Sharing Clinical Wisdom:
Orienting New Nurses to a Tertiary Care Hospital Center

Kimberley Ellen Tanguay

A Thesis

in

The Department

of

Education

Presented in Partial Fulfillment of the Requirements
for the Degree of Masters of Arts
Concordia University
Montreal, Quebec, Canada

August 2000

Sharing Clinical Wisdom:
Orienting New Nurses to a Tertiary Care Hospital Center

Kimberley Ellen Tanguay

Abstract

The intent of this study is to explore nursing orientation practices at the Montreal Children's Hospital. In particular, this paper sought to identify the gap between the existing preceptorship orientation program and the ideal orientation program.

Orientation is defined as those activities and experiences that are planned, implemented, and evaluated for either new employees or for those employees changing roles. Orientation is a means by which new staff members are introduced to the philosophy, goals, procedures, role expectation, physical facilities and special services in a specific setting. A preceptor is defined as an expert nurse who is responsible for the orientation of a new nurse to a particular unit for a limited time period. The goal of a preceptor program is to integrate newly employed nursing staff into the work setting.

The study begins with a historical overview of nursing. Then, an account of the existing nursing orientation program at the Montreal Children's Hospital is provided. A detailed review of the literature on nursing orientation helps shape the recommended changes. Interviews with three recently oriented nurses and their preceptors provide more data to launch the recommended changes to the existing orientation program. By drawing on Boone's Adult Education Program Design Framework, the reviewed literature and the results of the survey, ten recommendations for improving the current nursing orientation program are suggested.

Acknowledgement

There are not many opportunities that we get to thank the people who have helped us along the way. This is my chance. First and foremost, I would like to thank my children, Kristopher and Anthony for allowing me to pursue my studies at the expense of missing their soccer games, wrestling matches, and hockey games. Secondly, I would also like to thank my husband Nick for all the encouragement and validation he has given along the way.

Third, I would to acknowledge my extended family. Of special mention are my mother and father. They not only gave me the boost that I needed to return to school as an adult learner, but babysat my children on most of my class days. Thanks.

Fourth, I wish to mention the contributions of the nursing department at the Montreal Children's Hospital, especially the Associate Director of Nursing for Child and Adolescent Services and the Coordinator of Nursing Staff Development for Child and Adolescent Services, the leadership group on the 7th floor, and the nurses who I interviewed. Many of the ideas cited developed from conversations with these insightful and dedicated nurses. I would also like to thank Joanne Baird and Fleurette Gregoire, two great librarians for helping with the searches.

Finally, I wish to thank Professor Joyce Barakett for teaching me, for directing me towards this degree and for advising me. Your skills and patience were greatly appreciated.

Table of Contents

Introduction

The intent of this study is to explore nursing orientation practices at the Montreal Children's Hospital. In particular, this paper will identify the gap between the existing program and the ideal hospital-based orientation program. Suggestions to improve the current orientation program will be made.

Orientation is defined as those activities and experiences that are planned, implemented, and evaluated for either new employees or for those employees changing roles. Orientation is a means by which new staff members are introduced to the philosophy, goals, procedures, role expectation, physical facilities and special services in a specific setting (Abruzzese & Quinn-O'Neal, 1992).

Preceptor programs are now standard for orienting new nurses in many institutions. A preceptor is defined as an expert nurse who is responsible for the orientation of a new nurse to a particular unit for a limited time period (Bellinger & McCloskey, 1992). Staff nurses working on the same unit as the new nurse and having demonstrated clinical expertise are chosen by the head nurse to be preceptors. These preceptors act as role models, resource persons, and teachers for the new nurse (May, 1980). The goal of a preceptor program is to integrate newly employed nursing staff into the work setting (Balcain, Lendrum.

Bowler, Doucette, & Maskell, 1997). The assumption underlying preceptor programs for orientation is that the intense one-to-one relationship will enhance the learning and the socialization of the new nurse (Shamian & Inhaber, 1985).

Mentoring, shadowing, and coaching are terms that are synonymous with preceptorship and are commonly used to explain a type of peer support that is provided to new nurses during their orientation. Bellinger and McCloskey (1992), explain: "A preceptorship program includes a structured plan to ease the transition for nurses who are entering the professional role for the first time or who are in a new position" (p.322).

The beginning point for any paper describing an orientation program is an agreement on what learning is. According to Cronbach (1963): "Learning is shown by a change in behavior as a result of experience" (p. 71). Likewise Jerome Brunner's (1961) definition of learning describes three main processes in learning. According to Brunner, the three main and simultaneous processes in learning are: (1) The acquisition of new information; occasionally this new information counters or replaces what has been previously known: (2) The transformation process, or the course of manipulating knowledge which is aimed to acquiring the new tasks; and (3) An evaluation or checking of the acquired knowledge and transformation process to determine whether the manipulated knowledge is adequate for the task.

The metaphor of Sharing Clinical Wisdom is used as a title in an effort to capture the essence and tapestry of information that is transferred to the new nurse during the orientation process. Benner 's (1984) conceptualization of nurses' acquisition of knowledge and skill provides a useful framework. It describes clinical nursing practice and provides a backdrop to the understanding of how nurses develop their skills.

According to Benner (1984), there are five levels of skill acquisition: novice, advanced beginner, competent, proficient and expert. Benner's premise is that nurses function at various levels of clinical competency. For example, novice nurses are task oriented. Advanced beginners see recurrent situations and assign meaning to these situations. Competent nurses carry out deliberate planning whereas proficient nurses can anticipate events. And expert nurses not only perceive situations rapidly but are intuitive.

Benner maintains that each proficiency level is characterized by advances in perceptual knowledge and clinical knowledge that is achieved through exposure to different clinical experience. This framework and its definition of concepts will be referred to throughout this paper. It is particularly helpful when describing the differences in clinical practice and the dynamics between the clinical expert (preceptor), and the novice (neophyte).

The importance of a nursing orientation cannot be overstated. Nursing orientation is a vital and necessary activity linked to building competencies, making expectancies explicit, and establishing the "fit" between the neophyte and the organization. Orientation is an important mechanism bridging the new nurse's experience with nursing school focusing on the realities of the work setting.

With the need for greater and greater specialized skills, graduating from nursing school does not guarantee that the new nurse will be competent to practice nursing (Scrima, 1987). Moreover, because hospitals are legally responsible for their employee's actions, it is essential that a minimum requirement be set and that programs, such as orientation, be developed and continually updated to ensure staff competency (McGregor, 1990). Orientation then is a critical organizational activity that influences the integration of the neophyte. It affects the new nurse's success in the first few months and in the future. It is the starting point in the evaluation process.

A nursing orientation program can have lasting effects on the new graduate. For example, an ineffective orientation program can transform the neophyte personally and professionally leading to attrition either to another setting or out of the profession entirely (Godinez, Schweiger, Gruver, & Ryan, 1999). In fact, some estimate that 35-60% of new graduates will change their

place of employment during the first year (Coeling, 1990: Hamilton, Murray, Lindholm, & Myers, 1989). One nursing department reports an average turnover rate as high as 72.8% (Aldrich, 1988).

Orientation is a highly resource intensive endeavor. Establishing an effective orientation program can not only decrease the turnover rate but can decrease the cost associated with the individuals doing the orientation. This can have major fiscal implications. Moreover, with the current nursing shortage and the competitive recruitment strategies, it is vital that hospitals provide effective orientation programs to improve retention. One author writes,

> Registered nurse (RN) turnover is a severe problem in today's health care climate. That, coupled with the continuing escalation of competition among hospitals for qualified RNs serves to make the need more pressing (Aldrich, 1988, p. 377).

Another author commented that, " Traditional, informal, unit-based orientation have been blamed for the high staff turnover" (Craven & Broyles, 1996, p. 294). Both of these authors suggested improvements to their orientation programs as a way of attracting and retaining nurses.

Despite these facts nurses describe having inadequate orientations or no orientation at all. One celebrated nursing survey (Benner & Benner, 1979) demonstrated that orientation programs for all nurses should be improved. Nearly half of the new graduates in this survey indicated that their orientation was less

than effective with twelve percent indicating that they had no orientation to their job at all. Likewise, Dunt, Temple-Smith and Johnson (1991) found that 26% of the nurses they surveyed had not had a formal orientation.

Having made a case for the importance of nursing orientation and defined terms commonly associated with orientation, this paper will address issues around the implementation of a successful orientation program. A brief history of the nursing profession and its growth from an apprenticeship to a profession will be provided. The point of departure is the move of the nursing schools out of the hospital setting. Before this move occurred there is little written about the importance of orientation. Nonetheless, this necessary move has created a dichotomy between nursing education and the development of the skills required to practice which continues today.

There are many themes around the topic of nursing orientation. This paper will be concentrating on the literature that addresses the implementation and evaluation of nursing orientation programs. In particular, the literature focuses on research that explores role transition, clinical standards, competency-based programs, critical pathways and computer-assisted learning in nursing orientation. The socialization of new nurses to the role of staff nurse will also be discussed.

To summarize, in the first chapter a historical overview of nursing will be described. In chapter two, an account of the existing nursing orientation program will be provided. In chapter three, a review of the literature on nursing orientation will help shape the recommended changes to the existing orientation program. In chapter four, a detailed description of the Montreal Children's Hospital's nursing orientation will be presented using information obtained through interviews with three recently oriented nurses and the three nurses who oriented them. Chapter five will outline the proposed changes to the existing orientation program. The concluding statements will follow chapter five on the proposed changes to the existing program.

Chapter 1
Historical Background
140 years of practice

Nursing in the Seventeenth and Eighteenth Century

In order to fully appreciate the complex issues surrounding nursing orientation today, an historical review of the development of nursing is required. To "nurse," from the Latin word "to nourish" refers to a commitment to stand by and participate though joy, health, sickness, pain and death (Growe, 1991). Nursing actually predates medicine in which self-professed nurses came to help in the community when "called."

During seventeenth century Canada, these self-taught nurses were trained in France and then came to the West to be assigned to the Roman Catholic nuns. These same Catholic nuns founded Hotel Dieu Hospital in Quebec City. The first Montreal hospital was founded in 1644 by Jeanne Mance, two years after the counsellor of Maisonneuve founded the city. The hospital was named L'Hotel Dieu de Saint-Joseph at Ville Marie (Growe, 1991). In 1671, the French nuns were no longer being brought over because there were enough Canadian-born nuns able to carry out the duties. Sixty years later, the first nursing order called the Grey Nuns was formed and began visiting the homes of the sick.

Nursing in the seventeenth and eighteenth century remained unstructured and disorganized. Nursing care was largely being provided by women in religious orders who "tended the spirit" and who "had unquestionable morals." (Jervik & Martinson, 1979, p.31) Nurses were characterized as dedicated, with self-abnegation, and a strict obedience to authority.

Nursing in the Nineteenth Century

The beginning of nursing as a profession is credited to Florence Nightingale (Nightingale, 1969). Florence Nightingale, a wealthy British spinster, volunteered her skills during the Crimean War of 1860. During this war, she was able to reduce the mortality rate by simply improving the sick soldiers' ventilation, diet and cleanliness. Florence also insisted on providing the soldiers with warmth, light, an appropriate diet, and reducing the noise level they were exposed to. All of these interventions impacted on their survival. Nightingale believed that disease was a reparative process and that a nurse could facilitate the process by manipulating the environment (Nightingale, 1969). After she returned from the war, this "Lady of the Lamp" established the first nurse-training program based on these principles in London. The first Canadian Nursing School was established in 1874 in Ontario. It too was based on the Nightingale philosophy. However, over the course of the next sixteen years, medical care increased in complexity and began to overshadow the Nightingale approach to good health.

