

Fall 2013

The Effect of Preceptor Role Effectiveness on Newly Licensed Registered Nurses' Perceived Psychological Empowerment and Professional Autonomy

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THE EFFECT OF PRECEPTOR ROLE EFFECTIVENESS ON NEWLY LICENSED
REGISTERED NURSES' PERCEIVED PSYCHOLOGICAL EMPOWERMENT AND
PROFESSIONAL AUTONOMY

By

CHANELL WATKINS

A Thesis

Presented in Partial Fulfillment of Requirements for the

Degree of

Master's in Nursing Science

In the

WellStar College of Health and Human Services

Kennesaw State University

Kennesaw, GA

2013



Thesis/Dissertation Defense Outcome

Name Chanell Watkins

Program MSN Adv Care Management & Leadership

Title: THE EFFECT OF PRECEPTOR ROLE EFFECTIVENESS ON NEWLY LICENSED REGISTERED NURSES' PERCEIVED PSYCHOLOGICAL EMPOWERMENT AND PROFESSIONAL AUTONOMY

Thesis/Dissertation Defense: [X] Passed [] Failed Date 11-20-2013

All courses required for the degree have been completed satisfactorily [X] YES [] NO

Signatures

[Signature] Thesis/Dissertation Chair/Major Professor Date 11-20-2013

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Committee Member Date

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ACKNOWLEDGEMENTS

First, I would like to give thanks to my Lord and Savior Jesus Christ who is the head of my life. His supernatural power and strength has kept me through this process.

I would like to express my deepest, most sincere thanks to Dr. Patricia Hart. She has truly been my lifeline throughout this journey. She was instrumental in reducing much of the stress that could have been associated with such an endeavor as this. Her kind words kept me motivated and her consistent reminders kept me moving forward. She was my guiding light, gave of herself selflessly, and created a learning atmosphere that most only read about in theory. I would also like to thank Dr. Nicole Mareno whose timely feedback greatly aided in my effectiveness.

I would like to thank my family, my mother, Jessie Watkins, my father, Dwayne Watkins and my sisters Sylvia Robinson and Kendra Watkins, whom encouraged and prayed for me. They were most giving of their time when my son needed attention, gave their ear when I needed one, and gave their shoulder when the tears threatened to flow. My Master's career was made able because of them, and though I could try, I could never thank them enough.

Next, I would like to thank my friends and colleagues at Atlanta Medical Center – South Campus. They were more invested in my advancement and success than I could have ever imagined. I would like to thank Babu Kurien, Helen Irving, Merlene Peart, and Jariatu Roland whom, without complaint, worked extra days and weekends when I could not. I would also like to thank my manager and silent mentor, Gregory Samuels, for helping me view my impact on the nursing profession from a different perspective and continuously forcing me to think on a new level. Moreover, I would like to thank Rondalynn Westervelt, my transitional preceptor, who made me the nurse I am today.

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ABSTRACT

Purpose: To examine the relationship between newly licensed registered nurses' perceived preceptor role effectiveness and newly licensed registered nurses' perceived level of psychological empowerment and professional autonomy.

Design: A prospective, cross-sectional, descriptive research design was used.

Methods: Sixty-nine newly licensed registered nurses who graduated from an academic institution in the southeast United States were recruited and surveyed. Data collection occurred from August 2013 through October 2013.

Results: Newly licensed registered nurses had moderately high levels of perceived preceptor role effectiveness ($M = 63.04$, $SD = 9.77$), psychological empowerment ($M = 3.98$, $SD = .57$), and professional autonomy ($M = 198.90$, $SD = 21.23$). Preceptor role effectiveness had significant, moderately, positive relationships with professional autonomy ($r[69] = .326$, $p = .006$) and psychological empowerment ($r[69] = .486$, $p < .001$). In addition, a significant relationship was found between professional autonomy and psychological empowerment, $r(69) = .444$, $p < .001$.

Conclusions: Preceptor role effectiveness is an important element in the successful transition of newly licensed registered nurses to nursing practice. Effective preceptorships are linked to increased professional autonomy, psychological empowerment, competence, and confidence in newly licensed registered nurses. Effective preceptorships are necessary in easing the newly licensed registered nurses transition to practice and increasing retention rates.

Keywords: newly licensed registered nurse, preceptors, preceptorships, preceptor effectiveness, psychological empowerment, professional autonomy

CHAPTER 1: INTRODUCTION

With today's dynamic health care environment and the current nursing shortage, the need to recruit and retain newly licensed registered nurses (NLRN) is essential. Hodges, Keeley, and Troyan (2008) found that the transition into practice for a NLRN is a time of extensive learning, yet a time often referred to as difficult and stressful. NLRNs have cited developing competence and confidence as the most difficult aspects of the transition into practice within the realm of patient care (Hodges et al., 2008). In order to further understand these challenges, and, moreover, attempt to address them, factors that most influence NLRNs' successful transition into the first year of practice must be considered. One factor that influences the NLRN's successful transition into practice is the guidance and support from an effective preceptor (Hodges et al., 2008). Hodges et al. (2008) found that during this time of transition, NLRNs rely heavily on preceptors to answer questions, provide guidance, and serve as a resource to ease stress and fill gaps in knowledge.

This chapter presents the purpose of this study. This chapter discusses the background and significance of the study, provides a statement of the problem, and discusses the theoretical framework used to guide the study. In addition, this chapter presents the research questions, definitions, assumptions, and limitations of the study.

Purpose

The purpose of the study was to examine the relationship between NLRNs' perceived preceptor role effectiveness and NLRNs' perceived level of psychological

empowerment and professional autonomy. Because the turnover rate for NLRNs in their first year of practice is roughly 30%, but increases significantly to about 57% in the second year (Twibell et al., 2011), NLRNs within this two year or 24 month timeframe were studied. The level of preceptor role effectiveness, personal psychological empowerment and professional autonomy, as perceived by NLRNs, were explored. Finally, the relationships between perceived preceptor role effectiveness, psychological empowerment, and professional autonomy among NLRNs were explored.

