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Voyage: A Passage Through Orientation

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Voyage: A Passage through Orientation

Literature Review

Introduction

At a small community based non-magnet 250 bed hospital in the Midwest, graduate nurse retention is a concern. It has been noted that hospitals with a bed capacity of 200-299 beds and non-magnet status, have higher turnover rates of new graduate nurses (NGN) (Blegen, Spector, Lynn, Barnsteiner, & Ulrich, 2017). Further, the hospital resides in a low-economic area of a large metropolitan city and recruitment of NGNs has been difficult. Retention of NGNs who are hired, is a priority with unit managers and senior leadership. In order to positively impact the first year of practice and retention of the NGN, changes over the last year have been made to the Nurse Fellowship Residency Program (NFRP), night shift mentorship program, and preceptor program.

Beginning in January of 2019, the NFRP transformed from a 12-week program to a 12-month program. Previously, the NFRP met for four-hours every other week for 12-weeks, leaving the NGN without support as he/she completed unit orientation and left the protection of the preceptor. To provide a longer mentorship and more support during transition for the NGN, the NFRP transformed the curriculum to cover 12-months. During the first six-months of the new program, the NFRP cohort will meet every two-weeks for two-hours. A debriefing component begins each class followed by a discussion on various topics that are considered important for the smooth transition of the NGN. The last six-months of the NFRP has a mentoring component that supports the NGN through the end of the first-year. It has been shown that providing strong support like mentoring during the first-year of practice, has a positive impact long term on the career of the NGN (Clipper & Cherry, 2015).

In 2018, a night shift mentoring program was piloted. Using four very seasoned nursing resource nurses as mentors, the NGNs are rounded on during each night shift to ensure the NGN is not overwhelmed or stressed. The mentorship program has been very successful and deemed important for the NGN on nightshift. The mentorship nurses are now permanently scheduled out of the nursing resource office to provide nightly support to the NGN. The night shift mentors and the facilitators of the NFRP have collaborated to ensure the support given to the NGN is consistent between both programs.

Another intervention that changed in the past year, was the preceptor program. The preceptor program was transformed from a four-half day lecture course to a two-day interactive course for those precepting new employees in the hospital. Evaluations for the two-day course have been positive. The preceptor course is not specific to the NGN preceptor. It is a general course that teaches the concepts of precepting for all preceptors in the hospital from all departments.

In the winter of 2020, several changes occurred that influence the orientation of the NGN. Due to staffing in the education department, the 12-month NFRP was not sustainable. The 12-week program was restarted with a stronger relationship with the nightshift mentors. Unit educators had their responsibilities reduced to allow more one-on-one time with the NGN. Lastly, the preceptor course moved from the individual hospital and became a system course that is centrally located

In the Spring of 2020, the COVID-19 pandemic began. With the hospital located in a low-economic area, and the surrounding community inflicted with numerous health disparities such as diabetes, hypertension and end-stage renal disease, the patient admissions were primarily those positive for COVID-19. The hospital turned the 26-bed step-down unit into a COVID-ICU,

with overflow ventilated patients with COVID-19 admitted to the SICU. Two telemetry units were at capacity with non-ventilated COVID-19 patients. A medical floor was transformed to a COVID-19 long term care unit for those positive patients not allowed to return to their extended care facility. The rehab unit was transformed to the recovery unit for COVID-19 patients needing further therapy to recover. To meet the need of patient care, many educators and mentors were placed into staffing on the patient care units or reassigned to supportive roles. Due to social distancing practices, all classroom courses were cancelled which included Nurse Fellowship, the Critical Care Course, and the Preceptor Academy. Care for patients positive with COVID-19 became the focus of hospital resources for three-months.

The negative financial impact of caring for patients with COVID-19 over the three-month period in an area with poor payer sources, the high cost of staffing, and the loss of revenue from cancelled elective surgeries and procedures, caused over 200 employees to be furloughed after the surge. Several educators were furloughed, and some were reassigned to other supporting positions. The unit educators remaining, were forced to cover multiple patient care areas. Course content for Nurse Fellowship, and the Critical Care course was placed on-line in the form of voiced-over power points. But, the Nurse Fellowship E-Learning course was not sustainable. The facilitator was furloughed, and another educator was not available to manage the Nurse Fellowship E-Learning course. During the three-month surge of patients with COVID-19, NGNs received minimal orientation support. Concentration on orientation for the NGN reemerged in June of 2020 with the spring graduates.