Nursing in the Twentieth Century

Early in the Twentieth century, hospital administrators realized the economical value to having nurses carry out their training in hospitals. By 1909, seventy hospital based nursing programs existed in Canada. A typical day for a nursing student included nine hours of courses and three additional hours working as a student nurse on a ward at the hospital to which they were assigned (Weir, 1932). With little time off and under strict conditions, student nurses were trained in an apprenticeship manner in the hospital to which they would later work. In an attempt to advance the profession, the Canadian Nurses Association and a group of physicians began looking at the future direction of nursing. This small but influential group asked Professor Gerald Weir to commission a national survey on the status of nursing in Canada. It was the first national commission of its kind.

The Weir Report on the Status of Nursing

The Weir report in 1932 focused on the status of nursing education in Canada. Because the timing of this report coincided with the Great Depression, the economics of nursing practice was at the forefront of the report. Aspects of the report addressed the logistics of a "fee for nursing service." Furthermore, the report highlighted that the standard of nursing education should be elevated. The Weir report discounted the popular belief that if nurses were to pursue higher education, they would become filled with aspirations, and they would become

unfit for ordinary duty. Weir (1932) writes about the need to raise educational standards of nursing from an educational and economic perspective;

> True education, in fact, improves the fibre, moral, and intellectual, of her being and creates a healthy mental satisfaction by enabling her to realize worthy aspirations otherwise unattainable. Moreover, from an economical viewpoint if the educated nurse charges more for her services than otherwise would be the case, these services are probably worth more, and the transaction is economically sound. An educated and cultured nurse at five dollars a day, for instance, is likely to give relatively better value than an uncouth and uneducated one at three dollars. (p. 45)

The report summarizes information obtained by surveying nurses, doctors and laymen from all provinces in an effort to gain insight into the educational preparation required for nurses. One shocking result was that 65 percent of the nurses had a lower than high school academic standing upon entering nursing school.

Nursing Education Moves out of the Hospital Setting

In response to the Weir data, sweeping changes were recommended. One major recommendation was the need to remove nursing educational programs out of the hospitals setting. The report advocated that nurses required

not only technical but theoretical education. In reference to the current nursing schools and the need to change Weir wrote:

> These schools ordinarily place little emphasis on sound educational requirements for admission to training, and too frequently regard the so-called competent nurse as a mere technician or machine rather than an alert, efficient, and cultured human being. (p. 50)

> The development of training schools for nurses primarily as educational institutions, functioning as an integral part of the educational system of the Province and financed on the same principle as are normal schools should be made an immediate objective. (p. 116)

Shortly after the Weir report was published, the Canadian Nurses Association recommended that all nursing education be at the University level by the year 2000. Despite these recommendations nursing education remained largely under the control of the hospitals until the early seventies.

Today, there are no longer any hospital based nursing education programs that exist in Canada. However, the type of training required to practice nursing remains at the forefront of debates among nurses. This debate is evident by the two avenues available for entry to practice nursing: the diploma route achieved through a three year Cegep education and the Baccalaureate of Science in Nursing achieved through a four year university education.

Regardless of the route of entry a dichotomy exists between what is being taught in nursing schools and the realities of the work –hospital- setting. Attempts to ease the neophyte's transition from graduate to staff nurse are facilitated by hospital based orientation programs organized by nursing staff development departments.

Staff development departments are composed of nurse consultants, clinical nurse specialists and nurse educators who have an interest in hospital based continuing education. The mandate of the staff development department is to develop and provide ongoing educational opportunities for all nursing staff. Orientation is one of these on-going educational opportunities. In addition to the formal orientation program, preceptors programs and on the job training are part and parcel of most orientation programs.

The following chapter examines the current nursing orientation program at the Montreal Children's Hospital. Particular attention is placed on the program's strengths and weaknesses from my personal experiences and perspective.

Chapter 2
The Current Orientation Program at the Montreal Children's Hospital

At the Montreal Children's Hospital, an evaluation of the current orientation program reveals a multitude of strengths and weaknesses. The following section will present the author's perspective having personally witnessed the evolution of the program over the course of fourteen years.

At the outset it is important to outline the current orientation program. The current program, outside of the intensive-care unit, on general wards within the hospital is a four to six week preceptorship driven orientation. The head nurse or her delegate assigns the preceptor. The preceptor is a nurse who has demonstrated expertise and clinical competence. The new nurse usually spends the first week working an eight-hour shift where she/he is introduced to the unit. Part of this introduction includes assigning them a locker; sending them to Human Resources for an identification card and having them visit the union to sign the necessary documents. The major focus of this first week is to introduce them to the other health professional team members, to help socialize them to how the ward functions, and to begin introducing them to specific guidelines, such as our guidelines for medication administration.

The Strengths of our Current Orientation Program

The strengths of the current nursing orientation program include the nursing department's commitment to a four to six week orientation (which is more lengthy than other Montreal area hospital's orientation), the use of preceptors, and the integration of the neophyte into more responsibility. There is also an appreciation of the importance of the experiential approach to learning witnessed by involving new nurses in new situations. Narratives or story telling are important substitutes to experiential learning. Narratives have always been part of nursing practice. Initially, nurses trained in the hospital were treated as apprentices to the service. Without any nursing text, narratives were an important means to transferring information. Nursing practice has evolved and has become much more sophisticated, but the use of narratives and story telling remains part of orientation, to some extent, to this day. Nursing leaders echo the significance of sharing stories. For example Rogers (1997) notes, "Scenarios are images of the future that are constructed using in-depth knowledge of what is known in the present, as well as imagination and creativity" (p.5).

One of Benner's, Kyriakidis' and Stannard's (1999) objectives in their recent book entitled "Clinical Wisdom and Interventions in Critical Care- A Thinking in Action Approach," is to describe the nature of skill acquisition in critical care nursing practice. In their chapter "The Skilled Know-How of Clinical Leadership and the Coaching and Mentoring of Others," they highlight how clinical experts embody relational and clinical skills. Although their focus is on the clinical expert,

teacher, mentor or preceptor, they do describe skill acquisition in the neophyte which is the focus of this paper.

According to these authors there are three necessary qualities in clinical experts or preceptors. First clinical experts must have the ability to facilitate skill development in others. Second these experts must work with neophytes to sharpen their ability to recognize, interpret, and forecast early warnings of patient transitions and then provide them with the knowledge to intervene. Third, clinical leaders must identify gaps in patient care and mobilize resources to bridge these gaps. An example of this Thinking-in-Action approach by clinical experts is exemplified in the following situation that occurred at the Montreal Children's Hospital.

Barb, a twenty-year veteran nurse working on a surgical unit is handed a message from the ward secretary indicating that her patient's surgery has been cancelled. Barb probes the secretary and notes she was not given a rationale for the cancellation. Barb then calls the OR to ask why. The operating room clerk indicates that the patient has a temperature and the Anesthesiologist will not proceed with the surgery. Dumbfounded, Barb assures the operating room clerk that her patient is well and does not have a temperature. As a result of her inquiry the patient's operation proceeds as planned and the family never finds out that the surgery they have waited six months for was almost cancelled.

Barb was orienting a new nurse when this situation occurred. As a result, the new nurse learned three important lessons not found in textbooks or taught at school. First that a nurse assigned to a patient has a moral, professional and ethical responsibility to ensure that clinical decisions are based on accurate information. Second, the new nurse learned that the care delivery system has flaws in which she must learn to navigate. And third, the new nurse learned that care delivery involves embarking into a unique relationship with the patient and their family and in doing so the nurse becomes their advocate.

This narrative provides a poignant example of the qualities required in clinical experts. And as luck would have it, a new orientee was able to benefit from the experience. New information was formed which will guide future situations. This type of experiential learning is tremendously advantageous to new nurses. And when clinical experts guide the learning of another as Barb did, the results are immense. This type of learning is one of the great strengths of the orientation program.

However, I wonder how this neophyte would have learned these important lessons if this situation had not arisen. In other words, there is a serendipitous nature to our current orientation with emphasis on the learning of interventions. Narratives are not used to their full potential or not at all. Furthermore, with the complexity of health today, orientation demands that the type of learning characterized in the above narrative be captured and transferred and not left up

to chance. I will now proceed to examine the limitations of our current orientation program.

The Limitations of our Current Orientation Program

The limitations of the current orientation program can be linked to the restrictions in hiring imposed in the early 1990s, and the decentralized philosophy. Further limitations to the orientation program include the lack of a consistent hospital-wide approach, where needs assessments are not done, where expectations are not always made explicit and where training for the trainers, or preceptors, is not uniformly carried out. Another limitation is that the selection of the preceptor, or clinical expert, is based on the availability of personnel (because of a nursing shortage) and not always on the matching of teaching and learning styles.

All of the aforementioned shortcomings create obstacles to the evaluation of a program. Evaluation is a necessary exercise to determine the effectiveness of a program. In fact there has not been a systematic evaluation of the orientation program to date.

The intention of this exploration extends beyond a list of problems. Instead I hope to gain a greater insight in an effort to improve our orientation program. These limitations are broadly categorized into political, philosophical, and social influences.

Political Influences

There are ongoing effects on the nursing orientation program as a result of political decision making in the early nineties. In the early nineties, the need to downsize departments was mandated by the provincial government in an effort to save health care costs. Downsizing is an organizational activity aimed at looking at services and cutting wherever possible. At the Montreal Children's Hospital, downsizing efforts catapulted the merging of departments, decreasing the number of beds within the institution, putting a freeze on the hiring of full time employees and either laying off or offering early retirement packages to more senior employees.

Further political influences on nursing orientation practices can be traced to the 1996 decision of the then Provincial Health Minister, M. Roch, to close seven Montreal area hospitals. As a result of the closures the employees of these hospitals were redeployed into other hospitals one of which was the Montreal Children's Hospital.

Downsizing and the deployment of hospital workers from closed hospitals redefined not only the type of employee that was now being oriented but also the number of new nurses that were being hired. Nurses from the closed institutions had little time to cope with the closure of their hospital before being asked to

report for orientation to another. Some of these nurses were not willing participants joining our nursing department.

At the same time, new nurses graduating from local Cegeps and universities were being told that they had little chance of finding employment in any of the Montreal area hospitals because of the influx of these reassigned nurses. As a result, specialized orientation programs were planned for those nurses arriving from other centers, and new nurses that were hired arrived in too few numbers to offer a hospital-wide orientation.

These political decisions have lead to the demise of our general orientation programs and the move to decentralization of departments. The decentralization of the orientation program has resulted in each ward planning and carrying out their orientation without a consistent approach.

Another political influence that impacted on our orientation program was that Montreal area nursing schools were faced with the need to downsize. The provincial government placed a moratorium on the number of students that were admitted into Nursing Education Programs. Not surprising, Dr. Eva Ryten (1997) in her report for the Canadian Nurses Association about the future of nursing in Canada, used demographics to show that there would be a massive exodus of nurses because of retirement in years to come. She warned of a severe nursing shortage by the year 2011.

Philosophical Influences

Decentralization as a philosophical approach and an offshoot of downsizing was being toted within the nursing literature and at the Montreal Children's Hospital as a means for hospital wards to become more efficient in the early nineties. The decentralization philosophy meant that the hospital promoted initiatives that made the departments more self-sufficient. New nurses were being hired in small numbers mostly to replace vacationing staff. Experienced staff nurses' attrition continued at a steady pace and hospital wide education programs such as the Preceptorship Training Workshop, which trained the trainers, fell by the wayside. As a result some of the nurses who had little experience and little training themselves became preceptors and were now orienting new nurses.

The lack of a general orientation meant that the philosophy, ethos or spirit of the hospital and its approach was not being shared. The lack of a Preceptor Training Program resulted in new nurses occasionally being trained by ill-prepared preceptors. And the decentralization of the orientation program meant that no one individual or department was responsible for monitoring and improving the program. Humphrey and Milone-Nuzzo (1992) reverberate these sentiments pointing out that today in many institutions orientation of new nursing

The decentralization initiative not only prevented any mechanism for feedback between departments but also resulted in many different departments duplicating orientation for few numbers of new employees. In effect it could be considered more costly with no one department being fully responsible for the way in which new nurses were being indoctrinated into the nursing department.

