *The American Journal of Nursing*, *82*(3), 402-407. Retrieved from http://www.jstor.org/stable/3462928

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley.

Benner, P., Tanner, C., & Chesla, C. (1992). From beginner to expert: Gaining a differentiated clinical world in critical care nursing. *Advances in Nursing Science*, *14*(3), 13-28.

Benner, P., Tanner, C., & Chesla, C. (1996). *Expertise in nursing practice: Caring, clinical judgment, and ethics*. New York: Springer.

Boyer, S. A. (2008). Competence and innovation in preceptor development: Updating our programs. *Journal for Nurses in Staff Development*, *24*(2), E1-E6.

Bradley, H., Cantrell, D., Dollahan, K., Hall, B., Lewis, P., Merritt, S., Mills, L., Moe, K., & White, D. (2015). Evaluating preceptors: A methodological study. *Journal for Nurses in Professional Development*, *31*(3), 164-169. doi: 10.1097/NND.0000000000000166

Bry, B. H., & Krinsley, K. E. (1992). Booster sessions and long-term effects of behavioral family therapy on adolescent substance use and school performance. *Journal of Behavioral, Therapeutic, & Experimental Psychiatry*, *23*(3), 183-189.

Butler, M. R., & Felts, J. (2006). Tool kit for the staff mentor: Strategies for improving retention. *The Journal of Continuing Education in Nursing*, *37*(5), 210-213.

Carlson, E. (2012). Precepting and symbolic interactionism - a theoretical look at preceptorship during clinical practice. *Journal of Advanced Nursing*, *69*(2), 457-464. doi:10.1111/j.1365-2648.2012.06047.x

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

Dilbert, C., & Dolly, G. (1995). Preceptor's perceptions of benefits, rewards, supports, and commitment to the preceptor role. *Journal of Advanced Nursing, 21*, 1144-1151.

Figueroa, S., Bulos, M., Forges, E., and Judkins-Cohn, T. (2013). Stabilizing and retaining a quality nursing work force through the use of the married state preceptorship model. *The Journal of Continuing Education in Nursing, 44*(8), 365-373. doi: 10.3928/00220124-20130603-08

Firtko, A., Stewart, R., & Knox, N. (2005). Understanding mentoring and preceptorship: Clarifying the quagmire. *Contemporary Nurse*, *19*(1), 32-40.

Ford, K., Fitzgerald, M., & Courtney-Pratt, H. (2013). The development and evaluation of a preceptorship program using a practice development approach. *Australian Journal of Advanced Nursing, 30*(3), 5-13.

Forneris, S. G., & Peden-McAlpine, C. (2009). Creating context for critical thinking in practice: The role of the preceptor. *Journal of Advanced Nursing, 65*(8), 1715-1724. doi: 10.1111/j.1365-2648.2009.05031.x

Fox, K. (2010). Mentor program boosts new nurses' satisfaction and lowers turnover rate. *The Journal of Continuing Education in Nursing, 41*(7), 311-316. doi: 10.3928/00220124-20100401-04

Grindel, C. G., & Hagerstrom, G. (2009). Nurses nurturing nurses: Outcomes and lessons learned. *MEDSURG Nursing, 18*(3), 183-194.

Guerney, B. G., Jr., Vogelsong, E., & Coufal, J. (1983). Relationship enhancement versus a traditional treatment: Follow-up and booster effects. *Family studies review yearbook,* Sage, Beverly Hills, 738-756.

Hackman, J. R., & Oldham, G. R. (1980). *Work redesign.* Reading, MA: Addison-Wesley.

Haggerty, C., Holloway, K., & Wilson, D. (2012). Entry to nursing practice preceptor education and support: Could we do it better? *Nursing Praxis in New Zealand, 28*(1), 30-39.

Haggerty, C., Holloway, K., & Wilson, D. (2013). How to grow our own: An evaluation of preceptorship in New Zealand graduate nurse programmes. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 43*(2), 162-171.

Hallin, K. & Danielson, E. (2009). Being a personal preceptor for nursing students: Registered Nurses' experiences before and after introduction of a preceptor model. *Journal of Advanced Nursing, 65*(1), 161-174. doi: 10.1111/j.1365-2648.2008.04855.x

Health Resources and Services Administration. Bureau of Health Professions (2008). *The Registered Nurse Population. Findings from the 2004 National Sample Survey of Registered Nurses*. U.S. Department of Health and Human Services, Rockville, MD. http://bhpr.hrsa.gov/healthwork force/reports/nursing/samplesurvey00.

