1995

Professional Socialization and Mentoring Relationships in Beginning Nursing Practice

Barbara Ann Barnaby Darby

Suggested Citation
https://digitalcommons.unf.edu/etd/332

This Doctoral Dissertation is brought to you for free and open access by the Student Scholarship at UNF Digital Commons. It has been accepted for inclusion in UNF Graduate Theses and Dissertations by an authorized administrator of UNF Digital Commons. For more information, please contact Digital Projects.
© 1995 All Rights Reserved
PROFESSIONAL SOCIALIZATION AND MENTORING RELATIONSHIPS IN BEGINNING NURSING PRACTICE

by

Barbara Ann Barnaby Darby

A dissertation submitted to the Doctoral Studies Faculty of the College of Education and Human Services in partial fulfillment of the requirements for the degree of Doctor of Education

UNIVERSITY OF NORTH FLORIDA

COLLEGE OF EDUCATION AND HUMAN SERVICES

August, 1995

Unpublished work c Barbara Ann Barnaby Darby
The dissertation of Barbara Darby, S.S. # 099-40-5990 is approved:

Accepted for the Department: [Signature Deleted] 8/9/95

Accepted for the College/School: [Signature Deleted] 8/9/95

Accepted for the University: [Signature Deleted] 8/14/95
ACKNOWLEDGEMENTS

I thank God who is the giver of all good and perfect gifts. I am especially thankful to the graduates who graciously and candidly shared their beginning practice experiences. They made this study possible.

The love, encouragement, patience, sacrifices, support, and understanding of my daughter Tamara Nichole and my husband John enabled me to persist and to complete this journey. My parents Bethy Anderson and Lloyd Barnaby started me on my way many years ago with their unconditional love and to them I say--Thanks!

Others to whom I wish to express my sincere appreciation and gratitude for invaluable contributions to this project include:

My major professor Dr. Katherine Kasten, who has been a role model, and mentor. Her expert guidance, vast knowledge and experience with disciplined inquiry, and caring support helped me keep my sanity and perspective throughout a most challenging process.

Other members of my dissertation committee--Dr. G. Pritch Smith, whose thoughtful feedback and support have been sustaining throughout this educational experience; Dr. Paul Eggen, whose warmth and input instilled confidence and brought clarity at crucial times in the process; finally, Dr. Henry Thomas, whose willingness, encouragement, and supportive words have
given additional comfort.

Mrs. Lillian Loretta Bronner, my colleague and friend, who has provided typing services, encouragement, and support throughout the journey. Mrs. Edna Taylor and Mrs. Cheryl James, whose expert computer skills with WordPerfect 5.1, patience, and reassurance kept me from utter frustration.

My mentors Mrs. Hettie Mills, Dr. Lois D. Gibson, and Dr. Ezekiel Bryant, who blazed many trails before me and who have been excellent and caring role models.

My employer, Florida Community College at Jacksonville for providing the financial support and opportunity to make this goal a reality.

Finally, to my friends and colleagues who demonstrated interest and support by asking about my progress from time to time and offering to assist with various responsibilities.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>iii</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>x</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>ix</td>
</tr>
<tr>
<td>Chapter</td>
<td></td>
</tr>
<tr>
<td>I    INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Statement of Purpose</td>
<td>4</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>5</td>
</tr>
<tr>
<td>Delimitations and Limitations of the Study</td>
<td>6</td>
</tr>
<tr>
<td>Delimitations</td>
<td>6</td>
</tr>
<tr>
<td>Limitations</td>
<td>7</td>
</tr>
<tr>
<td>Research Questions</td>
<td>9</td>
</tr>
<tr>
<td>Significance of Research</td>
<td>11</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>12</td>
</tr>
<tr>
<td>Procedures and Methods</td>
<td>16</td>
</tr>
<tr>
<td>Chapter Summary</td>
<td>17</td>
</tr>
<tr>
<td>II   REVIEW OF THE LITERATURE</td>
<td>19</td>
</tr>
<tr>
<td>Professional Socialization</td>
<td>20</td>
</tr>
<tr>
<td>Socialization in Professional Fields</td>
<td>28</td>
</tr>
<tr>
<td>Professional Socialization in Nursing</td>
<td>35</td>
</tr>
<tr>
<td>Mentoring/Preceptorship Relationships</td>
<td>38</td>
</tr>
<tr>
<td>Locus of Control</td>
<td>47</td>
</tr>
<tr>
<td>Chapter Summary</td>
<td>51</td>
</tr>
<tr>
<td>TABLE</td>
<td>PAGE</td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>1</td>
<td>Pilot Study’s Focus Groups Participation.</td>
</tr>
<tr>
<td>2</td>
<td>Pilot Study’s Focus Groups Make-up.</td>
</tr>
<tr>
<td>3</td>
<td>Sample Demographics.</td>
</tr>
<tr>
<td>4</td>
<td>Focus Groups Make-up.</td>
</tr>
<tr>
<td>5</td>
<td>Focus Groups Average Length of Employment.</td>
</tr>
</tbody>
</table>
Abstract of the Dissertation

Professional Socialization and Mentoring Relationships in Beginning Nursing Practice

by
Barbara Ann Barnaby Darby

August, 1995

Chairperson: Dr. Katherine Kasten

The purpose of this study was twofold--to gain understanding of early professional socialization in beginning nursing practice from the beginning practitioner's perspective and to explore the influences of mentoring on the professional socialization of beginning nurses. Participants were thirty-one novice practitioners from an associate in science degree nursing program in the Southeast section of the United States.

The unique perspectives of beginning nurses were gained through the use of focus groups. Data analysis consisted of content analysis, data display and reduction, identification of themes, and conclusion drawing.

Findings supported the notion that professional socialization occurs in phases. Beginners anticipate initial work environments that facilitate ongoing socialization. Mentoring/preceptorship relationships are anticipated and desired as part of the socialization process.

Early in beginning practice novices demonstrated an external locus of control and focused on their preparation for the role and support systems. Late in beginning practice
novices demonstrated an internal locus of control and were concerned about impending independent practice and the continuing need to learn.

Findings may assist nursing educators and nursing practitioners to facilitate beginners' entry and role transition. Future research should address the mentors' perspective, locus of control, and differences based on the professional education program completed by the beginner.
CHAPTER I
INTRODUCTION

Upon graduation from a nursing education program, graduates are expected to have the core knowledge, technical competencies, internalized values and attitudes that are characteristic of a member of the profession. Consumers of nursing services and members of the profession presume that the new graduate will be a skilled practitioner, capable of making good professional judgments. While nursing and other professional education programs provide the requisite professional skills, they do so at an entry level (Cohen, 1981; McCain, 1985; Nelson, 1978; Saarman, Freitas, Rapps, & Riegel, 1992). It is widely recognized that the formal educational process experienced by the prospective professional constitutes the first stage of professional socialization (Brief, Sell, Aldag, & Melone, 1979).

Once on the job, the novice nurse must reconcile the formal training with the realities of the workplace. The skills, knowledge, and role expectations acquired during the formal educational process must be adjusted to the demands of the employing organization (Graen, 1976; Van Maanen, 1975). The novice's transition into beginning practice is marked by uncertainty and a lack of confidence (Kramer, 1974). With work experience, the beginning practitioner develops technical proficiency and confidence. This often
occurs with the assistance of supportive role models such as mentors/preceptors in an equally supportive environment (Kelly, 1993).

Rules 598, promulgated by the Florida Board of Nursing, provide for the beginning nursing practitioner to practice under the direct supervision of an experienced nurse. The defining term used in the board rules for this beginning nursing practitioner is "graduate nurse" (GN). Under the original policy, this formal mentoring relationship existed until the novice successfully completed the National Council Licensure Examination (NCLEX) (Agency for Health Care Administration, 1994). This mentoring period, during the early transition into practice, extended over approximately four months. The graduate nurse status has provided beginning nursing practitioners with mentoring by a registered nurse through the early transition into practice.

In the spring of 1994, the National Council Licensure Examination (NCLEX) was changed from a paper and pencil test to a computer test. Instead of having only two opportunities each year to take the NCLEX (February and July), graduates are now able to schedule the examination within thirty days of graduation. Notification of licensure status occurs within four to six weeks of graduation. With the change in the method of administration of the NCLEX, the Board of Nursing took concomitant action to restrict the period for graduate nurse status to no more than sixty days. The net effect of the Board's action was
the reduction of the required period of mentoring for the new graduate.

In practice, the Board's action made provisions for the new graduate nurse to practice under the direct supervision of a registered nurse until licensed, but for no more than sixty days. At the end of the sixty days, if not licensed, the new graduate loses graduate nurse status and with that the ability to practice. If licensed, the new graduate may function independently without the direct supervision of a more experienced registered nurse.

Nursing leaders have expressed concerns about the professional socialization of new graduates in the work setting. Underscoring the concerns of nursing leaders is the increasing pressure on health care agencies to reduce costs and maximize productivity. Nursing leaders are concerned about placing beginning practitioners in demanding roles that may require that they function in the role of expert sooner than prepared to do so.

In a changing health care delivery system and environment, the nurse needs a variety of skills. Among these skills are expert clinical judgment and the ability to prioritize, manage, delegate, supervise, and collaborate within a multidisciplinary team. Given these expanding responsibilities, nursing leaders believe that continuing support of the novice nurse will be critical to the development of practice (Florida Nurses Association, 1993).
Over the years, the professional socialization pattern of the novice nurse has altered in response to the changing needs of society (Wilson & Startup, 1991). Once again, advances in technology (computerized NCLEX) have demanded a change in nursing.

Statement of Purpose

The professional socialization pattern of beginning nurses has changed over the years in response to the changing needs of society. Most recently, a change in the policy governing the licensure and practice of novice nurses has altered the conditions for entry into the profession.

The original policy provided a formal mentoring relationship for novice nurses for approximately four months following graduation from an educational program. A recently implemented policy change has reduced the required period for the formal mentorship for new graduates to one month. Nursing leaders have held the belief that the original policy made adequate provisions for the early beginning socialization and role transition for beginning nursing practitioners.

Today's health care system demands nurses who possess expert clinical judgment and the ability to function in expanding roles on a multidisciplinary team. Nursing leaders are concerned that the new policy governing entry may place novice nurses in demanding roles that require that they function in the role of expert sooner than they are
prepared to do.

Missing in the current discourse about entry, early professional socialization, and the import of mentoring is the novice practitioner's perspective. Because the point of entry is important, obtaining the missing perspective may provide some direction to nursing education programs and nursing practice institutions as they collaborate to assist the beginning nurse to make the transition into professional practice. Thus, the purpose of this study is twofold--to gain understanding of early professional socialization in beginning nursing practice from the beginning nursing practitioner's perspective and to explore the influences of mentoring relationships in the professional socialization of beginning nursing practitioners.

**Definition of Terms**

Any attempt to promote understanding of a phenomenon and to engage others in the discourse should understandably begin with the establishment of a common language and awareness regarding important terms. Within the context of this study and for the clarity and understanding of the reader, the following definitions are offered to provide common ground for the discourse.

For this investigation, a graduate nurse is one who has completed a nursing education program and who has not yet been granted a license to practice as a registered nurse. The beginning nursing practitioner is defined as the nurse
who has been practicing nursing for not more than 12 months following graduation from a nursing education program. The terms novice, newcomer, and neophyte are used interchangeably to identify the beginning nursing practitioner. Possession of a license to practice professional nursing delimits the registered nurse in this study. The experienced nurse is one who has been an active practitioner of nursing for two or more years. Finally, a nurse mentor/preceptor is a registered nurse who has been identified by an employing agency and/or the beginning nursing practitioner as a successful nurse role model. This mentor/preceptor assumes the roles of teacher, advisor, intervenor, and sponsor for the new graduate (Fields, 1991).

**Delimitations and Limitations of the Study**

Despite the flexibility engendered by the evolving nature of qualitative research, certain constraints came to bear on the emerging data, their analysis, and the generalizability of the results. Delimitations and limitations of this study are addressed in the following sections. The reader must entertain the results of this investigation with these factors in mind.

**Delimitations**

The participants for this study were all graduates of the same nursing education program in the Southeast region of the country. Geographical and institutional differences in nursing education programs are commonplace. The
selection of graduates from one program in one region of the nation provided a group of participants who had a common frame of reference based on their professional education experience. It eliminated at least two confounding variables (geographical and institutional differences) that could impact the interpretation of the results of this investigation.

Limitations

The impact of previous health related work experience(s) on the professional socialization of the beginning nursing practitioner was not a variable addressed in this study. Past work experience(s) in the health field or in the current work environment may have influenced the participants’ perspectives regarding beginning practice.

Participants from various health agencies were involved in the study. The socialization and mentoring experiences described by participants were varied. The differences in approaches used by each agency were not controlled for or targeted by this investigation. These differences may very well have influenced the socialization experiences described by participants. The import of these differences for the outcomes of this investigation was not known.

Eliciting participants’ unique perspectives of their beginning socialization was the focus of this effort. When compared to their actual experiences, the perceptions shared by the participants were certainly subject to possible
inefficiencies of recall.

The majority of participants in this study were white females. There was one African-American female and several males. The gender and race of mentors was not known. Several studies addressed the influences of gender and race in mentoring dyads. However, results were mixed and at times conflicting. The effects of gender and race differences between mentors and mentees were not considered but certainly may have had implications for the relationships described by participants and for the study’s outcomes.

The sample for this study represented twenty-five percent of the total graduating class. The targeted sample size was forty participants. The actual number of participants in the study was thirty-one. The small sample size and the delimitations should cause the reader to exercise caution in generalizing the results of this study to other groups.

Qualitative methodology attends to these factors in that its fundamental assumption is that the participants’ perspective will be colored and flavored by all of their experiences and this is crucial to the qualitative research process. The qualitative researcher’s goal is not to control the research conditions, but to record the complex situations and interrelations as they occur (Marshall & Rossman, 1989). The researcher states the parameters of the
study and the reader determines transferability and applicability of the results to other groups or settings (Marshall & Rossman).

**Research Questions**

Today's beginning nursing practitioner faces many challenges in a changing health care environment. At a time when the health care environment is becoming more complex, entry into the field is accelerated. Practice sites have shifted from inpatient to outpatient, community-based facilities. The changing patient population consists of patients with higher acuity levels of illness. These patients often require the use of sophisticated, complex technology. To respond to these changes, the beginning nursing practitioner will not only need depth and breadth of clinical judgment but will need additional critical thinking skills. These additional skills include the ability to prioritize, manage, delegate, and collaborate within a multidisciplinary health team (Florida Nurses Association, 1993).

Over the years, the field of nursing has valued the mentoring relationships that were inherent in the licensure process for beginning practitioners. Recent changes in the licensure process has stimulated a great deal of attention and concern for the socialization of beginning nursing practitioners. This qualitative study sought to generate data that may assist our understanding of how
Mentoring/preceptorship relationships facilitate and/or hinder the critical period of beginning professional socialization. To that end, the research questions addressed in this study included those noted below.

1. How do beginning nursing practitioners describe their initial work experience and environment?

2. What are beginning nursing practitioners' perceptions about the support structures in their initial work environment?

3. What factors are viewed by beginning nursing practitioners as facilitating/hindering their beginning practice?

4. How do beginning nursing practitioners feel about their practice during the first six to twelve months following graduation?

5. How do mentoring/preceptorship relationships assist the beginning nursing practitioner to make the role transition?

6. How do mentoring/preceptorship relationships influence beginning nursing practitioners and their practice?

7. What do beginning nursing practitioners view as necessary and sufficient components in the professional socialization process?

8. In the absence of a formal mentor/preceptor, who do beginning nursing practitioners turn to for
assistance?

9. What difference, if any, will the absence of a mentoring/preceptorship relationship make in the role transition of beginning nursing practitioners?

**Significance of Research**

At the center of this investigation was professional socialization and the influences of mentoring/preceptorship relationships on the role transition of members of the nursing profession at entry level. This study's aim was to delineate and understand the important aspects of entry into professional nursing practice and ways in which the process may be facilitated from the beginning nursing practitioner's perspective.

Because the workplace is the site of the socialization of nurses to a greater extent than previously thought, the initial experiences encountered there by new graduates are all important to their retention, job satisfaction, and role identification (Lawler & Rose, 1987). All professions need, depend on, and are nurtured by the continual input of their neophytes (Kramer & Schmalenberg, 1978). The nurturing of these neophytes until they reach maturity requires a framework that provides for successful interactions with the field's professionals (Cohen, 1981). Understanding the dimensions of such a framework from the neophytes' frame of reference makes this an important research topic. The
understanding gained may be helpful in policy discussions concerning the professional socialization of beginning nursing practitioners. Finally, as we attend to the implications of this study for nursing education and nursing practice, additional import was seen for this investigation. Through the lens of beginning nursing practitioners, nursing education programs can address curricular content and needs. The goal of such efforts will be to facilitate graduates' role transition into beginning practice with minimal feelings of role ambiguity, conflict, and job tension and stress (Dailey, 1990). Grounded in the personal experiences of beginning nursing practitioners, this investigation was expected to yield data that would demonstrate that the socialization process for new professionals can or cannot be left to chance. As Cohen (1981) states, becoming one's own role model creates a great deal of inner anxiety and insecurity about one's acceptance by colleagues. Consequently, the socialization of beginning nursing practitioners will require attending to by all who claim membership in the nursing profession.

**Theoretical Framework**

The focus of this qualitative study was to gain further understanding of the import of mentoring/preceptorship relationships on the continuing professional socialization of beginning nursing practitioners. The unique, individual perspectives and perceptions of beginning nursing
practitioners provided the lens and foundation for this effort. The literature on professional socialization, mentoring/preceptorship relationships, and locus of control formed the theoretical framework for this investigation.

Professional socialization is a continuing process. It may span an individual's entire career. It, however, begins during the formal educational process experienced by the prospective professional. It establishes a reference group for the novice as he or she moves from the educational sphere to the practitioner sphere (Cohen, 1981). As a process, professional socialization results in the role transition for new members within a discipline.

Newcomers to a profession come with entry level knowledge, skills, and judgment. The point of entry is often characterized by a high level of motivation, questioning, reality testing, doubt, lack of confidence, and more. This initial period is a crucial one for the novice and the profession. Professional socialization, described as occurring in stages (Cohen, 1981; Kelman, 1961; Kramer & Schmalenberg, 1978; Ronkowski & Iannaccone, 1989), is the acquisition of the various dimensions that constitute a professional role. These dimensions include but certainly are not limited to the knowledge, skills, behaviors, attitudes, intellectual and emotional comfort, and internalization of the values that support an individual's transition into the professional role (Brief et al, 1979;
Cohen (1981) proposed a four stage model of socialization that provided the theoretical underpinnings for this investigation. The four stages identified by Cohen were unilateral dependence, negative independence, dependence/mutuality, and interdependence. Movement through the four stages was found to culminate in a beginning practitioner with not only intellectual but also emotional comfort with the professional role (Cohen).

Mentoring is one strategy identified in the literature to promote successful socialization. The relationship between a mentor and a mentee is perhaps one of the most important in the professional development of the mentee. Some authors identified it as an essential component for the development of the new professional. Mentoring/preceptorship relationships support the personal and professional development of the mentee and may enhance the quality of the mentee’s work life (Fields, 1991; Taylor, 1992). As with professional socialization, several authors described mentoring/preceptorship relationships as occurring in phases (Chao, 1991; Hsieh & Knowles, 1990). As a relationship between an experienced professional and a beginning practitioner, mentoring/preceptorship relationships have benefits for the beginning practitioner. Specifically, this relationship can significantly lower the level of role conflict and ambiguity, as well as workplace
stress (Dailey, 1990; Howard-Vital & Morgan, 1993). Kram (1983) and Chao (1991) offered the specific theoretical model for the mentoring component of this study. Kram posited that four identifiable and non-distinctive phases were observable in the mentoring process. The formation of the relationship between mentor and mentee was termed initiation. The process moved forward with the development of the relationship—cultivation. A third phase was denoted by the culmination of the relationship (separation). Finally, the relationship took on a different character, and Kram used the term "redefinition" for this phase.

The locus of control concept completed the triad of concepts providing the rationale for this study and its outcomes. It offered the structure for understanding the changes in the source of influence and control described by the novice practitioners who shared their unique perspectives in this study. Behaviors reported by participants during the early socialization period seemed to move along an influence continuum. Based in social learning theory framework, two dimensions have been associated with the locus of control concept. One dimension is seen in people who view events as being within their control and tied to their skills and abilities (internal) (Julian & Katz, 1968). The other dimension is that seen in individuals who see events as caused by external sources such as luck, chance, or fate (external) (Julian & Katz).
The theoretical framework addressed in this section established the foundation for this study. Professional socialization, mentoring/preceptorship relationships, and the locus of control concept set the context for focusing on the beginning nursing practitioner's entry into practice. The unique perspectives of participants, elicited through focus groups, provided the content for this investigation.

Procedures and Methods

Though a variety of qualitative approaches exist, this investigator utilized focus groups, document analysis, and a demographic questionnaire for data collection. A pilot study was conducted and served multiple purposes. Its foremost purpose was to establish baseline data for the study. In addition, it helped to identify issues related to mentoring/preceptorship relationships and their import for the early professional socialization of beginning nursing practitioners. The pilot established that focus groups were an appropriate methodology for data collection. Modifications of the study design (interview guide and sampling procedures) were an outcome of the pilot study. Finally, the pilot also pointed to the need to include the locus of control concept in the literature review for this investigation.

The sample for this study was drawn from graduates of an associate in science degree program in nursing from a community college in the Southeast region of the country. A
pilot study was conducted with a sample of 13 participants from the December 1993 graduates of the program. Thirty one of the May 1994 graduates served as the sample for the actual study.

A total of seven focus groups were held. The trustworthiness, credibility, transferability, and dependability of qualitative methods are aided by the process of triangulation wherein data are collected from a variety of sources (Marshall & Rossman, 1989). This bringing together of data from several sources to converge on a single experience is important in qualitative research. Triangulation in this study was achieved through the following data sources: taped focus group sessions, a series of forms completed by participants during the focus groups, a demographic questionnaire, a telephone survey of inservice educators at agencies where participants were employed, review of available new graduate orientation schedules, and the investigator’s notes.

Data analysis consisted of in depth examination, coding, interpretation, and the search for recurring themes, meanings, and relationships. A coding matrix facilitated the process.

Chapter Summary

Fostering understanding of mentoring relationships and their import for the professional socialization of beginning nursing practitioners was the purpose of this study. The
changing health care delivery system and environment, along with the changing parameters for entry of beginning nursing practitioners into the field, have implications for nursing education, nursing practice, and nursing research.

Understanding the support needed by beginning nursing practitioners is assisted by the unique perspective that they bring to the discourse. Given a chance to tell their stories, and framed by the theoretical concepts of professional socialization, mentoring, and locus of control, this investigation has generated data that can provide direction to those having an interest in assisting the beginning nurse to make the transition into professional practice.

This study is organized in the following manner: Chapter II consists of a review of the literature on professional socialization, mentoring, and locus of control. Chapter III presents the methodology, procedures, and data analysis. The results of the study are discussed in Chapter IV. The summary, conclusions, and recommendations for future research are addressed in Chapter V.
CHAPTER II  
REVIEW OF THE LITERATURE

Nursing professionals have long been concerned about the ways in which neophytes are prepared for professional roles. Failure of a beginning practitioner to develop a clear perception of the professional role can result in dissatisfaction, poor professional performance, diminished job satisfaction, and, ultimately, the abandonment of the field following graduation (Chao, 1991; Cohen & Jordet, 1988; Saarman et al., 1992). For this reason, the experiences of beginning practitioners as they make the journey from novice to expert, along with the factors that may influence the phenomenon of professional socialization, warrant investigation. Because mentors play a large part in the socialization of professionals, the focus of this qualitative study was on gaining further understanding of the import of mentoring/preceptorship relationships on the continuing professional socialization of beginning nursing practitioners. The unique perspectives and individual perceptions of beginning nursing practitioners supported by theoretical concepts provided the foundation for this effort.