At about the same time there was growing evidence of an impending nursing shortage just as Dr Ryten (1997) had predicted. Hospital wards began striving towards meeting the needs of patients by hiring and orienting nurses as best they could, always lagging behind in terms of filling nursing positions. The lack of a comprehensive hospital-wide orientation program as a result of downsizing and decentralization has also made an evaluation of the program impossible. Evaluation is the process of finding out how well a program, practice, or policy is working (Polit & Hungler, 1983). According to Lo Biondo and Haber (1990) there are two types of evaluation: formative and summative. Formative evaluation refers to the ongoing assessment of a program in meeting the expressed needs and then identifies areas for improvement. Summative evaluation refers to a process that is carried out at the end of a program. In general, most authors suggest that both forms of evaluations be carried out.

The importance of evaluating all education initiatives including orientation cannot be overstated. For instance, Bellinger and McCloskey (1992) have suggested that the preceptorship model of orientation has not been evaluated or researched to determine its effectiveness. And yet the preceptorship model is used in many of the University affiliated hospitals in Montreal. The lack of a systematic evaluation of the nursing orientation program at the Montreal Children's Hospital to date is a major shortcoming. Further discussion on the importance of evaluation will be elaborated on in the final chapter of this paper.

Sociological Influences

The sociological influences resulting in limitations in our nursing orientation are numerous. Some of the influences that I feel need to be mentioned are; the ineffective socialization of the neophyte in nursing school leading to conflict once they graduate; the ineffective socialization due to "toxic mentors;" the risk that ineffective teaching methods may be used in orientation which resemble a "banking approach;" and the dichotomy between the espoused beliefs in nursing school and the ideology supported in the hospital.

Kramer (1985) first described the ineffective socialization of new graduates, referring to the feelings of the new graduate as reality shock. According to Kramer, reality shock is defined as the shock-like reaction that an individual experiences as a result of having been reared and educated in a subculture of nursing. This subculture is promulgated by nursing schools but is

not part of the reality of their new work place. The term, reality shock, became popular as a result of nursing schools moving out of the service setting. While nursing education was under the control of the hospitals, nurses learned the care delivery of that single hospital. Once nursing education was taking place in colleges and universities, multiple sites and hospitals were hosting the student nurses during their clinical rotation. Nursing education became focused on the nursing care and away from concentrating on where the care was being delivered.

Today's nurse, who graduates and metamorphoses into the hospital setting, experiences conflict associated with changing priorities and pressures. Kramer writes that the new nurse must learn to balance the needs of their patients with the needs of the setting. For example, nursing schools typically do not give patients with the greatest need to their nursing students during their clinical rotation, yet they are expected to care for these patients upon graduating. As a result, new graduates experience competency gaps when their own performance does not meet the standard of nursing care (Carpenito & Duespohl, 1981).

Further evidence of the ineffective socialization of the new graduate is the result of the lack of a general orientation program. As a result new nurses do not have another nurse in a similar situation to share experiences with. In fact the socialization of the new nurse is mostly left to the preceptor. When much of the

socialization is left to an ineffective preceptor, the risk is that they will do a substandard job. Darling (1985) addressed these risks calling ineffective preceptors, "toxic mentors."

Toxic mentors are preceptors who are detrimental to the new nurse. Darling caricatured these preceptors as not accessible (avoiders), who let the new nurse flounder (dumpers), who avoid meeting the new nurse's learning needs (blockers), or who destroy or criticize. She suggests that preceptors be aware of their mentoring patterns, and that preceptees build networks with others for support (1985, p. 43, 44).

The organization of many of the current unit-based orientation programs provides evidence of inadequate socialization. In fact many wards rely on pre-determined *checklists* whereby the preceptor checks off when a task has been completed. Needless tc say, most orientations lack any form of a needs assessment. The use of checklists is an ineffective way of transferring information to an adult learner. Gurvis, Mitzi and Grey (1995) support this assertion about the uselessness of checklists. They write,

> Checklists are often used as tools for competence assessment. Many times, these checklists are simply a list of the content of orientation and do not provide the orientee with clear expectations of performance. (p. 247)

Checklists and other current approaches to education are what Paulo Freire (McLaren & Leonard, 1993) refers to as the "banking approach to learning." Freire's banking concept of traditional learning is exemplary of some of our orientation practices whereby the preceptor speaks and the orientee listens. Freire uses this term to point out that the banking approach to teaching or training negates the development of critical consciousness necessary to change and development. Freire (1970) writes, "Education thus becomes an act of depositing, in which the students are the depositories and the teacher the depositor" (p.58).

Freire further explains that in the banking approach to learning, the teacher issues "communiqués" and makes deposits rather than communicate with the students. The student patiently then receives, memorizes and repeats what the teacher has said. According to Freire (1970), "In the banking concept of education, knowledge is a gift bestowed by those who consider themselves knowledgeable upon those whom they consider to know nothing" (p. 60).

Another important aspect of this process is the socialization that the new nurse undergoes even before reaching the hospital. Nursing schools, like many other schools, teach a formal curriculum, but a hidden curriculum also exists. A hidden curriculum refers to, "the tacit teaching of norms, values, and dispositions that occurs through students social experiences in routine school activities" (Barakett & Cleghorn, 2000, p. 101). The outcome of this process is that the

individual acquires a way of thinking, behaving, seeing, and believing. In other words, a good nursing student is able to uncover what is the desired knowledge that they must possess. The question is; does this desired knowledge translate into what is needed to practice as a nurse? I personally believe that it does not. There is a dichotomy between what the nursing schools espouse as important knowledge and what the acute care centers espouse.

Caldwell (1997) reiterates the concern related to the hidden curriculum in nursing schools. She raises the point in the nursing literature that there are sociological influences on the nursing curriculum which then affect the orientation process. Caldwell suggests that nursing curriculum is influenced by prevailing societal ideologies and is not student-nurse centered. She suggests that society; students and educators recognize the ideological underpinnings of the dominant culture that nursing schools reinforce. Stated another way, nursing schools transmit the values and attitudes of the dominant group which has traditionally been white men. This issue will be elaborated on in chapter five- generating change.

In sum, the preceding section has outlined the strengths and limitations of the current orientation program at the Montreal Children's Hospital. The following chapter examines the literature on this topic.

Chapter 3
Literature Review

The following section provides a synopsis of the literature on nursing orientation. Particularly, the literature that addresses the nurse's role transition, the use of clinical standards and the quality improvement initiatives as they relate to nursing orientation will be further explained. Recent literature on competency-based education, preceptorship, nurse internship, as well as the use of critical pathways and computer-assisted learning will be explored. Because of my interest in the successful implementation of orientation programs, the emphasis will be placed on the literature that supports the evaluation of these programs.

Literature related to role transition and nursing orientation

Godinez (1999) outlined the steps towards role transition in the graduate nurse. A preceptorship model was used whereby new nurses were assigned to a more experienced nurses. During the three-week orientation period, the new nurse and his/her preceptor filled daily feedback sheets. Content analysis was used to analyze the data. Five major themes emerged including; Real Nurse Work, Guidance, Transitional Processes, Institutional Context, and Interpersonal Dynamics. Their analysis supports the notion that the transition from a graduating nurse to a competent staff nurse is a dynamic process guided by the interaction between the preceptor and the oreintee.

One criticism of this study is the manner with which the data were obtained. The data were obtained from 27 graduate nurses who filled in feedback sheets designed to facilitate communication between the preceptor and the graduate nurse. These feedback sheets contained information on the type of patient that the new nurse cared for, the actual or learned experiences, as well as the goals for the day. On the surface the feedback sheets appear to have provided a useful tool. However, these sheets were reviewed on a daily basis by the unit manager and were not anonymous. Therefore, a truthful depiction of what the new nurse was feeling cannot be assured.

Heizenroth (1996) recognized the importance of role transition and described key components in any orientation program. These components were the learner, the orientation process and the learning outcomes of the new employee. The author argues that the learner comes to the orientation with unique characteristics. These characteristics include their proficiency level, their style of learning, and their expectations of the position.

According to Heizenroth, the neophyte's proficiency level refers to their ability to fulfill the responsibilities of the position to which they are being oriented. Their style of learning is characterized by whether they are right or left brain thinkers and whether they can think abstractly. And their expectations are linked

to retention. The article stresses the importance of standards, written in the form of goals, which facilitate the definition of practice boundaries.

Strzelecki and Brobst (1997) profiled the role transition of a regular duty nurse to an acute care case manager. Acute Care Case Managers not only have the responsibility for ensuring that the patient's hospital stay is streamlined within a third party payor, they also coordinate all aspects of the nursing care for the patients they are assigned.

These authors used Benner's conceptualization for nurses' skill acquisition, described in the introduction, in the development of an orientation program for acute care case managers. Benner's adaptation, with its five level of proficiency of novice to expert, was helpful in designing their orientation program because it allowed for performance standards to be determined within the five levels.

Literature related to the use of clinical standards and quality improvement initiatives and nursing orientation

Two articles used clinical standards within the quality improvement model in an effort to enhance nursing orientation. Kuehn and Jackson (1977) introduced the use of nursing standards as a tool to help nurse managers evaluate nurses during their orientation. The authors criticize traditional approaches because of their focus on skill demonstration and checklists. Rather, these authors advocate methods that concentrate on patient outcomes.

Kuehn and Jackson (1977) suggest the use of standards linking them to the institution's defined policies and protocols as a means of determining the competency of the new employee. The authors explain that orientation programs co-exist with positive patient outcomes. They call this process a quality improvement initiative. Kuehn and Jackson refer to orientation as a set of building blocks. These building blocks include the patient, the process (orientation), and the performer (new nurse).

Lawton and Ernesti (1998) linked the quality improvement component to the orientation of new nurses within a shared governance framework. This shared governance model, commonly known as accountability-based professional practice, structures an orientation that mirrors the institution's mission and values. The authors illustrate the flexibility of their tool by providing us with an example of a new nurse who was having competency problems. Their use of a learning contract along with regular meetings to reinforce expectations contributed to the timely dismissal of this nurse. They propose that any quality improvement initiatives, including orientation programs, must have pre-determined timetable guidelines that go part and parcel with the goals and objectives.

The aforementioned articles describing the use of standards and other quality improvement tools provide a structure that is all too often restrictive in my opinion. The use of timetables and other quality improvement paraphernalia has

standardized orientation to the point of dictating when and what should be learned. This approach is in stark opposition to adult learning principles.

Literature related to competency-based education and nursing orientation

Many authors have revamped their orientation programs by introducing competency-based education (Britton, Raper, Walden, 1995; Hodges & Hansen, 1999; Stabb, Granneman, Page-Reahr, 1996; McGregor, 1990). Other authors have described the supportive roles of the clinical educator and the clinical nurse specialist in developing this type of orientation (del Bueno, Griffin, Burke, & Foley, 1990; Chaisson, 1995).

Del Bueno, Baker, and Christomyer (1980) were among the first to use competency-based education to guide them in the implementation of their general nursing orientation. Del Bueno and colleagues described competency in terms of six characteristics which included; an emphasis on outcome, the use of self-directed learning, flexibility in timetables, the use of a teacher, the assessment of previous knowledge, and the assessment of learning styles.

Alspach (1984) built upon del Bueno's characteristics and added that competency-based programs must have a curriculum grounded in the real world; it must be directed to a specific role; be derived from expert practitioners; be founded on competency statements; include expectations of the learner; have an

evaluation method and have the provision to be recycled. Alspach used this approach in critical care nursing orientation.

Bryant (1997) and Schramm (1995) used Competency-Based Practice (CBP) as a framework for orienting new nurses. Both authors stress the importance of defining what is expected of the new nurse as pivotal in competency-based programs. These programs typically use action statements to describe what is required of the learner. The action statements used in Competency-Based Orientation Programs are particular to the clinical area, nonetheless these authors point out that they must also state clearly the knowledge and skills required by the learner to fulfill their new role.