Hu, Y., Chen, S., Chen, I., Shen, H., Lin, Y., and Chang, W. (2015). Evaluation of work stress, turnover intention, work experience, and satisfaction with preceptors of new graduate nurses using a 10-minute preceptor model. *The Journal of Continuing Education in Nursing, 46*(6), 261-271. doi: 10.3929/00220124-20150518-02

Jones, C. B. (2005). The cost of nursing turnover, part 2: Application of the nursing turnover cost calculation methodology. *Journal of Nursing Administration, 35*(1), 41-49.

Kernan, W., Holmboe, E., & O'Connor, P. (2004). Assessing the teaching behaviors of ambulatory care preceptors. *Academic Medicine, 79*, 1088-1094.

Kingsley, R. G., & Wilson, G. T. (1977). Behavior therapy for obesity: A comparative investigation of long-term efficacy. *Journal of Consulting and Clinical Psychology, 45*, 288-298.

Lando. H. A. (1982). A factor analysis of preparation, aversion, and maintenance in the elimination of smoking. *Addictive Behaviors, 7,* 143-154.

Lee, T., Tzeng, W., Lin, C., & Yeh, M. (2009). Effects of a preceptorship programme on turnover rate, cost, quality and professional development. *Journal of Clinical Nursing, 18,* 1217-1225. doi: 10.1111/j.1365-2702.2008.02662.x

MacDonald, M. R., & Budd, K. S. (1983). "Booster shots" following didactic parent training: Effects of follow-up using graphic feedback and instructions. *Behavior Modification, 7,* 211-223.

McCloskey, J. (1974). Influences of rewards and incentives on staff nurse turnover rate. *Nursing Research, 23,* 239-247.

McCloskey, J. C., & McCain, B. E. (1987). Satisfaction, commitment and professionalism of newly employed nurses. *Image: Journal of Nursing Schloarship, 19*(1), 20-24.

Mueller, C. W., & McCloskey, J. C. (1990). Nurses' job satisfaction: A proposed measure. *Nursing Research, 39*(2), 113-117.

O'Brien-Pallas, L., Griffin, P., Shanuan, J., Bushan, J., Duffield, C., Hughes, F., et al. (2006). The impact of nurse turnover on patient, nurse and system outcomes: A pilot study and focus for a multicenter international study. *Policy, Politics, & Nursing Practice, 7*(3), 169-179.

Omansky, G. L. (2010). Staff nurses' experiences as preceptors and mentors: An integrative review. *Journal of Nursing Management*, *18*(6), 697-703. doi: 10.1111/j.1365-2834.2010.01145.x

Pellico, L., Djukic, M., Kovner C., & Brewer C. (2009, November 2). Moving on, up, or out: Changing work needs of new RNs at different stages of their beginning nursing practice.

[American Nurses Association]. *The Online Journal of Issues in Nursing, 15*(1). doi: 10.3912/OJIN.Vol15No01PPT02

Perri, M. G., McAdoo, W. G., McAllister, D. A., Lauer, J. B., & Yancey, D. Z. (1986). Enhancing the efficacy of behavior therapy for obesity: Effects of aerobic exercise and a multicomponent maintenance program. *Journal of Consulting and Clinical Psychology, 54*, 670-675.

Persaud, D. (2008). Mentoring the new graduate perioperative nurse: A valuable retention strategy. *Association of Operating Room Nurses, 87*(6), 1173-1179. doi:10.1016/j.aorn.2007.10.014

Romp, C. R., & Kiehl, E. (2009). Applying the Stetler Model of Research Utilization in Staff Development: Revitalizing a preceptor program. *Journal for Nurses in Staff Development, 25*(6), 278-284.

Sandau, K., Cheng, L., Pan, Z., Gaillard, P., and Hammer, L. (2011). Effect of a preceptor education workshop: Part 1. Quantitative results of a hospital-wide study. *The Journal of Continuing Education in Nursing,42*(3), 117-126. doi: 10.3928/00220124-20101101-01

Santucci, J. (2004). Facilitating the transition into nursing practice: Concepts and strategies for mentoring new graduates. *Journal for Nurses in Staff Development, 20,* 274-284.

Smedley, A., Morey, P., & Rice, P. (2010). Enhancing the knowledge, attitudes, and skills of preceptors: An Australian perspective. *The Journal of Continuing Education in Nursing, 41*(10), 451-461.

Waldman, J. D., Kelly, F., Sanjeev, A., & Smith, H. L. (2004). The shocking cost of turnover in health care. *Health Care Management Review, 29*(1), 27.

Whisman, M. A. (1990). The efficacy of booster maintenance sessions in behavior therapy: Review and methodological critique. *Clinical Psychology Review, 10,* 155-170.