Background and Significance

Though the current economic constraints have slowed and reduced the nurse turnover rates in the United States, the threat of retiring Baby Boomers is estimated to cause a shortfall of 260,000 nurses by 2025 (Twibell et al., 2011). In addition to this estimated decrease, research shows that the turnover rate for NLRNs in their first year of practice is roughly 30% and increases to about 57% in the second year (Twibell et al., 2011). With such staggering turnover rates and the increasing estimates of future shortfalls, the need for recruitment and retention of NLRNs is becoming more evident. Because the first year of practice is often described as difficult and stressful (Hodges et al., 2008), action must be taken to better facilitate NLRNs' first year transition. The process begins with diligence in researching best practice techniques effective in easing the first year transition, and advocating for implementation of best practice techniques to potentially increase retention rates.

One strategy shown to be effective in increasing retention rates is an orientation period that includes an effective preceptorship. A preceptorship involves the one-to-one pairing of an experienced learner with a less experienced learner with the goal of

achieving selected learning objectives (Giallonardo, Wong, & Iwasiw, 2010). Effective preceptorships have been shown to increase NLRNs' retention rates by anywhere from 15% to 37% (Pine & Tart, 2007). Mills and Mullins (2008) claim that though there is the initial cost of implementation of such a program, organizations could expect to save as much as \$1.4 to \$5.8 million over a three year period. In addition to monetary gains, preceptorships have also been shown to improve job satisfaction and increase the confidence of NLRNs (Mills & Mullins, 2008). Halfer and Graf (2006) found that improved job satisfaction and improved NLRN confidence lead to a significant increase in NLRNs' perceived professional autonomy, a factor shown to greatly influence their commitment to the profession.

Etheridge (2007) found that NLRNs who received what they perceived as an effective preceptorship were more comfortable with their surroundings and developed the confidence to seek out other knowledgeable co-workers as resources for support. The same NLRNs, after nearly a year into practice, trusted their own judgment and were content with what information they knew, as well as information they did not know (Etheridge, 2007). Identified as key in successful transition by NLRNs, preceptors helped to establish work environments in which NLRNs perceived as supportive and accepting. Preceptors aided in the promotion of a work environment that freely offered the guidance and direction that the NLRNs needed (Hodges et al., 2008). Larrabee et al. (2003) found such an environment to be critical in increasing psychological empowerment, another predictor of job satisfaction. Furthermore, Cho, Laschinger, and Wong (2006) found that higher levels of perceived psychological empowerment had a direct effect on NLRNs' commitment to the organization.

Statement of the Problem

The turnover rate for NLRNs in their first year of practice is roughly 30% and increases to about 57% in the second year (Twibell et al., 2011). High turnover rates have been shown to negatively affect job satisfaction, workplace morale, and the quality of patient care (Mills & Mullins, 2008). Most NLRNs attribute their attrition to the lack of confidence needed to function autonomously in their new role and the lack of competence needed to provide safe, effective patient care (Hodges et al., 2008). This lack of confidence and competence ultimately affects their degree of professional autonomy and psychological empowerment.

Preceptors are in the best position to assess and influence the NLRNs' perceived level of professional autonomy and psychological empowerment (Park, Wharrad, Barker, & Chapple, 2011). NLRNs that are the product of an effective preceptorship have higher levels of confidence that increases professional autonomy (Halfer & Graf, 2006) and higher levels of competence that increases psychological empowerment (Cho et al., 2006). Both perceived professional autonomy (Halfer & Graf, 2006) and perceived psychological empowerment (Larrabee et al., 2003) have been shown to positively affect job satisfaction and retention.

Despite supportive studies (Halfer & Graf, 2006; Cho et al., 2006; Larrabee et al., 2003) related to the effectiveness of preceptorships, the extent to which NLRNs experience an effective preceptorship continues to vary (Harrison-White & Simons, 2013). With the implementation of the University Health System Consortium (UHC)/American Association of Colleges of Nursing (AACN) Nurse Residency program in 2010, the effectiveness of residency programs and preceptorships is becoming

recognized at the national level, yet remains less than fully supported by the nursing profession. Despite research (Patterson, 2011; Fink, Krugman, Casey, & Goode, 2008) supporting the effectiveness of the UHC/AACN Nurse Residency Program coupled with its national recognition, nurse residencies and preceptorships have yet to become the standard of orientation for all NLRNs. If the profession of nursing is to attempt to reduce the estimated impact of the nursing shortage and decrease turnover rates, implementation of effective NLRN retention strategies is necessary. Making orientation with an effective preceptorship a standard in the transition process of NLRNs, and not a varying option, is one way to help reduce attrition.

Theoretical Framework

The theory that was used to guide this study was Peplau's Theory of Interpersonal Relations (Peplau, 1997). Peplau first introduced this theory in 1952. Peplau's Theory of Interpersonal Relations was developed with influences from Henry Stack Sullivan, Percival Symonds, Abraham Maslow, and Neal Elger Miller (Nursing Theories, 2011). Originally intended to help nurses build therapeutic relationships with patients, Peplau's Theory of Interpersonal Relations proposes that there are four overlapping stages to building an effective nurse-patient relationship. The four stages include orientation, identification, exploitation, and resolution (Peplau, 1997, Nursing Theories, 2011).

During the orientation phase the patient comes to know and trust the nurse, and recognizes the need for help. The orientation phase defines the problem and the needs of the patient. The nurse provides an atmosphere of trust and acts as a resource. Care is provided with compassionate verbal and non-verbal cues, with a respectful approach, and with nonjudgmental behavior. During the identification phase, the patient recognizes the

opportunity for improvement and responds to those who want to help. The patient begins to feel as if he/she belongs, and feelings of helplessness and hopelessness begin to decrease. In this phase the goals of care are set. The nurse begins to take on the role of a teacher and counselor giving instruction as well as providing guidance and encouragement to the patient (Peplau, 1997; Nursing Theories, 2011; Washington, 2013).

The third phase, exploitation, includes the patient using the nurse as a resource and support to help with improvements. The patient now feels as a part of the helping environment and may begin to make minor attention-seeking requests. The nurse takes on the surrogate role, advocating for the patient, but also acting as a leader, pushing the patient toward independence and helping the patient meet treatment goals. In the last phase of the relationship, resolution, dependencies subside, goals are achieved, and the ongoing relationship furthers developmental changes. The goal of the resolution phase is to dissolve ties and expose any psychological dependencies. The nurse continues to act as the leader helping the patient take responsibility for meeting treatment goals. The nurse and the patient evaluate the situation determining if goals were met and independence achieved (Peplau, 1997; Nursing Theories, 2011; Washington, 2013).

