Lessons Learned

Accessing the Voice of Nurses to Improve a Novice Nurse Program

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A novice nurse program was developed to address the need for educational and clinical support for entry-level nurses in a community hospital setting. A focus group was used to assess the novice nurses’ perception of the program and to synthesize lessons learned. Nursing professional development specialists are advised to access the voice of novice nurse participants to meaningfully evaluate and further develop residency programs.

In health care today, many acute care hospitals are employing new graduate nurses in response to the nursing shortage. New graduates help fill the staffing void in organizations where experienced nurses are not available. These novices face challenges with role transition and acclimation to their new environment, and often, “reality shock” sets in putting them at risk for leaving within the first year (Kramer, 1974). New graduate turnover rates within the first year of practice are estimated to cost $22,420–$77,200 per nurse (Halfer & Graf, 2006; Welding, 2011). Kovner and colleagues (2007) reported that 13% of newly licensed registered nurses changed jobs after 1 year, and as many as 37% already felt a need to change jobs. Other researchers have confirmed that between 35% and 65% of novice nurses choose to change positions within the first year (Halfer & Graf, 2006; Pelico, Djkic, Kovner, & Brewer, 2010). All of these statistics are concerning given the reported costs for onboarding new nurses. Nurse residency programs have been shown to temper this 1-year exodus of novice nurses by lowering turnover rates to as low of a range as 2%–14% (Harrison & Ledbetter, 2014; Pittman, Herrera, Bass, & Thompson, 2013). Nurse residency programs are considered an essential element for orienting new nurses in the acute care setting. The Institute of Medicine’s Future of Nursing speaks out on the difficulties of transitioning new nurses into practice, and supports the recommendation by The Joint Commission regarding the importance of nurse residency programs (Institute of Medicine, 2010; The Joint Commission, 2010).

The need for the development of nurse residency programs is especially significant for community hospital settings, because little is known about best practices for transitioning novice nurses from student to professional practice in these specific settings. Community hospitals often cannot afford to invest in residency programs as they are expensive and often not tailored to their needs (Trepanier, Early, Ulrich, & Cherry, 2012). Community hospitals often face decreased resources for developing and supporting nurse residency programs. The authors were challenged to develop a program in a community hospital that would support novice nurses, while gaining insights from their reflections on the experience for continuous improvement.

Novice nurses are in unfamiliar territory, thus making them vulnerable to feelings of stress, powerlessness, and marginalization (Casey, Fink, Krugman, & Probst, 2004; Halfer & Graf, 2006). To address these issues, healthcare organizations have developed various orientation programs geared toward meeting the specific needs of novice nurses. Interventions such as structured mentoring, team precepting, and ongoing support from educators were found to decrease staff turnover rates, increase job satisfaction, and increase perceived confidence and competence of novice nurses (Cheeke, & Dunn, 2010; Roche, Lamoureux, & Teehan, 2004; Ulrich et al., 2010). Several studies (Deppoliti, 2008; Laschinger, Finegan, & Wilk, 2009; Rheaume, Clement, & Lebel, 2011; Smith, Andrusyszyn, & Laschinger, 2010) have shown that orientation or onboarding programs that promote empowerment are linked to increased commitment to the profession and job satisfaction, and decreased burnout and incivility. In addition, experienced nurses’ satisfaction with novice proficiency increased after the introduction of a novice residency program (Rhodes et al., 2013). Efforts to ease the transition of new staff have
shown benefits of novice empowerment to both the individual and organization. Organizations strive to recruit nurses, decrease turnover, and subsequently reduce costs associated with training new nurses when developing residency programs. Subsequently, there is a need to evaluate the effectiveness of residency programs. One method of evaluation is to give voice to nurses who engage in the programs by soliciting their feedback through open discussion. The purpose of this article is to report a focus group evaluation of a 12-week community hospital residency program and to synthesize lessons learned from the experience.

LITERATURE REVIEW
Residency programs vary in length, curriculum, and format based on identified objectives and cost limitations. Programs range from 12 weeks to 2 years in duration, with an average program being 1 year in length (Goode, Lynn, Krsek, & Bednash, 2009; Little, Ditmer, & Bashaw, 2013; Strauss, 2009; Welding, 2011). One of the most well-known programs is Versant, a highly structured nurse residency for novice nurses that originated in 1999. As of 2009, this evidence-based program was launched as a national model that is structured on Benner’s novice-to-expert framework. Organizations can choose to purchase a residency program like Versant or develop their own (Ulrich et al., 2010).