From 2018 to 2020, many programs to support the NGN were put into place. Even prior to the COVID-19 pandemic, it was recognized by leadership that unit orientation with preceptor guidelines for the NGN was not standardized. Per an exploratory meeting of hospital unit

educators, guidelines for the NGN and preceptor to follow over the 12-week orientation period were not consistent on each unit. Not all unit educators were meeting with the NGN on a scheduled formalized basis. Without regular meetings with the educator, the preceptor and NGN were left to navigate the unit orientation on their own. NGNs from unit-to-unit were being precepted differently and the content of the orientation was also inconsistent. NGN preceptors were not given specific instructions or a road map on how to navigate a successful 12-week unit orientation for the NGN.

With a standardized road map for the preceptor to orient the NGN during unit orientation, the NGN should have a more positive transitional period on the unit. NGNs who do not experience a smooth transition from student to nurse, have been found to feel overwhelmed, to question their commitment to the nursing profession, and to leave their first job within the first 12-months of hire (Edwards, Hawker, Carrier, & Rees, 2015). Preceptors are also important to the integration of the NGN in the culture of the unit and to the NGN continued development as a professional nurse (Henderson, Ossenberg, & Tyler, 2015). Yet, the preceptor role is very demanding. While being required to socialize the NGN to the unit, the preceptor is also responsible to teach, to validate competency, and to role model the professional nurse role. With all the demands placed upon the preceptor, the preceptor can feel overwhelmed especially within the time constraints of an active inpatient unit (Cotter & Dienemann, 2016). Providing an organized and supportive orientation process, adequate knowledge and allocated resources from unit management, the preceptor can provide the environment needed to make a positive impression upon the NGN. When nursing leadership shows support for the preceptor and the entire orientation process, the NGN will be left with a feeling that the organization is an

attractive place to work reducing the NGNs desire to leave the organization (Lindfors, Meretoja, Kaunonen, & Paavilainen, 2018).

Aim

The aim of the literature review is to reveal evidence which supports a standardized unit orientation plan that influenced the retention or turnover of the NGN in the hiring inpatient area. The search separates into two parts: first being the role of the preceptor to assist with the embedding of the NGN in the unit environment and second being the strategies which support transition of the NGN from student to professional nurse (Edwards et al., 2015).

Search Strategy

The literature search concentrates on dates from 2015 to 2020. In the vast search, over 300 articles were read. The significant search words used were nursing orientation, nursing turnover and retention, new graduate turnover and retention, newly graduated nurses, newly licensed RNs, new nurse graduate role transition, preceptor, nursing preceptors, preceptor orientation, nurse fellowship, and orientation models. Search engines such as CINAHL, CINAHL complete, CINAHL advanced search, PubMed, Medline, Google, and Trip Data Base reveal the significant references for the project. Also, as a member of the Association for Nursing Professional Development, print material from the association's, Journal of Professional Development, was also researched. The same significant words were used to choose articles to read in print form. The Journal of Professional Development provided many research articles and references to this author in relation to orientation models, preceptor influence and NGN transition into practice. All research articles read in print form and through search engines, were published within the last five years.

Results

Interventions that positively influence retention during NGN transition to practice

In a systematic review, Brook, Aitken, Webb, MacLaren, & Salmon (2019), explored current literature that focused on interventions to increase the retention of the NGN. The review selected 53 relevant papers out of the original 11,656 that identified interventions to improve the NGNs intention to stay in the clinical area. Interventions included the influence of the preceptor, the mentor, the teaching/training, the formal assessment of performance, the length of intervention, formal preceptor and mentorship training programs, and standardized orientation/transitions to practice programs to name a few. Two interventions that were key to retention were found to be preceptorship and mentorship. The quality of the relationship of the preceptor with the NGN, positively influenced retention and reduced turnover. Also, the length of the preceptorship was found to be essential in the integration of the NGN. A combination of mentorship and preceptorship increased retention of the new grad by 15% and just preceptorship increased retention of the NGN by 23%.

Teaching and training and the length there of were found to be important components to NGN retention (Brook et al., 2019). In a systematic review by Edwards et al., (2015), structured transitional programs were found to increase the NGN confidence in providing competent patient care by 72%. A structured program that trained preceptors in the orientation process, was also found to improve the confidence of the NGN. Well trained preceptors ensure that the NGN is supported during the orientation process. Feeling the support of the preceptor gives confidence to the NGN and improves the ability to learn and to adapt to the clinical environment (Ke, Kuo, & Hung, 2017).