Literature related to preceptorship and nursing orientation

The concept and usefulness of a preceptorship model in nursing orientation first appeared in the literature in 1975 (Bellinger & McCloskey, 1992). Since then, numerous authors have described the implementation of preceptorship orientation programs (Gillis & Moran, 1989; Patton, Grace, & Rocca, 1981). Anectodal accounts of the positive impact of preceptorship programs abound in the literature.

Research studies dealing with the effectiveness of preceptor orientation programs have shown mixed results. Two studies demonstrated no significant difference in the clinical performance of students who had preceptors and those

who did not (Olson, Gresley, & Heater, 1984: Myrick, 1988), whereas other studies have demonstrated the effectiveness of preceptorship. Three studies evaluating the impact of a preceptorship orientation program are provided.

One of these studies is by Brasler (1993), who attempted to determine what variables in nursing orientation programs, were related to new nursing graduate's clinical performance. Brasler collected data using the graduate's self-assessment of her or his clinical performance and an evaluation of how well they felt their preceptor had fulfilled their role. Six different preceptor orientation programs in six different Metropolitan hospitals were compared. The author found that the most useful predictors of clinical performance were the emotional support provided by the new graduate's friends and their preceptor. However, two major flaws in this study were that it compared orientation programs that varied in duration and that the research design did not have a comparison group making interpretation of the results difficult.

Another study by Asselin and Barber (1991) incorporated a collaborative model into their preceptorship program whereby orientees and their preceptors were asked to provide feedback on the orientation program. There was a 61.9% and 59.4% response rate from the orientees and preceptors respectively. Their findings showed the respondents' satisfaction with the program. One major limitation is that they did not address the validity of the data collection tool.

Bellinger and McCloskey (1992) conducted an extensive study in an effort to evaluate their preceptorship program. Their purpose was to determine whether the preceptorship program enhanced the nurses' satisfaction, social integration, and sense of professionalism, while at the same time improved performance, and retention. The subjects were newly employed nurses, 177 who were assigned to preceptors, and 98 who were not. Data was collected at three time intervals. Their findings supported the use of preceptors as an effective modality in orientation.

Literature related to the use of nurse internship in nursing orientation

Aldrich (1988) described a study aimed at determining whether a nursing internship had an effect on the graduate nurse's role conception. According to Aldrich, nurse internship is a specialized nursing orientation program designed to prepare the newly employed nurse. The author sought to evaluate whether the nurse internship program would provide better outcomes than the traditional orientation program. Using Corwin's Role Conception Tool, two different groups of nurses were compared at the beginning and at the end of their six-month orientation programs. Twenty-two nurses who underwent the traditional nursing orientation program, called the control group, were compared to thirty-two nurses who underwent a newly redesigned nursing orientation program, called the experimental group. Results from this study demonstrated no statistical significance between the two groups of nurses (Aldrich, 1988). Of interest is that

qualitative data were collected at the end of the orientation period from ten respondents randomly selected from either the control or the experimental group. One major criticism of this study is its reliance on the Corwin Role Conception Tool, which measures commitment to the hospital, nursing profession, and the patient, as a determinant of satisfaction with an orientation program.

McKane and Schumacher (1997) provided an account of their critical care nurse internship program. Their program is the result of the merging of two different orientation programs that had traditionally existed, one for the novice and another for the more experienced nurse moving to critical care. McKane and Schumacher's program incorporated didactic classroom, a skills lab, computer-assisted learning, and preceptor instruction. Although they add that an evaluation and a request for feedback were given to the new nurses midpoint and at the end of their orientation, they do not report these findings.

Literature related to the use of critical pathways in nursing orientation

The use of critical pathways for nursing orientation has dominated the literature on nursing orientation in the last few years (Evers et al. 1994, Goodman, 1997, Francis & Batsie, 1998). Evers, Odom, Latulip, Gardner, and Paul (1994) where first to propose the use of critical pathways for orientation. Goodman (1997) used the critical pathway based on the case management model as a means of streamlining the orientation process. Goodman writes,

> The primary goals of this approach are to provide a consistent structure for orientation, streamlining the orientation, and enhance the development of the person being orientated to competent levels of nursing practice. (p. 205)

Goodman described that critical pathways outline for the neophyte nurse the sequence of events delineating activities and timelines. She uses Benner's (1984) model of Skill acquisition, Merriam and Cafarella's (1991) definition of social learning, and the adult learning principles defined by Knox (1980) and Knowles (1980) to guide her model.

Francis and Batsie (1998) introduce the evaluative advantages to critical pathways enabling the quick identification of nurses who are not functioning well. The evaluative advantage of these pathways is their ability to show when a discrepancy exists between the expectations of the new nurse and what they are able to accomplish.

Despite the popularity of critical pathways in the mid-nineties, recently fewer and fewer articles are being published on their usefulness. The stringent adherence of critical pathways to a timetable along with their inability to individualize has all but rendered them useless in orientation.

Literature related to the use of computer-assisted learning in nursing orientation

A search using the databases CINAHL and Medline reveals very little written on this topic in the last eighteen years. Much of the information relates to computer-assisted learning in nursing schools (Cobb, 1999; Holtzman, 1999; Ryan et al., 1999). No article was found that linked hospital-based nursing orientation, outside of the intensive-care unit, with any form of computer-assisted learning.

Literature related to the evaluation and research-based approaches in nursing orientation

There is a scarcity of literature using a research-based approach. Early studies by Kramer (1974), who was introduced in the previous section, emphasized the importance of organizational socialization of new nurses as an important element in retention. Kramer identified the concept of biculturalism, defined as the bridging of school and the work environment as a way of minimizing reality shock experienced by new nurses. As a result of this literature other authors have introduced the use of preceptors and internships in an effort to ease the transition of the new nurse to the work place (Fristsch-deBruyn, 1990).

Connelly and Hoffart (1998) outlined a research-based model to nursing orientation. The research-based model was derived from a naturalistic study of nursing orientation. The model incorporated the organizational aspects of

orientation, highlighting the characteristics of the learner, speaking to the importance of welcoming the new employee, and addressing the importance of assessing the clinical competencies of the new nurse.

Balcain et al. (1997) developed an "expectation framework" based on feedback from attendants at a preceptor-training workshop. The four themes of this expectation framework included: the benefits of the program, preceptor workload, preceptor schedule, and preceptor development. Action research was the theoretical framework used to guide the process because it provided a systematic way of addressing orientation problems according to the authors. Balcain's study seems to have solved some of the inherent problems with the way in which the preceptorship program was being carried out. However, one major drawback of this research study is the reported response rate. The clinical nurse educators reported a respectable 69% response rate, but failed to state the number of respondents. Without this knowledge it is difficult to make a decision about the meaningfulness of this response rate.

Straub, Mishic, and Mion (1997) evaluated the effectiveness of a Performance Based Development System (PBDS) used for their nursing orientation. Specifically, the purpose of this study was to explore the degree to which the Performance-Based Development System (PBDS) was tailored to meet the needs of the orientees. The Performance Based Development System is an orientation tool which uses a series of activities to assess the new nurse's

critical thinking, communication skills, and technical skills. Other writers have also had success with Performance-Based Development Systems especially with part time employees who require flexibility in their orientation (Anthony & del Bueno, 1993). Through this evaluation process, the authors in this study uncovered many problems in their approach. Some of the problems included the lack of uniformity in the interpretation of the PBDS results, and the lack of consistency in the communication of the results. Moreover, the authors found that the tools were rarely consistently completed because the user's (preceptors) doubted their usefulness.

The current trend in nursing orientation in the literature is a competence-based educational approach. Yet no research or evaluation of this approach was found to show its effectiveness. The importance of preceptors was also raised throughout the literature. The next section will summarize the data obtained from three recently oriented nurses and their preceptors using a pre-tested questionnaire at the Montreal Children's Hospital. This section will juxtapose chapter two-which was my assessment of our orientation program- with the review of the literature, in an effort to generate suggestions for improvements.

Chapter 4
Summary of Survey Findings

John Dewey (1933) was the first to draw our attention to the importance of including the learner's perspective when planning any instructional design. Today it is widely accepted to solicit information from the users of a program when updating or changing it. This chapter summarizes information obtained from interviews about the current orientation program. It has been conducted with nurses working on a surgical unit at the Montreal Children's Hospital,

The interviews were carried out with three recently oriented nurses and their three preceptors. A copy of the current orientation checklist (that they were supposed to have received) and a summary of their first week's orientation activities (facilitated by the educator and/or the Team Leader) are included in the appendix for reference.

The information presented in this chapter was gathered using a pre-tested questionnaire. The questionnaire was used as a guide while I conducted the interview. The questionnaire included three demographic questions, eighteen closed questions that were scaled and ranked, and six open ended questions. In as much as the new nurses were asked all of the questions, the preceptors were asked only the questions related to improving the current program.

Individual meetings were planned first with the new nurse and then with their preceptor. I recorded the information by note taking on the questionnaire during the interview. This method permitted me to probe deeper into the respondents' answer and/or clarify the question for the nurses.

Demographic Information

In terms of the demographic information, all three novice nurses had less than 6 months working experience at the time of the interview. The preceptors ranged in experience from three to twenty years. There was a mixture of educational preparation among all the respondents. Two out of three new nurses were university prepared, and one out of three preceptors had a university education. Only one of the preceptors had a clinical rotation as a student nurse at the Montreal Children's Hospital. All agreed to participate once the ethical guidelines were explained.

All of the respondents were employed on the same 28-bed pediatric surgical unit. None of the new nurses had worked as a nurse anywhere else before coming to the Montreal Children's Hospital. In other words, they had never before been oriented to a hospital ward as a registered nurse.

All of the nurses expressed that they learn best "by doing." The hands on or the experiential type of learning was mentioned by all as the most optimal way

they acquire information. In fact the new nurses expressed a strong need to acquire technical skills early in their orientation. One of these new nurses shared, "The need to practice your skills is really important because we don't get enough practice in nursing school."

All three of the new nurses appreciated the one-to-one learning that took place during their orientation with their preceptor. They revealed that their relationship with their preceptor was a rewarding one and that they continued to go to them for help long after the orientation period was completed.

Feedback from the New Nurses about their Orientation

The new nurses responded favorably to the first set of ranked questions related to the current program. All felt that the current program met, and in one case surpassed, their expectations. They stated that they felt welcomed. In fact one of the new nurses volunteered that she had opted to come to the Montreal Children's Hospital after being told by someone at another pediatric hospital that she would not flourish as a nurse and would "hate" nursing.

They voiced that they the program had a logical sequence with an appropriate patient assignment. However, one of the major shortcomings related to the lack of evaluations on their progress. The need for evaluations in the orientation is one of four weaknesses identified by the all of the respondents.

Feedback from the New Nurses and their Preceptor about the Orientation Program

The four major deficiencies that were given by the nurses include the lack of a structure to the orientation program, expectations are not made explicit, there is an informal but not a consistent formal evaluation process, and there is little training for the trainers. All of these themes will be examined in detail.

The Lack of a Structure to the Program

All of the preceptors stated that the program lacked structure. They stated that they felt they needed some guidance as to what their responsibilities were. All of them mentioned that some sort of booklet or handbook explaining what they should be doing with the new nurses would be appreciated. Interestingly the new nurses did not voice that the program lacked structure. Instead they said that they appreciated the first week of getting to know the ward, and felt their preceptors were well organized and prepared.

The preceptors also mentioned the need to guide the new nurse's learning more. One of their suggestions was to participate in the assignment of patients, which has been traditionally the responsibility of the team leader. That is, the preceptors would like to have a say in their own assignment, which patients they have on a day to day basis, and in doing so could show the new nurse the care related to the selected patient. All of the preceptors felt that this would lessen the

fragmentation that occurs when they send the new nurse to be with another nurse because she has a patient with a new disease entity. According to the preceptors, participating in patient selection would facilitate maximizing the new nurse's experience.

