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Transitioning Novice Nurses to Expert Nurses in Progressive Telemetry Care

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Transitioning Novice Nurses to Expert Nurses in Progressive Telemetry Care

by

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Abstract

New nurses do not possess the clinical skills necessary to thrive in a fast-paced, rapidly changing telemetry unit. The study explores the idea that nurses with less than two years' experience may not have the self-confidence or experience to begin a career on a telemetry unit. A search of the literature was performed to identify the skills needed to be successful in a critical care telemetry unit. Established orientation programs, nurse internships, and nursing experience were the keywords researched. Patricia Benner's Theory: From Novice to Expert Excellence and Power in Clinical Nursing Practice (1984) serves as the foundation for this investigation. The theory views nursing competency as a continuing learning experience based on individual experiences, exposures, and cumulative time in practice. The design is descriptive using qualitative, narrative analysis on focus group data. Two focus groups of five nurse participants were purposely selected for the study. One group represented novice nurses, and the other represented expert nurses. Novice nurses placed importance on completing the task list, keeping the patient safe, and receiving positive feedback from co-workers and management. Anticipation, symptomology, and intervention were demonstrated in the expert nurses in this study. Preceptorships, internships, and simulator science may assist in orienting novice nurses new to telemetry to critical thinking and time management skills, and for expert nurses learning a new cardiac skill-set for telemetry care and acting as resource personnel for less experienced colleagues.

Keywords: Patricia Benner, orientation, telemetry, novice to expert

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CHAPTER I

Introduction

A significant drop in the number of registered nurses in the United States has occurred in the last decade (U.S. Bureau of Labor Statistics, 2015). By 2025 the United States Department of Labor estimates a need for 260,000 new and replacement registered nurses (U.S. Bureau of Labor Statistics, 2015). Nurses are aging and retiring. The mean age for new nurses is 49.8 years, compared to nurses under the age of 30 being 8 % of the workforce (U.S. Department of Health and Human Services, 2008).

Adding to the shortage is the turnover rate. The number of new nurses leaving the practice setting within the first year ranges from 30% to 60% (Beecroft, Kunzman, & Krozek, 2001) and can be as high as 57% during the second year (Bowles & Candela, 2005). Furthermore, 37% of licensed registered nurses want to change their employment setting within two years. Numerous contributing explanations exist as to why newly licensed nurses leave practice. Challenges include technology, high patient acuity, fast-changing work environments, increasing workloads, and lack of psychological empowerment (Larabee et al., 2003).

A disregarded element in reversing the negative trend in nursing is the preparation of the nurse for success beginning with orientation. Critical care telemetry units are fast paced with high acuity with a six-to-one patient ratio. It is essential that newly licensed registered nurses be afforded the opportunity to develop the critical thinking skills to promote their success (Kaddoura, 2010). If nurses are to provide safe and sophisticated care, they have to be provided opportunities for developing critical thinking skills during orientation and preceptorship experiences (Kaddoura, 2010).

Background

Hospitals nationwide use telemetry extensively for continuous cardiac monitoring. Telemetry is the ability to transmit via radio frequency from the patient to a remote cardiac monitoring station (Scott, Matthews, & Kirwan, 2014). Telemetry is used for low-risk cardiac patients, with no critical cardiac process actively taking place. Telemetry provides the ability to monitor cardiac activity for different patients at the same time, instead of one patient by the use of a bedside monitor (Grossman et al., 2011). This type of surveillance within the acute care setting is typically used for patients transferred from intensive critical care or patients not meeting ICU criteria. The use of telemetry cultivates a fast-paced high acuity unit requiring critical thinking and analytical skills. Nurses must acquire high-level critical thinking skills to successfully care for patients in an environment which have a rapid technology expansion, and changes in patient population (Kaddoura, 2010).

The hospital in which the study was conducted is located in the Southeast United States, has a 41-bed telemetry unit and maintains accreditation as a Certified Stroke and Chest Pain Center. Currently new employee orientation is divided into two sections. Section 1 is academic classroom preparation for two weeks. Nurses review corporate policies and procedures, instructions on the point of care (POC) testing, and instructions on how to activate that appropriate emergency response teams. Section 2 is a 12-week preceptor experience on the unit. Every effort is made to keep the new employee with their assigned mentor. Unfortunately, this is not always possible due to scheduling conflicts, days off, and various other reasons. Newly employed nurses begin by shadowing their preceptor. Once a mentor feels comfortable that the new nurse has a

grasp of the daily routine, the preceptor will assign one patient to the new nurse and gradually increase the patient load. For three weeks after completion of orientation, the patient load for the new nurse will be limited to five patients, with the goal of begin able to manage a six patient assignment. Orientation teaches policies and practices on the telemetry unit but does not teach critical thinking or time management.

Evaluation of orientation occurs at the end with the surveys being designed to evaluate the preceptor, not the process or critical thinking skills. New nurses are consistently confused about medical treatment protocols, missed vital signs, and symptoms; possibly prolonging the hospital stay. The unit continuously maintains a low retention rate. According to the last evaluation, the average stay of a new nurse is 1 to 1.5 years before accepting a new position or leaving the hospital. No critical thinking or competency surveys have been designed or used to evaluate the problem. Only the evaluation of the preceptor is used when the orientation ends. The next assessment occurs at the employee's annual review.

Theoretical Foundation

Patricia Benner's Theory (1984), From Novice to Expert Excellence and Power in Clinical Nursing Practice provides the theoretical framework for this research. Based on the Dreyfus Model of Skill Acquisition created by Stuart Dreyfus and Hubert Dreyfus (1980), based on chess players and airline pilots; it postulates students or nurses pass through five levels of aptitude: novice, advanced beginner, competent, proficient, and expert (Benner, 1984). Advancement from one level of skill to the next requires expansion of three characteristics. Promotion of a level occurs when trust of abstract principles and experience combine as paradigms. The second happens when the nurse's

perception of the situation is connected with seeing equally relevant pieces of the problem with task completion (Benner, 1984). The third is the "process from detached observer to involved performer" (p. 13). (Figure 1)