Nurse residency programs are structured to meet the needs of new nurses transitioning into the nursing workforce. Programs are designed to promote effective role transition by developing competencies and critical thinking, and engaging the new nurses in evidence-based practice (Bratt, 2009). Many programs require new nurses to attend weekly or monthly educational sessions that incorporate debriefing, simulation, reflection, and leadership skills. Some residencies rotate new nurses during orientation to related areas outside their home unit within the healthcare setting to increase their understanding of all clinical components of care (Ulrich et al., 2010).

The novice nurse program (NNP) was developed at Martin Health System to meet the needs of a community hospital that was transitioning a number of novice nurses into the practice environment, while simultaneously attempting to focus on quality. Leadership had identified a need for individualized feedback and development goals for each novice nurse. Previously, there had been no unique orientation plan or follow-up for novice nurses. In particular, the Critical Care Service Line and Performance Excellence Team had become concerned about retention rates, available clinical support, and ways to respond to the educational needs of these new nurses. It became apparent that this was a house-wide need.

NNP at Martin Memorial Hospital
The NNP was implemented in January 2010. A needs assessment revealed that no other hospital within this geographic area was providing an NNP that addressed the concerns of new nurses. Before 2009, novice nurses attended a standard orientation, consisting of 1 week of general hospital orientation, followed by 6 weeks of preceptorship on their unit of hire. However, to increase retention, leadership now wanted these nurses to feel more comfortable and competent in their new roles. Initially, a staff nurse was approached by hospital administration to develop and launch a new orientation program tailored to the needs of these new nurses. This nurse was given the title of novice nurse educator (NNE) and became the coordinator and major support for the participants in the NNP program. The purpose for the NNP was to enhance the knowledge base of novices, increase critical thinking skills, ease transition from student to professional role, and promote retention, which would ultimately improve patient satisfaction and clinical outcomes.

The NNP is based on a model designed by Rosemary Timmerman, a clinical nurse specialist at Providence Alaska Medical Center’s Adult Critical Care Unit. Timmerman’s program was developed to promote the successful transition of students to critical care nurses (Timmerman, 2010). Although this model was geared toward critical care, Timmerman’s curriculum topics and structures were found to be applicable for novice nurses transitioning into the progressive care and/or medical–surgical units at Martin Health System.

The initial phase of the NNP consisted of specific clinical rotations through the cardiac catheterization laboratory, operating room holding, endoscopy, and interventional radiology settings so that novices could improve their understanding of the patient experience, learn periprocedural care, and have the opportunity to collaborate with other disciplines. Subject matter experts presented topics such as initiation of the rapid response team, risk management documentation, wound care, stroke care, and lateral violence. Participants were able to ask questions, link content to clinical experiences, and discuss the incorporation of policy and procedures on those topics. High-fidelity simulation experiences provided opportunities to refine nursing care and basic acute care skills. An unoccupied nursing unit was used to practice head-to-toe assessment skills, bedside rounding and reporting, and central line management and to familiarize the novice nurses with hospital equipment. Simulation scenarios were also incorporated for common diagnoses such as chronic obstructive pulmonary disease and heart failure. In one exercise, nurses were challenged to discover potential safety issues in a patient room. Potential errors included mislabeled intravenous bags, a bed left in elevated position with four side rails up, and a Foley catheter bag on the floor and not dated. These experiences served to refine the novice nurses’ understanding of medication and patient safety and regulatory compliance.

After the 2-week didactic and skills phase of the NNP, novices were assigned to a designated preceptor for
6 weeks of clinical orientation on their unit. Preceptors were chosen by the directors of those units. During the nurses’ 6 weeks of orientation, the NNE would rotate on each unit at least once a week to provide support to the individual novice nurse, and review time management and medication administration practices. Through these visits, the NNE addressed issues and concerns and provided encouragement. The NNE also worked closely with preceptors, charge nurses, and directors to obtain feedback and promote collaborative efforts in support of the novice nurse’s success. At times, the NNE would work one-on-one with struggling novices for a full shift in response to specific feedback on learning needs.