Wilson, G. (2012). Redesigning OR orientation. *Association of Operating Room Nurses Journal*, *95*(4), 453-462.

Zilembo, M., & Monterosso, L. (2008). Nursing students' perceptions of desirable leadership qualities in nurse preceptors: A descriptive survey. *Contemporary Nurse*, *27*(2), 194-206. doi: 10.5172/conu.2008.27.2.194

Zinn, J., Guglielmi, C., Davis, P., & Moses, C. (2012). Addressing the nursing shortage: The need for nursing residency programs. *Association of Operating Room Nurses Journal*, *96*(6), 652-657. doi:10.1016/j.aorn.2012.09.011

Appendix A

Eastern Kentucky University
Department of Baccalaureate and Graduate Nursing
Doctor of Nursing Practice Program

Statement of Mutual Agreement for DNP Project

The purpose of a Statement of Mutual Agreement is to describe the agreement between a designated clinical agency and the DNP student regarding the student's DNP project.

I. General Information

Student Name:	Kimberly N. Crawford, MSN, RN, CNOR
Project Title:	Perioperative Preceptor Education Embedded in a Hospital-Wide Preceptor Program
Agency:	Baptist Health Lexington
Agency Contact:	Kathleen Blair, MSN, RN, CNOR, NE-C, Director of Surgical Services

II. Brief description of the project

- Evidence-based intervention
- Expected project outcomes (products, documents, etc.)
- On-site Activities (DNP student role, required meetings, access to agency records, non-disclosure expectations)
- Products resulting from the DNP project with potential market value.
  Any products produced from collaboration with the agency must be discussed with the student, DNP Project Advisor, and appropriate agency representative. The ownership of intellectual property rights must be determined prior to the implementation of the project.

The DNP student will implement perioperative preceptor education within the hospital-wide Preceptorship Program at Baptist Health Lexington, with the aim of improving perioperative preceptor performance, job satisfaction, and perioperative nurse intent to stay.

The Preceptorship class will be mandatory, but the completion of the survey(s) is voluntary. Each preceptor will receive approximately four hours of education based on a power point curriculum and group work.

As a participant in the Capstone Project, preceptors and his/her orientees will be asked to complete a survey(s) before and after completion of the program, one if they are a preceptor and three if they are an orientee. These surveys include the Preceptor Performance and Proficiency Assessment, McCloskey/Mueller Satisfaction Scale, and Intent to Stay/Leave Job Diagnostic Survey. The survey(s) will take approximately five minutes each to complete. Responses will be anonymous, but coded with a unique identifier only known to the participant and the DNP student. When data measurement is completed the DNP student will destroy the spreadsheet identifying the participant name with unique identifier. Study results will be reported only as aggregate (group) data with no identifying information. The aggregate results from the project will be shared in written and oral presentation about the project.

Eastern Kentucky University
Department of Baccalaureate and Graduate Nursing
Doctor of Nursing Practice Program

III. **Agreement of written and oral communication**

- Reference to clinical agency in student's academic work, publications, and presentations
- Restrictions on discussion of any project or agency details
- Formal agency approval needed for any publicly shared findings.

The DNP Student will be allowed to use the name of Baptist Health Lexington and hospital specific data in the student's academic work. The student will review any planned publication for accuracy with Baptist Health Lexington.

IV. **Required Signatures:**

Kimberly Crawford — 9/7/17
Student — Date

[signature] — 9/7/17
DNP Project Advisor — Date

[signature] — 9/7/2017
Agency Representative — Date

Appendix B

OR Orientation Progression Examples

Weeks 1 & 2
Sam's Orientation

- Sam is a perioperative circulating nurse in week 2 of orientation. At the beginning of a case Sam goes to place a bovie pad on her patient, but has not inquired if the patient has had any joint replacement surgeries in the past. Sam's preceptor lets her know the patient has had a right hip replacement and she should place the bovie pad on the opposite side for patient safety. During the case an instrument gets contaminated and needs to be flash sterilized. She knows there is a policy regarding flash sterilization, but does not know where to locate it.

- At the end of the day Sam is taking the Neptune to the decontamination room to be cleaned, when arriving there she realizes she does not know how to "dock" the Neptune or what cleaning cycle to run it on. Sam realizes she needs to ask her preceptor for information regarding this piece of equipment.

- At the start of a case Sam realizes she needs to get all the equipment hooked up in a timely manner, but is unsure of what to hook up first. Her preceptor guides her accordingly. During the case, the surgeon's pager goes off. Sam returns the page and looks at her preceptor uncertain of whether or not to relay the message to the surgeon at this specific time.

