PREPAREDNESS TO PRACTICE AS PERCEIVED BY THE GRADUATE NURSE,

NURSING FACULTY AND HOSPITAL LEADERSHIP

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DEDICATION

I would first like to give thanks to God Almighty for seeing me through this process. I know without him none of this would be possible. To my husband Ray Wright, thank you for your support through the years and believing in me. To my children, Courtney, Corey and Kannon you officially have your mommy back. To my parent Watts and Joyce McKee, you have always been my biggest cheerleaders. I hope I have made you proud. This is especially dedicated to my grandmother Ethel McKee; your baby girl did it.

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ABSTRACT

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The purpose of this cross-sectional survey was to explore the differences in the perceptions of preparedness to practice of the graduate nurse as reported by hospital nursing leadership, the graduate nurse, and nursing faculty as measured by the Nursing Practice Readiness Tool (NPRT). Graduate nurses (less than 6 months post-graduation from AD and BS programs and working in acute care facilities), nursing faculty teaching senior-level courses in AD and BS programs, and hospital nursing leadership (acute care CNOs, directors, managers) completed an electronic version of the NPRT that asked participants (N=58) to rate their level of satisfaction with new graduate proficiency on 36 key nursing competencies. Significant differences in level of satisfaction were found between the 3 groups for total score (p<.005) as well as for 5 of the 6 subscales: Clinical Knowledge, Critical Thinking, Communication, Professionalism, and Management of Responsibilities. Hospital nursing leadership reported the lowest satisfaction scores for all subscales. 'Delegation of tasks' and 'conflict resolution' were two of the items with the lowest satisfaction ranking. The findings from this unique study delineate many

opportunities to address gaps in preparedness to practice as viewed by 3 different perspectives. For example, 77% of the graduate nurses were satisfied with their 'ability to prioritize,' while only 42% of faculty and 21% of hospital leadership were satisfied with this competency. However, the 3 groups were almost equal in satisfaction with 'respect for diverse cultures' and 'utilization of information technologies.' Academia and service must work together to better prepare new graduate nurses.

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CHAPTER I

INTRODUCTION

Historically, veteran and seasoned nurses have been called upon to provide essential and additional on-the-job training for new novice nurses post-graduation. However, the desire and need for new graduate nurses to be prepared with the ability to function independently has never been greater. According to Ellerton and Gregor (2003), "nurses work in acute care settings, where well-informed clinical judgments and skills are necessary and respected, and where resources for comprehensive orientation programs and clinical nursing education are limited" (p. 103). Currently, orientation and training of new graduates vary from unit to unit and from hospital to hospital. The knowledge and availability of preceptors also varies from setting to setting (Hillman & Foster, 2011). Some graduate nurse programs are very comprehensive including mentors, preceptors, and residency programs; while others lack such structure and attention to the needs of the new graduate nurse. Constant changes in technology and regulatory requirements only exacerbate the challenges associated with meeting the needs of service providers.

According to Berkow (2008), nearly 90% of academic nursing leaders believe their students are fully prepared to provide safe care as compared to only 10% of hospital and health system nurse executives. Oermann et al (2010) reported that nurse managers felt that new graduates lacked confidence in their skills and considered that a direct correlation to lack of preparedness to practice. According to Burns and Poster (2008),

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employers have claimed that new graduates were not prepared. However, they did not have evidence-based performance outcomes specifically targeted to change academic preparation thus leaving nursing schools in the dark on where the new graduate nurse lacked preparation. Nursing schools continue to struggle with limited time and clinical resources while providing a comprehensive curriculum that encompasses the knowledge new graduate nurses need to safely and successfully begin their careers (Ulrich et al. 2010). It has been argued that the differing perceptions between service and education regarding the preparedness of the graduate nurse are rooted in historical, social, economical, and political contexts (Duchscher and Cowin, 2006; Greenwood, 2000; McKenna et al., 2006). The new graduate's inability to immediately become a self reliant, proficient nurse is often attributed to the theory-practice gap, between academic and service requirements (Romyn et al., 2009). In a study conducted by Wolff and colleagues (2010), inconsistencies of who (academia versus service) is ultimately accountable for the preparation of the graduate nurse were reported. Participants reported concerns regarding the standards in which education programs are evaluated compared to the actual requirements of healthcare organizations.

No longer are service providers able to train new graduate nurses over an extended period of time. In the past, diploma hospital-based nursing education was the most common way in which nurses were educated. This model produced registered nurses familiar with providing practical nursing care (Fetherstonhaugh et al., 2008). With the advent of higher education nursing programs, some nursing leaders felt that

graduate nurses often lacked practical skills despite their significant increase in knowledge of nursing process and theory (Paterson & Grandjean, 2008). Hospitals have the daunting task of balancing safe, quality care with cost effectiveness. Hospitals expect nurses to provide quality care, while working in the confines of increase cost of products and services with a lower rate of reimbursement by managed care organizations. Regulatory agencies and managed care organizations are moving toward a pay for performance model, in which reimbursement is directly related to patient outcomes (U.S. Department of Health and Human Service, 2010). Allowing new graduate nurses to remain in orientation and/or preceptorship programs for extended periods of time is considered non-productive time and an expense that many are electing to minimize.

Typically, the three entry levels into nursing practice, diploma, associate degree, and baccalaureate, include an average of two years of nursing curricula. Academia is challenged with meeting the needs of providing education to new graduate nurses that will address the constant changes in technology, higher acuity of patients, and regulatory requirements while working within the confines of time spent in school (Gaynor et al., 2006; Halfer & Graf, 2006; Newton & McKenna, 2007) combined with a decreasing nurse faculty workforce (Allen, 2008). Academia is expected to produce graduate nurses with the ability to critically think and make independent clinical decisions (Etheridge, 2007; Newton & McKenna, 2009). According to the American Association of Colleges of Nursing (AACN) (2005), the shortage of nursing faculty continues primarily due to aging faculty and insufficient pool of younger replacements, salary differentials, and job

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dissatisfaction related to increased workload. The shortage of nursing faculty has been directly correlated with the nursing shortage (NACEP, 2010). While intended to increase preventative care and provide healthcare access to all, the Affordable Care Act will increase the number of patients requiring medical help thus increasing the need for nurses.

Academia uses the benchmark of National Council Licensure Examination (NCLEX) pass rate to determine minimal competency. According to the National Council of State Boards of Nursing, it is believed that successful passing of the NCLEX indicates the new graduate nurse demonstrates competencies to safely and effectively perform as a new-entry nurse (obtained from https://www.ncsbn.org/nclex.htm). According to the National Council of State Boards of Nursing (2012), nursing schools report an average NCLEX pass rate over 90% and therefore feel their new graduates are prepared to practice.

Problem of Study

The aim of this study was to: 1) determine perception of preparedness to practice in the competencies of clinical knowledge, technical skills, critical thinking, communication, professionalism, and management of responsibilities as reported by leadership, graduate nurses, and faculty, and 2) determine if there was a difference in the perception of the new graduate nurses' preparedness to practice as reported by hospital leadership, the graduate nurse, and nursing faculty.

Understanding the perception of preparedness between three of the four stakeholders (graduate nurse, nursing faculty and hospital leadership excluding the end-user the patient) is a step in the right direction. This study attempted to address the whether or not there was a difference in the perception of preparedness of the graduate nurse as reported by the graduate nurse, nursing faculty and hospital leadership. Understanding the perceptions of each group by using the Nursing Practice Readiness Tool (NPRT) helped to identify areas in which service, academia, and the new graduate nurse could potentially work together to close the theory-practice gap or at least set realistic expectations of each other.

Rationale for the Study

According to the American Association of Colleges of Nursing (AACN) (2014), the United States (US) is in the middle of an all time high nursing shortage that is only expected to increase and intensify as the baby boomers age and health care needs increase. It is projected that the number of registered nurses needed for replacement in the US could reach as high as nearly 500,000 by 2020. The Bureau of Labor Statistics (2014) has projected an increase in the size of the registered nurse workforce of 526,800 from 2012 through 2022. Buerhaus et al. (2009) attributes the aging workforce as being a major cause for the increase in registered nurse positions and shortages. In addition, the newly health care reform laws are predicted to increase the demand for health care; thus increasing the need for additional nurses (Institute of Medicine [IOM], 2010). Therefore, the need for new graduate nurses is at an all time high.

Historically, graduate nurses have a high turnover during the first year of employment (Beecroft, Dorey & Wenten, 2008). Kovner et al. (2007) reported that 13% of new graduates had changed primary jobs after one year, and 37% were ready for a change in their job. Winfield et al. (2009) reports that in some instances that the rate of turnover among new graduate nurses exceeds 50%. Registered nurse turnover effects organizations in quality of patient care, sustainability of the profession and both direct and indirect cost (Ulrich et al. 2010). In 2007 it was estimated that the replacement of each new nurse ranged from $82,000 to $88,000 (Jones, 2008). Hospitals averaged about $300,000 annually at every percentage point increase in nurse turnover in 2007 (Price Waterhouse Coopers, 2007). There has been documented correlation between new graduate employees' preparedness and their professional readiness which is noted as one of the most influential variables that effect graduate nurse retention (Bowles & Candela, 2005). The high stress and inexperience of the new graduate nurse increases their susceptibility to errors and turnover (Duchscher, 2008; Duchscher & Cowin, 2004; Smith & Crawford, 2003). Some new nurses describe feeling "unsupported, overwhelmed, and hung out to dry" as they enter the nursing profession (Christmas, 2008, p. 317).

In addition to the existing nursing shortage, the scope of nursing practice has broadened as a result of increased patient acuity, financial restraints, the ever changing knowledge and technology and the complex health care environment. Nurses in healthcare organizations are expected to provide higher quality care, while working in the confines of increases cost of products and services with a lower cost of reimbursement by

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managed care organizations. This is especially true for hospitals with such initiatives as

the Centers for Medicare and Medicaid Services (CMS) Bundled payment initiative.

This initiative seeks to align financial and performance accountability per episode of care

(2014). This leads to hospitals needing to hire graduate nurses due to cost yet there is a

need to be able to function independently and provide high quality care.

Academia continues to struggle with having adequate nursing faculty to meet the

demands thus increasing the demands of knowledge and skills of the faculty. As the

demands have increased, the allotted time for curriculum has not increased. Academia is

expected to educate new graduate nurses to function independently while being creative

due to limited clinical experiences (Fetherstonhaugh et al., 2008).