Expectations are not made Explicit

The need to make expectations explicit was stated as a need mostly by the preceptors. They voiced that there was ambiguity not only about the expectations of the orientee but also about themselves. One asked, "Am I expected to evaluate this new nurse?"

There was a sense from the preceptors of "where to start" when orienting the new nurses. One preceptor did not know what the new nurse had already been exposed to in the first week on the ward. The checklist developed for the orientation seemed to help. Nevertheless, it was considered lengthy and was inconsistently used. One preceptor said that she was unable to get a copy of the checklist because it was unavailable and the individual who had it saved on her computer had left on vacation. Stress related to the lack of explicit expectations was mentioned by all as being characteristic of the orientation process.

Additional, the lack of explicit expectations was raised as an issue when the usual preceptor was not available. One of the preceptors interviewed spoke about having to replace another preceptor and how difficult it was because she did not know what the new nurse had already been exposed to. She said,

"Replacing another preceptor is difficult when the expectations are not clear, you ask what am I supposed to do with her today?"

One preceptor nurse spoke about the relationship that forms between the preceptor and the preceptee and her sense of responsibility towards him or her. She discussed this issue as it relates to the lack of explicit expectations. She said, " Preceptors have a protective outlook...after 8 months I still felt responsible for her actions." Her ongoing sense of responsibility long after the orientation process has been completed illuminates the lack of explicit expectations for the preceptors in orientation.

.

The new nurses did not mention with great frequency that expectations were not explicit. Instead they stated that having a fixed but flexible guide to their orientation was an important aspect. All of them mentioned the importance of the preceptor-orientee relationship as another indicator of their success. They also greatly appreciated having the option, offered by the nursing leadership, of extending their orientation if they needed to. They felt that this option alleviated much of their concerns and met their individual learning needs.

All of the neophytes liked the first week of introductions. They particularly enjoyed the visit to the operating room and the concentration on the technical skills such as venipuncture. One of these neophytes felt that there should be more emphasis on acquiring practical skills during this first week. She felt that

there was too much emphasis on theory in the first week and was anxious to "get on" with the practical aspect. However, when asked specifically what sections of the first week could be omitted she was unable to commit to any one section. She then stated that perhaps it would be better to include more practicums. For example, practice administering medications after the section on the guidelines for medication administration.

The Lack of Formal Evaluations

The lack of explicit expectations lends itself to the next major issue in the orientation program. It is difficult to evaluate when expectations are not straightforward. All of the respondents felt that a formal evaluation should take place at regular intervals during the orientation period. All three new nurses stated that they had received regular informal evaluations from their preceptors but felt that they should have had a formal one. All of the respondents felt that these formal evaluations should be with either the head nurse or team leader with a written summary given to them at the end of their orientation. Interestingly, the new nurses did not consider the ongoing evaluations provided to them by their preceptors to be formal "enough" and that they needed to hear from the nursing leadership about their performance. None of the respondents had thought of using a self-evaluation as a tool for evaluations.

Most recommended that the formal evaluations should take place after one week and then again at the end of the orientation period. One nurse stated that after three months she asked if her employment was confirmed. She was confused as to whether she had been hired because she had not received her evaluation and thought that hiring was dependent on this evaluation.

Another new nurse related her expectation for a formal evaluation to how often evaluations are done in nursing school. She said that, in school, students receive regular and consistent orientation. She felt that going from a school environment, with regular evaluations, to a hospital-based program, with less frequent evaluations was difficult and unfamiliar for her. The new graduates felt that regular validation was critical to their success. Curiously, the preceptors also voiced their desire and need to be evaluated

The Lack of Training for the Trainers

Another theme among the preceptor respondents was their sense of being ill prepared to fulfill their role as preceptors. One of these preceptors stated, "I asked for regular feedback from the nurse I was orienting so that I could get a sense of how I was doing." Another preceptor said, " I felt I was chosen to be a preceptor because there was no one else available to do it." Probing further, I clarified with this nurse that it is the nursing leadership's obligation to provide a good orientation to a new nurse, and that the leadership would not have chosen

an incompetent nurse. This same nurse replied that she hadn't realized that at the time.

There were feelings of inadequacy related to the preceptor role especially when the preceptor had a previous negative experience. One preceptor said, "The only other person I have oriented didn't stay." Another preceptor spoke negatively about the experience at the beginning of the interview but said she felt she had been effective. After some discussion, she later said that she had found the experience rewarding and would be a preceptor again.

The preceptor's feelings of being ill prepared and at times inadequate are coupled with a lack of time to prepare themselves as a preceptor. Responding to the ever-increasing needs in patient care, new nurses are interviewed and hired sometimes very quickly. One of the preceptors said she found out in the morning because of unusual circumstances that she was going to be the preceptor for a new nurse. The lack of training for the trainers was mentioned recurrently as a need.

Feedback from the New Nurses and their Preceptor how to improve the Orientation Program

Generally, all the respondents felt that the basic program was fair in their evaluation but needed some fine-tuning. They strongly advocated that their preceptor was in the best position to teach the material. They preferred a one-to -

one relationship, meaning one person should be assigned to the neophyte, however they felt that other nurses with distinct expertise could participate.

Alternative ways to teach some of the general orientation material were suggested by the interviewed nurses, such as the sections on medication administration and infection control. The respondents felt that these two topics could be taught other than direct person to person. Computer-assisted learning and the use of videos were the most common alternative modalities suggested. Both the preceptor and new nurses agreed that some of the interventions, covered in the first week, could also be taught using another modality. For example, some of the technical interventions such as traction application and the changing of dressings could be taught using a video, or an interactive CD. All agreed that short tests should be used after any teaching not only to confirm the neophyte's knowledge but again to validate that the preceptor is teaching what ought to be taught.

The respondents also commented on the problems in the fluctuations of patients available on the unit as problematic during the orientation period. One new nurse stated that the first two weeks of her orientation to the unit were very quiet, while another said that the unit was so busy during the first week of her orientation that her preceptor was not able to spend a lot of time with her. One of the preceptors described the potential inability to "spend the time to teach the new nurses properly" as her major source of stress.

To conclude, there are four major themes for improvements to the current orientation program according to the interviewed new nurses and their preceptors. They are the need for a structure, the need to make expectations explicit, the need for a formal evaluation at regular intervals, and the need for preceptor training.

Having identified the existing orientation program and pointed to its problems, the next chapter will narrow the gap between the existing program and outline the ideal orientation program.

Chapter 5
Generating Change

The preceding chapters have attempted to build a case for the proposed changes to the current unit-based nursing orientation program at the Montreal Children's Hospital. This chapter will incorporate the accumulated information from the previous chapters and make recommendations to upgrade the current program. For the purposes of this chapter, the term "adult educator" will be used interchangeably with the term preceptor.

The intent is to work towards developing a conceptual model or structure for the design of the nursing orientation at the Montreal Children's Hospital. This model will provide a framework for the recommendations that arise from the literature and the survey results. Particular emphasis is placed on the importance for carrying out a needs assessment when designing instructional programs such as orientation, and on clearly defining the objectives or in this case the competencies required to nursing practice. Moreover, emphasis is placed on encouraging the evaluation of the preceptor, the new nurse, and the orientation program itself. Finally, the necessity for training the trainers including the need to involve them in the program's development is emphasized.

Boone's Framework for Designing Adult Education Programs

Edgar J. Boone (1985) describes a framework for designing adult education initiatives that provides a structure when developing or updating programs such as nursing orientation. The importance of incorporating a framework into the current orientation program was illuminated in the survey as a major shortcoming. Boone's conceptual model includes three major subprocesses: planning, design and implementation, evaluation and accountability. Boone writes that one of the objectives of his model is to provide, "A logical and rationale framework for directing and giving meaning to the efforts of adult educators in effecting educational programs designed to alter learner behavior" (p.41).

Many authors have defined adult education. One notable (Knowles, 1980) author offers the following definition, "Adult education describes a set of organized activities carried on by a wide variety of institutions for the accomplishment of specific educational objectives" (p.25). Knowles outlines four crucial assumptions about the characteristics of the adult learner that need to be considered in any adult educational program design. These four assumptions are that: (1) the adult learner's self concept is geared towards being self-directed; (2) the adult learner has a repertoire of experiences; (3) the adult learner has a readiness for learning; and (4) the adult learner has an orientation towards the immediacy in the application of new knowledge.

Planning Stage– An analysis of the organization

Planning is the first step in Boone's conceptual model. Planning is defined as an intentional, rationale, and evolving process of precise educational activities by adult educators operating from an organizational base. Boone asserts that there are two essential steps in the planning phase. They are an analysis of the organization's commitment for renewal, such as the nursing department of the Montreal Children's Hospital, and an analysis of the needs of the learners. Each of these two essential steps will be outlined as they relate to nursing orientation.

A significant number of adult education theorists espouse the dominant role that an organization plays in the shaping of education initiatives such as a nursing orientation program (Knox & Associates, 1980). Any changes therefore must be in line with the mission and philosophy of the organization (Boone, 1985). Boone posits,

> Adult educators need to examine, understand, and accept the functions, structure, and processes of the adult education organization through which their planned programs are generated and conducted. They must be thoroughly knowledgeable of and committed to the mission and philosophy of the organization, which provide a general framework for the behavior of its members; the objectives of the organization, which delineate the ends to be accomplished by the organization; organizational roles, which specify the required responsibilities of individual adult educators... in attaining maximal program impact. (p.83)

Based on Boone's model, the first recommendation that I would make to change or update the current nursing orientation program at the Montreal Children's Hospital would be to ensure that the program itself, and all other recommendations that follow, be in line with the current philosophy, mission, and overall organizational objectives of the nursing department.

Planning Stage- An assessment of the learning needs

The second step in the planning phase is an analysis of the needs of the learners. By establishing the needs of the learners, expectations for both the preceptor and the new nurse become more explicit. Making expectations for the neophyte and the preceptor more explicit was identified as a flaw in the current orientation program. A needs assessment is, "the systematic effort that we make to gather opinions and ideas from a variety of sources on performance problems or new systems and technologies" (Rossett, 1987, p.62).

According to Knowles (1990) there are three sources of data when identifying learning needs. They are the individual, the organization, and the society. Rossett (1987) notes that another important source of information are the "stakeholders" (p.63). They include supervisors, managers, incumbents, and members of the community. Data in a needs assessment can be gathered through interviews, surveys, or small group discussions. I have only begun to expose some of this data in previous chapters.

Determining what the needs of the learners are is a critical step in designing adult education programs such as nursing orientation. This statement is supported by many adult learning theorists who advocate starting with the learner's current interests in an effort to engage them early so that the program has meaning to them.

Houle (1972) states that the learner's interests are the focus of planning in adult education initiatives. Kidd (1973) advocates starting with the learner's current interests in an effort to engage them. And Szczypkowski (1980) supports that the assessment of the learner's needs is one of the generic processes in any program or instructional design. Knowles (1990) contends,

> To the cognitive, humanistic, and adult education (andragogical) theorists the individual's own perception of what he wants to become, what he wants to be able to achieve, at what level he wants to perform, is the starting point in building a model of competencies. (p.126)

Having established the importance of a learning needs assessment as the starting point to establishing a model for learning in orientation, the next question is what is a learning need?

A learning need is a gap between the competencies required and the learner's present level of functioning. More simply, the definition of a learning need, is a discrepancy between what is and what ought to be (Boone, 1985).

One of the critical elements in adult learning is that the learner's own perception of this gap between where they are now and where they want or need to be is a powerful initiator. Based on this assertion, it follows that the learner's or orientee's own self-assessment is critical.

Learners occasionally require guidance when determining learning needs. Knowles (1990) explains, "It is not assumed that the learner necessarily starts out contributing his perceptions to the model; he may not know the requisite abilities of a new situation" (p.127). Still there is an awareness of the responsibility or self-directedness that the learner plays in their learning. Lawton (1998) upholds the notion of self-directedness in adults. She writes, "Continuing development isn't the institutions obligation, but the individual staff member's responsibility" (p.28).