To assist in building a framework for this study, the review of the literature included the concept of professional socialization, socialization in specific
professional fields, socialization in nursing, mentoring/preceptorship relationships, and locus of control. The interrelationship of the three major theoretical concepts (professional socialization, mentoring, and locus of control) provided the support for the subject of this study as an important research topic. The professional socialization literature provided the basis for exploring beginning professional practice. The literature on mentoring, a component of professional socialization, gave strength to this study's focus on mentoring relationships. Finally, the locus of control literature provided the explanation for behaviors and attitudes reported by participants.

**Professional Socialization**

A profession is defined by a specific and unique body of knowledge, skills, and specialized services. The profession regulates its own growth and survival. Control is exercised over the body of knowledge that is specific to its practice, over the number of persons who may enter, and over the educational process that begins the socialization of prospects entering the profession (Hardy & Conway, 1978). Though the socialization process begins in the formal education program of a profession, it continues beyond the transition from school to work and may span an individual's total professional career (Hardy & Conway; Stein & Weidman, 1989). Thought to be a fairly complex process,
socialization is focused in the workplace to a greater extent than previously recognized (Lawler & Rose, 1987). The first job presents the opportunity to guide the socialization of the new professional. The situational adaptations that must be made by the new professional will perhaps set the pattern for the remainder of the work career (Kramer & Schmalenberg, 1978).

The first work experience may be fraught with uncertainties concerning the potential interactions between the newcomer and the organizational setting. The novice, at the point of entry, will often be faced with a sense of dissonance between the realities of the workplace, personal expectations, and sense of preparedness for the new role (Sarchielli, 1984). Some authors have used the term "reality shock" to describe the sense of discontinuity experienced by the newcomer to a profession (Kramer, 1974; Sarchielli).

First job intervention and support may be helpful to the new professional, especially if a safe bridge is provided for the novice to cross. First job intervention can also be beneficial from the employer's perspective in terms of employee retention and tenure. Efforts to better understand the professional socialization process and how relationships involving mentors/preceptors may impact it are clearly supported in the literature.

Several definitions and characteristics of professional
socialization were found throughout the literature. Some studies advanced the notion that professional socialization is a process or series of processes through which knowledge, skills, values, norms, and the requisite behaviors are gained in order to participate as a member of a particular profession (Hart, 1991; Lum, 1978; Ronkowski & Iannaccone, 1989; Saarman et al., 1992; Stein & Weidman, 1989). Others made distinction between levels of socialization as well as dimensions (Blau, 1988; Hart, 1991; Stein & Weidman).

For example, Stein and Weidman (1989) addressed institutional versus individual socialization as well as the cognitive and affective dimensions. Individual socialization was said to be that which culminates in the acquisition of a professional identity (Stein & Weidman). On the other hand, institutional socialization was defined as that wherein the roles adopted are framed by the institutional culture. Blau’s (1988) work on apprenticeship as a socialization strategy and Hart’s (1991) on leader succession differentiated between professional socialization and organizational socialization.

The work of some investigators focused on the affective, intellectual, and internal impact of professional socialization. These aspects of the process were all found to be integral to the role transition of novices. Brief et al. (1979) described professional socialization as the acquisition of the expectations and behaviors that set the
parameters for a role within an organization. Cohen (1981) and Lum (1978) posited that the professional socialization process enables an individual to become intellectually and emotionally comfortable with the professional role while experiencing external as well as internal changes. This role comfort occurs with the internalization of professional values and attitudes (Cohen).

The shaping and molding of the novice are ongoing in professional socialization. An array of authors (Cohen, 1981; Hart, 1991; Kelman, 1961; Kramer & Schmalenberg, 1978; Ronkowski & Iannaccone, 1989) described the socialization process as occurring in a series of steps or phases. Gennep's (1960) work presented the notion of three stages—separation, transition, and incorporation. In the first of the three stages, the individual physically or psychologically moves out of the current social status (nursing student). The transition period follows and is where the individual receives special knowledge and skills that result in some observable change in behavior (beginning weeks and months of practice). The individual then progresses to the final stage where by means of some public symbol the individual is incorporated into the new status (fully functioning professional).

Other researchers' work provided empirical support for the belief that socialization occurs in phases. Wanous (1980) added to the idea of the multiple stages by
identifying four. Though labeled differently, his stages paralleled those identified by other authors. Stage one was identified as facing and incorporating organizational realities. Clarification and definition of the specific role constituted stage two. Finding one’s place in the organizational structure was yet another stage cited by Wanous. Finally, effective job performance and organizational commitment were signposts of successful incorporation of the professional role.

Some socialization models were linear while others were seen as cyclical. Hart (1991) concluded that all of the frameworks had three common stages: uncertainty and learning, adjustment, and gaining balance. Gennep's (1960) framework reflects the three common stages identified by Hart. The separation phase parallels the uncertainty and learning phase commonly seen early in the socialization process. The transition phase is an adjustment period and a sense of balance is gained by the new professional in the incorporation phase. Cohen's (1981) model is another example that incorporates the common stages addressed by Hart. It is a four-stage model of professional socialization. During the first stage of the model, unilateral dependence behaviors are prevalent. Cohen posited that much reliance is placed by the individual on external influences and controls. In other words, the individual's locus of control appears externally placed.
Because the individual's confidence in personal experience and knowledge base is at a low level, the behaviors observed in this stage involve passive acceptance of concepts and ideas. The individual is hesitant to question or criticize during this stage.

Another characteristic of this first stage is the tendency to seek "the one right answer" and to look for absolutes. When played out in the work environment, the novice exhibits a thought process that limits the options that may be entertained in fulfilling aspects of the role. In essence, most situations may be viewed as black and white, with no room for gray areas.

Cohen (1981) likened the first stage to Erikson's stages of development. Specifically identified was the trust versus mistrust phase. According to Cohen's application of Erikson's theory, the new professional's behaviors reflect the need to trust the work environment and fellow practitioners. Trusting the professional environment for direction and support is akin to the cradle of security that infants need from parents or other significant adults. Translated, the novice practitioner is unilaterally dependent. Fellow practitioners are viewed as experts and are trusted for the knowledge they bring to the relationship. According to Cohen, failure to develop a sense of trust in the work environment could perhaps negatively impact the novice's ability to perform in a
variety of professional situations.

As the novice begins to trust the professional environment and develops confidence in self and personal knowledge base, questioning behaviors emerge. The individual's source of influence and control begins to move from a more external focus to one that is internal. Operationally, this phase was termed the negative independence phase (Cohen, 1981). Typically, information is questioned by the novice. A more critical and discerning eye is at work when viewing events in the professional environment.

Within this second phase of Cohen's (1981) model, comparisons were made with Erikson's autonomy versus shame, and doubt/willpower phase. The novice is willing to test the professional role and environment to the limits. In so doing, the new professional "tries on" various aspects of the role. Greater flexibility is displayed. Contrasts are made with experienced fellow professionals wherein the novice may even view personal ability as good as or greater than that of mentors and colleagues.

Stage three, dependence/mutuality, was paralleled with Erikson's stage of initiative versus guilt and purpose (Cohen, 1981). As children move beyond the negativism of the previous stage and become comfortable with their environment and skills, so do beginning practitioners. While continuing to learn new skills and developing others,
self esteem and confidence grow. This process is especially enhanced by the affirmation received from mentors and fellow professionals. The novice practitioner's efforts are directed toward seeking out other professionals with compatible practice models.

Interdependence marked the final phase of Cohen's (1981) model. The professional identity to be assumed by the novice is part of the task accomplishment of this phase. Erikson's identity versus role diffusion stage is congruent with the assumptions of this phase of socialization for the beginning practitioner. A sense of wholeness enables the new practitioner to continue to learn from others while exercising more independent judgment and practice. Confidence, comfort, and internalization of the professional values and culture indicate successful passage through the final stage of Cohen's model.

In summary, general agreement exists in the literature that professional socialization does occur and that it involves passage through stages. Given the vast number of research efforts found in the literature regarding the socialization of newcomers to a profession, it is reasonable to assert that the topic is one of importance and continuing interest. Novice practitioners experience a variety of changes, forces, and variables in the journey toward becoming professionals. Gaining insight into the process from the novice's unique perspectives may not only be
beneficial to those who are to come but to professional organizations and educational institutions alike. This study’s focus on the professional socialization of beginning nursing practitioners within the context of an externally imposed policy change was supported in the literature.

Socialization in Professional Fields

The socialization process is similar no matter the professional field. Newcomers experience a sequence of phases ultimately expected to result in professional competence, identification with the professional field, and commitment. The literature provides numerous examples of studies and reviews of studies that address socialization in various professional fields. The array of studies found in the literature are indicative of the significance and interest in this topic. This section of the review of literature provides a sampling of some of the research efforts addressing socialization in a variety of professional fields.

Studies covered the spectrum of professional fields. Among the fields addressed were education, business, health, and administration. Ronkowski and Iannaccone (1989) reviewed a number of studies that had the Van Gennep and/or Becker models of socialization in common. These studies attended to the socialization experiences of individuals in graduate studies, nursing, law enforcement, and educational administration. They provided empirical support for the
belief that the socialization process takes place in stages (Parkay, Currie, & Rhodes, 1992; Ronkowski & Iannaccone). In one phase individuals focused on making comparisons between self and others within the proximate work environment. A compelling desire to survive in the organization was also present. Another phase involved task orientation and concern with competence and control. Location and definition of self and a sense of stability (role transition) denoted the final phase within the socialization process. The review of studies done by Ronkowski and Iannaccone and others established a paradigm for examining the socialization process and programs designed to enhance, support, and/or facilitate it.

A review of the socialization literature in education revealed studies at various levels of the field. Notably, socialization of beginning teachers and administrators (principals and assistant principals) is well documented. Studies showed that formal professional education did not necessarily translate into an individual’s practice. Novice teachers were found to enter their first work experience with expectations that were divergent from the realities of the work place. The support and assistance of other professionals in the field were important factors in the successful socialization of newcomers. These themes were repeated throughout the literature of beginning teacher socialization (Carney & Hodysh, 1994; Etheridge, 1988; Hart
Socialization is an interactive process. The newcomer is affected by other professionals and by the work environment and in turn has an impact on them. This dynamic process of role transition resulting in the incorporation of the professional behaviors, attitudes, practices, and beliefs is documented in several studies. Etheridge (1988) through field interviews and observations followed thirty-one novice teachers over a 3-year period. Findings supported the dynamic nature of the role transition process. Beginning teachers used conscious selection, processing, bargaining, and rationalizing to adjust to the new professional role. According to Etheridge, these strategies enabled them to come to terms with the discontinuity experienced on entry to the teaching profession. Induction programs were identified as necessary components to provide the professional support for beginning teachers (Carney & Hodysh, 1994; Hart & Adams, 1986; Sanford, 1988).

The socialization of school administrators was a substantial part of the body of literature on socialization in the field of education. The career development path to school administration often involves the assumption of preparatory roles. A variety of community-based activities may provide the opportunity for the assumption of some role characteristics. Marshall and Kasten (1994) assert that the assistant principalship is a common entry point for school
administrators. This preparatory role may make the transition to principalship much easier.

Like beginning teachers, individuals moving into administrative positions feel overwhelmed and experience a lack of confidence and concern about their preparedness for the new role. Beginning school administrators also experience identifiable stages of professional socialization. They need support for continued professional development and role enculturation (Cantwell, 1993). The recurrent themes in administrator socialization parallel those found in the teacher socialization literature (Cantwell; Hart, 1991; Hart, 1992; Parkay, Currie, & Rhodes, 1992).

Many complex responsibilities and challenges face a new principal. The demands are many and without support, principals often feel isolated in their roles. Seventy-two assistant principals involved in a Super-Center program were subjects in a study of role perceptions, role conflict, and role behavior (Cantwell, 1993). The Super-Center was cited as an example of a center that sponsors specific programs targeting the continuing professional socialization of school principals and assistant principals during the initial years in those roles. Subjects responded to the Assistant Principal Role Questionnaire. This study was designed to identify specific ways that the professional socialization of assistant principals could be assisted.
One response emanating from the data was the need for support programs that would value and encourage innovations, openness, and the redefinition of the assistant principal’s role. A professional socialization program such as that provided via a Super-Center concept or structure was highlighted. Its primary purpose was to provide support in the form of networking, training, and coaching for the new principals.

Administrators consistently cited the importance of role models and support systems in assisting them to make the transition into administration. The support and guidance of other administrators enabled new principals to develop their personal practice styles. These styles were often a composite of the best and most comfortable examples observed by the novice. Parkay, Currie, and Rhodes (1992) offered recommendations as a result of their longitudinal study of 12 first-time high school principals. The focus of their study was to explore the experiences, perceptions, and concerns of high school principals during the 3 years following their appointment. They identified a five-stage prototype of the professional socialization process. Interestingly, their conclusions included the need for support programs for newly appointed principals.

The need for support programs for newcomers in any given field was prevalent in the literature. Successful role transition was found to be enhanced by such programs.
Blau (1988) studied a group of insurance managers. As in studies by Cohen (1981) and Kramer (1974) the issue of discontinuity between newcomers' expectations and the reality of their new work experiences was addressed. Blau's investigation looked specifically at the impact of apprenticeship as a socialization strategy on newcomers' expectations, role transition, and performance. All three were found to be positively influenced by the one-on-one relationships formed between the managers and novices.

Professional socialization has its beginnings in formal educational programs at the undergraduate and graduate levels. These programs initiate the acquisition of the norms, values, and attitudes of the professional role. Professional graduate education and the inherent socialization process that occurs was addressed in studies by Stein and Weidman (1989), and Becker, Geer, Hughes, and Strauss (1961). Stein and Weidman offered yet another view of the socialization process. In their study of socialization in graduate education, their focus was on the impact and the interaction between student characteristics and the socialization process. The reciprocal/interactional nature of the process was highlighted. Stein and Weidman's focus was unique in that most other studies reported findings based on the institutional and individual influences of professional socialization. However, the resulting conceptual framework presented the dynamic nature
of the socialization process. The model also depicted the mutual transfer of values, norms, and beliefs that occurs between one group of professionals and newcomers to the field.

In medicine, the socialization process is extensive. Pre-medicine undergraduate study is followed by medical school. For some, internships are followed by residency programs. At all levels, the novice physician is exposed to the norms, values, attitudes, ethics, and behaviors that are associated with the medical profession. A gamut of practice choices are presented during the process. The socialization of physicians was chronicled by Becker, et al. (1961) and Carlton (1978). Described as a rite of passage, the novice experiences a transition into the coveted professional ranks of medicine. The central question addressed by these investigations related to the impact of medical school as an organization on the development of medical students and their future practice choices as they move through the educational process. The researchers were specifically concerned with the major changes that individual students experience not only in skill development and knowledge base but in attitudes, behaviors, beliefs, and perceptions. The findings pointed out that students are afforded a variety of perspectives as they interact with the professional environment and culture. Carlton (1978) identified three perspectives developed by medical students as outcomes of
their socialization: the clinical, the legal, and the moral. Internalization of these perspectives constitutes the role definition for the developing newcomer to the field of medicine.

In summary, the literature on socialization in professional fields affirmed that newcomers to a field are affected by and affect the socialization process. This dynamic process begins with entry into the formal educational preparation program. It continues in the initial work experience. The process results in the acquisition of the characteristics each field associates with its definition of a professional in the field. Because it is an interactive process between the novice and the professional culture, clear benefits were demonstrated for the incorporation of support structures to facilitate the novice’s movement through the socialization process.

**Professional Socialization in Nursing**

A profession has been defined as one that is self-regulating and possesses a unique body of knowledge. It sets its own educational standards, code of ethics, and the parameters for entry of individuals into the field. A professional organization exists to meet a variety of needs of the profession and its members. Members of the nursing profession and others are engaged in an ongoing debate regarding the status of nursing as a profession. The debate revolves around the unique and special body of knowledge
claimed by nursing. Some may say that nursing is a semi-
profession. However, in this study, nursing is referred to
as a profession because it meets most of the criteria that
define a profession. Nursing has a professional
organization that sets standards of practice (American
Nurses Association). Governing bodies (Boards of Nursing),
comprised of active members of the profession, regulate
educational and credentialing requirements.

In nursing, as in other professions, the socialization
process assists beginning professionals to achieve specific
goals. Among these goals are learning the technology of the
profession, internalizing the professional culture,
developing a personally and professionally acceptable
version of the role, and integrating the professional role
into all other life roles (Cohen, 1981). While professional
socialization begins during the formal educational process,
it continues into the individual's initial employment
experiences. To successfully experience role transition,
beginning nursing practitioners like other professionals
need a reference group when moving from the educational
sphere to the practice sphere. Socialization promotes
interaction with nursing professionals and enables the
novice nurse to learn about clients, fellow practitioners,
and the problems involved in practice.

Socialization into the profession of nursing begins in
the formal educational program. Exposure to curriculum,
faculty, clinical agencies and their staff contributes to the socialization of the nursing student. Continuing socialization following graduation is one way to avert the disillusionment and lack of job satisfaction experienced by beginning nursing practitioners. Cohen (1981) wrote that the cause of disillusionment in nursing was rooted in problems in the socialization process. In a study of job satisfaction among new graduates, Munro (1983) reported that hospital nurses have more than three times the turnover rate as teachers and one and one half time the turnover rate of social workers. Wilson and Startup (1991) found in their study of socialization that the turnover trend may be counteracted by good staff relationships and a favorable unit climate. In short, staff, organizational climate, and support are highly relevant to socialization. The nature of the socialization process and how it can best be facilitated are important concerns in this study.

Additional support was found in the literature on professional socialization in nursing for the belief that socialization occurs in phases. Though the labels differed, generally speaking, the following phases were recurrent: beginning, intermediate, transition, and resolution. Brief et al. (1979), Kelly (1993), Lawler and Rose (1987), and Munro (1983) all found support for the notion that the socialization process occurs in phases in their studies of professional socialization in nursing. Brief et al.,
particularly, described the phases as anticipatory, adjustment, and role management. During the anticipatory phase, the beginning practitioner's role perceptions prevail. The incongruities between the beginning practitioner's perceptions and the actual demands of the role launch the new nurse into the adjustment phase. Through negotiation and modification, the third phase of role management is entered. In this phase the new nurse attempts to balance personal role preferences and the role expectations.

In summary, it is the responsibility of those in the profession to provide the best transition from undergraduate educational preparation into beginning practice for those who ultimately must receive and pass on the nursing culture (Cohen & Jorjet, 1988). The understanding gained about beginning nursing practitioners and their initial practice may add to the body of knowledge regarding successful professional socialization. Some guideposts for enhancing beginning nursing practitioners' role identity and transition may also be outcomes of this investigation.

Mentoring/Preceptorship Relationships

Promoting retention, job satisfaction, and professional development of the beginning nursing practitioner are current concerns of members of the profession. The literature on professional socialization in various fields repeatedly addressed the concept of providing supportive
structures for newcomers in order to enhance and facilitate their role transition. The importance and influence of positive role models in attending to this issue were also emphasized (Blau, 1988; Cohen, 1981; Cohen & Jordet, 1988; Feiman-Nemser, 1992; Hart & Adams, 1986; Kuzmic, 1994; Marshall & Kasten, 1994; Sanford, 1988; Stein & Weidman, 1989).

Mentoring has been of interest to several researchers. Investigators have been hard pressed to formulate a common operational definition for the concept of mentoring. Jacobi (1991) in her synthesis of the literature on mentoring and academic success cited several definitions used in various professional fields. Common elements in the definitions offered included the following:

1. an interactional and reciprocal process between two individuals.

2. a nurturing process that facilitates the personal, intellectual, and professional development of both mentor and mentee.

3. a process whereby a mentor functions as teacher, guide, supporter, sponsor, counselor, and role model for the mentee.

Jacobi condensed these common elements of mentoring relationships into three major components: providing emotional and psychological support, promoting professional development, and serving as a role model.
Characterized as a relationship between an experienced professional and a beginning practitioner, the mentoring process was described in a variety of ways in the literature. Formed by a mentor and a mentee, the two have distinct roles in the relationship. On the one hand, the mentor represents a trusted individual who assumes responsibility for guiding, counseling, and coaching another individual (Gladstone, 1988; Kram, 1983). The mentee, in turn, is one who is open to and values the perspectives of the mentor and is willing to accept change (Gladstone). Purposes of the relationship are to assist novices to make sense of what is happening around them in an organization, create a sense of community and care, assist them in the definition of their role, and assist in the construction of a sense of competence (Blau, 1988; Daresh, 1990).

Some mentoring relationships occur naturally between individuals while others are planned and structured. Viewed in many fields as a developmental process, mentoring relationships may be formal or informal (Chao, 1991; Gerstein, 1985; Jacobi, 1991; Jones, 1983). Informal mentoring relationships often involve a natural self-selection of mentor and mentee. The two persons demonstrate interest in establishing a relationship. The mentor willingly offers the mentee additional attention and facilitates that individual's personal and professional development (Chao; Noe, 1988a). Informal mentoring
relationships are usually bounded by a close relationship between the two participants. On the other hand, formal mentoring relationships involve the random matching of a mentor and mentee by the organization (Chao; Noe). Generally speaking, prior friendship between the two participants will be absent.

Many institutions use the model of assigned mentoring relationships to facilitate the newcomer's entry into the organizational culture. Noe (1988a) investigated the factors influencing successful assigned mentoring relationships. He reported that mentoring programs to be successful should have a specific purpose and goals, provide preparation for those serving as mentors, insure access of mentors, and base mentor selection on their motivation and desire to assist the development of other employees as well as the quality of their interpersonal skills. Gladstone (1988) added that successful mentoring programs should include effective feedback systems that keep the mentee on track, while focusing on the positive and minimizing failure.

Historically, the licensure regulations in nursing have provided for a formalized mentoring process. Novice nurses had to practice under the direct supervision of registered nurses until licensed. In studies about mentoring relationships, Dailey (1990) and Howard-Vital & Morgan (1993) reported that a formalized mentoring program for
beginning nursing practitioners could substantially decrease the levels of role conflict, role ambiguity, and job stress. Dailey went on to state that rather than leaving the socialization process to chance, a mentoring program could assist new nurses to learn the ropes from a successful nurse role model.

The mentoring relationship is interactional and reciprocal. Mentees, mentors, and organizations derive benefits from the relationship. Hogarty (1988) described the mentor approach as a legitimate response to the realities of practice by professionals currently in service. The interaction between mentor and mentee can positively affect the mentee's career by increasing the chance for success and enhancing the quality of the mentee's work life (Fields, 1991; Gerstein, 1985; Rawl & Peterson, 1992; Taylor, 1992). Specific ways in which mentees gain from the relationship include increased self-confidence and technical expertise, better understanding of the organization's administration, job advancement, greater control of the work environment, and more effective work patterns. Additional benefits derived from the mentoring relationship for the mentor include providing a guided apprenticeship, breaking ground for the mentee, intervening with influence, and serving as a sponsor for the mentee (Gerstein; Howard-Vital & Morgan, 1993; Steele, 1991). Organizational payoffs include transmission of the corporate culture, greater company
loyalty, and internalization of organizational norms by newcomers.

Similar findings were reported by Feiman-Nemser (1992). In a study that examined what is known about experienced teachers acting as mentors, the investigator noted that as mentors, experienced teachers not only contributed to the learning of novice teachers but also learned in the process. Through collaboration and experimentation within a professional learning community, experienced teachers helped novices to survive their first year of teaching. Other investigators concurred with the reciprocal nature of the mentoring relationship. Olian, Carroll, Giannantonio, and Ferren (1988) found support for these ideas in their experimental study. They reported conclusive results that mentees' attraction to mentors was significantly affected by the mentees' perceptions of the mentor's interpersonal skills.

Regardless of how the participating individuals come together, formally or informally, they move through a series of phases. A number of studies presented frameworks to conceptualize the phases of mentoring relationships (Chao, 1991; Hsieh & Knowles, 1990; Hunt & Michael, 1983; Kram, 1993). These phases were of variable timeframes and overlapped. Past experiences of mentee and mentor and the induction methods used by the organization may come together to influence the mentee's progress through the phases.
(Jones, 1983). The conceptual models offered by Kram and Chao provided the basis for understanding the perspectives of participants and the outcomes in this study.