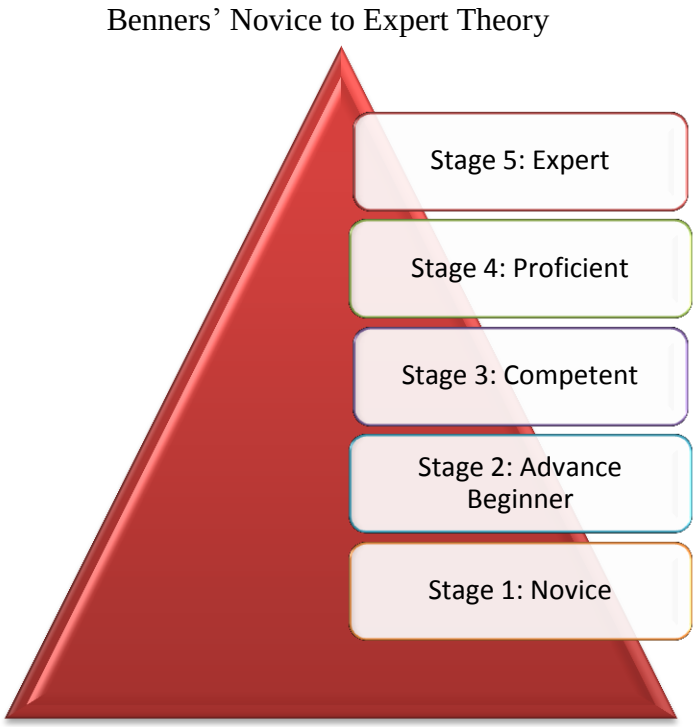

Figure 1. Benner's Novice to Expert Triangle

Benner's (1984) theory defines Novice as, "beginners, having no experience in the position they are to perform" (p. 20). Everyone, regardless of their years of experience, begins as a novice when transitioning into a new role or position. At this level the nurse is taught context-free rules to guide their thinking.

Rules governing the novice are extremely limited and arduous. The center of the problem occurs because the novice has little or no experience to navigate the situations they will face. Guidance is provided to the nurse by strict policies of the facility to guide

their performance. Unfortunately following the rules will also restrict satisfactory performance because the policies cannot guide the nurse through major primary tasks needing to be performed in an actual situation. New graduate nurses or employees enter a new clinical area as a novice because they possess the textbook procedures and terms, but not the experience. New hires may have experience in other clinical areas irrelevant to the new area in which they are currently assigned (Benner, 1984).

Benner's (1984) theory states, "Advanced beginners are ones who can demonstrate marginally acceptable performance, who have coped with enough real situations to note recurring meaningful components" (p. 22). Policies and guidelines are still useful at this point, but experience allows the nurse to go beyond a novice. However, a mentor may still need to identify similarities of occurrences to the nurse.

Benner (1984) defines a competent nurse as "the nurse who has been on the job in the same or similar situations for two to three years, and begins to see his or her actions regarding long-range goals" (p. 25). The nurse begins to recognize aspects of the current problem and contemplate priority steps needed in managing the situation, lacking the speed and flexibility, but has developed a sense of accomplishment in their actions.

Proficient nurses can perceive the situation has a whole, instead of small individual parts. At this level, the nurse understands the situation by recognizing its meaning and establishing long-range goals. Perception is the key word, because of clinical experience, the nurse can recognize when the expected normal outcome for the patient does not occur. They can identify a problem and develop a plan to address the problem (Benner, 1984).

The expert nurse is one who has amassed an enormous background of experience in their clinical field. They can zero in on the problem while systematically eliminating the nonimportant aspects of the situation. Expert nurses operate with a thorough understanding of the situation and uses a developed keen intuition of future events that may occur (Benner, 1984).

Benner's nursing model emphasizes the importance of clinical nursing as the foundation of the design. The model also advocates that observation and emulation of actions of a mentor or preceptor is the preferred method of learning. Mentors or role models are nurses who have already gained the experience to function at a higher level than the novice. This provides an opportunity for the novice to study the actions and thought process of the experienced nurse. An opportunity to observe the actions of an experienced nurse allows the novice nurse to expand their scope of practice in a more confident manner (Benner, 1984). (Figure 2)