The second recommendation that I will make to change or update the current nursing orientation is to carry out a regular needs assessment in an effort to assess whether the program is in line with what the neophytes, organization, and other stakeholders want.

Designing and Implementation Stage – Developing Objectives and Competency Statements

Boone's next stage in his conceptual model is designing and implementation of the orientation program. In this stage objectives and competencies are developed.

Objectives are the translation of learning needs into statements. Clear and realistic objectives help organize the learning activities (Knox, 1980). Objectives not only direct the process for the educator but also add clarity for the learner. Knox writes, "The main reason for setting objectives and selecting and organizing learning activities is to enable participants to increase their proficiency in ways suggested by the program objectives" (p.5). Ferguson (1998) contends, "The use of learning objectives focuses learner attention on what is important in the learning experience" (p.88).

There are multiple definitions for what an objective is. Gagne's (1965) definition of an objective is," a verbal statement that communicates reliably to any individual the set of circumstances that identifies a class of human performances" (p. 243). An objective is a statement that includes the participants involved, an action (or verb), the conditions in which these actions will be enacted, and the outcome (Ferguson, 1998). An example of an objective is, The nurse (participant) will demonstrate (action) with 100% accuracy (outcome) the calculation of medications (actions enacted).

Adult learning specialists prefer to use competencies, which are requisite abilities or qualities, rather than objectives which are manners of conducting oneself, behaving or performance (Knowles, 1990). The use of competency statements is a way to add clarity to what is expected of the new nurse. The need for clarity in what is expected was supported in the nursing orientation literature and by the nurses surveyed.

Competence may be defined as an integration of skills, knowledge, and attitudes that are required to performing a designated role (Gurvis & Grey, 1995). Competency statements encompass four components, a statement, the critical behavior, a learning option, and an evaluation method.

An example of a competency statement is the new nurse is able to manage a post-operative patient. Under this statement there would be a number of sub-categories listing all the elements required to manage a post-operative patient, such as the new nurse takes and interprets the patient's vital signs. A competency-based tool would also incorporate the new nurse's self-assessment, as well as suggestions for some learning activities, such as reviewing the prepared video explaining how to accept a post-operative patient. Competency-based tools include the method for evaluation. In this case the evaluation method would be that the preceptor observes the neophyte admitting a post-operative

patient. Competency statements are more involved than objective statements, and are more congruent with adult learning principles.

Competency-based nursing orientation programs were described with great frequency in the literature review. Competency-based orientation programs are primarily concerned with outcomes. That is they ensure that the neophyte can perform the activities that are required for them to fulfill their role.

The major advantage of competency-based nursing orientation programs is that they shift the focus from a process of instruction to a process of learning (Gurvis & Grey, 1995). Another advantage is that the preceptor is used as a facilitator and resource person. Since the new nurse is provided with learning options, varied ways of learning the required activities, they are able to tailor their learning.

My third recommendation then, is to develop a competency-based orientation program. Based on the literature and the feedback from the surveys, a competency-based nursing orientation program is warranted.

Designing and Implementation Stage- Incorporating Transformative/ Critical Reflectivity into the design

A recent thrust in the adult education literature, is that it is not enough for programs to identify the learning needs of individuals, but that these same programs should help adult learners to transform their way of thinking about themselves and their worlds. This new way of thinking about adult education programs is what Mezirow terms "perspective transformation" (Mezirow, 1995).

Mezirow (1995) states that the goals of adult education include helping the learners to be self-guided, self-reflective, and rational. Transformative learning is the process whereby new knowledge is acquired. It differs from the simple acquisition of knowledge that occurs in childhood. Transformative learning, rather, requires that the individual critically reflect on a situation.

Stephen Brookfield (1987) proposes that an individual's critical appraisal of alternative values and beliefs is essential in the learner-teacher transaction. He calls this process "critical reflectivity." Brookfield espouses that an individual's ability to think critically is important for advancing their sense of control and autonomy. Benner, Hooper-Kyriakidis, and Stannard (1999) refer to this learning process as thinking-in-action. *This recent thrust in the adult literature has generated my fourth recommendation. That is that to ensure that the current*

orientation program provides a means to ensure the ongoing development of new nurses beyond their orientation.

Designing and Implementation Stage-Incorporating the use of learning contracts

Another way to ensure that the expectations remain explicit is to use learning contracts. Learning contracts add clarity to the learning (Knowles, 1990). The use of learning contracts is an important educational tool that can help the preceptor and new nurse in making expectations clear. Learning contracts should be supported in nursing orientation. *My fifth recommendation then is to incorporate the use of learning contracts in the revision of our current orientation program.*

Designing and Implementation Stage- Benner's model of skill acquisition

Benner's model (1984) of nursing skill acquisition, previously introduced, provides a structure for how nurses progress through five distinct levels of expertise (novice, advanced beginner, competent, proficient and expert). Her model adds clarity to what is expected of the new nurse vis-à-vis their level of experience. This model is tremendously beneficial when constructing a learning framework conceptualizing the learner in terms of their clinical expertise. Benner's five levels should be considered when writing learning objectives or competencies. *The addition of Benner's model, particularly her five levels of skill acquisition, should be the cornerstone to our orientation program increasing our*

understanding of who the learner is. The use of Benner's model is my sixth recommendation.

Designing and Implementation Stage- Training for the Trainers

The lack of training for trainers was a recurrent theme in the responses from the nurses surveyed. Training for the preceptors should follow the steps delineated in Boone's (1985) conceptual design model previously outlined for the new nurses. There should be a planning stage incorporating the organization's philosophy and a thorough needs assessment. There should be a design and implementation stage where the objectives and competencies are determined. Finally, the evaluation and accountability phase should determine whether the preceptor-training program was effective or not.

This training ideally should include the teaching of adult learning principles including effective facilitation skills and characteristics of adults as learners (Knowles, 1990). The importance of helping the neophyte to become socialized into the new milieu should also be discussed. Benner's model for nursing skill acquisition and the importance of experiential learning should be emphasized. Finally these preceptors should participate in the development and ongoing updating of objectives or competency statements used in nursing orientation.

The trainers or preceptors also need to be active participants in the development and evaluation of any clinical program involving new nurses, such

as orientation. Others support this claim as well. For example, Tough (1979) has stated that individuals successful in the field (like nursing) are best suited to assess the learner's skills and knowledge and develop teaching processes to meet their needs.

Investment in the development of preceptors as effective trainers is vital. Herein lies another of my recommendations that a preceptorship program be developed and that these same preceptors participate in any ongoing changes to the orientation program. *The need for training for the trainers is my seventh recommendation.*

Designing and Implementation Stage- Preceptor Job Description

Upon reflecting on the results of the interview and particularly the preceptors' concerns related to the lack of explicit expectations, it became clear that there exists no preceptor job description. Hall (1980) explains that job titles, like preceptors, are not sufficient to clarify the expectations of individuals filing the position. Hall goes on to say that before steps are taken to fill a position such as a preceptor role, there should a description of the job and the specific competencies required to carry out the job.

Flippo (1979) defines a job description as "an organized, factual statement of the duties and responsibilities of a specific job" (p. 111). Job specification differs from job descriptions in that the former is a statement of the minimum

qualifications necessary. Job descriptions define what the preceptor is expected to do.

Therefore my eighth recommendations is that a comprehensive job description be developed for the preceptor role complete with duties, responsibilities, and accountabilities.

Designing and Implementation Stage- Incorporating Experiential learning through the Use of Narratives

One of the purposes of the questionnaire was to explore alternative means of transmitting information. Questions on the potential uses of computer-assisted learning were asked. Little or no information was obtained however. Even the literature review revealed little written on the use of computers in nursing orientation. Rather a plethora of data was collected about the importance of experiential learning witnessed through the eyes of the new nurses.

Although the respondents did echo the importance of experiential learning, all of them commented that this learning was influenced by the type of patients hospitalized on the unit at the time of their orientation. For example, the new nurses would not have the experience of caring for a patient with an appendectomy (an emergency and unplanned surgical intervention) if no patient was hospitalized with this condition at the time of their orientation.

It is because of the fluctuation in patients that the use of narratives becomes an important component in experiential learning. Experiential learning involving the use of narratives encourages the harmonization of what needs to be learned or taught. Experiential learning narratives are an important learning tool and are not used to their full potential in nursing orientation. Benner, Hooper-Kyriakidis and Stannard (1999) have written about the importance of experiential learning in nursing,

> Experiential learning always requires engagement in the situation and involves a turning around of preconceptions, recognition of patterns or sensing something disquieting or puzzling that generates a problem search (Benner, 1999). The process of experiential learning generates a narrative memory of the related clinical and ethical issues and one's emotional sense of the situation that is significant and therefore remembered." Narrative memory help the developing nurses to learn which can affect future situations. (p.9)

My ninth recommendation is that we collect and preserve nursing stories that will help neophytes learn and that we continue to explore alternative ways of learning such as computer-assisted learning.

Evaluation and Accountability Stage

Boone (1985) describes evaluation and accountability as the last steps in his conceptual model. Other theorists agree that the lack of formal and consistent evaluations appear to be an ongoing issue in staff development initiatives. Del Bueno, Griffin, Burke, and Foley (1990) write,

> Although validation of performance ability and assessment of learning needs are important, the ultimate outcome, i.e. continuous, consistent, effective practice, can only be achieved by subsequent clinical practice. Therefore the assessment-validation learning and clinical application is critical and essential. (p. 136)

Despite much of the emphasis being placed on the evaluation of the individuals, Boone's model as well as many other adult educators espouse that the educational program must also be evaluated. Knox (1980) highlights that the main purpose of program evaluation is the collection and analysis of the impact the program had on participant proficiency and performance. The results of this evaluation can assist program development. *The need for program and participant evaluation is the last of my recommendation.*

This chapter presented Boone's conceptual model for the design of adult education programs as a means of providing a structure to the orientation program at the Montreal Children's Hospital. The chapter also summarized ten recommendations for improving the current program based on the reviewed literature and the results of the surveys. These ten recommendations include; that the orientation program be in line with the organization's mission, philosophy, and overall objectives; that there be a thorough needs assessment carried out; that we adopt a competency-based orientation program; that learning contracts and Benner's model for skill acquisition be included; that training for the trainers following Boone' model be developed for the preceptors complete with a

job description and that an evaluation be completed for the neophyte, the preceptor, and for the program itself. The importance of promoting transformative learning, and incorporating experiential learning through the use of narratives were also suggested.

Conclusion and Summary of Recommendations

In this study I have explored nursing orientation practices at the Montreal Children's Hospital. I have collected and collated data from both the literature and through a small survey in order to support suggested changes to the program. I have tried to make the information transportable and have decided to concentrate and outline ten recommendations for improvement. These ten recommendations were as follows; one, that any changes to the current program be in line with the current philosophy, mission, and overall organizational objectives of the nursing department; two, that a regular needs assessment be carried out in an effort to assess whether the program is in line with what the neophytes, organization and what other stakeholders want; three, that a competency-based program be developed; four, that the orientation provides a means to ensure ongoing development of new nurses beyond their orientation; five, that the use of learning contracts be incorporated; six, that Benner's model of nursing skill acquisition be the cornerstone to our program helping to understand who the learner is; seven, that there is ongoing training for the trainers; eight, that a comprehensive job description be developed for the preceptor role complete with duties, responsibilities, and accountabilities; nine, that narratives be collected and used to facilitate learning and alternative modalities of learning, such as computer-assisted learning be explored and ten that there is ongoing program and participant evaluation.

There are indeed a great many suggestions that others could have suggested but these ten seemed to be the most important to me. There is a sense that I have just touched the tip of the iceberg. There is a feeling that more information could have been gathered, that more questions could have been asked and that more suggestions could have been made. I am guided, however, by the fact that this is the first time any evaluation of the nursing orientation program has ever been done and hopeful that it will be not be the last.