Theoretical Framework

The theoretical framework guiding this study is Patricia Benner's Novice to

Expert Model (Benner, 2001). The Novice to Expert model was developed from the

Dreyfus Model of Skill Acquisition, which identified five levels of competence. These

levels are Novice, Advanced Beginner, Competent, Proficient, and Expert (Dreyfus,

1980). According to Benner (2001), the Novice level applies to those who have no

experience in the environment in which they will perform; they are very task-oriented,

rule-governed, and focused on skill acquisition. The novice period usually lasts the first

year post-training (Benner, 2001). Advanced Beginners are able to recognize critical

issues from prior experience in actual situations; however, they are unable to anticipate

the care needed (Benner, 2001). The advance beginner phase for a nurse usually lasts one

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or two years post-training. The Competent level nurse develops plans based on previous encounters and are considered conscious, abstract, and analytic with contemplation of the problem. The Competent level nurse lacks the speed and flexibility of the Proficient level nurse (Benner, 2001). In addition to recognizing potential critical issues based on prior events, the Proficient level nurse also knows how plans may need to be modified (Benner, 2001). Lastly, the Expert level nurse has speed, flexibility, knowledge based on prior encounters and has an intuitive grasp on situations. The Expert nurse no longer relies on analytic principles to determine appropriate actions (Benner, 2001). Based on Benner's model, it is through interactions and engagement between the Novice, Proficient and Expert level nurses that transition occurs.

Typically, the new graduate nurse is not expected to have previous experience; therefore, academia and the graduate nurse would consider the new nurse at the Novice level based on Benner's definition. However, the current demand by the service sector is for the new graduate nurse to be at the Advance Beginner, and preferably Competent, level. As cost continues to rise and reimbursement continues to decrease, the ability to utilize resources to provide additional education and supervision to assist the novice nurse is difficult. The Advance Beginner demonstrates marginally acceptable performance, is efficient and skillful, requiring occasional support. During this phase, knowledge is also constantly developing.

This study utilized the NPRT to operationalize the graduate nurse's preparedness to practice (Virkstis et al., 2009). The NPRT was developed with input from academic

and industry experts and contains 36 tested competencies essential to safe and effective nursing practice. The NPRT is congruent with Benner's model in that the new graduate nurses' ability to function independently could range from novice to expert in the 36 competencies. How fast one is able to move from one phase to another is individualized based on experience and knowledge. Direct care experience is not always required in order to have knowledge of a particular situation.

Assumptions

The following assumptions are basic to this research.

1. The perceptions of new graduate nurses, nursing faculty, and service providers are real, accurate and can be measured.

2. New graduate nurses have the potential to progress from Novice to Expert.

3. Nursing faculty and nursing leadership have the ability to assess competency of the new graduate nurse.

Research Question

The research question for this study was: Is there a difference in the perception of the graduate nurse preparedness to practice as reported by hospital leadership, the graduate nurse, and nursing faculty as measured by the NPRT?

Definition of Terms

Listed below are the conceptual and operational definitions for key study terms and variables.

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Graduate nurse is conceptually defined as "one who completes an accredited basic nursing education program within the United States, its Territories, or Possessions and who applies for initial licensure" (Texas State Board of Nursing, 2010). For the purposes of this study, the operational definition of graduate nurse is an Advanced Beginner nurse because while they may not have 'true' experience as a registered nurse, they do have experience in a variety of clinical settings. The graduate nurse must be currently employed as a registered nurse, graduated within last six months from an accredited baccalaureate or associate degree nursing program, and working as nurse for the first time in an acute care hospital/facility as a bedside nurse (Wright, 2012).

Nursing faculty is conceptually defined as "all registered nurses who teach in an approved nursing program" (Department of consumer affairs board of registered nursing, 2013). Nursing faculty is operationally defined as a clinical educator instructing during the senior year in clinical settings in an accredited basic nursing associate or baccalaureate education program (Wright, 2011).

Hospital nursing leadership is conceptually defined as 'either formal or informal. Formal authority is based upon "legitimate authority conferred by the organization" and is described in the job description. Informal authority has no specific management role. The nurse rises to a leadership position by virtue of the influence imparted on the "efficiency of work flow" of the area" (obtained from http://www.ehow.com/about_6499264_define-nursing-leadership.html on February 28, 2012). Hospital leadership is operationally defined as hospital nursing personnel that

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directly supervise the graduate nurse, as a nurse manager or director in an acute care facility (Wright, 2010).

Preparedness to practice is conceptually defined as "the nurse is prepared to practice with patients including individuals, families, groups, communities, and populations across the lifespan and across the continuum of healthcare environments" (AACN, 2008).   Perception of preparedness to practice is conceptually defined as ones belief that the graduate nurse possess the necessary knowledge, skills and attributes to perform in a complex work environment demonstrating critical thinking including problem solving and clinical decision making complex skills, prioritization, organization, managing a caseload of patients (Wright, 2010). Perception of preparedness to practice is operationally defined as a weighted score derived using the Nursing Practice Readiness Tool (NPRT), a 36 item scaled instrument, comprised of six subscales – clinical knowledge, technical skills, critical thinking, communication, professionalism and management of responsibilities (Berkow et al, 2008).

Limitations

The limitations to this study include the small convenience sample size and the inability to directly match the new graduate nurse to specific nursing faculty and hospital leadership. Additionally, the findings of this study can only be generalized to those participants who responded to an email recruitment announcement and completed an anonymous online survey.

Summary

The preparedness to practice of the graduate nurse has significant effects on many, most importantly the patient. The graduate nurses' perception of their preparedness impacts their transition and is directly related to retention. Hospital leadership has great interest in this as well due to the changes in healthcare; graduate nurses are expected to be able to function independently almost immediately. Nursing education is always evolving; therefore, it is imperative that nursing faculty continue to be knowledgeable of the demands of the graduate nurse. Identifying the perception of preparedness amongst the three stakeholders will clearly outline areas in which academia and service can work together to close the practice gap between academia and practice.

CHAPTER II

REVIEW OF LITERATURE

Search Method

The articles in this review were identified by conducting online searches of

literature that examined the perception of preparedness to practice in the following

databases: PubMed, CINAHL, EbscoHost Health Source, Eric and ProQuest Nursing

and Allied Health among other databases. To ensure a comprehensive search of

published literature, individual searches were conducted in PubMed and CINAHL.

Combinations of the following key words were used in the searches: graduate nurse,

nurse faculty, student nurse, perception, readiness, preparedness to practice hospital

leadership and faculty perceptions. Additional references were identified from research

article reference lists. The search reveled many qualitative studies examining the newly

graduate nurses' perception and a few on hospital leadership and faculty perceptions;

however, there is a lack of any cross-sectional quantitative studies of the new graduate

nurse, academia, and hospital leadership in the same point of time and geographic

location.

The Graduate Nurse Perceptions of Preparedness to Practice

Effective communication is an essential element of nursing. Graduate nurses

viewed communication with patients, families, physicians and other members of the team

as being vital in providing quality cost-effective care (National Council of State Boards

of Nursing, 2003). Effective communication is at the center of holistic patient care. Communication is vital to patient teaching which is vital to prevention of illnesses.

Heslop et. al (2001) conducted a qualitative study of third-year student nurses *(n*=105) from a 3-year baccalaureate program at a large metropolitan university in Australia. The aim of the study was to identify third-year nurses/ expectations of the graduate nurse role and ascertains how prepared they feel to fulfill this role. Participants expressed some apprehension about meeting the performance expectations of the workplace, due to their perceived lack of clinical experience. Particularly, communication with other health care professionals is an area that some graduate nurse's feel well prepared however, others reported being unprepared to communicate with physicians. When graduating students were asked, "Do you believe you have been adequately prepared to fulfill the graduate programme role?" only 29% answered "yes", 47% answered "no" and 24% answered "yes and no." This study concluded that divisions exist between students' expectations of the graduate year and the actual work experience. Thus, one could conclude that there perception of preparedness to practice could be effected once they began to work.

Ellerton and Gregor (2003) conducted a qualitative study examining the new nurse graduate at 3 months. Open-ended interviews were conducted with 11 nurses employed in acute care settings at 3 months following graduation. Results showed new nurses viewed their work as skills and task. They reported a lack of effective communication with patient and families. Learned routines from clinical experiences

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were a guided principle. While feelings of being competent in performing clinical skills were reported, they did not understand significance of their findings. Graduated nurses rated themselves an average of 7 on a scale of 1 to 10 on readiness to practice; interestingly, they also reported that their undergraduate program had been deficient in providing clinical practice opportunities and was unable to effectively describe the influence that their formal education had on their readiness. This study concluded that at 3 months new graduates are apprehensive about their abilities as a registered nurse to handle the complex and large amount of work that is expected to manage safely and independently.

A study by National Council of State Boards of Nursing (2003) by Smith and Crawford, sought to determine a link between perceived adequacy of preparation to practice, nursing error, and perceived difficulty of entry-level practice. A stratified random sample of 4,000 RNs were selected from a list of candidates who successfully passed the NCLEX-RN exam between January 1 and March 31, 2001. Respondents included those without any prior nursing experience, those with previous nurse aide experience and prior licensed practice/vocational nurse (LPN/LVN). Nursing education was primarily in associate degree (AD) and baccalaureate degree programs. Eighty-seven percent were employed primarily in hospitals, most commonly in critical care (39%), medical surgical units (34%), and nursing homes (6%). Overall, the new graduates felt that their nursing education had properly prepared them to administer medication through common routes and provide direct patient care to 2 or more patients. The study reported

19% of BS nurses and 30.9% AD nurses felt prepared to administer medication to multiple patients. On the contrary, they felt less prepared to provide direct patient care to 6 or more patients effectively, supervise others providing care and knowing when and how to call the physician. Forty percent of the new graduates did not feel prepared to use information technology to enhance patient care. The research found that respondents who reported inadequate preparation in making decisions on care of the patient based on assessment and diagnostic testing data, performing psychomotor skills, supervising others who provide care, knowing when and how to call the physician, working effectively within the heath care team and understanding pharmacologic implications of medications were significantly more likely to be involved in nursing errors.