NGN orientation programs that were longer in length showed significantly higher transitional scores than those that were less than four-weeks in length. When it came to communication and leadership skills, NGNs who had an orientation that was longer than four-weeks outperformed NGNs with shorter than four-week orientation periods. It was also found that the NGN felt more supported and more satisfied with a longer than four-week transitional program. The longer transitional/orientation programs were found to improve overall NGN communication with patients and other professionals. With a longer length of orientation, personal connections with the nursing job also improved (Rush, Adamack, Gordon, Janke, & Ghement, 2015).

In the study by Rush et al. (2015), an implication for nurse leaders to improve NGN transition to practice and influence NGN retention was to ensure a structured unit orientation that focused on effective communication between the manager and the staff. Another implication from the results of the study, was to ensure that preceptors had formal training. Other suggestions from the study, were for managers to ensure the NGN had proper shift time to orientate, proper time with the preceptor to build a quality relationship, and proper time for the preceptor to provide strong transitional support to the NGN.

NGNs that are supported during the transitional period on a unit, will have a decreased desire to leave and turnover rates will reduce. Allowing time for the NGN to transition onto the unit, projects the sense of a nurturing learning environment. In a study by Wilson, Martin, & Esposito (2015), NGN participants spoke of three phases of orientation. The first phase was described as, “running uphill but not alone” (Wilson et al., 2015, p. 30). In this phase the NGN realization of not knowing as much as once thought was not as overwhelming with a supportive group of NGNs going through the same experience. This type of interaction can be associated

with an NGN residency program that provides a supportive group debriefing time in each session (Shinners, Africa, & Hawkes, 2016). The second phase was described as, “gaining perspective from the top of the hill” (Wilson et al., 2015, p. 30). At the top of the hill, the NGN was able to understand what was not known and grow with the caring support and teamwork of colleagues.

The third phase was termed, “Transformation: On the downhill side” (Wilson et al., 2015, p. 30). From the top of the hill, the NGN was able to have a broader view and realize that transformation would occur with the support of colleagues. With the support of peers and colleagues, the NGN learned to accept imperfection during the transitional period and understand orientation is a learning process. And most important, the NGN learned that nursing takes a team and the NGN would never be alone. This allowed the NGN to begin the downhill descent of the transformational period to a competent practicing nurse.

The relationships built with the NGN during the three-phases enabled the NGN to reciprocate the caring to colleagues and embed the NGN into the institution. Being emotionally connected to the institution has been found to reduce turnover and retain NGNs within the first-year of hire. Providing a supportive environment during transition to practice, retains the NGN and contributes to the preservation of the nursing workforce (Laschinger et al., 2016).

The influence of preceptors on the NGNs transition to practice

Preceptorship has been found to be an integral component in the success of the orientation process for the NGN (Quek & Shorey, 2018; Peltokoski, Vehvilainen-Julkunen, & Miettinen, 2015). In a systematic review of qualitative studies, Pasila, Elo, & Kaariainen (2017), found that some NGNs felt the preceptor was the most important component of the orientation process. By creating a very calm and nurturing learning environment, the preceptor eased the transitional process for the NGN. Some NGNs preferred one preceptor throughout the orientation

where others liked the variety of learning from several preceptors. In either case, the preceptors became role models, and many developed a mentor relationship with the NGN long term.

Innes & Calleja (2018) noted in their review of literature, that preceptors created a supportive environment for the NGN to gain knowledge and increase confidence throughout orientation. Preceptors bridge the gap between theory and practice and help the NGN navigate through the rigorous processes of becoming a competent and safe nurse. Another aspect found, was that preceptors provided the NGN with socialization into the field of nursing. And when the NGN was faced with the reality of nursing, the preceptor provided emotional support to build confidence in the NGN.

Reality shock can be devastating during the transitional period of the NGN. Pasila et al. (2017) identified that it is important that preceptors recognize the signs of reality shock and provide support to the NGN early. An unsupportive preceptor can create a negative experience for the NGN and delay the completion of orientation. Proper preparation for the preceptor to provide a nurturing and supportive learning environment is imperative for a positive NGN orientation experience.

Preceptor training

It has been reported that 49% to 53% of NGNs make a nursing error in the first-year of practice. Lack of confidence and nursing judgement were the contributing factors for the errors. Improper training during orientation has been found to also contribute to the errors made by the NGN. Experienced preceptors who are positive roles models, are respectful, respected, and enthusiastic about their role, can be emulated by the NGN (Clipper & Cherry, 2015). Yet, an experienced nurse who is a positive role model does not always make a great preceptor without proper training.

