

ABSTRACT

Cheryl R. Duke. THE LIVED EXPERIENCE OF NURSE PRACTITIONER GRADUATES' TRANSITION TO HOSPITAL-BASED PRACTICE. (Under the direction of Dr. Marie Pokorny) College of Nursing, May, 2010.

The purpose of this hermeneutic phenomenology (van Manen, 1990) was to gain insight into the meaning and lived experience of nurse practitioners (NP) with at least one year of work experience regarding their initial transition from new graduate to hospital-based practitioner. This study provided information regarding NP hospital-based transition experience that had not been revealed in the nursing literature. The meaning of transitioning into hospital-based practice was discovered through analysis of nurse practitioner letters and interviews in this phenomenological study. Six themes emerged from this research including: *Going from expert RN to novice NP; system integration; "Don't Give Up"; Learning "On the Fly"; They Don't Understand my NP Role; and Succeeding Through Collaboration.*

Master's prepared, board-certified NPs in North Carolina (NC) with between one and three years of NP practice experience in a hospital setting comprised the population of interest for this study. Twelve participants were purposefully sampled from nine hospitals in NC. Individual, voice-recorded, in-depth, open-ended telephone interviews were conducted with each participant.

The majority of the participants indicated a timeframe that ranged from six to 18 months regarding how long it took them to feel more comfortable in their NP role, the lack of comfort was most intense during the first nine months of practice. Participants confronted multiple obstacles and challenges as new NPs. These challenges included navigating and negotiating a new health care provider role; becoming integrated into a hospital system in what was a new role for them and sometimes for the system; learning how to function effectively as a NP while

simultaneously working to re-establish themselves as proficient clinicians with a newly expanded practice scope; building key relationships; and educating physicians, hospital leaders, clinical staff, patients, and families about the NP role.

This new knowledge demonstrates that although the transition to hospital-based practice for the new NP graduate is individually unique, there are important dimensions of the experience which are universal and should be considered by new NPs, employing hospitals and staff, physicians, and educators. This information can be used to help ensure an ideal transition occurs for the new hospital-based NP.

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HOSPITAL-BASED PRACTICE

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DEDICATION

To my phenomenal husband and best friend, James H. Duke, III, thank you for being my rock through this journey. I accomplished this with you by my side, the only way I would have done it. Your understanding and sacrifice were my foundation. Your love continues to show me dreams can come true. This work is dedicated to you.

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CHAPTER ONE: INTRODUCTION

Since the inception of the Nurse Practitioner (NP) role in 1965 (Sheer & Wong, 2008), NP practice settings have been primarily community-based with the exception of hospital-based neonatal intensive care units (NICU). More recently, however, the NP role has expanded beyond these traditional settings. Although advanced practice nursing in the acute care setting is not a new patient care approach, the NP role in hospital settings other than NICUs is fairly new and continues to grow (Barnett, 2005; Reveley, Walsh, & Crumbie, 2001; Whitcomb et al., 2002). The increasing utilization of hospital-based NPs in a widening variety of clinical areas can be attributed to several factors, including a continuing shortage of primary care physicians, resident physician work hour limitations, legislation allowing nurse practitioners to bill patients for their professional services, and growing numbers of baby boomers requiring hospitalization (Council of International Hospitals, 2003; Gates, 1993; Hanson & Hamric, 2003; Kleinpell & Hravnak, 2005; Lundberg, Wali, Thomas, & Cope, 2006).

As the demand for NPs continues to grow, it is expected that hospitals will employ increasing numbers of newly graduated NPs (Anderson, 1997; Burkholder & Dudjak, 1994; Cusson & Viggiano, 2002; Gates, 1993; Geier, 1999; Genet et al., 1995; Knaus, Davis, Burton, Felten, & Fobes, 1997; Maguire, Carr, & Beal, 1995; Martin, 1999; Schaffner, Ludwig-Beymer, & Wiggins, 1995). As more new NP graduates begin their practice in hospitals, it is anticipated that more transition-to-work programs to support and assist them will be needed (Chang, Mu, & Tsay, 2006; Cusson & Viggiano, 2002).

Many factors impact the level and quality of health care offered by new NP graduates who start their careers in hospital settings. Such factors include prior nursing experience and

skills, patient acuity, the organizational culture of the hospital, and the orientation program and mentoring that focus on new NPs transitioning into hospital settings. New NPs experience what some researcher's term situational role transition as they begin their new roles (Cusson & Strange, 2008). Situational role transition is defined by Schumacher and Meleis (1994) as a change in role function and scope of practice. The literature suggests that, regardless of practice setting, situational role transition for the new NP graduate can be a stressful and turbulent experience (Brown & Olshansky, 1997; Chang et al., 2006; Heitz, Steiner, & Burman, 2004; Kelly & Mathews, 2001; Maquire et al., 1995; Schumacher & Meleis, 1994).

To optimally facilitate the development of new NPs as competent health care providers, the practice environment should provide them support and assistance. According to Bahouth and Esposito-Herr (2009), such support could be facilitated through a robust orientation process during the initial months of employment. New NP graduates, however, are typically expected to "hit the ground running" (Bahouth & Esposito-Herr, 2009; Brown & Olshansky, 1998). Most employing hospitals offer no or limited NP orientation programs, with such programs reportedly varying from nonexistent to a few weeks in duration (Bahouth & Esposito-Herr, 2009; Duke, 2007).

Statement of the Problem

Little is known about the experience of role transition into hospital-based practice for newly graduated NPs (Reveley et al., 2001). Additionally, neither the meaning associated with such a transition nor the critical elements of a successful transition to practice experience by NPs has been studied. The purpose of this phenomenological study was to gain insight into the meaning and lived experience of NPs with at least one year of work experience regarding their initial transition from new graduate to hospital-based practitioner.

Definitions

For the purpose of this study, the following definitions were used:

Nurse Practitioner: A master's prepared registered nurse who has completed an NP program of study in an accredited master's program and is nationally certified as a NP. The NP is authorized to practice as a primary care provider with prescriptive authority in 49 states (American College of Nurse Practitioners, 2009), including the state of North Carolina, where study data was collected.

Transition: "the process of letting go of the way things used to be and then taking hold of the way things subsequently become" (Bridges, 2001, p. 2); Meleis (1986) defines transitions as "periods in which change takes place in an individual or an environment "(p. 4).

Situational transition: Transition to a professional role including functional and scope of practice changes (Schumacher & Meleis, 1994).

Role transition: Balancing competing new role demands such as, in the case of NPs, developing competency and developing safe, effective care (Cusson & Viggiano, 2002).

Significance of the Study

This study is significant for several reasons. The study gives voice to those whose initial adaptations to the practice setting were typically silent and thus unknown. These study findings present a needed holistic, detailed, contextual account of the lived experience of the newly employed hospital-based NP.

Although qualitative findings are not generalizable (Munhall, 2007) the voices of NPs who have experienced the transition from graduation to an initial hospital-based practice setting may serve to enlighten those who find themselves in similar circumstances and those who teach and supervise them. Participants' insights into NP transition experience and its meaning may

serve as a potential source of awareness about the challenges and positive aspects associated with such an experience. Nurse educators who prepare NPs may incorporate such insights into the nursing curriculum, thus enabling new NPs to anticipate the transitional issues they may face as they seek hospital-based careers. Greater understanding of the NP role in hospital settings may also assist NP students as they consider the potential areas of practice for which they are best suited.

As hospitals continue to employ new NPs as patient care providers, the issues that impact role transition for NPs initiating their expanded roles need to be known, understood, and prepared for by administrators. As the hospital-based NP role is developed and clarified, such knowledge can help nursing and other hospital leadership to provide needed support and assistance to these individuals.

In summary, understanding the transition experiences of newly graduated NPs to hospital-based practice will ultimately contribute to the development of such individuals as successful, effective members of the health care team. Such knowledge can be used in clinical practice, educational program development, and by hospital administration to promote the successful transition of new NP graduates into hospital-based practice.

Purpose

The purpose of this phenomenological study was to gain insight into the meaning and lived experience of NPs with at least one year of work experience regarding their initial transition from new graduate to hospital-based practitioner. The research question for this study was, “what is the lived experience and meaning of transitioning into hospital-based practice from the perspective of NPs with at least one year of work experience?”

Philosophical and Theoretical Perspectives

This study was informed by Max van Manen's (1990) hermeneutic phenomenological approach. Hermeneutic phenomenology is based on Husserl's descriptive and Heidegger's interpretive traditions which seek to grasp the meaning of an experience (van Manen, 1990). Hermeneutic phenomenology is a form of phenomenology focused on lived experience and interpretation of "texts" of life (Creswell, 2007). van Manen (1990) states that knowledge is gained through language and understanding, which are intertwined through interpretation (Richards & Morse, 2007, p. 49). The aim for this type of research is to establish a renewed contact with the original experience (van Manen, 1990). The lived experience of transition into practice for NPs in the hospital setting is a phenomenon that will vary among practitioners. The focus of phenomenology is to "describe what all the participants have in common as they experience a phenomenon" (Creswell, 2007, p. 57-58). Through the data collection process, individual experiences can be reflected upon and described. This ultimately provided an opportunity to understand the essence of this experience.

van Manen (1990) defines "essence" as the "internal meaning structures of a phenomenon that are grasped intuitively through the study of the ways in which they manifest themselves in the lived experience" (p. 177). He (van Manen, 1990) stated "that lived experience is the starting point and end point of phenomenological research" (p. 36). Through reflective awareness, the nature of what it was like to be a new NP practicing in a hospital was re-lived and expressed through individual verbal descriptions. This "reflective grasp" (van Manen, 1990, p. 77) allowed this lived experience to provide meaning. By transforming these descriptions into textual expressions, the meaning of these experiences were captured and interpreted, thus addressing the aim of phenomenology (van Manen, 1990).

Summary

NPs are increasingly practicing in hospital-based settings and thus more frequently experiencing a transition from training to new professional roles in hospital settings. The NP is responsible for providing safe and competent patient care through their knowledge of best practices (McKinley, 2004). Given the increasing demand for the NP in hospital settings, NPs are and will continue to be important providers of healthcare in hospitals. Despite a growing trend of employment of NPs in hospitals, a limited understanding existed about the NPs' lived experience of transition into hospital-based practice and the meaning that such a transition held for these nursing professionals. Gaining insight into the meaning and lived experience of this transition by means of this phenomenological study afforded opportunities for NPs and others to understand their experiences from their perspective and potentially improve the assistance, support, and oversight that NPs receive during this stage of their careers.

CHAPTER TWO: REVIEW OF THE LITERATURE

The nursing literature review was organized to include advanced nursing practice theoretical frameworks and models, research studies on NP practice in hospital and other settings, role development, and role socialization. The purpose of this literature review was to produce a thorough understanding of the literature related to role transition for the new NP. The literature review covered a 32- year time period, ranging from 1978 to 2010. The literature covered this particular time frame because this was the period in which relevant literature on these topics related to NP practice could be located. Each of these areas will be discussed.

NP Practice in the Hospital and Other Settings

Dr.'s Loretta Ford and Henry Silver developed the nurse practitioner role in 1965 in response to a shortage of primary care physicians (Sheer & Wong, 2008). The traditional practice setting for NPs has been community based primary care, in mostly rural and medically underserved areas (Jones, 1985; Molitor-Kirsch, Thompson & Milonovich, 2005). Approximately 90% of NPs work in outpatient settings (Cooper, Laud, & Dietrich, 1998). However, due to several recent trends in healthcare including changes in the physician workforce, medical resident duty hour restrictions, and healthcare finance reform, more NPs are practicing in the hospital setting and this growth is expected to continue (Burkholder & Dudjak, 1994; Cummings, Fraser, & Tarlier, 2003; Genet et al., 1995; Knaus et al., 1997; Lundberg et al., 2006; Maguire et al., 1995; Rosenfeld, McEvoy, & Glassman, 2003; Schaffner et al., 1995). Expansion of the NP role in this setting has been diverse. At the time of this study, NPs were being employed in a variety of inpatient areas including the emergency departments, neonatal intensive care units, obstetrics, medicine, surgery, and a variety of other specialty services (Cowan et al., 2006; Molitor-Kirsch et al., 2005).

The utilization of NPs in the hospital setting offers promise for increased efficiency and high quality care. Published studies have demonstrated positive outcomes for hospitalized patients when care was provided by a NP (Cowan et al., 2006; Dahl & Penque, 2000; Geier, 1999; Knaus et al., 1997; Lundberg et al., 2006; Nyberg, Waswick, Wynn, & Keuter, 2007; Schaffner et al., 1995). Hoffman, Tasota, Scharfenberg, Zullo, and Donahoe (2003) reported that medical teams with advanced practice nurses had decreased patient stays in ICU admissions, decreased length of hospitalization, and better discharge documentation. Current and future trends support the continued utilization of the NP in the hospital setting (Anderson, 1997; Gates, 1993; Geier, 1999; Genet et al., 1995; Martin, 1999). In summary, the utilization of NPs to practice exclusively in the hospital has grown over recent years. Organizations that hire nurse practitioners need to be aware of the role transition issues that are typically experienced.

Advanced Practice Nursing Role Development Models

Theoretical models and conceptual frameworks that have been applied to advanced practice nursing roles were compared in Table 1. These included Brown and Olshansky's (1997) theoretical model called "from Limbo to Legitimacy," and Hamric and Taylor's CNS role development model (Hamric & Spross, 1989; Hamric, Spross, & Hanson, 2009). Brown and Olshansky (1997) developed a theoretical model in their grounded theory study, which described the first year of primary care practice for the new NP.

Because of a limited understanding regarding the phenomenon of role transition for the new NP, Brown and Olshansky (1997) utilized grounded theory, which allowed a qualitative exploration of this phenomenon and development of their "from Limbo to Legitimacy" model in 1998. The categories in this model included: laying the foundation, which included pre-employment and recovering from school, seeking employment and working through licensure

Table 1

Advanced Practice Nursing Role Development Models

Limbo to Legitimacy NP Model
(Brown & Olshansky, 1998)

CNS Role Development Model
(Hamric & Taylor, 1989, 2009)

Laying the Foundation

Orientation

Launching

Frustration

Meeting the Challenge

Implementation

Broadening the Perspective

Integration

bureaucracy; launching, which included gaining employment, feeling anxious, and experiencing the impostor phenomenon, getting through the day, and working on management challenges; meeting the challenge, which included gaining competence and confidence, and developing a clearer sense of their NP role; and broadening the perspective, which included navigating the health care system with improved ability and effectiveness, developing active political involvement, self acknowledgement of capabilities and accepting more challenges. The NPs in Brown and Olshansky (1997) study were described as developing a “clear sense of themselves” (p. 48) at the end of the first year of practice. It was not clear if this has the same implications for the new NP graduate who began practice in a hospital setting.

Hamric and Taylor’s Clinical Nurse Specialist model (Hamric & Spross, 1989; Hamric, Spross, & Hanson, 2009) were also discussed as a model of role development. The four major categories in this model included: orientation, which included skills mastery and having intense mentoring; frustration, which included feeling overwhelmed, unsure of role choice, and tended to digress into previous RN role; implementation, which included acclimating to the advanced practice role (APN), adapting to change, and completing the transition into the advanced practice role, if needed; integration, which included continued evolution of the NP role and development of skill and competencies. Hamric and Taylor’s Clinical Nurse Specialist model (Hamric & Spross, 1989; Hamric, Spross, & Hanson, 2009) provided an additional perspective regarding the APNs development of skills for the new CNS.

The concept of transition, as globally defined by Meleis (1986), refers to “periods in which change takes place in an individual or an environment.” This definition and framework provided an appropriate conceptual model for this area of nursing research. Universal properties of transitions are that they occur over time. The nature of the transition can include change in

identity, roles, relationships, abilities, and patterns of behavior. Schumacher and Meleis (1994) described three types of transitions as developmental, situational, and health-illness. Meleis (1997) defined three global indicators of a successful transition, for all transition types, which were indicated by (1) subjective well-being, (2) role mastery, and (3) well-being of relationships.

The newly practicing NP experiences a situational transition, which is demonstrated by a change in role function and scope of practice. Situational transition, which is experienced by the newly graduated NP, is supported using Meleis' (1975) Transition Theory. Meleis' conditions and definitions as they would relate to the NP are shown in Table 2.

Meleis' (1975) Transition Theory was used by Kelly and Mathews (2001) and Chang et al. (2006) in their research on role transition for the NP. A qualitative approach was utilized by these researchers due to a lack of fundamental understanding of this phenomenon. The type of practice setting in the research conducted by Kelly and Mathews (2001) was not revealed other than indicating the study was conducted somewhere in central Illinois. The research conducted by Chang et al. (2006) was located at Taiwan in an acute care setting. This location of the research studies is pointed out because the NP roles and scope of practice in these situations were not equivalent. Despite these differences, Meleis' Transition Theory was appropriately utilized in both studies. As the foundation of this theory, Meleis defined transition as an adaptation or change in role, behavior patterns, abilities, and relationships. This application provided a framework to consider for defining the phenomenon of transition to practice for the new NP.

NP Role Development

Role development and successful transition depends on mastering five important elements that have been described in the literature. These include the development of self-

Table 2

Duke Adaptation of Meleis' Transitional Conditions and Definitions for Situational Transition for the Nurse Practitioner

Condition: Based on Meleis (1975)	Adaptation of Meleis' Definition as it Relates to an NP Transition Context
Meaning	Personal awareness and understanding of the anticipated or experienced transition from RN to NP.
Expectation	What the new NP expects of the transition. This includes cultural beliefs and attitudes.
Level of knowledge and skills	The event of RN to NP role transition that requires new knowledge and skill.
Environment	External facilitative resources. This includes people and the workplace.
Level of planning	Effective planning that will facilitate a positive transition with key people.
Emotional & physical well being	Includes a wide range of emotions encountered by the new NP such as low self-esteem, role confusion, apprehension, and stress.

confidence (Brown & Olshansky, 1997; Hayes, 1998; Jones, 1985; Kelly & Mathews, 2001; Rosoff, 1978; Shea & Selfridge-Thomas, 1997), perceived competence (Brown & Olshansky, 1997; Chang et al., 2006; Hamric & Hanson, 2003; Heitz et al., 2004; Lukacs, 1982), negotiating skills (Jones, 1985; Rosoff, 1978), professional autonomy (Heitz et al., 2004), and effective physician collaboration (Almost & Laschinger, 2002; Kelly & Mathews, 2001; Maguire et al., 1995). Each of these five elements will be discussed.

Self-Confidence

The first element that may influence NP role development was self-confidence. Brown and Olshansky (1998) defined self-confidence as a feeling of security regarding ability. Self-confidence increased naturally as the NP gained more independence through the creation of a diverse knowledge base and gaining of independence. Brown and Olshansky (1997) found that 35 new NPs experienced stress associated with their new responsibility of making decisions. During their first year of practice, however, these NPs were able to develop their skills and gained confidence. A positive influence on self-confidence was the support and feedback provided by mentors and other significant role models, including the collaborating physician (Kelly & Mathews, 2001; Maguire et al., 1995). In fact, Jones (1985) suggested that self-confidence was the most important characteristic that facilitated NPs' effectiveness. Conversely, self-confidence could be eroded by negative influences that impacted self-confidence such as defending professional credibility with co-workers and lack of necessary time to adapt (Brown & Olshansky, 1998). Inadequate time for adaptation resulted in difficulty making independent decisions, which could lead to prolonged feelings of self-doubt and apprehension. Thus, role transition would be negatively impacted if the NPs self-confidence was poor or stunted. Similar findings were reported by Heitz et al. (2004) who also focused on the

new NP graduate. According to these researchers, nurse practitioner interactions with others in the workplace significantly influenced role development in the first six months of practice.

