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Final DNP Project Report

Evaluation of APRN Transition to Practice Program

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University of Kentucky

College of Nursing

Fall 2018

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Dedication

I would like to dedicate my final DNP project report to my four year old son Hudson. When deciding to enter into this three year endeavor, I was married and Hudson was a baby. After family discussion Hudson was the deciding factor to pursue the DNP. I wanted to be a great mother and never put him second to anything or anyone and it was tough to see if I would be able to do so during this program. However, I knew if I could gain a small amount of support from family members I could complete the program and never neglect him. However, I went through a divorce and lost some of the routine and support I had planned to have during the program and my career. I had really bad days where I wanted to quit everything, but deep down I knew that was not an option. So with some additional resources utilized I continued to push forward taking a few wrong turns along the way. But today I stand here as a role model, to demonstrate to Hudson how much one can accomplish despite tough life circumstances and he too, can accomplish anything.

"There is strength in every struggle. Struggles create opportunities for you to become stronger, wiser and better. The moment you shift your thinking from 'I cannot' to 'I must', you will begin to see 'beyond the pain' and draw strength from within. Learn to see each obstacle as a stepping stone and watch your life change significantly."

"Life's best lessons are learned during the most painful experiences."

-Kemi Sogunle

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I would like to take a moment to recognize some very important individuals who brought forth great support, mentorship, care and guidance during the past three years. First and foremost I must recognize Dr. Sheila Melander as not only my Faculty Advisor throughout the program, but also the support, care and guidance she gave me during the toughest parts of my personal life and this program. I must also recognize Dr. Kim Tharp-Barrie for her tremendous love, care and support for not only finishing this degree successfully, but also maintaining my personal and professional life. Kim was kind and loving when she needed to be, but also tough and motivating when I needed to change gears or directions. Without these two women, I can honestly say I would not be standing here today. I must also recognize my clinical faculty Dr. Katie Rogers, who also played a significant role in the development of my project and helping me navigate through the intertwining network of providers within Norton Healthcare. Katie guided me in choosing appropriate clinical preceptors and sites, but more than that she communicated with me clearly and comfortably on a personal level to really dig deep to meet not just clinical needs, but needs for my project, career and personal life. With the combination of Sheila, Katie and Kim, we often questioned where I was in life, my mindset and my ability to safely finish the program. They frequently reassessed my mental and emotional capacity and was I really at a point where I could continue my DNP journey. Through tough conversations and many tears, we came up with creative paths untaken by others, for me to accomplish this degree. I know all three of these women went to bat for me, putting their faith in me and never gave up on me; without that, I would have lost the drive and motivation to continue. I must also thank my sister Jody, my sister Lindsey, my brother Daniel, my nephew Dallas and my mother Kim, for always being my backup when I needed last minute child care or merely personal support to keep pushing forward when life threw curveballs and it would've been easy to quit. I cannot ever exclude my life mentor CJ Sgro for lighting a fire within my soul at a very young age to always push the limits and never give up when things seem impossible. Pushing me beyond my limits in the littlest ways gave me the strength to fight battles like this one. He often taught me there are many failures in the process of succeeding, but the lessons learned by each failure gives guidance for how to proceed in the future. I must also acknowledge my cohort 3 acute care group of classmates who walked this journey by my side and found our way through

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Abstract

The purpose of this quality improvement project is to evaluate the newly implemented APRN Onboarding Model. The Onboarding pilot began in the summer of 2018. This project focused on the second offering (pilot) of the onboarding program which occurred in June of 2018. The APRN participants of the onboarding consisted of newly hired APRN's into Norton Healthcare. Both Adult-Gerontology Acute Care Nurse Practitioners and Family Nurse Practitioners were included in this program evaluation. For this program evaluation a single survey instrument was developed to measure participants demographic, educational and work experience. Additionally perceptions of their level of confidence and self-efficacy in assuming their APRN role was included in the survey. With the data gathered we can determine APRN's perceptions of preparedness for transitioning into entry level practice.

Quality Improvement: Evaluation of APRN Transition to Practice Program

Background and Rationale

In 2010 The Institute of Medicine (IOM) issued and released an initiative on the future of nursing. A component of this initiative included categorical division of each type of APRN didactic educational track and dictated and enforced practice in that given role and the ability of the APRN to practice at optimum level of scope. The Advanced Practice Registered Nurse (APRN) serves as a vital component of the healthcare system and access to care (Institute of Medicine, 2010). It has been concluded in other research studies that APRNs completing structured transition to practice programs have higher retention rates, higher level of practice and improved patient outcomes. APRNs feedback has indicated individualized transition to practice programs based upon specialty still leave gaps in the successful transition (Scholtz, King, & Kolb, 2014).

The American Academy of Colleges of Nursing (AACN) and the National Organization of Nurse Practitioner Faculty (NONPF), as well as other national organizations have been working on revisions to the already established Doctor of Nursing Practice (DNP) essentials which came out in the early 2000's. Each essential is a necessary component of the educational preparation for every DNP program and the student must achieve and demonstrate for completion of the program. According to new core competencies for the DNP prepared APRNs are now open for public comment from colleges of nursing and their faculty. The data collected in this study will be analyzed to better understand the onboarding program's elements, core competencies and timeline of the impact on practice. This work will surely serve to inform future work around APRN onboarding and transition to practice.

The IOM and the NONPF have advanced the role of APRNs to foster practice at the highest level of scope possible.