In applying this theory to the preceptor-NLRN relationship, the requirements of the nurse and preceptor and the needs of the patient and NLRN are similar. A preceptor's confidence in his/her level of competence, expertise, and role directly affects the preceptor-NLRN relationship and its outcomes. The ability to act as the teacher and impart knowledge will affect the transfer of knowledge to the NLRN and directly affect the NLRN's competence once the relationship has been terminated. Additionally, a preceptor has to be versatile in the different roles that he/she plays within the

relationship. In addition to teacher, the preceptor is a role model, an advocate, and a support person. The smooth transition from one role to the next and the commitment to being a nurturer of independence and improvement are essential (Peplau, 1997; Washington, 2013).

The attitude of the preceptor, their keenness to important cues, and the use of effective therapeutic communication throughout the process help to facilitate the professional transition of the NLRN. The preceptor's attitude and attentiveness to the NLRN direct the progression of the relationship both negatively and positively. An encouraging attitude, knowing when to initiate the next phase, and using communication techniques that corrects yet encourages are best. Done correctly, together, these techniques increase feelings of satisfaction in the relationship and confidence in personal capability. Such techniques have been shown to positively affect the relationship and make it effective in achieving its goals (Halfer & Graf, 2006; Cho et al., 2006; Larrabee et al., 2003). The NLRN depends on the preceptor for a relationship whose ultimate goal is competence, confidence, and independence. From orientation until resolution, the focus of the relationship is the growth and well-being of the NLRN (Peplau, 1997; Washington, 2013).

Research Questions

The research questions used to guide this study were:

1. What is the perceived level of preceptor role effectiveness among newly licensed registered nurses?
2. What is the perceived level of psychological empowerment and professional autonomy among newly licensed registered nurses?

3. What are the relationships between newly licensed registered nurses' perceived preceptor role effectiveness and perceived levels of psychological empowerment and professional autonomy?

Conceptual Definitions

Newly licensed registered nurse (NLRN). A registered nurse who has been licensed to practice 24 months or less.

Preceptor. A licensed registered nurse with more than 24 months of acute care experience that functions in the preceptor role and assists the NLRN through the professional role transition period.

Perceived preceptor role effectiveness. The degree to which a preceptor can form a trusting, relational connection with the NLRN, assist the NLRN with integration into the workplace, share her/his skills and knowledge of the profession, and exhibit supportive behaviors during the transitional period (Ferguson, 2010).

Psychological empowerment. A cognitive state characterized by a perceived sense of having the control and competence necessary to function in one's professional role and internalization of goals set by the organization governing the individual (Menon, 1999).

Professional autonomy. The authority to give total patient care, the unrestrained power to make clinical judgments, and the confidence to take action in initiating patient care (Skar, 2010).

Operational Definitions

Perceived preceptor role effectiveness. The preceptor role effectiveness was measured using the Preceptor Role Effectiveness Scale (PRES), a modification of the

Clinical Instructor Characteristic Ranking Scale (CICRS) (Rauen, 1974). The total score of the PRES was calculated.

Psychological empowerment. Psychological empowerment was measured using the Psychological Empowerment Scale (PES) (Spreitzer, 1995). The mean score of the PES was calculated.

Professional autonomy. Professional autonomy was measured using the Schutzenhofer Professional Nursing Autonomy Scale (SPANS) (Schutzenhofer, 1987). A total weighted score of the SPAS was calculated.

Assumptions

Assumptions of this research study included: 1) the first 24 months of practice for NLRNs is a challenging experience, 2) All NLRN's need guidance during the first 24 months of practice, 3) NLRNs desire to have preceptors guide them during the first 24 months of transition to practice, 4) experienced nurses want to be preceptors that help guide NLRNs into practice, 5) the preceptor relationship affects the transition into practice for the NLRN, and 6) preceptor role effectiveness influences NLRNs' perceived level of psychological empowerment and professional autonomy.

Limitations

Limitations of this study included: 1) the fact that the study sample was recruited from only one school of nursing new graduates which could limit generalizability, 2) the use of self-report questionnaires which could have reflected some bias in responses due to factors such as social desirability, and 3) the method of recruitment through email was dependent on the assumption that participants would respond in a timely manner, this dependence could have affected the sample size thus increasing response bias.

CHAPTER 2: REVIEW OF LITERATURE

This chapter presents nursing literature that supports the purpose for this study. The chapter begins with a presentation of the research findings regarding the difficulties faced during NLRNs' transition to practice and the impact of preceptors and preceptorships in relation to this transition. Research findings related to professional autonomy and professional empowerment and their impact related to job satisfaction are presented. The chapter concludes with a summary that describes the research findings and their significance to the purpose of this study.

NLRN Transition to Practice

The transition into nursing practice is complex, and many factors contribute to the smoothness and/or turbulence of the process. Clark and Springer (2012) found that poor nurse-physician relations, heavy workloads, incivility within work environments, and the difficulty of transitioning to practice were some common trends among NLRNs. Morrow (2008) conducted a focus group of NLRNs and reported finding themes such as difficulty finding "rhythm in the chaos," not feeling valued as a team member, and the stress of "not knowing" to describe their first year experience. The current requirement for new graduate nurses to be "job-ready" leaves them feeling "overwhelmed, unsupported" and "hung out to dry" (Christmas, 2008, p. 317). Though licensed, many NLRNs question their abilities to provide safe, competent, quality patient care. More than 57% are simply overwhelmed by the overall responsibility of providing adequate patient care (Halfer & Graf, 2006). A theme found in a qualitative study conducted by Harrison-White &

Simons (2013) stated, “You learn theory, but in practice, it is completely different” (p. 25).

With increased job vacancies and a decreasing pool of experienced nurses, Goode and Williams (2004) found that NLRNs are regularly assigned the care of patients with high acuity and complex healthcare needs. From a survey of NLRNs from 35 states and the District of Columbia, Kovner, Brewer, Greene, and Fairchild (2009) found that NLRNs are increasingly assigned patients with the same acuity of more experienced nurses. To meet the needs of such patients, NLRNs must have the knowledge and skills necessary to properly assess these complex cases. Problems arise when NLRNs are assigned these complex cases during a time when they are still figuring out how to master nursing skills and make sound clinical judgments (Goode & Williams, 2004). The demand for competent nurses and the growing nursing shortage requires NLRNs to step out into the fullest of their professional role before having adequate time to successfully make the role transition (Clark & Springer, 2012).