The four phase mentoring model described by Kram (1983) included initiation, cultivation, separation, and redefinition. During the initiation phase, mentees look to their mentors for support and guidance. Heavy dependence and reliance on the mentor as the expert typifies this beginning phase. Hunt & Michael (1983) concurred and used the term power-dependency. Denoted as the most active phase, the cultivation phase involves the testing of expectations by the mentee. Mentors’ expectations are tested against the realities of the work environment. The mentee’s sense of confidence is boosted by modeling, acceptance, and affirmation from the mentor. Separation provides the mentee with the opportunity to function independently without feelings of anxiety and loss. A period of difficult adjustment, this phase results in psychological and structural separation—marking the changed nature of the relationship. Finally, Kram’s model culminated in the redefinition phase. The mentee looks upon the mentor in more realistic terms. The mentor’s strengths and weaknesses are assessed. Contact continues between the mentor and mentee, though informal. A sense of more equal footing and indebtedness are part of the mentee’s transformation.
Other researchers sought to determine identifiable patterns in the mentoring process. They also looked at the implications of such patterns for facilitating the process. Hsieh and Knowles (1990) studied the preceptorship relationship in nursing education. They identified seven components as important for successful mentorship/preceptorship relationships. They are trust, clearly defined expectations, support systems, honest communication, mutual respect and acceptance, encouragement, and mutual sharing of self and experiences.

Diversity issues were clearly not the focus of this study. However, they represent factors that may influence mentoring relationships and their outcomes. Diversity of age, race, and gender was addressed in some studies (Blau, 1988; Merriam, 1983; Noe, 1988b; Olian, Carroll, Giannantonio, & Feren, 1988; Shapiro, Haseltine, & Rowe, 1978). In studies of mentoring for African American women, there were no race or gender specific functions noted for the mentor (Howard-Vital & Morgan, 1993; Steele, 1991). However, when looking at minorities in higher education, mentoring was cited as a tool toward the end of recruitment and retention of minority faculty. Further, a positive relationship was noted between minority faculty retention and the retention and graduation rates of minority students (Howard-Vital & Morgan; Steele). Speizer (1981) noted that most studies addressing mentoring focused on white female
students, leaving a void in the application of the concept to mentoring relationships involving minorities.

The influences of gender in mentoring relationships were given importance in the literature. The impact of gender on the effectiveness of mentoring relationships received mixed reviews. In some studies, the impact was seen as neutral. Others found that same gender mentoring relationships were reported to be more satisfying. Negative experiences were reported by some in cross gender mentoring experiences. The specific professional field often dictates the gender of the mentor. In female dominated fields (social work, nursing), mentors more often than not are females. An obvious paucity of female mentors exists in the corporate field, law, medicine, and engineering. Hunt and Michael (1983) reported in their study of same gender and cross gender mentoring relationships, that gender played an important role and should be controlled for in investigations. Olian, Carroll, Giannantonio, & Feren (1988) found no evidence of differences in same-sex and cross-sex mentoring relationships. Noe (1988a) reported that, surprisingly, mentors who were matched with mentees of the opposite gender indicated that the mentees made more effective use of the relationship than did those who were of the same gender. His findings also indicate that females were more effective in the utilization of the mentoring relationship than were males. Fagenson (1989) concluded
that in terms of career outcomes, mentoring worked equally well for men and women. From these reports, it would appear that variables such as gender, age, and race may be important to consider when matching mentors and mentees in a mentoring relationship (Blau, 1988; Hunt & Michael, 1983; Noe, 1988b).

In summary, many variables may impact the mentoring relationship. These variables should be considered when forming such relationships. The literature supported the notion that significant psychological and instrumental benefits can be derived from mentoring relationships. The support structures that mentoring relationships provide for novices assist them toward personal and career development as well as a smooth transition from beginner to the professional role. The literature affirmed this investigation's focus on the professional socialization of beginning nursing practitioners and the exploration of the import of the mentoring/preceptorship relationship on the process.

**Locus of Control**

Newcomers to a professional field enter with specific needs. These needs include but are not limited to the need for support, guidance, instruction, and acceptance. Early in the socialization process, these needs are often reflected in dependent and externally focused behaviors. While this investigation's focus was not the locus of
control concept in its pure sense, the locus of control concept literature offered the paradigm for understanding some of the behaviors described by participants.

Several authors suggested that locus of control exists on a continuum and can influence performance, confidence, and responses to the environment (Cheng, 1994; Klein, 1990; Phares, 1976). The participants in this study described behaviors that reflected a changing pattern along the locus of control continuum as the socialization process evolved.

The degree to which people internalize or externalize responsibility for the outcome of their actions is one definition of locus of control found in the literature (Basgall & Snyder, 1988; Cheng, 1994; Julian, & Katz, 1968; Klein, 1990; Lefcourt, 1966, 1976, 1981; Phares, 1978; Rotter & Hochreich, 1975; Strickland, 1989). Another definition addresses the generalized expectancy that people hold regarding the potential efficacy of their behavior. Internally focused individuals view their actions as influencing their outcomes. They attribute responsibility for success and failure to personal attributes such as effort and ability (Davis & Davis, 1972; Noe, 1988a). In contrast, externally placed locus of control places responsibility for success and failure to some external force or focus.

Externals and internals have divergent perspectives regarding personal control within their environments and in
different situations (Cheng, 1994; Phares, 1976). Individuals with an internal locus of control assume responsibility for actions and see their actions as influencing their outcomes. They exert significant effort at mastering their environments, exercise higher levels of self-control, are less subject to the influence of others, and approach situations with caution (Phares). Externally focused individuals generally perceive their outcomes as having more to do with luck, chance, fate, or as under the control of others or even unpredictable (Phares).

Phares (1976) posited that the locus of control paradigm is assistive in fostering understanding of behavior. However, caution must be exercised in its application because of its multidimensional nature and the situation-specific variables that may be at play.

The work of several investigators supplied the background that gave significance to the locus of control concept in this study. The professional socialization literature typically defined the newcomer to a profession in the following way: lacking in experience, unsure about knowledge and skills, often deferring to more experienced professionals in the work environment. These characteristics are often accompanied by behaviors that reflect an external focus. Lefcourt (1966) reported the predictive attribute of locus of control as it relates to a variety of social behaviors, performance outcomes, and
achievement-related activities. Rotter & Hochreich’s (1975) work further expanded the locus of control concept. Their work suggested that locus of control influences performance in unfamiliar environments such as a new profession or organization. In Noe’s (1988a) investigation of mentoring relationships, he reported that in the context of such relationships, mentees whose locus of control was internally placed may be more apt to interact and effectively use the relationship.

The relationship of locus of control to the performance of beginning professionals early in their practice is an important one. In his study of Hong Kong teachers, Cheng (1994) reported that the locus of control seemed to be a powerful indicator of teachers’ attitudes and perceptions of the organization. More positive levels of job and social satisfaction, role clarity, job attitudes, and organizational commitment were found in the teachers that were subjects in Cheng’s study. Several characteristics were identified for the teachers with an internal locus of control when compared with those who had an external locus. Internals were more positive and confident about their roles, work, and ability to meet the challenges of the organization. Social relationships with colleagues were more satisfying. Cheng found his outcomes to be consistent with those for western populations. Phares (1976) had similar findings. He found that individuals with an
internal locus of control had a sense of independence and reliance on their thinking and decision making skills. They were significantly less conforming and more independent than those with an external locus of control.

In summary, internal and external locus of control have implications for the behaviors described by participants in this study in the context of the mentorship/preceptorship relationship. The newcomer's progress through the phases of socialization, assisted by a supportive environment, must be further investigated from the power-dependency perspective. This study included a beginning exploration of this perspective. The locus of control literature provided the lens for exploring and understanding behaviors described by study participants.

**Chapter Summary**

The literature review provided the conceptual framework and support for this study. Professional socialization, and Cohen's (1981) model specifically, provided the foundation for describing and understanding the beginning nursing practitioner's entry into professional practice. The import of mentoring relationships for the continued socialization and successful entry into practice and role transition was also a significant component of this study. Finally, locus of control provided the lens for viewing and understanding particular behaviors described by participants in the study.

This study's focus on the long standing assumptions by
the nursing profession regarding the import of mentoring/preceptorship relationships on the beginning nursing practitioner's entry into practice and professional socialization is supported in the literature. The novice's unique perspectives of what would constitute the most assistive and helpful process of socialization are important. They may inform the nursing profession's interest in and concern for the socialization and role transition of the new nursing practitioner.
CHAPTER III
PROCEDURES AND METHODS

Fostering understanding of mentoring/preceptorship relationships and their import for the professional socialization of beginning nursing practitioners was the purpose of this study. Of particular importance in this investigation was the unique individual and collective perspectives of the participants. Investigations that target people's understanding are well served by qualitative methods (Bogdan & Biklen, 1992). Understanding the phenomenon being studied from the participants' perspective is a goal of qualitative approaches. Because qualitative methods are dynamic and creative in nature, they provide insight into real-world, real-life conditions. Unrestricted by pre-determined outcomes, goals, or treatments, qualitative methods are sensitive to the perceived reality of individuals (Patton, 1990). Because of the focus of qualitative methods on the naturalistic aspects of events as perceived/experienced by individuals, external variables occupy a secondary position.

Though a variety of qualitative approaches exist, this investigator utilized focus groups, document analysis, and a demographic questionnaire for data collection. The trustworthiness, credibility, and dependability of qualitative methods are aided by the process of
triangulation wherein data are collected from a variety of sources (Marshall & Rossman, 1989). This bringing together of data from several sources to converge on a single experience is important in qualitative research. Triangulation in this study consisted of data from the following sources: tapes of the focus group sessions, word lists, journey maps, and sentence completion statements done by participants during the focus groups, a demographic questionnaire, a telephone survey of inservice educators at agencies where participants were employed, graduates’ orientation schedules, and the investigator’s notes and observations.

Generalizability of the findings of qualitative studies has often generated discussion among members of the research community. According to Morgan (1993), when the researcher’s goal is specification rather than generalization, focus groups and other qualitative strategies are appropriate methods. The needs and expectations of the reader are important in qualitative research. Thus, transferability of results in qualitative research is left to the reader (Marshall & Rossman, 1989; Morgan).

Focus groups provide a natural setting where participants can feel free to talk and share insights, observations, and experiences. A number of characteristics can be cited for this data collection strategy (Krueger,
Focus groups presume that participants have a particular event, activity, or situation in common. In other words, the groups are homogenous as it relates to the subject of discussion. A moderator leads the focused discussion with the assistance of an interview guide. Consensus is not the goal of the discussion. Rather, attention is focused on understanding the participants' perspectives on the issues (Krueger, 1994). The data generated from the participant's perspectives are of a qualitative nature.

In this investigation, the participants were all beginning nursing practitioners within the first 12 months of initiating practice. The focused discussion for this homogenous group was beginning nursing practice and mentorship/preceptorship relationships. The discussions occurred in a socially arranged setting in a central location. This investigator served as moderator for the sessions and utilized an interview guide consisting of open ended questions to address the major areas of inquiry. The interaction generated in each group focused on the subjective experiences of the participants. The range of responses elicited provided rich qualitative data that may help broaden the sociological and psychological understanding of the particular sphere of human experience that is under investigation.

The effectiveness of focus groups as a data collection
tool was addressed in the literature. Among the factors considered important were providing for adequate range, specificity, depth, personal context, and nondirection of the interview questions (Merton, Fiske, & Kendall, 1990). Krueger (1994) added that the level of participant identification with the interviewer could also impact the outcomes of the groups. Specific advantages cited were the natural environment, flexibility, and high face validity. Disadvantages noted included difficulty of data analysis, difficulty assembling groups, and variations in quality of group interaction. The interviewer's ability to demonstrate genuine interest in learning as much about the participants' experiences was viewed as important. When coupled with an atmosphere that places participants at ease and free to share their views, a free flowing and productive conversation on the topic should be the outcome.

Sample

The sample for this study was drawn from graduates of an associate in science degree program in nursing from a community college in the Southeast region of the country. The May 1994 graduates were approached by the investigator during their final week of the program to determine their interest in participating in the study. A total of sixty-three graduates signed up (Appendix A). Names, addresses, and telephone numbers were requested of graduates at the time of the investigator's preliminary contact. Each
prospective participant was first contacted personally by telephone by the investigator. Each was asked about continuing willingness to participate in the study. Those who were willing to participate were read a list of proposed dates for the focus groups and asked to identify at least two dates and corresponding time frames when they would be available to participate in a focus group. Once all prospects were contacted and date/time preferences noted, the investigator structured the focus groups to capture the dates and times most convenient for the participants. A second call was made by the investigator to each prospect to confirm the date and time for his/her participation.

Thirty-one of the May 1994 graduates of the program served as the sample for the study. This represented 25% of the total graduating class and 49% of the graduates who signed up initially to participate. Correspondence explaining the study, addressing voluntary participation, and guaranteeing anonymity was sent to each prospective participant who was confirmed by telephone contact. Included in the correspondence was a demographic questionnaire (Appendix B). The cover letter (Appendix C) instructed participants to bring the completed questionnaire to the focus group sessions. Two days prior to their scheduled focus group session, participants were contacted by telephone as a reminder and to confirm their plans to attend. A total of seven focus groups were held at a
central location in the city where the program is located. Appendix D contains the focus groups schedule. Informed consent (Appendix E) was obtained at the beginning of each focus group, following an explanation of the study, its benefits and disadvantages.

An attempt was made by the investigator to contact the members of the May 1994 graduating class who had not signed up to participate in the study. The goal of this attempt was to increase the size of the sample. The response to this attempt was negligible (two) and the sample size remained at thirty-one.

Methodology

The primary data collection method in this study was focus groups. Open ended questions, designed to address the broad areas targeted by the research questions, were used as an interview guide with the focus groups (Appendix F). All sessions were tape recorded and took place over a 1 1/2 - 2 hour period. Appendix G consists of a sample transcript for the fourth focus group. Duplicate tapes of each session were made. Light refreshments were provided for the comfort of participants. Seating charts were used by the investigator to track and chart each speaker during the focus groups and to facilitate transcription of data.

Focus group participants had experienced between three and twelve months of practice as beginning nursing practitioners. Each focus group participant was asked to
make written comments in response to the investigator's instructions at transition periods during the focus groups. Appendix H was used by participants at the beginning of each phase of the interview to record the five words that best described their thoughts and/or feelings for each of the phases listed. Appendix I was completed by each participant at the end of each phase and prior to the transition into the next phase of the interview. At the end of each focus group, participants were asked to create "journey maps" depicting their beginning practice experience. On a blank sheet of paper, they noted the major highlights or points of the journey.

Additional data were collected via a telephone survey of inservice educators at four of the major agencies where participants were employed (Appendix J). Orientation schedules for new graduates were also requested and received from some of the agencies. These forms along with the moderator's transcription notes, summary notes and the forms completed by the participants during the focus groups constituted the document analysis aspect of this study.

**Data Analysis**

Qualitative data are rich in content and meaning. Data analysis in qualitative research involves creating order, organizing, structuring, and giving meaning to the mass of information that has been collected (Marshall & Rossman, 1989). Immediately following each focus group session, the
investigator, who served as moderator for the sessions, recorded moderator notes, summarizing each phase of the interview guide. Duplicate tape recordings were made of each focus group. One set of tapes were transcribed by a professional transcription service. The second set of interview tapes were reviewed by the investigator following each focus group and transcription notes summarizing each phase of the interview guide were completed.

The nine research questions generated at the beginning of this investigation served to focus the analysis of the data. The investigator examined, coded, and interpreted the data noting themes, meanings, and relationships. These processes are in keeping with those of data reduction, data display, conclusion drawing and verification cited by Miles & Huberman (1984). Through content analysis and content charts, recurrent and emerging themes and categories were identified. This process was assisted by frequency counts and consensus. At the end of each focus group, the investigator sought consensus from participants by summarizing and seeking confirmation from participants of the content of the summary. Inconsistent data and themes were also analyzed across groups. The resulting coding matrix included statements made by participants that supported the investigator's interpretations and were duly noted in Chapter IV. Appendix K contains a sample data analysis matrix for the fourth research question.
Results of the Pilot Study

The pilot study served multiple purposes. Its primary purpose was to establish baseline data for the study. Salient issues surrounding the influences of mentoring/preceptorship relationships on the early professional socialization of beginning nursing practitioners were identified. The methodology for data collection was supported as an appropriate strategy for this study. Modifications of the interview guide, sampling procedures, and expansion of the review of literature were additional outcomes of the pilot study. This section presents specific results of the pilot study.

Eight focus groups were scheduled for the pilot study, five were held. There were no participants in attendance for three of the scheduled groups. Table 1 presents a summary of the focus groups' participation.

Table 2 describes the make up of the five focus groups held. Three of the thirteen participants were white males, nine were white females, and one was an African-American female. The average length of work experience since graduation was three months.
Table 1

Pilot Study's Focus Groups Participation

<table>
<thead>
<tr>
<th>Focus groups scheduled</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus groups completed</td>
<td>5</td>
</tr>
<tr>
<td>Focus groups without</td>
<td></td>
</tr>
<tr>
<td>participants in attendance</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 2

Pilot Study's Focus Groups Make Up

<table>
<thead>
<tr>
<th>Focus Group</th>
<th>No. in attendance</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F</td>
</tr>
<tr>
<td>#1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>#2</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>#3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>#4</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>#5</td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>

Immediately following each focus group session, the investigator, who served as moderator, recorded moderator notes. Data generated by each phase of the interview guide was summarized. The tape recordings of the focus groups were transcribed by the investigator. Four primary areas of focus were used to organize the data: pre-mentoring/preceptorship phase, mentoring/preceptorship phase, post-mentoring/preceptorship phase, and relationship
with other staff.

Though very complex, qualitative data have a richness that promotes thinking. New meanings and understandings about mentoring/preceptorship relationships and their influences on the professional socialization of beginning nursing practitioners were generated by the data.

The beginning nursing practitioner's experience can be viewed from several perspectives. But, perhaps the more telling perspective is that given by the beginning practitioner. This perspective brings a different level of understanding for the import of mentoring/preceptorship relationships on the professional socialization of beginning nursing practitioners.

The pre-mentoring/preceptorship period as described by beginning nursing practitioners was typified by these statements:

"I was very anxious, very excited. I had looked...I had put in applications everywhere and it's like they are not calling, they must not want me, I am not good enough..."

"Ok, I was scared. The reason I was scared, was because it was something new that I was going to be doing and I didn’t know what to expect. I was excited because I had finished school and that was what I wanted to do. I felt relieved... about the hustle and bustle of school."
"...I have worked toward my goal of becoming a nurse for what seems like my whole life, and to finally say: I am a RN and I work at so and so, was something that brought tears to my eyes on a daily basis."

These statements made by participants reflect that the pre-mentoring/preceptorship period was characterized by ambivalence regarding assumption of the role for which they had been prepared. Though there was a strong sense of excitement tied to the achievement of long held goals and dreams, it was intermingled with other feelings. Self-doubt regarding competence, knowledge, and ability to meet the expectations of employing agencies was present. Fear of the unknown was prevalent among the expressions of these beginning nursing practitioners.

During the mentoring/preceptorship phase the beginning nursing practitioners experienced divergence between their expectations for the period and the realities they encountered. Though in every case there was at least one mentor/preceptor formally or informally provided, significant variations in the experiences were reported by the participants.

When asked to give their definition of a mentor, participants expressed their expectations for the role. Following are comments reflecting participants' expectations for the mentoring role.

"It should be somebody that, that can guide you, that
can guide you and show you a path, show you alternatives to that path, ah, and just, you know, just give you guidelines ah, either as a back up for you, ah somebody that, that's kind of a security blanket...ah"
"A mama you can run to (laughter) when you don't know what to do."
"A saving grace when you're in over your head and you don't know what to do."
"...Hopefully, she is watching you very well..."

Beginning practitioners had clear notions about the role a mentor/preceptor should play in the socialization process.

Six aspects of the mentoring/preceptorship relationship evolved during the analysis of the pilot study data. These components provided an organizing structure for the focus interview data and include the following: the extent of the relationship, quality of the relationship, time spent with the mentor/preceptor, influence of the relationship on beginning practice, closeness of the relationship, and kind of role modeling present in the relationship.

Typically, the relationships were confined to the work setting and were limited to the work schedule of the mentor/preceptor. One participant stated:
"...my preceptor worked 5 days a week and I worked with her 5 days a week. And whenever she was off, I was off..."

The beginning nursing practitioners deferred to their
mentors/preceptors in matters of judgment concerning patient care. These novice nurses cited a sense of inadequacy and lack of confidence in their own skills as the basis for this reliance on the preceptors.

"But for the first, the first three weeks for me I hardly opened my mouth, all I said was ah ah, ah ah, ah ah, yes (lots of laughter from all participants) cause I was so scared, you know, and probably the first three weeks were the roughest for me cause I went home and I kicked myself all the way home every day...And I felt like you know, I can't be a nurse, you know, who am I fooling? Don't they know I..."

This statement is illustrative of the external locus of control that was evident in beginners' behaviors early in the socialization period.

Although beginning nurses reported varying levels of satisfaction with their mentoring/preceptorship experiences, there was consensus that learning took place even in the worst of situations. The following statement illustrates the attitudes of the new nurses.

"...You get to see different styles and you know you take a little bit from each one and you incorporate that and you develop your own style. And you learn things that one does that another doesn't and you learn real quick what not to do because you can see the difference and the results of the difference."
These thoughts expressed by a novice illustrate the adjustment theme that Hart (1991) identified in her work on socialization.

The post-mentoring/preceptorship phase was reported by most participants as one wherein they began practicing independently of the mentor/preceptor. In some cases, the novice nurses were assigned permanently to the same unit as their preceptor while others were not. Some beginning nurses reported that their mentors/preceptors became their supervisors.

Bonding and a continuing relationship between mentors/preceptors and novice nurses were rarely reported as an outcome of the experience. Yet, most participants expressed that they felt comfortable contacting and communicating with their mentor/preceptor after the official preceptorship period ended.

Other staff members (professional and non-professional) served as sources of support, warmth, and encouragement for the beginning practitioners. Several participants expressed that they were comfortable approaching other nurses for information and with questions about practice. The statement that follows summarizes what most of the participants felt regarding the relationship with other staff on the unit.

"I was comfortable with the nurses because they were all really good. I mean, nobody seemed to be ah,
standoffish or anything. You know, they were always there."

Participants spoke in positive terms about the relationship with staff on the patient care units. Some participants who had worked in other roles on the unit prior to beginning practice expressed a sense of discomfort with their new role which now involved supervising those who were but a short time before their peers. The discomfort was expressed by one participant in this manner:

"Ah, and like I said before, the transition with the techs was the hardest because I had been a technician. So I was uncomfortable with that part, ah cause I didn’t want to offend anybody . . . ."

The relationship with physicians was noted by most participants as intimidating, belittling, and confrontational. It was clear that the relationship with physicians was one that would have to be developed over time.

In summary, the pilot study provided baseline data for later comparisons, proposed modifications for the study design, and affirmed that the data collection methodology was appropriate for this study. While the pilot study data raised questions about the real importance of mentoring relationships in the socialization of beginning nursing practitioners, the data suggest that our understanding of
beginning nursing practice, the socialization of beginning nursing practitioners, and the role of mentoring/preceptorship relationships in these processes will be expanded.

Chapter Summary

Qualitative methods capture the subtleties and perceived realities needed in investigations that seek to bring increased understanding to a topic of interest. The primary instrument in qualitative inquiry is the researcher. The evolving nature of qualitative research gives it flexibility and a dynamism that makes whatever emerges important to understanding the event (Patton, 1990).

Focus groups were utilized to gather qualitative data in this study of beginning nursing practice and the influences of mentoring/preceptorship relationships. The interviews were treated as narratives as suggested by Silverman (1993). Using "naturally occurring data" is a hallmark of qualitative methodology. A pilot study demonstrated the appropriateness of this methodology for this investigation. The rich qualitative data when analyzed provided participants' perspectives of beginning nursing practice. The results of the study are presented in chapter IV. The summary, conclusions, and recommendations for future research are covered in chapter V.
CHAPTER IV
ANALYSIS OF DATA

This chapter consists of the analysis of the qualitative data generated in this investigation. The purpose of this study was twofold—to gain understanding of early professional socialization in beginning nursing practice from the beginning nursing practitioner’s perspective and to explore the influences of mentoring/preceptorship relationships on the professional socialization of beginning nursing practitioners.