- During turnover between cases Sam does not delegate any tasks to her NA, as a result Sam's room turnover time is longer than normal. Once in pre-op and reviewing the patient chart, Sam is unfamiliar with a medication on the patient's allergy list. Sam wonders if BHL has a resource to look up this medication. While reviewing the chart Sam notices a hx of MH. Once in the OR and asleep the patient begins exhibiting signs & symptoms of an MH crisis, but Sam fails to notice these.

Weeks 3 & 4
Jason's Orientation

- Jason is a perioperative circulating nurse in week 4 of orientation. Jason is placing the bovie pad on a patient and knows that the patient has had a right hip replacement, so he places the bovie pad on the left side for patient safety. During the case an instrument gets contaminated and needs to be flash sterilized. Jason is not positive about the policy regarding flash sterilization, but is able to locate it on BEN.

- At the end of the day Jason is taking the Neptune to the decontamination room to be cleaned. Jason correctly docks the Neptune for cleaning, but is uncertain which cycle is appropriate for the end of the running the Neptune at the end of shift. Jason then discusses with his preceptor the cycles for this piece of equipment.

- At the beginning of a case Jason realizes he needs to get all of the equipment hooked up in a timely and efficient manner. Jason is nervous, and proceeds to plug in the surgeon's headlight first thing. The preceptor reminds Jason that while the headlight is important, it is more important to hook up the bovie first, followed by the suction, so the surgeon can begin the procedure. The preceptor tells Jason that it is okay to delegate these tasks to the nursing assistant as well, while he is further assisting with the start of the case. During the case the surgeon's pager goes off. Jason returns the page, and believes it is an okay time to relay the message to the surgeon, but requests assistance from his preceptor to make this determination. The preceptor explains it is not a critical time during the procedure, and therefore, it is okay to discuss the message with the surgeon.

- Realizing the importance of an efficient turnover between cases, Jason delegates appropriate tasks to his NA. Once in pre-op and reviewing the patient's chart, Jason is unfamiliar with a medication on the patient's allergy list. He remembers BHL offers Micromedex as a resource to look up medications, but does not know where it is located. Jason's preceptor assists him in using Micromedex to familiarize himself with the medication. While reviewing the chart Jason notices a family hx of MH, and identifies this as a potential risk for the patient. Jason knows he needs to take measures to help ensure patient safety and prevent harm. With his preceptor's assistance, he locates the MH cart and has it available outside the room, and plans out other appropriate interventions. Once in the OR with patient intubated and asleep, Jason notices the patient begins exhibiting signs & symptoms of an MH crisis and, with his preceptor's assistance, he intervenes appropriately and timely.

Weeks 5 & 6
Julia's Orientation

- Julia is a perioperative circulating nurse in week 6 of orientation. Julia is placing the bovie pad on a patient and knows that the patient has had a right hip replacement, so she places the bovie pad on the left side for patient safety. During the case an instrument gets contaminated and needs to be flash sterilized. Julia is aware of the correct way to use a flash pak and the appropriate cycle for the instrument. Julia also realizes that if she was uncertain about the policy, it can be easily found on BEN.

- At the end of the day Julia is taking the Neptune to the decontamination room to be cleaned. Julia knows exactly how to dock the Neptune and the difference between the various cycles it can be ran on. If a Neptune were to malfunction, Julia knows who to contact for maintenance and troubleshooting.

- At the start of a case Julia realizes she needs to get all the equipment hooked up in a timely manner. She can critically think and realize it is important to hook up the bovie first thing so the surgeon can cut and cauterize, then she knows she needs to hook up the suction, and the surgeon's headlight. She verbalizes that if she had a nursing assistant in her room she would have delegated to him/her the act of plugging it in. During the case the surgeon's pager goes off. Julia returns the page, and assesses that it is an okay time to relay the message to the surgeon because it is not a critical time during the procedure, and therefore, it is okay to discuss the message with the surgeon.

- Realizing the importance of an efficient turnover between cases, Julia delegates appropriate tasks to his NA. Once in pre-op and reviewing the patient's chart, Julia is unfamiliar with a medication on the patient's allergy list. She remembers BHL offers Micromedex as a resource to look up medications, and is able to successfully pull it up on the computer. While reviewing the chart Julia notices a family hx of MH, and identifies this as a potential risk for the patient. She knows she needs to take measures to help ensure patient safety and prevent harm. In order to do this Julia locates the MH cart and has it available outside the room, and plans out other appropriate interventions. Once in the OR with patient intubated and asleep, Julia notices the patient begins exhibiting signs & symptoms of an MH crisis and she intervenes appropriately and in a timely manner.