In addition to rising patient acuity, staffing shortages and complex new technologies (Haggerty, Holloway, & Wilson, 2012), the intricacy of the NLRN transition is complicated by the erroneous assumption that there is an array of methods available to effectively recruit and orient NLRNs. There is varying agreement to the extent of guidance and support that is given during the first year, even the first few months, of practice. Research shows that there is a lack in consistency when it comes to deciding which approach to follow when transitioning NLRNs into the role of professional nurse (Good & Williams, 2004). Studies have shown that NLRNs require a minimum of 12 months of guided and supported practice to feel comfortable labeling

himself or herself a competent, confident professional nurse (Goode & Williams, 2004; Casey, Fink, Krugman, & Propst, 2004).

According to McKenna and Green (2004), during the first six months of transition, the NLRN's focus is internal. The NLRN's main focus is learning and surviving. During this time, the NLRN is still becoming proficient in developing essential nursing skills and performing adequate assessment. During the next 6 months, the NLRN begins to focus more externally. At this point, the NLRN has learned how to survive, has some mastery of essential skills, and can begin to focus on varying situations with understanding and appropriate interventions. This is when, 12 months into the transition, that the NLRN feels most comfortable and competent in providing quality patient care (McKenna & Green, 2004). The issue is that unguided, many NLRNs fail to make it to the 12-month milestone.

In addition to and accompanying this process, Goode, Lynn, Krsek, Bednash, and Jannetti (2009) described a "V-shaped" pattern of emotional distress that is experienced by NLRNs. Initially, NLRNs are excited about transitioning into practice and growing professionally. Within the first six months of practice, NLRNs become progressively dissatisfied with their new role. During this period of time, as they begin to cope with their new identity and the realities of the profession, NLRNs frequently begin to experience some degree of "culture shock". Research shows that it is typically at this point, without proper guidance and encouragement; NLRNs make the decision to leave (Goode et al., 2009). For those deciding to stay, by the end of the first 12 months, the enthusiasm initially felt about their role as a nurse begins to return and their personal confidence and professional competence are discovered (Goode et al., 2009).

Preceptors and Preceptorship

Preceptorship involves a one-to-one pairing of an experienced learner with a less experienced learner with the goal of achieving selected learning objectives. The “New Graduate Initiative” implemented in Ontario, Canada defined nursing preceptorship as a “nurse preceptor providing individualized supervision, support, and teaching” to a NLRN (Giallonardo, Wong, & Iwasiw, 2010, p. 994). Preceptorships were designed to help NLRNs identify positive professional attitudes, learn appropriate behaviors necessary for professional socialization, and lessen the gap between practice and educational knowledge (Giallonardo et al., 2010). Preceptorships have become essential in making the transition from novice to expert as smooth as possible (Park et al., 2011). Those who complete this transition with the support of a preceptor are more likely to provide effective care sooner and show, overall, more confidence in their nursing role (Harrison-White & Simons, 2013).

NLRNs involved in effective preceptorships have shown significant achievement of many qualities needed to survive the transition to a safe, competent professional (Marks-Maran et al., 2012; Lee, Tzeng, Lin, & Yeh, 2009). NLRNs, as a result of preceptorships, have more specialized knowledge and skill sets, have better communication skills, and enjoy higher levels of patient and personal satisfaction (Lee et al., 2009). Preceptorships have been shown to enable NLRNs to better manage stress and feel more supported at work. NLRNs that are supported by preceptors freely share their anxieties regarding their new role and more quickly settle into and take on the responsibilities of a functioning practitioner (Marks-Maran et al., 2012).

Giallonardo, Wong, and Iwasiw (2010) found that authentic preceptorships positively affect NLRNs' work engagement and job satisfaction. Work engagement and increased job satisfaction were found to be essential in NLRNs retention, with researchers recommending that the profession invest in developing authentic preceptor-preceptee relationships as a means of improving NLRNs' retention rates (Giallonardo et al., 2010). In addition, Halfer and Graf (2006) found that NLRNs' retention rates are increased with the utilization of a preceptor to assist with the transition into practice. Furthermore, Lee et al. (2009) found similar results showing that turnover rates of NLRNs improved significantly with the implementation of preceptorships, decreasing rates by more than 50%.

Additionally, preceptors have been shown to increase NLRNs' professional confidence and competence. After involvement in a California nurse mentor project, NLRNs reported significant positive changes evidenced by increased selection of two confidence indicators: "I have the skills to carry out my job responsibilities," and "I am good at what I do" (Mills & Mullins, 2008). Additionally, NLRNs indicated that their confidence in communicating with colleagues, patients, relatives, and managers also developed as a result of an effective preceptorship (Marks-Maran et al., 2012). NLRNs surveyed by Marks-Maran et al. (2012) reported that preceptor involvement improved clinical competence. Seventy-five percent of preceptees surveyed stated that an effective preceptorship enhanced their confidence levels in dealing with and making decisions regarding patient care, 68% stated improved competence in medication administration, and 68% indicated improved competence in health and safety-related issues (Marks-Maran et al., 2012).

NLRNs further disclosed that having an assigned preceptor helped build trust, gain a sense of security, and promote an efficient learning and work environment.

Preceptorship programs help promote close interactions between new nurses and their experienced colleagues, helping them to understand the culture of the profession and adjust to being part of a working team (Lee et al., 2009; Marks-Maran et al., 2012).

Marks-Maran et al. (2012) found that preceptorships helped NLRNs deal with difficult work relationships and develop techniques to deal with other disciplines, including physicians.

Sorensen and Yankech (2008) echoed these results stating that preceptors are able to elicit a higher level of thinking in NLRNs. Sorensen and Yankech found that preceptors in a structured preceptor program used learner-centered cognitive approaches and teaching-learning strategies that facilitated critical thinking. UHC/AACN program leaders advocate a variety of teaching styles like games, case studies, role plays, and evidence-based practice projects to increase learning. Such teaching techniques not only promote critical thinking, but also allow engagement of a variety of learning styles (Anderson, Hair, & Toder, 2012). In addition to critical thinking, preceptors encouraged thoughts regarding professional development. Having a preceptor increased the NLRN's reflection on their practice and encouraged the NLRN to further plan his/her career. In addition, the preceptor's point of view directly enhanced the NLRN's role satisfaction and heightened the NLRN's awareness of professional accountability and development of high practice standards (Marks-Maran et al., 2012).