> In 2010, the Institute of Medicine released their report 'The Future of Nursing: Leading Change, Advancing Health'. Two of its four recommendations address the importance of examining education of NP's to (a) ensure that nurses can practice to the full extent of their education and training, and (b) improve nursing education. (Keough et al., 2011, pp. 195-196)

As many of the population are likely aware Advanced Practice Registered Nurses (APRNs) play a vital role in our nation's healthcare system. APRNs are able to help bridge the gaps in care by offering more access to care and reaching more individuals with healthcare needs. Prior to 2004, APRN educational programs were a master's level degree that prepared nurses with didactic and clinical experiences for competency as an entry level provider. However, in 2004 the first Doctor of Nursing (DNP) program was developed for APRNs and other nurse leaders to further their education. The Doctor of Nursing Practice degree helps prepare APRNs and nurse leaders to function in an active role in translating research and evidence based practice into daily practice. While occupying a small percentage of the nursing population, doctorally prepared nurses are the vessels that carry forward necessary change in the ever evolving healthcare system. When gaining a DNP degree for an APRN role, the standard curriculum for the clinical preparation is merged with other realms of healthcare education such as leadership, research and technology. However, despite the multi-faceted educational preparation, newly hired APRNs sometimes struggle transitioning into their APRN role. Research has been conducted and has indicated APRNs with some form of a structured transition to practice program such as orientation, residency or onboarding, function at a higher skill level,

have higher job satisfaction and job retention rates. This is mutually beneficial for both the APRN and the healthcare system. Just as with any degree curriculum, the competencies for a DNP APRN are outlined by national bodies, but state boards of nursing as well as individual healthcare systems can limit their scope of practice, so practice opportunities may vary among institutions. With this in mind, when an APRN is hired into a healthcare system, the system must have in place some form of structured standardization to ensure the APRNs are meeting the baseline entry level requirements without assuming their educational background adequately prepared them for the specific needs of the employing healthcare organization. It is often not the formal education itself that creates a barrier for the transition of the APRN into practice, but rather other aspects of the experience. This is where transition to practice programs are the most beneficial.

The literature suggests 48% of hospitals in California employ acute care nurse practitioners (ACNP's) in the hospital settings and 43% perform invasive procedures (Jalloh, Tadlock, Cantwell, Rausch, Aksoy, & Frankel, 2016). Therein lies one example of the need to assure the performance of advanced skills with confidence and documented competency by the ACNP. This is just one example, but is also apparent in other specialty areas as well. As indicated in the research, "although general scope of practice is regulated at the state level, local and regional scope of practice is governed by hospitals" (Jalloh et al., 2016, p. 357). As previously indicated successful transition to practice includes not only formal educational preparation, but also other resources and support during the transition phase itself. As indicated, from an organizational perspective, it is evident development and implementation of a transition to practice model for APRNs would be of value.

Literature suggests transition to practice programs not only include general system orientation and skill competency, but also elements of administrative infrastructure, work environment, peer mentors, networking and support (Scholtz, King, & Kolb, 2014). The American Association of Colleges of Nursing (AACN) white paper competency document of 2016, for both Adult Gerontological Acute Care Nurse Practitioners and Primary Care Nurse Practitioners (National Organization of Nurse Practitioner Faculties [NONPF], 2016). Currently, NONPF in coordination with AACN makes general recommendations on the competency level for entry level practice (NONPF, 2016). However, within each healthcare organization lies the responsibility and regulation of how and what competencies and privileges are attained or allowed for any given APRN depending on their specialty. With adherence to the white paper guidelines, the general APRN education will still have much variance among academic institutions, clinical experiences and amongst healthcare organizations and their specific onboarding or orientation processes. APRNs will enter into practice in various specialty roles. Each specialty may require varying areas of knowledge and skill performance. However, there will be some degree of general competency consistency across the board for all APRNs at a given organization. A structured transition to practice program helps to ensure competency objectives are met for entry level practice for the APRN. It must also be taken into account the Patricia Benner philosophy of nursing practice from novice to expert performance (Benner, 1982). Assuming, rules can be taught to given scenarios and novice level providers can follow these rules to provide care. However, as most know, there are always exceptions to the rules. This is where real life experience and situational aspects come into the decision making process of the provider (Benner, 1982). The continuum from novice to expert has five levels; novice, advanced beginner, competent, proficient and expert (Benner, 1982). It must not be assumed

every APRN enter into practice at a competent or expert level, but it is necessary for healthcare organizations to provide structured processes to progress APRNs along the continuum, safely providing effective care until they reach competent level and beyond.

Literature has also indicated a need for standardization across the state and nation. The literature reviewed up until this point, has been indicated previously. Just as mentioned, The AACN developed a white paper competency document in 2016 for APRNs which outlines not only educational content but also competency development. The competency guidelines is most always a topic of discussion at the National Organization of Nurse Practitioner Faculty (NONPF) conferences. Research suggests not only standardizing transition to practice programs, but also indicate the need for other key components to the programs such as institutional infrastructure, networking with peer APRNs, work conditions and support during transition (Cragg & Bailey, 2012). APRNs face many challenges during their transition to practice. These challenges include feelings of fear and uncertainty, and lack of support (Hart & MacNee, 2007). APRNs also report a need or desire for role clarification, connectedness and support opportunities (Kelly & Matthews, 2001). These key elements are often not discussed in formal education and are critical to successful transition for the APRN. The transition phase can be extremely stressful for an APRN (Scholtz et al., 2014). Not only is the APRN assuming an entirely different role, but also caring higher acuity and more complex patient scenarios (Scholtz et al., 2014). Given that and the given stress from transition, APRN turnover and patient outcomes are ultimately at risk without successful APRN transition to practice (Scholtz et al., 2014).