Candela and Bowles (2008) conducted a study examining the RN graduate perceptions using The Survey of Nurses' Perceptions of Educational Preparation, a descriptive survey developed by the researchers. This three part scaled survey tool looked at the first position held by the respondents after completing initial nursing education program, the respondents' perceptions of how well their educational program prepared them for practice and demographic information regarding current employer. The survey was mailed to 3,077 nurses obtained from the Nevada State Board of Nursing with 352 nurses participating. Overall, respondents were satisfied with their preparation regarding skills; however, they felt least prepared in the areas of management, leadership, and organizational skills. Medication administration was also an area that 51% of graduate nurses felt unprepared. While they felt prepared in regards to professional

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development, 77 %t indicated they did not feel prepared in the area of accessing and

managing electronic patient information. Fifty one percent felt their education prepared

them for the NCLEX-RN examination more than preparing them for practice. Most did

not feel their education program provided them with enough clinical hours. AD

graduates were slightly more satisfied with their education than their BS counterparts

although not significant ($p=.057$).

Mozingo et al. (1995) conducted a quantitative study examining factors associated

with perceived competency levels of graduating seniors in a baccalaureate nursing

program. This study used the following tools: Spielberger Trait Anxiety Inventory,

Norbeck's Social Support Questionnaire and Perceived Competency Scale developed by

Mozingo and Thomas. Students were within 2 weeks of graduation ($N=204$). The study

reported that 75% of BS graduating seniors agreed or strongly agreed that they were

lacking in technical skills; however, 84% felt they were prepared through their education

programs to be safe clinicians.

Boychuck Duchsher (2001) conducted a phenomenological qualitative study

exploring how five nurses perceived their first 6 months as professional nurses. "Not

knowing" was perceived as weakness, rather than as an expectation of the graduate nurse.

New graduates expressed fear of calling the physician as well as the perceived inability to

think about why something was being done yet more focus on completing the task with

efficiency was noted.

Hospital Leadership Perception of the New Graduate Nurse Preparedness to Practice

Berkow and Virkstis (2008), in conjunction with the Nursing Executive Center, developed the New Graduate Nurse Performance Survey, with the goal to help academic and hospital–based nurse leaders have a more focused discussion regarding new graduate preparation. More than 5,700 surveys were collected from frontline nurse leaders requiring the respondent rate new graduate nurse proficiency on 36 individual competencies and overall. More than 400 nursing school deans, directors, and department chairs completed the survey as well. Nurse leaders were most satisfied with the new graduate nurses' competency regarding: utilization of information technologies (eg, computers, electronic medical records, etc), rapport with patients and families, respect for diverse cultural perspectives, conducting patient assessments (including history, physical examination, and vital signs), and customer service. The competencies that nurse leaders were least satisfied with were: delegation of tasks, ability to anticipate risk, ability to prioritize, conflict resolution, and ability to keep track of multiple responsibilities. Only about 25% of nurse leaders were fully satisfied with new graduate performance.

A descriptive quantitative and qualitative study conducted by Hickey (2009) examined preceptors' views of new graduates readiness for practice using a specific set of criteria (*n*=62). The Clinical Instructional Experience Questionnaire developed by the researcher was used to measure the effectiveness of the clinical instructional experiences

of the BS nursing program. The study found that 72% of preceptors reported that the new graduates "are able to perform basic technical skills: vital signs, hygiene, safety, positioning, independently and completely"; 91% most of the time and that this was important or very important. When examining the ability of the new graduates to perform independently and competently on more advanced skills: wound care, medication administration, maintenance of IV fluids this was viewed as sometimes or less often; with 81% feeling that this is important or very important. Sixty-three percent felt the new graduates need more assistance than expected in regards to performing skills. Fifty percent felt that physical assessment skills were adequate sometimes, but was important or very important by 94% of respondents. The competency of critical thinking skills demonstrated a wide array of variation in perceived ability to perform. A mere 13% felt that new graduates could set priorities most of the time; 47% felt that this occurred sometimes. Critical thinking was viewed as important or very important by 93% of respondents. Similarly, only 20% of respondents felt that most of the time new graduates demonstrated good clinical decision-making and 82% felt that this was important or very important. Thirty-five percent of respondents felt that time management was appropriate sometimes and was of average importance (33%) and important or very important (57%). Eighty percent of respondents felt that sometimes or less new graduates effectively demonstrated organizational skills with 98% stating that this is important or very important for entry into practice. Delegation was viewed by 70% of respondents as important or very important yet demonstrated by new graduates

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only sometimes or less often by 80% of respondents. When twenty-three respondents were asked "Are there any skills that the new graduate was particularly weak in, or lacking upon hire?" the categories and competencies were: Psychomotor skills: patient safety, IV medications, medication administration, five rights, drug interactions, dressing changes, Foley catheter care and insertion, management of tubes and drains, pumps and safety; assessment skills: head-to-toe, re-evaluating patient responses; critical thinking: problem solving, prioritization, decision making, self-confidence, and motivation; time management: organization, caseload management and delegation; communication: written and verbal, documentation; and teamwork: working with ancillary staff, working with other RNs.

Burns and Foster (2008) reported, based on the Performance-Based Development System, that weaknesses of new registered nurses were failure to give relevant nursing actions related to specific diseases, indeterminate prioritization, providing incomplete and irrelevant information to physicians, difficulty providing rationale for actions, and not knowing laboratory values.

Nursing Faculty Perception of the New Graduate Nurse Preparedness to Practice

The current literature is lacking research examining the perception of nursing faculty of the readiness to practice of the graduate nurse. However, in a study examining the educational preparation of the undergraduate nursing students in pharmacology which included surveys completed by nursing administrators, staff nurses, nurse educators and consumers recommendations to include courses in ethics, communication, research and

professional standards were noted by faculty and consumers reported the need for more

preparation in clinical training, communication skills and problem solving (Bullock &

Manias, 2002).

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

A descriptive non experimental survey design was utilized to measure if there was a difference in the perception of the graduate nurse's preparedness to practice as reported by hospital leadership, the graduate nurse, and nursing faculty.

Setting

The 3 groups of participants, the graduate nurses, nurse leaders, and faculty, were recruited via email and letters to participate in the study by completing an anonymous electronic survey. The settings for this study were hospitals and schools in the states of Virginia and North Carolina and Washington DC area. Graduate nurses who work in the clinical areas of acute care, critical care, emergency department, pediatrics/neonatal, surgical services and women's health and nursing leaders were recruited from hospitals (n=13) in the Novant Health System. These hospitals included Novant Health Brunswick Medical Center (74 beds), Novant Health Forsyth Medical Center (921 beds), Novant Health Franklin Medical Center (70 beds), Novant Health Kernersville Medical Center (46 beds), Novant Health Medical Park Hospital (22 beds), Novant Health Presbyterian Medical Center (607 beds), Novant Health Huntersville Medical Center (60 beds), Novant Health Matthews Medical Center (117 beds), Novant Health Charlotte Orthopaedic Hospital (156 beds), Novant Health Prince William Medical Center (170 beds), Novant Health Rowan Medical Center (268 beds), Novant Health Thomasville Medical Center (149 beds), and Upstate Carolina Medical Center (125 beds). These

hospitals represent the following patient care areas: medical/surgical, pediatrics, intensive care, mother/baby, neonatal intensive care, emergency department, women's service, hematology/oncology, behavioral health, telemetry, and neurology.

Nursing faculty were recruited from nursing schools (n=38) located in the Northern Virginia and North Carolina area. These nursing schools place their nursing students at the above listed hospitals for clinical education. The following schools are located in Northern Virginia: George Washington University (ABSN), Northern Virginia Community College (ADN), George Mason University (BSN), Georgetown University (BSN), Shenandoah University (BSN), and Marymount University (BSN). The following schools located in North Carolina: Appalachian State University (BSN), Brunswick Community College (ADN), Cabarrus College of Health Sciences (ASN, BSN), Cape Fear Community College (ADN), Cleveland Community College (ADN), Central Piedmont Community College (ADN), Davidson County Community College (ADN), Duke University (BSN), ECPI University (ADN), East Carolina University (BSN), Edgecomb Community College (ADN), Forsyth Tech Community College (ADN), Gardner-Webb University (BSN), Guilford Tech Community College (ADN), Kaplan College (BSN), North Carolina A&T (BSN), Pfeiffer University (BSN), Queens University (ASN, BSN, ABSN), Rowan-Cabarrus Community College (ADN), South Piedmont Community College (ADN), Southeastern Community College (ADN), Southwestern Community College (ADN), Stanly Community College (ADN), Surry Community College (ADN), UNC Pembroke (BSN), UNC Chapel Hill (BSN), UNC

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Charlotte (BSN), UUNC Greensboro (BSN), UNC Wilmington (BSN), Wilkes

Community College (ADN), Wingate University (BSN), and Winston-Salem State

University (BSN).

Population and Sample

The population for this study consisted of newly graduated associate degree

nurses and baccalaureate degree nurses, nursing faculty, and nursing leadership.

Convenience sampling was used to obtain the 3 groups of participants. Power analysis

was conducted prior to recruitment. In order to reach a minimum power of 0.80, an alpha

of 0.05, and estimating a moderate effect size of 0.25, a total of 159 participants were

needed. Due to lack of funding and resources in accessing population, the final sample

size was $N=58$ ($n=15$ graduate nurse, $n=28$ hospital nursing leadership, $n=15$ nursing

faculty).

The inclusion criteria for the new graduate nurse included employment as a

licensed registered nurse (RN), recently graduated within last six months, and working as

nurse in first position post-graduation. For the nursing faculty, inclusion criteria included

teaching/supervising senior level nursing students. For the hospital nursing leadership,

inclusion criteria included employed as a Nursing Director and/or Nurse Manager for a

hospital unit(s) that employs new nursing graduates. Exclusion criteria for the new

graduate nurse included graduate nurses who previously worked as a LVN or LPN or

who have previously worked in any nurse capacity.

Protection of Human Participants

To ensure the adequacy of human participant protection, Institutional Review

Board (IRB) approval was obtained from Novant Health and Texas Woman's University.

The survey was anonymous and informed consent was implied if the participant

completed the survey instrument.

Instruments

The investigator developed demographic instrument was utilized to collect the

following data: age, gender, race/ethnicity, marital status, highest level of education,

clinical area of interest, type of nursing degree program, years of experience as a RN,

years of experience as a nursing educator or hospital leader, clinical area of responsibility

(see Appendix A).