These interactions included negativity such as when the NP asked a nurse for help or experienced challenging encounters from colleagues and patients that required them to defend their role. They proposed that self-doubt resulted from fear, apprehension, and disillusion, which resulted in emotional turmoil when faced with independent role responsibilities (Heitz et al., 2004). One participant described the work setting in this study as a family planning clinic. These findings cannot be generalized to the hospital setting.

Perceived Competence

Perceived competence was found to influence role development for the NP (Brown & Olshansky, 1997). This element was found to be closely related to self-confidence and increased over time, resulting in diminished anxiety. New NPs experienced improved feelings of competence through repetition of performing clinical skills and decision making (Brown & Olshansky, 1998). These positive feelings of competence were experienced by NPs in the primary care practice setting, but it remains unclear if their findings can be generalized to new hospital-based NPs.

Although the hospital setting may be one of the practice sites where the NP received clinical experience as a student, it may still be difficult to feel comfortable there as a new NP. Researchers in Taiwan described 10 acute care NPs experiences in the hospital and noted that the NPs felt unfamiliar in their initial practice period. These NPs experienced stress and felt pressure to adapt to their new role (Chang et al., 2006). These findings could not be applied to the hospital in the United States due to differences in NP roles, culture, and scope of practice from one country to another, but raise important NP issues in the hospital setting.

Negotiating Skills

The NP is also influenced by the development of negotiating skills. This includes being able to negotiate contracts, salary, benefits, continuing education, and professional fees (Marquis & Huston, 1996). Rosoff (1978) proposed many years ago that NP training needed to include contract negotiations and goal setting which could assist with successful entry into practice and role transition for the new NP. Interestingly, Brown and Olshansky (1998) suggested that negotiating skills were not necessary; instead new NPs needed to be able to decide what expectations they were willing to give up with their first NP position. They suggested that NPs may not have an accurate perception of this role at graduation when seeking employment. These conflicting reports raised a need to better understand the NP experience in the hospital setting.

Autonomous Decision-Making

Autonomous decision making skills were another critical element of successful NP role development (Cajulis & Fitzpatrick, 2007). Autonomous decision-making is particularly difficult for the new NP because it requires adaptation to an expanded scope of practice (Cusson & Viggiano, 2002; Heitz et al., 2004). These authors suggested that the development of autonomous decision-making was a confusing process for the new NP, thus hindering the attitude necessary for autonomous decision making. This confusion may be attributed to previous RN training in a traditional helper role versus the assertive and decisive role characteristics required by the NP who has moved from primarily practicing dependently in acute care to having independent decision making and care determination (Luckas, 1982). The development of autonomy occurred on a continuum and in stages as the NP gained comfort and was able to be accountable with the responsibility of decision-making (Lukacs, 1982). The

evolution of autonomy as it relates to role transition can be highly dependent on the NPs practice environment and needed to be further understood.

NP and Medical Doctor (MD) Collaboration

The collaborative relationship between the NP and physician also influences the role development for the new NP. Without a mutually respectful relationship regarding each other's knowledge and competence, quality patient care may be compromised (Almost & Laschinger, 2002; Jones, 1985; Maguire et al., 1995). NPs practicing in hospitals are effective and essential members of the healthcare team (Molitor-Kirsch et al., 2005). It was anticipated that the responsibility of collaboratively managing hospitalized patients would continue to involve the NP (Institute for the Future, 2003). The new NP needs validation of decisions made and constructive feedback in order to assure learning occurs (Heitz et al., 2004; Shea & Selfridge-Thomas, 1997). One challenge identified with this collaborative relationship was prior RN education.

Historically, nurses have been trained in roles subordinate to those of the physician (McLain, 1980). Current practice has evolved to promote collaboration between the RN and MD. However, depending on when the NP received RN training, the NP could display behaviors more supportive of physician authority and dominance instead of a collegial and constructive relationship. In addition, physician's lack of knowledge regarding the NPs graduate education, role and scope of practice may have a negative impact on the evolution of an optimal collaborative relationship (Clarín, 2007; Jones, 1985). Chang et al. (2006) proposed that establishing a close working relationship with the physician may be difficult for the NP. The only study found on collaboration in the hospital was done in Taiwan.

Nurse practitioners have a unique collaborative physician relationship. The physician may be the only mentor or preceptor for the new NP (Duke, 2007). What was not known was how this relationship influenced the transition to practice for the hospital-based NP.

In summary, self-confidence, perceived competence, negotiating skills, autonomy, and the collaborative relationship with the physician impact role development for the new NP. A healthy self-esteem and a preexisting ability to be assertive can result in successful utilization of skills. The new NP needs to possess these skills in order to experience a positive and efficient transition into the healthcare system (Rosoff, 1978). New NPs perceived competence during the orientation process may be influenced by a lack of confidence and inadequate competence during this transition period. Negotiating skills, seen as a critical skill set for a successful transition, are not typically taught in NP programs (Kelly & Mathews, 2001). The result is a source of stress for the new NP. These five elements found have significant influence on the development of the NP role. However, how they are experienced during the transition to practice in the hospital remains unknown.

NP Role Socialization

Cusson and Viggiano (2002) described role socialization as exposure to the responsibilities and scope of the NP role through educational experiences and mentorship by another NP. The degree of acceptance for the NP role in a hospital setting(s) also has significant implications. Influences identified in the literature that may impact the NPs role socialization include: organizational issues (Almost & Laschinger, 2002; Chang et al., 2006; Hamric & Hanson, 2003; Jones, 1985; Maguire et al., 1995; Schaffner et al., 1995); orientation (Brown & Olshansky, 1998; having a mentor (Brown & Olshansky, 1998; Hayes, 1998), and having a support network (Heitz et al., 2004; Kelly & Mathews, 2001).

Organization Issues

The first identified influence, which may impact the NPs role socialization, was the organization in which the NP was employed. The organizational infrastructure of the hospital, philosophy of nursing, and level of support for this advanced practice role may also impact the NPs nursing identity as they practice using a blended model of medicine and nursing (Maguire et al., 1995). NPs are dependent on key players such as administrators, managers, physicians and other staff with whom they interact (Almost & Laschinger, 2002; Maguire et al., 1995). If these individuals are not familiar with the NP role and scope of practice, the NP experiences poor support (Chang et al., 2006; Jones, 1985). A lack of understanding about the NP role by the NP himself or herself or the organization may also result in inappropriate use of the NP (Hawkins & Thibodeau, 1996). A hospital organization that lacks a supportive environment and poor understanding of the NP role negatively impacts role transition (Hawkins & Thibodeau, 1996; Kelly & Mathews, 2001).

Orientation

According to Brown and Olshansky (1997), the employing organization must provide time beyond the graduate program in order to allow for optimal professional development. During the orientation process constructive feedback is needed from key people such as the MD, mentor, peers and administrator or manager. The NP role is a blend of nursing and medical practice. For example, some nurse practitioners are organized under the medical division and some under the nursing department (Bahouth & Esposito-Herr, 2009; Duke, 2007). This combination of practice can contribute to a stressful transition experience (Olge, 2007).

In most hospital settings, nurse practitioners are considered part of the non-physician providers and are required to obtain hospital credentialing and privileges in order to practice in

this setting (Klein, 2008). This privileging process provides formal recognition as a patient care provider (Knaus et al., 1997). Although educational programs for physician(s) and NPs differ greatly, a particularly important difference is the physician residency and internship. NPs programs are currently not structured this way. Program structure may influence system integration. Physicians are socialized to the physician role in the hospital setting during their training experiences. This opportunity for the NP student depends on specialty and training experiences. New NP integration into the medical staff culture and how that may influence transition to practice has not been described in the literature.

There were few reports published specifically describing NP orientation programs. The orientation program descriptions that have been published vary widely in their scope and content. Knaus et al. (1997) described development of a 4-month orientation program at a 440-bed teaching hospital in Missouri for only one vascular NP. The vascular attending physicians working with the NP had no previous experience regarding the NP role. These same physicians were responsible for mentoring the NP. Issues that developed in the first year of this program included the fact that the NP had experience as a student in primary care but the inpatient setting was less familiar in the role of NP. Also, the physicians, fellows, and residents were not familiar with the NP role resulting in difficulty around role definition and collaboration, role ambiguity and lack of clarity (Knaus et al., 1997).

McKay (2006) studied orientation programs of trauma NPs. She sent a demographic and orientation survey electronically to NPs via a list serve for the Society of Trauma Nurses, the number of surveys sent was not indicated. Orientation programs were described as being structured by a NP, Clinical Nurse Specialist, or a trauma nurse coordinator or manager. The length of these orientation programs ranged from two to 90 days (McKay, 2006). Responses

about the orientation included in-depth management of patients requiring enteral support, assessment techniques, and antibiotic use. Feelings of inadequate knowledge regarding pain management were reported from this study. This study cannot be generalized because there were only 10 surveys returned.

Federico (2007) described the development of a new NP role for the post-anesthesia care unit (PACU). The setting was in a 500 + bed teaching hospital which employed approximately 100 NPs at the time this study was conducted. The PACU attending physician retired and was replaced with a board certified FNP who had 20 years of RN experience including PACU, with advanced cardiac life support (ACLS) and certified critical care RN (CCRN) certifications. This orientation program developed through the case management department was an intense, 18 week, hands on experience, which included lectures, OR airway management, and meeting with key personnel. The orientation was developed so that the NP could function independently. Federico (2007) reported that this orientation was a success because the NP was prepared to practice independently. A limit of this study was that it is a case study of one NP.

In contrast to studies with one or few participants, Bahouth and Esposito-Herr (2009) developed a comprehensive NP orientation program at the University of Maryland Medical Center, a 705-bed teaching hospital. This medical center has over 100 NP employees who practice in a variety of specialty service lines. This need was realized when their new NP graduates described feelings of inadequate preparation and lack of support in their new role. The leading research question used was, “tell me about your orientation” (M. Bahouth, phone interview, May 13, 2009). In response to study findings, a 12-week orientation program was developed for novice NPs that included obtaining hospital credentials and privileges, development of a self-paced CD-ROM orientation module that included administrative

checklists, and organizational resources needed for clinical practice. Managers were also provided written documentation on the NP role to prevent role confusion regarding the NP, physician assistant, and medical residents. Within the first six months of employment, the novice NPs working in the critical and intensive care units were required to complete a fundamentals course developed by the Society of Critical Care Medicine. This course was provided through the medical centers division of professional development at no expense for the NP. In addition, senior NP leaders participated in a 1-year Chiron mentoring program offered through Sigma Theta Tau. Evaluation of this program had not occurred but a consistent approach regarding orientation had been found to support a successful transition (Bahouth & Esposito-Herr, 2009).

The limited number of studies related to NPs in the hospital setting suggested this research opportunity. The perspectives of the NP on how these programs may impact transition to practice remained unclear. However, the need for enhanced communication, improved collaboration, and improved structure had been recommended (Bahouth & Esposito-Herr, 2009; Federico, 2007; Knaus et al., 1997). There were no studies that could be found in the literature describing the characteristics of the orientation experience that promoted transition to hospital-based practice for the new NP.

Mentoring

A mentor may impact role socialization for the NP; however, little had been published regarding this aspect of NP practice. Having a mentor, supportive preceptor, or role model for professional disciplines such as nursing had been shown to be beneficial (Cusson & Viggiano, 2002). Teaching style, level of helpfulness and role modeling were key components for the new NP during role socialization (Heitz et al., 2004). A nurturing mentor was highly valuable and

may help assure adequate role development, job satisfaction and role transition (Bosch, 2000; Kelly & Mathews, 2001).

Support Network

The fourth and final influence that may impact role socialization for the NP was having an interconnected relationship with NP colleagues. A supportive network in the hospital environment had shown to lessen the stress of transition for the new NP (El-Sherif, 1995). Supportive systems that include friends, coworkers, former classmates and faculty had also been suggested by Brown and Olshansky (1998) as being important for new NPs. Significant support included activities such as comforting, complaining, guiding and consulting with each other (Chang et al., 2006). This can also include time together away from the workplace such as through NP professional groups. In addition, feelings of approval by patients and their families were perceived as a positive informal source of support by the new NP (Heitz et al., 2004). Regardless of the type of support, whether formal or informal, the new NP was better able to cope successfully with role transition if there was a strong network of support. What needed to be better described was how the support network available for the NP in the hospital influenced transition to practice.

The influences that have been researched in the role socialization for the new NP are organizational issues, orientation, having a mentor, and having a professional network. First, NPs need a work environment that provides access to necessary information, resources and support (Almost & Laschinger, 2002). Second, orientation was significant to role transition and adequate time was needed to allow role socialization for the new NP. Third, having an experienced NP mentor was essential for facilitating the transition process (Schumacher & Meleis, 1994). Fourth, having a professional network had been reported as the most frequently

mentioned coping strategy for new NPs during the transition process (Kelly & Mathews, 2001). These four influences may impact role socialization for the NP. How they influence transition to practice in the hospital setting needed further investigation.

Summary

The literature related to NP transition to practice described five elements, self confidence, perceived competence, negotiating skills, autonomous decision making, physician collaboration and four influences which were organizational infrastructure, orientation, having a mentor, and having a support network. These elements and influences are important to the NP; how they specifically influence transition to hospital based practice remains unknown.

As health care delivery continues to change, the NP will have a key role in the provision and management of patient care. These current and anticipated changes in health care costs including rapid growth in the elderly population, increased patient acuity, restricted resident work hours, and insufficient numbers of physicians to care for those hospitalized. As the new NP acquires clinical and technical skills, the ability to make valid contributions to the care of patients will also occur. The NP is most successful when supportive relationships exist with all members of the healthcare team and they are valued as key contributors to the care of patients (Anderson, 1997).

This literature and research review identified, summarized, and evaluated the current knowledge gaps about NPs transitioning to practice in the hospital. As the utilization of NPs in this setting continues to increase, a better understanding about this NP experience is needed (Cooper et al., 1998). This study offers new knowledge for NPs, educators, future employers and colleagues of the NP that can provide information on successful transition to practice.

CHAPTER THREE: METHOD

The purpose of this phenomenological study was to gain insight into the meaning and lived experience of NP's with at least one year of work experience regarding their initial transition from new graduate to hospital-based practitioner. In this chapter, I addressed the foreshadowed research question, rationale for phenomenology as a research approach, study design and credibility, sampling, data collection strategy, data analysis, and my assumptions and preparation to conduct this study.

Research Question and Approach

I used a phenomenological approach to address the research question, "What is the lived experience and meaning of transitioning into hospital-based practice from the perspective of NPs with at least 1 year of work experience?" Phenomenology is particularly effective in capturing the essence of a phenomenon such as, in this study, a role transition experience (Creswell, 2007). Insight into the phenomenon of role transition was gleaned from the perspectives of NPs who had actually experienced such a transition. van Manen (1990) suggests that a phenomenological approach can provide a deeper understanding of participants' perceptions about a phenomenon. Phenomenological inquiry potentially provides an opportunity to gain new knowledge as a consequence of participants' descriptions of their experiences of making the transition from new graduate to hospital-based practitioner (van Manen, 1990). These experiences and their meanings are captured through in-depth conversations with participants (Polit & Beck, 2004; van Manen, 1990).

Hermeneutic philosophy is a theoretical framework that informs phenomenological qualitative inquiry. Thus, hermeneutics provides a framework that focuses on interpretation of texts, documents, and stories of human experiences aimed to improve understanding and

meaning (Patton, 2002). In hermeneutic phenomenology, the interview has specific purposes, which includes providing a means for exploring and gathering narrative information in order to allow a deeper understanding of a human experience (van Manen, 1990). As described by Patton (2002), the *hermeneutic circle* is the “analytical process aimed at enhancing understanding, offers a particular emphasis in qualitative analysis, namely, relating parts to wholes, and wholes to parts” (p. 497). In this hermeneutic phenomenological study, the interview approach allowed NPs to individually describe their lived experience in order to gain a better collective understanding of transition from NP training to hospital-based practice.

Sampling

Phenomenological method sampling is generally done by selecting participants using two established criteria (Munhall, 2007; Streubert & Carpenter, 1999). These two criteria include (1) Experiential fit, defined as selecting participants who have experienced the phenomenon under study, and (2) Qualities of a good informant, defined as having the willingness to talk, reflect, describe, and share their experience with the researcher (Munhall, 2007). Lincoln and Guba (1985) and Patton (2002) labeled this type of sampling as “purposive sampling.” Purposive sampling allows for the selection of information rich cases from which the researcher can learn about the phenomenon of interest (Patton, 2002; Powers & Knapp, 2006). Thus, participants for this study included selection based on the criterion of having begun their NP career in a hospital setting, had at least 1 year of NP practice, and were willing to share their experience (Munhall, 2007; Patton, 2002). These criteria helped ensure that all participants had similar professional characteristics.

After obtaining University and Medical Board Institutional Review Board (UMCIRB) approval of the study (see Appendix A), I identified and selected a purposive sample of 12 nurse

practitioners who had practiced in various hospital settings located in North Carolina for at least one year. Purposive sampling ultimately ensured that the interviews resulted in rich and varied descriptions of their transitions from NP training to hospital-based practice experience (Polit & Beck, 2004).

Sample Identification

In an effort to disseminate information about the study, in May 2009, I obtained from the North Carolina Board of Nursing (NCBON) the names of all NPs practicing in hospital settings in NC (N=1251). In addition, I attended the 2009 North Carolina Nurses Association (NCNA) NP Spring Symposium and obtained the attendee list with 221 NP names and email addresses. Because not all email addresses were available through the NCBON, the additional information from NCNA NP Spring Symposium attendee list was used for additional contact information.

Participant Selection

I sent a letter of invitation to North Carolina NPs to participate in the study (see Appendix B) if they met the following study criteria:

1. Graduation from an accredited NP program with a Master's degree or post Master's Certificate;
2. Current board certified by a national credentialing body (American Academy of Nurse Practitioners or American Nurses Credentialing Center);
3. NP role in a hospital setting initiated immediately following NP training program;
4. Continuous hospital based practice for a minimum of one year and no more than three years post graduation;
5. Able and willing to recall and share their experiences as a NP;

6. Able and willing to write a letter to a newly graduated NP about entering hospital based practice;
7. Willing to voluntarily participate in this study; and
8. English speaking.

I invited the first 12 respondents who self reported that they met the study criteria, understood what was asked of them, and willingly volunteered to participate in this study. The participants were asked to review the informed consent document (see Appendix C) prior to assuring their participation. The limitation of 12 participants for this study enabled the researcher to gather in-depth data related to the research question (Patton, 2002).