This has been my odyssey to explore orientation practices at the Montreal Children's Hospital. It has left me filled with an appreciation of the complexity of the problem and a new list of potential solutions.

References

Abruzzese, R., & Quinn-O'Neal, B. (1992). Orientation for general and special areas. In N.D. Como and L. Sparks (Eds.) *Nursing staff development* (p. 249-270). St. Louis: Mosby.

Asselin, M., & Barber, E.D. (1991). Unit orientation for experienced nurses: process and evaluation. *Journal of Nursing Staff Development, 7*(3), 126-129.

Aldrich, S.K. (1988). A neurosciences internship and graduate nurse role conception. *Journal of Neuroscience Nursing, 20* (6), 377-385.

Alspach, J. (1984). Designing a competency based orientation for critical care nurses, *Heart & Lung, 13* (6), 655-662.

Anthony, C.E., & del Bueno, D. (1993). A performance-based development system. *Nursing Management, 24* (6), 32-34.

Balcain, A., Lendrum, B.L., Bowler, P., Doucette, J., & Maskell, M., (1997). Action research applied to a preceptorship program. *Journal of Nursing Staff Development, 13* (4), 193-197.

Barakett, J., & Cleghorn, A. (2000). *Sociology of education: An introductory view from Canada*. Scarborough, Ontario: Prentice-Hall Canada Inc.

Bellinger, S.R., & McCloskey, J.C. (1992). Are preceptors for orientation of new nurses effective? *Journal of Professional Nursing, 8* (6), 321-327.

Benner, P., & Benner, R. (1979). *The new nurse's work entry: A troubled sponsorship*. New York: Tiresias.

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

Benner, P., Hooper-Kyriakidis, P., & Stannard, D. (1999). *Clinical wisdom and interventions in critical care: A thinking in action approach*. Philadelphia: W.B. Saunders Company.

Boone, E.J. (1985). *Developing programs in adult education*. Illinois: Waveland Press.

Brasler, M.E. (1993). Predictors of clinical performance of new graduate nurses participating in a preceptor orientation program. *The Journal of Continuing Education in Nursing, 24* (4), 158-165.

Britton, B.P., Raper, J.T., Walden, C.M. (1995). From development to evaluation: Making a competency plan work. *Journal of Nursing Staff Development, 11* (4), 210-214.

Brookfield, S. (1987). *Developing critical thinkers*. San Francisco: Jossey-Bass.

Brunner, J.S. (1961). *The process of education*. Cambridge, Mass: Harvard University Press.

Bryant, G.A. (1997). Suggestions for a competency-based orientation for an orthopedic unit. *Orthopedic Nursing, 16* (2), 67-75.

Caldwell, K. (1997). Ideological influences on curriculum development in nurse education. *Nurse Educator Today, 17* (2), 140-44.

Carpenito, L.J., & Duespohl, T.A. (1981). *A guide for effective clinical instruction*. Maryland: Aspen Publication.

Chaisson, S.F., (1995). Role of the CNS in developing a competency-based orientation program. *Clinical Nurse Specialist, 9* (1), 32-37.

Cobb, K.L., (1999). Interactive videodisc instruction with undergraduate nursing students using cooperative learning strategies. *Computers in Nursing, 17* (2), 89-96.

Coeling, H.V.E. (1990). Organizational culture: Helping new graduates adjust. *Nurse Educator, 15* (2), 26-30.

Connelly, L.M., & Hoffart, N. (1998). A research-based model of nursing orientation. *Journal of Nursing Staff Development, 14* (1), 31-39.

Craven, H.L., & Broyles, J.G. (1996). Professional development through preceptorship. *Journal of Nursing Staff Development, 12* (6), 294-299.

Cronbach, L.J. (1963). *Educational psychology. 2nd edition*. New York: Brace and World.

Darling, L.W. (1985). The mentoring dimension: What to do about toxic mentors. *The Journal of Nursing Administration, 15* (5), 43-4.

Del Bueno, D., Baker, F., & Christomyer, C. (1980). Implementing a competency based orientation program, *Nurse Educator, 11* (5), 16-20.

Del Bueno, D., Griffin, L.R., Burke, S.M., & Foley, M.A. (1990). The clinical teacher: A critical link in competence development. *Journal of Nursing Staff Development, 6* (3), 135-138.

Dewey, J. (1933). *How we think.* Boston: D.C. Heath.

Dunt, D.R., Temple-Smith, M.J., & Johnson, K.A. (1991). Nursing outside hospitals: The working experience of community nurses: Job characteristics. *International Journal of Nursing Studies, 28* (1), 27-37.

Evers, C., Odom, S., Latulip-Gardner, J., & Paul, S. (1994). Developing a critical pathway for orientation. *American Journal of Critical Care, 3*, 217-221.

Ferguson, L.M. (1998). Writing learning objectives. *Journal of Nursing Staff Development, 14* (2), 87-94.

Fillipo, E.B. (1979). *Principles of personnel management, 4th edition.* New York: McGraw-Hill.

Francis, R.J., & Batsie, C. (1998). Critical pathways: Not just for patients anymore. *Nursing Management, 29* (10), 46-48.

Freire, P. (1970). *Pedagogy of the oppressed.* New York: Continuum.

Fristsch-deBruyn, R.R. (1990). A process for determining content for a nurse internship program. *The Journal of Continuing Education in Nursing, 21* (3), 118-124.

Gagne, R.M. (1965). *The conditions of learning.* New York: Holt, Rinehart and Winston.

Gurvis, J.P., & Grey, M.T. (1995). The anatomy of a competence. *Journal of Nursing Staff Development, 11* (5), 247-252.

Gillis, P., & Moran, V. (1989). Preceptor program evaluation demonstrate improved orientation. *Journal of Nursing Staff Development, 5* (1), 17-24.

Godinez, G., Schweiger, J., Gruver, J., & Ryan, P. (1999). Role transition from graduate to staff nurse: A qualitative analysis. *Journal for Nurses in Staff Development, 15* (3), 97-110.

Goodman, D. (1997). Application of the critical pathway and integrated case teaching method to nursing orientation. *Journal of Continuing Education in Nursing, 28* (5), 205-210.

Growe, S.J. (1991). *Who cares: The crisis in Canadian nursing*. Toronto, Ontario: McClelland & Steward.

Hall, J.C. (1980). In Alan B. Knox and Associates', *Developing, administering, and evaluating adult education*. San Francisco: Jossey-Bass Publishers.

Hamilton, E.M., Murray, M.K., Lindholm, L.H., & Myers, R.E. (1989). Effects of mentoring on job satisfaction, leadership behaviors, and job retention of new graduate nurses. *Journal of Nursing Staff Development*, 5 (4), 159-165.

Heizenroth, P.A. (1996). Key components of perioperative orientation. *American Operating Registered Nurses Journal, 63* (1), 183-190.

Hodges, J., & Hansen, L. (1999). Restructuring a competency-based orientation for registered nurses. *Journal for Nurses in Staff Development, 15* (4), 152-158.

Holtzman, G. (1999). The development of a self-directed module for orientation of nursing students to multiple inpatient clinical sites. *Journal of Nursing Education, 38* (8), 380-382.

Houle, C. (1972). *The design of education*. San Francisco: Jossey-Bass Publishers.

Humphrey, C.J., & Milone-Nuzzo, P. (1992). Home care nursing orientation model: Justification and structure. *Home Health Care Nurse, 10* (3), 18-25.

Jervik, D.K., & Martinson, I.M. (1979). *Women in stress: A nursing perspective*. New York: Appleton-Century Crofts.

Kidd, R.J. (1973). *How adults learn*. New York: Association Press.

Knowles, M. (1980). *The modern practice of adult education: From pedagogy to andragogy*. New York: Cambridge Books.

Knowles, M. (1990). *The adult learner: A neglected species, 4th edition*. Houston: Gulf Publishing Company.

Knox, A. (1980). Proficiency theory of adult learning. *Contemporary Educational Psychology, 5*, 378-404.

Knox, A., & Associates. (1980). *Developing, administering, and evaluating adult education*. San Francisco: Jossey-Bass Publishers.

Kramer, M. (1974). *Reality shock: Why nurses leave nursing*. Saint Louis: Mosby.

Kramer, M. (1985). Why does reality shock continue? In J.C McCloskey & H.K. Grace (Eds.), *Current issues in nursing*. Boston, MA: Blackwell Scientific Publication.

Kuehn, L., & Jackson, K. (1977). Using nursing standards to evaluate competency. *Nursing Management, 28* (8), 32K-32P.

Lawton, S., & Ernesti, D. (1998). Are staffers headed in the right direction? *Nursing Management, 29* (7), 28-30.

Lo Biondo – Wood, G., & Haber, F. (1990). *Nursing research: Methods, critical appraisal and utilization*. Toronto: Mosby.

May, L. (1980). Clinical preceptors for new nurses. *American Journal of Nursing, 80*, 1824-1826.

McKane, C.L., & Schumacher, L. (1997). Professional advancement model for critical care orientation. *Journal of Nursing Staff Development, 13* (2), 88-92.

McGregor, R.J. (1990). A framework for developing staff competencies. *Journal of Nursing Staff Development, 6* (2), 79-83.

McLaren, P., & Leonard, P. (1993). (Eds.) *Paolo Freire: A critical encounter*. New York: Routledge.

Merriam, S.B., & Caffarella, R.S. (1991). *Learning in adulthood*. San Francisco: Jossey-Bass.

Mezirow, J. (1995). In J.L. Elias & S.B. Merriam's, *Philosophical foundations of adult education, 2ND edition*. Florida: Krieger Publishing Company.

Myrick, F. (1988). Preceptorship: A viable alternative clinical teaching strategy? *Journal of Advanced Nursing, 13*, 588-591.

Nightingale, F. (1969). *Notes on nursing: What it is and what it is not*. New York: Dover Publishing (First U.S edition 1860).

Olson, R.K., Gresley, R.S., & Heater, B.S. (1984). The effects of an undergraduate clinical internship on the self-concept and professional role mastery of baccalaureate nursing students. *Journal of Nursing Education, 23*, 105-108.

Patton, D., Grace, A., & Rocca, J. (1981). Implementation of the preceptor concepts: Adaptation to high stress climate. *The Journal of Continuing Education in Nursing, 12* (5), 27-30.

Polit, D.F., & Hungler, B.P. (1983). *Nursing research: principles and methods.* Philadelphia: Lippincott.

Ryan, M., Carlton, K.H., & Ali, N.S. (1999). Evaluation of traditional classroom teaching methods versus course delivery via the World Wide Web. *Journal of Nursing Education, 38* (6), 272-277.

Ryten, E. (1997). *Tableau statistique de la situation passée, présente et future des infirmières autorisées au Canada.* Ottawa: Association des Infirmières et Infirmiers du Canada.

Rogers, M. (1997). *Canadian nursing in the year 2000, five future scenarios.* Canadian Nurses Association: Ottawa.

Rossett, A. (1987). *Training needs assessment.* New Jersey: Educational Technology Publications.

Schramm, C.A., & Hoshowsky, V.M. (1995). Developing competency-based perioperative orientation programs. *American Operating Registered Nurses Journal, 62* (4), 579-590.

Scrima, D.A. (1987). Assessing staff competency. *Journal of Nursing Administration, 17* (2), 41-45.

Shamian, J., & Inhaber, R. (1985). The concept and practice of preceptorship in contemporary nursing: A review of pertinent literature. *International Journal of Nursing Studies, 22,* 79-88.

Stabb, S., Granneman, S., & Page-Reahr, T. (1996). Examining competency-based orientation implementation. *Journal of Nursing Staff Development, 12* (3), 139-143.

Straub, C.W., Mishic, B., & Mion, L.C. (1997). Focus: Evaluation of an orientation. *Journal of Nursing Staff Development, 13* (3), 163-169.