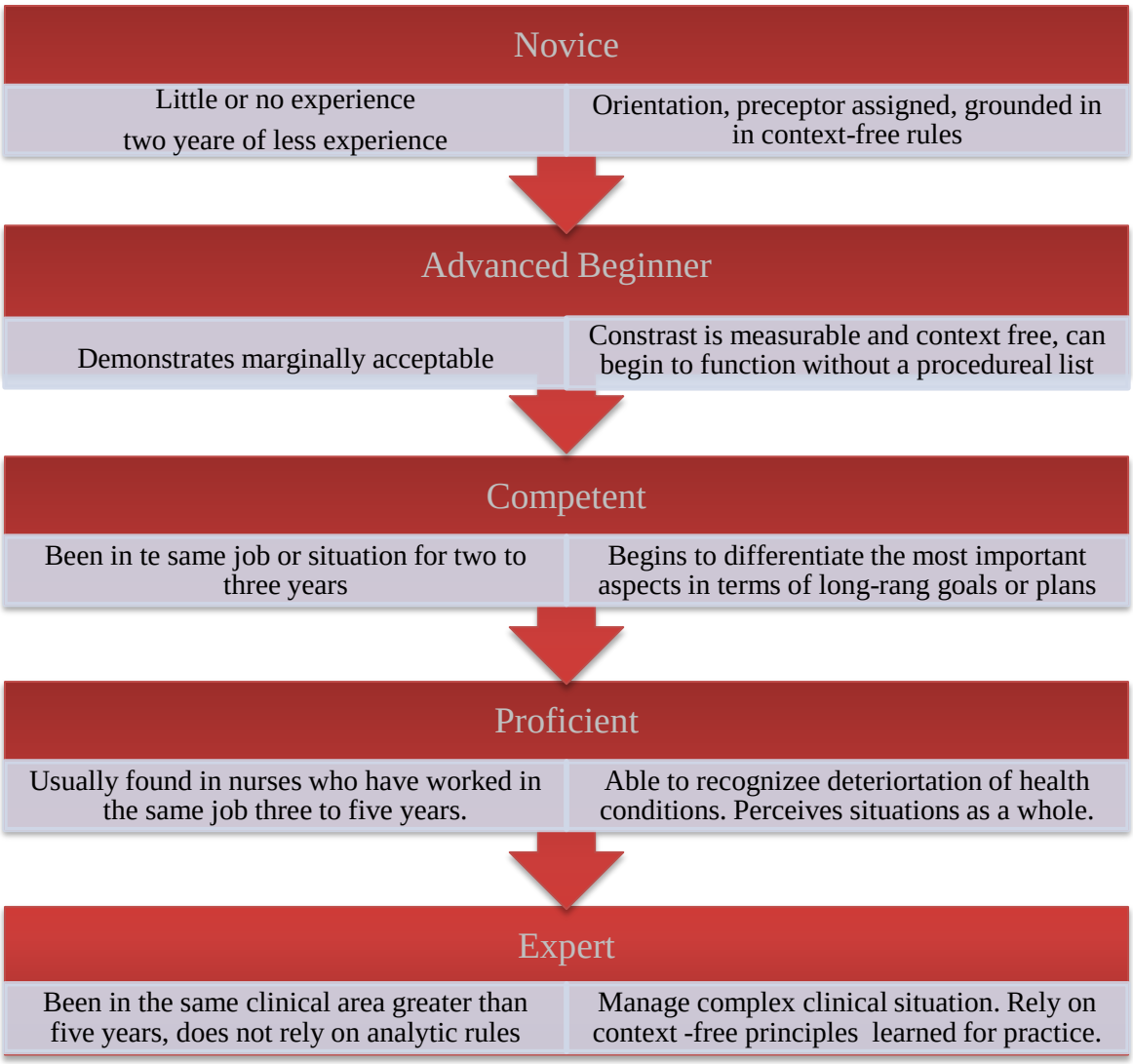

Figure 2. CTE Diagram

CHAPTER II

Literature Review

Search Strategy

An online search was performed at John R. Dover Memorial Library at Gardner-Webb University using the online databases CINAHL plus, DynaMed, Ebsco Host, PubMed.gov, and SAGA. Using the phases: " Novice to Expert in Nursing", " Benner's Novice to Expert Nursing Theory", " nursing orientation based on Benner's Nursing Theory", "successful oriented programs based on novice to expert", " increasing employee retention", " nursing deficits", " decreased retentions in nursing", " novice to expert theory in education", "nurse internships", "successful nursing management", " job predictions in nursing in the future". Additional searches were conducted using phases: "low employee retention and cost", "cost of employee training", "nursing shortages in the future", "successful orientation models based on nursing theories", and "promoting critical care thinking".

Theoretical Literature

Patricia Benner's (1984) From Novice to Expert Excellence and Power in Clinical Nursing Practice provided the theoretical foundation for this research because it outlines the skill, time, and experience needed to transcend from a novice to expert nurse. The term novice and expert are described, including expectations, education, and intuition required to progress from one level to the next. It provides clear examples of conversations with nurses taking place to demonstrate the interpretation required with each level of expertise. The theoretical literature chosen outlines programs based on Benner's theory.

Ian English's (1993) work provides an exegesis of Benner's theory. The literary review identifies Benner's theory as the framework used to develop an educational program titled Project 2000 in Britain. English's scholarly article debates Benner's Novice to Expert Theory and seeks to define what an expert is. Benner's theory proposes intuition is a significant component of being an expert (English, 1993).

Penprase's (2012) scholarly article acknowledged the importance of preceptorships. Her research findings are relevant to this study because it indicates preceptorship and orientation programs make a significant impact on new grads, second-degree nurses, and new hires in empowering them for success. It supports Patricia Benner's Theory of Novice to Expert Excellence and Power in Clinical Nursing Practice by describing the importance of an active preceptorship program in the transitions for a student nurse to a Registered Nurse.

Banner Good Samaritan Medical Center bone marrow transplantation program developed a systematic approach bases on Benner's (1984) theory. The organization used the Novice to Expert theory to cultivate a philosophy of continued education, leadership development, orientation; opportunities for staff, coaching, skill sharing, mentorship; and additional career opportunities. Marble's (2009) study addresses the success of the program and how Benner's (1984) theory was used to establish a five step model of excellence, with each level using Benner's (1984) description of each level of competency (Marble, 2009).

Evan and Donnelly (2006) recognized the relationship between knowledge, skill, and the nurse's judgment. Relying on Benner's Novice to Expert Theory, the authors outlined an interrelationship between competency levels and acquired skills.

Horwarth's (2010) described the use of Benner's Theory as a foundation for developing an improved employee orientation program. Horwarth's research used Benner's theory to clarify that novice is not just for the new graduates on the floor, but relates Benner's Theory to new nursing managers also.

Empirical Literature

Some hospital nurse educators have adapted didactic orientation programs to facilitate skills to promote learning of critical thinking based on the Essential of Critical Care Orientation (ECCO) program as recommended by the American Association of Critical Care Nurses (AACN). Kaddoura's (2010) study identified new graduate nurses believed their critical thinking skills improved throughout orientation based on ECCO recommendations. All of the participants believed their critical thinking skills improved during orientation by increasing their knowledge. However, some participants expressed concerns over the limitation of the programs, which may have limited the growth of critical thinking skill. Most of the didactic study was online without theoretical content and peer discussion. Astonishingly, no additional research could be located about the American Association of Critical Care Nurses Essentials of Critical Care Orientation.

Zin, Guglielmi, Davis, and Moses (2012) researched a nurse residency program to prepare novice nurses for their career. It is impossible for a nursing program to prepare a graduate nurse for every aspect of nursing practice. The study promotes internships to increase retention, increase satisfaction, and decrease the expected nursing shortage.

By using creative problem solving, relationship development, and positive influence, the nurse manager is able to influence the nursing atmosphere. Longo, Roussel, and Hoying (2013) conducted a study in a Midwestern pediatric hospital, asking nurses to

self-identify their level of practice based on Benner's (1984) nursing theory. One goal of the study was to determine if the staff nurse's perceptions of their level of confidence was the same as their managers. This study focused on Benner's (1984) recommendations in her research, which outlined the importance of a clinical manager understanding the direct care RN. Examples of solving staff shortages, clinical promotion, meaningful recognition, and successful orientation was recognized as critical thinking skills of successful managers. By quick identification and solving of problems, managers increased retention rates of their staff. An increase in retention decreases cost for the unit, which provides more revenue for training and equipment.

Summary

Literature reviews of 24 articles were conducted. Eight of them supported Benner's (1984) From Novice to Expert Theory in establishing a nursing orientation program. Each study outlined how a novice became an expert through time on the job, experiences, and acquired skills from repetitive task, and critical thinking. Regardless of the years in nursing, transferring to a new clinical area starts the nurse back as a novice. Experience may propel the nurse forward through each level in Benner's theory quicker, but they still begin as a novice and have to gain expertise in the new clinical area to succeed.