Appendix C

OR Teaching Scenario 1 – Prepping w/ Chloraprep

Preceptor: You are discussing set-up for a CABG procedure. You are teaching a new nurse about how to use chloraprep to prep a chest. Utilize adult learning principles to demonstrate how you will educate the orientee on the proper use of chloraprep, including 1) pinching the lever only once to activate the antiseptic, 2) using gentle back-and-forth strokes for 30 seconds on the incision site, then progressing from the incision site to the periphery of the surgical field, 3) allowing the solution to completely dry before draping the area, and not blotting or wiping away the solution. Also include safety considerations such as, not allowing the solution to pool, due to risk of fire, and do not use on open wounds.

Orientee: You are a new nurse and as you begin to discuss the CABG procedure and realize you prep with chloraprep, you say to your preceptor, “Oh, I’ve heard about chloraprep. It is super easy to use, you just paint it on really quick and then you’re done.”

OR Teaching Scenario 2 – Patient Positioning

Preceptor: You are preparing for a mastectomy procedure. Your orientee has had a few weeks in the OR so in order to determine what he/she already knows and to assess learning needs you ask her to teach you what she knows about patient positioning, since teaching is a good way to learn and promote retention. Following her explain/demonstration, you utilize adult learning principles to inspire critical thinking regarding patient positioning in the operating room.

Orientee: You give a brief and vague discussion about various aspects of patient positioning with your preceptor, only discussing padding boney prominences, and the importance of a safety strap. Then you tell your preceptor, "The patient is just going to be supine, so positioning is really no big deal."

OR Teaching Scenario 3 – Sterile Technique

Preceptor: You are observing your new nurse orientee pass medication to the sterile field, you notice he/she is about to contaminate the sterile field. How do you quickly address this to keep the patient safe, while not embarrassing or alienating the new nurse orientee who is already anxious?

Orientee: You are distributing 0.5% Marcaine with epinephrine to the sterile field. While doing so you are anxious and are about to unintentionally contaminate the sterile field.

Appendix D

OR Lunch & Learn: Preceptor Study Guide (2017)

Presented by: Kimberly Crawford, MSN, RN, CNOR

- **Adult Learners…**
  - Need to understand relevance of what they are learning
  - Bring past experiences with them
  - Have other concerns in life
  - Learn best by teaching others, practicing the skill, and/or discussing in a group

- **Teaching Tips**
  - Spiral curriculum: Revisit topics and reinforce information throughout orientation; building with detail and application each time
  - Involve multiple senses in the learning process for improved retention
  - The "TeachBack Method" is the best way to learn…have them teach back what they have learned.

- **Preceptor Roles**
  - Role Model
    - Lead by example
    - Demonstrate confidence
    - Convey effective communication
    - Follow policies at all times
    - Be enthusiastic & positive
    - Adhere to the implementation of the standards of care
    - Discuss how you handle unfamiliar situations
    - Remember…the orientee is ALWAYS watching your behavior
  - Socializer
    - Introduce to peers/coworkers
    - Familiarize with layout of the unit & unwritten rules of the unit
  - Educator
    - Assess learning needs of the orientee and determine individualized needs
    - Facilitate learning opportunities
    - Provide *constructive feedback* and address deficits as soon as they are identified
      - *Constructive feedback* is not always negative…Remember to point out what they are doing correctly too.
    - *Debriefing*: Ask the orientee, "How did you decide to do it that way? What would you do differently in the future?" (even if skill performed correctly)
    - As you are teaching, "Think Out Loud" (facilitates the orientee's understanding of "why")
    - Evaluate skill competency
    - *BEER Method*: Behavior, Effect, Expectation, Result

- Servant Leader
  - Advocate for orientee
  - Serve as the supervisor of orientee and escalate any concerns to educator or management
  - Set the bar for you unit
  - Be a shoulder to cry on

References:

Rogers, B. (2003). The effective nurse preceptor handbook: Your guide to success. *HCPro, Inc*.

Ulrich, B. (2012). Mastering precepting: A nurse's handbook for success. *Sigma Theta Tau International.*

Appendix E

Baptist Health Lexington Preceptor Performance and Proficiency Assessment: Nurse Preceptors

All responses are ANONYMOUS.

Please mark your response (√).