Data Collection Procedure

Data collection included the following components: participant's letters to newly graduated NPs entering hospital-based practice, demographic questionnaires, verbatim transcriptions of audio-recorded individual, in-depth, open-ended qualitative interviews that were conducted by telephone, my hand written notes taken during the interviews, and my journal log.

After each respondent contacted me after receiving my letter of invitation and volunteering to participate in this study, I replied to each respondent with the same detailed message (see Appendix D). I mailed or faxed the informed consent document with my signature to the individual. If the consent was mailed, two documents were sent to ensure the individual was provided with their own copy of the consent. I requested that, after reading and addressing any questions that she/he had, the individual sign the consent form and return it to me via a stamped self-addressed envelope or by fax. I addressed the participants' questions and concerns about the study prior to them signing the consent. I then scheduled telephone interviews with participants after obtaining their signed informed consent document.

Prior to conducting the interview, I requested each participant write a letter to a newly graduated NP who was entering hospital-based practice for the first time. I asked that the letter focus on what the participant wanted to share with this new NP to prepare her or him for hospital-based practice. The participants' letters served as a catalyst for further discussion during the telephone interviews. If the letter was not received electronically or mailed back with the signed consent, I allowed additional time for the participant to dictate the letter to me during our scheduled phone interview. A total of eleven letters were obtained from the twelve participants.

My data collection by telephone began by completing a general demographic questionnaire (see Appendix E). I recorded participants' data on the demographic questionnaire as part of the interviewing process. Following completion of the demographic questionnaire, I conducted an audio-recorded in-depth telephone interview with each participant that was flexible but was focused by an interview guide (see Appendix F). The interview guide included open-ended questions but allowed me to ask about unanticipated topics or issues that emerged during the interview. The open-ended interview approach assured that I asked similar questions of all study participants (Patton, 2002) but did not preclude my exploration of additional questions or issues that emerged in response to my dialogue with the participants (DiCicco-Bloom & Crabtree, 2006). I also took hand written notes during the interviews, as part of the data collection.

In order to assure participant anonymity, I requested that each participant choose a pseudonym. The pseudonym was used on all documents associated with the study, including the transcripts and reports of study findings. In addition, I modified or changed any information about a participant that may have identified him or her in order to protect his or her anonymity.

The final number of participants was determined at a point when data saturation had been reached, which I recognized by the occurrence of redundancy of information and the emergence of no new information or themes (Munhall, 2007). I anticipated that data from approximately 12 participants was needed in order to reach saturation (Creswell, 2007).

In-Depth, Open-Ended Interview

My goal throughout each interview was to demonstrate acceptance without judgment and I encouraged participants to share as much information as possible (Patton, 2002) about their thoughts and experiences as new hospital-based NPs. I anticipated that my open-ended, in-depth interviews would involve a three-phase process: introduction, interview, and conclusion. During the introduction phase, I initiated rapport building as I reviewed the purpose of the study, revisited the informed consent, and collected demographic information. During the second phase, I facilitated the interview itself by aiming to conduct the interaction as a facilitated conversation and one that privileged participants' voices. During the interview, if available, I used the participant's letter as a catalyst for further discussion. During the closure phase, I requested each participant provide any additional comments or address any issues we did not talk about during the interview. I summarized my understandings about the participant's perspectives, reminded the participant about how to contact me should they have questions about the study or something they wished to add, and formulated a plan to share study findings with the participant.

While I conducted my interviews, I made every effort to establish rapport and trust with the participants (DiCicco-Bloom & Crabtree, 2006). My role as a practicing NP facilitated the rapport-building process but I remained cognizant of the stages of rapport as described by DiCicco-Bloom and Crabtree (2006). These stages included apprehension, exploration, co-

operation, and participation. In the first stage, apprehension, my goal was to enable my participants to find their voice and begin talking. I accomplished this by using a general, non-threatening conversation starter such as, “Where did you do your NP training?” I strived to maintain a neutral stance not only during the initial interactions, but also throughout the interview process. Neutrality, as described by Patton (2002), meant I would not think more or less of the participant by the content of their comments. In the second stage of rapport building, exploration, I engaged the participants in in-depth information sharing. The third stage, cooperation, was characterized by increased comfort in information sharing. I used opportunities during this time to ask for clarification about any comments previously made during the interview or requested information about more sensitive issues. During the final stage, participation, I recognized the establishment of positive rapport when the participant more actively guided the interview (DiCicco-Bloom & Crabtree, 2006).

I transcribed all 12-telephone interviews verbatim. As each transcript was completed, I compared it to the voice-recorded interview to verify accuracy. Once accuracy was verified, I read the interview transcripts several times for overall meaning and also to identify significant and meaningful statements. Repeated reading of the transcripts enabled me to become immersed in the data and thus more fully aware of the NPs’ experience.

Data Analysis

I analyzed the participants’ letters separately from the interview transcripts. van Manen’s (1990) hermeneutic phenomenological approach guided the data analysis, interpretation, and synthesis of the interviews and letters. Six activities elemental to his approach included focusing on the phenomenon, investigating lived experience, isolating themes, writing descriptions, staying oriented to the research question, and stepping back to look at the whole. These six

activities for data analysis described by van Manen (1990) were not done in isolation of each other; this process was iterative.

Focusing on the Phenomenon

Focusing on the phenomenon of interest for this study was exploring the transition to hospital-based practice. Throughout the course of this study, I was committed to and focused on deeply questioning the transition experience of NPs. Transition to hospital-based practice for the new NP graduate was a lived experience for these nurses and was explored in this study. During the data analysis and writing, my aim was to “transform this lived experience into a textual expression” (van Manen, 1990, p. 36) that was meaningful and accurate.

Investigating Lived Experience

According to van Manen (1990), lived experience can never be grasped in its immediate manifestation but only reflectively as past presence (of the experience). In this study, I invited the participants to recall their memories of what it was like to move through the NP transition experience and to share those memories with me through memory recorded interviews and letters.

The point to phenomenological research is to “borrow” other people’s experiences in order to better be able to come to an understanding of deeper meaning or significance of an aspect of human experience, in the context of the whole human experience” (van Manen, 1990, p. 62)

During the data analysis and writing, I remained immersed in the data (participant’s words) to gain an understanding of this experience.

Isolating Themes

In this research activity, I sought to uncover the structure of meaning regarding this experience by identifying themes that emerged from the data. I used the three approaches for isolating themes as described by van Manen (1990). The first approach I used was repeatedly reading the text as a whole for overall meaning. After reading the text, I wrote a brief summary of the transition experience of each participant. In the second approach, I selected and highlighted significant statements within the data types, which included the letters and interviews. In the third approach, after reading each sentence or segment of text multiple times, I considered what the participants' words revealed about the NPs transition experience to hospital-based practice.

I used the aforementioned approaches in the initial identification of codes, which are labels used to describe meaning. I categorized the lengthy list of codes by grouping the coded sentences and segments of text that were descriptive of similar phenomenon. I re-coded the categorized data. Through repeated readings and reflections, I collapsed the codes of statements that described similar phenomenon. New codes were developed if selected statement(s) did not fit new existing or collapsed codes. Codes were further developed into themes throughout the analysis process. For example, the coded data I had categorized as nursing background, role uncertainty, in-betweenness, and feelings described culminated in the identification of the theme, *Going From Expert RN to Novice NP*.

During this process, I categorized data in an organized format by developing a codebook (Fonteyn, Vettese, Lancaster, & Bauer-Wu, 2008). I developed the codebook in two phases. In phase one, I identified each code, wrote a description of it, and developed inclusion and exclusion criteria for applying the code to the transcribed text. This provided a tool which

enabled consistency and provided supportive evidence in grouping excerpts and significant statements from the participant letters and interviews that were similarly coded for the codebook in phase one. In phase two, I utilized the codebook to develop a theme book. I cut and pasted electronically from the transcripts into the theme book under the topic headings where the corresponding text was best represented in the face sheet as shown in Appendix G. This process created a 34-page Microsoft Word document. An example of this stage is illustrated in Table 3. The theme book functioned as a working tool for storing supportive evidence for each theme throughout the analysis.

Writing Descriptions

I described the phenomenon of NP transition by means of writing and rewriting. “Creating phenomenological text is the object of the research process” (van Manen, 1990, p. 111). Through transcription of letters and in-depth interviews, I developed a comprehensive text of these NP experiences, as described by the participants. Through writing and re-writing, I captured and transformed these descriptions and revealed the meaning of the NP lived experience of transition to hospital-based practice. Maintaining a strong connection to my nursing experience helped produce a text that was oriented, strong, meaningful, rich, and distinct. The data analysis process included these steps in order to capture and transform the participants’ descriptions into phenomenological text.

Staying Oriented to the Research Question

The research question used for this study was, “What is the lived experience and meaning of transitioning into hospital-based practice from the perspective of NPs with at least 1 year of work experience?” As the researcher, I have lived the experience of transition to hospital-based practice. I realized that my experience is only one perspective on this phenomenon. Throughout

Table 3

A Sample of Theme Book with Corresponding Data from Three Transcripts

Theme	Description	Inclusion Criteria	Exclusion Criteria
From expert RN to novice NP	Participant statements about expert RN and novice NP roles, including the process of going from expert RN to a novice NP	Participant statements about nursing background & NP education, role uncertainty, dimensions of RN and NP roles (including similarities and differences), and feelings that may be experienced	Participant statements that do not refer to the process of going from expert RN to novice NP

Note.

Participant #1

Line 89-90: “It was scary at first going from the expert nurse to the novice nurse practitioner.”

Participant #3

Line 92-97: “Honestly, at first, I was a little overwhelmed. One reason, this was a brand new program when I started. So, not only was it a new program, but they were dealing with a new NP. So I was a little worried going into it. Now, there are 2 more NPs that do what I do. So, my biggest thing was feeling overwhelmed...”

Participant #10

Line 131-133: “I still have a bit of that, what do they call it, “Impostor Syndrome” and I think, “I hope they don’t see through me.”

the analysis and writing, my goal was to “construct a possible interpretation of the nature of” (van Manen, 1990, p. 41) the transition experience for the new hospital-based NP graduate.

Stepping Back to Look at the Whole

I balanced the research by considering the parts and the whole. Maintaining a balance between the parts and the whole was described by van Manen (1990) as achieving cohesiveness between the research process and the writing of the text.

Throughout the data analysis and writing, I strived to present a narrative that captured the purpose and significance of the study and answered the research question.

In addition to this work, a majority of the letters and transcribed interviews were randomly selected and analyzed individually and together by the dissertation chair and a committee member who has expertise in qualitative methods. The dissertation chair and committee member mentored this researcher throughout the research process and particularly during the data analysis procedure. The researcher and the reviewer(s) engaged in multiple discussions regarding ongoing interpretations and theme development throughout the analysis process, which included returning to the text several times for clarification.

The researcher wrote and re-wrote drafts of the interpretation of the data in order to develop final meaning in the form of themes based on the data interpretation, always returning to the participant’s words for clarification and context. Following identification of the final themes, the researcher verified the themes that were essential versus incidental using the “free imaginative variation” process described by van Manen (1990, p. 107). This process verifies a theme as essential if the phenomenon would lose its fundamental meaning if the theme were to be changed or deleted (van Manen, 1990, p. 107). For example, if the theme *Going from Expert*

RN to Novice NP was deleted, this experience would lose essential meaning as described by the participants.

Data Validity and Trustworthiness

Qualitative traditions involve the use of techniques that produce high quality data that are credible, trustworthy, balanced about the phenomenon under study and fair to the participants' being studied (Patton, 2002). Lincoln and Guba (1985) described criteria needed to establish trustworthiness in qualitative research studies. Their criteria include: credibility (truth value), dependability (consistency/reliability), confirmability (neutrality), and transferability (applicability). Qualitative researchers adhere to these criteria to ensure trustworthiness is established when conducting and reporting research (Lincoln & Guba, 1985). I established trustworthiness in this qualitative project using a variety of strategies related to the criteria advocated by Lincoln and Guba (1985).

I did not return to the participants for interpretation validation. For the purpose of this study, I was seeking their description of the lived meaning of transition to hospital-based practice. The participants possibly had a different conceptualization of the lived meaning of this lived experience. I offered to share a brief summary of my study findings for those participants who stated they would like to receive this information, which was every participant.

Credibility

The concept of credibility in qualitative research parallel's internal validity in quantitative research. Credibility or truth-value in qualitative research is demonstrated through accurate documentation of the process and valid representation of the findings (Lincoln & Guba, 1985). Credibility assures that researcher interpretation truthfully represents the respondents'

experience (Schwandt, 2001). I accomplished credibility in this study by maintaining an audit trail and engaging in self-reflection/reflexivity and peer debriefing.

Audit Trail

The purpose of an audit trail is to contribute to the credibility of qualitative research studies (Koch, 1994). In this study, the audit trail provided a clearly traceable path from the raw data to data synthesis and interpretation (Creswell & Miller, 2000; Wolf, 2003). My audit trail included the interview guide, audiotapes of the interviews, interview transcriptions, letters, data reduction notes, categories and codes, and field journal notes. I also used a field journal to document how I gained access to the participants, issues, and other data sources (see Appendix H). The purpose of the field journal was to document these significant and various aspects of the research process (Koch, 1994).

Self-Reflection/Reflexivity

Continuous self-reflection on my subjectivity during this research process was necessary. This critical self-reflection also called reflexivity (Powers & Knapp, 2006) is defined as the process of continuous self-reflection of biases and assumptions. Reflexivity informs the analysis which assures accuracy and bias control (Powers & Knapp, 2006). I accomplished reflexivity by writing in my researcher's diary about how my own experience could influence the study findings. This diary was a separate notebook dedicated to keeping a chronological log of daily events and my reflections throughout this project by recording my personal feelings, responses and reactions. I kept the interview audiotapes, interview transcripts, field journal notes, and researcher's diary in a locked cabinet in my home office.

Peer-Debriefing

Peer debriefing “involves seeking input (substantive or methodological) from knowledgeable colleagues, seeking their reactions as listeners, and using them as sounding boards for the researcher’s ideas” (Powers & Knapp, 2006, p. 126). In this study, peer debriefing contributed to ensuring credibility, as previously described, by providing support, challenging assumptions and asking questions about interpretations (Lincoln & Guba, 1985). I accomplished peer debriefing through on-going dialogue and communication with my dissertation chair which was done in order to review and explore the evolution of my dissertation research project. Through ongoing collaborative discussions and conversations between dissertation members and I, verbal and written summaries were presented at predetermined points throughout the research process. These collaborative conversations allowed a deeper insight and understanding of the phenomena under study (van Manen, 1990). This particular contribution to establishing study credibility was particularly important to me as I engaged in analysis and interpretation of the data.

Dependability

The concept of dependability in qualitative researcher parallel’s reliability in quantitative researcher. Dependability was accomplished through the audit process (Tobin & Begley, 2004). Dependability was focused on making certain the research process was carefully documented and providing evidence of logical and traceable conclusions (Schwandt, 2001). Dependable research is a “precondition” for validity (Lincoln & Guba, 1985). Because this was a dissertation research, my chair and committee members reviewed the processes and conclusions, which contributed to establishing dependability for this study.

Confirmability

The concept of confirmability in qualitative research parallels objectivity in quantitative research. Confirmability is demonstrated when researcher findings and interpretations can be substantiated and linked to the data (Powers & Knapp, 2006). Confirmability was established through the audit trail as described in the aforementioned credibility section (Lincoln & Guba, 1985). The audit trail provided evidence of activities and thought process that led to my conclusions. In addition to these techniques including the researcher's diary as previously described in the credibility section; Lincoln and Guba (1985) also suggested two additional techniques for establishing confirmability, which included triangulation, and bracketing.

Triangulation

Creswell and Miller (2000) described triangulation as a procedure used to contribute to validity and purpose through “convergence” (p. 127) between multiple sources of information used to develop themes in a study. This practice provides corroboration of evidence through collecting multiple sources of data (Lincoln & Guba, 1985). I triangulated the data in this study by conducting semi-structured interviews, taking hand-written notes during interviews, and collecting written letters by the participants. The participant letters and interviews were analyzed separately.

Bracketing

van Manen (1990) stated a problem with phenomenological inquiry was knowing too much about what we want to investigate. In qualitative research, the ability to be completely objective is not humanly possible, (Ahern, 1999), but qualitative researchers are expected to put aside personal values and biases (Ahern, 1999). It is recommended by van Manen (1990) to “make explicit our understandings, beliefs, biases, assumptions, presuppositions, and theories”

(p. 47) instead of forgetting “what we already know” (p. 47). As suggested by Gearing (2004), I accomplished bracketing in this study by thoughtfully making explicit my experience and my understanding, assumptions and biases about transition to hospital-based practice prior to and during my study of participants’ experience regarding transition. I operationalized bracketing by writing about these issues in a separate section of this dissertation and in my researchers diary during my entire course of conducting this study.

Transferability

The concept of transferability in qualitative research parallels external validity in quantitative research. Transferability is established when research findings have sufficient detail and can be determined as meaningful to others in comparable situations (Powers & Knapp, 2006). I accomplished transferability by using rich and thick description in presenting the research findings. Lincoln and Guba (1985) reported “description must specify everything that a reader may need to know in order to understand the findings” (p. 125). In this study, I accomplished transferability by using the rich descriptions of the participants themselves and their experience in their transition to hospital-based practice. This will enable the reader to apply this information other similar situations.

Researcher’s Personal Preparation, Assumptions, and Biases

Qualitative research begins with self-reflection on personal experiences of the researcher (Munhall, 2007). The terms “human science” (van Manen, 1990, p. 2) and phenomenology are often used interchangeably (van Manen, 1990). A presumption of phenomenological or human science research is that a prior interest exists and “aims at establishing a renewed contact with an original experience” (van Manen, 1990). This renewed contact with a lived experience as described by van Manen (1990) grounds the experience and makes it special. It is this lived

experience that builds context to one's reality (Lincoln & Guba, 1985). Lincoln and Guba (1985) explained that some things have to be experienced in order to be understood. This is defined as "tacit knowledge" (p. 195). As the researcher, I have lived this particular experience of interest and I was well prepared to be the primary research instrument (Munhall, 2007; van Manen 1990). It is my lived experience as a hospital-based NP that has prepared me to be a research instrument in this study.

My 22-year career as a Registered Nurse (RN) has been very rewarding. I decided to return to school for my post master's family nurse practitioner (FNP) certificate when I realized I wanted to be able to influence patient care in a more autonomous way. I knew adding prescriptive authority to my scope of practice was a missing link and the NP role would equip me with those skills I desired. As a RN, I had practiced in community and hospital settings and enjoyed working in both settings.

After completing my post-masters NP in 2002, I decided to return to the hospital setting to develop my NP role working with the Internal Medicine resident service. I had worked as a staff nurse for many years in a variety of acute care settings and felt very comfortable there. In the hospital, I expected to feel as comfortable in my NP role as I did in my RN role. I quickly found out my expectations were not realistic. I experienced many challenges which included feelings of guilt and obligation writing "doctor's" orders, having my scope of practice and authority challenged by nurses, patients, and other providers, having to educate everyone including residents, physicians and hospital administration about the NP role, and continuously proving to other providers that the NP role was not a source of professional competition. These were not issues that my NP program had prepared me for.