A literature review of 16 articles related to critical thinking was conducted. Critical thinking is a burgeoning concept that varies from individual to individual. It is based on experiences, different thought processes, and it is difficult to teach. There is not a real definition of critical thinking skills. It is, however, a collection of intellectual traits that include confidence, contextual perspective, integrity, open-mindedness, and

willingness to investigate circumstances (Kaddoura, 2010). There were no research articles on the critical thinking and clinical skills necessary to develop confidence on a busy telemetry unit.

CHAPTER III

Methods

Purpose and Research Question

The goal of this study was to identify the extent to which novice and expert nurses, as defined by Benner (1984) theory, perceive themselves prepared to manage the care of six patients on a busy telemetry unit and if past clinical experiences assist in transitioning to telemetry nursing.

The research questions were:

1. What is the perception of clinical confidence in novice and expert nurses on a telemetry unit?
2. What factors facilitate confidence in novice or expert nurses working on a telemetry unit?

Design

The research is a descriptive qualitative design.

Sample

The research was conducted at a 268-bed hospital in the Southeast United States on a 41-bed telemetry unit. A purposive sample was selected for the study; five novice nurses and five expert nurses who are working full-time on the telemetry unit.

A novice nurse is defined, according to Benner (1984), as a nurse with little or no experience in situations in which they are to function. They are allowed entry to gain information about their current clinical position. This research project used the classification of a novice for nurses with two years or less clinical telemetry experience. Benner (1984) described an expert nurse as one who understands the context of the

situation and is no longer dependent on analytical methods. This research project uses the classification of the expert nurse as any nurse with five or more consecutive years nursing experience in the clinical telemetry area. Expert nurses have served as preceptors and resource person for new graduates and employees. Age, sex, and level of education were not a consideration for selection. Nurses involved in the management of the telemetry unit or hospital were excluded to protect the participants' anonymity.

All nurses selected by the PI and meeting the inclusion criteria, regardless of which shift they were assigned, were given an information sheet (see Appendix A). The data sheet contained the name and contact information of the researcher, university involved, the length of time required to participate in the focus group, and how and where the results are disseminated. Each nurse approached could call the researcher Monday through Saturday from 8 am to 8 pm to volunteer for participation. The purposive sample were not direct reports to the PI.

Method

The University's Institutional Review Board (IRB) and host hospital's Institutional Review Board granted authorization for the research.

Once the nurses had agreed to participate, arrangements were made to secure a conference room at the hospital and the delivery of food and drinks from the cafeteria. The focus groups met on different days, One day for the novice group and one day for the panel of experts. A three-hour period was chosen to provide time for eating, data collection, debriefing, and field notes.

The use of focus groups to complete this research was aimed to promote verbal data and group interaction by the sharing of experiences and feelings. Focus groups made

up of homogeneous participants produced communication elements by the exchange of similar experiences. By asking open-ended questions to focus groups, data was provided for qualitative research. Usage of open-ended questions with focus groups produced more data than using a survey because it provided honest responses. The choice to use a focus group is a simple research method that provides informal discussion among the participants. The aim of the focus group was to gain an understanding of each group's experiences and feelings. The use of focus groups to complete the research gave control of the research to the participants and allowed the researcher to be the moderator (Liamputtong, 2010).

Using focus groups to perform this study provided an opportunity to understand each person's feelings and experiences. It allowed for an in-depth interaction with a small group of individuals and provided the opportunity for individuals to share experiences and opinions; thus, keeping the focus on the research. The usage of focus groups produced an environment where everyone involved has the same culture and concerns (Liamputtong, 2010).

The researcher served as the moderator and explained the purpose and procedure of the study. Participants were reminded they may choose not to answer questions if they felt uncomfortable, and they could withdraw and leave the conference room at any time without fear of reprisal. After the moderator reviewed the informed consent and answered any questions, participants were asked to sign the consent (see Appendix B). The researcher collected the signed consent forms and secured them in an envelope. Members of the focus groups did not receive any incentives, and the names of the participants were numerically coded for group identification on the excel spreadsheet.

Each focus group was conducted separately. Once everyone was seated an engaging question was asked to allow the group to interact and feel safe, such as; *How is your day going?*

Five open-ended questions were posed by the researcher. The goal of the moderator was to generate independent opinions from the group members while being an active listener. Five broad questions was asked to both focus groups:

1. Share with me a story about when you began to feel confident in your clinical abilities on the telemetry unit?
2. How long did it take for you to feel confident?
3. What facilitated your confidence?
4. What was the most arduous task for you to master?
5. Based on your current experience, how do you facilitate confidence in new graduates or employees?

Field notes and audio recordings were made during the interview by the researcher; this included mood, facial expression, body language, hand gestures, and distractions (Polit & Beck, 2012). The researcher paraphrased some responses back to the individual for clarification, as necessary.

Questions were designed to be broad-based and were delivered verbally in the same format. The goal of the moderator was to generate the maximum amount of independent opinions from the individual group members while being an active listener. The conversation was free flowing and unscripted except for the designed questions asked of each person. Five broad issues were the center of the discussion for the novice

and expert focus group. After completion of the focus groups, the recordings were typed into transcripts.

Analysis

This project is a descriptive qualitative study using narrative analysis to compare each focus group member's thoughts, feelings, and experiences. It concentrates on the experiences of focus group participants on the journey of obtaining confidence in clinical skills (Millward, 2012). The researcher read transcripts, listened to the recordings, and reviewed field notes several times to understand the experiences of confidence building in novice and expert nurses.

For each question, individual quotes were listed on an Excel spreadsheet. A separate spreadsheet was used for each group. Within the Excel workbook, one worksheet per question was utilized (Gee, 1991). The worksheet was divided into three columns and labeled as follows. (Figure 3)

Group ID	Quote	Body Language
N-1 (Novice 1)	"I was scared I'd hurt someone."	She was sitting on the edge of the seat.

Figure 3. Date Analysis Spreadsheet

The letter N identified the novice focus group on the excel spreadsheet, and the letter E. designated the expert focus group. The researcher developed common themes from the data for each question. All data was stored on the investigator's personal computer in a password-protected file. At the conclusion of the research, all written data was submitted to the University IRB committee to be kept in locked storage for 10 years then destroyed.

Budget

Any hospital, company, or university did not provide funding for the research. The budget consisted of $100.00. This was financed by the researcher and used to provide refreshments and light snacks for participants in the research.

Dissemination

Results of the research was distributed by a poster and verbal presentation at the University in April 2016 and the Institutional Review Board at the participating hospital in May 2016. Results from the study will be submitted for publication in ProQuest database.