Proper preceptor training should include well organized programs that are supported by the Chief Nursing Officer (CNO) and other senior leaders (Delfino, Williams, Wegener, & Homel, 2014). Guidelines for preceptor selection should be established prior to the initiation of a preceptor program. The preceptor attributes should include clinical competency, leadership qualities, teaching ingenuity, communication, and team expertise (Senyk & Staffileno, 2017). Workshops for preceptor training can come in many forms from a one-to-two-day workshop (Delfino et al., 2014; BMed, Fillipucci, & Mahajan, 2019) to a computer-based course that is 1.5 hours in length (Senyk & Staffileno, 2017). Other methods include “Just-in-Time” training for novice preceptors when a preceptor workshop is not available (Nelson, Joswiak, & Brake, 2019). The curriculum of a preceptor program should include role and responsibilities of the preceptor, learning styles of the NGN, facilitation of learning, critical thinking, conflict resolution, validating competency, providing feedback, and evaluating progress in the preceptee (BMed et al., 2019; Clipper & Cherry, 2015; Senyk & Staffileno, 2017). Other important components for the preceptor to understand is how to build confidence, integrate socialization, and surround the NGN with a solid support system (Clipper & Cherry, 2015).

When developing a preceptor workshop, it should have a variety of teaching methods for the preceptor to use with the NGN that stimulate the three domains of learning: knowledge, skills and attitude. According to Bloom’s Taxonomy of Learning, knowledge includes the cognitive aspects of learning; skills include the psychomotor or hands on aspects of learning; and attitude include the affective or emotional aspect of learning (Russell, 2019). The preceptor needs to learn how to incorporate all aspects of learning into the orientation of the NGN.

As a preceptor, evaluation of the knowledge base of the NGN is extremely important to assess where to begin building on the base. Embedding knowledge begins with the ability of the

NGN to remember the skills or process through understanding, applying, analyzing, to evaluating the results and creating a safe way to practice on the unit. Observing current skills and the smoothness of the acquisition of skills is important to ensure patient safety with procedures. The preceptor should understand that the NGN will at first imitate the procedure for the skill to become natural in practice. As experience with a task increases, the more natural the skill becomes. As the NGN becomes more emotionally embedded into the unit, the more the NGN values the policies, procedures and pulse of the unit. Being sensitive to the emotional state of the NGN will enable the preceptor to provide feedback in a positive and effective manner that supports the NGN through the transitional period (Yap & Melder, 2018; Russell, 2019).

Using an interactive and engaging format in a preceptor workshop will enhance active learning and encompass the affective domain of learning for the preceptor. By evaluating each component of the preceptor workshop in an interactive format, the preceptor can transfer the content of the program into the practice of precepting. Also, promoting learning through games is fun and stimulates pleasant mood states that can improve cognitive learning. Lastly, self-reflecting activities can enlighten the preceptor to their own biases and values. The preceptor can then evaluate how those biases and values will interfere or augment the orientation process for the NGN (Listopad, 2019).

Computer based preceptor programs have been developed to provide easy access for the preceptor to learn the concepts of precepting. The curriculum of a computer-based program is essentially the same as a preceptor workshop in a classroom. The computer-based program is condensed and gives the preceptor the ability to learn the concepts of precepting on his/her time. Computer-based preceptor programs enable an organization to save money on class time, enable

more preceptors to be trained, and enable the preceptor to learn in a self-paced environment (Senyk & Staffileno, 2017).

A blended learning format that includes classroom and computer-based learning allows for group interaction and self-paced learning. Having the best of both worlds, the educator can reinforce the computer-based concepts in the classroom. Some computer-based programs give the preceptor continuous access to the E-Learning content which can reinforce concepts learned (Cotter & Dienemann, 2016).

Though “Just-in-Time” preceptor training is not ideal, it may be a necessity when a novice preceptor needs to be trained to meet the demands for orientating an NGN. A formalized course may not be available or ideal for a just-in-time need for a preceptor. Nelson et al. (2019) developed a program that supports the quick training of novice preceptors in an efficient manner. The novice preceptor meets with the educator or other unit leader to review the preceptor checklist. The clinical aspects of precepting are reviewed with emphasis given on completing orientation forms, giving feedback, and evaluating competencies. Once the novice preceptor feels comfortable with the components of precepting, the novice preceptor can precept the NGN. When a formal course is available, the novice preceptor is enrolled in the program for further education.