My new NP role felt strange and confusing. I felt myself clinging to my RN roots while experiencing an awkward “in-betweeness” of my RN and NP roles. I was quite confident and competent in my RN role and grieved over the perceived loss of this part of my professional being. At the same time, I was so proud because I had completed my NP program. I was board certified as a NP and licensed by the medical board to diagnose, prescribe, prevent and treat disease. This aspect of how I could directly impact a patient’s state of health was what I had wanted; it was both exhilarating and terrifying. It was a balancing act and I found myself facing a difficult transition.

My challenge was trying to embrace my new “practitioner” role while simultaneously protecting and preserving my “nurse” role. What I experienced I thought was unique to me; however, since that time, I talked with other NPs in the hospital about what it was like for them. These casual conversations with fellow NPs planted a seed of curiosity in me. This is how I came to want to understand, on a deeper level, what other new NPs transitioning into hospital-based practice have experienced.

My assumptions regarding new NPs in a hospital environment include: in order to move from being a new NP to being a fully functioning and comfortable NP is a transition process, the NP hospital-based transition experience would differ from the NP in the outpatient practice setting, the hospital-based transition experience would be challenging and stressful, and NPs who practiced in the same hospital as a RN may have additional challenges with colleagues regarding their adjustment and acceptance of the role change for the new NP. My biases regarding new NPs in a hospital environment include: the desire to understand the experience of transition to practice in the hospital setting would be important to new NPs, educators, hospital leadership, and physicians.

Summary

The purpose of this phenomenological study was to gain insight into the meaning and lived experience of NPs with at least one year of work experience regarding their initial transition from new graduate to hospital-based practitioner. A qualitative phenomenological method (van Manen, 1990) was an appropriate for the research question posed for this study. Rigor and trustworthiness was established through utilization of established criteria which includes credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985).

CHAPTER FOUR: FINDINGS

The purpose of this phenomenological study was to gain insight into the meaning and lived experience of NPs with at least one year of work experience regarding their initial transition from new graduate to hospital-based practitioner. This study provided information regarding NP hospital-based transition experience that had not been revealed previously in the nursing literature. The meaning and lived experience associated with transitioning into hospital-based practice was discovered through an analysis of nurse practitioner letters and in-depth, open-ended interviews in this exploratory descriptive study. The shared experiences of twelve NPs participants are represented in this presentation of findings.

The research approach utilized to explore and describe the lived meaning of the NP experiences was hermeneutic phenomenology (van Manen, 1990). The researcher used six research activities as detailed by van Manen's (1990) qualitative hermeneutic phenomenological approach to analyze, interpret, and synthesize the research data from the interviews and letters.

The data originated from eleven letters written by study participants to theoretical other NPs new to hospital based practice and twelve audio-recorded telephone interviews. The telephone interviews ranged from 20 to 50 minutes in duration, with the average phone interview being 27 minutes. Five participant letters were completed prior to the scheduled telephone interview; one letter was hand written and sent via U.S. postal service, and four letters were typed and e-mailed to the researcher. Two participant letters were completed following the scheduled telephone interview; one letter was typed and faxed and the other letter was typed and e-mailed to the researcher. Four letters were composed by the participant during the scheduled telephone interview. One participant never completed the letter.

Participant Description

Master's prepared, board-certified nurse practitioners (NPs) in North Carolina with between one and three years of NP practice experience in a hospital setting were the population of interest for this study (see Appendix I). The researcher used purposive sampling to identify and select twelve study participants who were ultimately recruited from nine hospitals in North Carolina. After the researcher interviewed the first ten respondents who self reported that they met the study criteria, the researcher experienced data saturation as evidenced by no new information was provided by the participants (Creswell, 2007). The researcher confirmed saturation by interviewing Participants 11 and 12.

The 12 NPs participants who participated in this study were direct patient care providers who worked exclusively in hospital settings. The ages of the participants ranged from 29 to 51 years, with an average age of 38.9 years. The number of practice years as registered nurses (RN) prior to obtaining their NP licenses ranged between four to 27 years, with the average number of years of RN experience being 10 years. Of the 12 participants, six participants had 10 or more years experience as an RN prior to obtaining their NP license. Nine participants had worked as a RN in the same hospital as where they started practice as a new NP graduate. Five participants were the first NPs utilized in their particular service or unit. Four of these participants began their NP role in the same clinical area in which they had initially worked as an RN.

The 12 participants' NP educational preparation included acute, adult, and family care. Three participants were acute care nurse practitioners (ACNP), three participants were adult nurse practitioners (ANP), and six were family nurse practitioners (FNP). All 12 participants were board certified NPs at the time of the study. Nine of the participants were board certified by the American Nurses Credentialing Center (ANCC) and three participants were board

certified by the American Academy of Nurse Practitioners (AANP). Participants graduated from their NP programs at some point during the years 2006 to 2008. The total number of years that participants practiced as NPs ranged between one and three years, with an average number of 1.6 years of active NP practice. All NPs were employed full time in the hospitals where they practiced.

Practice sites for the 12 participants included nine hospitals in North Carolina. Four of the NP participants practiced in the same hospital. The hospital sizes varied according to number of beds: small with less than 100 beds; medium with 100 to 500 beds; or large with 500 or more beds. One hospital was small, one hospital was medium, and six hospitals were large hospitals with affiliated medical schools. The participants' clinical specialties included specific service or unit based models. Service models included hospitalist, rehabilitation medicine, critical care, palliative care, hematology-oncology, internal medicine, cardiology, trauma-emergency and general surgery. Unit based models included cardio-thoracic intensive care unit, transplant unit, medical intensive care unit, and emergency medicine.

The Lived Experience of New NP Graduates

Analysis of the letters and interviews revealed remarkable consistency between the themes discovered from both data types. The findings from these two types of data will be presented together. Six essential themes emerged from the data which included *Going From Expert RN to Novice NP*, which describes participant statements about expert RN and novice NP roles and the process of going from expert RN to a novice NP; *System Integration*, which describes participant comments about NPs integration into the hospital system; *Don't Give Up*, which describes participant statements about holding up and following through a persistent course of action especially in difficult situations as a new NP and advanced practice leader;

Learning “On The Fly,” which describes participant statements about learning as you go regarding how to be a NP, and the significance of a mentor; *They Do Not Understand My NP Role*, which describes participants statements about others lack of understanding about the NP role; and *Succeeding Through Collaboration*, which describes participant statements about building collaborative relationships with physicians, staff, including leadership and how these relationships impact transition for the new NP. These themes will be presented in this particular order with the intention of telling a collective story in a chronological fashion, indicative of the transition experience described by the participants.

Going From Expert RN to Novice NP

“It was scary at first going from the expert nurse to the novice nurse practitioner”
Participant #1

All the participants spoke and wrote in their letters about the period of time encompassing graduation from NP training and initial hospital-based practice as a pivotal point in their lives and careers. A theme that emerged from the data analysis reflected the phenomenon of a relatively abrupt and unanticipated change in their identity and expertise. They discussed the experience of having been an expert RN as they faced being a novice NP graduate with no experience. Participant #6 spoke about the differences in role RN and NP roles, *“Even though I started out in that setting as a nurse, it was completely different as a nurse practitioner. Instead of making the suggestions, you are making recommendations and writing orders.”* They referred to the importance and helpfulness of their nursing background and experience during that period. Adult nurse practitioner (ANP) participant #11 offered to a new NP in her letter, *“Dig deep into what you know as a nurse, this will help you during this time.”*

Despite having had a good foundational nursing experience as a RN, study participants expressed a great deal of role uncertainty about themselves and their new NP roles in both their

letters and interviews. Participants who had worked at the same hospital as a RN prior to their NP role described familiarity with the hospital and its routines as helpful to them when they returned as NPs. Family nurse practitioner (FNP) participant #5 described how his background and prior knowledge about commonly used drugs was helpful, *“I knew these medications and what the doctor was going to order before they would write for them because I saw it every single day.”* FNP participant #7 also referred to the helpfulness of her nursing background when she commented, *“When I became a nurse practitioner, it was not that hard. But at times, you find yourself going back to the (nursing) basics, but you know you can do it.”*

The transition from expert RN to novice NP evoked an array of emotions. They described both positive and negative feelings associated with taking on their new NP role. They described their NP role, for example, as *“exciting,” “fun,”* and *“empowering.”* On the other hand, they also described negative perceptions of what it was like to be a new NP, including the workload (*grueling*), the personal emotions of fear (*scared*), anxiety (*nervous/anxiety*), and feelings of being *overwhelmed*, and feeling like a fraud (*impostor syndrome*) as they learned to become more expert. Some experienced a sense of loss related to their former expert selves and the role they once played in patient care as RNs. As acute care nurse practitioner (ACNP) participant #2, who practiced at a large hospital in North Carolina, eloquently stated in her letter, *“It is such a role change to become an advanced practice nurse, you know how to be a great nurse, (but) you have no idea how to be a nurse practitioner.”*

Several participants spoke about the unexpected differences between the RN and NP roles. FNP participant # 6 wrote in her letter, *“The role of the NP is totally different than the role of (the) RN.”* FNP participant #12 described what this was like to be a new NP graduate, *“It was nerve wracking. I really was very scared because it is like you go from not being an*

advanced practice nurse to being an advanced practice nurse and you are charged with being the expert instantly it seems.”

Participant #2 vividly described feeling overwhelmed despite having worked in the same hospital and clinical area as a RN and having a good working relationship with the unit staff, “*I knew the nurses, the residents, and the fellows, but not how to do that job. I thought I knew how to do that job until I started doing that job.*”

It takes time. Participants indicated that learning to think and feel and behave like a NP took several months. As one participant (#2) noted in her letter, “*You won’t feel like a nurse practitioner for MONTHS [sic] – that is totally normal!*” The majority of the participants indicated a timeframe that ranged from 6 to 18 months regarding how long it took them to feel more comfortable in their NP role. Participant #2 described how long it took to feel comfortable in her NP role,

After the 9-month mark, once I realized I could do this job and I really did love being a nurse practitioner and I would not leave. Once I started to feel more comfortable, I would say that was around the one-year mark.

During this challenging time, participant #2, recalling the advice she had received, offered the following comments when asked about what advice she would have for a new NP graduate beginning hospital based practice,

Give it some time, don’t give up too early and don’t judge it too quickly. People kept telling me, ‘give it six months, give it six months.’ If I had only given it six months, I wouldn’t be doing it today, you know? I mean if it is something you think you will love, stick with it, I mean I am so glad that I gave it that extra two or three months. So now, I have the job that I love. And then I would say remember why you wanted to go to school

in the first place. Remember what motivated you, because that really is what motivates you.

Drawing on the past to inform the present. In their written letters to future NP graduates planning a hospital based career, study participants cautioned new NPs to remember the expert clinical skills they had gained from their former nursing experience; participant # 11 wrote in her letter, *“This role does not come naturally. Remember what you know as a nurse.”* Such skills would be helpful to them as they moved forward in their transition to functioning as an NP.

Yes, I feel a wide range of nursing experience helps you much more-I don't know-maybe I am bias [sic], but when you work as a nurse practitioner, you come into the role as a nurse practitioner, you pull a lot from your nursing experience because other than being a good assessor, and a keen evaluator, you have to have experience to know how to corroborate your assessment and plan.

The helpfulness of previous nursing experience was also written about by participant #9 wrote in her letter, *“I've discovered that my experience as a nurse has had a huge impact on my success as an NP. You bring your background and experience while learning your new role as an NP.”*

Gaining a new self-identity as NP. The challenge of being a new, inexperienced NP posed a major challenge in participants' role transition, but the ability of being able to impact patient care at the level of NP was described as satisfying and *“a lot of fun,”* as described by participant #10. Part of this challenge for the participants was changing their self-perception from RN to NP. For some, the transition was accompanied by sadness associated with the perceived loss of their former RN role. FNP participant #5 described such feelings during the interview, *“So I had a six week transition there and it was hard to give up, for me personally, not*

being at the bedside anymore. The hardest transition thing for me, was giving up the role of registered nurse.”

Time in the new role eventually led to the formulation of a new identity. Almost three years into the NP role, for example, a participant described her ultimate successful transition in self-identity to that of an NP. *“Even now, I identify more, even though I have been a nurse for 12 years, I have been a nurse practitioner going on year three, I find myself identifying more with nurse practitioners than I do with nurses.*

All participants agreed during the interviews that they had gained comfort and confidence in their NP roles, but acknowledged self-education and continuous learning was essential and would always be necessary in order to achieve and maintain expert status as an NP. During the interview with participant #12, she shared that after graduating from her NP program she realized that she was no longer an expert despite having her advanced practice degree. She commented,

At that point, you have to step up (with) self-education and motivation and learning. It just starts at a whole different level, I felt like. Because I was licensed and credentialed, it implied I had a skill set at this point to offer interventions and that was nerve wrecking in the beginning.

In summary, the process of going from expert RN to novice NP involved a change in role and self-identity for the new NP graduate beginning practice in a hospital setting.

Taking on an NP role was characterized as empowering, grueling, scary, anxiety provoking, and associated with feeling overwhelmed. What helped the transition was the ability to capitalize on prior nursing knowledge and expertise. What challenged the transition was essentially having the credentials to function in an advanced practice role without the self-confidence or work

experience. In addition, a self-expectation and expectation by others of instant expertise was problematic for new NPs. New NPs faced an initially overwhelming situation that they perceived was remedied with time and practice in order to get through the transition successfully.

System Integration

“When you are new, the system can be very overwhelming and new to you”
Participant #7

Participants described their integration into the hospital system as key to their survival and ultimate success as a hospital-based NP. Their experiences of integration into the hospital system where they were employed reflected a process involving four interrelated and sometimes overlapping phases. These phases include pre-employment preparatory, getting credentialed, getting started, and practicing.

Pre-employment preparatory phase. In the pre-employment preparatory phase of system integration, two participants’ spoke about the competitiveness they faced in obtaining a hospital-based position as a new graduate. The competition was heightened due, in part, to the limited number of available hospital positions compared to the number of new NP graduates seeking them. They also competed with physician assistants (PAs) for such positions. In addition, it was more difficult for them to secure a hospital-based position if the NP graduate first began practicing in an outpatient arena. As one FNP (#4) recalled, *“People don’t want to hire you if you go outpatient. Especially in North Carolina, you know, the market is so saturated and so many NPs and PAs are looking for jobs.”*

Participant #7 shared the advice given to her by a physician with whom she worked while a nurse and a student NP. He suggested to her that the best way to secure a hospital-based NP position was to have a hospital-based clinical rotation while a student. She took this advice and spoke about how it influenced her transition to hospital-based practice.

(The physician explained), 'It will be much more difficult transitioning in another hospital. Being a nurse or case manager is one thing, but being a nurse practitioner is totally different.' He said, 'we strongly suggest that you try to complete some rotation within a hospital setting, whether it is [one of two other hospitals]. If you have a hospital you want to get into, we strongly suggest you do that.' So I did, and it was good because I was able to work with doctors in the emergency room and all the way through the hospital.

The participants' perceived that having prior employment as an RN provided an advantage in being hired at the same hospital after NP graduation. Thus gaining employment as a NP student was one potentially helpful strategy for getting a foot in the hospital door in what was a highly competitive environment for NP employment at the time of this study. Once in the door, getting started had its own challenges.

Getting credentialed phase. Following graduation and passing national NP board examinations and accepting a hospital based NP position, new NPs had to obtain hospital credentials and privileges in order to practice. The point at which NPs could begin practice was a hospital specific determination. Some NPs were not allowed to begin practice in their hospitals until the hospital issued the participants full credentials. Being issued full credentials meant no restrictions existed that would limit the NP from functioning in the NP role. Having full credentials meant full access to all patient care areas, medical records, having required access numbers in order to assess a variety of systems with protected patient information or areas not accessible by the general public such as electronic medical records, the dictation system, radiology viewing areas, the morgue, pathology department, physician work rooms, and various staff offices. Other participants were granted partial privileges, which limited their scope of

practice until they were granted full credentials and hospital privileges. In addition to maintaining an active and unrestricted RN license, the NP had to subscribe to additional regulatory requirements that could be time consuming. As described by participant #12,

There was lots [sic] to learn, I mean, like with credentialing that is just an incredible hurdle to overcome. All the required paperwork, all the required checks and balances, all those things to make sure you are in compliance, not just as a nurse, but with the Medical Board as well.

The credentialing process required completing an application that including a criminal background check, verification of unrestricted licensure(s) to practice, obtaining written recommendation by peers, written verification of NP education program completion, and completion of regulatory paperwork required by the NC Boards of Medicine and Nursing. All this documentation had to be completed before the application went to the Chief Medical Officer and Chief Nursing Officer at the employing hospital for final signatures of approval. Depending on hospital policy, until all these steps were accomplished, the NP could not practice in that hospital.

According to several participants, it usually took a time period of several months to obtain full and unrestricted hospital credentials and privileges. According to participant #10, “*I would say it took forever to get credentialed.*” The slow process was attributed to hospital-related internal factors as well as factors external to the hospital. Participants attributed slow internal processing of credentials and accordance of hospital privileges to what they perceived to be an inefficient credentialing process.

A lack of credentials sometimes negatively impacted care by denying the NP access to key resources needed for practice. As ANP participant #11 described,

The credentialing was not well organized. There was no structure or support for finding (and accessing hospital) resources. For example, because I was not credentialed when I started my role in the hospital, I was not set up to do order entry in the electronic medical record. Because of this, it held up patient care.

The external reasons linked to the hospital credentialing process including waiting for specific documents from licensing or regulatory agencies such as the North Carolina Medical Licensure Board and Drug Enforcement Agency (DEA). For example, something that impacted NP scope of practice was obtaining a U.S. Department of Justice DEA number. Having an assigned DEA number gave the NP authority to prescribe controlled substances. FNP participant #10 described her experience of being allowed to work in her NP role prior to being granted full hospital privileges and not yet having her DEA number. She described how she and her physician partner worked around the obstacle that a lack of DEA number posed,

And beyond that, then it took me three months to get a DEA number, so even though I got credentialed, I didn't have any prescriptive rights, so there I was. So we worked around that. I would present every patient to the doc and they would come in and eyeball them and I'd say they need Amoxicillin, and they would give me a script.

In some instances, if prescribing controlled substances was encompassed in the NPs scope of practice, full prescriptive authority might not have been granted until the DEA number was obtained. In the case of participant #10, for example, not having her DEA equated to no prescriptive authority and prevented her ability to prescribe antibiotics. While waiting for NP licensure from the NC Medical Board, another external regulatory agency, participant #10 described her situation that almost prevented her from getting a job.

That was almost a deal shooter, because they needed me working. It took months and months and months. Especially waiting on the medical board because at the time, they only met once a month or something and if you didn't have your paperwork in November for December, then you had a 30 to 45 day waiting period.

When asked by the researcher what the perfect role transition would look like, several participants described a seamless process including an efficient credentialing process when beginning hospital-based practice. This was described by ANP participant #8,

A perfect transition would be, you complete your application process, have your credentialing process completed, then during the time you are going through your classroom (hospital) orientation, the credentialing process should be completed, so when you complete your classroom orientation, you should smoothly transition from the classroom to the unit you are working, so the first day after orientation, you are in working environment, and you should be actively working with the patient.