Introduction

Within Norton Healthcare (NHC), until 2018 no standardized orientation, onboarding, residency, fellowship or transition to practice program existed for APRNs and other Advanced Practice Providers (APP's). A standardized onboarding program was developed by another individual. The newly developed transition to practice onboarding program began with its pilot in May of 2018. The pilot was followed by two additional program offerings in the summer months of 2018. The transition to practice program began with approximately 20 APRNs from both cohort 2 of the Doctor of Nursing Practice program through the University of Kentucky and Norton Healthcare collaboration, whom graduated in December of 2017 and other newly hired APRNs who did not graduate from that program. This group of APRNs will include both acute and family prepared APRNs. The goal of this program is to enhance knowledge, ensure competency, promotion of confidence and successful transition in the independent practice of the APRN at NHC.

Purpose

The purpose of this quality improvement project to develop a standardized onboarding program that includes framework for entry level APRN practice. Upon review of existing literature on APRN orientation and competency programs the need for outlined objectives and competencies impacts entry level of practice and APRN perceptions of their role. Prior to 2018 the newly hired APRNs practicing at Norton Healthcare underwent a basic system orientation, computer training, then followed by some form of shadowing a provider. Beyond that period, there is no outlined framework of who and how APRN independent practice is determined. Some APRNs practiced with high autonomy and almost completely independent from the oversight of another credentialed provider. However, other APRNs worked with close oversight

of a monitoring provider and weren't practicing independently, although their licensure, competency and scope as deemed by the local and state levels had been granted. There was no designated length, structure, skills competency or assessment of the APRNs ability to practice independently. Furthermore, Norton Healthcare has now recognized the need for supporting entry level to practice for APRNs. Hence NHC taken steps to implement a new structured transition to practice program for newly hired APRNs. The new orientation process for NHC includes four general categories; onboarding, didactic, clinical rotations and preceptorship. This guideline and the objectives are continually being evaluated and revised accordingly. The overall objective in the long term will be to develop a holistic onboarding for APRNs that includes skill competency check off and outlines the objectives an APRN must demonstrate and who designates them able to practice independently. This project is not meant to be a barrier to practice, but rather put into place an organizational standardized onboarding program, so deeming an APRN independent does not fall into the lap of another colleague. This long-term goal of a holistic onboarding must eventually be broken down into separate components delineated by specialty that likely become quality improvement projects of their own. This specific quality improvement project will focus on developing a framework for structured transition to practice for APRNs. The data will help gauge which components make an impact on practice as well as the timeline of meeting benchmarks. The data will then be utilized to determine what changes need to be made to the transition to practice programs offered to be sure they are meeting objectives, and providers are taking the skills learned and using them in real life practice, thus proving the worth and necessity of such programs at this organization. Data gathered will be system-wide. This will then encompass the skills portion and the general orientation phase into a standardized, holistic onboarding for APRNs and eventually utilizing the

framework to add additional realms for each specialty. Furthermore, large healthcare organizations with similar culture and within the region where NHC is located, would likely utilize similar models, framework and objectives.

The opportunity posed, based on the nature of the skill needed, will be best addressed with assessing the baseline content, providing both content and skill development training with return demonstration to assure providers have both knowledge and competence to perform skills independently at the highest level of scope possible. The skill set and ability to perform independently could directly impact both the respect as an individual provider within the local organization and nationally as a profession; but also the timeliness of appropriate intervention, improved patient care and better patient outcomes.

The training needed to practice as an APRN observed and learned in classroom and clinical rotations, on the job training or orientation programs. Based on the variability of educational programs and orientation processes the level of skill of an APRNs practice and obtain and retain competencies varies greatly. Skill level, scope of independent practice, competency determination and evaluation procedures also varies widely across healthcare systems (NONPF, 2016). Ultimately each institution determines how skill competency is deemed and upheld, but it is also the APP's responsibility to also maintain practice within their scope (NONPF, 2016). It is very important that after an APRN specializes the skills needed for that given specialty are delineated and cultivated. This poses a great need for an onboarding experience at each facility, beginning in a broad encompassing onboarding then delineated and based on specialty, for a more uniform competence verification process to ensure safe practice. As indicated in the research, "although general scope of practice is regulated at the state level, local and regional scope of practice is governed by hospitals" (Jalloh et al., 2016, p. 357).

Meaning, scope of practice is defined nationally, can be restricted further by state governing bodies or boards, and again privileges can be restricted within state scope by each healthcare organization. This indicates, from an organizational perspective, the need for developing and implementing a transition to practice model for newly hired APRNs.

Objectives

The objectives of evaluating this transition to practice program model were; to determine the variation of each subject's response, experience, feelings and utilization of the Transition to Practice program. Other sub-objectives included in the survey include assessing various components pertaining to the APRNs perception of job satisfaction and ease of transitioning into the APRN role using the two existing instruments, the Misener Job Satisfaction Scale and the Nurse Practitioner Role Transition Scale.