The Nursing Practice Readiness Tool (NPRT) (Appendix B) was developed by

researchers (Virkstis et.al., 2009) to better understand the root cause of concern related to

the new graduate nurse preparedness to practice. The intent of the tool was to capture

new graduate nurse performance across 36 key nursing competencies. The tool assesses

performance on both clinical and non-clinical skills. According to Virkstis (2012), the

NPRT was developed by researchers after performing a crosswalk of multiple

tools/models, including the AACN's Essentials of Baccalaureate Education and the

QSEN competencies (also referred to as KSAs: Knowledge, Skills, and Attitudes). A list

of competencies was developed through interviews and focus groups held nationwide

with academic and service nurse leaders. The 36 competencies were required to be

specific, actionable, and reflective to the current needs of hospitals (The Advisory Board

Company, 2009). After which the tool was informally vetted over a year time period

with nearly a thousand nurse leaders (CNOs, directors, and nursing school deans) at the

Nursing Executive Center's national meetings.

The NPRT contain 36 items that represent 36 critical nursing competencies that

can be divided into 6 subgroups with 6 items/competencies per group: Clinical

Knowledge (CK), Technical Skills (TS), Critical Thinking (CT), Communication (CM),

Professionalism (PR), and Management of Responsibilities (MR). The tool uses a 6-

point scale (1 = strongly disagree, 2 = disagree, 3 = tend to disagree, 4 = tend to agree, 5=

agree, 6 = strongly agree) and respondents are asked to agree/disagree to statements

based on their satisfaction with the graduate nurse practice. The instrument is scored by

combining the Agree options to measure Satisfaction level. The percentage of agreeing

that the new graduate nurses are proficient on each of the 36 competencies is rank

ordered from highest to lowest proficiency,.

Psychometric testing of the NPRT with over 850 nurses at seven institutions

yielded a Cronbach's alpha coefficient of 0.972. The authors of the tool also completed a

split-half reliability analysis to ascertain reliability and reported a value of 0.916

(Virkstis, 2012). Validity was also established through research staff repeatedly

reviewing the list with nursing experts until consensus was reached and no further

revisions were needed. The 36 competencies are considered shared goals among the

nursing school and hospital leaders (The Advisory Board Company, 2009).

The NPRT was modified with the permission from the author; thus 3 versions were used based on the targeted groups (see Appendix B). For the purpose of this study, the NPRT was scored in 2 different ways. Mean scores were calculated for Total Score and each of the 6 subscales. Additionally, the answers to the 6-point scale were collapsed into 2 categories: Satisfied/Agree and Not Satisfied/Disagree and then ranked ordered from highest to lowest Satisfaction.

Data Collection

Data collection protocols and procedures were followed as outlined. The convenience sample of nursing faculty was recruited from the nursing schools affiliated with Novant Health. The investigator emailed a letter of intent of the study (see Appendix C) to the prospective contact person at each nursing school. For recruitment of new graduates and hospital leadership participants, the PI is a Nursing Director in the Novant Health System and sent recruitment letter email (Appendix C) to a convenience sample of nursing leaders and new graduates describing the intent of the study. The letter explained the study and procedure for completing the electronic survey. The survey included the demographic data sheet and the Nursing Practice Readiness Tool (NPRT). The NPRT has 3 versions: new graduate, faculty, and hospital leader version. It was estimated the entire survey could be completed in 15 minutes. The survey was completed anonymously electronically using PsychData.

Treatment of Data

Completed data were downloaded directly from PsychData into SPSS Version 18.0 and then coded and analyzed. Demographic information were analyzed using descriptive statistics including frequencies, percentage, mean and standard deviations will be computed for the group responses. A one-way analysis of variance examined the mean differences between the scores reported by the graduate nurses, the hospital nursing leadership, and nursing faculty. Posthoc analyses were then conducted for significant F-values. The Pearson chi-square test was used to analyze differences in the satisfaction of the 36 items amongst the three groups. Pearson chi-square analyses examined the differences between group frequencies related to Satisfaction with the 36 individual items. The 36 items were ranked order from highest to lowest satisfaction. Level of significance was set at 0.05.

Pilot Study

A feasibility pilot study was conducted prior to the dissertation study. Senior nursing students from both AD and BS schools of nursing ($n=22$), nursing faculty ($n=4$) and nursing leadership ($n=6$) were surveyed using the demographic form and NPRT. Pearson Chi square yielded statistical significance on 12 of 36 items ($p<.05$). The items that were statistically significant in rank order of satisfaction with proficiency of the new graduate nurse (strongly agree/agree) were: respect for diverse cultural perspectives ($X^2 = 6.23$, $p=.044$); compliance with legal/regulatory issues relevant to nursing practice ($X^2=7.39$, $p=.25$); ability to work as a part of a team ($X^2=14.54$, $p=.001$); ability to accept

constructive criticism (X^2=7.07, p=.029); accountability for actions (X^2=10.30, p=.006); utilization of clinical technologies (e.g., IV smart pumps, medical monitors, etc) (X^2=7.62, p=.022); patient education (X^2=8.96, p=.011); ability to work independently (X^2=10.8, p=.004); ability to prioritize (X^2=7.69, p=.021); completion of individual tasks within expected time frame (X^2=9.11, p=.010); ability to keep track of multiple responsibilities (X^2 =7.69, p=.021); understanding of quality improvement methodologies (X^2=11.1, p=.004); and conflict resolution (X^2=7.00, p=.030). The subscale of professionalism (PR) had the highest number of items with statistical significance. Clinical knowledge (CK) and technical skills (TS) had the lowest number of items with statistical significance. Five items showed a statistical significance of p<.001; four of which were in the professionalism (PR) subscale. Therefore, one can conclude that professionalism is an area that the new graduate nurses perceives as being most prepared.

Overall, senior nursing students felt least prepared to practice in the following: conflict resolution (CM), ability to anticipate risk (CT), communication with physicians (CM), decision making based on nursing process (CT), understanding of quality improvement methodologies (CK), interpretation of physician and interprofessional orders (CK), knowledge of pharmacological implications of medications (CK), delegation of task (MR), ability to keep track of multiple responsibilities (MR) and completion of individual tasks within expected time frame (MR).

Overall, nursing leadership was least satisfied with the proficiency of the graduate nurse on several items. The items that nursing leadership rated as 0% were: conflict

resolution (CM), understanding of quality improvement methodologies (CK), ability to keep track of multiple responsibilities (MR), completion of individual tasks within expected time frame (MR), ability to prioritize (MR), ability to work independently (PR), patient education (PR), ability to work as a part of a team (PR). Comparatively, nursing faculty was most satisfied with the proficiency of the graduate nurse, rating the following at 100%: administration of medication (TS), rapport with patient and families (CM), respect for diverse cultural perspectives (PR), documentation of patient assessment data (TS), communication with interprofessional team (CM), compliance with regulatory issues relevant to nursing practice (CK), utilization of information technologies (TS), ability to work as a part of the team (PR), utilization of clinical technologies (TS), and ability to work independently (PR).

CHAPTER IV

ANALYSIS OF THE DATA

The purpose of this study was to determine if there was a difference in the

perception of preparedness to practice of the new graduate nurse between hospital

leadership, the graduate nurse, and nursing faculty, and determine degree of preparedness

to practice in clinical knowledge, technical skills, critical thinking, communication,

professionalism, and management of responsibilities as reported by leadership, graduate

nurses, and faculty. A demographic instrument was utilized to attain the following data:

age, gender, race/ethnicity, marital status, highest level of education, clinical area of

interest, type of nursing degree program, years of experience as a registered nurse (RN),

and years of experience as a nursing educator or hospital leader, clinical area of

responsibility. The Nursing Practice Readiness Tool (NPRT) was developed (Berkow et

al., 2008) to better understand and quantify the root cause of concern related to the new

graduate nurse practice preparedness. Descriptive statistics were used to summarize the

obtained demographic data. Data related to perception of preparedness to practice were

summarized using descriptive statistics and analyzed using one-way analysis of variance

(ANOVA) and chi-square analyses. Internal consistency reliability of the NPRT was

estimated by calculation of Cronbach's alpha for the six subscales of the instrument and

the entire instrument (α=.986). The six subscales internal consistency reliability estimates

were as follow: Clinical Knowledge (α=.908); Management of Responsibilities (α=.963);

Critical Thinking (α=.958); Professionalism (α=.922); Technical Skills (α=.958); and

Communication (α=.913).

Description of the Sample

Graduate Nurses

A convenience sample of Graduated Nurses (*n*=15), defined as graduating within

the past 6 months, completed the study instruments. The distribution of female and male

participants was fourteen female (93.3%) and one male (6.7%); this was the same

distribution for Nursing Faculty participants in the study. The ages of the new graduate

nurses ranged from 22 years to 40 years, with a mean age of 27.53 years (see Table 1).

The new graduate nurse participants were 86.7% white, 6.7% black, and 6.7% Asian. The

majority of the graduate nurses were single (*n*=10, 66.7%) and without any children (*n*=9,

60%).

There were almost equal numbers of bachelors of science degrees in nursing

(BSN) graduates (*n*=8, 53.3%) and associate degree in nursing (ADN) graduates (*n*=7,

46.7%). Additionally, for the majority of the graduate nurses, the nursing degree was

their first college degree (*n*=11, 73.3%). Other reported previous degrees were

baccalaureate degrees in anthropology, health management, health sciences, and exercise

physiology.   All the participants were working at their first nursing job post-graduation

and the facility size varied from a bed size of 99 to over 700. Almost half of the new

graduates (*n*=7, 46.7%) worked at a facility with 99 to 200 beds, followed by 33.3%

working at facilities with over 700 beds. The critical care/emergency department was the

most common unit of work amongst the group (*n*=6, 40%), followed by medical/surgical/telemetry (*n*=5, 33.3%), women's/children health (*n*=2, 13.3%), and neonatal ICU (*n*=1, 6.7%), and one participant did not specify a unit. Previous jobs amongst the group varied; however, the majority reported working in some capacity in the medical field (*n*=7, 46.7%).

Nursing Faculty

Nursing Faculty ages ranged from 24 years to 67 years, with a mean age of 49.67 years. Nursing faculty participants' race/ethnicity was 78.6% white, 7.1% black, 7.1% Hispanic, and 7.1% other. The majority of the faculty participants had a masters degree in nursing (*n*=6, 40%) followed by a baccalaureate degree (*n*=4, 26.6%), a doctoral degree in nursing (*n*=2, 13.3%), a doctoral degree in other discipline (*n*=2, 13.3%), and masters degree in other discipline (*n*=1, 6.67%). Additionally, the majority of the faculty (*n*=10, 66.7%) taught in a BSN degree program compared to (*n*=5, 33.3%) teaching in an ADN program. Years of experience as a registered nurse (RN) ranged from 33.3% (*n*=5) of faculty with 30 years or more experience as a RN, followed by 20% (*n*=3) with 16 to 20 years and 13.3% (*n*=2) with 0 to 5 years, 6 to 10 years and 11 to 15 years experience. Only 6.67% (*n*=1) of nursing faculty has 21 to 25 years of experience as a RN.