1. I have worked ___ years as an RN.
2. I have worked ___ years as an RN at this hospital.
3. I work full-time Yes__No __
4. Most of the time I work on which unit?
5. Most of the time I work: 7a-7p _____ 7p-7a _____ other (specify):_____
6. I have precepted a new RN within the last 12 months Yes ___ No ___
7. I have attended the RN Preceptor Class. Yes ___ No ___ within the last year __ 1-2 yrs ago__ 3-5 yrs ago__ more than 5 yrs ago__

As a Preceptor for New Nurses, I…

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. Really enjoy teaching				
2. Assess learning needs				
3. Build on the learner's previous experiences				
4. Collaborate to design learning goals				
5. Teach according to the preferred learning style of the new nurse				
6. "Think out loud" to teach problem-solving				

As a Preceptor for New Nurses, I…	Strongly Disagree	Disagree	Agree	Strongly Agree
7. Ask open-ended questions to facilitate thinking				
8. Structure learning from simple to complex				
9. Provide meaningful feedback				
10. Model debriefing at the end of each shift				
11. Role model professional behavior				
12. Assist new nurses to feel comfortable w/in the unit				
As a Preceptor for New Nurses, I ensure that new nurses are proficient in:				
13. Required skills				
14. Documentation				
15. Communicating with patients				
16. Communicating with significant others				
17. Early identification of the deteriorating patient				
18. Managing the deteriorating patient				
19. Locating hospital policies				
20. Identifying appropriate resources (e.g., Rapid Response Team, House Supervisor)				
21. Delegating tasks to members of the team				
22. Working effectively despite interruptions				
23. Setting priorities relative to patient care				
24. Effectively dealing with the stress inherent in the nurse's role				
25. Communicating with physicians				
26. Critically analyzing issues related to the complex patient				
27. Transitioning to independent practice				

As a Preceptor for New Nurses, I ensure that new nurses are proficient in:	Strongly Disagree	Disagree	Agree	Strongly Agree
28. Being appropriately assertive as a team member				

Comments:

Did you feel supported by management in your role as preceptor?

Yes ___ No ____

Please describe:

_____

_____

Would you like to have more support and/or resources from educators to assist with challenging issues during preceptorships?

Yes ___ No ____

Please describe:

_____

_____

Thank you!

Baptist Health Lexington Preceptor Performance and Proficiency Assessment: New Graduate Nurses

All responses are ANONYMOUS.

Please mark your response (√).

1. I graduated from nursing school:
2. I worked as a patient care technician prior to working as an RN: Yes ___ No ___ If yes, where I worked: • on the unit where you are presently and RN _____ • on another unit at this facility _____ • at a different facility _____
3. I am ____years of age
4. My precepted orientation was _____ weeks long.
5. I worked with ___ number of preceptors during my orientation.

During orientation, my preceptor…

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. Helped me to develop confidence in my nursing role				
2. Assessed my learning needs				
3. Built on my previous experiences				
4. Collaborated with me to design learning goals				
5. Taught according to my preferred learning style				
6. "Thought out loud" to teach problem-solving				
7. Asked open-ended questions to facilitate thinking				
8. Structured learning from simple to complex				

During orientation, my preceptor…	Strongly Disagree	Disagree	Agree	Strongly Agree
9. Provided meaningful feedback				
10. Modeled debriefing at the end of each shift				
11. Role modeled professional behavior				
12. Assisted me to feel comfortable w/in the unit				
During orientation, my preceptor ensured that I was proficient in the following:				
13. Required skills				
14. Documentation				
15. Communicating with patients				
16. Communicating with significant others				
17. Early identification of the deteriorating patient				
18. Managing the deteriorating patient				
19. Locating hospital policies				
20. Identifying appropriate resources (e.g., Rapid Response Team, House Supervisor)				
21. Delegating tasks to members of the team				
22. Working effectively despite interruptions				
23. Setting priorities relative to patient care				
24. Effectively dealing with the stress inherent in the nurse's role				
25. Communicating with physicians				
26. Critically analyzing issues related to the complex patient				
27. Transitioning to independent practice				

During orientation, my preceptor ensured that I was proficient in the following:	Strongly Disagree	Disagree	Agree	Strongly Agree
28. Being appropriately assertive as a team member				
Additional Question:				
29. My preceptor and I could have benefitted from additional support from the educators during my orientation				

Comments

Do you have any suggestions for improving the preceptored orientation?

Yes ___ No ___

Please Describe:

_____

_____

Thank you!

Appendix F

From: **Norris, Heather** Heather.Norris@eku.edu
Subject: RE: Permission to use article eval tool for DNP Capstone Project
Date: April 4, 2016 at 8:10 AM
To: Crawford, Kimberly N. kimberly_crawford@mymail.eku.edu

Good morning Kimberly,

Thank you for your request to use the Baptist Health Lexington Preceptor Performance and Proficiency Assessment. It is very nice to hear about nurses taking interest in improving preceptorship experiences.