Project Methods

Setting

This study was conducted within the Norton Healthcare System under the branch of Norton Medical Group. The NHC organization consists of five hospitals and 14 immediate care centers, 190 physician practice locations with continued expansion across all sectors. NHC is a not-for-profit organization that provides care to the Louisville Kentucky and surrounding areas. NHC provides care across the lifespan and includes a pediatric facility. This organization is located in a suburban city in the mid-west. The organization employees over 1000 providers.

Sample

The study population chosen for this study was a convenience sample of newly hired APRNs who were participants in one of the very first pilot offerings of the onboarding program within the Norton Healthcare System in 2018. The number of study population was determined

based on enrollment capacity in each offering of the onboarding program. It is assumed there were 20-30 participants per onboarding program initiation, however we allowed for an unlimited number of subjects in the case of additional participants. There were no demographic exclusion criteria. The inclusion criteria included being a newly licensed APRN, newly hired within Norton Healthcare, transitioning from a Registered Nurse role, with employment in a position under Norton Medical Group.

The determination of potential subjects who could possibly be entering into the onboarding program was gathered through the data analytics department and Human Resources department at Norton Healthcare. The two departments provided the pool of potential subjects as those who are newly hired APRNs and their start date. The final 20 participants will be recruited through the roster of newly hired APRNs entering the onboarding program on the given start date of June 2018. As proposed, the subject did not have any direct interaction with the PI as there were no requests for such interaction through a complaint following the study's completion.

Procedure and Measures

Electronic copy of cover letter and survey/evaluation tools were distributed to the subject by the existing Norton healthcare email system, at a time interval of 3-4 months from initiation of the onboarding. The electronic cover letter, survey and evaluation tool were distributed to the subjects existing Norton Healthcare email address obtained from the Norton healthcare email system database. The electronic copy was sent out every 3 days for a two week timeframe. The subject then had approximately three weeks to decide on volunteer participation in confidence, without pressure or influence from other subjects or research personnel. The subject then completed the survey from the Qualtrics link provided in the email. The survey was completed anonymously and access to the survey answers and data was available through the Qualtrics

survey platform program. The cover letter determined a deadline of approximately three weeks for the subject to decide on participation and return of the completed survey. At the deadline determination of the final number of subjects willing to participate was gathered by the number of subjects who returned the form. The cover letter explained in more detail the benefits and risks of participation.

A waiver of documentation of consent was utilized with a cover letter on the front survey. Completion of the survey indicated the APRNs consent to participate. Upon completion the survey responses were kept in anonymous electronic form on the Qualtrics platform software and via the link provided in the email. The responses and data remained on the Qualtrics software until the PI retrieved the aggregate data for analysis. There was minimal risk to the participants. The survey also included, "prefer not to respond", as an option for every survey question. Project was submitted to the University of Kentucky Internal Research Board and Norton Healthcare office of Research and Administration for approval. Upon approval, when the appropriate time point was reached, the study was started.

The questionnaire was delivered to all of the advanced practice registered nurses (APRNs) participating in the June 2018 Onboarding Program. This included both family and adult-gerontology/acute care prepared APRNs. The questionnaire polled the basic demographic data for each provider; Title, educational background/preparation, population served, area of specialty, and length of practice as a registered nurse. The questionnaire also polled the APRN about feelings regarding comfort, confidence, skill level competency, commitment to Norton Healthcare and job satisfaction. Two existing tools utilizing Likert scale were used to gauge the provider’s perceptions and feelings. The two existing tools utilized were the Nurse Practitioner Role Transition Scale (NPRTS; See Appendix A) and the Misener Nurse Practitioner Job

Satisfaction Scale (MNPJSS; See Appendix B). The scale used for responses on the NPRTS were; one-strongly disagree, two-disagree, three-neither disagree or agree, four-agree, five-strongly agree and NR-prefer not to respond or those who have no knowledge or expertise in that item. The MNPJSS utilizes a 1-6 Likert scale as well. The scale for responses for the MNPJSS were; one-very dissatisfied, two-minimally dissatisfied, three-dissatisfied, four-satisfied, five-minimally satisfied, and six-very satisfied. The questionnaire was obtained at approximately the 3-4 month interval after the initiation of the Onboarding Program. After completed, the data was anonymously returned to the Qualtrics software platform where aggregate data was obtained and statistically analyze thereafter. Individual survey responses and data were de-identified when presented to the PI from Qualtrics. Conclusive survey data and numbers were reported from Qualtrics in aggregate format. Confidentiality was also maintained through direct communication to the Qualtrics software platform utilizing the link provided in the email distributed to the subjects. The Qualtrics survey and survey responses were password protected through the PI's account with Qualtrics, and was accessible only by the PI.

Data Analysis

Both qualitative and quantitative measures were used. Descriptive statistics including frequency, means and standard deviations were used to describe demographic data, as well as survey responses on individual items and as a whole.

Results

APRN Characteristics

Of the 28 APRNs who were invited to participate in the survey, 13 submitted survey responses. Nine of the 13 completed the survey in its entirety. Four of the 13 surveys had partial completion. Those four surveys were from subjects who completed only the open response

demographic and subjective data questions and none of the instrument based Likert scale items. This resulted in a 32.14% response rate. The entire sample was Caucasian and female. The ages reported ranged from 29-49 years with a mean of 35 years old. The sample population included both family nurse practitioner and adult-gerontology/acute-care specialty with practice in both inpatient and outpatient arenas.