Hospital Leadership

The Hospital Leadership group (*n*=28) consisted of 26 females and 2 males. The ages ranged from 28 to 63 years, with the mean age of 49.71. The primary roles of nursing leadership were: directors (*n*=4, 14.3%), managers (*n*=16, 57.2%), nurse

educator (*n*=6, 21.4%), and staff nurse (*n*=2, 7.1%). These participants worked at

facilities with 99 to 200 beds (*n*=15, 53.6%), followed by 701 and above beds (*n*=9,

32.1%), 301 to 400 beds (*n*=2, 7.1%), 201 to 300 beds (*n*=1, 3.6%) and 601 to 700 beds

(*n*=1, 3.6%). Types of units in which leadership worked majority of the time were:

critical care/emergency department (n=5, 17.9%), medical/surgical/telemetry (n=9,

32.1%), women's/children health (n=7, 25%), and the remaining (n=6, 21.6%) in other

areas (centralized telemetry, operations/surgical services, nursing education and nursing

supervision). In the past three years, most of nursing leadership reported not working as

a nurse preceptor (*n*=17, 60.7%). Table 1 compares the three groups of participants. The

gender composition was almost identical for all 3 groups. For age, the hospital leadership

and faculty participants were almost identical while the new graduates were about half

the age of these 2 groups.

Table 1

Comparison of Demographic Data of 3 Groups

Variable	Mean (SD)	Range	Statistic
Age in years			
Graduate Nurses (*n*=15)	27.5 (5.4)	22-40	$F(2, 57) = 25.0$
Faculty (*n*=15)	49.7 (15.2)	24-67	$p < .000$
Leadership (*n*=28)	49.7 (9.4)	28-63	
	Female	Male	Statistic
Gender			$X_2 (2) = .005$
Graduate Nurses	14	1	$p = .997$
Faculty	14	1	
Leadership	26	2	

Note: N=58

Findings of the Study

The NPRT tool was used and modified into three versions (new graduates, hospital leadership, and nursing faculty) with the approval of the author to assess the perception of preparedness to practice. For the new graduates, the survey was completed within the first 6 months of becoming a registered nurse. The NPRT was administered to all 3 groups electronically using PsychData, a secure, web-based survey tool. The tool was sent out to all 3 groups at the same point in time. The NPRT's 36 items, divided into 6 subscales, are scored based on the sum of each item that is scaled from 6 to 1 (6=strongly agree, 5=agree, 4=tend to agree, 3=tend to disagree, 2= disagree, 1= strongly disagree). The higher the total score and the higher of the subscale score equates to higher perception of preparedness to practice. The range of Total Score is a high of 216 to a low of 36.

Mean scores were calculated for the entire instrument and each of the subscales (Table 2) and one-way ANOVA evaluated differences between the 3 groups (graduate nurses, hospital leadership, and nursing faculty). The familywise ANOVA results found significant differences between the groups for Total Score and all the subscales except for Technical Skills. The higher the score equates to greater perception of preparedness to practice. For the Total Score and all subscales, the New Graduates reported a higher raw score across the board.

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Table 2

Mean Scores and Familywise ANOVA Results

Instrument and Subscales	Mean	SD	Statistic
Total Score			$F(2, 46) = 5.87$
Total Group	162.61	33.00	$p < .005$**
Graduate Nurses	186.38	30.91	
Faculty	159.92	35.50	
Leadership	151.08	26.65	
Clinical Knowledge			$F(2, 48) = 5.42$
Total Group	26.63	5.24	$p < .008$**
Graduate Nurses	30.38	5.04	
Faculty	25.67	4.03	
Leadership	25.08	5.24	
Technical Skills			$F(2, 48) = 2.47$
Total Group	28.76	5.67	$p < .096$
Graduate Nurses	31.54	5.94	
Faculty	28.58	6.86	
Leadership	27.33	4.43	
Critical Thinking			$F(2, 48) = 4.94$
Total Group	26.39	6.51	$p < .011$*
Graduate Nurses	30.46	6.16	
Faculty	26.83	6.60	
Leadership	23.96	5.67	
Communication			$F(2, 48) = 4.31$
Total Group	27.31	5.50	$p < .019$*
Graduate Nurses	30.85	5.54	
Faculty	26.67	5.26	
Leadership	25.71	4.83	
Professionalism			$F(2, 48) = 7.27$
Total Group	28.29	5.72	$p < .002$**
Graduate Nurses	32.85	4.02	
Faculty	27.33	7.19	
Leadership	26.29	4.32	

Management of Responsibilities	25.24	6.66	$F(2, 48) = 6.88$
Total Group	30.31	5.56	$p < .002$**
Graduate Nurses	24.83	5.37	
Faculty	22.71	6.42	
Leadership			

Note: N=58. *significant for $p < .05$; **significant for $p < .01$.

Pairwise comparisons were then calculated for the significant findings (Table 3).

Table 3

Pairwise Comparisons for Significant Values

Instrument and Subscales	Groups	Mean Difference	Standard Error	Significance
Total Score	GN and F	26.47	12.05	.099
	GN and L	35.30	10.36	.004**
	F and L	8.83	10.64	1.00
Clinical Knowledge	GN and F	4.71	1.93	.055
	GN and L	5.30	1.66	.008**
	F and L	.583	1.70	1.00
Critical Thinking	GN and F	3.63	2.41	.419
	GN and L	6.50	2.08	.009**
	F and L	2.87	2.13	.553
Communication	GN and F	4.18	2.06	.146
	GN and L	5.14	1.78	.017*
	F and L	.958	1.82	1.00
Professionalism	GN and F	5.51	2.04	.029*
	GN and L	6.55	1.75	.002**
	F and L	1.04	1.80	1.00
Management of Responsibilities	GN and F	5.47	2.39	.080
	GN and L	7.60	2.05	.002**
	F and L	2.12	2.11	.957

Note: *significant for $p < .05$; **significant for $p < .01$. GN = graduate nurses
F = faculty. L = leadership.

Pairwise comparisons showed for the Total Score and all the tested subscales, differences in perceptions of preparedness existed between Nursing Leadership and GNs. Across the board, with the exception of Technical Skills, Nursing Leadership reported scores significantly lower than GNs; meaning Nursing Leadership perceived the GNs as being less prepared to practice compared to the GN perceptions. This was not the same finding for scores between Faculty and GNs. The only significant difference found between Faculty and GNs was for the subscale of Professionalism, meaning Faculty and GNs had similar perceptions of preparedness to practice. There were no differences in scores between Nursing Leadership and Faculty meaning these 2 groups reported similar scores on perception of preparedness to practice for the GN.

In order to examine perceived satisfaction for the 36 items or competencies of the new graduate, answers were collapsed into 2 categories: Agree/Satisfied (strongly agree, agree, tend to agree) and Disagree/Not Satisfied (strongly disagree, disagree, tend to disagree). Table 4 displays the percentages of the 3 groups' satisfaction (Agree) with new graduate proficiency rank ordered from most satisfied (Agree) to least satisfied (Disagree).

Table 4

Rank Order of Items and Frequency (%) of Satisfied/Agree of GN Proficiency

Questions (subscale)	Total Group (N=49) (%)	GN (n=13) (%)	Faculty (n=12) (%)	Leadership (n=24) (%)	$X_2 (df=2)$ p-value
#30 Respect for diverse cultural perspectives (PR)	39 (80)	11 (85)	9 (75)	19 (79)	.360 .835
#12 Utilization of information technologies (e.g., computers, EMRs, etc). (TS)	38 (78)	11 (85)	9 (75)	18 (75)	.507 .776
# 24 Patient advocacy. (CM)	35 (71)	10 (77)	9 (75)	16 (67)	.534 .766
#17 Recognition of when to ask for assistance. (CT)	34 (69)	12 (92)	9 (75)	13 (54)	6.01 .050*
#19 Rapport with patient and families (CM)	34 (69)	11 (85)	10 (83)	13 (54)	5.14 .077
#28 Customer service. (PR)	34 (69)	12 (92)	9 (75)	13 (54)	6.01 .050*
#5 Compliance with legal/regulatory issues relevant to nursing practice. (CK)	33 (67)	12 (92)	7 (58)	14 (58)	5.01 .082
#7 Conducting patient assessments (including history, physical exam, vital signs). (TS)	32 (65)	11 (85)	9 (75)	12 (50)	5.12 .077

#8 Documentation of patient assessment data. (TS)	32 (65)	12 (92)	8 (67)	12 (50)	6.68 .036*
#11 Administration of medication (TS)	32 (65)	10 (77)	9(75)	13 (54)	2.59 .274
#26 Ability to work as a part of a team. (PR)	32 (65)	13 (100)	8 (67)	11 (46)	10.93 .004**
#29 Accountability for actions. (PR)	32(65)	12 (92)	9 (75)	11 (46)	8.70 .013*
#20 Communication with interprofessional team. (CM)	31 (63)	10 (77)	9 (75)	12 (50)	3.57 .168
#10 Utilization of clinical technologies (e.g., IV smart pumps, medical monitors, etc). (TS)	30 (61)	11 (85)	8 (67)	11 (46)	5.54 .063
#22 Patient education. (CM)	30 (61)	10 (77)	8 (67)	12 (50)	2.77 .250
#18 Recognition of unsafe practices by self and others. (CT)	29 (59)	11 (85)	8 (67)	10 (42)	6.81 .033*
#1 Understanding the principles of evidenced-based practice (CK)	28 (57)	12 (92)	7 (58)	9 (38)	10.35 .006**
#2 Knowledge of pathophysiology of patient conditions. (CK)	27 (55)	10 (77)	7 (58)	10 (42)	4.30 .116