Models for a standardized unit orientation

Just as important as a properly trained preceptor is to the success of the NGN, a well-organized unit orientation plan is also just as important. Using the three domains of learning, knowledge, skills and attitude, a structured orientation plan can increase critical thinking and judgement, time management, and organizational skills in the NGN (Joswiak, 2018). Tiered or phased orientation models use the three domains of learning and incorporate Pat Benner’s novice

to expert model. Benner's model is framed around five stages for clinical experience: novice (less-than-six-months), advanced beginner (six-to-12-months), competent (one-to-three-years), proficient (four-to-five-years) and expert (more-than-five-years). The NGN enters unit orientation at the advanced beginner stage. Having some clinical experience from nursing school but not enough to be confident and competent in the role as a practicing nurse, the preceptor's role is to move the NGN from the advanced beginner stage to the competent stage during the unit orientation. Once in the competent stage, the NGN can base patient decisions on real scenarios from actual clinical experience (Stinson, 2017).

A tiered orientation model progresses the NGN through tiers of skills. Once the NGN proves competency in a tier, the NGN is moved to the next tier. This does not mean that an NGN is proficient at taking care of all the needs of a patient or an entire team. It means that the NGN has proved proficiency in the specific skills for that tier. Specific skills might include collecting and analyzing vital signs, calculating and comparing intake and output, and entering accurate documentation in the electronic medical record (EMR). As the NGN progresses through the tiers, the skills become increasingly harder. Using the previous tier as a base for knowledge, the NGN progresses to the next tier and builds on the base of the previous tiers. If an NGN is having difficulty achieving all the objectives in a tier, the preceptor can meet with the unit educator or unit leadership to develop a plan of action for the acquisition of the skill in the tier (Joswiak, 2018).

Moving the NGN through a tiered acquisition skills model allows the preceptor to adjust the movement through the tiers based on the learning needs of the NGN. The preceptor is assigned a full patient team which allows the NGN to have multiple patient experiences while

increasing skills at his/her learning pace. The NGN can learn organizational skills and build confidence in caring for an entire team of patients.

The tiered orientation model can reduce orientation costs for the unit by reducing the number of nurses needed to care for patients and reducing the amount of orientation time for the NGN. Taking an entire team reduces the need for additional nurses to offset a smaller patient assignment for the preceptor and NGN. It also increases confidence in the NGN at a faster pace which can reduce the amount of time the NGN is in unit orientation (Joswiak, 2018).

A phased orientation program is an innovative design that works off Imogene King's theory of goal attainment (McQueen, Cockroft, & Mullins, 2017). NGNs are mostly millennials. Millennials are confident, technological savvy, and goal attainers. Millennials have been raised by baby boomers who have fought hard to obtain their achievements and have taught their children to be self-assured hard workers towards their own goals. These NGNs want to achieve their goals and not be held back. King's theory of goal attainment falls within three systems that include interacting with self, groups, and society (McQueen et al., 2017). If King's theory is used during unit orientation, the millennial NGN would be allowed to achieve goals for him or herself, the unit, and the hospital organization. A phased orientation model can achieve this for the NGN.

A phased orientation process sets competencies for each foundation level based on patient acuity. Foundation 1 is for competencies associated with the lowest acuity patient, Foundation 2 is for competencies associated with the moderate acuity patient, and Foundation 3 is for competencies associated with the highest acuity patient. In each foundation, the NGN is scheduled for a set number of shifts so the competencies established for each level can be achieved. The number of scheduled shifts can be altered if the NGN needs more time to

complete the competencies. The preceptor takes a reduced team to allow time with the NGN to validate competencies and promote confidence in caring for each patient at the level of acuity set by the foundation (Rivera, Shedenhelm, & Gibbs, 2015).

After the NGN has completed the competencies set within the foundation level and the preceptor agrees the competencies have been proficiently performed, the NGN begins to take a patient team on his/her own. For example, the NGN can be assigned one patient for three shifts, two patients for four shifts and three patients for five shifts. The acuity of the patients assigned to the NGN is based on the foundation level just completed with the preceptor. During the assigned shifts, the preceptor remains close with his/her own team and can support the NGN with his/her patients. Once the NGN shows competency with caring for patients at the set acuity level, the NGN is placed back with the preceptor to learn to care for patients at the next acuity level. Again, after those competencies are accomplished, the NGN nurse is assigned his/her own patients for an established number of shifts with the preceptor close by to support the NGN. This process continues until all foundation levels are completed and the NGN has shown competence in all levels of care (Rivera et al., 2015).