The outcome measure used to assess competence for participants in the NNP was the Watson–Glaser Critical Thinking Appraisal (W-GCTA; Toth, 2013). The alpha reliability of the W-GCTA is reported as .84 for healthcare professionals, and the tool is widely used to assess cognitive abilities such as decision making, problem solving, and openness to experiences. Pre-NNP assessments were available for the 71 novice nurses who initially began the program. During the training, 16 of those participants left the employment of Martin Health Systems. Of the 55 participants left in the program, only 19 attended the last session where the final survey was given. Ten of the 19 showed a higher score in critical thinking on the W-GCTA. The other 36 NNP participants concluded their training but did not attend the final session and complete the survey. This decrease in assessment participation prompted a need to conduct two separate focus groups. The first focus group consisted of novice nurses who completed pre- and post-NNP assessments. The second focus group consisted of novice nurses who were originally enrolled in the NNP, but did not complete the final session and survey. To investigate reasons for limited engagement and to conceptualize lessons learned for ongoing NNP planning, institutional review board approval was obtained to conduct these two focus groups. The other 36 NNP participants concluded their training but did not complete the final session and survey. To investigate reasons for limited engagement and to conceptualize lessons learned for ongoing NNP planning, institutional review board approval was obtained to conduct these two focus groups. The other 36 NNP participants concluded their training but did not complete the final session and survey.

**EVALUATIVE PROCESS**

The overall purpose of the focus group discussion was to gain insight into the reasons why some individuals did not complete the NNP, whereas others did. In addition, there was interest in perceptions about NNP effectiveness and recommendations for improving the program. The specific questions guiding the evaluation were the following:

1. What factors facilitated engagement in the NNP through to the completion of the post-NNP assessment?
2. What factors were barriers to engagement in the NNP through to the completion of the post-NNP assessment?
3. What recommendations were shared by NNP participants for improving the program when it is offered in the future?

**Methods**

Two focus groups were conducted. All nurses who completed the pre- and post-NNP assessments (n = 19) were invited to the first group; three attended. All nurses who did not complete the NNP post-assessment (n = 36) were invited to the second group; five attended. All the participants were women and agreed to participate after receiving an email invitation from the NNE.

The focus group facilitators included two doctoral students and one research faculty member; none of the focus group facilitators had experience with participants in the NNP. Both groups were recorded using digital audio recorders. One of the doctoral students led the focus group discussion, asking the four questions listed below, and subsequent probes as required to clarify responses. The second doctoral student took notes regarding the focus group responses to serve as a backup should there be any portion of the tapes that were unclear or uninterpretable. In addition, the research faculty member took notes on verbal and nonverbal responses, such as body language and eye contact.

The first session lasted nearly an hour, and the second session lasted 35 minutes. The four primary questions that were asked to guide the focus groups were the following:

1. “How did you come to be a part of the NNP at the Martin Health System?” This question was intended to establish a connection between the focus group members grounding ongoing conversation.
2. “What aspects of the program did you find useful? What would you add or remove from the program?” These questions addressed facilitators for participating in the NNP.
3. “Were you able to complete the program? Can you identify barriers to participating in the program through completion of postprogram assessment?” These questions addressed barriers to participating in the NNP.
4. “Please provide recommendations for increasing attendance, program completion, and program enhancements for future participants.” This statement was included to gain insight into novice nurses guidance for ongoing NNP sessions.

Once the focus groups were concluded, the three facilitators listened to the digital recordings separately to increase the likelihood that no comments relevant to the evaluation questions were overlooked. Each one recorded all of the relevant participants’ responses consistent with the three research questions addressing facilitators, barriers, and recommendations. The three lists were then compared for uniqueness and consistency. There was high agreement between all three coders, and any discrepancies were discussed to achieve consensus. Once checked for agreement, the lists were merged to eliminate redundancy and coded for emerging lessons about facilitators, barriers,
and recommendations. Coding included linking data within each evaluation question and then grouping like statements to arrive at lessons learned.

**Results**

Analysis of the data provided insight into how the NNP could be improved. Several areas were identified that could inform the process for educating novice nurses so that they would follow the program through to completion (see Table 1). The lessons learned were categorized into seven key areas.

**Careful Selection of NNE and Preceptors**

Participants in both groups had only positive feedback regarding the NNE. They commented on the amount of time she spent and how much she gave of herself, highlighting the importance of having a committed NNE when designing NNPs. This appreciation for the NNE translates to a lesson about the importance of selecting an individual who can live up to the expectation for generous giving of self.