#9 Performing clinical procedures (e.g., sterile dressings, IV therapy, etc). (TS)	27 (55)	9 (69)	6 (50)	12 (50)	1.43 .490
#35 Ability to take initiative. (MR)	25 (51)	10 (77)	9 (75)	6 (25)	12.75 .002**
#4 Interpretation of physician and interprofessional orders. (CK)	24 (49)	11 (85)	6 (50)	7 (29)	10.38 .006**
#16 Decision making based on nursing process. (CT)	24 (49)	10 (77)	8 (67)	6 (25)	11.08 .004**
#21 Communication with physicians. (CM)	24 (49)	9 (69)	7 (58)	8 (33)	4.91 .086
#27 Ability to accept constructive criticism. (PR)	24 (49)	12 (92)	6 (50)	6 (25)	15.29 .000**
#36 Conducting appropriate follow-up. (MR)	24 (49)	10 (77)	8 (67)	6 (25)	11.09 .004**
#13 Recognition of changes in patient status. (CT)	23 (47)	10 (77)	7 (58)	6 (25)	9.96 .007**
#15 Interpretation of assessment data (e.g., history, exam, lab testing, etc). (CT)	23 (47)	9 (69)	7 (58)	7 (29)	6.26 .044*
#25 Ability to work independently. (PR)	23(47)	11 (85)	5 (42)	7 (29)	10.59 .005**

#31 Ability to keep track of multiple responsibilities. (MR)	22 (45)	11 (85)	5 (42)	6 (25)	12.18 .002**
#3 Knowledge of pharmacological implications of medications. (CK)	21 (43)	8 (62)	6 (50)	7 (29)	3.94 .140
#6 Understanding of quality improvement methodologies. (CK)	21 (43)	11 (85)	3 (25)	7 (29)	12.66 .002**
#32 Ability to prioritize. (MR)	20 (41)	10 (77)	5 (42)	5 (21)	10.98 .004**
#34 Completion of individual tasks within expected time frame. (MR)	20 (41)	8 (62)	6 (50)	6 (25)	5.21 .074
#14 Ability to anticipate risk (CT)	18 (37)	10 (77)	4 (33)	4 (17)	13.25 .001**
#23 Conflict resolution (CM)	16 (33)	10 (77)	2 (17)	4 (17)	15.77 .000**
#33 Delegation of task. (MR)	15(31)	9 (69)	2 (17)	4 (17)	12.42 .002**

Note: N=58. CK = Clinical Knowledge. PR = Professionalism. CT = Critical Thinking. MR = Management of responsibilities. CM = Communication. TS = Technical Skills. * *p*<.05; ** *p*<.01

The 36 items in Table 4 are ranked ordered by Total Group satisfaction. For

items reporting at least a 50% Satisfied frequency for the Total Group, items #30, #12,

#24, #19, #5, #7, #11, #20, #10, #22, #2, and #9, there were no differences found between

the 3 groups. For the top 50% satisfied items, starting with the top 4th and 6th ranked

items, #17 *Recognition of when to ask for help*, and #28 *Customer service*, there is a

difference in satisfaction with Leadership reporting 54% satisfaction compared to the GN

satisfaction of 92%. For remainder of the items ranking in the 50% satisfied level, this

difference in satisfaction is found repeatedly between Leadership and the GN: #8

Documentation of patient assessment data (50% Leadership; 92% GN), #26 *Ability to*

work as a part of a team (46% Leadership; 100% GN), #18 *Recognition of unsafe*

practices by self and others (42% Leadership; 85% GN), #1 *Understanding the principles*

of evidence based practice (38% Leadership; 92% GN), #35 *Ability to take initiative*

(25% Leadership, 77% GN). In summary, for the top 50% ranked items, there were

significant differences between Leadership and GN satisfaction in clinical competencies.

For the remaining 16 items, the Total Group reported less than 50% satisfaction

with GN competency. Most of these lower ranking findings report differences between

the 3 groups with Leadership notably Not Satisfied with the NG competencies. The top 5

competencies the GN is not satisfied are *Communication with physicians, Interpretation*

of assessment data, Delegation of tasks, Knowledge of pharmacological implications of

medications, and *Completion of individual tasks within expected time frame*. The top 4

competencies the faculty are *Not Satisfied are Understanding of quality improvement*

methodologies, Ability to anticipate risk, Conflict resolution, and *Delegation of tasks*.

And the top 4 competencies the Nursing Leadership are Not Satisfied are *Ability to prioritize, Ability to anticipate risk, Conflict resolution,* and *Delegation of tasks*. In summary, for the lower ranked competencies, Nursing Leadership and Faculty report low satisfaction frequencies (<33%). The GNs lowest satisfaction frequency was 62%; the GN more or less feels more prepared to practice compared to Nursing Leadership and Faculty.

Summary of the Findings

A total of 58 participants participated in this descriptive non experimental survey to measure if there was a difference in the perception of the graduate nurse's preparedness to practice as reported by hospital leadership, the graduate nurse, and nursing faculty. Perception of preparedness to practice was measured with the NPRT tool (Berkow et al., 2008). The analyses revealed that perceptions of preparedness to practice did significantly differ with nursing leadership reporting lower preparedness to practice scores compared to graduate nurses. While nursing faculty scores were similar to leadership scores, the differences between graduate nurses and faculty were not as significant.

CHAPTER V

DISCUSSION OF FINDINGS IMPLICATIONS AND FUTURE RESEARCH

This non-experimental descriptive study examined if there was a difference in the perception of the graduate nurse's preparedness to practice as reported by hospital leadership, the graduate nurse, and nursing faculty. This chapter summarizes the study and includes a discussion of findings, conclusions, implications for nursing practice, and recommendations for further study.

Discussion of the Findings

Fifteen new graduates, fifteen nursing faculty, and twenty-eight hospital leaders completed one of three modified versions of the NPRT survey for the study. While the sample size was low in comparison to proposed goal, the NPRT instrument demonstrated adequate reliability with a Cronbach alpha of 0.986 for total score. The tool is comprised of 36 scaled items, comprised of six subgroups that also demonstrated adequate reliability scores with alpha greater than 0.90 for all subscales. One of the major findings from the study was that hospital leadership reported the lowest scores on new graduate preparedness to practice. These scores were significantly different when compared to the New Graduate Scores. Overall, the new graduate felt prepared to practice. This is congruent with Berkow et al (2008), study in which frontline leaders viewed new graduates had the greatest opportunity for improvement. Mozingo et al. (1995) reported 84% of graduating seniors felt they were prepared through their education programs to be safe clinicians. However, Heslop et al. (2001) reported that new graduate nurses had

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apprehension about meeting the performance expectations of the workplace due to perceived lack of clinical experience.

Clinical Knowledge

The scores on the subscale of clinical knowledge were significantly different between new graduates and hospital leadership ($p=.008$). Nursing faculty and hospital leadership scores showed no differences between their scores ($p=1.00$). Clinical knowledge questions were ranked as follow from lowest to highest in Satisfaction: Understanding of quality improvement methodologies (Satisfied: GNs 85% compared to faculty 25% and leadership 29%); knowledge of pharmacological implications of medications (Satisfied: GNs 62% compared to faculty 50% and leadership 29%); interpretation of physician and interprofessional orders (Satisfied: GNs 85% compared to faculty 50% and leadership 29%), knowledge of pathophysiology of patient conditions (Satisfied: GNs 69% compared to faculty 50% and leadership 50%), understanding the principles of evidenced-based practice (Satisfied: GNs 92% compared to faculty 58% and leadership 38%), and compliance with legal/regulatory issues relevant to nursing practice (Satisfied: GNs 92% compared to faculty 58% and leadership 58%).

Ellerton and Gregor (2003) reported that graduate nurses felt competent in performing clinical skills, they did not understand the significance of their findings. The study conducted by the National Council of State Boards of Nursing (2003) by Smith and Crawford, found that respondents who reported inadequate preparation in understanding

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pharmacologic implications of medications were significantly more likely to be involved in nursing errors.

Technical Skills

The subscale of technical skills showed no difference in scores between GNs and hospital leadership (p=.094) and between GNs and nursing faculty (p=.558). Nursing faculty and hospital leadership showed no significance difference (p=1.00). Technical skills questions were ranked lowest to highest in Satisfaction as follow: performing clinical procedures (e.g., sterile dressings, IV therapy, etc) (Satisfied: GNs 69% compared to faculty 50% and leadership 50%), utilization of clinical technologies (e.g., IV smart pumps, medical monitors, etc) (Satisfied: GNs 85% compared to faculty 67% and leadership 42%), administration of medication (satisfied: GNs 77% compared to faculty 75% and leadership 54%), documentation of patient assessment data (Satisfied: GNs 92% compared to faculty 67% and leadership 50%), conducting patient assessments (including history, physical exam, vital signs) (Satisfied: GNs 85% compared to faculty 75% and leadership 50%), and utilization of information technologies (e.g., computers, EMRs, etc) (Satisfied: GNs 85% compared to faculty 75% and leadership 75%).

The study conducted by the National Council of State Boards of Nursing (2003) by Smith and Crawford supported this study when it found that overall, the new graduates felt that their nursing education had properly prepared them to administer medication through common routes. However, 19% of BS nurses and 30.9% AD nurses felt prepared to administer medications to multiple patients. This study also showed forty

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percent of the new graduates did not feel prepared to use information technology to enhance patient care.

Candela and Bowles (2008) found that 51% of graduate nurses felt unprepared for medication administration and seventy-seven percent indicated they did not feel prepared in the area of assessing and managing electronic patient information. Mozingo et al. (1995) study reported that 75% of BS graduating seniors agreed or strongly agreed that they were lacking in technical skills. Berkow et al (2008) study reported that nurse leaders were most satisfied with the new graduate nurses' competency regarding: utilization of information technologies (e.g., computers, electronic medical records, etc); conducting patient assessments (including history, physical examination, and vital signs). Hickey (2009) found that 72% of preceptors reported that the new graduates "are able to perform basic technical skills: including vital signs. This study also reported that respondents felt that upon hire new graduates were particularly weak in or lacking skills in medication administration, IV medication, drug interactions, dressing changes, foley catheter care and insertion, management of tubes and drains, pumps and safety, and patient assessment skills. Additionally, fifty percent felt that physical assessment skills were adequate sometimes.