The nine research questions addressed by this investigation are as follows:

1. How do beginning nursing practitioners describe their initial work experience and environment?

2. What are beginning nursing practitioners’ perceptions about the support structures in their initial work environment?

3. What factors are viewed by beginning nursing practitioners as facilitating/hindering their beginning practice?

4. How do beginning nursing practitioners feel about their practice during the first six to twelve months following graduation?

5. How do mentoring/preceptorship relationships
assist the beginning nursing practitioner to make the role transition?

6. How do mentoring/preceptorship relationships influence beginning nursing practitioners and their practice?

7. What do beginning nursing practitioners view as necessary and sufficient components in the professional socialization process?

8. In the absence of a formal mentor/preceptor, who do beginning nursing practitioners turn to for assistance?

9. What difference, if any, will the absence of a mentoring/preceptorship relationship make in the role transition of beginning nursing practitioners?

The researcher's analysis was guided by the processes of content analysis, data display, data reduction, coding, identification of themes, and the drawing of conclusions as described by Miles and Huberman (1984). Five themes evolved from the data as having importance for beginning practitioners. The consistency of the themes throughout data analysis provided the rationale for the organization of this chapter. The presentation of findings is organized into the following sections: (a) demographic overview, (b) pre-employment considerations of beginning practitioners, (c) entry issues, (d) roles of the
mentor/preceptor,
(e) factors that facilitate or hinder beginning practice,
(f) transition from novice to professional, and (g) summary.
The unique perspectives, interpretations, and verbal
formulations of beginning nursing practitioners provide the
lens for understanding beginning nursing practice and
mentoring relationships in this study.

Demographic Overview

The sample for this study consisted of 31 graduates of
the May 1994 class of an associate in science degree nursing
program in the Southeast region of the United States.
Females represented seventy seven percent of the sample and
males 23%. Thirteen percent of the sample was
ethnically/culturally diverse. Table 3 summarizes the
sample demographics.

Seven focus groups were scheduled. Though a total of
40 participants confirmed their intent to attend, 31 were
actually in attendance. Table 4 shows the make-up of the
focus groups.

Owing to different employment dates, the length of
employment varied for individual participants even though
all graduated at the same time. Seventy one percent of the
sample responded to the date of employment item on the
demographic questionnaire. For those responding to that
item, the average length of employment was 4.5 months. The
range was three to seven months. Table 5 shows the average
length of employment by focus groups. It is based on each
group's responses to the item on date of employment on the
demographic questionnaire. Place of employment varied: 58% 
of the sample were employed in acute care hospitals
(hospitals providing a full range of in-hospital care and 
services); 19%, in nursing homes; 6%, in psychiatric 
institutions; and 17% did not identify the type of facility
where employed.

Table 3

<p>| Sample Demographics |
|----------------------|----------------|</p>
<table>
<thead>
<tr>
<th>Male</th>
<th>Percent</th>
<th>Female</th>
<th>Percent</th>
<th>Culturally Diverse</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>23%</td>
<td>24</td>
<td>77%</td>
<td>4</td>
<td>13%</td>
</tr>
</tbody>
</table>
### Table 4
**Focus Groups Make-up**

<table>
<thead>
<tr>
<th>Focus Group</th>
<th>Number Confirmed</th>
<th>Number in Attendance</th>
<th>Gender</th>
<th>Culturally Diverse</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>7</td>
<td>5</td>
<td>1 4</td>
<td>1 (F)</td>
</tr>
<tr>
<td>B</td>
<td>4</td>
<td>4</td>
<td>1 3</td>
<td>-</td>
</tr>
<tr>
<td>C</td>
<td>8</td>
<td>8</td>
<td>- 8</td>
<td>1 (F)</td>
</tr>
<tr>
<td>D</td>
<td>4</td>
<td>4</td>
<td>2 2</td>
<td>1 (M)</td>
</tr>
<tr>
<td>E</td>
<td>3</td>
<td>2</td>
<td>1 1</td>
<td>1 (M)</td>
</tr>
<tr>
<td>F</td>
<td>8</td>
<td>6</td>
<td>1 5</td>
<td>-</td>
</tr>
<tr>
<td>G</td>
<td>6</td>
<td>2</td>
<td>1 1</td>
<td>-</td>
</tr>
</tbody>
</table>

### Table 5
**Focus Groups' Average Length of Employment**

<table>
<thead>
<tr>
<th>Focus Group</th>
<th>Responses to Date of Employment</th>
<th>Average Length of Employment in months</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>40%</td>
<td>5</td>
</tr>
<tr>
<td>B</td>
<td>100%</td>
<td>3.75</td>
</tr>
<tr>
<td>C</td>
<td>63%</td>
<td>4.8</td>
</tr>
<tr>
<td>D</td>
<td>100%</td>
<td>5.25</td>
</tr>
<tr>
<td>E</td>
<td>100%</td>
<td>3</td>
</tr>
<tr>
<td>F</td>
<td>50%</td>
<td>5</td>
</tr>
<tr>
<td>G</td>
<td>100%</td>
<td>4</td>
</tr>
</tbody>
</table>
In summary, the sample for this study was diverse when matched against several criteria. Diversity of gender, culture, length of employment, type of agency where employed, and the kind of clinical units where assigned for beginning practice were but a few of the characteristics of the sample. The insights and perspectives of the participants provided the data for this investigation. The rich qualitative data generated by the participants formed the basis for gaining understanding of the early professional socialization of beginning nursing practitioners and the import of mentoring/preceptorship relationships on their beginning practice.

**Pre-employment Considerations**

The period between graduation and employment provides a time for reflection for beginning nursing practitioners. Their thoughts seem to focus on three distinct subjects—personal achievement, expectations for the initial work experience, and preparation for the real world of practice. This section consists of a discussion of these three themes in the pre-employment period.

**The Excitement of Achievement**

When asked to share their feelings, thoughts, experiences, concerns, and wishes prior to going to work as beginning nursing practitioners, participants responded in very consistent themes across focus groups. They expressed a sense of personal achievement. Many had made personal
sacrifices to complete the professional education program. Their aspirations and hopes were centered on achieving the title of "RN" (registered nurse).

Graduates exuded excitement in their accomplishment. Attaining their goal was of paramount importance. A novice nurse who had been working in an acute care facility for approximately four months stated her position succinctly when responding to the sentence completion exercise:

"Just prior to beginning practice as a new graduate, I felt happy to finally be able to start on my career path and excited to have my first job as a nurse."

Her sentiments were echoed universally by other participants. In fact, their focus was on self. They appeared to be saying, "Look at me, I’ve done it."

Graduates’ outlook was influenced by visions of new earning power, financial independence, stable and full time employment, and practicing as nurses. More than half of the participants used words such as "excitement", "relief", "pride", "happiness", "elation", "hope", and "confidence" to describe their emotions. One graduate summed it up by saying:

"I was excited because I was finally going to start."

While excitement was very much a part of the new graduates’ experience, it was tempered by the awareness of the challenges that awaited them as beginning practitioners. The next section addresses the anticipatory expectations of
new graduates as they looked toward becoming employed.

**Pre-employment Expectations**

Without exception, all participants had planned to go to work as beginning practitioners. After all, they had prepared themselves educationally and were now ready to take on the challenges of employment. New graduates expected to find employment in the field without difficulty. What one third of them found proved to create feelings of frustration, hopelessness, anger, and doubt in their marketability. Responding to one of the sentence completion items, a male graduate wrote the following:

"I felt like I was never going to get a job. Concern that I would lose my edge, start to forget what I had learned."

The frustration experienced by many with the delay in becoming employed was captured in this way by one participant:

"I think my expectation was getting hired a lot quicker and sooner than I was. It was frustrating because we had gone through all this [education]."

At least one third of the participants voiced similar feelings. Graduates found an employment market that could or would not absorb them as readily as they expected. One beginning practitioner in the fourth focus group who had been employed for five months in a nursing home shared her pre-employment experience this way:
"I was anxious, excited, ready to take on the field on one hand; hopeful that I would get a job in a chosen field, disappointed when I didn’t."

Clearly, the employment market did not meet the pre-employment expectations of graduates. Some experienced unanticipated delays in their quest to practice as beginning nursing practitioners. The following statement was made by a female participant who had been working for seven months in an acute care hospital:

"I felt excited about graduating, but saw nothing in the work force to be excited about. I felt hopeless, tense, and with very little hope of starting work as a nurse."

The statement sums up the pre-employment expectations of graduates and the impact of a sluggish job market.

While seeking employment, mental images of the initial work environment were formulated by new graduates. In their view, these environments would be supportive, encouraging, and innovative. Recognizing that they were new to the field, new graduates felt they would certainly receive training. A term used commonly to define the training and help that were expected was "orientation." One graduate in focus group "C" expressed her expectations:

"I hoped I would get trained and have somebody to help me along. But uh, I didn’t. But uh, I really hoped that there would have been someone."
All graduates numbers expressed a desire to have a support figure in the initial work environment.

Considering their neophyte status and entry into an unfamiliar work environment, beginners felt shortchanged in many instances. Some had six weeks of orientation, others had two weeks, and yet others shared that they had none. Here is how two participants who were in different focus groups expressed what they found:

"I was promised at least two weeks of orientation. I never got my orientation."

Another graduate expressed concern about the length of time:

"The employer gives you six weeks but you know, to me, I think you need a little more time than six weeks, you know."

As graduates shared the discontinuity between their expectations for a proper orientation and what they actually received, their tone was one of disbelief and disappointment with the quality of the beginning experience.

Beginning practitioners who were employed by one particular acute care hospital or who had been assigned to critical care units, shared very different experiences. In the case of the one hospital, a well planned 12 week orientation was implemented as perceived by the participants. Novice nurses assigned to critical care units experienced a more targeted orientation. The lower patient load (one nurse to one patient or one nurse to two patients)
as well as the acuteness of the illness of patients in critical care units were in part responsible for the differences in the orientation received. Less than one third of the participants reported satisfaction with the length or appropriateness of the orientation experience.

Preparation for Beginning Practice

Another pre-employment expectation of beginning practitioners was to be supported in the beginning work experience. Looking ahead to the time when they would become employed, the realities of nursing practice and the inherent responsibilities loomed large for the graduates. A discussion of this aspect of graduates' pre-employment considerations follows.

Graduates' emotions fluctuated between their strong sense of achievement and doubt concerning preparation for practice. In one fashion or another, more than two thirds of the participants expressed similar feelings of ambivalence. They pondered whether the educational program had provided them with the kind of knowledge and skills that would facilitate an effective and smooth transition into beginning practice. For example, the eight participants in focus group "C" voiced sentiments along these lines. The following statement made by a female participant with a little more than three months work experience characterizes the general mood of graduates:

"I felt excited at starting in the field I had chosen,
anxious about my lack of knowledge, fearful that I would make a mistake. . ."

Graduates' self-doubt was prevalent early in beginning practice and made them very reliant on the external environment.

Specific issues raised by graduates regarding their preparation for beginning practice revolved around the subject of competence. They wondered if they possessed the knowledge base to handle multiple responsibilities and to deliver competent, skillful care. A common theme among graduates was the concern for the safety and well being of their patients. One graduate expressed it in this fashion:

"I felt scared. Would I be competent enough to actually take care of the patients and recognize danger signals."

Beginners were concerned that lack of experience could result in harm coming to their patients.

Coming to terms with the excitement of achievement, a sluggish employment market, and the realities of the demands of practice was a significant challenge for beginning practitioners. Yet, one graduate employed in a mental health agency summed it up optimistically:

"...in the end, I am confident that God and my education would see me through it all."

Summary

Graduates were excited about their educational
achievement and eager to begin a new career. They held expectations for gaining employment and for the beginning practice experience. Excitement had to give way to unanticipated delays in employment and to fears about readiness to do the job when employed.

Entry Issues

Beginning nursing practitioners expected support structures in the initial work environment. They perceived newness to the field, inexperience, lack of confidence, and a new environment as factors that warranted support structures.

Analysis of the data generated by the telephone survey of inservice educators at four of the major health agencies where participants were employed produced interesting outcomes. The results were not congruent with the perceptions of the beginning nursing practitioners. Of the four agencies providing information, all reported the following:

1. Beginning practitioners received a formal orientation program.
2. Orientation programs ranged between 3 - 12 weeks.
3. Mentors/preceptors were assigned to beginning practitioners.
4. The mentor/preceptor assignments were for the entire length of each agency’s orientation program.
5. Orientees and mentors shared the same patient care
One agency noted that orientees and mentors shared the same patient care assignments according to the patient care unit involved. Two agencies provided copies of their orientation schedule. The schedules reflected daily activities and the assignment of a preceptor.

Prior to employment, graduates envisioned a work environment that would provide them with support, encouragement, help, guidance, and a planned orientation. The analysis of the data reveals several aspects of the beginning work experience and environment that hold significance for beginning nursing practitioners. Two major emergent concerns frame the entry of novice practitioners into beginning nursing practice: institutional support structures and the relationship with team members in the initial work environment.

**Institutional Support Structures**

Beginning practitioners' perceptions of the initial work environment were shaped by the institutional philosophy and policies that were communicated and reflected in the practices within each institution. One of the salient institutional concerns addressed by participants in this study related to the institutional support structures.

The first institutional support structure having import for beginning practitioners was the institution's preparation for their arrival. Neophytes encountered an
apparent lack of formal preparation for their arrival in some agencies. They concluded that the attitudes, behaviors, and comments of staff were indicators that effective pre-planning had not occurred. Novices perceived the surprise of staff when they arrived on patient care units, the assignment of multiple mentors/preceptors, and the assignment to a variety of patient care units as a lack of planning on the part of the institution. In each focus group, several participants shared statements that support this perception. The following comment made by a male participant who was employed in a nursing home is illustrative:

"The assistant director of nursing kind of just said 'okay, come on we're gonna go down here.' And we went down there and she said 'this is T. K.. He's the new RN that we just hired to do nights. He's gonna be here for a few days. Show him around.' And that was it. They didn't know that I was coming. Of course, later I found out that they didn't want me either."

The staff's apparent unawareness of the assignment of a novice nurse to their unit was viewed as a lack of preparation on the institution's part.

A contrasting picture was shared by one participant who was employed in a psychiatric institution. Responding to a question addressing the welcome received on arrival to her assigned unit, she stated:
"They had a banner that said welcome. They were very nice. They fought over who would get to work with me."

From her perspective, the banner signaled that she was expected. The attention indicated she was wanted. Beginners hoped to have similar experiences but did not in most instances.

Another example of the perceived absence of institutional preparation was shared by a participant (employed 4 months). She stated the following with a sense of dismay in her voice:

"One unit that I went to, they didn’t even know that I was coming. I came in the morning and they said: we don’t have...well we don’t know that you’re supposed to be here. And I showed them my schedule and said I’m supposed to be here and they said okay. We’ll find somebody for you to work with. That to me wasn’t, it wasn’t good for me to know that they weren’t particularly concerned about me."

This participant’s experience was not uncommon across the seven focus groups. A male participant, practicing in a hospital, shared his experience:

"My first preceptor was at my first day of orientation. The charge nurse told her that she was going to have an orientee. She did not know I was standing behind her and she turned around and said she didn’t want to have nothing to do with having an orientee. Of course she
was told she would anyway."

Participants' initial impressions of the work environment were negatively impacted by the apparent lack of even the appearance of prior planning in anticipation of their arrival.

Several key aspects of institutional support were anticipated by novice practitioners. Among them were establishing "fraternity" with the mentor, confiding in the mentor without feeling stupid, having a mentor who would be a role model, and working with one who would care to get to know the novice. These expectations suggest a desire for a consistent and stable environment that would foster the development of trusting relationships between mentors and neophyte nurses. The institutional practice of assigning novices to multiple preceptors and patient care units was not viewed by beginning nurses as supportive of their expectations. One novice (employed four months) practicing in a hospital captured the impact of the institutional practice of multiple assignments of mentors and units with this statement:

"...so I really had only two weeks of good preceptorship that I feel was good because I was with the same person and I was working the same shift that she was and I had time to display what I could do and what I needed help with. 'Cause it takes time for that person to realize where your weaknesses are. And they
can't figure that out the first day. And so I think it's important that there's some continuity."

Closeness and continuity of the relationship were perceived as desirable. One participant expressed the view of more than half of the participants in this statement:

"I was precepted for twelve weeks and I had several different preceptors and it was very confusing. Um, I precepted sometimes days, sometimes evenings. Uh, sometimes my preceptor wasn't there and they just took me to another unit . . . ."

The institutional practice of assigning multiple mentors to novices was viewed as having a negative impact by participants.

Patient load assignments presented another area of concern for novices. Patient load assignments were viewed as demanding and unrealistic. A beginning nurse with previous work experience in the health field expressed her views in this way:

"I'm just overwhelmed that we're starting the program now where you have like a charge nurse, who's supposed to have a lighter patient load in order to help us with our patients. And supposedly we were supposed to get lighter patient loads too, but I don't think that's the case."

Another participant in the same focus group who had worked as a Nursing Care Technician (ancillary personnel) six
months prior to her employment as a nurse concurred. She voiced a widely held view among the study's participants:

"You know, because when we first went in to the, to watch the nurses and everything, some of them where I was working as NST [nursing technician], some of them had fourteen patients. You know, and I think it's, there's no way. School didn't prepare me to take care of fourteen patients. I can do four or five maybe, you know. But not fourteen."

Beginners were particularly concerned about the impact of a heavy patient load assignment on their ability to give safe patient care.

Even with previous work experience and familiarity with the health care environment, patient load assignments were viewed as difficult for a novice to handle. The following statement was most telling concerning this issue:

"I came home and I was in tears. They had not prepared me for this [patient load]."

Participants' perceptions of support structures at the institutional level were influenced by their experiences upon arrival. These experiences and institutional practices created feelings of instability for novice nurses.

A variety of explanations can be offered for the divergence in the information shared by the agencies and the perceptions reported by participants. From the institutional perspective, it is possible that though a
planned orientation exists, the implementation may be impacted by factors such as staffing, level of preparation for the preceptor role, and the changing demands related to patient census. From the beginning practitioners’ perspective, it is plausible that the individual human characteristics of mentors such as personality, attitude, personal commitment, and interest could affect beginners’ experiences positively or negatively.

**Relationship with Team Members**

The primary principals in the work environment of beginning nursing practitioners are the assigned mentors/preceptors and other team members (staff nurses, physicians, ancillary personnel) who participate in the care of patients. Standards and patterns of practice and care are established by mentors/preceptors and other team members. Because of the perceived importance of mentors/preceptors in the role transition of novice nurses, they will be addressed exclusively in another section of this chapter.

Beginning practitioners were exceedingly positive in their description of the overall atmosphere provided by teams of staff nurses. The environment on the patient care units was described as positive, supportive, encouraging, helpful, open, cooperative, friendly, and warm. Phrases such as "everyone on the unit works together," "lots of chipping in and teamwork," "close knit group," "one big
family," and "lots of cooperation on the unit" were used to describe the work atmosphere on patient care units. Nurses on the same work team (intra-team) seemed to enjoy a collegial working atmosphere. However, inter-team collegiality was less evident. Inter-team conflicts, "backbiting," and negative feedback were reported. A novice nurse (employed five months) practicing in a nursing home offered the following concerning inter-team conflicts:

"It's common [inter-team conflicts]. At [our institution] my first impression was none of the shifts get along. That was my first initial impression. This shift does this. This shift doesn't do this. That was my first impression when I went in my first evening. I don't know why that is. It is bad. I thought I was going to quit all the time and go look for something else."

These sentiments were echoed by participants in several focus groups.

Novice practitioners noted that staff attitudes overall were positive and supportive. Responses to the sentence completion form captured the views and experiences of neophyte nurses. At least three fourths of the responses conveyed novices' satisfaction with the relationship with team members. One neophyte (employed seven months) wrote:

"I felt accepted as one of them."

Another novice who was employed on a medical-surgical unit
(five months) expressed her thoughts in this way:

"I felt my relationship with others on the unit was one of cooperation and genuine caring."

A novice working in a psychiatric facility (three months) summed it up with this statement:

"I felt the relationship with others on the unit was excellent. I felt accepted and part of the team."

Team spirit and support on the units were viewed positively by participants in this study.

Physicians and ancillary personnel (assistive personnel who work under the direct supervision of nurses) proved to be exceptions to the positive reports about the support on patient care units. Several participants stated that the relationship with physicians was not good. Physicians’ expectations of the new nurse were viewed as too great. Following is an example of what neophytes perceived to be high expectations held by physicians. The speaker had been employed for seven months:

"He wanted me to pull the patient’s sutures out before discharge. And I told him that I could not, I really didn’t know how and it was not in my job description. He called the nurse management team and he said that I knew how to do it and wouldn’t."

This interaction seemed to suggest a less than collegial tone between novice nurse and physician. Another participant (employed in a hospital) added her sentiments:
"Nurses talk to the doctors like they were gods. Communicating with doctors is most difficult for me."

One neophyte nurse employed at a psychiatric institution offered this explanation for the difficult communication with physicians:

"We didn't get a lot of practice talking to doctors. When to call them, just how to judge what you really need to call now for or what can wait for an hour or two."

The communication pattern with physicians signaled a subordinate relationship. The nature of the relationship made it difficult for novice practitioners to judge when to call physicians after traditional business hours.

Ancillary (assistive personnel who report directly to the nurse) care givers were also a challenge for beginning practitioners. The following dialogue between two participants was very typical of the perceptions held by novice nurses regarding their relationship with ancillary personnel. The first speaker was employed in a nursing home while the other worked in a hospital.

#1: "And the C.N.A.s [Certified Nursing Assistants] don't like the nurses and the nurses don't like the C.N.A.s."

#2: "And the C.N.A.s go and complain about the nurse and instead of the DON [Director of Nursing] backing the nurse up and saying that the nurse and
that nurse's license is on the line, you have to say and explain why you made the decision you made."

#1: "In the beginning I had a real problem with one. The night supervisor was kind of lenient with them because she feels like they show up. That's fine, we laugh and have a good time. She'll [CNA] come in and talk to us, but brings books, and it was real hard for me because that's not the way it is."

#2: "But you're resented for it."

#1: "Well not to my face."

This excerpt from the transcripts reflects the tension that characterized the working relationship between nurses and ancillary personnel. A participant working in a nursing home with responsibility for 25 patients expressed her thoughts this way:

"Out of all of the people, I think that the ACTs [nursing assistants] were the worst. They were extremely difficult to work with. That was the one thing that we uh, did not learn in school and I did not learn from my preceptor. But I just had to learn on my own. They just push you."

The consensus across focus groups seemed to point to a difficult relationship among nurses and ancillary personnel.
Summary

This investigation identified institutional support structures and team relationships that can both hinder and facilitate the early socialization of beginning nursing practitioners. Regardless of the quality of their experiences, a common theme shared by novice practitioners was the need for helpful support structures and relationships. Understanding these needs from the novice practitioners' perspective has import for employing institutions and nursing education programs as they work to make new professionals ready for practice.

Roles of the Mentor

Professional socialization has its beginnings in the professional education program. It continues in the work environment. Its aim is to facilitate an effective role transition that results in the acquisition and internalization of the values, attitudes, and behaviors of a profession (Ronkowski & Iannaccone, 1989). The single most critical component in the socialization process identified by neophytes was a mentor. This section presents a discussion of the roles of mentors. Mentors exert their influence by familiarizing the novice with the institutional culture, modeling technical and cognitive competence, and demonstrating behaviors and attitudes that are characteristic of the profession.

A novice (employed five months) practicing in a
hospital finished one of the sentence completion items in this manner:

"The value of having a preceptor was having a resource right at your side--ready to help and guide you through any problems."

Many other participants conveyed similar beliefs about the mentor role. Another participant (employed six months) summed her thoughts up in this fashion:

"The value of having a preceptor is having someone to be accountable with you and for you for the first part of your work experience. As well as providing some tips and facts about the real world that are not in the books."