Discussion

The data represents a sample of not only the specialty of family Nurse Practitioner, but also Adult-Gerontology Acute Care Nurse Practitioner. The data is representative in the cultural needs of the specific healthcare organization surveyed. On the MNPJSS, the NHC total summative survey mean was 108.78, which falls into the range of dissatisfied. Three other studies utilizing the MNPJSS was administered to APRNs and had means of 186.12, 195.26 and 206.36, all of which fell into the satisfied or very satisfied range. However, in those three studies the time interval differed from this study. The other three studies indicated polling APRNs within their first year of practice, but we cannot conclusively identify what month within that range. Therefore, there cannot be comparison of those study's summative means to the NHC study. The NHC sum indicates a mean of 2.47 per item. The total MNPJSS has been validated and can be broken down into six categorical sub-types of items. The six sub-types are intra-practice partnership/collegiality (14), challenge/autonomy (10), profession/social/community interaction (8), professional growth (5), time (3) and benefits (2). As indicated each of the sub-types had an unequal number of items with intra-practice partnership/collegiality with the highest number of totals items. The sub-types are respectively listed in descending number according to the number of items falling into that given sub-type (see Table 5). The NPRTS administered to the NHC subjects produced a mean of 111.11 with a standard deviation of 25.95, which falls

above the median range of 77.5. Lower scores indicate a more difficult transition to practice and higher numbers indicate an easier transition. The NPRTS contained 31 items of which 16 items were validated in previous studies and were then divided into categorical themes; developing comfort and building confidence in the role (8), understanding of the role by others (5), and collegial support (3). Each of the three components of the NPRTS also had unequal number of items. Of the 13 NHC subjects 84.6% (n=11) had assigned preceptors, one without an assigned preceptor and one indicated not applicable. The NHC APRN subjects practice settings included, six inpatient and seven outpatient. One of the subjective open response items polled the APRNs perception of what skills or competencies were important to the APRN in practice regardless of specialty. Some subjects indicated multiple skills or competencies. In this item responses were grouped together by theme and 10 themes emerged. The themes were Communication and Collaboration (7), Assessment skills (7), Critical thinking (3), RN foundation (2), Interpretation of labs and pharmacology (2), Bedside Manner (1), Conflict Resolution (1), Patient Advocacy (1) and Evidence Based-Practice (1). This indicates of the 25 subjective skills and competencies were mentioned in the subjects responses, 56% were within communication/collaboration and assessment skills, with 28% each. Differences across organizations can impact the importance and weight of aspects of the onboarding and orientation program. It is important to recognize the importance of addressing the various aspects of successful transition to practice and aspects of job satisfaction. It is costly to hire, orient and train a newly hired APRN. Therefore, if the transition process is not easy and job satisfaction is low, it can result in high turnover. High turnover can then impact patient outcomes and organizational costs.

Limitations

There were several limitations to this study. This population group has been the subject of several recent research endeavors and possibly had some level of study fatigue resulting in a low response rate. The survey tool was intended to only collect data from newly licensed APRNs transitioning into their first APRN role. One of the subjects within the sample was not screened out and had two years of experience as an APRN prior to beginning this onboarding program. This is not important for the Misener Job Satisfaction Scale, but more important in the Nurse Practitioner Role Transition Scale since the transition phase for a nurse transitioning from an RN role to an APRN role is going to be much different than an existing APRN transitioning to a new organization within the same APRN role. Other limitations include open response demographic and subjective data questions. The open responses were difficult to group together by theme or commonality therefore, resulting in some non-utilized data. Since the data was reported in aggregate format it is especially important to note the data includes Family and Acute care specialty Nurse Practitioners. Hence, the data is more applicable to the APRN population as a whole, rather than individualized by specialty. There were a limited number of subjects and the study was conducted at only one site. The time constraints prevented the study from being longitudinal and rather gave us a snapshot or baseline at one point in time.

Implications for Future Research

Numerous takeaways were learned from this study that may serve to support future teaching and learning opportunities. The takeaways may enhance NHC learning platforms and onboarding processes at NHC. As with any study, there is also much that will be important to look at proceeding forward with changes to current programs. In the future it will be important to revise the existing tool by rewording and restructuring the demographic and subjective

questions into multiple choice, ranking or Likert design. This will allow for easier grouping and conclusive data. It will also be important to carry forward with this style study into a longitudinal study with the same sample population used, as well as future newly hired APRNs over various intervals in time. Ideally this will help reveal shifts in perception categories at given time points and allow for adjustment to the onboarding schedule or objectives. Overall the sample size was small and there is an indicated need to replicate the study in larger populations and samples. It would be worthwhile to examine the cost benefit analysis of a transition to practice program at any given organization. This could help healthcare organizations report back to administrative leaders the financial impact of such transition to practice programs. After review of the limitations of the study, it can also be interpreted the need for separate onboarding programs for APRNs with existing experience in the APRN role and those APRNs transitioning into the role for the first time.

Conclusion

The literature review conducted as the background for this study helped to gauge the drastic growth that has occurred for the APRN and the doctorally prepared APRN in the past twenty years. With this exponential growth this survey and the literature help to support the need for developing programs and routes for the APRN to enter into independent practice with increased confidence. These programs will need to be continually evaluated and adjusted until APRNs reach an adequate level of satisfaction and ease of transition. When those objectives are met, it can be projected there will also be data that supports decreased length of stay, improved patient outcomes and higher patient satisfaction. Ultimately, meeting all of these objectives will advance the APRN and their entry level independent practice, but furthermore the profession in its entirety.