Critical Thinking

The subscale of critical thinking showed the significant differences between new graduates and hospital leadership ($p=.009$) and no differences between new graduates and nursing faculty ($p=.419$). Nursing faculty and hospital leadership showed no significance

difference (*p*=.553). Critical thinking questions were ranked ordered as follow from lowest to highest Satisfaction: ability to anticipate risk (GNs 77% compared to faculty 17% and leadership 17%), interpretation of assessment data (e.g., history, exam, lab testing, etc) (GNs 69% compared to faculty 58% and leadership 29%), recognition of changes in patient status (GNs 77% compared to faculty 17% and leadership 17%), decision making based on nursing process (GNs 77% compared to faculty 67% and leadership 25%), and recognition of when to ask for assistance (GNs 92% compared to faculty 75% and leadership 54%).

Berkow et al (2008) study reported that one of the competencies that nurse leaders were least satisfied with the new graduates' ability to anticipate risk. Hickey (2009), reported that preceptors felt that 13% felt that new graduates could set priorities most of time while 47% felt that this occurred sometimes. Only 20% of respondents felt that most of the time new graduates demonstrated good clinical decision-making. Critical thinking skills: problem solving, prioritization, decision making, self-confidence, and motivation were cited when asked if there were any skills that the new graduate was particularly weak in, or lacking upon hire. Interestingly, Boychuck-Duchsher (2001) study viewed "not knowing" as a weakness rather than as an expectation.

Communication

The subscale of communication also showed significant differences between new graduates and hospital leadership (*p*=.017) and no differences between new graduates and nursing faculty (*p*=.146). Nursing faculty and hospital leadership showed no significance

difference (p=1.00). Communication questions were ranked order as follow from lowest

to highest in Satisfaction: conflict resolution (GNs 77% compared faculty 17% and

leadership 17%), communication with physicians (GNs 69% compared to faculty 58%

and leadership 33%), patient education (GNs 77% compared to faculty 67% and

leadership 50%), communication with interprofessional team (GNs 77% compared to

faculty 75% and leadership 50%), rapport with patient and families (GNs 85% compared

to faculty 83% and leadership 54%), and patient advocacy (GNs 77% compared to

faculty 75% and leadership 67%).

In the National Council of State Boards of Nursing study (2003) by Smith and

Crawford new grads reported they felt less prepared to know when and how to call the

physician. Boychuck-Duchsher (2001) study reported new graduates 6 months as a

professional expressed fear of calling the physician. Rapport with patients and families

was one of the competencies reported by nurse leaders (Berkow et al, 2008) as being

most satisfied. Hickey (2009) cited communication written and verbal and

documentation as being a weakness of new graduates.

Professionalism

The subscale of professionalism was the only subscale to show significances

between new graduates and hospital leadership (p=.002) and between new graduates and

nursing faculty (p=.029). Nursing faculty and hospital leadership showed no significance

difference (p=1.00). Professionalism questions were ranked ordered in Satisfaction from

lowest to highest Satisfaction: ability to work independently (GNs 85% compared to

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faculty 42% and leadership 29%), ability to accept constructive criticism (GNs 92%

compared to faculty 50% and leadership 25%), accountability for actions (GNs 92%

compared to faculty 75% and leadership 46%), ability to work as a part of a team (GNs

100% compared to faculty 67% and leadership 46%), customer service (GNs 92%

compared to faculty 75% and leadership 54%), respect for diverse cultural perspectives

(GNs 85% compared to faculty 75% and 79% of hospital leadership 79%).

Respect for diverse cultural perspectives was one of the competencies reported by

nurse leaders (Berkow et al, 2008) as being most satisfied. In the study by National

Council of State Boards of Nursing (2003) by Smith and Crawford, new grads reported

inadequate preparation in working effectively within the health care team. Customer

service was one of the competencies reported by nurse leaders (Berkow et al, 2008) as

being most satisfied. Hickey (2009) reported that teamwork including working with

ancillary staff and other RNs was a skill new graduates were also particularly weak.

Management of Responsibilities

The subscale of management of responsibilities also showed significant

differences between new graduates and hospital leadership ($p=.002$) and no differences

between new graduates and nursing faculty ($p=.080$). Nursing faculty and hospital

leadership showed no significance difference ($p=.957$). Management of responsibilities

questions were ranked ordered as follow lowest to highest for Satisfaction: delegation of

task (GNs 69% compared to faculty 17% and leadership 17%), completion of individual

tasks within expected time frame (GNs 62% compared to faculty 50% and leadership

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25%), ability to prioritize (GNs 77% compared to faculty 42% and leadership 21%), ability to keep track of multiple responsibilities (GNs 85% compared to faculty 42% and leadership 25%), conducting appropriate follow-up (GNs 77% compared to faculty 67% and leadership 25%), and ability to take initiative (GNs 77% compared to faculty 75% and leadership 25%).

In the National Council of State Boards of Nursing study (2003) by Smith and Crawford new graduates reported they felt less prepared to provide direct patient care to 6 or more patients effectively. While the Candela and Bowles (2008) study reported that the RN graduates felt overall satisfied with their preparation regarding skills, they felt least prepared in the areas of management, leadership and organizational skills. Berkow et al. (2008) reported nurse leaders were least satisfied with new graduates ability to delegate tasks. The study conducted by Hickey (2009), thirty-five percent of respondents felt that time management was appropriate sometimes, while 80% felt that that sometimes or less new graduates were able to effectively demonstrate organizational skills and new graduates ability to demonstrate delegation skills were only sometimes or less often. Skills that were felt that new graduates were particularly weak in or lacking also included time management: organization, caseload management and delegation.

Conclusions and Implications

The following conclusions are derived from the findings of this study:

1. Overall, graduate nurses perceived themselves more prepared when compared to nursing leadership and faculty. While nursing faculty reported similar scores to

nursing leadership, there were more significant differences between GNs and leadership. Only for the subscale of Professionalism was there a difference between GNs and nursing faculty.

2. Clinical knowledge: New graduates perceive themselves more prepared in the area of clinical knowledge when compared to nursing leadership. Nursing faculty and nursing leadership perception was almost identical in their scores related to clinical knowledge of new graduate nurses. Compliance with legal/regulatory issues relevant to nursing practice was highest ranked in satisfaction (67%) and knowledge of pharmacological implications of medications was lowest ranked (43%).

3. Technical skills: There were no differences in technical skill scores between the 3 groups. Additionally, technical skills are the area in which overall perception of preparedness is the highest for all 3 groups of participants.

4. Critical thinking: New graduates perceive themselves more prepared in the area of critical thinking compared to nursing leadership.

5. Communication: New graduates perceive themselves more prepared in the area of communication compared to nursing leadership.

6. Professionalism: New graduates perceive themselves more prepared in the area of professionalism than nursing faculty and nursing leadership. Professionalism is the highest area of perception of preparedness of the new graduates.

7. Management of responsibilities: New graduates perceive themselves more prepared in the area of management of responsibilities compared to nursing leadership. Management of responsibilities is also the area that all three groups perceive the new graduate as being least prepared. This is also the lowest perceived area by nursing leadership and nursing faculty.

8. Not only are many of the responses of the nursing faculty and hospital leaders similar, but their age in years are almost identical.

9. The greatest variation in perception is consistently seen between the new graduate nurse and hospital leadership.

10. The modified versions of the NPRT performed statistically well to answer the research question.

11. In conclusion, the overall competencies that most felt the new graduates are prepared to practice are: respect for diverse cultural perspectives; utilization of information technologies (e.g., computers, EMRs, etc); patient advocacy; recognition of when to ask for assistance; rapport with patient and families and customer service.

12. Overall the greatest opportunities for improvement based on perceptions are: delegation of task; conflict resolution; ability to anticipate risk; completion of individual tasks within expected time frame and ability to prioritize.

Implications for Clinical Practice

The results of this study provide useful data for the nursing discipline on the perception of preparedness to practice of the graduate nurse. It is one of the first studies to quantitatively examine and compare the perception of the new graduate, nursing faculty, and hospital leadership at the same point in time in the same geographical location. In terms of previous studies, the findings of this research indicate hospital nursing leadership perceive graduate nurses to not be a prepared to practice when compared to the perceptions of the graduate nurses.

The following are implications for practice:

1. More collaboration between academia and service is needed to determine what is reasonably needed and expected prior to graduation.

2. Service should explore the use of nursing extern programs to assist with the student nurse exposure to clinical settings and opportunities to gain more experience prior to graduation.

3. More focus should be given to the new graduate nurses experience with regards to prioritizing and managing multiple task in a timely manner and delegation. This could be accomplished through simulated clinical scenarios and/or case studies. Delegation and prioritization need to be taught together as one needs to know how to effectively do both at the same time.

4. Senior level nursing students should be placed in more "real life" simulations of handling several patients with various levels of acuity having total responsibility.

5. More consideration should be given to nursing students clinical being 12 hour shifts (depending on the region) in an effort to gain more realistic experiences.

6. While positive reinforcement is vital to learning, receiving feedback positively is more important. Academia should seek opportunities to provide feedback to nursing students to assist them in becoming comfortable receiving feedback in the workforce.

Recommendations for Future Research

The following recommendations are made for future research:

1. Studies are needed that matches the newly graduate nurse to their academic setting/nursing faculty and work setting/hospital leadership.

2. Studies are needed that replicate the perception of preparedness to practice of the graduate nurse at hire, 3, 6, and 12 months of employment.