Preceptees felt that the involvement in an effective preceptorship was crucial to their clinical practice and career development (Marks-Maran et al., 2012). NLRNs were

in agreement that a preceptorship program would be useful for anyone new to the profession or changing their clinical specialty (Marks-Maran et al., 2012). Effective preceptorships have the potential to improve the quality of care in the form of reduced medication errors, reduced incidents of falls, and reduced adverse events (Lee et al., 2009) while growing and improving the future of the profession.

Professional Autonomy

Though regarded as an essential element of professional nursing status, autonomy has neither been thoroughly researched, nor has it been thoroughly defined within the profession. Research aimed at defining autonomy has yet to provide a definition that encompasses all aspects of the term, but has revealed themes common to its idea (Daly & Carnwell, 2003; Carryer, Gardner, Dunn, & Gardner, 2007; Turner, Keyzer, & Rudge, 2007). Researchers agree that it is not a static state or condition, but varies according to the situation with different determining factors and constraints (Varjus, Leino-Kilpi, & Suominen, 2011; Wade, 2004). Professional autonomy is a broad and self-defining term that differs according to experience, education, confidence, and empowerment. Core themes include one's ability to do, independence to act, control, responsibility, accountability, authority, and governance over one's own practice (Varjus et al., 2011). Skar (2010) states that though the capacity in which one acts autonomously may differ, the desire to act with autonomy is common to all nurses. Autonomy develops from the ability to critically and analytically assess situations, the development and use of multiple types of knowledge, and the ability to implement acquired knowledge in the form of high quality nursing care (Mantzoukas & Watkinson, 2007).

In addition to its multifaceted definition, many external factors influence professional autonomy. Laschinger and Finegan (2005) conducted a non-experimental, predictive study with a random sample of 273 staff working in medical-surgical and critical care nursing units. Laschinger and Finegan found a significant, positive relationship between nurses' perceptions of job-related empowerment and autonomy. Furthermore, Laschinger and Finegan found that nurses who had access to sources of job-related empowerment also had a higher level of perceived control over their work environment. Varjus et al. (2011) declares that when nurses are empowered to function autonomously, there is an increased liberty and willingness to take on the responsibilities of being autonomous and making patient care decisions.

Level of education is a significant factor influencing nurses' perceived level of autonomy (Facteau & Nelson, 2000; Shaver, 2000; Halpern, Corcoran-Perry, & Narayan, 2001). Nurses with higher levels of education have a greater base of knowledge, and in return are more confident in applying the knowledge in clinical settings. The researchers further explained that autonomy stems from a sense of "knowing" in a situation (Facteau & Nelson, 2000; Shaver, 2000; Halpern et al., 2001). Furthermore, Skar (2010) found that nurses' confidence in knowing what they know in addition to the courage to act upon what they know, were significant predictors of nurses' abilities to make autonomous decisions and clinical judgments related to patient care.

Skar (2010) found that the courage to act autonomously was correlated with qualifications, training, and work experiences. Mrayyan's (2005) research demonstrates that not only academic knowledge, but the knowledge attained from experience also increases nurses' perceived level of autonomy. Papathanassoglou et al. (2005) found that

experience gained over time is directly related to an increase in nurses' perceived work autonomy. Although nurses may gain a foundation for autonomous practice through their education, experience in clinical practice is the driving force behind the development of the operational competence needed to act autonomously in the workplace (Ministry of Education Research and Church Affairs, 2000).

In a study conducted by Chen-Chung, Samules, and Alexander (2003), researchers found that autonomy was the second most significant predictor of job satisfaction among nurses working in a hospital setting. A literature review conducted by Zurmehly (2008) on job satisfaction and its correlation with autonomy indicated that nurses with low levels of perceived autonomy in the work setting had higher levels of frustration and dissatisfaction. In addition, a study conducted by Laschinger, Shamian, and Thompson (2001) suggest that high levels of autonomy, control, and collaboration indicated higher levels of trust in management, which in turn were associated with increased job satisfaction. Since Zurmehly (2008) found that, overall, nurses report independence, recognition, and responsibility as major contributors to the autonomy needed to increase job satisfaction, it may benefit the profession to invest in research, education, and execution of techniques shown to increase professional autonomy.

Psychological Empowerment

Psychological empowerment, the same as professional autonomy, has not been clearly defined. Researchers have found common themes among nurses when attempting to define the term, but it too, changes according to context and situation (Bradbury-Jones, Sambrook, & Irvine, 2011; Manojlovich, 2007; Menon, 2002; Nyatanga & Dann, 2002). Rao (2012) defined psychological empowerment as “a state in which an individual nurse

has assumed control over his or her practice, enabling him or her to fulfill professional nursing responsibilities within an organization successfully” (p. 399). Cho and Faerman (2010) stated that psychological empowerment dealt with “individuals’ cognitive orientation or psychological state at a micro level” (p. 37). Cho and Faerman (2010) argued that empowerment was not only a cognitive state, but a two-fold concept requiring integration of structural empowerment, the power given to employees from management to act, and psychological empowerment, internally initiated empowerment.

Bradbury-Jones, Sambrook, and Irvine (2011) found that psychological empowerment was necessary for nursing students to have a perceived sense of control and self-efficacy for those in their care. Bradbury-Jones et al. (2011) also found that students’ perceived psychological empowerment was greatest when students were valued as a learner, valued as a team member, and valued as a person. Students suggested that effective mentorship and a supportive environment were factors that significantly influenced their sense of empowerment. Bradbury-Jones et al. (2011) findings also showed that feeling devalued resulted in disempowerment. Feelings of disempowerment were found to have a detrimental impact on learning and students’ intention to complete their nursing program (Bradbury-Jones et al., 2011).

In addition, psychological empowerment has been linked to learning (Bradbury-Jones et al., 2011; Karagözoglu, 2009; Zahrani, 2012). Karagözoglu (2009) found that when dealing with nursing students, the nursing curriculum impacted perceived levels of empowerment. Karagözoglu (2009) surveyed nursing students at each year of training, first-year, second-year, third-year, and fourth-year. Surprisingly, as students progressed through their nursing curriculum their level of psychological empowerment decreased.

Similarly, Zahrani (2012) found that psychological empowerment was positively related to workplace learning suggesting that higher levels of perceived psychological empowerment increased the learning that took place in the workplace setting.