In general, the experience of obtaining hospital credentialing was fraught with difficulty and delays. The overall consensus was that the credentialing process took too long due, in part, to inefficiencies with the credentialing process. Credentialing delays resulted in significant delays in participants' ability to begin fully functioning as NPs in the hospital. This had a negative impact on NP participants as they started their new roles. They spoke of their frustrations, which included having to do "work arounds" with their physicians so their patients received needed care without delay and without the NP being placed in compromising situations such as being allowed on the unit to function as a NP but not being granted NP provider access to the electronic medical record (EMR) or having limited prescriptive authority. Ultimately,

these situations resulted in compromised safety and patient care due to a limited ability of the NP to fully function as an NP.

Getting started phase. Aspects of getting started that challenged the participants included issues that they faced when beginning their hospital-based NP role. These issues included challenges such as gaining comfort with working through a patient encounter efficiently and independently. This included performing a good physical examination, making a correct diagnosis, and prescribing appropriate treatment. In addition, presenting themselves to the patient, family, and staff confidently was initially difficult. Participants described the experience of being challenged by the nursing staff regarding their decision-making. As recalled by participant #2, *“the nurses did not want to take orders from me. It wasn’t the old ones or the new ones, it was my peers who actually were the problem.”*

Prior experience in the system. Getting started in practice as an NP was eased somewhat for those who were already familiar with the particular hospital system where they gained employment as an NP. Several of them, for example, found it advantageous to have worked at the same hospital as a nurse when they began work as an NP. Their prior knowledge of the system, including its culture, politics, and computer system, helped them integrate into the system and transition in their role from RN to NP, but was insufficient in addressing the issues that occurred early in their NP practice. Prior familiarity with the system did not, for example, alleviate the stress and anxiety that most experienced as they started functioning in their new role. Nor did their prior knowledge help them address the many questions and concerns they had as they began treating patients and interacting in new ways with patients and staff.

Orientation to the system. Regardless of their familiarity with the hospital environment, the NPs in this study recognized and understood the need for a formal hospital orientation that

was tailored to them and their new role. Participant #6 suggested in her interview, “*New (NP) grads need to have a little bit longer of an orientation, just like new grads in nursing, to make sure they have a chance to get their feet on the ground.*” As stated by participant #7 who had previously worked as a nurse at the hospital where she was hired as a NP,

I knew all the systems, documentation systems, the EMRs, but it was at a different level. I still had to take all the (orientation) classes because it was at the physician level and with my background, I could have gotten into the different departments.

Nine participants identified an orientation to hospital-based practice as essential for the new NP, particularly for those NPs completely unfamiliar with the specific hospital system in which they found themselves. Three participants were new and initially unfamiliar with their hospital systems. Seven of the participants had some type of orientation but only two of these participants described their orientation as adequate. Both of these participants had previously worked at the same hospital as a RN and both participants had a designated mentor available to them during their orientation. In response to the researcher’s question regarding the NPs concept of an “ideal” orientation, participants recommended three specific components. These components included: (1) finding a mentor, (2) having a well-defined role, and (3) understanding physician expectations. They believed that having a NP, PA, or MD available as a mentor was advantageous. They envisioned such a mentor would be present to ask questions and engage in decision making before implementing a plan of care or ordering a treatment modality. They found it helpful to be apprised of a clearly defined role as reflected in a written job description and collaborative practice agreement. The participants explained that having a formally written document that detailed their job duties and scope of practice would also help new NPs better understand their role. They also wanted to have a clear understanding of

collaborating physician expectations. This was information that needed to be asked by the NP of the MD about specific patient issues about which the MD expected notification. Since these expectations varied from one physician to another, participants suggested having a conversation up front with the MD to address these issues.

Participants' recommendations about the orientation program for a new hospital-based NP included both standardized and individualized approaches to assure that the NPs early practice needs and support were adequately addressed. As described by participant #2, *"make sure they (new NPs) have an incredible orientation, and that could be different for everybody, depending on what level they are at, well, (their) background experience."* Of particular importance in their personal role transition experiences was how NPs were integrated or reintegrated into the hospital in their new roles.

Practicing phase. Several participants spoke of how their scope of practice was greatly influenced by what they were asked to do by the physicians and hospital leadership as a new NP. For example, depending on the model or floor/unit of practice, the NP might have been expected to function more independently, without the readily accessible support of another clinician. If the NP model or floor/unit had consistent availability of other providers (NP, PA, or MD), as might happen with a team approach, the NPs scope of practice may be different. In most instances, new NPs ultimately had to speak up and request help for themselves if they perceived they were exceeding their comfort level. Participant #4 addressed this issue in her letter: *"In a hospital setting, you will be asked to do things that, quite frankly, are outside of your scope of practice."* In addition, how the participants were exposed and integrated into the hospital culture as a NP influenced how the NP role was defined. The participants spoke of how their role in the

hospital system was in part affected by the practice model on their particular unit or service in which they practiced.

Continuity of care. Three participants mentioned the continuity of care they provided as an important component of their NP scope of practice in their hospitals. Specifically, in larger hospital settings, the NP role offered a consistent presence and better knowledge about the status of patients on a day-to-day basis than those health care providers who periodically rotated through the unit. NP consistency was particularly key to continuity of care since medical residents and attending physicians were available only episodically and over relatively short time periods due to their rotations among various units. In addition, residents were sometimes unavailable because they had to leave the hospital after working a restricted number of consecutive hours, referred to as being, “*post call.*” They also attended classes and, like attending physicians, left the hospital to see patients in outpatient clinics. As described by ANP participant #8,

That is one of my goals, is to be that continuity. Our residents and interns rotate every month, our attendings [sic] rotate every one to two weeks, so as the patients either come back and forth or are here for multiple weeks, I can help out when someone on the team says, ‘have we done that, or not, or tried this,’ so I can keep them from reinventing the wheel so to speak.

The NP role. The NP participants detailed their role as providing direct patient care, such as assessing patients’ health status, diagnosing health problems, treating such problems, and managing patient care. They also conducted research with fellow NPs; communicated with patients, family, and staff; and served as integral members of the medical team.

In terms of the big picture of hospital based NP practice, the NP participants recognized that they filled a unique role in a hospital setting. They saw themselves as providers of high quality and cost effective care, often “*filling in the gaps*” in patient care that occurred in the absence of medical residents or physicians. They saw opportunities for providing health care in an era of health care reform and potential future changes in health care delivery models.

The significance of their self-perceived contributions to health care was expressed by participant #1, an ACNP who perceived that NPs provided quality, cost effective care in acute care settings:

I think nurse practitioners are the future...the nurse practitioners, according to the literature, can provide quality care comparable to physicians. So I think we bring something extra to the table with the nursing piece of it.

In summary, regarding system integration, the participants spoke about the importance of determining their practice site and gaining experience in that site before graduating from their NP programs. After beginning their new NP role, the participants spoke about being integrated into the system including the hurdle of credentialing and importance of an adequate hospital orientation. Finally, how their leadership exposed them to the system influenced their scope of practice and how their NP roles were implemented.

“Don’t Give Up”

“You’ll learn. You’re prepared for this job, don’t give up, it will all fall into place!”
Participant #2

Data analysis revealed a theme of not giving up despite the particular obstacles related to gaining personal and professional acceptance as a health care provider. During the interviews, several of the participants spoke about how important it was to persevere, particularly during the initial transition period. Half of the participants described difficult situations they experienced as

a new hospital based NP that may have caused them to question their decision to become a NP in that setting. Commenting about the need for perseverance, participant #1 said in a letter to NPs, *“stick with it and you will get through the difficult transition from expert to novice. You will get your confidence level up, and once you get through that, you are pretty good to go.”*

One of the initial challenges for NPs was gaining personal acceptance within the units to which they were assigned. They experienced resistance from two primary sources: peers who were reluctant to accept them in an expanded role as NPs and other providers who were resistant to the presence of NPs in general.

Colleague resistance. It was not unusual for participants to initially experience others’ resistance to them as NPs. The origin of such resistance was sometimes a personal reaction of peers who had known them previously in their nursing roles. Resistance also sometimes emerged as a non-personal reaction of medical staff that did not welcome the overall contributions of NPs.

Peer resistance. Some participants faced the challenge of collegial resistance as they engaged in their new role as NPs. An ACNP (participant #2) shared about her experience with a few nurses with whom she had worked side-by-side with on the same unit as a staff nurse then again as she became a NP on that same unit,

It wasn’t the ones with 25 years of experience, that I thought might have a problem taking orders from me, and me directing the care of their patients; it was the nurses at the same level of nursing experience as me, they did not want to take orders from me. It wasn’t the old ones or the new ones, it was my peers; who actually were the problem.

Medical staff resistance. In addition to situations where nursing staff was reluctant to respond appropriately to the former RN enacting a new role, the medical staff offered their own

opposition toward the new NP. ANP participant #3, ANP described her experience with the cardiologists with whom she worked, *“When we (she and another nurse practitioner) first started working, some of the doctors wouldn’t utilize our services. And it wasn’t because we weren’t doing a good job, it was their personalities and they would rather do it (themselves).”*

Gaining professional respect. The participants described the work required as a NP as challenging. This included aspects of the role such as development of the NP role to expert that included developing diagnostic skills, decision making in regards to patient treatment modalities, and overall responsibility to providing comprehensive, high quality care. Participant #8 worked in a large hospital with a team of medical residents. He wrote in his letter how his experience over time contributed to becoming an effective NP: *“Especially with this steep learning curve, don’t get frustrated. Don’t give up, it will come to you over time, it does take more time depending on how complex your patients are.”*

Participants believed that gaining the professional respect of some RNs was enhanced by them holding health care provider status as an NP. Perhaps this was due to the comfort, understanding, and reduced intimidation that existed among nurses, albeit one of whom was an advanced practice nurse. FNP participant #4, wrote the following insight:

I have also found that as a nurse practitioner, nurses and other staff members are more likely to call you for patient matters as they do not want to “bother” the physicians. This means that sometimes you are busier than the physicians you work with.

Despite experiencing many challenges to themselves and their work as health care providers, participants emphasized doing all they could personally, not only to promote excellent patient care, but also to gain the respect of health care professionals in general. They wanted to reinforce the positive contributions that NPs were capable of making in hospital-based health

care delivery. They recognized the importance of reacting carefully, appropriately, and professionally to all situations that confronted them. This recognition implied an understanding that their actions collectively contributed to legitimizing the role and work of NPs in general. Participant #8 hoped, for example, that his work would lead to a positive view of NPs in general. He said, *“I think that hopefully they (medical residents) have some good respect for my role and that knowledge, like you say, will have a favorable opinion, of our profession.”*

Some participants believed or hoped that, in their role as advanced practice nurses, they would be viewed as nurse leaders in the hospital setting, particularly by RNs. This desire was written in the letter by participant #4, *“Just remember you are now a leader and be thoughtful in the way you present yourself and your profession.”* In essence, participants perceived their professional behavior and response to challenging situations as representing all NPs. They were aware of the tacit expectations and professional standards to which NPs must subscribe. Participant #12 explained during the interview, *“To gain that credibility, you have to be very measured in what you say (and do) to build your validity. If you think that way, you will be that way.”* In her letter, participant #4 wrote about the importance of how the NP responds to the multiple demands that may be experienced:

The hospital is an exciting place and that may be part of the reason that you have chosen to start your NP career there, but it is also a very demanding environment that requires you to prioritize everything. As a member of an acute care team, I am always at the mercy of my pager. In the course of five minutes I may be asked to go evaluate a patient who just coded in the ICU, a cardiogenic shock patient in the ER, and a crashing patient in the cardiac catheterization lab. No matter what is going on around me, it is important that I remain calm and retain the ability to prioritize.

In summary, related to the theme of not giving up, the participants spoke about the importance of allowing time to enable the new NP identity and role to evolve. Participants suggested that new NPs avoid taking the resistance of others personally. In addition, the participants described the importance of the NP role as leader. They underscored the importance of professionalism during challenging situations since their behavior represented NPs in general. The theme of not giving up can be equated to having endurance and perseverance in a challenging time such as the role transition for the new hospital based NP.

Learning “On the Fly”

“I think a more formalized type of orientation (is needed) with sit down and hands on information with someone who knows exactly what you will be doing, instead of jumping right in...just winging it and learning on the fly.”

Participant #8

Participants’ perspectives and experiences as new hospital-based NPs indicated that they invariably participated in learning “*on the fly*.” They indicated that “*on the fly*” referred to the necessity of performing new NP skills in a way that was unplanned, without preparation, and that sometimes involved improvisation. This theme emerged from participants’ statements about the challenges of learning their role in a hospital setting. The issue of learning “*on the fly*” reflected the availability of two particular influences on their transition: mentoring and a formal orientation to hospital-based practice.

Alone and winging it. The theme of learning “*on the fly*” was supported by participants’ numerous comments about feeling alone as a new NP in the hospital. Not having someone to “*teach me the ropes*” was mentioned by participant #2, despite the availability of another NP and PA with whom she worked, neither of whom displayed interest in serving in a mentoring role for this individual. At times, the work schedule contributed to learning “*on the fly*.” As participant #3 shared, “*The biggest thing is working at night. So some things I had to*

wing it on my own, but obviously, if it was something I really did not know, I would call my physician.”

Although the feeling of being alone in the beginning of their practice was strongly expressed, the participants acknowledged retrospectively that support was available when they needed it. However, because most of the participants were among the first NPs to be hired in their particular service or model, they described feelings of having no support and feeling alone, in part, because there were no other NPs like themselves with whom they could consult, discuss issues, or express a need for assistance. They described themselves as having to pick up the information and learn along the way.

Mentoring is key. In regards to learning “*on the fly*,” all the participants commented about the importance of having a mentor, particularly since most of them did not have a designated mentor when they started their NP role. Such a mentor could be an RN or other provider, including a physician, nurse practitioner, or physician assistant, but needed to be someone who understood NP practice, was willing to devote time to facilitating NPs’ clinical expertise, and was readily available for consultation and support. Participant #11 wrote in her letter, “*Find a mentor who will help you grow and be successful.*”

In some cases of physician-provided support or mentoring, differences in practice between an NP and physician could result in the NP not feeling mentored, despite some degree of physician presence or oversight. As participant #1 explained, “*I did not have a nurse type of mentor. I had to basically pick up the pieces from the physicians. You know the physicians practice differently than the nurse practitioners.*”

Getting oriented. Not surprisingly, the availability of a formal hospital orientation influenced the NPs learning process. The experience of learning “*on the fly*” tended to be

heightened when participants' integration into the hospital system did not include a formal orientation to the system. Participant #9 spoke about her poor orientation experience, "*It would have been nice having that (orientation) structure in place. I have found as a NP, you are more responsible for (getting oriented) yourself.*" Participants' comments such as being alone and winging it, learning "*on the fly,*" and not having a mentor, coupled with a lack of critical information up front, at the point of initiating their practice, were indicative of an improvised learning experience for the new NP. Some conceived such an orientation as a "*classroom*" experience that occurred prior to entry into the hospital unit(s) to which the NP was assigned.

In the end, the participants contended that future NPs had to be proactive and assume personal responsibility for finding a mentor if one was not designated for them. The mentor did not have to be another NP, but did need to be someone who was available to collaborate and talk with extensively, supportive, and helpful in cultivating the instincts and clinical expertise they needed as an NP.

Mentoring and a formal orientation for hospital based NP practice were clearly important adjuncts in the initial adjustment to practice as a mediator of the stress associated with being a novice in hospital-based practice. The absence of either element, however, did not deter the participants from eventually finding their way and effectively performing their NP roles. After having two years of NP practice experience at the time of the interview, for example, participant #1 was optimistic about the outcome of her transition, as reflected in the following statement, "*I feel really good about it. You know, there is always a lot of stuff to learn. You learn new stuff every day, so I am tweeking [sic] my practice every day. I really do feel good, practice wise.*" The availability of a mentor and a formal orientation would, however, have eased the stress and

perceived difficulties involved in transitioning to hospital-based practice and perhaps have decreased the time required to accomplish a successful transition.

They Do Not Understand My NP Role

“So the physicians not being familiar with our role, the nursing staff not being familiar with our role as a nurse practitioner. And some of the administration, like nursing management, not the VP of patient care services, but, the higher level nurses, not understanding the nurse practitioner, thinking that all we can do is educate, or this or that, not understanding that we can do pretty much everything a physician does.”

Participant #1

Misunderstandings by hospital personnel and others about the NP role and needs clearly influenced the NPs initial role transition. Several of the participants described frustrating or difficult experiences with hospital staff as well as patients and families when such individuals did not understand their role.

Physician understandings and acceptance of NP role. Physicians’ lack of understanding or acceptance of the NP role had a particularly negative impact on the role transition experience for new NP graduates. Participant #1 described the individual physician determined NP oriented roles as either collaborative or supervisory, recognizing that some of the physicians did not wish to involve or compete with NPs as medical care providers.

Some of them (physicians) do (collaborate); (however), some of them see it as a supervisory role, instead of a collaborative role. Some physicians definitely understand your role and what my role is and the patient care delivery in this organization. Some of them still think you are going to ‘pee on their tree.’

Patient and family understandings and acceptance of NP role. Patients and their families’ lack of understanding or acceptance of the NP role was described as a frustrating experience, which impacted the role transition experience for new NP, graduates. Participant #1

described the experience of patients and families not understanding the NP role and function as a provider and being asked by the patients and family members, “*When is the doctor coming?*” Participant #5 also recalled being asked by a patient for whom he was providing care, “*Is my doctor sick?*” The participants described the frustration of having to explain their NP role to patient and families and noted that the older population particularly had more difficulty in understanding the NP role.

Hospital-based practice constraints. Limited physician understanding and/or acceptance of the NP role, resulting in physician oversight as a supervisor rather than the NP-preferred physician role of collaborator, affected NP autonomy. The specific practice setting can also influence autonomy. Participants attributed inadequate utilization of the full scope of NP practice to hospital-based practice constraints. They noted a need to comply with medical staff bylaws that guided hospital practice standards for physicians and other provider staff. Participant #4 compared her NP experience practicing in a large hospital with that of an outpatient clinic setting.

Well, I think working in a hospital you are giving up some of that autonomy that goes along with the NP role. I think when you do outpatient, because this last year, we did have the opportunity to do some outpatient clinic work, and I did do that. So, when you are seeing a patient in the outpatient clinic, you are really functioning in your full scope of practice. In the hospital, it is different, because of all the organizational regulations, like you may have to have a doctor sign off on your orders, I think it is in some ways, when you work in a hospital you are not really functioning as an NP like you do as in outpatient. That was a challenge for me, I felt like a lot of that I could have done as a nurse. Everything you do is in collaboration with a doctor, in the hospital.

Administrative issues. Because the hospital-based NPs are a relatively new phenomenon, administrators did not necessarily have a clear understanding about their roles, the regulations guiding their practice, and their work-related needs. In many hospitals, administrators and others were learning in concert with the NP about such issues. As a consequence, sharing information among NPs was sometimes fragmented and NPs often had no administrative “home” to which they could appeal in the event of unresolved issues and problems.