CHAPTER IV

Results

Approval from the host hospital and the Univerisity's IRB was received. The PI handed a flyer containing a short description of the study, location, date and times, and contact information to each person invited to attend the focus group. One individual meeting the novice nurse criteria verbally consented to participate immediately. Two novice nurses took a day to agree and notified the researcher the following morning by telephone. Two invitees did not respond to the invitation, which was perceived as a decline to take part in the study. The novice focus group meeting was set for a Monday at 12:00 PM. The conference room was reserved for a three-hour time block to accommodate the focus group. Arrangements for food and refreshments were not made with the cafeteria due to exceeding the budget for the research. Instead cheese and meat tray and drinks were purchased from a local deli.

The three members of the novice focus group arrived within five minutes of each other. As planned, 10 minutes was given to obtain a drink and snacks. In attendance were three focus group members and the primary investigator. The consent was reviewed, signed, and sealed in an envelope by the primary investigator. A small digital recorder was placed on top of the table to record the conversation. The PI reminded the participants that the session would be audio recorded; all members were in agreement, and no objections were voiced. After the focus group concluded, the PI transcribed the recording into a word document. No names or identifiers were used in the transcripts. Field notes were taken by the PI on paper to document body language, hand actions, and facial expressions.

Each group session provided time for socialization and was opened with the engaging question of *"How has your day been ?"* The intent was to promote a relaxed atmosphere, resulting in open free flowing conversation. Members of the group appeared to be comfortable and willing to take part in the research. Documentation of body language and hand gestures was difficult to do because of the pace of the conversation. The PI was able to successfully accomplish documenting body language by dividing a sheet of paper into the columns representing each member. On the left-hand side of the page was a corresponding number of the question. The researcher placed a number at the top of each column to identify each participant. In addition, immediately following the focus group session, the PI documented body language and added voice tone to the field notes while listening to the audio recordings. This format was conducted for both focus groups, allowing the PI to document body language without delaying the conversation to make notes.

All audio recordings were transcribed into a word document. Excluded from the transcripts were laughter and inconsequential conversations about unrelated topics, (childcare, relationships, etc.). The audio recordings were listened to a multitude of times to confirm no important data was accidentally excluded. While transcribing the conversation, body language, voice tone descriptions, facial and hand gestures descriptions added in the transcripts and identified by the term "Body Language." Tables 1 through 5 identify one-sentence quotes from each participant in the novice focus group with the main theme of the question. Exemplars listed after Table 5 demonstrated the full content of the story from the novice group, including body language as an example of their feelings about the question.

Question one was designed to identify what act(s) may have taken place to promote confidence in a novice nurses' clinical abilities. According to Benner's (1984) theory, the question was designed to determine if the novice nurse placed importance on task completion as theorized.

Table 1

Question 1 for Novice Nurse Group

1. Share with me a story about when you began to feel confident in your clinical abilities on the telemetry unit?		
Group ID	Comment	Body Language
Novice-1	"I feel confident when I leave, and the workload is complete, all medications were given, and everyone is safe."	Voice had a higher pitch on the term confident.
Novice-2	"Support from other nurses, accomplishing tasks, such as starting an IV without help. Completed workload."	Relaxed, sitting back in the chair.
Novice-3	"Support from other nurses, but I am still scared and have been here almost a year."	Embarrassed, slow to respond, face flushed.

Study question two was designed to obtain an estimated time frame for when the novice nurse begin to feel confident on the unit, and was later used for comparison with an estimated time frame from the expert nurses.

Table 2

Question 2 for Novice Nurse Group

2. How long did it take for you to feel confident?

Group ID	Comment	Body Language
Novice-1	Four to five months, this is a busy unit	Higher voice inflection on the term busy
Novice-2	Six months	Relaxed
Novice-3	Six months or longer	Slow to respond, watching others

To increase retention, an understanding of factors facilitating confidence have to be understood. Question three was intended to promote conversation about different factors and needs promoting confidence. According to Benner's (1984) theory, the needs will be different between the two focus groups. By identifying the needs an orientation program can be devised to meet the needs of the groups.

Table 3

Question 3 for Novice Nurse Group

3. What facilitated your confidence?

Group ID	Comment	Body Language
Novice-1	Praise from co-workers, preceptors, providers, and family members	Relaxed sipping a drink. No hesitation
Novice-2	Complements from fellow nurses, CNA's, doctors, being told you're doing a good job. Recognition during leadership rounding	Relaxed sitting back in the chair
Novice-3	Experience, doing everything over and over	Relaxed

Each nurse, regardless of the level of experience, must learn to master new skills when orienting to a telemetry unit-question #3 promoted free conversation to characterize common burdensome tasks between groups

Table 4

Question 4 for Novice Nurse Group

4. What was the most arduous task for you to master?

Group ID	Comment	Body Language
Novice-1	Time management and prioritization	Leaning forward in the chair
Novice-2	Time management	Relaxed leaning backward in the chair
Novice-3	Talking with families	Tense, face flushed, looking down

Question five was intended to determine how each nurse assisted new graduates and new employees. Identifying the nurse's values in promoting confidence will allow incorporation of their standards into the future training of new graduates.

Table 5

Question 5 for Novice Nurse Group

5. Based on your current experience, how do you facilitate confidence in new graduate or employees?

Group ID	Comment	Body Language
Novice-1	A positive attitude is where is all begins	Stern voice tone
Novice-2	Provide constructive criticism correctly in a positive manner	Leaned toward the table
Novice-3	I try to be a resource person	Sitting back in chair

The closed-door session lasted 35 minutes. The session concluded with time provided to answer any participant questions. There were no questions or interruptions. The PI thanked everyone for attending the focus group and provided another opportunity for questions. There were no further questions or concerns voiced. Everyone then vacated the room except for the PI. After the conclusion of the focus group, the PI stayed in the conference room alone for two hours to listen to the audio recordings repeatedly while transcribing the conversation into a word document.

According to Benner (1984), novice nurses can take in just a small aspect of the situation. The concept of managing the patient's care while in the telemetry unit is complex. It is a new and complicated environment in which to develop a specific set of nursing skills. The following examples demonstrate how task oriented the novice is.

While asking the first question the following conversation took place between the PI and a novice nurse.

- EXEMPLAR I

She was sitting back in her chair, sipping a refreshment and appeared to be relaxed; her voice was soft:

PI: Share with me a story about when you began to feel confident in your clinical abilities on the telemetry unit?