Beginners recognized that the learning curve was steep and viewed the mentor role as supportive in the process of taking on a new role. A participant (employed five months) expressed the experiences and sentiments of many:

"The first six weeks was pure hell. I mean I'd get home in tears and say I just had a terrible day. Had it not been for my second preceptor, I don't know if I would have made it through orientation."

This statement is indicative of the stress that accompanies the beginning practice experience. Mentors/preceptors were perceived as key persons to assist the beginner through the early period of entry into the profession.
Introduction to the Institutional Culture

Among other factors, the institutional culture is framed by the employees, mission, written and unwritten policies, practices, and philosophy of an institution. The initial work environment is often new and unfamiliar with a culture all its own. Along with the issues of self-doubt and fear, beginning practitioners must negotiate entry. The mentor/preceptor relationship was perceived to be assistive in the acclimation of the novice. Neophytes' sense of comfort was increased by the introduction to key individuals, practices, and policies within the institution. The value of the mentor in this role was expressed by all participants. One participant (employed five months) working in a hospital expressed her feelings this way:

"And to this day, I do everything that she taught me. She taught me the system on how to do my notes, how not to use pencil."

This statement implies that the influence of a mentor may be long lasting.

Meeting key individuals in the work environment facilitates entry. A novice (employed seven months) practicing in a critical care unit addressed the importance of meeting key individuals in the work environment:

"They did go out of their way to make sure that I did know who the doctors were. Uh, and anybody that might come from somewhere else, you know, a different
department. They went out of their way to make sure that you met everybody."

Becoming comfortable in the new work environment involved meeting those individuals with whom contact was inevitable. Collegial relationships with other individuals on the patient care team were viewed as important to the quality of patient care.

The need to be familiar with the specific practices of an institution was conveyed by a novice nurse (employed four months):

"Each hospital does things differently. So those kinds of things I had the preceptor help me on."

"Learning the ropes" is the common term used by novices to describe becoming acquainted with the work environment with the assistance of the mentor.

In summary, introducing the novice to the new work culture facilitates entry and assists the novice in the early beginning practice phase. Beginners perceive the mentor's role as important in the process.

**Technical and Cognitive Competence**

Beginning nursing practitioners perceive technical and cognitive competence as important. Included are the knowledge, skills, and experience that are content related in the discipline. Novices perceive these as necessary qualities and value them in mentors. By modeling technical and cognitive competence, mentors/preceptors assist
beginning practitioners to develop confidence, refine existing skills, and acquire new skills. One participant (employed in a hospital) expressed her thoughts on this issue when she wrote the following on the sentence completion form:

"The value of having a preceptor was learning how to put all my knowledge to practice in a successful way."

Speaking to the specific skills she continued:

"... prioritizing patient care and seeing the whole picture."

Novices enter the practice setting almost void of "real" independent practice experience. While enrolled in the professional education program, practice experiences occur primarily under the tutelage of nursing faculty. Observing mentors at work provides novices with a template for the professional role.

Working alongside the mentor/preceptor, beginning practitioners receive first hand experience and opportunities to observe the technical and cognitive aspects of the professional role. One participant (employed seven months) practicing in a hospital shared how he was assisted to develop his technical and cognitive competence:

"And there's a kind of sharing of information and also uh, they give you the opportunity to do probably every type of procedure [technical procedures] that's done on the unit outside of what you would normally get."
Building confidence in the performance of psychomotor skills (technical skills) was of high priority for novices. By modeling technical and cognitive competence, mentors assist novices to develop personal standards of quality and efficiency in patient care.

The ability to manage the assigned patient load and the associated tasks was also an important part of the competence beginners sought to develop. A novice (employed three months) explained the significance of this aspect of the professional role when he shared the following:

"She [preceptor] told me right from the beginning that our goal was that we could handle at least six patients with comfort. Some days were going to be wilder than others. It was conveyed several times that you got to be able to get through six patients and sometimes take others including transfers from other units."

Mentors assisted neophytes to develop the skill of time management. This point is illustrated in the statement that follows:

"My preceptor helped me learn how to manage and how to judge what really is important at that moment. When to phone or not to call that person."

This statement was shared by a novice with previous health related work experience who had been employed for five months.

Handling multiple priorities while caring for a large
number of patients was perceived by novices as part of the technical and cognitive competence required of the professional role. Instructing and preparing novices to handle significant volumes of paperwork, maintaining communication with other members of the health team, managing and caring for large groups of patients, and giving advice about how to work with greater speed were perceived by neophytes as important behaviors for mentors to model.

In summary, technical and cognitive competence are perceived as important by beginning practitioners. They value these qualities in mentors. One novice (employed in a hospital) expressed it this way:

"Mine [preceptor] was very effective. And she knew things that I can't even begin to comprehend and it's just all natural knowledge that she's gained over the years. And what I'd like to copy from her is being able to retain the information that I've learned from one patient to the next."

Effective role transition is facilitated when novices are assisted to develop confidence in their technical and cognitive competence.

Characteristic Behaviors and Attitudes

While interacting with novice practitioners, mentors/preceptors have opportunity to demonstrate the behaviors and attitudes that are characteristic of the discipline of nursing. Novices are able to observe and
identify qualities that they wish to incorporate in their personal practice. Two key attitudes that novices observed were caring and assertiveness. One participant (employed four months) expressed her observations of caring in her mentor:

"One patient in particular, I remember the preceptor in dealing with the family and presenting things in a realistic light, but at the same time being kind and not short and uh, helping to guide them toward thinking about things and making the necessary arrangements for the person who was terminally ill."

Novices expressed admiration for mentors and staff members who displayed genuine caring in their practice.

In day to day interactions with patients, mentors were able to model some of the essential components of human interactions in the health field. Another participant (employed six months) shared her perceptions of the importance of a caring attitude:

"I hope that if I got to a point where I was only in it for a paycheck, I would get out. To me you have to be a caring individual and care about what you’re doing or else you pass it on to your patients. You want them to feel like you care whether they get well or not."

Novices observed and listened for the evidences of the characteristic behaviors and attitudes of the professional role in their mentors.
Assertiveness as a professional behavior and attitude was also seen in the role models. Because of the advocacy role assumed by nurses on behalf of patients, assertiveness was perceived as an important component in practice. One participant (employed seven months) shared the following advice she received from her mentor:

"Don’t be upset if you make someone mad. If you did, that’s your job. I mean you’re supposed to do what you think is best for that patient."

Opportunity to observe mentors/preceptors working through a variety of situations in the work environment was facilitative. Beginning practitioners were assisted to assimilate the behaviors and attitudes associated with the profession.

Summary

The mentor/preceptor relationship assists the novice to fine tune skills, develop confidence, try on the new role, and grow in comfort while learning from the mentor and others in the work environment. Three roles of the mentor/preceptor emerged as important in the eyes of novice nurses: (a) introduction to the work environment, (b) modeling technical and cognitive competence, and (c) demonstrating the characteristic behaviors and attitudes associated with the profession.

Absence of a Mentor

Rationale for having a mentor were offered by
participants. This section addresses those whom novices self-select as mentors absent a formal assignment. The personal qualities that novices consider in their selection process are also addressed. The absence of a mentor in the initial work environment may impact the quality of the role transition experienced by novice nurses. Though role transition can and does occur absent a mentor, the evidence in this investigation indicates that beginning nursing practitioners will self-select a support figure even in the absence of a formal assignment.

In this investigation, several novice nurses reported not having had a formal mentor/preceptor relationship. In the absence of a formal mentor, novices indicated that they self-selected a mentor. One participant (employed four months) shared her experience:

"Well I really didn’t raise my hand because I really didn’t have a preceptor, I just more or less had an orientation. And you know, where you went through all the necessary cautions that you would have. But, uh, there was another RN working on my unit, but she was kind of left to her own. So the night, uh, the evening supervisor, I just kind of made her my mentor. Because she was really somebody that...she... I could call her."

A number of participants related similar experiences regarding non-assignment of a mentor. One participant
employed at a nursing home said:

"Yeah, and I kind of attached to one person which was good in a way. Because you can’t have three or four people trying to tell you what to do. And that’s the way they precept everybody. It wasn’t just me. That’s the way they do everybody. They just kind of throw them out and say—‘go get ‘em’!

In an unfamiliar environment and with a fairly new and untested set of skills and body of knowledge, novice nurses sought support and guidance. Even when no formal arrangements were made by the employing institutions for a support figure, beginning nurses looked for that support person that helped them feel more comfortable in the new environment.

Often novices selected individuals who held supervisory positions. Included among the supervisory titles were nurse managers, head nurses, charge nurses, evening supervisors, and directors of nursing. The following statement shared by a beginner (employed in a hospital) exemplifies how informal mentoring relationships developed:

"The charge nurse I worked with. I felt that she was, uh, excellent. She was real protective. I feel like I can go to her and I can ask her any question and she doesn’t look at me as ‘you dummy,’ or anything. I mean she takes time to explain it. Also, if she hears of others coming to ask me something that she feels I’m
not ready for, she says 'no that’s not in her job
description.' And she stands up for me. And she
doesn’t allow them to put things on me that I am not
ready for. So I think she’s great."
The "safety net" desired by novice nurses helped in their
self-selection of a mentor. The novice’s comfort level with
the individual selected was a determining factor as well.
Novices also saw other team members as potential
candidates for the role of mentor. A novice nurse (employed
three months) practicing in a mental health agency shared
her reasons for selecting a non-nurse as a mentor:
"I even went to the mental health tech, because they’re
very much involved with the clients. And some of the
ones that I’m working with, they’ve been there for
years, and they are really knowledgeable about what’s
going on."
A respiratory therapist was among some of the other health
team members selected by a neophyte as a mentor.
Novices targeted particular personality qualities when
selecting the individuals they selected as mentors. Factors
that seemed to attract beginning practitioners to particular
individuals in the work environment included experience,
knowledge, willingness, friendliness, availability,
competence, personality, and level of respect enjoyed by
the individual. Of these qualities, knowledge steeped in
experience and willingness to help were key factors
considered by beginning nurses in the self-selection process. The following statement made by a beginner who was employed in a hospital is revealing:

"If I’m on the floor, and I’m working with two or three other nurses, there’s usually one that I’ll go to first. I know that she’s the one that’s more apt to drop what she’s doing and come to me."

Getting assistance in a timely fashion was viewed as an important selection criterion. Individuals demonstrating the quality of willingness were viewed as good candidates for the role of mentor.

In summary, absent the formal assignment of a mentor, novice nurses sought to establish a support system. A number of criteria were included in the identification process used by novices. Key among these factors were knowledge, experience, and willingness to help. The ultimate goal was to have a "safety net" early in the practice experience.

Factors that Facilitate or Hinder Beginning Practice

The role transition for beginning nursing practitioners may be facilitated or hindered by a number of factors. This investigation’s focus was on the novice practitioners’ perception of factors that negatively or positively affect the assumption of the professional role. Beginning practitioners had clear notions about what facilitated or hindered their beginning practice experience.
**Assistive Factors**

Assistive factors are those perceived by beginning practitioners as facilitating beginning practice. Those receiving greatest attention were a) consistent mentor/preceptor assignments, b) self-help strategies, c) previous work experience in health, d) feedback, and e) orientation on the unit to be assigned to.

First and foremost in the view of novice nurses was the mentor/preceptor relationship. A novice nurse (employed four months) expressed the views of the majority of the participants. She wrote:

"The value of having a preceptor was the ability to have someone who could see the whole picture, who could answer any questions, who was supportive, who gave encouragement, and who was there for me."

Her statement echoed that of participants across the focus groups.

The role of the mentoring/preceptorship relationship was described in the "journey map" of a novice nurse working in a hospital:

"Preceptorship--time spent learning responsibilities and expectations on the unit and by the hospital. Preceptor allows me to "do" or ask and watch. I am moving carefully and at my own pace. I am allowed to ask a thousand questions without feeling 'stupid.' Everyone is supportive and gives encouragement. Maybe I can make it."
Novices perceived a sense of safety related to having one specific individual to call on in times of need. The section on the role of the mentor presents a full discussion of the import of the mentor/preceptorship relationship on beginning practice.

Self-help strategies were also cited as beneficial. Positive self-talk, affirmations, the use of "cheat" cards, and reliance on past work experiences were included in self-help strategies mentioned by novice nurses. Following is one beginner's statement regarding the usefulness of self-talk:

"You just have to trust yourself. Tell yourself you know your stuff. So everyday I'd be walking around going: 'I know this, I know this, I know how to do this. I can do this [laughter] stuff.' That really seemed to help me."

The laughter that her statement generated from the group seemed to indicate support and identification with this concept. Heads nodded in agreement.

Having resource materials at hand was also perceived as assistive. One beginner (employed seven months) shared that she carried all of her lecture notes to work with her. Another added:

"Having some helpful cards saying what this means and what that means is comforting."

Novice nurses recognized personal resources to be as helpful as other external resources.

Beginners who had been employed in the health field in ancillary positions called on their past experiences to assist
them. Approximately 50% of the participants reported previous work experience on the demographic questionnaire. A novice (employed five months) shared the following in support of the value of past work experience:

"I worked as a Patient Care Tech [ancillary personnel] for six months. The stress level was greatly reduced because now I had this on hand experience of handling patients, of moving them. The I.V.s and everything and I wasn't as, it's not just a total shock. . ." 

Another participant (employed five months) practicing in a hospital expressed the value of past work experience from her perspective:

"I kind of knew what I was getting into. I worked there for a few years. They worked with the nurses and nurse extenders [ancillary personnel] so that I had an idea what it was going to be like."

Previous work experience was perceived as an assistive factor because it diminished the sense of shock experienced by many beginning nurses when confronted with the realities of practice.

Receiving feedback from mentors/preceptors and other team members was deemed to be important by novice nurses. The self-doubt that beginners reported experiencing early in beginning practice fueled a desire for periodic reports on their progress. One neophyte (employed three months) expressed the need for feedback in this way:

"Yeah, I think that [feedback] is kind of important. I know
there are times when I thought, you know, am I doing O. K. It’d be nice. You might want a pat on the back. You know, you’re doing good, keep it up—sometimes means a lot. I got that some and then there were some nights when I felt totally overwhelmed, you know, like I’m stuck with all this. Just because one day I’m a RN there’s not really a big difference in me but I have a license now. But, gosh I’d like some encouragement. But I got along, but more is nice."

The impact of receiving no feedback was explained by another participant in the same focus group in this manner:

"There was no saying of what you needed to continue to work on next week. You work on this. You did well at this. It’s like you passed now, go on. And I was a little disappointed."

A nurse (employed four months) expressed her concerns with the following statement:

"I would have liked to have had feedback like that. We didn’t have those. And I don’t know if that’s because I was at several different units or if it was because of the hospital."

Novices felt that feedback concerning their performance and progress was important for their growth in the new role.

While expressing the need for feedback, participants were quick to explain what they perceived to constitute good feedback. One novice in the first focus group (employed seven months)
commented:

"Yeah, and it [feedback] was genuinely given. And feedback was sincere."

Beginning practitioners viewed feedback as an important way to grow professionally. They concluded that both positive and negative feedback were necessary.

Non-Assistive Factors

Non-assistive factors are those perceived by neophytes as having negative influences on beginning practice. Among those receiving greatest attention were (a) assistance received from mentors, (b) preparation of mentors for the role, (c) novices' non-assertive behavior, (d) mentors' patient load assignments, and (e) orientation of novices on multiple units.

A fair number of mentors had difficulty "letting go." They exercised more control with the delivery of care than novices felt necessary or practical. The following statement made by a participant (employed four months) is illustrative:

"I never had a full patient load that I had to take care of completely on my own until the night before I was on my own. I mean my last day. Well, by helping me out, it really didn't help me because then I wasn't able to prioritize all my patient care. So the first night I was expecting help and didn't get any."

A balance between nurturing assistance and "handicapping" assistance was viewed as essential in the early socialization of beginners.
A fairly common view held by neophytes was that mentors had not been adequately prepared for their role. Novices concluded that the attitudes and behaviors of some mentors were directly related to the level of preparation they received. This conclusion is evident in the following statements made by a neophyte:

"I think it's real important that they choose preceptors that want to be preceptors."

"I wonder, do they choose to do this? Mine did not. We just kind of, whoever was there, they assigned us to. Uh, and uh, that didn't work too well."

Preparation for the role of mentor was deemed by beginners as necessary in the socialization process.

Some beginning nurses soon realized that non-assertive behavior could hinder their growth in the professional role. Fewer than half of the participants expressed this as a major concern, as represented by the following statement by a novice (employed five months):

"You know, and my husband said 'what you need to do is, you need to sit down and decide what you’re gonna want tomorrow.' So I decided that I wanted to see myself confidently and completely in control of that [patient care] and that was what I really wanted to do. So the next day I went in, this was not, it was another lady. I went in and I said: 'This is what I want to learn today' and she said, 'Okay.' And everything else kind of flowed, and I got to do
what I wanted to do, so that next night when I went home I said: 'Good, well I learned this and now I can go on.' You know, but I had to speak up and say this is what I want to learn today. Because sometimes they don’t know how, these preceptors, they’ve been nurses for so long, that all they know how to do is move their tail. You know? So I found it, you know, me being able to say, this is what I want to do, instead of them leading me. I guess it just depends on the person you’re dealing with too."

Some neophytes came to the realization that the quality of the beginning experience would require active participation on their part. Active participation would involve identifying their needs, strengths, weaknesses, and interests.

Preceptors’ work load also became an issue for novice nurses. The practice within most institutions of having mentors carry a patient load while working with mentees was viewed as non-assistive. Decreased availability and access to the mentor were direct outcomes of this practice. A novice (employed five months) shared her reaction:

"I felt that preceptorship would be like going with your preceptor and she kind of takes you under her wings, and follows you around and makes sure that you do everything according to protocol, you know. They had their own patient loads, at least where I was. But a lot of times she would be too busy with procedures too and she was saying: 'Well, you know, you have to do it the best you can.'"
Novices believed that having a mentor who would be readily available to assist them with issues surrounding patient care was important for their transition.

Some institutions oriented beginning nurses on multiple patient care units. Novice nurses did not view this as a helpful approach to a new environment. Some participants expressed a sense of instability associated with the movement from one to unit to another. A nurse expressed her views this way:

"I think that it would have been easier for me if I had been oriented in the unit I would stay in. But I think it would be better for someone to be oriented to one unit specifically."

Assignment to multiple units was viewed as negatively affecting the development of a trusting relationship among mentors, novices, and other staff members. With each move, novices had to begin building relationships and establishing credibility in their competence anew. This statement by a novice nurse is illustrative:

"You know, after I was there and they knew that I was competent, and was able to take some of the work off of their hands, they were more than happy to help me. But, but, I think that in the past, they know people that aren’t competent and that just creates more work for them and so then it’s just a matter of proving to them that I was going to do more to help than hurt."

It appeared that staff members were reluctant to make an
investment of time and energy when the novice would not be on their unit on a long term basis. The "safety net" that mentors/preceptors represented was weakened by this and other institutional practices.

**Summary**

Inherent in the beginning practice environment and experience are factors that may facilitate or hinder the growth, progress, and development of the novice nurse in the professional role. Assistive factors are those perceived by novice nurses as exerting positive influences on beginning practice and role transition. They include (a) consistent mentor/preceptor assignments, (b) self-help strategies, (c) previous work experience in health, (d) feedback, and (e) orientation to the unit to be assigned to. Non-assistive factors are viewed as negatively impacting the early socialization and practice of novice nurses. They include (a) assistance received from mentors, (b) preparation of mentors for the role, (c) novice's non-assertive behavior, (d) mentors' patient load assignments, and (e) orientation of novices on multiple units.

**Transition from Novice to Professional**

The experiences, views, perceptions, and observations shared by the participants in this study provided the lens through which this investigator sought to gain understanding of the role transition experience. The novice nurse's transition to the role of professional is addressed in this section. Two phases were evident in the novice's transition: the early beginning
practice phase and the late beginning practice phase. More specifically, these phases are defined by the focus of novices' locus of control and their concerns and feelings.

**Early Beginning Practice Phase**

Beginners in the early beginning practice phase demonstrated an external locus of control. They experienced fear, self-doubt and fragile self-concepts. Their concerns focused on preparation for the role and the availability of support systems. This section addresses these issues as perceived by novices.

Participants relied on mentors and other members of the team for guidance and assistance. Novices' perceived level of control over events in the practice environment was consistent with an external locus of control. The following statement made by a beginner (employed in a hospital) is illustrative:

"My concept of preceptorship was that someone was watching over you. I felt like you felt [speaking to another participant in the focus group]. I felt that I didn’t have the knowledge. I just needed someone to say, ‘Yes, you do know how to do this. You do know how to do that. I’ll walk you through it one time and then you’re on your own.’" 

Another nurse stated it simply with these words:

"We [new nurses] followed, they [preceptors] showed and talked."

Novice nurses seemed to rely passively on the mentor and others in the work environment during this phase.

Fear was acknowledged by a novice nurse (employed six
months). Talking about her list of words that described the preceptorship period, she shared the following:

"I also put fear. Fear because I’m going to handle lives day to day that may result in death. I can never correct it [mistakes] again."

Another nurse employed in a hospital described the fear she experienced when her preceptor was suddenly moved to another unit:

"In my case, my preceptor went to another floor, so I was, I was real scared."

A third neophyte shared her experience:

"I was so scared the first two nights because my preceptor was not working that night and I felt I was by myself. And I was nervous, but I did just fine."

The majority of participants identified with the fear that was a part of the early beginning practice phase.

Novices consistently expressed self-doubt in their competence and ability to meet the demands of practice in the early beginning practice phase. A novice nurse who was working in a critical care unit shared his feelings of self-doubt:

"For me I was feeling really anxious that I had come. And also unsure, unsure of where I was standing, because all the people working with me were like 14 years, 20 years, and here I was just graduated. Still coping and learning and trying..."

The majority of participants voiced similar feelings of self-
doubt concerning abilities and skills to meet the demands of the new role.

Novice nurses felt that maintaining an intact self concept in the new work environment was extremely important. Several participants expressed how important it was not to appear stupid or to not ask what may be perceived as dumb questions. A neophyte nurse (employed three months) practicing in a psychiatric agency summed up her need to protect her self concept this way:

"I didn’t want to look stupid. That was one thing, I really didn’t want to look stupid. And uh, she [preceptor] was real good at making me feel comfortable."

Another participant (employed four months) working in a hospital commented on her preceptor’s ability to promote a positive self concept in her mentee by sharing the following:

"She never made me feel like this is a dumb question."

Another participant (employed three months) shared the lengths to which she went to avoid injury to her self concept:

"I felt very stupid and I still do a lot of times. I’m scared to ask questions and so I carry around my nursing book, my drug book, my dictionary, my lab book, all with me at all times. I have to have some stability."

Novices described this early phase as stressful, traumatic, and marked by tears and significant self doubt. Beginning practitioners expressed openly their need to preserve and protect their self concept. Often they accomplished this aim by assuming
passive, externally focused behaviors.

The novices' fragile self concepts intensified beginning practitioners' need for positive feedback in the early phase. As noted earlier, the mentors/preceptors who recognized this need and provided positive feedback, strokes, and "warm fuzzies" provided an invaluable service to their mentees.

During this early phase beginners also expressed concerns about preparation for the new role and the availability of support structures. One participant (employed seven months) assigned to a critical care unit in a hospital shared his concern about preparation for the new role and the adequacy of his knowledge and skills in this manner:

"My fear or concern was not doing something wrong, it was having some situation coming up that I didn’t know how to deal with as far as, you know. Is this patient experiencing heart failure and I am not picking it up?"

Another participant (employed four months) in the same focus group quickly added:

"Or if they’re dying and you have no idea."

The following comment shared by a participant working in a nursing home further illustrates novice nurses' concern with issues surrounding practice:

"I felt completely overwhelmed. I felt totally unprepared. I was scared for the residents. I didn’t want to do anything on them. I uh, I knew that I could do the skills, but I couldn’t be in everybody’s room at the same time."
The demands of practice presented a considerable challenge for beginners.