Regulatory misunderstandings. A lack of administrative understanding of the NP regulations and practice laws issued by the NC general assembly posed issues related to regulatory compliance by NPs new to hospital practice. As participant #3 recounted,

One thing that I did find frustrating, and it is not anybody's fault, because this was a new program for them [sic] too. They did not understand what all we needed, for example, the paperwork we needed; the collaborative practice agreement, they were like, 'well, no you don't need that'.

Office space. Access to an office space to do work-related activities was an important but sometimes unrecognized aspect of NP based-practice related to administrative misunderstandings of the NP role. Participant #3 explained that hospital administration did not initially support the need for a separate designed workspace away from the clinical area. NPs, however, found such areas useful to perform dictation, make follow up phone calls, research various aspects of clinical care, or to just get away. Participant #3 explained,

We had a meeting, and we were all trying to get this together. And he (the physician) said, well, are they going to have an office? And they said, the (administrative) director, said, well, no, they can use the doctors lounge. And my doctor said, no, they need a place

for themselves, where they can get away and that is so true. Because, you know, going on the floor, it is like being a bee and honey, they just swarm around you. You need a place to kind of get away.

NP performance evaluation. Some of the participants voiced frustration about leadership who did not clearly understand their NP role, due in part to lack of experience as an NP. Typically, a nurse administrator or nurse manager did the performance evaluation with feedback from the physicians. Several of the participants spoke negatively about administrators or managers who conducted NP performance evaluations and who had a poor understanding of the NP role and scope of practice. NPs believed that someone who had practiced as an NP and had an accurate understanding and appreciation of the NP role should conduct performance evaluations. Participant #9 described this situation regarding one of her NP colleagues,

One of my friends is a nurse practitioner in a cardio-thoracic ICU and they are 100% paid by the hospital, so she (is accountable) to them and has her evaluations done by someone who has never practiced as a nurse practitioner.

In summary, the role transition experience for these hospital-based NPs was influenced by others lack of understanding about their NP role. This lack of understanding was on the part of essentially everyone with whom the NP came into contact, including physicians, hospital leadership and management, nursing staff, and patients and their families. The misunderstandings negatively influenced their role transition. Many of the participants found that when they started their hospital based practice; everyone had to learn together about the NPs role, including the NP.

Succeeding Through Collaboration

“There are so many things that are new, and challenging, particularly if you work in a large hospital. So, for me, it was just working with good physicians.”

Participant #4

A theme that emerged from the data analysis related to NPs succeeding through collaborative relationships. They forged or attempted to forge collaborative relationships with others including physicians, staff, and administration. These relationships impacted transition for the new NP. Every participant spoke about the importance of such, in ensuring a successful transition for the NP. The primary relationships referred to in the letters and interviews primarily included hospital administrators, peer NPs, nursing staff, and the physician(s) with whom they worked. Participant #2 spoke about the positive influence of relationships with the nursing staff and NP peers was for her,

The support was the big thing. And (co-workers name), she and I worked well together, so she helped me, my co-worker. Also the nurses helped a lot. I have learned that some are very valuable resources. They really helped me, like I know who I can go to. Like with a person I am not quite sure what to do with their insulin, we have several nurses, who are unfortunately diabetics, but I know I can trust them with my patients. So, definitely, co-workers helped.

They discussed the importance of having a collaborative working relationship with a supportive physician in their role transition experience. Participant #5 spoke about this relationship:

I guess I would say I really depended on the doctors. They were vested in teaching me and I think that makes such a big difference. And I know you read that letter I wrote, there are so many things that are new, and challenging, particularly if you work in a

large hospital. So, for me, it was just working with good physicians. For me, I don't know how NPs do it, if you don't see them (the physician), you don't talk to their doc. I have learned more from them, in working, than I ever did in school, in reality.

The majority of the participants shared that a supportive relationship with the primary collaborating physician was essential to having a positive role transition in the hospital. Those who described physicians positively used such words as “*helpful,*” “*patient,*” “*available,*” “*invested in teaching,*” “*present,*” and “*team.*”

The participants elaborated about how essential it was for the NP in a new working relationship with a physician to be aware of the physician's expectations regarding the patient issues or problems about which the NPs should contact them. The participants suggested that such expectations be addressed up front at the start of their working relationship. Knowing the physician expectations up front from that start ensured a better chance of success for the NP in terms of feeling empowered and making a positive transition. Physician expectations required that the physician understand where the new NP was in his/her role development. This would ensure the expectations would be consistent with the NPs level of experience. As mentioned earlier, study participants suggested a positive working relationship would be collaborative rather than supervisory. Participant #2 explained the importance of a positive working relationship with a physician by making the following suggestions to physicians:

Be patient with them (the NP). And tell them what you expect out of them, and tell them how you expect the practice to be run. What are their responsibilities, what should they ask you about. What do you want them to call with, how much autonomy will there be. I mean really spell it out for them....especially the red flags like, if there is ever this, then you need to be notified.

In addition, participant #7 explained,

If you are going to be working with a particular physician, make sure you have a good idea of what their expectations are of you as a nurse practitioner. I have been very fortunate and don't have that much interaction, and have been nothing but supported from my collaborating physician. That is important, that relationship needs to be strong, you need to feel empowered and feel like you have that autonomy and that you have that support too and they are promoting you. Knowing prior what my goal is, what my role is, let the physicians know that (while) we may not have as much medical knowledge up front, we have a lot of knowledge that they don't (have), and they do have an opportunity to learn from us as nurse practitioners.

Summary

This chapter provided the qualitative findings from eleven letters and twelve one-on-one in-depth interviews with NP participants with at least one year work experience regarding their initial transition from new graduate to hospital-based practitioner. The use of letters to potential future NP graduates supplemented the one-on-one interviews in this study.

Through the analysis of the letters and interview transcripts, six themes emerged from the narratives shared by the participants regarding their lived experience regarding their initial transition from new graduate to hospital-based practitioner. The six themes and that emerged included: *Going From Expert RN to Novice NP, System Integration, Don't Give Up, Learning 'On The Fly', They Don't Understand My NP Role, and Succeeding Through Collaboration.* These themes provided the framework for understanding the NP experience as experienced by the participants.

The theme of system integration revealed particular importance regarding the transition experience for the new hospital-based NP. It was within this theme in which the participants adopted and developed their NP skills. As they were integrated into their particular hospital system in which they practiced as a NP, they also developed their sense of role identity as a NP.

CHAPTER FIVE: DISCUSSION, RECOMMENDATIONS, AND CONCLUSION

Discussion

This chapter presents the discussion and conclusion based on study findings relevant to the meaning and lived experience of NPs with at least one year of work experience regarding their initial transition from new graduate to hospital-based practitioner. In the chapter, I will examine these findings in the context of research study findings and theoretical and other perspectives published in the research literature regarding NP transition. Specifically, I will address findings from the present study in the context of Meleis' Transition Theory, Advanced Practice Nursing Models, and will present implications for hospital-based novice NPs.

The researcher used hermeneutic phenomenology (van Manen, 1990) as the research approach for this study because it is a form of phenomenology which focuses on lived experience and gaining a deeper understanding of the meaning of everyday experiences (van Manen, 1990). In conducting this phenomenological study, the researcher strived to achieve insightful descriptions of the way the world was experienced by the participants (van Manen, 1990). As a consequence of researching lived experience, study findings will inform nursing administrators' and others' awareness and sensitivity to the novice NPs experience to initial transition to hospital-based practice including needs and concerns. This will enable nursing administrators to tailor the NP orientation to meet those needs.

The twelve NP participants' characteristics in this study were similar to those of other novice NPs in two primary ways. Like most practicing NPs, the participants in this study had prior years of experience as a RN and secondly, shared a general lack of NP-related experience.

The NP participants' characteristics in this study also differed in several ways from that of other NP graduates described in the literature. All the NP participants in this study were

master's prepared NPs, which became a national requirement in 2005. Participants in studies conducted before 2005 may not have included all masters prepared NPs (Almost & Laschinger, 2002; Bosch, 2000; Brown & Olshansky, 1997; Cusson & Viggiano, 2002; Dahl & Penque, 2000; Heitz, Steiner, & Burman, 2004; Hoffman et al., 2003; Kelly & Matthews, 2001; Rosenfeld et al, 2003). All participants in this study began practice as new adult, family, and acute care NPs, while new NPs in prior studies were located in outpatient, primary care settings. Some of the reviewed studies included more homogenous groups of NPs, such as acute care (Cajulis & Fitzpatrick, 2007; Chang, My, & Tsay, 2006; Cowan et al., 2006; Cusson & Strange, 2008; Hoffman et al., 2003), or primary care NPs (Bosch, 2000; Brown & Olshansky, 1996; Heinz et al., 2004) or the type of NP was not indicated (Dahl & Penque, 2001; Kelly & Mathews, 2001). Almost & Laschinger (2002) studied a combination of acute care and primary care NPs but the researchers did not reveal the NP type in that study.

Six themes emerged from the data, *Going From Expert RN to Novice NP, System Integration, Getting Credentialed, Don't Give Up, Learning 'On The Fly', They Do Not Understand My NP Role, and Succeeding Through Collaboration*. The researcher's investigation into the meaning of new NPs' lived experience of transitioning to hospital-based practice revealed the transition to be taxing for these individuals, particularly for the first nine months. Participants confronted multiple obstacles and challenges as new NPs. Among the challenges they faced was navigating and negotiating a new health care provider role; becoming integrated into a hospital system in what was a new role for them and sometimes for the system; learning how to function effectively as a NP while simultaneously working to re-establish themselves as proficient clinicians with a newly expanded scope of practice; building key

relationships with staff, physicians and other providers; and educating physicians, hospital leaders, clinical staff, patients, and families about the NP role.

At the time of the study, a review of the literature revealed that the meaning and lived experience of family, adult, and acute care novice NPs transition to hospital-based practice had not been investigated. The present study explored participants' perspectives and experiences as new NP graduates who initiated their practice in the hospital setting, which, in 2010, were relatively new practice sites for NPs.

Meleis' Transition Theory

Meleis' Transition Theory (1975) informed the changes that participants in this study experienced regarding their situational transition that encompassed significant role identity and scope of practice changes in moving from RN to NP. Findings from the present study clearly reflected Meleis' definition of transition as an adaptation or change in role, behavioral patterns, abilities, and relationships. The NPs situational transition experience (Meleis, 1975) was supported by changes they expressed in their professional nursing roles and was associated with their need to acquire additional skills and knowledge, while coping with emotions such as low self-esteem, stress, and uncertainty. The role transition from RN to NP for the participants was consistent with several of the transitional conditions as described by Meleis (1975). These included the dimension of time, meaning and expectations, level of knowledge and skills, environment, level of planning, and emotional and physical well-being.

Hamric, Spross, and Hanson (2009) have characterized the experience of transition as a process that occurs over a period time. The temporal nature of the RN to NP transition was supported by participants' perspective that it took them several months to think and feel like a

NP. Schumacher and Meleis (1994) defined this condition as degree of identity crisis experienced.

The meaning and expectations of the situational transition for the NP participants was revealed through participants' experience of gaining a new self-identity as a NP. This element of transition was revealed by the theme *Moving from Expert RN to Novice NP*, which described statements about the expert RN and novice NP roles. Knowledge and skill development was revealed through the acquisition and application of new skills and knowledge gained by the participants during first 6 to 18 months of practice. The environment was an important condition for the NP participants since environmental factors impacted their transition into the system. Elements of the environment included people in the workplace such as hospital leadership, physicians, peers, and other clinical staff. A perceived lack of understanding and support for the NP was revealed by the theme *They Do Not Understand My NP Role*, which described statements about others' lack of understanding about the NP role. Environmental issues also consisted of physical space issues, such as the described dilemma around having designated workspace for NPs within the hospital setting.

The transitional condition described by Meleis (1975) as level of planning refers to effective planning with key people that will facilitate a positive transition for, in the case of this study, NPs. The themes *System Integration*, which described comments about integration into the hospital system, *Learning on the Fly*, which described learning as you go regarding how to be a NP and the significance of a mentor, and *Succeeding Through Collaboration*, which described building collaborative relationships, relate to such planning. For the participants in this study, planning for NP practice began prior to graduation and was influenced by competition for the limited hospital-based NP positions available at the time of this study. After securing

employment, level of planning consisted of elements involving orientation, having a mentor, and getting credentialed.

Participants experienced a wide range of feelings throughout the transition experience. The emotional impact of transition was addressed by Meleis' transition condition of emotional and physical well-being. This aspect of transition was revealed by NPs in the theme *Don't Give Up*, which described holding up and following through a persistent course of action especially in difficult situations, and their descriptions of the transition process as a challenging experience. Transition outcomes for the participants in this study were positive in that all participants eventually experienced what they perceived to be a successful transition that led to full functioning as a NP.

The application of Meleis' conditions and definitions to the NPs situational transition from graduation to hospital-based practice provides a useful framework for understanding the phenomenon of role transition by new NP graduates. The newly practicing NP experienced a situational transition that involved a change in role function and scope of practice. The findings in this current study supported the application of Meleis' Transitional Theory (1975). The researchers' application of Meleis' theory was consistent with its application by Kelly and Mathews (2001) to NPs in outpatient primary care settings and by Chang et al. (2006) to NPs in a hospital in Taiwan.

Advanced Practice Nursing Models

Two major studies about the role transition experience for new advanced practice nurse (APN) have been published in the literature. They include the "Role Development of the Clinical Nurse Specialist" (Hamric & Taylor, 1989, 2009) and "From Limbo to Legitimacy: A Theoretical Model of the Transition to Primary Care Nurse Practitioner Role" (Brown &

Olshansky, 1997). The purpose of the research conducted by Hamric and Taylor (1989) was to describe the role development of 100 new CNS graduates. The purpose of the research conducted by Brown and Olshansky (1997) was to describe the transition experience of 35 new primary care NPs during the initial 12 months of practice (see Table 1).

Hamric and Taylor's Clinical Nurse Specialist Model

Hamric and Taylor (1989) studied the characteristics and tasks of role development for 100 new Clinical Nurse Specialists (CNS). From this research, they developed a model that described the four major phases of CNS role development (1989): orientation, frustration, implementation, and integration. They discovered new CNSs with three years or less experience progressed through orientation, frustration, and implementation within two years, and attained integration after three years in their CNS role. The NP participants in the current study described completing the transition process usually between twelve to eighteen months. The four phases of this model, orientation, frustration, implementation, and integration, will be discussed and compared with the findings of this current study in the following sections (see Table 4).

Orientation. This phase of Hamric & Taylor's CNS Role Development Model (1989, 2009) emphasizes the development of a structured orientation plan. The importance of an orientation was clearly supported by participants in the current study as evidenced in the theme *System Integration*, which described comments about integration into the hospital system. An orientation was found to be important in both the Hamric and Taylor (1989) and the present study due to the anxiety experienced by the participants as they began their new APN roles. In addition, Hamric and Taylor's recommendations for new CNSs were to learn key leaders with whom they will be working, establish relationships, and have a mutually agreed upon expectations of their CNS role. The findings of the current research support these

Table 4

Comparison of Hamric & Taylor and Duke Models

CNS Role Development Model <i>(Hamric & Taylor, 1989, 2009)</i>	Hospital-Based NP Transition to Practice <i>(Duke, 2010)</i>
Orientation	System Integration Succeeding Through Collaboration
Frustration	Don't Give Up System Integration They Don't Understand My NP Role
Implementation	Succeeding Through Collaboration System Integration From Expert RN to Novice NP
Integration	From Expert RN to Novice NP

recommendations and are reflected in NP participant references to the importance of building relationships through collaboration and having a mentor. This was evidenced in the theme *Succeeding Through Collaboration*, which described the importance of building collaborative relationships.

Frustration. This phase in the Hamric and Taylor model represent feelings of being overwhelmed and experiencing resistance. Participants in the current study also reported feeling overwhelmed and experiencing collegial resistance by peers and medical staff, as reflected in the theme *Don't Give Up*, which describes statements about holding up and following through a persistent course of action especially in difficult situations as a new NP. The NPs in the current study also experienced frustration due to the challenges associated with theme *System Integration*, which described the NPs integration into the hospital system, including the ordeal of getting credentialed. Another source of frustration by experienced NPs in the current study was reflected by the theme *They Don't Understand My NP Role*, which described others lack of understanding about the NP role. Frustrations included hospital-based practice constraints, and feeling alone and isolated. Isolation required the NPs in the current study to improvise as they sought to apply new knowledge and practice new skills in the absence of a structured orientation plan to the hospital setting.

Implementation. Hamric and Taylor's implementation phase included receiving positive feedback, identifying accomplishments, and completing the transition. In the current study, the participants described receiving positive feedback, as discussed in the context of the theme *Succeeding Through Collaboration*, which described the importance of building collaborative relationships. The NP participants in the present study did not speak specifically about identifying accomplishments, although they did identify elements that were helpful to them in

their transition from RN to NP. These elements included having prior RN experience and knowledge (as referenced in the theme, *From Expert RN to Novice NP*, which described statements about expert RN and novice NP roles), as well as, for some, having worked in the same hospital as an RN prior to practicing as an NP role in the same institution. Study participants also discussed the positive impact of their role in assuring continuity of patient care as they established themselves in their role and gained professional respect as health care providers.

Integration. This phase in the Hamrick and Taylor model included elements such as the ability of CNS to engage in self-assessment at the advanced level of practice. According to the authors, this phase was usually experience at or after three years of practice in the CNS role. They viewed continued role development as important in strengthening competencies as well as continuing involvement in professional activities such as publications, presentations, and research. The current study provided contrasting data regarding integration as reflected in the phase *From Expert RN to Novice NP*, which included comments about expert RN and novice NP roles. Some of the NPs in the present study voiced achieving competence in their NP roles, but were reluctant to refer to themselves as experts. Regarding professional activities, the NP participants in the present study spoke about the importance of continuing their educational journey to achieve the knowledge base they needed to function at a level that satisfied their own expectations. Only one of the NP participants spoke about conducting research as part of his NP role during his first three years of NP practice. Others spoke of providing education to residents and other clinical staff as part of their roles regardless of where they were in the process of transition from RN to NP.

In summary, the CNS Role Development Model developed by Hamric and Taylor (1989, 2009) provided applicable elements that related to the transition experience for new hospital-based NPs. Characteristics mentioned in the CNS Role Development Model (Hamric & Taylor, 1989, 2009) were also found in the present study. This observation supports the notion that some key components in the transition process exist for those new to the CNS and NP role.

Brown and Olshansky's Novice Primary Care NP Transition Model

Grounded theory research conducted by Brown and Olshansky (1997) addressed the issues that thirty-five new, primary care, community based, NPs faced during their first year of practice. Brown and Olshansky's (1997) model of transition for novice NPs reflected their experiences as they began their NP roles. Their model includes four major themes: laying the foundation, launching, meeting the challenge, and broadening the perspective. The themes for this model will be discussed and compared with the findings of this current study in the following sections (see Table 5).