Novice Nurse: " *I was not long out of orientation, and I was giving report to a night shift nurse when she looked at me and complimented me on having everything done. She told me, " A lot of new nurses leave us wondering what they have done all day. You always have everything finished." That made me feel great, that someone noticed. As for my clinical ability, one of the biggest things that made me feel confident was getting an IV without help the first time. It made me feel like a rock star. I did not need someone holding my hand, and it made me feel like a nurse on her own."*

- EXEMPLAR II

PI: What facilitated your confidence?

Novice Nurse: Her voice tone is soft, she is sitting back in the chair relaxed, *"That is a tough question. Other nurses saying I was doing a good job. My preceptor telling me I was getting it and everything would be OK. The patients telling me "thank you" when I got the IV for them. Patient's family when they do not have any complaints, and they feel all the patient's needs have been met. That goes a long way knowing the families feel I did a good job."*

The session for the expert focus group followed the same format as the novice focus group and was held on a Wednesday at 12:00 pm in the same conference room used for the novice group. The conference room also was reserved for a three-hour time block to accommodate the focus group and to allow time for the PI to listen to the audio recordings over and over and to review field notes. The session was a closed door session to decrease the chance of interruptions. There were no interruptions. Attending was four of the five invitees and the PI.

Recruitment of members of the expert focus group followed the same format as the novice group. The primary investigator selected each nurse and gave the same flyer explaining the study. The nurses were approached in private. One person immediately agreed to participate in the focus group; two members notified the PI by phone the next day; and the fourth informed the PI the following shift in person.

Refreshments were purchased from a local deli instead of the hospital cafeteria due to budget constraints. Time for socialization was provided; the consent was reviewed, signed by the participants, and placed in a sealed envelope. Time was given to answer any questions; there were no issues voiced. The PI reminded the expert focus group that the conversation would be audio recorded, No objections were voiced about the format or audio recordings.

All information and instructions given to the novice group were given to the expert group. Tables 6 through 10 represents the expert focus group and follows the same format as the novice group. Exemplars after Table 10 are used to portray the feelings and thought processes of the expert focus group. The goal was to compare and contrast the experiences of novice and expert nurses new to telemetry nursing.

Before asking any questions, the PI explained the questions were designed to solicit each person's individual interpretation of the question based on their experience on the telemetry unit. The group was encouraged to be as honest and open as possible without being uncomfortable. The expert group was informed they would be asked the same questions as the novice group. Field notes were taken in the same format used for the novice group.

Table 6 begins with the first question directed to the experts. Short quotes and themes are identified to determine if the expert group emulated Benner's (1984) theory and would process the questions with increased critical thinking and have different goals.

Table 6

Question 1 for Expert Nurse Group

1. Share with me a story about when you began to feel confident in your clinical abilities on the telemetry unit?

Group ID	Comment	Body Language
Expert-1	Ability to function without looking up protocol and assist employees without giving them incorrect information	Relax, smiling
Expert-2	It was when I began to see the different diseases and react comfortably and recognize the different symptoms	A long silence before answering, looking upward
Expert-3	Having the ability to anticipate a provider's orders, and being ready to take verbal orders from the physician	Sitting with elbows on the table, relaxed
Expert-4	Being a travel nurse and being able to function as a nurse with a full assignment with only a three-day orientation	Laughing and smiling

The second question was asked of the expert group to determine if their time frame to feel confident was close to what the novice nurse stated. Most of the experts listed a time span to feel confident twice as long as the novice group.

Table 7

Question 2 for Expert Nurse Group

2. How long did it take for you to feel confident?

Group ID	Comment	Body Language
Expert-1	Four to five months maybe six	Relaxed, laughing
Expert-2	After the first year and when I started training people	Sitting back in the chair
Expert-3	A year and a half before I could reach my mark	Seated in a chair, looking forward
Expert-4	Seven years before I felt comfortable.	Sitting with legs crossed.

The PI asked the expert's question three to determine if the factors facilitating their confidence were similar to the novice group. The experts' influences appear to be more related to critical thinking than task driven.

Table 8

Question 3 for Expert Nurse Group

3. What facilitated your confidence?

Group ID	Comment	Body Language
Expert-1	Being able to perform skills, tasks, and duties with minimal help	Relaxed, sitting back in the chair
Expert-2	Watching the case from beginning to end and seeing the results of the decisions, good or bad	Leaning forward in the chair relaxed.
Expert-3	Repeated exposure	Leaning back in the chair, tapping a finger on the table
Expert-4	Repeated exposure	Leaning back in the chair with legs crossed

For the experts, the most difficult tasks are management and clinical related. There were competency concerns about nonrepetitive skills on the telemetry unit, ethics, and interpersonal communication.

Table 9

Question 4 for Expert Nurse Group

4. What was the most arduous task to master?

Group ID	Comment	Body Language
Expert-1	Code Blues, knowing the different responsibilities	Tense, leaning forward, arms on the table
Expert-2	Keeping up to date on skills not used daily, for example, chest tubes and PCA pumps	Arms are resting on the table, looking at another co-worker
Expert-3	From a skill standpoint; understanding all the different things that have to be done for various procedures. From a social point of view, it is ethics	Sitting erect, tapping table top
Expert-4	Dealing with different personalities and delegation	Sitting with legs crossed

The experts were asked question five to determine how their years of experience contributed to their support of new graduates and employees.

Table 10

Question 5 for Expert Nurse Group

5. Based on your current experience, how do you facilitate confidence in a new graduate or employee?

Group ID	Comment	Body Language
Expert-1	Encouraging words, advice, not making them feel stupid in front of family	Arms are resting on the table
Expert-2	Teach them as much as possible, being a good resource person	Leaning back in the chair
Expert-3	Learning their background, assess their skills, establish goals for them	Sitting with arms on the table in a relaxed manner
Expert-4	Encourage education and research about different diseases	Standing and stretching

One essential component an expert nurse brings to the treatment course of a patient is the ability to anticipate future events. According to Benner (1984), expert nurses have witnessed many patients' conditions improve and deteriorate; they have a reality-based expectation of what is expected, what symptomology to monitor. They are grounded in contextual thinking. Their thinking is based on what might be occurring with a particular individual, instead of the what might occur with the general patient population. The exemplars listed are a representation of contextual thinking from a conversation between the primary investigator and experts nurses.

- EXEMPLAR III

PI: Share with me a story about when you began to feel confident in your clinical abilities on the telemetry unit?