Additionally, Zahrani (2012) found a strong correlation among self-determination and workplace learning indicating that psychological empowerment also significantly impacts self-determination among employees. Together these findings suggest the promotion of psychological empowerment within both the educational setting and the workplace to increase student learning.

Researchers have shown a link between psychological empowerment and increased trust in the workplace (Laschinger & Finegan, 2005; Laschinger, Finegan, Shamian & Casier, 2000). Laschinger and Finegan (2005) used a non-experimental predictive design to examine the effects of employee empowerment on perceptions of organizational justice, respect, and trust in management. The sample consisted of 273 medical-surgical and critical care nurses in urban teaching hospitals. Laschinger and Finegan (2005) found that nurses' perceptions of empowerment impacted their attitudes about fair management practices, the degree which they felt respected within the workplace, and their level of trust in management.

Nurses' level of perceived empowerment also influences organizational commitment. Laschinger, Finegan, Shamian, and Casier (2000) conducted a predictive, non-experimental study with a sample of 412 staff nurses working in acute care hospitals. The study examined the effects of organizational trust and empowerment on organizational commitment. Laschinger et al. (2000) found that nurses who felt empowered reported higher levels of organizational trust and affective commitment to

remain with their healthcare organization. Laschinger et al. (2000) suggested that fostering workplace environments that enhances perceptions of empowerment and organizational trust would increase organizational effectiveness.

Psychological empowerment in the workplace has also been linked to increased job satisfaction, work effectiveness, and retention rates (Casey, Suanders, & O'Hara, 2010; Laschinger, Wilk, Cho & Greco, 2009). Casey et al. (2010) examined the relationships between structural, psychological, and critical social empowerment on nurses' job satisfaction levels. Casey et al. (2010) conducted a predictive, non-experimental research study with a sample of 306 nurses and midwives. The findings from the study revealed that structural, psychological, and critical social empowerment were significant predictors accounting for 46% of the variance in perceived job satisfaction ($R^2 = 0.46, p < .001$) (Casey et al., 2010). Casey et al. (2010) suggest that empowered nurses who perceive they have a greater voice in organizational and practice decision-making are more engaged, innovative, and productive resulting in improved patient care outcomes.

Similarly, in a study by Laschinger, Wilk, Cho and Greco (2009), a group of NLRNs were compared with experienced nurses. The relationship between work engagement and effectiveness and workplace empowerment and effectiveness were studied. Laschinger et al. (2009) found that for NLRNs, an empowering workplace environment was more predictive of increased feelings of professional effectiveness in the workplace than with experienced nurses. These findings indicated the possibility that during the early stages of transition, work engagement does not impact feelings of professional effectiveness as significantly as an empowering environment (Laschinger et

al., 2009) when considering NLRNs. Because empowerment was found to be more significant to NLRNs than being engaged with their work, Laschinger et al. (2009) suggested that increased access to information, support, and relevant resources are fundamental to a positive transitional and work experience. Laschinger et al. (2009) concluded that empowerment does increase work engagement, so it might benefit nurse managers and experienced nurses working with NLRNs to increase levels of engagement. This can be accomplished in gestures such as soliciting NLRNs' ideas regarding workplace decision-making, and not dismissing them because of their lack of experience in the profession. Additionally, techniques effective in promoting empowerment and engagement could possibly increase NLRNs' retention rates (Laschinger et al., 2009).

Lastly, research shows that increased levels of empowerment are linked to decreased burnout and decreased job strain among nurses (Greco, Laschinger, & Wong, 2006; Laschinger, Finegan, Shamian, & Wilk, 2003). Greco, Laschinger, and Wong (2006) examined the relationships between nurse leaders' empowerment behaviors, perceptions of staff empowerment, and staff reported burnout. A cross-sectional correlation study of 322 staff nurses working in acute care hospitals was conducted. The researchers found that staff nurses perceived their leaders' behavior to be somewhat empowering and their work environment to be moderately empowering, and a staggering 53% of the same nurses reported severe burnout. Greco et al. (2006) concluded that leadership empowering behaviors had an indirect effect on staff nurses' level of burnout. The researchers recommended that organizations focus on ensuring appropriate job-fit in leadership roles to enhance workplace empowerment and help prevent burnout among nurses.

Laschinger, Finegan, Shamian, and Wilk (2003) conducted a longitudinal study to determine if nurses' perceived level of psychological empowerment was a predictor of future burnout among a sample of 192 staff nurses. Laschinger et al. found that psychological empowerment had a direct effect on perceptions of emotional exhaustion, which was predictive of self-reported burnout. Laschinger et al. suggested that fostering environments that enhance perceptions of empowerment was an effective way of preventing burnout among nurses and maintaining a positive work environment.

Summary

The transition from nursing student to a professional registered nurse is difficult and stressful. Researchers have shown that preceptors play a significant role in this transition (Marks-Maran et al., 2012; Lee et al., 2009). Done correctly and effectively, preceptorships have the potential to ease NLRNs' transition into practice (Park et al., 2011). Preceptorships have been shown to give NLRNs the confidence and competence (Mills & Mullins, 2008) needed to function with autonomy and feel psychologically empowered. Higher levels of perceived professional autonomy have been linked to increase job-related empowerment (Laschinger & Finegan, 2005), higher levels of job satisfaction, and better quality of care (Giallonardo et al., 2010). Levels of professional autonomy are influenced by higher educational degrees, experience, training, and additional qualifications such as certifications (Facteau & Nelson, 2000; Shaver, 2000; Halpern et al., 2001). Psychological empowerment has been associated with increased work effectiveness (Casey et al., 2010; Laschinger et al., 2009), increased trust in the workplace (Laschinger & Finegan, 2005; Laschinger et al., 2000), higher job satisfaction

and retention rates (Casey et al., 2010), decreased levels of burnout and job strain, and better patient outcomes (Laschinger et al., 2003).

When it comes to research, studies regarding psychological empowerment and professional autonomy and their relationship to NLRNs are limited. Moreover research is limited in its assessment of how an effective preceptor or preceptorship alters these relationships. A plethora of research is available on the effects of the preceptor and the NLRN experience and/or overall transition, but very scarce in regards to the relationships between NLRNs' perceived preceptor role effectiveness and NLRNs' perceived levels of professional autonomy and psychological empowerment.