Participants shared their "battle" stories. A sense of ineptness was experienced by one participant (employed four months) who shared the following story:

"The first day out was awful, I enjoyed working with people, but patients were different and I came home and I knew that they had not prepared me for this [Laughter.] I mean, I couldn’t even take a blood pressure. I was so anxious and I doubted myself and then uh, the very next day the preceptor I had came up to me and I was feeling like a bowl of jello." The ability to implement the new role was very much of concern in the early beginning practice phase.

Recognizing and accepting their inexperience in practice, beginners anticipated support systems would be in place to assist them in the early phase. One participant (employed five months) concluded:

"I didn’t have the confidence that I needed and I didn’t feel that I could ask questions...never. I guess I was expecting someone to just walk around and be my shadow."

This statement also reflected some of the passive behaviors assumed by neophytes in this early phase.

In summary, the early practice experience was characterized by fear, self doubt, concerns about preparation for the role and availability of support structures. Beginning nurses looked to the external environment for support as well as to attribute
blame for the sense of inadequacy they experienced. This blame was at times posited on the formal education program. At other times, the employing agency's support systems were in question.

**Late Beginning Practice Phase**

Beginners in the late beginning practice phase described behaviors that were indicative of an internal locus of control. They experienced apprehension and ambivalence about embarking on independent practice. They were concerned about the impending "solo flight" as practitioners and the continuing need to learn. Novices demonstrated more independent thinking and selectiveness about the nature of their practice during this phase. They indicated greater confidence in their decisions. One novice (employed four months) explained:

"The floor I work on is extremely opinionated. So my people were free in giving out opinions. You just take them all and then you do it the way you feel will best work out for you."

This statement reflects the shift to a more internal locus of control noted in the late beginning practice phase.

Some neophyte nurses expressed eagerness to begin practicing on their own. Most, however, felt apprehensive about being on their own. Despite the ambivalent feelings about independent practice, most participants shared that they were comfortable with beginning practice. They enjoyed beginning practice. One male participant (employed seven months) expressed his view of independent practice this way:
"I was real anxious about being on my own. But I knew there were still gonna be people there that would be able to help me out."

Another novice nurse (employed three months) working in a hospital shared how she arrived at the realization that she was ready for independent practice:

"And I guess I was ready cause I was getting kind of tired of being taught. Yeah, and having to take my doctor's charting to be reviewed at the end of the day."

For some beginners, continuing to work with a mentor/preceptor was reminiscent of their student days during the formal educational program. They expressed a sense of eagerness to experience the nursing role fully. Independent practice was viewed as the way to do just that. One participant (employed five months) practicing in a hospital expressed that sense of eagerness in this manner:

"I couldn't wait to be able to be the nurse. So, I could perform all the duties."

Novices experienced a variety of signals that they were ready to make the transition to independent practice.

While beginning nurses looked forward to the time when independent practice would be the order of the day, they were very much aware of the ongoing need to learn in their new role. Approximately two thirds of the participants expressed this awareness on their journey maps. Interestingly, the journey maps reflected and offered support for two phases--the early and late
beginning practice phases. Novices' comments in the early phase addressed issues pertaining to self concept and preparation for the role. The comments in the latter aspect of the journey maps pointed out the shift to an internal locus of control and the focus on learning. Following are excerpts taken from select journey maps that illustrate the focus on learning:

"I'm learning a lot about nursing."

"I still learn everyday."

"I take advantage of learning opportunities."

"Each day is a learning experience for me."

"I am slowly learning to be confident in my decisions and patient care."

"Still learning."

Acknowledgement of the continuing need to learn was expressed by a novice nurse (employed five months) who said:

"Clinical practice and the education. There was so much more to learn and so many blanks to fill in."

Another member of the same focus group concurred:

"Because now I realize that um, those things that I don't know can be learned and can be reinforced by practice."

One nurse (employed seven months) shared her perception regarding the benefits of continuing to learn:

"And education, education breeds confidence. So, they just keep shoving it and shove, shove, shove. As much as you want, you can have it all."

The role transition of beginning practitioners involved a period
of increased learning concerning the role and the recognition that it would be a continuing need.

In summary, beginning practitioners make the transition to independent practice during the late beginning practice phase. Learning was perceived to be of importance during this phase. Novice nurses experienced ambivalence about independent practice but seemed ready to take their place among other independent practitioners.

Summary

Beginning nursing practitioners experienced at least two phases in the transition toward independent practice. The early phase was denoted by fear, self doubt, and an external locus of control. The late phase found practitioners with some ambivalence about independent practice but ready to take on the challenge. A more internal locus of control was evident in that they acknowledged and took responsibility for creating, seeking, and taking advantage of learning opportunities.

Chapter Summary

The purpose of this study was twofold--to gain understanding of early professional socialization in beginning nursing practice from the beginning practitioner's perspective and to explore the influences of mentoring/preceptorship relationships on the professional socialization of beginning nursing practitioners. Data analysis was guided by content analysis, data display, data reduction, coding, the identification of themes, and the drawing of conclusions (Miles & Huberman, 1984).
The findings discussed in this chapter indicate that upon employment, beginning nursing practitioners experience dissonance among work place realities, personal expectations, and perceived level of preparation. Support systems in the practice environment assist beginning nursing practitioners to resolve this dilemma and to make the role transition. These support systems facilitate familiarity with the institutional culture, the development of technical and cognitive competence, and internalization of characteristic behaviors and attitudes. Novices identified the mentoring/preceptorship relationship as an important component in professional socialization. The summary, conclusions, and recommendations for this study are presented in Chapter V.
CHAPTER V
SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This chapter consists of the summary, conclusions, and recommendations resulting from this study of beginning nursing practice. The summary provides an overview of the study. Conclusions related to socialization, responsibilities of institutions preparing and receiving novice nurses, and roles and responsibilities of mentors are presented. Finally, recommendations for nursing education, nursing practice, and nursing research are addressed.

Summary

The purpose of this study was twofold. It sought to gain understanding of early professional socialization in beginning nursing practice from the beginning nursing practitioner’s perspective and to explore the influences of mentoring/preceptorship relationships on the professional socialization of beginning nursing practitioners.

The review of literature focused on professional socialization, professional socialization in nursing and other fields, mentoring, and locus of control. The review of literature provided support and a theoretical framework for the study.

The unique perspectives of beginning nursing practitioners were of particular significance in this study. Gaining understanding of particular phenomena from the unique perspective
of individuals is a goal of qualitative methods. Hence, focus
groups were used to generate the qualitative data for this study.
Nine research questions guided the research process and data
collection. A pilot study established base line data and support
for focus groups as an appropriate data gathering strategy. The
interview guide and sampling procedures were modified and the
literature review expanded as a result of the pilot study.

Thirty-one beginning nursing practitioners from an associate
in science degree nursing program in the Southeast section of the
United States were the participants for this study. Data
analysis was accomplished through content analysis, data display
and reduction, identification of themes, and conclusion drawing.
The data analysis identified several components to be included in
the discourse on beginning nursing practice and mentoring
relationships. These components include pre-employment
considerations, entry issues, roles of the mentor, absence of a
mentor, factors that facilitate or hinder beginning practice, and
transition from novice to professional.

Beginning nursing practitioners anticipated becoming
employed soon after graduation. But unanticipated delays in
employment were experienced. Self-doubt and insecurity about
competence and knowledge prevailed in the early professional
socialization experience. Consequently, novice practitioners
anticipated and desired support relationships and systems to
assist them in the role transition.

The major import of support relationships and systems in
this study was to build confidence in competence, provide guidance, and serve as a safety net. Regardless of the quality of their experiences, beginning practitioners felt that support relationships were desirable and helpful. When these relationships are not formally provided, beginning practitioners self select individuals for the role based on perceived knowledge, experience, and personality.

Several ideas were offered to make support relationships optimal. These include planned activities and experiences, institutional policies that indicate commitment to supporting beginning practitioners, and training for those who would participate in or provide leadership in support relationships. These actions could very well make the difference in the quality of the role transition experience for beginning nursing practitioners.

Conclusions

The twofold purpose of this study was to gain understanding of early professional socialization in beginning nursing practice from the beginning nursing practitioner’s perspective and to explore the influences of mentoring/preceptorship relationships in the professional socialization of beginning nursing practitioners. Conclusions related to socialization as an ongoing process, responsibilities of institutions preparing and receiving novice nurses, and the roles and responsibilities of mentors are presented in this section.
Conclusions Related to Socialization

The conclusions related to socialization address novices' sense of preparation for the professional role and their role transition. According to Sarchielli (1984), the novice, at the point of entry, is faced with incongruities related to the realities of the work place, personal expectations, and sense of preparation for the new role. The findings in this study were supportive of this assertion.

As described in Chapter IV, novice nurses enter the field not fully functional. They feel ill prepared and ill equipped for the professional role. They declared self-doubt and fear as frequent companions early in beginning practice. Novices compared the demands of practice with their perceived level of competence and lamented the incongruities. For example, prepared to comfortably care for 4 to 5 patients, most novices found patient load assignments far above that number (7-42). Notwithstanding, beginning nursing practitioners perceive the socialization process as the bridge that provides for gradual transition into the professional role and safety from the difficult waters that flow under.

The findings in this study support the notion that professional socialization, which begins in the formal education program, continues in the workplace. Beginners perceive socialization as necessary. They anticipate initial work environments that will facilitate the ongoing socialization process. They experience the process in phases.
As beginning practitioners moved through the socialization process, they experienced a change in focus and in the nature of their concerns. Over time, behaviors that were initially externally focused gave way to more internally based behaviors and attitudes. For example, novice nurses who early in practice relied heavily on the judgments and advice of mentors and others, became more self-reliant. They elected to trust their own decisions and judgments about patient care more often.

Whereas, early in beginning practice, beginners were more concerned about self-concept issues and survival in the new environment, the focus of their concerns changed later in beginning practice. They reported greater interest and concern for personal growth in the role through continuous learning. Through the eyes of the participants in this study, professional socialization occurs in phases cued by the change in locus of control and the nature of novices' concerns.

The phases evident in the data presented in Chapter IV are congruent with two of the socialization models discussed in Chapter II—Cohen (1981) and Brief et al. (1979). The characteristics presented for the first three phases of Cohen's model—unilateral dependence, negative independence, and dependence/mutuality—were evident in the reports of the novice nurses in this study. The interdependence phase of the model was not clearly reflected in the data. Perhaps, participants were not that far along in their role transition.

Brief et al. (1979) described three phases—anticipatory,
adjustment, and role management. Participants expressed anticipatory expectations for the initial work experience as presented in Chapter IV. When confronted with the demands of the work environment, matched against their perceived level of preparation, participants had to make adjustments. Participants' focus on learning in the late beginning practice phase and their increasing level of comfort in the role paralleled the role management phase.

In summary, conclusions related to socialization address the ongoing nature of the process. Beginning in the formal education program, socialization continues in the initial work environment. Novice practitioners' behaviors and concerns change focus signaling the existence of phases in the socialization process. Socialization targets the integration of an acceptable version of the professional role by novice practitioners.

Conclusions Related to Institutional Responsibilities

Conclusions related to institutional responsibilities are presented for preparing (sending) institutions and for accepting (receiving) institutions. The first are the educational institutions, the latter are the employing institutions.

Preparing Institutions. The formal education program equips the beginning practitioner with the foundation knowledge, skills, and values for entry into practice. Novice practitioners anticipate that the educational program has made them ready for practice. Chapter IV includes a discussion of the incongruities reported by novices between perceived level of preparation and
the realities of the initial work environment. For example, novice nurses frequently indicated that one of the most important skills they learned from their mentors/preceptors was that of time management related to accomplishing all tasks involved in patient care. Novice's experience with lighter patient loads than those found in actual practice did not facilitate the honing or fine tuning of an important aspect of practice. Novices reported significant levels of frustration, self-doubt, and fear associated with this issue.

Another area that emerged as problematic for beginning practitioners was the relationship with ancillary personnel and physicians. Novices perceived these as difficult and less than satisfying. They reported having had limited experience communicating with these members of the health team during the formal educational program.

The discontinuity between the formal education experience and the realities of practice as well as the interpersonal relationships with physicians and ancillary personnel need to be addressed by educational programs. Curricular offerings and content should target these areas perceived by novice practitioners as negatively impacting their role transition.

Accepting Institutions. Novice practitioners view employing institutions as carrying the burden and responsibility for establishing the standards for supportive beginning practice environments and experiences. Practitioners had pre-employment expectations to find supportive work environments and planned
orientation programs. This investigation identified perceived institutional patterns that can both hinder and facilitate the early socialization of beginning nursing practitioners. Understanding these patterns from the novice practitioner's perspective has import for employing and educational institutions.

The absence of a plan or a poorly planned introduction of the novice to the initial professional experience may place the novice practitioner in an initial work environment that is psychologically traumatic and filled with disillusionment. Institutional philosophy, policies, and practices must in the view of novice nurses convey a commitment to their role transition. For example, novice practitioners often reported that mentors were not readily available for assistance or consultation because they too carried a patient load assignment while working with a mentee. In the view of novices, the commitment of financial resources to provide continuously and consistently available mentors would be an appropriate institutional response.

In summary, conclusions related to institutional responsibilities address the responsibilities of educational and employing institutions to the novice nurse's role transition. Educational institutions have responsibilities at the curricular level to insure graduates' readiness for practice. Employing institutions have responsibility for introducing neophytes to a supportive environment where they can continue the socialization
process toward ultimate role transition.

Conclusions Related to Roles and Responsibilities of Mentors

The conclusions related to the roles and responsibilities of mentors include the impact of mentoring relationships and the role of mentors. Beginning nursing practitioners believe that it is the responsibility of those in the profession to provide the best role transition experiences as they begin professional practice.

Impact of Mentoring Relationships. The impact that practicing nurses can and do have on the continuing professional socialization of novice nurses is important. Beginning nursing practitioners anticipate and desire support relationships and systems in the initial work environment. Novice nurses perceive the technical and cognitive skills required by the discipline as critical because they have implications for patient safety and well being.

The interaction with nursing professionals influences beginners' professional growth and the development and fine tuning of their skills. In the view of novice practitioners, a policy that forces a mentor-mentee relationship may insure that the beginner has someone specific to turn to for help but does not necessarily insure a positive mentoring relationship or role transition. In Chapter IV, examples were given of mentors who had been assigned the role who were unwilling and expressed their unwillingness but had to do it anyway based on institutional policy. Novice nurses reported less than satisfying
relationships with these mentors.

Neophyte nurses perceive the quality of the mentoring relationship as having import for their role transition. They judge quality by the level of trust, degree of mutual respect, and the open sharing that exists in the relationship. With these components present, beginners anticipate having a satisfying professional socialization process.

Role of Mentors. Mentors/preceptors are perceived by beginners as important in the socialization process. The interaction of novice practitioners with experienced nursing professionals influences the beginner in a variety of ways. The roles of mentors are manifold. They include clarifying of the professional role, teaching the novice about patients and the problems involved in practice, teaching the novice about the practices and policies of the agency, assisting the novice to develop a sense of competence, and role modeling the characteristic behaviors, attitudes, and values that are associated with the profession.

Novice nurses perceive the effectiveness of mentors in carrying out their roles as dependent on the preparation they receive for the role. Mentors must be prepared to "let go," while assisting beginners to greater levels of independent practice. A well planned training program was perceived by novices as one that will attend to the needs of beginners and can ultimately affect their retention and tenure.

In summary, novice nurses perceive supportive systems and
supportive relationships as central to their professional growth. Absence of support relationships may negatively impact the beginning practitioner's role transition and professional satisfaction and could result in the loss of an otherwise qualified individual to the profession.

Recommendations

This study's focus was on beginning nursing practice and mentoring relationships. The professional development, retention, and job satisfaction of beginning nursing practitioners are current concerns of the profession. The recommendations resulting from the study are presented for nursing education, nursing practice, and nursing research.

Nursing Education

Professional socialization begins in the formal professional education program. An effective nursing education program must not only teach students the fundamentals of nursing, but it must also ready them for practice (Cohen & Joret, 1988). Graduates who enter the initial work experience with realistic expectations will experience less of the trauma and "reality shock" described by participants in this study.

Specific recommendations resulting from the findings of this study address two issues--preparation for the workload assignments in the practice setting and building foundational interaction skills to relate to physicians and ancillary personnel. A discussion of each follows.

Participants in this study consistently reported feeling
overwhelmed with the workload demands in the initial work environment. Clearly, this is an issue that needs the attention of the profession. Nursing education programs must include in their curricula clinical experiences that progressively challenge students' ability to manage numbers of patients that approximate those to be realistically encountered in the work environment.

The interactions with physicians and ancillary personnel were strained at best. Because the team concept prevails in health care today, it is important that beginning nursing practitioners have comfortable and collegial interactions with physicians and ancillary personnel. Nursing curricula must increase the focus on these relationships. Providing more opportunities for meaningful student interaction in the natural work environment will begin to address this concern.

**Nursing Practice**

The graduate's first job is a continuation of the professional socialization process initiated in the professional education program. The quality of the role transition experienced by beginning nursing practitioners is dependent on the support structures put in place by employing agencies. The recommendations generated by the findings of this study specifically address the support structures needed by beginning practitioners.

In the absence of the legal requirement for mentoring early in beginning practice, it becomes even more crucial that "accepting" institutions plan a well structured entry for novice
nursing practitioners. Employing agencies must focus on the mentoring relationship and invest in it to provide an optimal entry experience for new graduates. Specific approaches include:

1. planning and implementing consistent and continuous mentoring/preceptorship programs.

2. allocating the necessary resources to support the programs.

3. establishing a selection process that targets participants who have the motivation, interest, willingness, commitment, and personality to serve as mentors/preceptors.

4. providing training for mentors/preceptors that prepares them to be role models, to provide emotional and psychological support, and to promote the professional development of beginners.

5. continue to formally assign mentors/preceptors to beginners.

6. within the basic mentoring program, provide for individualizing content and length of the program based on specific needs of the beginners.

The benefits to be derived by agencies who make this commitment are untold, but may include employee retention and satisfaction, greater company loyalty, and transmission of the institutional culture and norms to the beginner.

_Nursing Research_

Future research studies are suggested by the findings in
this investigation. A small sample of nursing graduates from an associate degree program in the Southeast section of the United States served as participants in this study. Replication of this study using a larger sample from various geographical areas is recommended. Further, a study using graduates of baccalaureate nursing programs may provide yet another perspective and address differences based on the formal professional education program completed by beginners.

A quantitative study where a measurement of graduates’ locus of control is determined prior to employment may add insight regarding the behavioral patterns and attitudes involving locus of control that were reported in this study. Moreover, a look at early professional socialization and mentoring/preceptorship relationships in beginning nursing practice from the perspective of mentors/preceptors could bring balance to the picture begun by this effort.

Summary

The recommendations for nursing education, nursing practice, and nursing research were gleaned from the data and their analysis. They represent one effort to address issues surrounding an important topic in nursing and other professions—the successful role transition of beginning practitioners.
Appendix A

Study of Graduate Nurses Interest Form
STUDY OF GRADUATE NURSES

Yes, I would be interested in participating in a study of "graduate nurses" to determine the impact of the elimination of the "graduate nurse" designation on the practice of beginning nursing practitioners.

NAME

Address with zip code

Telephone #
Appendix B

Demographic Questionnaire
SURVEY
MENTORING AND BEGINNING NURSING PRACTICE

Date of graduation from nursing program ______
Address ____________________________________ Tel. #________
Current Employer ___________________________________________
Date employed_______Type of Patient Care Unit___________

1. Have you worked at this institution in any other capacity before graduation from the nursing program?
   __________ Yes__________ No
   If you have, give position/title__________________________

2. How long were you employed in his capacity?________

3. Current working hours (Check one)
   __________ 7:00 am - 3:00 pm
   __________ 3:00 pm - 11:00 pm
   __________ 11:00 pm - 7:00 Other (specify)

4. Total number of hours worked per week (check one)
   __________ 10 - 20 hrs. ______ 31 - 40 hrs.
   __________ 21 - 30 hrs. ______ More than 40 hrs.

5. Previous work experience in health field:
   Position/Title length of time
   __________________________

6. Did you receive a formal orientation for your current position?
   __________ Yes__________________________ No

7. Length of Orientation (Check one)
   __________ 1 - 2 weeks ______ 5 - 6 weeks
   __________ 3 - 4 weeks ______ 7 - 8 weeks
   __________ More than 8 weeks

8. Were you assigned a nurse preceptor/mentor?
   __________ Yes________ No

9. If you were assigned a preceptor/mentor, did you share the same patient assignment(s)
   __________ Yes________ No
   Please
   Explain________________________________________


Appendix C

Letter to Participants
January 18, 1995

Dear Melody,

Thank you for agreeing to participate in the research study of beginning nursing practice. The purpose of the study is to gain understanding of beginning nursing practice and the impact of mentoring relationships on the practice of the beginning nurse from your unique perspective.

The primary data collection strategy will be focus groups (focused interviews) with graduates of Florida Community College at Jacksonville’s associate degree nursing program. You have consented to be a part of the focus group scheduled for:

Date:       Friday, January 27, 1995
Time:       1:00 p.m. - 3:00 p.m.
Location:   Florida Community College at Jacksonville
            Donald T. Martin Center for College Services
            501 West State Street
Room:       376 - Third floor

Please complete the enclosed questionnaire and bring it with you. If you have questions or find that you will be unable to attend, please call me at 757-0889 (H) or 766-6619 (O). I will be giving you a reminder call the day before your session.

With kind regards,

Barbara A. Witherspoon-Darby
Dean of Instruction, Health Programs
Appendix D

Focus Groups Schedule
## Focus Groups Schedule

<table>
<thead>
<tr>
<th>Date</th>
<th>Focus Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 23, 1995</td>
<td>A</td>
</tr>
<tr>
<td>January 25, 1995</td>
<td>B</td>
</tr>
<tr>
<td>January 26, 1995 (AM)</td>
<td>C</td>
</tr>
<tr>
<td>January 26, 1995 (PM)</td>
<td>D</td>
</tr>
<tr>
<td>January 27, 1995</td>
<td>E</td>
</tr>
<tr>
<td>February 1, 1995</td>
<td>F</td>
</tr>
<tr>
<td>February 15, 1995</td>
<td>G</td>
</tr>
</tbody>
</table>
Appendix E

Informed Consent Form
Research Title: Professional socialization and mentoring relationships in beginning nursing practice

Mrs. Barbara Witherspoon-Darby, a graduate student in the Educational Leadership program at the University of North Florida, College of Education and Human Services, has requested my participation in this study of beginning nursing practice. I have been informed that the purpose of the study is to gain understanding of professional socialization and mentoring relationships in beginning nursing practice.

I understand that my participation in the study will be as a member of a focus group discussion (group interview) for a 1½-2 hr. session. I have been informed that the focus group sessions will be tape recorded and transcribed. All information and data concerning me will be kept confidential and anonymous. I further understand that my participation is voluntary and that I may withdraw at any time.

There are no known risks, costs, or immediate benefits to me for participating in this study. I have had an opportunity to discuss the study with Mrs. Witherspoon-Darby. I may reach her at 766-6619 (O) or at 757-0889 (H), if I have questions later.

I (print name) __________________________ hereby give my consent to participate in this study.

<table>
<thead>
<tr>
<th>Date</th>
<th>Subject's Signature</th>
</tr>
</thead>
</table>

| Date | Researcher's Signature |
Appendix F

Interview Format
INTERVIEW FORMAT

INTRODUCTIONS

PURPOSE AND GOALS

PROCESS
(USE NEWSPRINT OUTLINE)

ROUND ROBIN QUESTION

HOW LONG HAVE YOU BEEN WORKING AS A NURSE? WHAT KIND OF UNIT?

WHAT IS YOUR WORK SCHEDULE? WHAT IS YOUR TYPICAL PATIENT LOAD?

INTRODUCTORY QUESTION

FOCUS: PRE-PRECEPTORSHIP EXPERIENCE
REFLECT ON THOUGHTS, FEELINGS, BEHAVIORS JUST BEFORE BEGINNING PRACTICE AS A NEW NURSE

TRANSITION QUESTION

FOCUS: PRECEPTORSHIP PERIOD
HOW WOULD YOU DEFINE/DESCRIBE A MENTOR?