Strzelecki, S., & Brobst, R. (1997). The development of an acute care case manager orientation. *Journal of Nursing Staff Development, 13* (5), 266-271.

Szczypkowski, R. (1980). In Alan B. Knox and Associates' *Developing, administering, and evaluating adult education.* San Francisco: Jossey-Bass Publishers.

Tough, A. (1979). *The adult's learning projects*. Toronto: Ontario Institute for Studies in Education.

Weir, G.M (1932). *Survey of nursing education in Canada*. Toronto: The University of Toronto Press.

Appendix

Current Orientation Checklist and a Summary of the Usual First Week's Activities

7C1 NURSING ORIENTATION

Monday	Tuesday	Wednesday	Thursday	Friday
Introduction Orientation Plan Review of Objectives Tour of Unit/Hospital Lockers Allocation (Security)/ Human Resources (I.D) Union Visit Review of Roles: Head Nurse Team Leader Staff Nurse PCA Ward Cleric Consultant Treasure Hunt	▲ ▲ ▲ ▲ ▲ ▲ ▲ OR Experience ▼ ▼ ▼ ▼ ▼ ▼ ▼	07:00-08:00 Report 08:00-09:30 Documentation 09:30-10:00 Charlotte 10:00-10:30 Physio 10:30-11:30 Respiratory Therapy/ ER Cart 11:30-12:00 PCA activities 13:00-14:00 Infection Control 14:00-15:00 ACM	07:00-08:00 Report 08:00-09:00 Fluids/Intake &Output 09:00-09:30 Child Life 10:00-10:30 IV fluids & documentation 10:30-11:00 Pumps 11:00-12:00 Venipuncture 13:00-14:00 Caring for an Adolescent in Crisis 14:00- 15:00 Staff Meeting	07:00-08:00 Report 08:30-09:30 Medication Administration 10:00-11:00 Medication Administration/ Practicum 11:00-12:00 Pain Management 12:45-15:00 Computer Search Experience

7C1 ORIENTATION CHECKLIST

Knowledge/Skills Required	RESOURCES	OBJECTIVES	COMMENTS
Human resource visit	ROOM F-136		
Locker acquisition	SECURITY		
Treasure Hunt	7C1		
Tour of Hospital	HAND-OUT		
Emergency procedures			
• Codes (red, blue, pink, yellow	MUHC INTRANET		
MUHC web page			
White, black, brown, orange			
Grey and green)			
• Fire/evacuation procedures	MUHC INTRANET		
(extinguishers/red phone)			
• CPR			
(verify date of certification)			
• Review of nurse's response to	EMERGENCY CART		
Codes (white/ pink 1st nurse,			
Second nurse)			
• Resuscitation sheet	COMPUTER		
• Emergency buzzer	PATIENT ROOMS		
• 7C1 disaster plan	EMERGENCY MANUAL		
• Y2K Plans	DISASTER MANUAL		
• Evacuation equipment	CODE GREEN EQUIPMENT		

Knowledge/Skills Required	RESOURCES	OBJECTIVES	COMMENTS
Nursing Department			
Nursing department organization	NURSING DEPARTMENT ORIENTATION MANUAL		
MUHC nursing department			
MCH nursing objectives			
<u>Ward organization</u>			
• Patient focused care	COORDINATED CARE PHILOSOPHY		
• primary nursing			
• evidence-based practice			
• Alternative care module			
• Team leader role			
• PCA role			
• Unit coordinator			
• Satellite pharmacy			
• Consultant role			
<u>Position information</u>			
Schedule			
Requests			
Changing shifts			
Vacation posting, seniority			
Position requests			
Evaluation			
Union (FIIQ)	ROOM F-200		

Knowledge/Skills Required	RESOURCES	OBJECTIVES	COMMENTS
Documentation	ARTICLE		
Charting by exception	MANUAL		
Charting standards	MANUAL		
Documentation form;	SAMPLE CHART		
Pre-op package(checklist, OR record)			
Antibiotic form			
M.D's orders			
Initial sheet			
Tests/consultation			
Patient profile			
PRN sheet			
Nsg history			
Medication forms –standard and PRN			
Calculation record			
Requisition			
Computer	NURSING STATION COMPUTER		
Teddy-Bear menu			
PRN points			
Diet			
CSR ordering			
Lab results			
Discharge instructions			
Report			
Morning report			
Giving report			

Knowledge/Skills Required	RESOURCES	OBJECTIVES	COMMENTS
Caring for families with; <u>General surgical conditions</u> • Appendicitis/appendectomy Acute, gangrenous, perforated • Pyloric stenosis/pyloromyotomy • Hirschsprung's disease/pull-thru • Gastro-esophageal reflux disease/ Fundoplication • Malrotation/Ladds repair • Intussusception/barium enema • Imperforated anus/analplasty <u>Orthopedic surgical conditions</u> • SCFE (slipped capital femoral Epiphysis)/hip pinning • Scoliosis/anterior-posterior spinal fusions, halo traction • Fractured femur/traction application (skin, skeletal) • Supracondular fracture/pining or closed reduction • Tibial or fibular fractures/ illizarov, hoffman • Leg length discrepancy/epiphysiodesis	SURGICAL REFERENCE MANUAL CLINICAL GUIDELINES PEDSURG.COM ORTHOPEDIC REFERENCE MANUAL SCOLIOSIS CARE MAP, VIDEO, D/C TEACHING TRACTION MANUAL CAST APPLICATION PICTURE BOOK POSITIONING POST-OPERATIVE PIN SITE CARE ORTHOSEEK.COM		

Knowledge/Skills Required	RESOURCES	OBJECTIVES	COMMENTS
<u>Plastic surgery conditions</u> • Cleft lip • Cleft palate • Burns/ graft/flap <u>Urological conditions</u> • Ureteral relux/ reimplantation • Hypospadius • Posterior ureteral valves/pyeloplasty • Neurogenic bladder/augmentation ileocystoplasty <u>Psychiatric conditions</u> • Attempted suicide/assessing risk • Toxic ingestions • Sitter policy • 09:00 meetings with ACIT • Restrictions • Role of the ACIT	PLASTIC SURGERY REFERENCE MANUAL BURN MANUAL UROLOGY REFERENCE MANUAL SUICIDE POLICY		

Orientation Questionnaire

Background information

1. Please check highest educational achievement;

Diploma nursing _____
Baccalaureate _____
Master's level _____

2. Please indicated the number of months you have been working_____
3. Please indicate the number of years of practice_____

4. Please describe the type and experience you have had with other orientation programs (if applicable).

_____
_____
_____

5. Please indicate the way in which you learn best?

_____
_____
_____

Orientation Questions

Strongly agree (SA)
Agree (A)
Are not sure (?)
Disagree (D)
Strongly Disagree (SD)

Please CIRCLE the response that indicates the degree to which you agree with the following statements

1. The current orientation program met my needs as a new employee.	SA	A	?	D	SD
2. The objectives of the orientation program were communicated to me at the beginning of the program.	SA	A	?	D	SD
3. As a new employee, I felt "welcomed" by the rest of the staff.	SA	A	?	D	SD
4. The orientation program had a logical sequencing.	SA	A	?	D	SD
5. My patient assignment during my orientation program was appropriate.	SA	A	?	D	SD
6. I received regular evaluation of my progress.	SA	A	?	D	SD

Questions about how to improve the orientation program

Only one designated person should be responsible for orienting me.	SA	A	?	D	SD
Several team members, each with unique expertise, should take part in my orientation.	SA	A	?	D	SD
The person responsible for the orientation program should have specific training in the principles of adult learning, teaching techniques, and evaluation.	SA	A	?	D	SD
The amount of time allotted for orientation should be determined	SA	A	?	D	SD

according to the individual needs of the nurse being oriented.

The nurse being oriented should be evaluated during the orientation process.	SA	A	?	D	SD
The preceptor should be evaluated during the orientation process.	SA	A	?	D	SD
Self-evaluations should be encouraged throughout the orientation period.	SA	A	?	D	SD
The role of the nurse is an important issue and should be emphasized in the orientation program.	SA	A	?	D	SD
A comprehensive orientation package should be used complete with objectives to provide the new nurse with what will be expected of him/her.	SA	A	?	D	SD
Each preceptor should design his or her own orientation program.	SA	A	?	D	SD
The roles of the other professional members of the team should be emphasized in the orientation program.	SA	A	?	D	SD
I would like other learning modalities, such as videos, CD-Roms, and interactive computer-assisted learning methods used in the orientation program.	SA	A	?	D	SD

1. Please list some examples of the types of information that could be offered in different ways and indicate how you would like it to be taught.

Types of information		learning modality
Example: infection control	→	interactive CD-ROM

2. Please indicate how you would suggest the following material be taught? Some options include lectures, practice, observation, and reading.

Guidelines for medication administration_____
Providing a safe environment_____
Fluid and Electrolytes_____
Pain Management_____
Venipuncture_____
Family-centered care_____

3. Please indicate at what frequency you feel that evaluations should be carried out.

Every week____
Every other week___
Every month___

4. How do you feel evaluations should be offered? *By: (please check)*

A meeting with the head nurse, yourself and the preceptor_____
A meeting between yourself and the head nurse_____
A meeting between yourself and the preceptor_____
A meeting and a written summary with a copy given to you_____

5. Are there any other gaps in the nursing orientation program that you can comment on?

Ethics Protocol

1. Title of Research Project:
Nursing Orientation; An analysis of the Nursing Orientation Program at the Montreal Children's Hospital.

2. Sample of Persons to be Studied:
The sample for this study will be drawn from a convenient sample of nurses who have recently undergone the nursing orientation program in the past year and the nurses (preceptors) who helped orient them.

3. Method of Recruitment:
Participants will be selected from a list of recently hired nurses obtained from the Department of Nursing. Potential participants will be contacted and asked to participate.

4. Treatment of Participants in the Course of the Research:
Participants will be asked to complete take part in a 30-minute interview using a questionnaire developed for this study as a guide. The questionnaire is designed to collect data related to the orientation program that participants have recently experienced as well as what they would perceive as the ideal orientation program. The data collected will be in a Likert scale format with respondents choosing from strongly agree (SA), agree (A), are not sure (?), disagree (D), and strongly disagree (SD). Open ended questions and questions related to the respondents educational preparation and experience are also included.
Following the survey, the data will be collated and analyzed. Proposed changes to the orientation program will be implemented.

5. Indicate Briefly how the Research Pans Deals with the Following Ethical Concerns:

(a) Informed Consent:
Participation in this research will be on a volunteer basis. Participants will be contacted by the author and explained the purpose of this study. Interviews will be carried out after full explanations of the ethical guidelines are explained.

Deception:
The purpose of this study is to narrow the gap between the current orientation program and the ideal nursing orientation program. There is no intent, nor is there any need to deceive the participants. All explanations will be clear and truthful.

(b) Freedom to Discontinue:
Participants will be informed at the commencement of the interview about their right to withdraw.

(c) Risk to Subjects' Physical and Psychological Welfare:
There is no risk to any of the subjects' physical and psychological welfare.
(d) Post-Research Explanation and/or Debriefing:
At the end of the interview the author will do a debriefing with the participants.
(e) Protecting and/or Addressing Participant "At Risk" Situations:
There is no potential for "at risk" situations. All interview material will be used for the refinement of a new orientation program. Participants will view this as beneficial.

6. **Bearing in Mind the Ethical Guidelines of your Academic and/or Professional Association, Please Comment on any other Ethical Concerns which may arise in the Course of the Research:**

None expected.

7. **Please Comment on the Expected Benefits to be Derived from this Research:**

This study will identify the gap between the existing program and the ideal orientation program. Data collected from the questionnaire will promote the development of a comprehensive nursing orientation, one that socializes the neophytes to their new role while at the same time educates them using adult education principles. Furthermore, the researcher hopes to use computer-assisted learning as a new way method for carrying out nursing orientation. At a time of a nursing shortage, the final benefit will be to promote the recruitment and retention of new nurses by offering an excellent orientation program.