Expert Nurse*: "That is a hard question. For me it would have been the first time I had a person with chest pain, I knew what we were going to do, and I implemented it. I knew we were going to order a stat EKG, so I ordered it because I knew if it was not ordered it would have nowhere to go. I also knew that the doctor was going to order a stat troponin and CKB, so I had it all queued up on the computer to accept the verbal order, and I could finish that up. I calculated when the last troponin had been drawn so I could calculate future draws. I knew when the patient had received the last NTG that was ordered and had reviewed the blood pressure to see if the blood pressure would support giving another NTG. At that point I felt very confident and sound in my abilities and my knowledge of the protocols. "*

- EXEMPLAR IV

PI: What was the most arduous task for you to master?

Expert Nurse: "*From a clinical standpoint the most difficult task is understanding all the different things we have to do based on the orders. For example, a thoracentesis or paracentesis doesn't require the patient to be NPO, but we need to stop Lovenox, but a VQ scan requires we stop Metformin, but I have cheat sheets on that on my phone that helps me. From a social point of view, I struggle with some of the work ethics that are in our unit. People come in and they don't always want to do everything that is needed to be done on a busy day. It can very overwhelming and demanding to complete and can be a struggle to motive people to meet the mark before the shift ends."*

Narrative Analysis

Data was evaluated using narrative analysis. Central themes were placed on an excel spreadsheet, reviewed, and placed in a chart for comparison. Body language was recorded as field notes; most participants appeared relaxed throughout the session.

Novice Nurse

Patricia Benner's (1984) From Novice to Expert Theory guided the conceptual framework of the study. The theory outlines a "novice nurse functioning in a context-free rule environment" (p. 21). Without the experience, novice duties are task-oriented. The perception of clinical confidence for a novice nurse is mission driven. All of the novice nurses stated that completing the work list, patient safety, and support of co-workers promoted their confidence. Two out of three novice nurses reported that independently completing a task, such as establishing intravenous access without help, improved their confidence. All the novice nurses agreed that it took six months before they began to feel confident.

Expert Nurse

Benner's (1984) theory described an expert nurse as one who "no longer relies on an analytic principle" (p. 31). All of the expert nurses stated being able to function without looking up protocols and recognition of disease symptoms as foundations' of clinical confidence. Seventy-five percent estimated a year was needed to become clinically confident in telemetry; one expert stated that it took seven years to achieve a level of clinical confidence in telemetry.

One hundred percent of the novice and expert groups agreed that a positive preceptor attitude, praise from co-workers and managers, and opportunities to repetitively

perform tasks promoted their confidence. Sixty-six percent agreed that positive, constructive criticism delivered in private helped create a safe learning environment. Areas identified as obstacles in developing trust were time management, prioritization, and co-workers not willing to help or teach in telemetry.

One hundred percent of expert nurses agreed that repeated exposure to disease and symptoms, performing a skill, tasks, and duties with little or no help increased their clinical confidence. Treating a patient from admission to discharge, observing and being part of the positive and adverse outcomes heighten their clinical ability. Seventy-five percent regularly participated in additional continuing education. One hundred percent of the expert nurses agreed that being able to answer correctly questions from student nurses and new graduate nurses bolstered their confidence and empowered their clinical knowledge. Areas identified as negatively impacting confidence were maintaining clinical skills not frequently used, delegation of duties, trust in co-workers, and maintaining competence in multiple treatment protocols.

Summary

Novice nurses are task driven, they value completion of a work list, and the safety of the patient has indicators of clinical confidence. Accentuation is placed on the recognition of co-workers, other nurses, and management in promoting their clinical confidence. This emulates Benner's (1984) theory. This domain is a core foundation for all novice nurses. Being task driven is evidence of context-free thinking of a novice and is a crucial step in the evolution of becoming an expert nurse.

Experience is one of the core components of an expert nurse. The term experience as used is this study does not denote just the passage of time. Instead, experience is the

enhancement of critical thinking skills developing patient interactions. The expert nurse has exceeded the context-free thinking phase, which has been replaced with anticipatory thinking (Benner, 1984). Instead of striving to complete a task list, the expert nurse works to prepare for perceived future problems the patient may experience. Expert nurses strive to recognize a change in symptomology of a disease process. Anticipation, symptomology, and intervention are the foundation for expert thinking and were demonstrated in the expert participants in this study.

CHAPTER V

Discussion

Interpretation

New graduate nurses in this study mirror Benner's (1984) theory accurately for novice nurses. New nurses work in a concept-free environment and use written guidelines during the shift. They rely heavily on a printed work list showing the task needing to be accomplished. Nurses in this study felt confident when checking off each job. Novice nurses placed importance on completing the task list, keeping the patient safe, and receiving positive feedback from co-workers and management. There was no mention of additional education or research from the novice group. One difficulty everyone agreed with was prioritization of tasks in the face of multiple admissions or unexpected circumstances, such a chest pain.

The expert nurses also followed Benner's (1984) theory, indicating that their level of competency no longer require analytic principles. Expert nurses indicated comfortability in functioning in a multitude of roles, from recognition of symptomology, anticipation of test and lab work, and operating from protocol knowledge. Emphasis was placed by the expert nurses on continued education, protocol knowledge, appropriate delegation, and recognition of disease progression and symptoms. All experts in the focus group expressed the importance of becoming a good role model, resource person, and preceptor as a top priority.

The study highlighted a chasm of the expected time frame between the groups becoming confident in their clinical abilities. The novice group was steadfast in a six-month timeframe in beginning to achieve confidence in their clinical skills. Respectively

the expert nurses stated a minimum of six months and in some incidents as long as seven years, with the mode time frame of 1.5 years. This also follows Benner's (1984) timeframe of becoming an expert nurse. Both groups unanimously agreed that repeated exposure to different situations and positive attitude was a major factor in achieving confidence in one's clinical abilities.

Discussion

The study supported Benner's (1984) theory as she outlined the difference between novice and expert nurse. Novice nurses have little or no experience. They rely on concert rules, experienced nurses, and preceptors to direct them correctly. Novice nurses require understanding for co-workers, positive reinforcement from their teachers, and managerial tolerance of impending mistakes. Novice nurses need the experiences that time provides to expand their knowledge and skill. Universally the focus groups agreed that a top priority is a patient safety.

Expert nursing is not a level achieved quickly. It is achieved through the accumulation of time, experience, and exposure to a multitude of factors that propel the nurse to an expert level. The expert nurses shared common themes of continued education of disease management, research of evidence-based practice, support, and accurate information given to new graduates and employees. They enjoy teaching, provide accurate instruction, and voluntarily serve as resource persons for the new graduate or employee after orientation has been completed. Every member of the expert focus group expressed the desire to be a resource person with a strong base of knowledge for novice nurses or new employees. Both groups valued the support of nursing managers and providers.