You are welcome to use the instrument for your DNP capstone. Please be aware that if you change the wording or the structure of the instrument in any way, you will need to change the name of the instrument and our testing results will no longer apply. This is the standard response I have been advised to share with anyone who requests to use the instrument. Down the road, if you submit to be published, you will also need permission from Karen Hill to publish.

If you would be interested in sharing the answers on the instrument survey from your capstone, there may be an opportunity for further evaluation of the instrument items and possible publication.

Best wishes and please keep in touch,
Heather Norris

-----Original Message-----
From: Crawford, Kimberly N. [mailto:kimberly_crawford@mymail.eku.edu]
Sent: Sunday, April 03, 2016 10:12 PM
To: Norris, Heather <Heather.Norris@eku.edu>
Subject: Permission to use article eval tool for DNP Capstone Project

Hi Ms. Norris,

I am a DNP student here at EKU, and I am also a surgical services perioperative staff RN at Baptist Health Lexington. For my evidence-based Capstone Project, I am working to create a preceptor program specific for the Operating Room at BHL, and for this I will need to utilize an evaluation tool. Since you are the first author on the article Evaluating preceptors: A methodological study (2015) I would like to formally request your permission to use, in my Capstone Project, the evaluation tool from this article.

Thank you,

Kimberly Crawford
EKU DNP student

Appendix G

McCloskey/Mueller Satisfaction Scale (MMSS) Copyright 1989

How satisfied are you with the following aspects of your current job?

Please circle the number that applies.

	Very Satisfied	Moderately Satisfied	Neither Satisfied nor Dissatisfied	Moderately Dissatisfied	Very Dissatisfied
1. Salary	5	4	3	2	1
2. Vacation	5	4	3	2	1
3. Benefits package (insurance, retirement)	5	4	3	2	1
4. Hours that you work	5	4	3	2	1
5. Flexibility in scheduling your hours	5	4	3	2	1
6. Opportunity to work straight days	5	4	3	2	1
7. Opportunity for part-time work	5	4	3	2	1
8. Weekends off per month	5	4	3	2	1
9. Flexibility in scheduling your weekends off	5	4	3	2	1
10. Compensation for working weekends	5	4	3	2	1
11. Maternity leave time	5	4	3	2	1
12. Child care facilities	5	4	3	2	1
13. Your immediate supervisor	5	4	3	2	1
14. Your nursing peers	5	4	3	2	1
15. The physicians you work with	5	4	3	2	1
16. The delivery of care method used on your unit (e.g. functional, team, primary)	5	4	3	2	1

	Very Satisfied	Moderately Satisfied	Neither Satisfied nor Dissatisfied	Moderately Dissatisfied	Very Dissatisfied
17. Opportunities for social contact at work	5	4	3	2	1
18. Opportunities for social contact with your colleagues after work	5	4	3	2	1
19. Opportunities to interact professionally with other disciplines	5	4	3	2	1
20. Opportunities to interact with faculty of the College of Nursing	5	4	3	2	1
21. Opportunities to belong to department and institutional committees	5	4	3	2	1
22. Control over what goes on in your work setting	5	4	3	2	1
23. Opportunities for career advancement	5	4	3	2	1
24. Recognition for your work from superiors	5	4	3	2	1
25. Recognition of your work from peers	5	4	3	2	1
26. Amount of encouragement and positive feedback	5	4	3	2	1
27. Opportunities to participate in nursing research	5	4	3	2	1
28. Opportunities to write and publish	5	4	3	2	1
29. Your amount of responsibility	5	4	3	2	1
30. Your control over work conditions	5	4	3	2	1
31. Your participation in organizational decision making	5	4	3	2	1

Appendix H

THE UNIVERSITY OF IOWA
COLLEGE OF NURSING

Permission to use form:

This gives permission to use the McCloskey/Mueller Satisfaction Scale (MMSS) to Kimberly Crawford for the purpose as stated in the request dated 10/19/2016.

The instrument may be reproduced in a quantity appropriate for this project.

Signed:

Sue Moorhead

Sue Moorhead, Associate Professor, College of Nursing

Date: November 1, 2016

The University of Iowa
The Center for Nursing Classification & Clinical Effectiveness
College of Nursing 407 CNB
Iowa City Iowa 52242 USA

Appendix I

Intent to Stay/Leave Job Diagnostic Survey

Each of the statements below is something that a person might say about his or her job. Please indicate your own personal feelings about your job by marking how much you agree with each of the statements below. Please place an X in the box that corresponds to your response for each statement.