Appendix A

Nurse Practitioner Role Transition Scale – Item String with Corresponding Item Number

1 My workday was just how I imagined it would be when I was a student

2 My education prepared me to effectively manage my patients

3 I was comfortable in my role

4 I was treated as a professional by my colleagues

5 My nurse practitioner role was very well understood by my physician colleagues

6 My nurse practitioner role was very well understood by my nurse colleagues

7 My nurse practitioner role was very well understood by my patients/families

8 My nurse practitioner role was very well understood by the public

9 My nurse practitioner role was very well understood by management

10 I was very comfortable managing my patients

11 I felt anxious about the integration of theory into my practice

12 I felt very competent managing my patient case load

13 My supervisor was very available/approachable

14 My mentor was very available/approachable

15 I felt that my nurse practitioner role was seen as a substitute for a resident

16 I had trouble applying the theory to practice when I was under stress

17 I felt that I was doing more than one person's work

18 I felt that I was isolated

19 I felt that I got very little support

20 I felt less confident than I did before becoming a nurse practitioner

21 I felt it was easy to transition from nurse to nurse practitioner

22 I felt I had the skills to deal with the role transition

23 I felt I developed my nurse practitioner role within a nursing framework

24 I felt I developed my nurse practitioner role within a medical framework

25 I felt that I was an invisible provider on the healthcare team

26 I felt that I had a poor relationship with the MDs

27 I felt anxious in my communications with other health care providers

28 I felt that I needed extra time to complete my responsibilities

29 I was able to navigate the health care system to develop my new role

30 I had a clear understanding of third party reimbursement

31 My nurse practitioner program prepared me for a smooth role transition

Using Likert Scale 1-6

1=Strongly Disagree

2=Disagree

3=Neither Disagree or Agree

4=Agree

5=Strongly Agree

6=Prefer Not to Respond

Appendix B

Misener Nurse Practitioner Job Satisfaction Scale

Instructions:

The following is a list of items known to have varying levels of satisfaction among NPs. There may be items that do not pertain to you, however please answer it if you are able to assess your satisfaction with the item based on the employer's policy, i.e., if you needed it would it be there?

HOW SATISFIED ARE YOU IN YOUR CURRENT JOB AS A NURSE PRACTITIONER WITH RESPECT TO THE FOLLOWING FACTORS?

V.S. = Very Satisfied M.D. = Minimally Dissatisfied S. = Satisfied D. = Dissatisfied M.S. = Minimally Satisfied V.D. = Very Dissatisfied

V.S. S. MS. M.D. D. V.D.

6 5 4 3 2 1

1. Vacation/Leave policy 6 5 4 3 2 1

2. Benefit package 6 5 4 3 2 1

3. Retirement plan 6 5 4 3 2 1

4. Time allotted for answering messages 6 5 4 3 2 1

5. Time allotted for review of lab and other test results 6 5 4 3 2 1

6. Your immediate supervisor 6 5 4 3 2 1

7. Percentage of time spent in direct patient care 6 5 4 3 2 1

8. Time allocation for seeing patient(s) 6 5 4 3 2 1

9. Amount of administrative support 6 5 4 3 2 1

10. Quality of assistive personnel 6 5 4 3 2 1

11. Patient scheduling policies and practices 6 5 4 3 2 1

12. Patient mix 6 5 4 3 2 1

13. Sense of accomplishment 6 5 4 3 2 1

14. Social contact at work 6 5 4 3 2 1

15. Status in the community 6 5 4 3 2 1

16. Social contact with your colleagues after work 6 5 4 3 2 1

17. Professional interaction with other disciplines 6 5 4 3 2 1

18. Support for continuing education (time and $$) 6 5 4 3 2 1

19. Opportunity for professional growth 6 5 4 3 2 1

20. Time off to serve on professional committees 6 5 4 3 2 1

21. Amount of involvement in research 6 5 4 3 2 1

22. Opportunity to expand your scope of practice 6 5 4 3 2 1

23. Interaction with other NPs including faculty 6 5 4 3 2 1

24. Consideration given to your opinion and suggestions for change in the work setting or office practice 6 5 4 3 2 1

25. Input into organizational policy 6 5 4 3 2 1

26. Freedom to question decisions and practices 6 5 4 3 2 1

27. Expanding skill level/procedures within your scope of practice 6 5 4 3 2 1

28. Ability to deliver quality care 6 5 4 3 2 1

29. Opportunities to expand your scope of practice and time to seek advanced education. 6 5 4 3 2 1

30. Recognition for your work from superiors 6 5 4 3 2 1

31. Recognition of your work from peers 6 5 4 3 2 1

32. Level of autonomy 6 5 4 3 2 1

33. Evaluation process and policy 6 5 4 3 2 1

34. Reward distribution 6 5 4 3 2 1

35. Sense of value for what you do 6 5 4 3 2 1

36. Challenge in work 6 5 4 3 2 1

37. Opportunity to develop and implement ideas. 6 5 4 3 2 1

38. Process used in conflict resolution 6 5 4 3 2 1

39. Amount of consideration given to your personal needs 6 5 4 3 2 1

40. Flexibility in practice protocols. 6 5 4 3 2 1

41. Monetary bonuses that are available in addition to your salary 6 5 4 3 2 1

42. Opportunity to receive compensation for services performed outside of your normal duties. 6 5 4 3 2 1

43. Respect for your opinion 6 5 4 3 2 1

44. Acceptance and attitudes of physicians outside of your practice (such as specialist you refer patients to) 6 5 4 3 2 1