CHAPTER 3: METHODS

This chapter introduces the methods by which the research study was conducted. This chapter discusses the research design, describes the setting in which the research took place, delineates the research sample by describing the population surveyed, outlines the procedures used to protect human subjects, and examines threats to validity. In addition, this chapter provides an assessment of the data collection instruments, discusses the data collection and analysis plan, and describes the steps taken to ensure data security.

Research Design

A prospective, cross-sectional, descriptive research design was used. This research design provided a method to describe NLRNs' attitudes toward perceived preceptor effectiveness, psychological empowerment, and professional autonomy. Furthermore, this research design was used to examine the relationships between NLRNs' perceived preceptor effectiveness, psychological empowerment, and professional autonomy. The research was guided by the following questions:

1. What is the perceived level of preceptor role effectiveness among newly licensed registered nurses?
2. What is the perceived level of psychological empowerment and professional autonomy among newly licensed registered nurses?
3. What are the relationships between newly licensed registered nurses' perceived preceptor role effectiveness and perceived levels of psychological empowerment and professional autonomy?

Setting

The research took place at an academic institution located in the southeast United States (US). The academic institution enrolls, prepares, and graduates over 200 student nurses each academic year. The academic institution offers baccalaureate, master's, and doctorate degrees in nursing (Kennesaw State University Virtual Information Center, 2013).

Population and Sample

The sample consisted of recent graduates from the academic institution's baccalaureate nursing degree program. A convenience sample of newly licensed registered nurses was recruited. Participants inclusion criteria included: 1) must be 18 years or older, 2) able to speak and read English, and 3) licensed as a registered nurse for 24 months or less. Recruitment took place from August 2013 to October 2013. A power analysis was conducted using G Power software (Faul, Erdfelder, Buchner, & Lang, 2009) to estimate sample size to ensure adequate statistical power for data analysis. With a power of .80, an alpha of .05, and an effect size of 0.30, 85 NLRNs were needed for the sample.

Procedure for Data Collection

Data collection took place via Survey Monkey, an online survey-compiling program. The online survey consisted of a consent form (Appendix A), a demographic questionnaire (Appendix B), the Preceptor Role Effectiveness Scale (PRES) (Appendix C), the Psychological Empowerment Scale (PES) (Appendix D), and the Schutzenhofer Professional Nursing Autonomy Scale (SPANS) (Appendix E). With permission from the Associate Director of the Undergraduate Nursing Program, NLRNs' email addresses

were obtained for graduates from the past two years (Appendix F). NLRNs were sent a link to the survey via a solicitation email that invited them to participate in the research study. To enhance participation, a tailored design method (Dillman, 2000) was used. This method involved sending three email solicitations to encourage participation in the study. The first email invited the NLRNs to participate in the study and provided a link to the survey (Appendix G). A second email, also with the link to the survey, was sent two weeks after the initial email as a reminder of the opportunity to participate in the study (Appendix H). A third email, to again remind participants of the opportunity to participate in the study and to ensure the sample size was sufficient in regard to the number of participants needed for statistical analysis, was sent two weeks after the second email (Appendix H).

Instruments

A demographic questionnaire (Appendix B), the Preceptor Role Effectiveness Scale (PRES) (Appendix C), the Psychological Empowerment Scale (PES) (Appendix D), and the Schutzenhofer Professional Nursing Autonomy Scale (SPANS) (Appendix E) were the instruments used for this study. The demographic questionnaire consisted of nine items: gender, age, race/ethnicity, months licensed as a registered nurse, whether the NLRN received orientation at his or her first place of employment after graduation, amount of time spent in orientation with his or her first employer after graduation, whether the NLRN thought the orientation received was effective in helping the NLRN's transition into practice, current employment status, and whether the NLRN currently works for his or her first employer after graduation.

Preceptor Role Effectiveness Scale (PRES). After a review of literature, no instruments were found that measured perceived level of preceptor role effectiveness among NLRNs. The Clinical Instructor Characteristics Ranking Scale (CICRS) (Rauen, 1974) is an instrument developed to measure students' expectations of their clinical instructor. With permission from the CICRS's author, (Appendix I), the CICRS was revised for this study to examine perceived level of preceptor role effectiveness among NLRNs. The original 18 items were used, but the instructions and scoring was revised to reflect NLRNs' perceptions of their preceptor role effectiveness during their orientation period. The scoring format was revised to the following 4-point Likert response scale: 1) strongly disagree, 2) disagree, 3) agree, and 4) strongly agree. The total score from all responses were calculated. The scores ranged from 18 to 72 with higher scores indicating higher perceived level of preceptor role effectiveness.

In the original CICRS, students are asked to rank three groups of characteristics related to the instructor's role as a person, a nurse, and as a teacher. Each group contains six characteristics yielding a total of 18 instructor characteristics. Characteristics were developed by a review of the literature. Nursing educators established content validity. A group of 25 experts were required to agree with the content and the categorization of content by 80% or greater. A random sample of 84 freshman and senior nursing students with similar clinical experience and curricular backgrounds were recruited to complete the scale. A sample of 50 junior nursing students were administered the scale a second time to establish test-retest reliability. Spearman-Brown (S-B) prophecy formula yielded a .75 reliability coefficient (Rauen, 1974).

The original CICRS is an 18-item scale composed of six items from each categorization. Each item is a statement representing an instructor's characteristic. Students are asked to rank each item according to its importance. The following 5-point Likert scale was used to respond to each item: 1) not important, 2) of little importance, 3) moderately important, 4) important, and 5) very important. The sum of scores for each category is compiled to determine which clinical instructor role is most important to the students.

Psychological Empowerment Scale. The PES is an instrument developed to measure psychological empowerment in the work place. From a review of literature, Spreitzer (1995) constructed the following psychological definition of empowerment: “a motivational construct manifested in four areas of cognition: meaning, competence, self-determination, and impact” (Spreitzer, 1995, p. 1444). Spreitzer (1995) discusses the definition of each dimension and states that the four dimensions combined provide an active, overall understanding of psychological empowerment. The primary sample used to establish construct validity consisted of 393 randomly selected mid-level employees from diverse units of a *Fortune 50* industrial organization. A second sample, selected by a stratified random sampling technique, was comprised of 128 lower-level employees from an insurance company. The second sample was used to cross-validate the results of the model and establish internal consistency and test-retest reliability. The Cronbach's alpha reliability coefficient for the overall empowerment construct was .72 for the primary sample and .62 for the second sample. From the second sample, both, internal consistency and test-retest reliability were established for each dimension of the scale (Spreitzer, 1995). The items used to comprise the dimension of meaning yielded

Cronbach's alpha reliability coefficients of .85 to .87, and the items combined for competence yielded coefficients of .79 to .81. The items for self-determination and impact yielded coefficients of .82 and .88, respectively.