The telemetry unit has a low retention rate. People willing to serve as preceptors and a resource person are instrumental in a novice nurse becoming an expert nurse on the telemetry unit. An expert nurse can instruct a novice nurse on how to manage a Pleurovac chest tube drainage system. Expert nurses can coach novice nurses in central line dressing changes, EKG interpretations, and recognition of early symptoms of disease progression. Expert nurses serve as an interpreter of protocols that may be several pages long, ambiguous, and intimidating to the novice.

Limitations

The study was conducted on a small scale with a total attendance of eight nurses, although the purposive sampling contributed to reliable data for narrative analysis. The researcher was new to focus group management and qualitative data analysis but had faculty assistance. There was only one male represented in the sample. Half of the novice group graduated together from the same nursing program and may have resulted in an unintentional bias of experiences as a student. Four members of the focus group were close in age, possibly limiting the data to views from younger nurses.

Implications

With the impending nurse shortage approaching, actions will need to be taken to improve education, orientations, and preceptorships. The cost of declining retention and increased training continues to climb. According to human resources, the new graduate nurse's salary is $22.00 per hour, an experience nurse's salary is approximately $30.00 per hour (Efird, T. 2016, personal communication). Orientation for a new nurse is 12 weeks long. It costs the organization approximately $23,000 for a new graduate to complete orientation (Efird, T. 2016, personal communication). The total cost represents

$9,504 paid to the new nurse and $13,500 labor cost for the preceptor. Telemetry has lost 10 nurses who were out of their preceptorship in the last six months. If the unit could have maintained a 50% retention rate, it would have been a saving of $115,000, which could be spent on new equipment, raises, or more staff.

Benner's (1984) theory recognizes the importance of time and experience needed for nurses to advance from novice to expert. Employers and nursing programs may need to provide more opportunities for new graduates and new employees to develop clinical confidence. Best practices for simulation experiences and internships, residency programs, and precepted orientations need to be explored and implemented in telemetry. Simulator science can be used to educate novice nurses about the correct uses of the National Institute of Health (NIH) Stroke Scale (Efird, T. 2016, personal communication).

Internships can be used to lengthen the stay of a new graduate and increase retention but allow the nurse time to learn the unit and develop essential time management skills. Preceptors can become mandated resource personnel for new graduates and employees, providing a safe environment for asking questions, understanding protocols, and expressing anxiety. Simulator science can be used to improve non-repetitive skills, such as chest tube management, titrations of cardiac drips, application, and management of Bilevel Positive Airway Pressure (BiPAP) airway maintenance, and operations of Continuous Positive Airway Pressure (CPAP).

Management operating the hospitals must review the role of the nurse educator, the length of orientation programs, and resource services must be consistently reviewed for all levels of nurses. Simulation experiences for telemetry nurse can provide a safe,

structured atmosphere for a nurse at all proficiency levels to safely learn. Nurse residency programs would allow new nurses and employees to build confidence in clinical decision-making when the patient has complex system trauma or disease pathophysiology

Future of Research

Due to the increased cost of training combined with declining retention, additional resources will have to be devoted to improving employee retention while providing a safe atmosphere to obtain experience. Future research should place emphasis on outcomes resulting from longer preceptorships, comprehensive orientation programs and residency programs, and sufficient resources for nursing staff regardless of their level of proficiency. Future research should include larger populations, representative genders, and age groups.

Conclusion

Educated nurses save lives. The more education and experiences a nurse has the more positive outcomes the patient experiences. New graduate nurses and nurses new to clinical specialty areas deserve a successful transition with respect and a stable support system. This study described the experiences of novice and expert nurses and their transition as confident and competent practitioners of patient safety in telemetry care. It illuminated the thinking process changes from novice to expert nurse.

To be successful in a telemetry unit, novice nurses need the opportunity to develop time management skills to care for six patients. New nurses need a safe resource person to seek answers to questions. Orientation needs to be longer than a 12-week time period to provide an opportunity for a new graduate of employee to become familiar with managing six patient, policies, and electronic medication dispensing. Simulator science

can provide a safe environment for novice and expert nurses to learn how to function in cardiac-emergencies, Preceptorships, internships, and simulator science can assist in forming the foundation for novice nurses to achieve expert status, and experts to learn new skills and function as resource personnel for less experienced colleagues.

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Appendix A

Information Sheet

Nurses Needed for Novice and Expert FOCUS GROUP

Research is being performed to determine the interpretation of clinical skills between nurses with two years or less nursing experience and nurses with five years of more nursing experience. You will participate in a focus group to share your stories, suggestions, and feelings. Lunch will be provided. No incentives will be offered and participation if voluntary.

Time 12 P.M to 1 P.M

Where Fourth Floor Conference Room

Qualifications Novice Focus Group: 2 years or less nursing experience. Expert Focus Group: 5 or more years nursing experience

When TBA

If interested, please call Tim Fraley (researcher) at 336-926-7183 Monday through Saturday from 8 AM to 8 PM.

Appendix B

Informed Consent

I _____, consent to take part in the research project to assist in completing a Master's Thesis. The research will be conducted using focus groups. The name of the thesis is, "Transitioning Novice Nurses to Expert Nurses in Progressive Telemetry Care." I understand participation in this project does not constitute any treatment, and the research project is for information gathering only. I understand there are no lab tests, physical assessments, or medical care that will take place.

By agreeing to participate in this research project, it is my understanding that anonymous data will be collected and secured; and any reference to my identity will be confidential. Data collection consists of the number of years of nursing experience, interpretation of my competency, perceived strengths and weaknesses, and past work experience.
I understand that participation is voluntary, and I can withdraw from the research at any time without fear of reprisal or ridicule. There will be no incentives offered for participation in the study, and all participants are selected by the researcher, based on previous experience. I understand there is no expectation of any monetary gains, stipends, or reimbursement from this research project.

By signing this consent, I have been given a chance to ask any questions about the project; and have been informed there is minimal risk to my physical, emotional, social status, or employment. I can contact the researcher Tim Fraley at 336-926-7183 between 8 A.M. to 5 P.M. Monday through Friday and will receive a return call from him by the next business day. I can also contact the Institutional Review Board at Gardner-Webb University at 704-406-4000.

Participant: _____