Laying the foundation. Brown and Olshansky's model encompassed the time period between graduation and the first year of employment as a new NP. The researchers' identified recovering from school, negotiating the bureaucracy of taking the certification exam, getting a job, and worrying about issues such as not finding a job, financial stressors, and not passing the certification exam as part of "laying the foundation" for a transition into the NP role. The certification requirements at the time of Brown and Olshansky's 1997 study should be noted since they differed from those of the present study. Prior to 2005, new NP graduates could work up to a period of 18 months in an interim status before taking the National Certification Examination. Since 2005, this phase of the model has been significantly shortened since NPs have been required to hold national board certification prior to obtaining NP licensure and

Table 5

Comparison of Brown & Olshansky and Duke Models

Limbo to Legitimacy <i>(Brown & Olshansky, 1997)</i>	Hospital-Based NP Transition to Practice <i>(Duke, 2010)</i>
Laying the Foundation	System Integration
Launching	Going from Expert RN to Novice NP Don't Give Up
Meeting the Challenge	Don't Give Up Learning on the Fly System Integration
Broadening the Perspective	Succeeding through Collaboration

beginning practice. The phase of “Laying the Foundation” identified by Brown and Olshansky also included gaining the momentum and energy to begin completing tasks such as obtaining licensure and beginning employment as a NP. The findings of the current study support this aspect of the Brown and Olshansky model (1997) in that NPs in the current study spoke of a pre-employment preparatory phase and also acknowledged the potential competitiveness of gaining employment in a hospital setting (as described in the theme, *System Integration*, which described comments about integration into the hospital system).

Launching. In this phase of Brown and Olshansky’s model, the novice NP characterized their experience as difficult and accompanied by feelings of insecurity. Subcategories of launching included: feeling like an impostor, confronting anxiety, getting through the day, and battling time (Brown & Olshansky, 1997). In the current study, the themes *Going from Expert RN to Novice NP*, which described expert RN and novice NP roles, and *Don’t Give Up*, which describes holding up and following through a persistent course of action especially in difficult situations as a new NP, are reflected in Brown and Olshansky’s “Launching” phase. Findings from both studies were consistent in that new NP graduates described the first several months of NP practice as an overwhelming period of adjustment as they became adjusted to their new role. The emotions NPs described in both studies such as feeling like an impostor, having anxiety, and experiencing high levels of stress during the first year of practice were attributed to a lack of work experience as a NP. In the current study, the importance of prior RN experience and existing knowledge was helpful in transitioning into the NP role. Although Brown and Olshansky (1997) did not specifically address prior nursing knowledge and experience as facilitating their transition, it could be inferred that the transition strategies recommended in their

model such as mobilizing problem solving skills and using positive self talk are rooted in having prior experience and knowledge as an expert RN.

Meeting the challenge. Gaining a sense of self in their new roles characterized this phase of Brown and Olshansky's model. During this phase, NPs increased their competence, gained confidence, and acknowledged system problems (Brown & Olshansky, 1997). This evolved over a period of time by practicing as a NP clinician, which resulted in gaining confidence and competence. In addition, their participants referred to the benefits of their previous knowledge and valued using their "intuition." This supports the previously mentioned importance of expert RN knowledge and experience.

The themes in the current study (including *Don't Give Up*, which described holding up and following through a persistent course of action especially in difficult situations as a new NP, and *Learning on the Fly*, which describes learning as you go regarding how to be a NP and the significance of having a mentor) resonate with the phase "Meeting the Challenge," in a few ways. In this phase, Brown and Olshansky (1997) described gaining situational knowledge, developing their own styles in the provision of patient care delivery, and managing uncertainty as important aspects that helped facilitate their role transition (Hamric, Spross, & Hanson, 2009). The current study offered a deeper perspective of these particular tasks as the NPs identified a need to persevere in challenging situations and become of how they approached clinical situations. This issue of uncertainly paralleled the theme of *Learning on the Fly*. In the current study, the participants recalled the need to improvise as they developed their skills.

Acknowledging system problems as described by Brown and Olshansky (1997) overlapped perspectives in the current study related to getting credentialed, experiencing no or limited orientation, and encountering in others a lack of understanding and resistance to the NP role.

Broadening the perspective. This phase encompassed the NPs' perceived improved efficiency and capability within the primary care system, which required them to develop system savvy, affirm themselves, and up the ante. NPs also increased their ability to identify their developed strengths and experienced improved self-esteem compared to the first few months of their practice. These aspects of NPs broadened perspectives are similar to associated findings associated with the current study (revealed in the theme *Succeeding Through Collaboration*, which described the importance about building collaborative relationships). Brown and Olshansky (1997) recommended that communication with colleagues was important, which would include physicians, peers, other clinical staff, as well as practice administrators. The findings of the current study support this recommendation. In addition, the reference to "system" made in both studies differs in terms of practice setting. Brown and Olshansky (1997) focused on primary care settings, while the current study focused on hospital settings. However, recommendations regarding communication appear to be important and similar across both settings.

Like the participants in the present study, novice primary care NPs engaged in a process of having to establish themselves as legitimate NPs despite a lack of experience and feelings of being overwhelmed. Brown and Olshansky (1997) provided a greater focus on some of the internal characteristics that may influence the role transition experience for new primary care NP graduates. This current study revealed both internal and external characteristics that may influence the transition experience for new hospital-based NP graduates. These differences may be explained by the focus on NPs in hospital-based practice, which contributed new and different perspectives.

A Nursing Model to Consider: Benner's Model of Expert Practice

Benner's model is introduced in this section because it was not found in the literature regarding NP role transition reviewed by this researcher. However, the participants' experiences in the current study are reflected in Benner's model in that the participants referred to themselves as expert RNs but acknowledged themselves as novice NPs when beginning their NP practice. The introduction of this aspect of their experience gives this model relevance because the novice and expert levels of competence were actually referenced during the interviews as they described their transition experiences.

According to the participants in the present study, successful engagement in the NP role required continuous learning and self-education. Similarly, this aspect of role development and acquisition of practice knowledge gained over time is described in Benner's (1984) novice to expert model. Benner's stages of clinical competence include novice, advanced beginner, competent, proficient, and expert. This model has broad applicability to the current study findings. Benner developed the model from a study of nurses whose expertise was gained through work experience; these nurses were not APNs. Benner's model is applicable to the present study findings because Benner considered level of expertise as situational, with the level of skill and competence varying according to situation (Alligood, 2010; Benner, 1984). As the NP participants' knowledge base was established through practice experience, their expertise advanced and they increased competency and proficiency. Various clinical situations provide important learning opportunities. Benner (1984) explained that nursing competencies were gained at various times in an ongoing process. As participants in this study gained experience and learned skills over time, they developed clinical competency in their NP roles. In addition, they spoke about the importance of having prior nursing knowledge and experience to draw on

that informed their role as a newly practicing NP. Benner's model provides a conceptual framework for APN transition research.

The Hospital-Based NP Transition Experience

All of the NP participants in this study revealed experiencing many challenges associated with their initial transition in role and identity to hospital-based NP provider. Their transition experience evolved over a time period of six to eighteen months, but was most intensively experienced during the first nine months of practice. Participants described transitioning in their roles and identity beginning from pre-graduation preparations for hospital practice, then described experiencing the process of moving from expert RN to "*novice*" NP. Over a period of time, the participants gained proficiency with their NP skills, self-assurance, and eventually an identity as a NP. Participants described the transition process as exciting but stressful.

The participants in the present study believed that utilizing their existing nursing knowledge enabled them to work through various unfamiliar situations in their NP role. In other words, their practical nursing knowledge and intuition was helpful to them as they perceived themselves as a novice NP. Self-confidence increased as the NPs gained experience and were able to function more autonomously and gain professional respect. Autonomous decision-making developed through the establishment of self-confidence. This is supported by research findings done by Lukacs (1982) and Brown and Olshansky (1997). Lukacs' (1982) survey findings described how skill and knowledge increased over time for newly practicing NPs. Brown and Olshansky (1997) similarly found that NPs gained confidence and competence as they increased their skills during the first year of practice as primary care providers.

The participants described a well-structured integration into the hospital system as essential for a good transition to practice. In order to begin their practice, the credentialing

process negatively influenced their transition of some NPs, though the influence was institution specific. Several participants reported they had to wait months to begin practice, while others were permitted to be in the hospital while waiting for their credentialing to be completed. The delayed receipt of credentials resulted in limitations that placed some of the NPs in compromised situations and hindered patient care. The problems with credentialing NPs are supported by Klein's (2008) recommendation to standardize the NP credentialing process within healthcare settings. Several barriers currently exist regarding NP credentialing. These barriers include differing NP scopes of practice and regulatory requirements from state to state, differences in how insurance companies recognize nurse providers, and chief nursing officers (CNOs) who may be poorly prepared regarding validation requirements specific to the NP role. Findings from the current study supported Klein's (2008) statement that factors such as these may contribute to an inefficient credentialing process and underutilization of trained NPs due to an unnecessarily restricted NPs scope of practice.

An essential element related to system integration identified by the participants was the need for hospital orientation. In addition to offering an orientation for NPs regardless of practice setting, Bahouth and Esposito-Herr (2009), Brown and Olshansky (1997), and Hamric and Taylor (1989, 2009) noted that an adequate orientation should include essential constructive feedback on role performance. Such feedback would ensure that the new NPs received a meaningful and comprehensive orientation to their work within their employment setting.

The participants also shared that supportive hospital leadership was essential to how effectively and quickly they became integrated into the hospital system. Maguire et al. (1995) stated that new NPs were essentially dependent on administration, physicians, and staff for providing a supportive environment which would facilitate their positive transition to practice.

Administrators, physicians, and clinical staff were key individuals on whom the new NPs were essentially dependent for easing their integration into a hospital setting. Not surprisingly, the results of this study confirmed that if leaders do not have a good understanding of the NP role and comprehensive integration is lacking, the transition to practice would be influenced negatively and development to expert status could be delayed. This was particularly true for NPs unfamiliar with the hospital in which they began their practice. This study refutes Aktan's (2010) opinion that the new NPs consider not practicing at the same site where they previously practiced as a RN. The NP participants in this study found that practicing as an NP at that same hospital where they previously worked as an RN positively impacted their role transition, though some had initial problems with the unresponsiveness of former colleagues to their new role.

When the participants were asked to reflect back on their practice and what advice they could offer the new NP graduate, the participants collectively advised "*don't give up*" and spoke about how important it was that new NPs be patient with themselves and give themselves time to acclimate to their new roles. How much time this would require varied among the participants; six to twelve months was recommended as adequate. This timeframe supported Brown and Olshansky's (1998) recommendation that new NPs should have adequate time to socialize to the NP role and have a supportive network to help with transition and learning the NP role. The discussion around this issue of collegial support described by Brown and Olshansky (1998) did not take into account the impact of collegial resistance from peers and medical staff that were experienced by the participants in the present study. The findings of this research support the description by Chang et al. (2006) about how collegial support encouraged the new NP to keep pushing forward. Any type of support, including formal mentors and

informal peers provided the new NP with a network that enhanced NP coping through the initial challenging period (Heitz et al., 2004).

This study validates the findings of Heinz et al. (2004) that obstacles to NP transitioning include a lack of professional support in the work setting for new NPs. When participants believed they had a supportive environment, their learning was less improvised. Specifically, when participants had a supportive physician or other provider available to serve as a mentor, their transition experience differed in quality and duration from those who did not have a designated mentor. Consistent with the participants' descriptions, Cusson and Viggiano (2002) reported that having a professional mentor or role model was beneficial for the new NP.

Participants' in the current study revealed that the process of learning about their NP role often occurred "*on the fly*." Their unplanned learning about how to function in the APN role contributed to the perceived challenge of their new situation. They often perceived themselves to being alone during their initial transition into NP practice.

In response to what they perceived as being alone in their new role, participants felt they lacked someone to teach them how to be a NP. This resulted in them having to learn serendipitously along the way, as situations presented themselves. The participants talked about how uncomfortable this was for them as they preferred to learn in a more structured environment such as a classroom setting, while serving in the student role and having another provider accessible to ask questions and problem solve before having to make a life or death decision about a patient. The current study findings support Kelly and Matthews' (2001) report that feeling isolated resulted from the lack of support and mentorship that could help the new NP with decision-making about clinical issues. The NPs isolation contributed to a lack of

organizational fit and feelings of not belonging or being connected. It also increased their anxiety about competently providing patient care.

Several of the participants revealed that their NP role was not well understood by those in the hospital in which they practiced. Other peoples' level of understanding regarding the NP role had a direct relationship on how they transitioned into the NP role. NPs are required to interact with and depend on several individuals including administrators, physicians, patients, and clinical staff in their work. When these individuals had a poor understanding about the NP role, it led to frustration for the participant. The findings from this current study support the views of Chang et al. (2006) and Kelly and Mathews (2001) that inconsistent role expectations and a lack of understanding by others about the NP role resulted in NP frustration and insecurity. For example, if the physician was not familiar with the NPs scope of practice, their level of autonomy was reduced and the NP experienced dissatisfaction and frustration. Interestingly 25 years ago, Jones (1985) noted that a hospital organization that lacking support and understanding regarding the NPs scope of practice would serve as a barrier in NP role transition.

All the participants in this study revealed that a hospital network that was supportive and collaborative was very important for them in their new NP role. Key relationships with hospital leaders previously mentioned made a significant difference in how they transitioned into their hospital-based role. Specifically, physicians, hospital administration, nursing staff, and peers were among the key relationships necessary for a good transition. Almost and Laschinger (2002) reported that these relationships empowered the NP through a nurturing work environment. Specifically, ensuring the NP was provided access to information, support, resources, and opportunities was key to an effective transition to practice. Organizations that provided this type of environment were reflective of a collaborative workplace. A collaborative work environment

results in a lower level of work strain and improved the transition process for the new NP graduate (Almost & Laschinger, 2002).

Many of the participants spoke specifically about the significance of the relationship with the physician(s) with whom they worked. Of particular importance was the level of collaboration and communication between the NP and physician colleague. Several factors influenced the success of transition in this aspect including the physicians understanding of the NPs level of expertise, the NPs scope of practice, the physician's level of involvement with mentoring, and the physician role in educating NPs as they transitioned to practice. Kelly and Mathews (2001) also supported findings that the physician was particularly important in the NPs coping and transition process.

Recommendations

Implications for New NPs Entering Hospital-Based Practice

These study findings offer new NP graduates entering hospital-based practice some insight as to what may be expected when beginning NP practice in this particular setting. New knowledge gained from this study can be used to facilitate an efficient transition from graduation to practice for those NPs entering hospital-based practice following graduation. Understanding what influences may impact role transition, both negatively and positively, may provide assistance and promote an efficient transition to practice experience. The typical feelings and emotions experienced were challenging and included being overwhelmed and stressed. This offers insight for the new NP regarding what to feelings to anticipate which may be experienced. External factors included challenges associated with regulatory agencies such as licensing boards should also be anticipated. This information can be utilized to promote a successful transition to hospital-based-practice for the new NP graduate.

Implications for Hospital Leadership

For hospital administrators and leadership, understanding the lived experience and meaning of the transition experiences of newly graduated NPs to hospital-based practice is significant for the following reasons. Development of integration strategies for the new NP staff member needs to be role specific. The NP role is unique and offers the challenge in that neither orientation for the nursing and medical staff will meet the needs of NP. Trying to fit the NP into these existing processes will not be adequate. Inadequate integration into hospital-based practice could result in a transition that is delayed or possibly unsuccessful for the NP.

A key component of how these NP participants transitioned occurred around how they experienced integration into the hospital. System challenges identified by these participants included bureaucracy associated issues such as an inefficient credentialing process and antiquated medical bylaws that unnecessarily restricted their NP scope of practice. The process of integrating NPs into this particular setting may benefit from re-evaluation of current on-boarding processes. Also, the participant descriptions regarding not having a NP leader or someone performing their performance evaluations that had an authentic understanding of the NP role negatively influenced the transition to practice experience.

Implications for Physicians

The NP participants' in this study repeatedly spoke of the vital importance physician collaboration was for them in their transition to hospital-based practice. The level of physician support and understanding of what the NP role can offer had a direct impact on how efficient the transition process was for the NP participants. This study suggests that physicians have a significant opportunity to promote and endorse the NP role in the hospital setting. The NP

participants voiced the importance of having critical conversations with their physicians in the beginning of the collaborative working relationship.

Implications for NP Educators

Nursing educators may identify opportunities to adapt NP curricula that will complement current program structure. Implications from the study suggest an opportunity exists to consider NP curricula in the final semester that focuses on role preparation and what to anticipate regarding practice setting, particularly if the NP graduate will be practicing in a hospital setting. Some participants described that having adequate role preparation in their final semester of NP program, particularly regarding regulatory requirements was beneficial. Knowing this information saved them problems as they started practicing and working with hospital leadership who did not know about these aspects.

The NP participants also described inconsistent experiences regarding their clinical experience. While the majority of these participants had the opportunity for a hospital-based clinical rotation as a student, some had to negotiate for a clinical rotation in this setting. One participant described how two of her faculty members initially did not agree on approving this clinical rotation request resulting conflict among her faculty members before she was ultimately granted approval. This was particularly important for those participants who knew they wanted to begin their NP role in the hospital.

Implications for Hospital-Based NPs

Practicing NPs may use the knowledge of their own transition experience and what is offered from this research to inform beginning practice for new NP graduates in the hospital setting. This is based on the assumption that strategies can be developed that focus on this particular lived experience and is important to newly graduated and experienced NPs. The

importance of having a mentor for these participants was extremely important regarding the new NPs role development and socialization, especially if the new NP did not have a clinical rotation as a student. Experienced hospital-based NPs have a wonderful opportunity to help facilitate the transition for new NPs beginning their APN practice in the hospital setting.

Conclusion

Qualitative research typically consists of a purposeful sample. This study required a purposive sample. A homogeneous group of NPs who reported to meet the inclusion criteria were utilized for this study. These results were limited to this study's sample and may not be generalizable to a larger group of other NPs. Typical of all qualitative, hermeneutic phenomenological studies the findings of this study are subject to alternative interpretation. My assumptions and biases were recorded in my researcher's journal. However, these findings were within the context of my NP knowledge of this experience. Interpretation by a different researcher may have resulted in different findings. Based on the findings of this hermeneutic phenomenological research study of the meaning and lived experience of NPs with at least one year of work experience regarding their initial transition from new graduate to hospital-based practitioner considerations for future studies need to be considered.

Research exploring the lived meaning of initial transition for the new NP practicing in different institutions is indicated. This study provided specific data for new NP graduates that began their role in the hospital setting. The experience of NPs working in other institutions such as prisons or long term care facilities may provide different data.

Research exploring the lived meaning of initial transition for the new NP practicing in one specific unit in the same hospital is indicated. This study provided specific data for new NP

graduates practicing in a variety of clinical areas within several different hospitals across North Carolina. Research focused on one specific unit or service line may provide different data.

Further research question asking does the lived meaning of initial transition for new NPs practicing in hospital differ among NPs with different educational preparation? For example, is this experience different for the acute care, adult, and family NP? Research done in Taiwan by Chang et al. (2006) with ACNPs found that despite having trained to practice in the hospital setting, these NPs still felt unfamiliar in their initial practice period. Further comparisons of the themes and lived meanings of transition to practice for NPs with different NP educational preparation are indicated.