	Disagree Strongly	***Disagree***	***Disagree Slightly***	***Neutral***	***Agree Slightly***	***Agree***	***Agree Strongly***
1. It's hard, on this job, for me to care very much about whether or not the work gets done right.	1	2	3	4	5	6	7
2. My opinion of myself goes up when I do this job well.	1	2	3	4	5	6	7
3. Generally speaking, I am very satisfied with this job.	1	2	3	4	5	6	7
4. Most of the things I have to do on this job seem useless or trivial.	1	2	3	4	5	6	7
5. I usually know whether or not my work is satisfactory on this job.	1	2	3	4	5	6	7
6. I feel a great sense of personal satisfaction when I do this job well.	1	2	3	4	5	6	7
7. The work I do on this job is very meaningful to me.	1	2	3	4	5	6	7
8. I feel a very high degree of personal responsibility for the work I do on this job.	1	2	3	4	5	6	7
9. I frequently think of leaving this job.	1	2	3	4	5	6	7
10. I feel bad and unhappy when I discover that I performed poorly on this job.	1	2	3	4	5	6	7
11. I often have trouble figuring out whether I'm doing well or poorly on this job.	1	2	3	4	5	6	7
12. I feel I should personally take credit or blame for the results of my work on this job.	1	2	3	4	5	6	7
13. I am generally satisfied with the kind of work I do in this job.	1	2	3	4	5	6	7
14. My own feelings generally are not affected much one way or the other by how well I do on this job.	1	2	3	4	5	6	7
15. Whether or not this job gets done right is clearly my responsibility.	1	2	3	4	5	6	7

Appendix J

BAPTIST HEALTH
LEXINGTON

PHONE: 859.260.6100
1740 Nicholasville Road Lexington, KY 40503

May 30, 2017

Kimberly N. Crawford, MSN, RN, CNOR
Surgical Services
Baptist Health Lexington
1740 Nicholasville Rd.
Lexington, KY 40503

RE: #BHL-17-1395 (Reference#013257) Perioperative Preceptor Education Embedded in a Hospital-Wide Preceptor Program

Dear Ms. Crawford,

Your new protocol listed above was approved under the expedited review process on 05/30/2017 and will be reported at the 06/15/2017 meeting of the Baptist Health Lexington Institutional Review Board.

The IRB approval for this protocol will expire on 05/29/2018. Please submit your continuation request by 05/15/2018 in order to avoid lapses in approval of your research.

As principal investigator, you are responsible for complying with IRB decisions, conditions and requirements. The protocol procedures should be implemented as approved by the IRB and any other changes in this protocol, including closure, must be reported promptly to the IRB through iRIS, the IRB submission system. No change may be initiated without review by the IRB, except where necessary to eliminate apparent immediate hazard to the participant. In addition, any unanticipated problem involving risk to the participant or others must be reported immediately to the IRB

If you have any questions, please contact the IRB office at 859-260-6074.

Sincerely,

Signature applied by Dee Beckman on 05/30/2017 11:25:18 AM EDT

Dee Beckman, MBA, MSN, RN, NE-BC
IRB Chairperson

Appendix K

BAPTIST HEALTH
LEXINGTON

1740 Nicholasville Road Lexington, KY 40503
PHONE: 859.260.6100

July 20, 2017

Kimberly N. Crawford, MSN, RN, CNOR
Surgical Services
Baptist Health Lexington
1740 Nicholasville Rd.
Lexington, KY 40503

RE: #BHL-17-1395 (Reference#013519) Perioperative Preceptor Education Embedded in a Hospital-Wide Preceptor Program

Dear Dr. Crawford,

Your amendment for the protocol listed above, request to add Preston Lewis to the study and addition of a thirty-minute OR Lunch and Learn session for the Perioperative preceptors who attended the BHL preceptor class to reinforce the main points of the preceptor content covered during the preceptor class, was approved under expedited review on 07/20/2017. This will be reported at the Baptist Health Lexington Institutional Review Board meeting on 08/17/2017. With this submission, you have continued approval until 05/29/2018.

As you are aware, any change in this protocol must be reported promptly to the IRB. No change may be initiated without review by the IRB, except where necessary to eliminate apparent immediate hazard to the participant. In addition, any unanticipated problem involving risk to the participant or others must be reported immediately to the IRB.

If you have any questions, please contact the IRB office at 859-260-6074.

Sincerely,

Signature applied by Dee Beckman on 07/20/2017 09:39:16 AM EDT

Dee Beckman, DNP, MBA, MSN, RN, NE-BC
IRB Chairperson