KEY QUESTIONS

FOCUS: PRECEPTORSHIP EXPERIENCE

ENDING QUESTION

FOCUS: PRECEPTORSHIP EXPERIENCE

SUMMARY

WHAT ADVICE WOULD YOU GIVE TO SOMEONE WHO WAS ASKED TO SERVE AS A PRECEPTOR?
DID YOUR PRECEPTOR FOLLOW THIS KIND OF ADVICE WITH YOU?
QUESTIONS

PRE-PRECEPTORSHIP:

1. WHAT WERE YOUR EXPECTATIONS FOR YOUR BEGINNING WORK EXPERIENCE AS A NEW GRADUATE?

2. WHAT WERE YOUR FEELINGS ABOUT BEGINNING YOUR PRACTICE?

3. WHAT WERE YOUR ANXIETIES? YOUR HOPES?

DURING PRECEPTORSHIP:

1. HOW DID YOU FIRST MEET OR LEARN ABOUT YOUR PRECEPTOR AND WHAT WERE YOUR INITIAL FEELINGS CONCERNING YOUR PRECEPTOR?

2. HOW MANY HOURS PER DAY DID YOU WORK WITH YOUR PRECEPTOR?

3. DESCRIBE YOUR RELATIONSHIP WITH YOUR PRECEPTOR.

4. WHAT WAS YOUR LEVEL OF COMFORT WITH YOUR PRECEPTOR? COULD YOU TALK ABOUT YOUR ANXIETIES? IF NOT, HOW LONG BEFORE YOU COULD?

5. WHAT DID YOU LEARN FROM YOUR PRECEPTOR ABOUT NURSING AND YOUR WORK ENVIRONMENT?

6. WAS YOUR PRECEPTOR AN EFFECTIVE NURSE? WHAT WOULD YOU MODEL? WHAT WOULD YOU REJECT?

7. IN WHAT SPECIFIC WAYS WOULD YOU SAY YOUR PRECEPTOR WAS OF HELP TO YOU?

8. WHEN THERE WERE DECISIONS TO BE MADE ABOUT YOUR PATIENTS' CARE, HOW WERE THEY ARRIVED AT?

9. GIVE SOME SPECIFIC EXAMPLES OF FEEDBACK YOU RECEIVED FROM YOUR PRECEPTOR?

10. HOW WOULD YOU DESCRIBE THE EXPECTATIONS YOUR PRECEPTOR HAD FOR YOUR BEGINNING PRACTICE?

11. DID YOU ENGAGE IN ANY OTHER ACTIVITIES AT OR OUTSIDE THE WORKSETTING WITH YOUR PRECEPTOR? PLEASE SHARE.

12. WITH WHAT SPECIFIC PRACTICE ISSUES WAS YOUR PRECEPTOR MOST HELPFUL? LEAST HELPFUL?
13. WHAT WERE YOUR FEELINGS WHEN THE PRECEPTORSHIP EXPERIENCE ENDED?

RELATIONSHIP WITH OTHERS:

1. WHAT WERE YOUR FEELINGS ABOUT THE EXPECTATIONS OF OTHER NURSES ON THE UNIT?

2. WHO DID YOU TALK WITH ABOUT ISSUES OF PROFESSIONAL PRACTICE? WHY DID YOU CHOOSE THESE INDIVIDUALS TO TALK WITH ABOUT QUESTIONS OF PRACTICE?

3. DID YOU FEEL WELCOMED AND SUPPORTED ON THE PATIENT CARE UNIT? WHAT SPECIFICALLY CONTRIBUTED TO THOSE FEELINGS?

POST PRECEPTORSHIP:

1. WOULD YOU EXPECT A CONTINUING RELATIONSHIP WITH YOUR PRECEPTOR?

2. WHO DO YOU GO TO NOW FOR PROFESSIONAL ADVICE?

3. WHAT IS YOUR CURRENT RELATIONSHIP WITH YOUR PRECEPTOR?

4. WHAT WOULD YOU CHANGE ABOUT YOUR EXPERIENCE WITH YOUR PRECEPTOR? YOUR BEGINNING PRACTICE? WHY?
Appendix G

Sample Transcript
...Share with me what kind of institution you worked in. Whether it's long term care, public health, hospital,..? What kind of unit you're working on? Uh, what your typical patient load is? And what your typical working hours are, in terms of whether you work a twelve hour shift, eight hours, three days a week. Just basically that kind of general information. Okay? Anybody can start. And in any kind of order that you want to go in.

#1: Okay, I took a job in a long term care facility. Uh, I work on the skilled nursing unit. That's their medicare unit. My hours on my shift are seven p.m. to seven a.m.

BD: That's weekends included?

#1: And filling in during the week. I have to see about, twenty-four residents on the hall until eleven. And then I pick up another hall and so that would be forty-eight to fifty-two (Laughs)

BD: Which is real heavy.

#1: I don't know how ______.

BD: After eleven a.m.?

#1: Until seven a.m.

BD: Oh, seven a.m.

#1: Seven p.m. to seven a.m.

BD: Oh, okay.
#1: So from eleven p.m. to seven a.m. I have about, right now it’s forty-eight. Uh, before...from seven p.m. to eleven I have one hall so it’s about twenty-four.
(Pause)

#2: I work at ___________. I did work on the cardiac research floor. Which they revamped the hospital now and I’m in pulmonary. Well it’s supposed to be pulmonary. I’ll say it that way (Laughs). Uh, the patients..I work seven p to seven a, which I chose to do. But I chose to do that. Our patient load is anywhere from three to eight. And that just depends on how many patients are there. How many nurses are there. Usually from uh, seven to eleven like her, we might have _____ from five to six patients. And then we may have to pick up two or three after that, so about eight. The most I have ever had is about ten. And that was just ‘cause we were really short of help and people just kept coming in and coming in.

#3: I took a job in a long term care facility. Uh, like __________, I mainly work the skilled nursing and medicare floor. I work from eleven at night to seven in the morning. And that usually ran on to eight or eight-thirty trying to get everything finished. Uh, normally, I took care of anywhere from uh, thirty eight to forty-five of those patients, but kind of a rough average would have been about forty-two. That was
about what our census stayed at most of the time. Sometimes it would go up and we'd ship a few out to the hospital or whatever. And then it would go back down. But right around forty-two is a good average for the number of people that we had to take care of. Uh, what else did you want.

BD: I think that was about it.

#3: Yeah, that was about it.

BD: Very good. Now I'm going to stop this just for a minute and ask .............. And I might ask you to say a little bit about it depending on what you share.

#2: Alright uh, tense, hopeless and wasting time. Because when we uh,... I was working at ______ as a NST and nobody would talk to me to a fresh graduate nurse. They didn't want to look at you they didn't even want you to mention the fact that you were a graduate or that you were looking for a position. It was just very, you know, and I felt, you know, that I just wasted my whole time. I've worked here for four months and they're not even gonna consider me.

BD: Tell me about the tense.

#2: Well, you've got student loans that's coming up. They're gonna be coming due, 'cause I wasn't planning on going back to school. You know, I had bills I needed to pay, you know, things that I had put off, you know, while I was in school, you know, I got extensions
on, and were coming due. You know, I needed money that had to be put out. You know, I was a bit worried there.

BD: And the hope?

#2: Well, that you know I could be a just another way of saying that eventually somebody was gonna have to talk to me some how or another.

BD: Someone else?

#3: I put down, anxious, uncertain, hopeful and confident. Anxious, I guess uh, more about the state boards. That was an anxious time trying to figure out, you know when am I gonna do this? Do I really want to do this? Should I really make this phone call? You know all those things and uncertain. The uncertainty came because I left a job that paid eighteen dollars an hour. And I left it in the middle of July before I had taken the state board. But I knew me well enough to know that if I didn’t go on an put myself in a position where I had to do it, I’d just keep putting it off. So I resigned, from the civil service, and about a month after that I took the state boards, and about a month after that, I got a job. So there was a real...there was uncertainty. You know, when you have something that’s got good benefits and good pay, it’s ..there’s uncertainty when you start thinking about do I really want to leave the comfort of this place. And hopeful that you’re gonna get a good...that you’ll pass the
boards, you'll get a decent job and be happy where you are. And after I passed the boards, I was confident that I could get a job. I wasn't sure what it would be. And I experienced a lot of the same things that _____ did. Because the hospitals, even __________, who notoriously hired new graduates, "We're not interviewing new graduates, we're not gonna take any new graduates in. People who had been promised jobs that I knew weren't getting them at ______. Uh, just, there was like a major crunch with very few job opportunities out there. So it was, it was uh, some hopelessness.

#1: I was confident that I would eventually get a job, but like these two, I didn't, I was considered for one and then I got a second interview. Which was good, because I knew a lot of people that weren't even getting them. And then I didn't get it so, it was pretty devastating. And um, so after that I kept looking. I was concerned about hours because I have little children. Uh, I was worried. I wasn't sure that I'd get a position in a field that I really wanted. Uh, I was also excited. I wasn't sure what to expect. Uh, so I was a little anxious.

BD: Very good. Now let me ask you in terms of your expectation of your beginning work experience, what were they? Your own personal expectations. You
hadn’t started working yet, but you had some idea of how you thought it should go once you got on board.

#2: I figured that they have to give, uh, ______ is real good, they give you six weeks. You know, but, you know, to me I think you need a little more time than six weeks, you know. That was the only thing that would bother me. You know, because when we first went in to the, to watch the nurses and everything, some of them where I was working at NST, some of them had fourteen patients. You know, and I think it’s, there’s no way, school didn’t prepare me to take care of fourteen patients. I can do four or five maybe, you know. But not fourteen. And also it was scary, all the medications that they were given, that I was seeing being given at one time. You know, and things like that. So you know, I was scared to make a mistake. But then again, like I said, ______ was really good about during the six weeks and they give you a preceptor. Which that made me, you know I felt a lot more comfortable. There was gonna be someone there besides me looking over my shoulder saying you did that okay. Or, you need to re-check this.

BD: Okay. Other expectations, you might want to share prior to going to work. You might want to share what you expected that beginning experience was going to be like.
#3: A whole lot different than what it was. It was ....#1, I felt like I would be able to get a job in a hospital. That didn’t work. I felt that wherever I went, I would get at least an adequate preceptorship deal to function at a level that I was comfortable with and that didn’t happen either. Uh, the perceptions prior to were just a lot different from what reality was when I actually got into practice.

BD: And I’m gonna be asking you to share that when we get to that phase. ____ did you have any expectations that were....

#1: I expected a little more preceptorship. I (fades)...my preceptorship was over... ’cause they were short of staff. And I felt kind a like I just got tossed into more than I could handle.

BD: Anything else? And other expectations?

#2: The work load was supposed to be quite as hard in reality, it really is. The teachers in school kept saying, you know, you got NST, blah, blah, blah. They don’t exist. On certain floors, yes they may have a NST, you know. And that’s the harder floor. But on the floor like where I work at____. There’s nobody else. I mean you do everything for that patient. And that means everything. If they got to go to the bathroom, even though you’ve got other things you’ve got to do, you’ve got to go help that person go to the
bathroom. There is not a lot of help, extra help that we could use.

BD: Now uh, looking at that period again before you started working, uh, Jim mentioned that he was anxious about insurance and you Pam about your bills. Were there any other anxieties that you had prior to starting work? Things that you were really concerned about, in terms of going into practice?

#1: Not really, I was pregnant and that was about the only thing.

BD: Alrighty, what I'd like you to do now is take that other sheet with ...(tape was stopped) ...that period when you started working.

#2: Okay, I'll start. Well I was very happy and again I was still very tense and nervous and relieved, that I finally got to use the education that I had worked for. And to be on the unit that I want to work on. I had worked at ______ a couple of times as NSC., and I really enjoyed it. I liked the way it was organized, the way it was run. I was happy to be in the position where I was. But nervous again, simply because with cardiac patients you never know what minute you walk in and they're gonna be dead. You know and things like that.

#1: I put down uh, unwanted and ostracized, and I say that because when I walked in and they introduced me to the
L.P.N. who was gonna precept me, 'cause I didn't have a R.N. preceptor. Uh, I was told right off the bat that they didn't think R.N.'s had any place in long term care. Uh, but then it changed when I got on to my eleven to seven shift and there was another R.N., a new R.N. by the way who had just passed the state boards, and a G.P.N., the three of us, that's what ran the eleven to seven. A G.P.N. and two brand new R.N.'s. And then, but at least I felt needed and accepted. And we all related to each other very well. And I developed a real good rapport with my clients and my residents and they accepted me. And the people I'm working with, they pretty much accepted me. I had no trouble with the C.N.A.'s accepting, number 1, an R.N., number 2, a man. Because apparently they had been able pretty much to do what they wanted to. And I just wouldn't do it. When I went on I told them. I said "I expect number 1, these people be breathing and number 2, they gotta be clean and dry, and number 3, they gotta be turned. And if you're doing that, you're gonna stay busy." And they didn't like that. That's what I expected, and that's what eventually happened. So I just wouldn't settle for anything less. And it caused problems because the facility was so afraid that they would lose their C.N.A.'s, that you know, if you, even if you don't really get on one. I mean, I never
wrote anybody up. I never wrote anybody up. I preferred to go to them and say "Look, here's the problem that I have. Let's look at a way to resolve it. This is what I expect, now what can we do to get there?" And I would be called in and the D.O.N. would say "Well the C.N.A.'s are complaining because you're following them around and dogging them out." And I was just kind of going, what do you mean? I had to pad.....I made 10:30 rounds. And at 10:30 I checked to see how my forty-two people were laying. And some of them can turn themselves, so I didn't worry about those people. But the ones that couldn't, I knew. And then I'd make a midnight drug pass. And you hit all three corners of the three halls that I had. You hit the very back end of all of them. So as you go down, you look at all your people again. I mean it's just normal that you look in a room and make sure everybody's okay. And they're still laying there. And then when I did the one o'clock feedings, we had to change out all of the tubing and feeding bags on my shift, and I'd be passing them and it happened that all my beds, with all my feedings because I had to go to the end of every hall, because I had at least one person on the end of a hall that would be getting feeding. And between one and two they were still in the same position that they were in at 10:30. And I explained, I said "Well I
don't have to follow them, all I have to do is do my job. And in the course of doing my job, I know they're not doing theirs. So, uh, it was understood. But everytime something happened, it was a matter like, we really need these C.N.A’s and we really gotta work with them and it was.....But as far as the nurses that I was working with, we had a real good relationship.

BD: Any thought _____?

#1: I was completely overwhelmed at one minute and then I just feel confident with things that look familiar. Uh, then I start feeling good. And then get overwhelmed again. Uh, and it went on like that for a couple of weeks. I feel that six....Uh, my preceptorship was about a week, so it was short. And uh, I was... when I was finished, I didn't feel adequately prepared.

#4: For me I was feeling really anxious that I had come. And also unsure of where I was standing, because all the people working with me were like 14 years, 20 years and here I was just graduated. Still coping and learning and trying to get my ________ done. And ______ feel it can be done in twelve weeks. So it's like almost overwhelmed. Again I need to be ______ `cause my own preceptor, was uh, she would lead the way in so that I would be more successful in what I do. And especially drugs, I would need help with drugs,
which we ______ in school. Uh, drug calculations. We went through twelve weeks of preceptorship and just about that whole amount of time. Also she made me more confident in what to do.

BD: What I want to ask you to do for me now is just to describe or define a mentor as you view or see one being. In your estimation what would you want a preceptor to be.

#3: Someone who was knowledgeable, uh, someone who was at least my equal. Had been in nursing for a while. Someone who could explain to me in a way that I could understand. And wouldn’t say you’re ______ when I say I don’t understand what you’re trying to say. To me that’s a mentor. Someone that if you have a question and you know you can go to them and say, "Look I don’t understand this. I know we covered it in school but we covered it in school and we covered it twelve months ago. And I don’t recall it and I can’t find it in a book, could you explain it to me?" And they would do it. That to me is a mentor. Someone who kind of takes you under their wings and says this is it this is the real world and I’m gonna help you get to, where you can function there.

BD: Explain what you meant by your equal.

#3: Well, when I say my equal, I really didn’t expect to be precepted by an L.P.N. who knew less about nursing than
I did when I was a new graduate.

BD: That shouldn't happen

#3: I mean things that we were taught in school that were absolutely no-no's, like feeding bags hanging over 24 hours. And this individual told me well, we can leave these bags hanging for 48 hours and things like that. And I'm sitting here thinking to myself..."No, no, no, no, no, that's not the way it's supposed to be." And there were a number of things ....uh, to be able to make the nine o'clock, because I started on the day shift and then I went to midnight. Uh, all ...to be able to pass nine o'clock medications and just started at seven, and a lot of the stuff they would pre-pour and pre-pull all their meds and stuff like that. And you know, who knows and the ______ rights, it was like, I'll give the meds and then I'll mark them off when I get back to the nurses station. And that's the way it was. And I'm sitting here going. And then later it showed up because I saw that medications were marked as been given to people who at the particular time the medication was supposed to be given, they were not in the facility. Things like that. So when I say my equal, at least someone who at least, knew as ...the basics of what we were taught.

#2: Basically, the same thing that he said. Someone that watches over you. I mean, not...I don't mean right
there watching every move that you make. But you know, watches over you, and lets you know that that’s not exactly right. It might be easier to do it this way. You know, she points out things you can do easier to use your time wisely. Basically a mother hen.

#1: And someone that you’re comfortable with. That knows you know and cares that you know and will offer, fill in when, not screw you all around. But someone you can ask questions to. Uh, will jump in when you need it and offer suggestions.

#4: A mentorship to me should be based on trust and acceptance. The biggest would be trust because when you get started the very first day, they need to trust what you can do and what can’t do. So the way you have to trust the mentor because they should guide you to get out. Acceptance in such a way that you can do the functions in a way....(fades away))

BD: Let me ask you how did you first meet your mentors, your preceptors when you first started working. Tell me about that meeting and your initial feelings. Tell me how it happened, looking at that initial meeting. I’m trying to find out what happened, and whether it seemed like it had been planned and you had been prepared for in terms of beginning your work experience.

#2: Mine was kind of unique because I had worked with her
as a N.S.T several times, and uh, the nurse manager just chose, there were several people on the floor that could be preceptors and she just chose her. And you know she told me that I had chosen the next day when I went in for something else, she said "I had chosen so-and-so to be your preceptor, is that suitable with you?" You know cause I had worked on the floor and I knew most of the nurses anyway, so that was fine, someone I had worked with before.

BD: So you were comfortable going into that relationship?
Good feelings....

#2: Right, because I knew what her work was like. The type of nursing that she did everyday. And she was an older nurse. Not one extremely old, but you know, we were both about the same age. But she had put in about 15 years. And uh, I had kind a voiced that when I did my interview. I'm a new nurse and I said you've got some young girls out there and I would prefer not to be you know, put in the position of them being my preceptor. And not for the fact that they weren't wise enough or whatever. But I just thought that it would complicate things.

#4: For me I was in the same situation as _____ and I felt comfortable working with my preceptor. ***END OF SIDE 1***

#1: Uh, the first one was really like the mother figure. I
learned a lot from her. The second one, I could see by the way she was nursing that she was a really good nurse. But I had a problem because she was from the Philippines and I had difficulty communicating with her. And I don’t feel that I, when I asked her questions. I wasn’t sure what she was telling me. So I didn’t feel like....

BD: Because of the language barrier?

#1: So I was watching what she was doing and it, I felt like it hindered it those two days. But uh, the working relationships are fine from the beginning of the preceptorship.

BD: ___ did you want to add anything, because I know you mentioned that you felt ostracized.

#3: As far as introduction and preparation. I went in that morning about eight o’clock, we watched some films on universal precautions, patient rights, proper lifting techniques, how to wear a pro-flex belt, how to use a gait belt. And when all that was done, they said go eat lunch and come back. And we went and ate lunch and came back and the assistant director of nursing kind of just said "Okay come on we’re gonna go down here". And we went down there and said this is ___ he’s the new R.N. that we just hired to do nights. He’s gonna be here for a few days show him around. And that was it. They didn’t know that I was coming. Of course,
later I found out that they didn’t want me either. But
that was there was no....

BD: Okay so this was like to everyone that was there
instead of just one person?

#3: Yeah, and I kind of attached to one person which was
good in a way. Because you can’t have three or four
people trying to tell you what to do. And that’s the
way they precept everybody. It wasn’t just me. That’s
the way they do everybody. They just kind of throw
them out and say “Go get ‘em!”

BD: The one that you attached yourself to, were there any
particular characteristics or what made you ....

#3: She was the youngest thing and nice looking! (Laughter)
You gotta be honest right? No there wasn’t anything in
particular. The way they ran, really to be serious,
she was young and single. And she wasn’t acting
single, but that didn’t have anything to do with it
because I was in the process of getting "Happily
Married" again. But the uh,

BD: Oh you got married since graduation?

#3: Well, no, my relationship has smoothed out
considerably.

BD: Okay, school will do that to a relationship.

#3: Oh, it was that way before, so it wasn’t school.
School didn’t help any, but school didn’t cause the
problems. Uh, what, the way they ran theirs, they had
one nurse that kind of stayed, and they didn’t have any R.N.’s, so I had to take a L.P.N., I mean there wasn’t a choice. They had one L.P.N. that passed meds and that’s the one that I went with. They had one that stayed at the desk and also did treatments. So, I could either sit at the desk, or I could go with the person who was at least passing meds. So I chose to go with the person passing meds.

BD: Okay, in terms of the preceptors, you either self-selected or had assigned. How many hours a day did you spend with them in that beginning period of work?

#2: Well at that time we worked two twelves, two eights. And we were together the whole eight hours, the whole twelve hours.

BD: Was that pretty much the same for the whole shift?

#3: Well see my actual preceptorship on days, lasted about three days. And then it was three months, and I would come in and they said you’re gonna pass meds. What they did was instead of the L.P.N. having the whole hall, they split the hall. I got half of it she got half of it. And that was after about the third day. The first two days I was pretty much with the same person.

BD: Uh, would you describe what your relationship was with your preceptor.

#2: Well my preceptor made it very easy for me. She didn’t
belittle me because I wasn’t as smart as she thought I should be. Or she may have thought that I was smarter than I was or whatever. She accepted me for who I was and the knowledge that I had and she didn’t. You know, if I asked her a question, she didn’t, it wasn’t well you should know that. It wasn’t any of that. She was just really helpful in all ways. And no matter how stupid the question was, and I asked a couple of stupid ones, she never acted like it was stupid. She explained it thoroughly and everything was basically done by the book. And it’s more like being in school. When we would go in to do something, she would say, "Now listen to this and tell me what you hear." So that she could evaluate what I was hearing. And then she would say, well that was right but you need to listen, you didn’t hear this or you didn’t hear that. And so it was more like being in school.

#1: The one for me, that was from the Philippines in the beginning I would ask her questions and she, if I asked her again because I didn’t understand it. I felt like she was going "Oh you should know that, I told you already" or something. It was like I was getting that feeling from her. And now to see it that way at all. It’s just that she’s so busy all the time and overwhelmed, that she maybe was tired of it herself. But in the beginning it was making me seem like I was.
And the other one, well, she was understanding that I was right out of school. And it was more comforting for me to talk to them.

BD: Describe your relationship with your preceptor.

#4: Uh, very trusting and we had ______ usually. For the first twelve weeks, I had patients and she was going over what I did.

BD: ___, anything that you would want to add that was ....

#2: I think that when I went on nights and I got around people that I would be working with, even though it was supposed to be a preceptorship. It really wasn’t. The other R.N. that I worked with, who was also a new R.N. had been in long term care for quite some time as a C.N.A. And she had worked at that facility for a number of years prior to....and I felt really comfortable going to her and say I don’t understand this or where is this at, or how do they do this here? Because even though she hadn’t been an R.N. there, or even a L.P.N, she worked close enough with the nursing staff that she knew how things were done. So when I got on midnights, it was a lot better because I felt real comfortable. The G.P.N that we had working with us, she was real knowledgeable, she cared about the residents. And it was...,going from days to the preceptorship I had at night was totally different. So that was good.
BD: Did you all have uh, a level of comfort with your preceptors where you felt like you could share those things that you were anxious about or you were fearful about or you had concerns about in terms of how things were going? Share that kind of information with me. Your level of comfort in terms of communicating, some of the things you mentioned about being uncertain and concerned. And if you feel like you could. So why and if not, why?