The NNE was identified as a major source of support, and many participants reported an increase in their confidence as a result of her guidance. One nurse commented that “it is nice to know that there was always someone there to help.” Whereas another NNP nurse added, “That if you felt insecure, the nurse educator would come anytime day or night to provide support.” One nurse stated that “you can call the NNE anytime and get an answer. It doesn’t matter if it was day or night she would always find time to meet with you.” Another participant shared that “the NNE did a masterful job in scheduling to meet with everyone. Whenever she worked she would pop in.” Another nurse said, “I could go to her at any hour of the day.” All nurses described the NNE as a resource, and one said, “Since the NNE was an experienced ICU nurse she was a tremendous support.”

Careful screening was suggested for future programs so that the best preceptors would be selected to facilitate the development of the novice nurses. This stance was supported by the following statement, “Some floor preceptors were not as good. I felt that I got dropped off to whomever, and that was a big disappointment.” Participants in the second group shared that “preceptors should be those who liked to teach novice nurses, or should be good at teaching.”

**Support that Extends Beyond 12 Weeks**

Many people suggested that the program was too short. Focus group participants expressed a desire for an extension of the NNP follow-up after the structured 12-week program. “There needs to be continual contact with the educator over the six months.” One nurse commented that “this program needs to be longer, it is too short with not enough follow up.” Another nurse added, “We’re looking for more support, not just the orientation. We need more programs like this.” Another nurse stated that “it would be nice to have a refresher course on the equipment that we don’t see frequently like patient controlled analgesia pumps and wound vacuum assistive devices.”

Participants shared concerns about differences in support in the transition between the NNE and the preceptor. One nurse commented that “there was a disconnect between the NNP and the preceptor.” This recommendation was coupled with a request for accountability of those participating as preceptors. In addition, it was suggested that the preceptors should have an ongoing connection with the NNE to keep everyone informed.

**Opportunities for Experiential Skill Acquisition in a Nonthreatening Environment**

Both groups also mentioned the many skills that they learned through the NNP. They recognized the value of experiential learning to enhance competencies. One nurse commented that “the most important and helpful aspect of this program was that it gave me the tools to realize when something was not right.” Regarding competency, another suggested, “Add more rapid response experiences... drills and mock codes would be nice.” This lesson learned suggests that there needs to be some ongoing assessment of competency with established periods for meeting competency standards. In addition, many of the NNP participants were happy with the nonthreatening nature of the program. “It’s the most beneficial thing they’ve done here. I do not have to worry about making mistakes while I am training.”

Focus group participants also recommended a program component that would eliminate floating until the novice nurse felt competent. One nurse commented, “Changing

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**TABLE 1 Lessons Learned**

| 1. Careful selection of the novice nurse educator (NNE) and the preceptors to assure commitment to the novice nurse |
| 2. Support that extends beyond the 12-week structured program with a smooth transition from NNE to preceptor, creating a formative loop that includes key stakeholders |
| 3. Opportunities for experiential skill acquisition in a nonthreatening environment with consideration to limit floating until competencies are met |
| 4. Making policy meaningful through real-world connections |
| 5. Lateral violence deserves a prominent place in the novice nurse program education process |
| 6. Ensuring all novice nurses have access to hospital email |
| 7. Selection of meaningful, practical outcome measurements |
units gives me anxiety. I wish I could wait until I had a stronger knowledge base.”

Making Policy Meaningful
One nurse identified that the review of the hospital policies during orientation enabled her to distinguish why some treatments were not appropriate and gave her the insight and confidence to know where to find policy and procedure information in the future. Another nurse suggested that “…the policies are presented on the website so we did not have to spend all of that time on them.” She agreed with other group members that knowing the policy information “gives you confidence that I did not receive during…nursing education.”

Others were happy that they were able to learn specific procedures not covered in school. Both groups thought that their skill development was improved because “they (the educator/preceptors) tied the policy to specific simulations.”

Lateral Violence Should be Examined
The conversation differed between the groups in one major aspect. The group that completed the final assessment was the only group that had a short but active discussion on lateral violence. This discussion was best summarized by the following quote, “The lateral violence presentation given during the NNP helped me manage the lateral violence that I faced on my floor.” The nurse sitting beside her mentioned that lateral violence was not covered during her nursing program. Charge nurses were identified in the discussion as a resource for education on how to respond to the lateral violence.