3. Studies are needed to replicate this study in multiple/different geographical area with a larger sample size.

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Appendix A:

Demographic Information Form

Demographic Information Form

New Graduate

Age _____ years

Sex
Male = 1   Female = 2

Race/Ethnicity
White = 1   Black = 2   Hispanic = 3   Asian = 4
American Indian = 5   Pacific Islander = 6   Other = 7

Marital Status
Married = 1   Divorced = 2   Widowed = 3   Single = 4

Type of nursing degree pursuing
Associate Degree in Nursing = 1   Bachelor of Science in Nursing = 2

Is this your first college degree?   yes = 1   no = 0

If no, what other college degree(s) have you earned? _____

Which of the following best describes the unit on which you are interested in working?
Critical Care or Emergency Department = 1
Medical/Surgical or Telemetry = 2
Women's or Children Health = 3
Other = 4, please specify _____

Previous job: _____

Demographic Information Form

Nursing Faculty

Age _____ years

Sex
Male = 1   Female = 2

Race/Ethnicity
White = (1)   Black = (2)   Hispanic = (3) Asian = (4)
American Indian = (5) Pacific Islander = (6)   Other = (7)

Highest level of education
Bachelors = (1) Masters (Nursing) = (2)   Masters (Other)   = (3)
Doctoral (Nursing) = (4)   Doctoral (Other) = (5)

Type of nursing degree program you teach in:
Associate Degree in Nursing = (1)
Bachelor of Science in Nursing = (2)

Number of Years experience as a RN _____ **years**

Number of Years experience as a Nursing Educator _____**years**

Demographic Information Form
Hospital Leadership

Age _____ years

Sex   Male = 1 Female = 2

Race/Ethnicity
White = (1)   Black = (2)   Hispanic = (3) Asian = (4)
American Indian = (5)Pacific Islander = (6) Other = (7)

Highest level of education
Bachelors = (1)   Masters (Nursing) = (2)   Masters (Other) = (3)
Doctoral (Nursing) = (4)   Doctoral (Other) = (5)

Number of Years experience as a RN _____ years
Number of Years experience as a Hospital Leader _____years

Which of the following titles best describes your primary role?
Director (oversees multiple managers; reports to chief nursing officer) = (1)
Manager (oversees a nursing unit or units; reports to nursing director = (2)
Nurse Educator = (3)
Clinical Nurse Specialist = (4)
Charge Nurse = (5)
Staff Nurse = (6)
Other = (7), please specify _____

Which of the following best describes the unit on which you work the majority of the time?
Critical Care or Emergency Department = (1)
Medical/Surgical or Telemetry = (2)
Women's or Children Health = (3)
Other = (4), please specify _____

Approximately what percentage of new graduate nurses on your unit have:
     An associate's degree in nursing
     0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

     A bachelor's degree in nursing
     0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

Have you worked as a nurse preceptor within the past three years?
Yes = (1)   No = (0)

Appendix B:
New Graduate Nurse Performance Survey

New Graduate Nurse Performance Survey

Directions: For each of the questions in this section, please indicate the extent to which you agree with the statement provided.

A NEW GRADUATE NURSE IS DEFINED AS AN INDIVIDUAL WHO GRADUATED FROM AN ENTRY-LEVEL REGISTERED NURSE PROGRAM WITHIN THE LAST YEAR.

I am satisfied with my proficiency in the following competency areas:

	Strongly Disagree	Disagree	Tend to Disagree	Tend to Agree	Agree	Strongly Agree
CLINICAL KNOWLEDGE						
1. Understanding of the principles of evidence-based practice.						
2. Knowledge of pathophysiology of patient conditions.						
3. Knowledge of pharmacological implications of medications.						
4. Interpretation of physician and interprofessional orders.						
5. Compliance with legal/regulatory issues relevant to nursing practice.						
6. Understanding of quality improvement methodologies.						
TECHNICAL SKILLS						
7. Conducting patient assessments (including history, physical exam, vital signs)						
8. Documentation of patient assessment data.						
9. Performing clinical procedures (e.g., sterile dressing, IV therapy, etc.)						
10. Utilization of clinical technologies (e.g., IV Smart						

Pumps, medical monitors, etc.)					
11. Administration of medication					
12. Utilization of information technologies (e.g., computers, EMRs, etc.)					
CRITICAL THINKING					
13. Recognition of changes in patient status					
14. Ability to anticipate risk					
15. Interpretation of assessment data (e.g., history, exam, lab testing, etc)					
16. Decision making based on the nursing process.					
17. Recognition of when to ask for assistance.					
18. Recognition of unsafe practices by self and others.					
COMMUNICATION					
19. Rapport with patients and families.					
20. Communication with interprofessional team.					
21. Communication with physicians.					
22. Patient education					
23. Conflict resolution					
24. Patient advocacy					
PROFESSIONALISM					
25. Ability to work independently.					
26. Ability to work as part of a team.					
27. Ability to accept constructive criticism.					
28. Customer service.					
29. Accountability for actions.					
30. Respect for diverse cultural perspectives.					
MANAGEMENT OF					

RESPONSIBILITIES						
31. Ability to keep track of multiple responsibilities.						
32. Ability to prioritize						
33. Delegation of tasks						
34. Completion of individual tasks within expected time frame						
35. Ability to take initiative						
36. Conducting appropriate follow-up						

New Graduate Nurse Performance Survey Faculty

Directions: For each of the questions in this section, please indicate the extent to which you agree with the statement provided.

I am satisfied with the proficiency of the graduating nursing students at my academic institution in the following competency areas:

	Strongly Disagree	Disagree	Tend to Disagree	Tend to Agree	Agree	Strongly Agree
CLINICAL KNOWLEDGE						
1. Understanding of the principles of evidence-based practice.						
2. Knowledge of pathophysiology of patient conditions.						
3. Knowledge of pharmacological implications of medications.						
4. Interpretation of physician and interprofessional orders.						
5. Compliance with legal/regulatory issues relevant to nursing practice.						
6. Understanding of quality improvement methodologies.						
TECHNICAL SKILLS						
7. Conducting patient assessments (including history, physical exam, vital signs)						
8. Documentation of patient assessment data.						
9. Performing clinical procedures (e.g., sterile dressing, IV therapy, etc.)						
10. Utilization of clinical technologies (e.g., IV Smart Pumps, medical monitors, etc.)						
11. Administration of medication						

12. Utilization of information technologies (e.g., computers, EMRs, etc.)					
CRITICAL THINKING					
13. Recognition of changes in patient status					
14. Ability to anticipate risk					
15. Interpretation of assessment data (e.g., history, exam, lab testing, etc)					
16. Decision making based on the nursing process.					
17. Recognition of when to ask for assistance.					
18. Recognition of unsafe practices by self and others.					
COMMUNICATION					
19. Rapport with patients and families.					
20. Communication with interprofessional team.					
21. Communication with physicians.					
22. Patient education					
23. Conflict resolution					
24. Patient advocacy					
PROFESSIONALISM					
25. Ability to work independently.					
26. Ability to work as part of a team.					
27. Ability to accept constructive criticism.					
28. Customer service.					
29. Accountability for actions.					
30. Respect for diverse cultural perspectives.					
MANAGEMENT OF RESPONSIBILITIES					
31. Ability to keep track of multiple responsibilities.					

32. Ability to prioritize					
33. Delegation of tasks					
34. Completion of individual tasks within expected time frame					
35. Ability to take initiative					
36. Conducting appropriate follow-up					

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New Graduate Nurse Performance Survey
Hospital Leadership

Directions: For each of the questions in this section, please indicate the extent to which you agree with the statement provided.

A NEW GRADUATE NURSE IS DEFINED AS AN INDIVIDUAL WHO GRADUATED FROM AN ENTRY-LEVEL REGISTERED NURSE PROGRAM WITHIN THE LAST YEAR.

I am satisfied with the proficiency of new graduate nurses on my unit in the following competency areas:

	Strongly Disagree	**Disagree**	**Tend to Disagree**	**Tend to Agree**	**Agree**	**Strongly Agree**
CLINICAL KNOWLEDGE						
1. Understanding of the principles of evidence-based practice.						
2. Knowledge of pathophysiology of patient conditions.						
3. Knowledge of pharmacological implications of medications.						
4. Interpretation of physician and interprofessional orders.						
5. Compliance with legal/regulatory issues relevant to nursing practice.						
6. Understanding of quality improvement methodologies.						
TECHNICAL SKILLS						
7. Conducting patient assessments (including history, physical exam, vital signs)						
8. Documentation of patient assessment data.						
9. Performing clinical procedures (e.g., sterile dressing,						

IV therapy, etc.)					
10. Utilization of clinical technologies (e.g., IV Smart Pumps, medical monitors, etc.)					
11. Administration of medication					
12. Utilization of information technologies (e.g., computers, EMRs, etc.)					
CRITICAL THINKING					
13. Recognition of changes in patient status					
14. Ability to anticipate risk					
15. Interpretation of assessment data (e.g., history, exam, lab testing, etc)					
16. Decision making based on the nursing process.					
17. Recognition of when to ask for assistance.					
18. Recognition of unsafe practices by self and others.					
COMMUNICATION					
19. Rapport with patients and families.					
20. Communication with interprofessional team.					
21. Communication with physicians.					
22. Patient education					
23. Conflict resolution					
24. Patient advocacy					
PROFESSIONALISM					
25. Ability to work independently.					
26. Ability to work as part of a team.					
27. Ability to accept constructive criticism.					
28. Customer service.					
29. Accountability for actions.					

30. Respect for diverse cultural perspectives.					
MANAGEMENT OF RESPONSIBILITIES					
31. Ability to keep track of multiple responsibilities.					
32. Ability to prioritize					
33. Delegation of tasks					
34. Completion of individual tasks within expected time frame					
35. Ability to take initiative					
36. Conducting appropriate follow-up					

Adapted with permission of the author.

Appendix C:
Recruitment Letter

August 26, 2013

Dear New Nursing Graduates, Nurse Faculty and Nurse Leaders,

I am a doctoral student at Texas Woman's University and am in need of your assistance in completing my dissertation. You are invited to take part in a survey that examines the perception of preparedness of the graduate nurse as reported by the graduate nurse, nursing faculty and hospital leadership. This study investigates clinical knowledge, technical skills, critical thinking, communication, professionalism and management of responsibilities. The survey takes about 10 minutes to complete. Your participation is voluntary. You may withdraw from the study at any time. There are minimal risks from completing the survey.

The inclusion criteria for the new graduate nurse: currently employed as a new Registered Nurse, recently graduated within last six months, and working as nurse in first position post-graduation. For the nursing faculty, currently teaching/supervising senior level nursing students; for the hospital leadership currently a Nursing Director and/or Nurse Manager for a hospital unit(s) that employs new nursing graduates. Exclusion criteria for the new graduate nurse includes graduate nurses who previously worked as a LVN or LPN or who have previously worked in any nurse capacity.

Your answers will be completely anonymous and confidential. All of the data will be sent to one database and the results will be reported as aggregate data rather than by a single participant.

Please access the survey using the following links:
New Graduate survey: https://www.psychdata.com/s.asp?SID=130169
Nursing Faculty survey: https://www.psychdata.com/s.asp?SID=154816.
Hospital Leadership survey: https://www.psychdata.com/s.asp?SID=155070

If you have questions about the survey, **please contact Angela P. Wright, MBA, RN, at** u_11green@twu.edu **or call 713-545-9680**.

Completion of this survey indicates that you have read and understand the above statements and indicates your consent to participate in this study.

Angela P. Wright, RN

Angela P. Wright, RN

Thank you for your valuable time and input,
Angela P. Wright, MBA, RN
Doctoral Student