Table 1

Demographic Traits and Subjective Questions of Subjects

Specialty	
Family	3
Acute Care	3
Unable to Determine	7
Years as RN	
6	2
7	2
8	1
9	1
10	1
11	3
13	1
18	1
21	1
Assigned Preceptor	
Yes	11
No	1
N/A	1
Setting	
Inpatient	6
Outpatient	7
Important Skills or Competencies	
RN Foundation	2
Labs/Meds	2
Communication/Collaboration	7
Assessment	7
Bedside Manner	1
Critical Thinking	3
Conflict Resolution	1
Patient Advocacy	1
Evidence Based Practice	1
Charting/Documentation/Billing/Coding	3

Table 2

Descriptive Summary of NPRTS Component 1 Scores

	Range	Mean (SD)
Component 1 – Competence		
I was very comfortable managing my patients	1-5	3.15 (1.04)
I felt very competent managing my patient case load	1-5	3.19 (1.04)
I was comfortable in my role	1-5	3.10 (1.13)
I felt it was easy to transition from nurse to	1-5	2.77 (1.15)

nurse practitioner		
I felt I had the skills to deal with the role transition	1-5	3.65 (0.97)
I felt less confident than I did before becoming a nurse practitioner	1-5	3.04 (1.31)
My nurse practitioner program prepared me for a smooth role transition	1-5	2.93 (1.10)
I felt that I needed extra time to complete my responsibilities	1-5	2.90 (1.18)

Potential scores ranged from 1-6; higher scores indicate easier transition

Table 3

Descriptive Summary of NPRTS Component Scores

Component 2 – Understanding of Role by Others		
	Potential Range	Mean (SD); Range (Min-Max)
My Nurse Practitioner role was very well understood by management	1-5	3.78 (0.833); 2-5
My nurse practitioner role was very well understood by my patients and families.	1-5	3.78 (0.667); 2-4
My nurse practitioner role was very well understood by the public	1-5	3.67 (0.47); 3-4
My nurse practitioner role was very well understood by my physician colleagues.	1-5	3.67 (0.707); 3-5
My nurse practitioner role was very well understood by my nurse colleagues.	1-5	4.22 (0.441); 4-5

Potential scores ranged from 1-6; higher scores indicate easier transition

Table 4

Descriptive Summary of NPRTS Component Scores

Component 3 – Collegial Support		
	Potential Range	Mean (SD); Range
I felt that I got very little support	1-5	2.11 (0.782); 1-3
I felt that I was isolated	1-5	2.44 (1.014); 1-4
I was treated as a professional by my colleagues	1-5	4.22 (0.667); 3-5

Table 5

NPRTS Item Mean by Category and Total Summative Mean

Category	Mean	Standard Deviation	Minimum	Maximum
Component 1: Competence	3.44	0.34	3.00	3.88
Component 2: Understanding of Role by Others	3.71	0.39	3.00	4.20
Component 3: Collegial Support	2.93	0.40	2.67	3.67
Summative Total of all items	111.11	25.95	83.00	145.00

Table 6

MSNPJSS Sub-types

Sub-type	Number of items	Mean of total	Standard Deviation	Minimum	Maximum
Intrapractice partnership/collegiality	14	38.56	10.00	28	55
Challenge/autonomy	10	21.89	4.91	16	31
Professional/social & community interaction	8	18.78	4.99	11	26
Professional growth	5	16.67	7.11	7	31
Time	3	8.44	3.05	6	16
Benefits	2	4.44	1.33	3	6

Table 7

Descriptive Summary for Category 1 of MNPJSS: Intra-practice Partnership/Collegiality

Item	Mean	Standard Deviation	Minimum	Maximum
(6) Your Immediate Supervisor	2.00	0.50	1	3
(9) Amount of Administrative Support	2.56	1.13	2	5
24	2.33	0.87	1	4
25	3.00	1.66	2	7
26	2.11	0.78	1	3
30	2.67	1.80	1	7
33	2.67	1.22	1	5
34	3.44	1.67	2	7
37	2.78	1.64	2	7
38	2.88	1.69	2	7
39	1.75	0.71	1	3
41	4.33	1.80	2	7
42	4.11	1.96	2	7
43	2.11	0.33	2	3

Table 8

Descriptive Summary for Category 2 MNPJSS: Challenge/Autonomy

	Mean	Standard Deviation	Minimum	Maximum
7	1.89	0.60	1	3
12	2.44	0.88	2	4
13	2.33	0.87	1	4

27	2.33	0.50	2	3
28	1.89	0.60	1	3
29	2.67	1.73	1	7
32	1.89	0.60	1	3
35	2.22	0.44	2	3
36	2.00	0.50	1	3
40	2.22	0.67	1	3

Table 9

Descriptive Summary of Category 3 MNPJSS: Professional Social and Community Interaction

	Mean	Standard Deviation	Minimum	Maximum
10	2.11	1.05	1	4
14	2.22	0.97	1	4
15	2.11	0.60	1	3
16	2.22	0.67	1	3
17	2.33	0.50	2	3
23	2.22	0.97	1	4
31	2.67	1.80	1	7
44	2.89	1.69	1	7

Table 10

Descriptive Data for Category 4 MNPJSS: Professional Growth

	Mean	Standard Deviation	Minimum	Maximum
18	2.33	0.87	1	4
19	2.22	0.67	1	3
20	3.22	1.86	1	7