A phased unit orientation has been found to be successful with NGNs. The NGNs were very satisfied with the process and felt very confident with their achieved skills and ability to care for patients. The NGNs noted that the Foundation 1 level of care with the lowest acuity patients, gave the NGN time to learn the basic care given on the unit. Preceptors were also very satisfied with this innovative phased orientation model. The preceptors felt more confident with precepting as the levels well defined the care to be taught to the NGN. The preceptors did not feel as overwhelmed as time was given to teach all levels with the different types of patient acuities (Rivera et al., 2015).

The phased orientation model can reduce unit orientation costs. The NGN is only considered non-productive during the time with the preceptor. When the NGN is next to the preceptor and is carrying his/her own patient assignment, though a small team, the NGN is coded as productive time. The preceptor is also carrying her own team which helps with patient staffing. Phased orientation has been shown to reduce the amount of non-productive time the NGN needs to complete unit orientation. Goal attainment is faster with phased orientation which improves satisfaction with the orientation process for the NGN (Rivera et al., 2015).

Beamer, Kromer, & Jeffrey (2020) found that a tiered skills acquisition model (TSAM) in orientation built on trust allowed the preceptor and preceptee to set meaningful goals more frequently, balance priorities of the day, and improve on time management. The model began on medical units with a core tier that included the general clinical orientation and pre-orientation set up with the unit educator. Building on the core tier, Level 1 tier included skills related to assessment and documentation such as assessing patients, reporting abnormal findings, and documenting those findings in the EMR. Level 2 included medication management, patient and family interaction, and multidisciplinary communication. Level 3 focused on safety and quality. The preceptor concentrated on educating the preceptee in ways that prevented patient harm and hospital acquired infections. Skill checks focused on high risk procedures that included blood transfusions, central line venous access device care, and specimen collection. Level 4 concentrated on the continuum of care by focusing on patient admission, discharge, and transfer.

Level 5 and the “ongoing” tiers concentrated on professional development. The preceptee was given tools to manage an entire team of patients that included all aspects of patient care learned in the previous levels. An experienced nurse was able to reach Level 5 quicker than an NGN. After the achievement of Level 5 the preceptee graduated from orientation with the

preceptor and was given information on other ways to grow in the organization. Those ways included shared governance, professional development clinical ladders, and other growth opportunities the organization offered (Beamer et al., 2020).

In the TSAM, the preceptor along with the preceptee were assigned a full patient team. The preceptee performed the patient tasks in his/her current level while the preceptor provided the other patient care. If the preceptor found an opportunity to educate on a task not in the preceptee's current tier, the preceptor was given permission to give the opportunity for the preceptee to learn the skill. Changing to the TSAM on medical units, Beamer, Kromer & Jeffrey (2020) found that orientation weeks were reduced, cost of orientation was reduced, goal setting for the preceptee was improved, and time management with full patient teams was improved. Preceptees were found to interact with their preceptors effectively and found to feel more confident interacting with patients. Preceptees and preceptors had an overwhelming feeling of satisfaction at the end of the TSAM orientation (Beamer et al., 2020).

In the TSAM model the preceptee and preceptor are in a married state. In other words, the preceptee and preceptor work side by side. The married state preceptorship model (MSPM) encourages experiential learning opportunities for the NGN. Having the preceptor at the side of the preceptee for all learning opportunities, the NGN gains confidence, critical thinking skills, time management proficiency, and collaborative team intelligence. As the NGN transitions to independent practice, the anxiety in the NGN is reduced and patient safety is increased. The MSPM along with the TSAM allows the NGN to learn the role of the professional nurse by gaining necessary skills in a phased and highly supported orientation process (Figueroa, Gardner, Irizarry, & Cohn, 2016).

Conclusion

In order to meet the needs of the NGN during unit orientation, innovative ways to orientate must be examined. It is imperative that changes are made to improve unit orientation, so NGN satisfaction and overall retention improves at this author's hospital. Support for both the NGN and the preceptor for skills acquisition must be given to encourage the optimal orientation process on the unit. Preceptors need to have the tools to precept and understand the models for teaching so that the acquisition of knowledge, skills, and values are included and nourished during unit orientation. As the NGN flows through the transitional period from student to practicing nurse, the gap must be filled with support and patience for the NGN. This is important for the NGN to transition smoothly, the preceptor to always provide, nursing leadership to reinforce, and safe delivery of care to our patients.

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