Ensuring Access to Hospital Email
When discussing the barriers to engagement in the NNP through to the completion of the post-NNP assessment, there was a call for sensitivity to the computer access and capabilities of the novice nurses. The NNP included the NNE posting clinical cases for the participants to review. One person in the noncompleter group stated that “one of the major barriers was that there was a lack of time to respond to the email cases, and that I could not access my hospital email from home.”

Selection of Outcome Measurements
Finally, in the group that did not complete the final assessment, several nurses commented that the assessment tool was too long and was not a measurement specifically created for nursing, but rather measured general critical thinking skills. They identified a need for meaningful, practical outcome measurements. One suggestion was to involve the preceptors in giving feedback as to their progress: “Ask those who supervise us, they can tell you.” Another participant felt that simulation was a viable option:

“You can test by letting them do the scenario at first and then again after a year.”

Discussion
Although residency programs directed to community hospitals call for attention to setting uniqueness, many of the lessons are relevant across bridging experiences. Bridging new graduates from their formal nursing education to professional role development requires a foundation of supportive engagement with experienced nurses and experiential learning relevant to the practice setting (Remillard, 2013). Nursing professional development (NPD) specialists working in community hospitals are challenged to deliver these essential components in a manner that balances fiscal constraints with quality agendas. These NPD specialists are advised to access the voice of participating novice nurses who can provide expert guidance for ongoing program development.

Nurses in their first year of practice are vulnerable to burnout and career abandonment. An NNP, such as the one described in this article, can provide support to novice nurses as they make the transition from education to practice. When tailoring programs to meet the needs of unique practice settings, it is critical to understand the experience of those who are actually engaged in the initiatives. Allowing the program participants to discuss their experiences through a focus group provided some valuable lessons. The use of researchers with whom they had no prior relationship allowed the NNP participants to be candid without fear of reprisal.

The goal was for all novice nurses to complete the NNP. Nurses who did not achieve this goal noted several personal reasons for discontinuing participation, like family obligations, time limitations, and feeling independent in their nursing practice. Despite these personal reasons, they were specific about recommendations. The first suggestion was to make the NNP required for all novice nurses. Secondly, stakeholders including administrators and preceptors, need to be actively engaged in fostering a culture that supports a smooth transition for the novice nurses.

The focus group members all spoke very positively about the support they received from the NNE. However, some described a lack of consistency with the support received from unit-based preceptors. Recruiting NPD specialists and preceptors that are able to provide strong interpersonal relationships with novice nurses while facilitating effective learning is ideal.

Many participants reported the program was shorter than they would have liked. Identifying the suitable timeline for each individual novice nurse to achieve competency and feel confident to practice independently requires an individual action plan, appropriate evaluation tools, and a great deal of communication. Organizational needs will
also require that NPD specialists study how this can be done in a cost-effective manner.

One learning activity attempted by the NNE was not well received by the novices and had minimal participation. This was the emailing of clinical cases with questions to increase critical thinking skills. There were two barriers to this type of learning. Once engaged in direct patient care responsibilities, there were constraints on how much time the novice nurses had to complete didactic work in the practice setting. Upon leaving the facility, there were varying levels of access to hospital email. Therefore, it is recommended that time be built into the schedule to allow for participation in virtual clinical scenarios. Making this change could also promote critical thinking and increase the participants’ post-survey scores on the W-GCTA.

Finally, the lack of participation in the post-survey highlights the need for continued engagement throughout the program. Focus group participants expressed that they felt removed from the orientation process when it was time to complete the final evaluation. Providing regularly scheduled contact with participants would increase overall commitment and the likelihood of providing programmatic feedback.

**Conclusion**

This community hospital developed an NNP that successfully assisted novice nurses to transition from new graduates to professional nurses. Novice nurses obtained knowledge and skills pertaining to patient care, safety, and relating to other members of the team. The role of the NNE was critical to this process; however, preceptors were not always as successful in providing support. Further research should be done to identify which preceptor behaviors or characteristics were seen as supportive. More attention could then be given to preceptor development. Factors that led to participants leaving before completing the NNP also require further evaluation. The focus group evaluation provided insight into which experiences were deemed valuable or not, what barriers were encountered, and which factors facilitated successful program completion. Novice nurses should be held accountable by leadership and human resources for adhering to all program components including evaluations to enhance future programs.

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**References**


Timmerman, R. (2010). Who is going to take care of that patient: A program for successful transition from student to critical care nurse.
Presentation at the National Teaching Institute and Critical Care Exposition, Washington, DC.