21	3.44	1.88	1	7
22	3.11	1.62	2	7

Table 11

Descriptive Summary for Category 5 MNPJSS: Time

	Mean	Standard Deviation	Minimum	Maximum
5	2.89	1.69	2	7
8	2.56	0.73	2	4
11	3.00	1.66	2	7

Table 12

Descriptive Summary for Component 6 MNPJSS: Benefits

	Mean	Standard Deviation	Minimum	Maximum
23	2.22	0.97	1	4
3	2.22	0.67	1	3

Table 13

MNPJSS Categorical Sum Ranges

1	2	3	4	5	6
Very Dissatisfied	Dissatisfied	Minimally Dissatisfied	Minimally Satisfied	Satisfied	Very Satisfied
44-87	88-131	132-175	176-219	220-246	247-264

Table 14

NPRTS Categorical Sum Ranges

1	2	3	4	5
31-61	62-92	93-123	124-154	155-186
Difficult				Very Easy

References

Barnes, H. (2015). Exploring the factors that influence Nurse Practitioner role transition. *The Journal for Nurse Practitioners*, *11*, 178-183. https://doi.org/https://doi.org/10.1016/j.nurpra.2014.11.004

Benner, P. (1982). From novice to expert. *American Journal of Nursing, 82*, 402-407. Retrieved from https://www.jstor.org/stable/3462928?origin=JSTOR-pdf&seq=1#page_scan_tab_contents

Cragg and Bailey, 2012. Cragg, B., & Bailey, P. (2012). Nurse practitioner graduate transition to practice (PowerPoint presentation). Retrieved from http://resources.cpha.ca/CPHA/Conf/Data/2009/A09-177e.pdf

Dillon, D. L., Dolansky, M. A., Casey, K., & Kelley, C. (2016). Factors related to successful transition to practice for Acute Care Nurse Practitioners. *AACN Advanced Critical Care*, *27*(2), 173-182. http://dx.doi.org/http://dx.doi.org/10.4037/aacnacc2016619

Hart and Macnee, 2007. Hart A.M., and Macnee C.: How well are nurse practitioners prepared for practice: Results of a 2004 questionnaire study. Journal of the American Academy of Nurse Practitioners 2007; 19: pp. 35-42

Institute of Medicine, 2010. The future of nursing report. Washington, DC: National Academy Press, 2010.

Jalloh, F., Tadlock, M., Cantwell, S., Rausch, T., Aksoy, H., & Frankel, H. (2016). Credentialing and privileging of Acute Care Nurse Practitioners to do invasive procedures: A statewide survey. *American Journal of Critical Care*, *25*(4), 357-361. http://dx.doi.org/http://dx.doi.org/10.4037/ajcc2016118

Kacel, B., Millar, M., & Norris, D. (2005). Measurement of Nurse Practitioner Job Satisfaction in a Midwestern State. *Journal of American Academy of Nurse Practitioners*, *1*, 27-32. https://doi.org/10.111/j.1041-2972.2005.0007.x

Kapu, A. N., Thomson-Smith, C., & Jones, P. (2012, August 11). NP's in the ICU: The Vanderbilt initiative. *The Nurse Practitioner*, *37*(8), 46-52. http://dx.doi.org/10.1097/01.npr.0000413485.97744.11

Kelly and Matthews, 2001. Kelly N., and Matthews M.: The transition to first position as nurse practitioner. The Journal of Nursing Education 2001; 40: pp. 156-162

Kentucky Board of Nursing. (2017). APRN Practice. Retrieved April 18, 2018, from https://kbn.ky.gov/practice/Pages/aprn_practice.aspx

Kleinpell, R. M. (1997). Acute-care nurse practitioners: Roles and practice profiles . *AACN Clinical Issues: Advanced Practice in Acute and Critical Care*, *8*, 156-162. Retrieved from https://www.ebscohost.com

Misener, T. R., & Cox, D. L. (2001). Development of the Misener Nurse Practitioner Job Satisfaction Scale. *Journal of Nursing Management*, *9*, 91-108.

National Organization of Nurse Practitioner Faculties. (2016). Adult Gerontology Acute Care and Primary Care NP Competencies . Retrieved from http://c.ymcdn.com/sites/www.nonpf.org/resource/resmgr/competencies/NP_Adult_Geri_competencies_4.pdf

O'Keeffe, A. P., Corry, M., & Moser, D. K. (2015). Measuring job satisfaction of advanced practitioners and advanced midwife practitioners in the republic of Ireland: a survey. *Journal of Nursing Management*, *23*, 107-117.

Pron, A. L. (2013). Job satisfaction and perceived autonomy for nurse practitioners working in nurse-managed health centers. *Journal of the American Association of Nurse Practitioners*, *25*, 213-221.

Scholtz, A., King, K., & Kolb, S. (2014). The care model of the future: Supporting APRNs through an innovative transition to practice program. *Journal of Pediatric Health Care*, *28*, 276-279. https://doi.org/10.1016/j.pedhc.2013.11.002.

Squiers, J., King, J., Wagner, C., Ashby, N., & Parmley, C. L. (2012, February). ACNP intensivist: A new ICU care delivery model and its supporting educational programs. *Journal of the American Academy of Nurse Practitioners*, 1-7. http://dx.doi.org/10.1111/j.1745-7599.2012.00789.x

Strange, Sally N., "The Development and Psychometric Testing of the Nurse Practitioner Role Transition Scale" (2015). Doctoral Dissertations. 661