#1: I was just gonna say I was more comfortable with one than the other because I had more than one. But I felt there came..., well I didn’t give up when I felt like I wasn’t getting the answers I needed. I felt like I was bothering her. So uh, I would go maybe to somebody else.

BD: Uh, the somebody else that you went to was it always the same person.

#1: Yes,

BD: And what was it about that person?

#1: Well, at first she was like, oh you’re right out of school. And because I didn’t know some things. But after that we developed a relationship where I would go to her and ask questions and she would always help me. She would always come down with me and help.

#2: I felt very comfortable with my preceptor. And I felt there was nothing that I could not tell her. Even if,
even like the supervisor or the assistant nurse manager. Even if she said some things that I didn't care for. I felt that I could discuss that with my preceptor and work through those things. You know anything. From the fact that I was scared to death. One of my patients was dying. I did have a dying patient. And it was really bothering me. And I was just really comfortable talking to her about anything.

#4: I would like to mention about being, when I started working I felt uncomfortable for the first couple of weeks because what you learn in school against working in a high-tech environment. You don't have time to play around. You have to draw blood through accucheck and everything. You can't be a "lax" person and I had a lot to learn in a short period of time. And I suppose I felt inadequate. There are so many things that I have learned in the period that I worked, those twelve weeks.

BD: How did your preceptor help you through that in terms of your comfort level?

#4: By following the basic guidelines from when we were in school. Being able to go step by step. The way she would do it, I would do it differently, and also knowing what to do with the patients.

BD: ___, anything that you want to add?

#3: Not really, because I think that I told it before I
felt so comfortable once I got on my regular shift. I felt so comfortable with a couple of the people that I worked with. The one that I was not comfortable with, ended up leaving probably about three or four weeks after I got on the shift and I didn’t have to deal with that anymore. But the three of us that were left, four and then three, they cut back our shift. We got along real good. We didn’t have any problems. I had one very experienced L.P.N. that I relied on and then the R.N., the other new graduate R.N. And I felt really comfortable with her level of knowledge so I didn’t have any problems.

BD: What did you learn from your preceptors about nursing and the nursing practice and the work environment? What specific things did they teach you or show you? Not talking about skills necessarily. It could be skills if that’s what you want to share. But I mean about practicing nursing. The role of a nurse in the work environment and negotiating a new work setting?

#4: All I can say, I was down at ______. As far as the setting, the ______ had policies that you follow and we also ______. Your relationship is determined by how flexible you are. And the extended curriculum is always there to help you out. To guide you through the way it’s supposed to be done

BD: What else did you learn about nursing and the practice
of nursing?

#1: You learn a whole lot about nursing decisions that we didn’t learn about in school. How to do things. We didn’t get a lot of practice talking to doctors. When to call the doctors. A lot of nurses don’t like to call them in the middle of the night with a problem because it wakes them up. Just how to judge what you really need to call now and what can maybe hold off for an hour or two hours. Because at the beginning I was the in the facility and I wanted to do everything by the book. UH OH he didn’t call me back. You know, you do but they don’t always have to call right back. Just talking to other nurses about using judgement.

#2: Of course we have a really good support system. We have a night supervisor that you know, hey if there’s something weird going on with your patient, and you’re not understanding that ... do I need to call the doctor or don’t I need to call the doctor? You can always pick up the telephone and call. And then of course there are other nurses there with you and you run everything by them and you make a collective judgement if it’s in the middle of the night, three o’clock in the morning. Do y’all really believe that I should call the doctor or do you think we can wait till six o’clock? And you have one brain, you have five brains.
My preceptor helped me learn how to manage time and how to judge what really is important at that moment. When to phone or not to call that person. Even the supervisor, I mean she’s busy too.

BD: ____, anything that you want to add.

#3: Talking about nursing judgement. I ran into several situations where I would use what I considered to be good nursing judgement and be second guessed by people on days. And eventually called down on ______ about it. I can give you an example of a patient who was in congestive heart failure. Whose blood pressure went up to like 185/110 during the night. But the lady was not in any acute distress. She wasn’t seeing stars, she wasn’t having headaches. She wasn’t diaphoretic. Just her blood pressure was high. Everything else with her was okay. And I made the judgement not to call the physician because the lady wasn’t in any real acute distress. Her blood pressure was elevated, but it wasn’t anywhere near where we would normally expect someone to stroke. And I made a judgement not to call. An experienced L.P.N called me over and asked me what I thought and that’s what I thought. Unfortunately I didn’t know that they didn’t think very much of the L.P.N. either. So the next day, it was batch time, you know when days get on? I did call the physician that morning and talk to him and he said go on and give her,
her nine o’clock med round and that’s basically all he said. He said she’s not in any.....and I still to this day feel like the judgement was right. But at that particular point and time, they felt like it was not right. And I said well, we don’t have a written protocol on when to call the physician and when not to call the physician. The physician hadn’t written any orders that say if the blood pressure goes over a certain......things like that. You know, you would use judgement and then your judgement got questioned. And from what I understand the facility that I was at, was really bad enough and the bashing was.....and since I have left, the G.P.N. that did get her license she past her state boards, she has become the brunt of the .....you know, it’s like they have to have someone.

And I still don’t feel like in that particular instance that the judgement was wrong. There was another lady who was, the L.P.N. and I was working with. At that time she only worked weekends. I didn’t know that much about her, but it was a lady that she should have picked up on. The lady was in distress and she didn’t. And they ended up coming to me and saying "Well why didn’t you know?" I said "Nobody told me. I can’t know unless somebody communicates" and ended up having to stay and deal with that person’s family when basically we knew that she was gonna die that day. And that was,
then they're saying well you should have known, you should have known. Well I can't know if someone doesn't come tell me. I can't... even though I'm supposed to be the supervisor, I'm working strictly the medicare hall. When we had three nurses on, one of us, whoever was the designated supervisor, would take the skilled nursing, all the medicare hall. One of the L.P.N.'s would take the A Wing, which was mostly ambulatory resident that didn't require a lot of care. And then, the other L.P.N. would take what we call the front hall. Which was non medicare, but it was people who required considerably more assistance. And if someone doesn't come over and tell you something, and that's what I'm trying to say. They didn't tell me. I can't act when I don't know. It was just a bad situation. It really was. I was there, the longer I was there, the more uncomfortable I got.

BD: Were your preceptors effective nurses. And tell me what things that you observed from your preceptors that you would model. And what things you would reject.

#1: Using the resources that we have, sometimes at our facility it's not always what we learn in school, or it doesn't seem like a respirator ______. We have limited stuff... a lot of time we don't have the correct equipment to do the right kind of dressings, but how to make a dressing that would be sufficient with what we
BD: You felt both were effective nurses?

#1: Um, yes.

#3: The night nurses that I worked with I felt that they were effective. The one in particular that precepted me on days, I did not feel was effective at all.

#2: Mine was very effective. She, as a matter of fact, she had been in __________ for years and years and then she went to the cardiac on the third floor. And she knew things that I can’t even begin to comprehend and it’s just all natural knowledge that she’s gained over the years. And what I’d like to copy from her is being able to retain the information that I’ve learned from one patient to the next.

#4: I liked my preceptor, the entire twelve weeks I worked with her I had only one preceptor. I like her very much. Again she has such a good sense of judgement and she can just by looking a patient she can really tell the condition. And one thing that I like in her, sometimes, she would just take the time to talk even if it meant staying over time.

BD: Okay, you mentioned the fact that they were knowledgeable that they had good sense of judgement. These were some of the things that you mentioned. The fact that they could improvise with what was available, were some of the things that made you consider that
your preceptors were effective. Were there any other characteristics that you could share that you looked at and said this is why I feel that she is effective. This is why I feel he is effective?

#4: Just one word, priority. What you do, whatever you do prioritize. What’s important and what’s not important. That way you would be able to get all your work done. Because you could be trying to do a bed change while the patient is short of breath and it’s not gonna work. So you need to prioritize what works at what time.

#1: Being able to have different roles and different relationships with different people. Being able to handle all the things you’re expected and being able to communicate very well makes one real effective.

BD: When you had decisions to make about your patient’s care, and I know that __ has shared some of his experiences already. While you were working with your preceptors. How were those decisions arrived at?

#1: Basically the questions, a lot of them that I had to arrive at in the night like when I was pretty much by myself. I had to go to another unit and get some help. I would pretty much ask them what they thought. I had one lady that died my second week of work. But I talked to her family that evening and she was real terminal with brain cancer and they didn’t want anything else done. So when they left that evening I
knew she was going to die, 'cause even though I'm not an experienced nurse, I could tell. And when she died, I had to talk to the family. The daughter was acting like, I guess she didn't expect that it would happen then. But I had to deal with them then. So I went to some of the other nurses and asked them how they would do it.

#2: I had a patient that was assigned to me, assigned to both of us. We both had the same amount of patients. Her patients were my patients. But after three or four weeks, we got in the habit that I did the assessment in the mornings and the medications and she was just there to back me up and say if I missed something and things like that. She wasn't there to tell me what to do every second. But, I had a patient that was dying and the family wanted him to be fed. Well he had already refused to be fed. So I went to talk to ____ about, you know the daughters are coming in. How am I going to explain that they cannot force-feed this man if he does not want to be force fed? He's still, his mind was still there. He still knew what he wanted and what he didn't. So, she said ____, you just need to, these are some points that you need to make to the family. But then you need to trust your own judgement. She didn't want to put words in my mouth because I'm going to have to deal with the people who are dying later on.
So she just kind of helped me prioritize the things that I need to focus on and talk to the family about. Because this patient had decided that that’s not what he wanted. He didn’t want stuff stuck in him to keep him alive. He was tired and he wanted to go. So, she wasn’t always telling me what to do, she was leading me to my on conclusions, to use my own judgement. But she was pointing out certain ways that I could go to get this across to the family.

BD: Any thing else that anyone would add on that one? (Pause) Feedback is very important to all of us as we work and do what we have to do. We need to know how we’re doing and if we’re doing as we should. Would you share what kind of feedback you got from the preceptors. Did you get any feedback? Was it helpful feedback or feedback that made you feel less than appropriate or competent. Just generally whether you got the feedback you needed at the beginning of practice.

#1: I got the feedback from the other nurses. Especially the ones that work the alternate shift when we do twelve hour shifts. We get a lot of good feedback back and forth. I felt that I was missing more other nurses in the morning from the ______ and the directors. The one we have now, is new and I haven’t seen her I didn’t get any feedback whatsoever. And I complained
about it and I needed, I wanted something and I didn’t feel like I got it. Not the feedback that I thought I was gonna get.

#2: We had a skill book, well almost exactly like a skillbook at school. And we would sit down every day and go over what I had accomplished that day, new things that I had done. Where she would say ‘she’s skilled enough to do this on her own.’ ‘She doesn’t need nobody to watch her do this any longer.’ Then at the end of the week we had another more like this. The checklist has space where we wrote down things that I needed to work on. That she felt that I needed to work on. That I don’t do this well enough now or I do this excellently well. And then the supervisor at the end of the second week, she went over a lot of things, like pop-quiz questions, as you’re going down the hall. She’s letting you know that I expect you to know these things. And then she gives you feedback, like okay you’re doing great. All of your patients have nice things to say about you. Your preceptor says you’re doing well. And then the big supervisor gave me a call the third week or so and said how she felt I was doing. And so it was all the way up. And of course the other nurses that I worked with put their two cents worth in. It was real good. None of it was really negative. The way they organized it and everything, the way they do
it, it's all very helpful. It's not negative. Or that unit was not real negative.

#4: Our feedback we usually set goals every week of what you’re supposed to have every week for the whole twelve weeks. And my preceptor would go over it and show me what I need to work on. I say as a new nurse I need to prove myself to (fades)

BD: ___, anything you want to add?

#3: A lot of what ___ said. It really applied to me. Especially when you work nights. I work nights for two reasons. Number one, because I’m a night person. Number two, because you don’t have to deal with all the bureaucracy during the day time. It’s just a fact of life. You’ve been there and you know what I mean. But the thing that you miss, is you miss feedback. And the other thing is that you’re not there when people are saying things that you need to be made aware of so that you can make a change in what you’re doing. Or you can say I did this because of this. Two weeks later is a bit late. And with our D.O.N. and A.D.O.N. was the way that it was. Two or three weeks after an incident, it would be brought up. The feedback on the shift was good. The feedback between the shifts was not very good. It was like days was their own kingdom. And you just didn’t get a lot out of them and most of it was negative. One of the other problems in the facility
that I was working in was that no one knew how to be non-punishable. They had never read Dr. Flemming’s book on total quality leadership or anything like that. A lot of times, not so much with me because in the entirety of the time, the three months that I was there, I probably got called in three or four times to explain different things. Only once was a really not good time. And I had made a medication error and didn’t realize that. And I learned from that. And I won’t make that error again. So that even though in a sense, it wasn’t handled right, in a sense, it taught me something I needed to remember. They would leave nasty little notes on things and stuff like that. There was one girl who went to her time cards and there was a nasty little note from one of the C.N.A.’s, who I considered to be one of our better ones, went to her time card and ended up with a little note on her time card when she came in. You know, a nasty-gram. She was concerned about that at midnight, I got a call at home. And I told her to put it in with my time card and I would come in tomorrow morning and take care of it which I did. But that, I don’t know if it’s unique to the facility that I was working in or if it’s common in long term care.

#1: It’s common. At ours my first impression was none of the shifts get along. That was my first initial
impression. This shift does this. This shift doesn't do this. That was my first impression when I went in my first evening. I don't know why that is. It is bad. I thought I was going to quit all the time and go look for something else.

#3: Well I did finally leave. It just got to the point where I just couldn't take it. There were other reasons, but that was one of them. The backbiting that went on in that facility.

#1: And the C.N.A.'s don't like the nurses and the nurses don't like the C.N.A.'s.

#3: And the C.N.A.'s go and complain about the nurse and instead of the D.O.N. backing the nurse up and saying that the nurse and that nurses license is on the line, you have to say and explain why you made the decision you made.

#1: In the beginning I had a real problem with one. The night supervisor was kind of lenient with them because she feels like they show up. That's fine we laugh and have a good time. She'll come in and talk to us, but bring books, and it was real hard for me because that's not the way it is.

#3: But you're resented for it.

#1: Well not to my face.

#3: But you don't need to be sitting there reading a book if it's not your break or lunch time. You need to be
checking on your patients.

#1: I don’t care as long as everybody’s turned over and they’re all clean and they each all have twelve to fifteen patients. I mean that’s not a small load.

#3: I didn’t mind someone bringing a book in as long as like you said everyone was turned and cleaned. But then if I am in the process of doing the rounds or something and found someone that wasn’t. I would just say that so-and-so just had a bowel movement or so-and-so is wet or whatever. And that’s when I got to the place where I said if the rounds aren’t till whenever and the person is wet now...... And apparently the same thing that happened at your facility happened at mine so this was allowed and acceptable practice.

#1: At least on the eleven to seven shift.

#3: And then when you came in and said I want these people better taken care of. And I may be jumping ahead, but I think going in a long term care facility was a major mistake straight out of school. I really do. I feel like I’ve been set back at least six or eight months.

#1: And my other supervisors feel the same way so you know it’s not just you.

#3: I had supervisory skills. I got them when I work civil service. But I wanted to learn nursing.

BD: Let me ask you to share or describe what you thought your preceptors expectations were of you when you first
started and did they convey that they had certain expectations either verbally or non verbally as you worked with them?

#1: I don't think my preceptors had any expectations of me. I don't think they knew I was coming.

#3: There you go. I agree. Really.

#2: I think they had very high expectation because I came from ___ and most of the people I worked with were graduates of FCCJ and they expected me to be as good as they were.

BD: That's the first I've heard that.

#2: Well a lot of them there they don't have their B.S.'s they only have their A.D.N. degree and they all, a lot of them when I first started working were ______ students.

#3: It's funny you should say that because my wife had surgery when she was up on the fifth floor women's.....

#2: Uh huh, five east in the main building.

#3: And they, she had told them that I was taking state boards or whatever, and I had taken them, but I didn't have any idea. That was one of the things, I walked out of there and I had done on the state boards. When the computer shut down, I know I hadn't answered one hundred questions, but I still had no sense of. It was like, they would ask me. I remember one of them saying that she was trying to work and go to school at ____.
She said that you can tell that there's a world of difference between the nurses at ____ and other nurses. Because the FCCJ nurses are not afraid to work.

#2: And that is basically the same that they have some, ____ nurses that I refuse to follow behind at night time. I will not take her ______. Because you spend five hours catching up. And they, like I said, the supervisor people that were there when I first got hired, they were graduates of ____ and they expected the same things that they did from me. Expected my work to be very high.

#3: I'm very serious. That's what I was told. And when you said that it just reminded me that my skilled care person she said same thing, she hated working with the four-year nurses. Not the ones that have been nursing for a while, but just the ones straight out of school.

BD: Any other expectations? (Pause) Did any of you engage in activities outside of the worksetting with your preceptors?

#4: What type of activities?

BD: Like dinner, movies, picnics,

#4: We had like a Thanksgiving, Christmas parties. My manager, she was very nice.

#2: We had parties on the unit. You know we would bring in stuff. It didn't have to be a special occasion. We
all just said we’d have lunch and we’d all put down what we wanted to bring. But that was during work hours.
Appendix H

Word List Form
PRE-PRECEPTORSHIP:

DURING PRECEPTORSHIP:

RELATIONSHIP WITH OTHERS:

POST-PRECEPTORSHIP:
SENTENCE COMPLETIONS

COMPLETE THE SENTENCES:

JUST PRIOR TO BEGINNING PRACTICE AS A NEW GRADUATE, I FELT....

OF THE THINGS I LEARNED FROM MY PRECEPTOR, THE THING I CONSIDER MOST IMPORTANT IS.......

THE MAJOR MESSAGE MY PRECEPTOR CONVEYED TO ME WAS.......

I FELT THAT MY RELATIONSHIP WITH OTHERS ON THE UNIT WAS...

THE VALUE OF HAVING A PRECEPTOR WAS.........
Appendix J

Employer/Inservice Educators Questionnaire
EMPLOYER/INSERVICE EDUCATORS QUESTIONNAIRE

Institution ____________________________
Address ________________________________
Position/Title ___________________________

1. Are you directly responsible for the orientation of beginning nursing practitioners at your institution?
   Yes _____________ No ________________

2. Between December 17, 1993 and May 17, 1994, how many beginning nursing practitioners have been employed by your institution? (check one)
   None ____________ 1 - 2 ____________
   3 - 4 ____________ 5 - 6 ____________
   7 - 8 ____________ More than 8 _______

3. Did each beginning nurse practitioner have a formal orientation program?

4. How long was the orientation program for beginning nurse Practitioners?
   Yes ________________ No ________________
   1 - 2 weeks ____________ 5 - 6 weeks ______
   3 - 4 weeks ____________ 7 - 8 weeks ______
   More than 8 weeks ______

5. Were beginning nursing practitioners assigned to a preceptor/mentor?
   Yes ________________ No ________________

6. How long was the average preceptor/mentor assignment? (check one)
   Entire length of orientation program
   Less than the length of the orientation program
   Longer than the length of the orientation program
7. Did the beginning nursing practitioner and preceptor/mentor share the same patient assignments during the orientation period?

_________________________ Yes ___________________________ No

Explain ________________________________________________

8. Briefly describe your institution's method of identifying beginning nursing practitioners at the time of employment.
Appendix K

Sample Data Analysis Matrix
SAMPLE DATA ANALYSIS MATRIX

<table>
<thead>
<tr>
<th>Transcript</th>
<th>Wordlist</th>
<th>Sentence Completions</th>
<th>Journey Maps</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>(E) Focus initially is narrow</td>
<td>Learning (llll lll l) Excitement</td>
<td>(E) Concern about making a mistake</td>
<td>(E) Anxious ↓</td>
<td>Two phases in beginning practice experience.</td>
</tr>
<tr>
<td>(E) Fear of missing an important sign or symptom</td>
<td>Confident (llll ll) Anxious (llll l)</td>
<td>(E) Value of a mentor is immeasurable</td>
<td>(E) Frustrated ↓</td>
<td>Early Phase&lt;br&gt;Fear&lt;br&gt;Self-doubt&lt;br&gt;Concern about patients&lt;br&gt;Overwhelmed&lt;br&gt;External locus of control</td>
</tr>
<tr>
<td>(E) Concern about patient dying and not having any idea</td>
<td>Overwhelmed lllll</td>
<td>(L) Nursing is a great profession</td>
<td>(E) Relieved to be finished with school</td>
<td>Late Phase&lt;br&gt;Increased comfort&lt;br&gt;Ambivalence about independent practice&lt;br&gt;Readiness to take on challenge of independent practice&lt;br&gt;Internal locus of control</td>
</tr>
<tr>
<td>(L) Want to be out on own</td>
<td></td>
<td>(L) Being able to think things through</td>
<td>(L) Enjoying work ↓</td>
<td></td>
</tr>
<tr>
<td>(L) Apprehension about being on own</td>
<td></td>
<td>(L) anxious about being on own ↓</td>
<td>(L) comfort/confidence in abilities ↓</td>
<td></td>
</tr>
<tr>
<td>(L) Feel nursing skills are adequate</td>
<td></td>
<td>(L) seeking learning opportunities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Legend**

E = Early beginning practice phase

L = Late beginning practice phase
References

Agency for Health Care Administration. (1994). Florida

Board of Nursing Rules 59S.

Basgall, J., & Snyder, C. R. (1988). Excuses in waiting:

External locus of control and reactions to success-failure feedback.


white: Student culture in medical school. Chicago,

Il: The University of Chicago Press.


organizational socialization strategy. Journal of Vocational Behavior,

32, 176-195.


education: An introduction to theory and methods. Boston, MA:

Allyn and Bacon.

Brief, A. P., Sell, M. V., Aldag, R. J., & Melone, N.

(1979). Anticipatory socialization and role stress

among registered nurses. Journal of Health and Social Behavior, 20,

161-166.


What do proteges look for in a mentor? Results of three 

Professional socialization: A longitudinal study of first time high 
school principals. *Educational Administration Quarterly, 28*(1), 
43-75.


Morristown, NJ: General Learning Press.

Exner, Jr. (Eds.), *Dimensions of personality* (pp. 263-304). NY: 
John Wiley & Sons.


VITA
BARBARA ANN BARNABY DARBY
2445 Dunn Avenue, Apt. 508
Jacksonville, Florida 32218
PROFESSIONAL EXPERIENCE

Management:
Florida Community College at Jacksonville
1994 - Present - Instructional Dean, Health Programs
1989 - 1994 - Assistant Instructional Dean, Nursing Programs
1988 - 1989 Instructional Program Manager, Nursing Programs
1987 - 1988 Course Coordinator, Bridge Option Track-ADN Program

Family Health Services, Inc.
1974-1979 Agency Supervisor/Advanced Registered Nurse Practitioner

Teaching:
Florida Community College at Jacksonville
1981-1988 Nursing Professor
1979-1981 Adjunct Nursing Professor

Family Health Services, Inc.
1973-1979 Health Educator

EDUCATION
University of Florida M.S. Nursing (1988)
Florida Agricultural & Mechanical University M.Ed. Adult Education (1979)
Jacksonville Hospitals Educational Program (JHEP) 1974 Certificate Advanced Registered Nurse Practitioner
Hunter College B.S. Nursing (1970)

LEADERSHIP ACCOMPLISHMENTS
National Leadership Institute for Leadership Development - Leaders Program, March 1995
Women and Minority Leadership Program - Leadership Institute, Florida Community College at Jacksonville - December 1994
Leadership Jacksonville Alumnus - Class of 1993
COMMUNITY INVOLVEMENT

Mental Health Resource Center Board of Directors—Member, 1991 - present
Chamber of Commerce—Minority Economic Development Board member, 1991 - present
Delta Sigma Theta Sorority, Inc. - Past President and Member 1978-present
Bold City Chapter of Links, Inc. Co-Chair Projects Committee, 1990-present
Jacksonville Women’s Network - Member 1994 - present