Does the lived meaning of initial transition experience for the new NP practicing in a hospital differ if the hospital leadership consists of another NP? This question was suggested as important by some of the participants regarding this aspect their NP role and genuinely being understood by their leadership. Research focusing on the influence of the initial transition experience for NPs who are lead by another hospital-based NP is needed.

Ten of the twelve of these participants were female. It is unknown if gender impacts this experience differently. It may be of interest to compare the characteristics of transition to practice for male hospital based NPs and female hospital based NPs. The lived meaning of the initial transition experience for the new NP practicing in a hospital different for NPs who are men would be the question to be considered.

All these NPs were employees of the hospital in which they practiced. Hospitals have many NPs who practice at that location but may have a different employer. Leaders of private practice or academic groups may not be in the nursing profession. This could be suggestive of a different transition experience for the new NP graduate. It is not known if the employer itself

has a significant impact on this NP experience. Research is needed on the lived meaning of initial transition experience for the new NP if the employer is other than the hospital as the practice site. Having different employers such as private practice or an academic group may mean the transition to practice will vary.

Several of the participants spoke of the positive relationship of having a mentor on their transition. Not surprisingly, the absence of a mentor had a negative influence on the role transition. The research question to be considered is what would be the impact on the initial transition experience for the new NP graduate if a member of the NPs faculty served as a mentor starting in the final semester through the 1st year post graduation? Research focusing on the influence of having a mentor designated for the NP student and throughout the transition period post-graduation is needed.

Understanding the transition experiences of newly graduated NPs to hospital-based practice will ultimately contribute to the development of such individuals as successful, effective members of the health care team. Such knowledge can be used in clinical practice, educational program development, and by hospital administration to promote successful transition of new NP graduates into hospital-based practice. Current nursing knowledge of the lived meaning of the transition experience for new hospital based NPs may potentially further define the nursing discipline and facilitate changes in practice that will improve this significant event for the new NP.

Publication of these study findings into the nursing literature can offer the opportunity for professional and collaborative discussions on current processes utilized by NPs, educators and employers. As programs are developed which focus on improving the NP transition to hospital based practice, open discussion and evaluation methods could be developed. In addition,

development of collaborative advanced practice consortiums that bridge education and hospital systems could promote sharing current and ongoing development of systems for improvement which focus on maximizing the APN role in the hospital setting. In the current wake of health care reform, the model of APN utilization in the hospital setting offers abundant opportunities for provision of health care delivery models that include all APN roles.

The research question answered conducting this hermeneutic phenomenological study was, “*what is the lived experience and meaning of transitioning into hospital-based practice from the perspective of NPs with at least one year of work experience?*” The lived meaning of transitioning into hospital-based practice from the perspective of NPs with at least one year of work experience was interpreted and found to be challenging. This was evidenced by facing multiple obstacles of being a new NP that included navigating into hospital based practice as a health care provider, learning how to be a NP while simultaneously establishing oneself a NP clinician, building key relationships which included time for physicians, hospital leaders, clinical staff, patients, and families to learn about the role of the NP. The lived meaning of transitioning into hospital based practice for the NP was revealed by this study. The six themes that emerged from the data include, *Going from Expert RN to Novice NP, System Integration, Don’t Give Up, Learning ‘On The Fly’, They Do Not Understand My NP Role, and Succeeding Through Collaboration.*

This new understanding of NP transition into hospital based practice, not previously addressed in the literature added new knowledge for the profession and discipline of nursing. This new knowledge demonstrates that although the transition to hospital based practice for the new NP graduate is individually unique; there are important dimensions of this NP experience

that should be considered by new NPs, employing hospitals and staff, physicians, and educators that will support and ensure an ideal transition for the new hospital-based NP.

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APPENDIX A: INTERNAL REVIEW BOARD APPROVAL LETTER



University and Medical Center Institutional Review Board
East Carolina University • Brody School of Medicine
600 Moyer Boulevard • Old Health Sciences Library, Room 1L-09 • Greenville, NC 27834
Office 252-744-2914 • Fax 252-744-2284 • www.ecu.edu/irb
Chair and Director of Biomedical IRB: L. Wiley Nifong, MD
Chair and Director of Behavioral and Social Science IRB: Susan L. McCammon, PhD

TO: Cheryl Duke, PhD, College of Nursing, ECU, 3166-A LAHN Building
FROM: UMCIRB JTC
DATE: October 26, 2009
RE: Expedited Category Research Study
TITLE: "The Lived Experience of Nurse Practitioner (NP) Graduates' Transition to Hospital Based Practice"

UMCIRB #09-0764

This research study has undergone review and approval using expedited review on 10/23/09. This research study is eligible for review under an expedited category because it is a collection of data from voice, video, digital, or image recordings made for research purposes and it is research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. (NOTE: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b)(2) and (b)(3). This listing refers only to research that is not exempt.) The Chairperson (or designee) deemed this unfunded study no more than minimal risk requiring a continuing review in 12 months. Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a continuing review/closure application to the UMCIRB prior to the date of study expiration. The investigator must adhere to all reporting requirements for this study.

The above referenced research study has been given approval for the period of 10/23/09 to 10/22/10. The approval includes the following items:

- Internal Processing Form (dated 10/22/09)
- Informed Consent (dated 10/22/09)
- Conflict of Interest Disclosure Form (signed on 10/26/09)
- Letter of Invitation to Participate
- Communication to Volunteer Respondants
- Demographic Questionnaire
- Guideline for Interview Questions

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

The UMCIRB applies 45 CFR 46, Subparts A-D, to all research reviewed by the UMCIRB regardless of the funding source. 21 CFR 50 and 21 CFR 56 are applied to all research studies under the Food and Drug Administration regulation. The UMCIRB follows applicable International Conference on Harmonisation Good Clinical Practice guidelines.

APPENDIX B: LETTER OF INVITATION TO PARTICIPATE

Dear Nurse Practitioner colleague,

I am a practicing Nurse Practitioner (NP) and a Doctoral Candidate in Nursing at East Carolina University College of Nursing in Greenville, N. C. I am currently conducting a study describing the Nurse Practitioner graduates' transition to hospital-based practice experience.

A need currently exists to better understand this unique NP experience. More NPs are beginning their practice in a hospital setting immediately following graduation. Your experience, as a NP, is significant and very important. Sharing your experience can contribute to assisting future NPs, physicians, and hospital leadership regarding successful transition to hospital based practice. You have been identified as a potential candidate for this study. Please contact me within the next week if you meet the study criteria (see below) and would be interested in participating. Participation is completely voluntary and your identity will be kept confidential.

The study is limited to NPs who meet the following criteria:

1. Graduation from an accredited NP program with a Master's degree or post Master's Certificate;
2. Current board certified by a national credentialing body (American Academy of Nurse Practitioners or American Nurses Credentialing Center);
3. NP role in a hospital setting initiated immediately following NP training program;
4. Continuous hospital based practice for a minimum of one year and no more than three years post graduation;
5. Able and willing to recall and share their experiences as a NP;

6. Able and willing to write a letter to a newly graduated NP about entering hospital based practice;
7. Willing to voluntarily participate in this study; and
8. English speaking

If you are interested in participating in this study, please contact me at your earliest convenience by replying to this correspondence using the following email address: cduke@pcmh.com. You may also reach me by phone (252) 847-5938 or pager (252) 561-9133 if I can answer any questions you may have regarding this study. Thank you for your consideration in participating in this research study.

Sincerely,

Cheryl Duke
Cheryl Duke PhD(c), MSN, FNP-BC

APPENDIX C: CONSENT DOCUMENT

Title of Study: Title of Research Study: The Lived Experience of Nurse Practitioner (NP) Graduates' Transition to Hospital based Practice



East Carolina University



Informed Consent to Participate in Research

Information to consider before taking part in research that has no more than minimal risk.

Title of Research Study: The Lived Experience of Nurse Practitioner (NP) Graduates' Transition to Hospital based Practice

Principal Investigator: Cheryl Duke, PhD(c), RN, FNP-BC
Institution/Department or Division: East Carolina College Of Nursing-Student
Address: 827 V.O.A. Site C Road, Greenville, NC, 27834
Telephone #: (252) 341-2276 (cell) or (252) 757-0615 (home)

Researchers at East Carolina University (ECU) study problems in society, health problems, environmental problems, behavior problems and the human condition. Our goal is to try to find ways to improve the lives of you and others. To do this, we need the help of people who are willing to take part in research.

You may have questions that this form does not answer. If you do, feel free to ask the person explaining the study, as you go along. You may have questions later and you should ask those questions, as you think of them. There is no time limit for asking questions about this research.

You do not have to take part in this research. Take your time and think about the information that is provided. If you want, have a friend or family member go over this form with you before you decide. It is up to you. If you choose to be in the study, then you should sign the form when you are comfortable that you understand the information provided. If you do not want to take part in the study, you should not sign this form. That decision is yours and it is okay to decide not to volunteer.

Why is this research being done?

The purpose of this research is to gain insight into the meaning and lived experience of NPs with 1-3 years of work experience regarding their initial transition from new graduate to hospital-based practitioner. The decision to take part in this research is yours to make. By doing this research, we hope to learn what the lived experience and meaning of transitioning into hospital-based practice is from the perspective of NPs with 1-3 years of work experience?

Why am I being invited to take part in this research?

You are being invited to take part in this research because of your transition experience as a Nurse Practitioner. If you volunteer to take part in this research, you will be one of about 10 people to do so.

Are there reasons I should not take part in this research?

You could be excluded from this study if you do not meet the following inclusion criteria:

1. Graduation from an accredited NP program with a Master's degree or post Master's Certificate;

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Consent Version # or Date: 10-22-09
UMCIRB Version 2009.08.15

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Participant's Initials

UMCIRB
APPROVED
FROM 10-22-09
TO 10-22-09

Title of Study: Title of Research Study: The Lived Experience of Nurse Practitioner (NP) Graduates' Transition to Hospital based Practice

2. Current board certified by a national credentialing body (i.e.: American Academy of Nurse Practitioners or American Nurses Credentialing Center);
3. NP role in a hospital setting initiated immediately following NP training program;
4. Continuous hospital based practice of 1-3 years post graduation;
5. Able and willing to recall and share their experiences as a NP;
6. Able and willing to write a letter to a newly graduated NP about entering hospital based practice;
7. Willing to voluntarily participate in this study; and
8. English speaking

What other choices do I have if I do not take part in this research?

You have the choice of not taking part in this research study.

Where is the research going to take place and how long will it last?

The research procedures will be conducted via face to face or telephone interview to discuss your NP transition experience to hospital-based practice. The total amount of time you will be asked to volunteer for this study is approximately 1 hour. Ms. Duke will tape record the interview so that she can create a word for word transcript for review and analysis. She will also take notes with paper and pen during the interview.

What will I be asked to do?

You are being asked to do the following: 1) write a letter to a newly graduated NP who is entering hospital-based practice for the first time. The purpose of the letter is to serve as a catalyst for further discussion during the interview; 2) to answer questions asked by the PI related to your transition to work experience.

What possible harms or discomforts might I experience if I take part in the research?

This study poses minimal risk to you as a participant. The interviews will be conducted face to face or by telephone at a mutually agreeable time. Participation is totally voluntary, you may withdraw at any time, and you are assured of anonymity.

What are the possible benefits I may experience from taking part in this research?

We do not know if you will get any benefits by taking part in this study. This research might help us learn more about the lived meaning of NP transition to hospital based. There may be no personal benefit from your participation but the information gained by doing this research may help others in the future.

Will I be paid for taking part in this research?

You will not be paid for the time you volunteer while being in this study.

What will it cost me to take part in this research?

It will not cost you any money to be part of the research.

Who will know that I took part in this research and learn personal information about me?

To do this research, ECU and the people and organizations listed below may know that you took part in this research and may see information about you that is normally kept private. With your permission, these people may use your private information to do this research:

- The primary investigator.
- The University & Medical Center Institutional Review Board (UMCIRB) and its staff, who have responsibility for overseeing your welfare during this research, and other ECU staff who oversee this research.

UMCIRB Number: 09-0764

Consent Version # or Date: 10-22-09
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Participant's Initials

UMCIRB
APPROVED
10-22-09

APPENDIX D: COMMUNICATION TO VOLUNTEER RESPONDENTS

Dear NP colleague,

Thank you for volunteering to participate in my research study titled, “The Lived Experience of Nurse Practitioner Graduates’ Transition to Hospital Based Practice.” You should find included with this letter two copies of the Informed Consent to Participate in Research document, both copies have been signed by me, and a self addressed stamped envelope. Please read and sign one of the consent forms and return that form to me via the self addressed stamped envelope. Feel free to contact me if you have any questions before you sign the consent. In addition, I am requesting each participant write a letter to a newly graduated NP who is entering hospital-based practice for the first time. Focus your letter on what you would like to share with this new NP to prepare her or him for hospital-based practice. You may send me the letter electronically by email or hand written and mail it to me with your signed consent form in the self addressed self envelope. When I have received your completed documents, I will contact you to schedule our interview. Again, thank you for agreeing to participate in this study.

Sincerely,

Cheryl Duke

Cheryl Duke PhD(c), MSN, FNP-BC

APPENDIX E: DEMOGRAPHIC QUESTIONNAIRE

Date _____

Participant Number _____

1. Participant Pseudonym _____
2. Age _____
3. Current title _____
4. Area of specialty _____
5. Name & address of practice site _____
6. Number of beds _____
7. Is this a teaching hospital? Yes _____ No _____
8. How long have you been practicing in the hospital setting as a NP?
_____ years _____ months
9. Where did you get your NP education _____
10. Type/focus of NP training (FNP, ANP, ACNP, etc) _____
11. Year of graduation _____
12. National certifying organization _____
13. Number of years practicing as a RN prior to obtaining NP license _____
14. Who do you report to in the organization (who is your boss) _____
15. Would you like to see a summary of these study findings? Yes ____ No ____
If yes, what is your email address: _____

APPENDIX F: GUIDELINE FOR INTERVIEW QUESTIONS

I am interested in the new NP graduates' transition experience into hospital-based practice.

Overarching question:

- 1. Tell me what it was like for you moving into your new role of nurse practitioner.**

Subset of possible follow up questions:

2. Tell me about your first NP position.
3. While you were an NP student, did you have an inpatient hospital rotation?
4. If yes, in what areas(s)?
5. Tell me what elements helped you successfully transition into your new NP role?
6. What elements made it hard for you to transition into your new NP role?
7. As a new hospital-based NP, did you have a mentor and if so, who was it?
8. Where are you today in your transition?
9. What advice would you have for a new NP?
10. What advice would you have for hospital leadership hiring these NPs?
11. What advice would you have for the physicians working closely with these NPs?
12. Would you do anything different with your letter now that we have talked?
13. Is there anything else I need to know about NP transition to hospital-based practice?
14. If you could wave a magic wand, what would the ideal transition look like?

APPENDIX G: THEME BOOK

THEME BOOK			
<i>Theme</i>	<i>Description</i>	<i>Inclusion Criteria</i>	<i>Exclusion Criteria</i>
Going from expert RN to novice NP	Participant statements about expert RN and novice NP roles, including the process of going from expert RN to a novice NP	Participant statements about nursing background & NP education, role uncertainty, dimensions of RN and NP roles (including similarities and differences), and feelings that may be experienced	Participant statements that do not refer to the process of going from expert RN to novice NP
System Integration	Participant comments about NPs integration into hospital system	Participant comments about the NPs integration into hospital, including orientation, and NP scope of practice and utilization in the hospital	Participant comments that do not refer to hospital integration into hospital system or the NPs role in the hospital
Don't Give Up	Participant statements about holding up and following through a persistent course of action especially in difficult situations as a new NP and advanced practice leader	Participant statements about believing in oneself, following through despite adversity, such as compromised autonomy, and representing the profession as an advance practice leader	Participant statements that do not refer to believing in oneself, following through despite adversity and representing the nursing profession as an advanced practice leader
Learning 'On the Fly'	Participant statements about learning as you go regarding how to be an NP, and the significance of a mentor	Participant statements about learning the NP role / practice, and how role transition is influenced by presence or absence of a mentor	Participant statements that do not refer to learning on the fly

<p>They Don't Understand My NP Role</p>	<p>Participant statements about others lack of understanding about the NP role</p>	<p>Participant statements about how their role is not understood by physicians and others and how this influenced role transition</p>	<p>Participant statements that do not refer to others lack of understanding about the NP role</p>
<p>Succeeding Through Collaboration</p>	<p>Participant statements about building collaborative relationships with physicians, staff, including leadership and how these relationships impact transition for the new NP</p>	<p>Participant statements about the importance of establishing key relationships and the influence on role transition.</p>	<p>Participant statements that do not refer to succeeding through collaboration</p>

APPENDIX H: FIELD JOURNAL

1. Communication from committee
2. Codebook versions
3. Data reduction
4. Actions and decisions
5. Dissertation sections
6. Access (my process of entry)
7. Issues (problems, conflicts, predicaments, dilemmas, etc)
8. Other sources of data (communications, conversations, additional readings, memos, etc).
9. Participant communication
10. Consents

APPENDIX I: PARTICIPANT DESCRIPTION

Participant	Age	# of RN practice years prior to NP	NP type	Certifying Organization	Year of Graduation	# Of NP practice years	NC Hospital Size <i>Small= <100</i> <i>Medium= 100-500</i> <i>Large= > 500</i>	# Of Beds	Teaching Hospital	Clinical Specialty
1. L.L.	29	5	ACNP	ANCC	2006	2	Medium	205	No	Hospitalist
2. L.C.	34	9	ACNP	ANCC	2006	2	Large	840	Yes	CT-ICU
3. M.W.	31	8	ANP	ANCC	2007	1	Large	800	No	Cardiology
4. C.G.	43	4	FNP	AANP	2006	3	Large	800	No	Transplant
5. C.M.	42	15	FNP	AANP	2006	2	Small	80	Yes	Rehab Medicine
6. J.S.	48	12	FNP	ANCC	2006	2	Large	840	Yes	MICU
7. D.A.	38	17	FNP	ANCC	2008	1	Large	725	Yes	Trauma, emergency & general surgery
8. E.A.	36	10	ANP	ANCC	2008	1	Large	750	Yes	Internal Medicine
9. M.M.	31	6	ACNP	ANCC	2006	2	Large	840	Yes	Critical Care
10. S.B.	34	7	FNP	ANCC	2007	2	Large	750	Yes	Emergency Medicine
11. K. H.	50	26	ANP	AANP	2007	1	Large	840	Yes	Hem-Onc
12. P.B.	51	27	FNP	ANCC	2006	3	Large	800	Yes	Palliative Care

Note. ACNP=Acute Care Nurse Practitioner; FNP=Family Nurse Practitioner; ANP=Adult Nurse Practitioner; AANP=American Academy of Nurse Practitioners; ANCC=American Nurses Credentialing Center; Hem-Onc=Hematology-Oncology; CT-ICU=Cardiothoracic Intensive Care Unit; MICU=Medical Intensive Care Unit.