The PES is a 12-item scale composed of items related to each subscale or dimension. Each item is a statement that represents a condition of psychological empowerment. The scale uses a 5-point Likert scale response format. Participants are asked to respond indicating the degree to which they agree or disagree with the statement. The scale format is as follows: 1) strongly disagree, 2) disagree, 3) neither agree nor disagree, 4) agree, and 5) strongly agree. A mean score is obtained by taking the average value of the 12 items. Higher mean scores indicate a higher degree of perceived level of psychological empowerment. Permission was obtained from the instrument author to use the scale in this study (Appendix J).

Schutzenhofer Professional Autonomy Nursing Scale. The SPANS was developed as a tool to measure perceived degree of professional autonomy among registered nurses (RN) (Schutzenhofer, 1987). The working definition of professional autonomy used for this scale was, "the practice of one's occupation in accordance with one's education, with members of that occupation governing, defining, and controlling their own activities in the absence of external controls" (Schutzenhofer, 1988, p. 3). The scale was originally introduced as a 12-item instrument developed from a review of nursing literature. Content validity was established by a group of nursing deans, service administrators, and clinical nurse specialists. The 12-item scale failed to demonstrate acceptable reliability, so the instrument was expanded to a 30-item scale. A random sample of 500 RNs was surveyed for the 30-item scale, and 119 usable surveys were

returned. After data analysis, the surveys demonstrated acceptable internal consistency reliability yielding a Cronbach's alpha coefficient of .92. The test-retest approach was used on two convenience samples of RNs ($n = 58$, $n = 62$) and yielded reliability coefficients of $r = .68$ and $.79$, respectively (Schutzenhofer, 1988).

The most current version of the SPANS is a 35-item scale. Only 30 of the items are scored, while 5 of the items were added to the scale as experimental items. Therefore, only the 30 items intended for scoring were administered for this study. Each item describes a situation in which a nurse would have to exercise some degree of autonomy. The scale asks participants to respond to each item even if they have never, or may never, encounter the situation. The following Likert scale format is used to answer each item: 1) very unlikely of me to act in this manner, 2) unlikely of me to act in this manner, 3) likely of me to act in this manner, and 4) very likely of me to act in this manner (Schutzenhofer, 1987). Responses are weighted to measure three levels of autonomy (1 = low level of autonomy to 3 = high level of autonomy). The adjusted scores are then combined resulting in a score range from 60 to 240. Low level of professional autonomy scores range from 60 to 120, mid-level of professional autonomy scores range from 121 to 180, and high level of professional autonomy scores range from 181 to 240 (Schutzenhofer, 1988). Permission was obtained to use the instrument in this study (Appendix K)

Threats to Validity

The study used a convenience sampling technique, which could threaten internal validity. This type of sampling could have led to response bias limiting generalizability of the findings. Also, because the sample was limited to baccalaureate prepared NLRNs

from one academic institution, generalizability to other NLRNs with other types of nursing degrees is limited (Polit & Beck, 2012).

A threat to external validity included what is known as reactivity. Reactivity is the potential effect that participating in the study will have on participants' responses. This phenomenon is also known as the Hawthorne Effect. The Hawthorne Effect says that participants' behaviors are affected by personal values or desires to please the researcher, therefore influencing the results of the study (Polit & Beck, 2012).

Data Analysis

Descriptive and inferential statistics were analyzed using SPSS for Windows Release 21.0. A pre-analysis data screening was conducted to ensure the accuracy of data entry. Descriptive statistics (frequencies, percentages, means, and standard deviations) were performed to describe the sample characteristics and NLRNs' perceived preceptor role effectiveness, psychological empowerment, and professional autonomy.

Correlational analyses were conducted to examine the relationships between NLRNs' perceived preceptor role effectiveness, psychological empowerment, and professional autonomy. In addition, Cronbach's alpha reliability coefficients were calculated to determine internal consistency reliability of the PRES, PES, and SPANS.

A *p* value of ≤ 0.05 was considered statistically significant.

Protection of Human Subjects

Prior to any data collection, approval for the study was obtained from the Kennesaw State University Institutional Review Board (IRB). An informed consent (Appendix A) was presented to the participants explaining the purpose of the study and their rights as research participants. Participants were informed that they would complete

a demographic form and three other surveys. Participants were informed that the surveys would take approximately 15 minutes to complete. Completion of the surveys indicated participants' consent to participate in the study. Participants were advised that all information collected for the study was kept confidential.

Data Security

Participant confidentiality was protected by only collecting survey responses and pertinent demographic information. No participant identifying information or Internet Protocol (IP) addresses were solicited or stored via Survey Monkey, a secure, encrypted, Secure Sockets Layer (SSL) system. The email address file was deleted immediately after data collection ended. The survey responses and any data collected were transmitted and stored via Survey Monkey. Access to the responses was password protected. Data were shared with the researcher's faculty and those directly involved in data analysis.

The data were entered into an SPSS database for data analysis. The SPSS file was stored on a jump drive and secured in a locked file cabinet when not in use. All data related to the study will be secured and stored for a minimum of five years and then destroyed. The data belongs to the researcher and will not be accessed without permission and ethical review.

CHAPTER 4: RESULTS

This chapter presents a summary of the data analyzed. This chapter discusses the data analysis plan, sample characteristics, and the results of the analysis. The data analysis answers the following questions: 1) What is the perceived level of preceptor role effectiveness among newly licensed registered nurses? 2) What is the perceived level of psychological empowerment and professional autonomy among newly licensed registered nurses? 3) What are the relationships between newly licensed registered nurses' perceived preceptor role effectiveness and perceived levels of psychological empowerment and professional autonomy?

Data Analysis

The purpose of the study was to examine the relationship between NLRNs' perceived preceptor role effectiveness and NLRNs' perceived level of psychological empowerment and professional autonomy. Descriptive and inferential statistics were analyzed using SPSS for Windows Release 21.0. A pre-analysis data screening was conducted to ensure the accuracy of data entry. Upon examination of the data points, minimal missing data were noted for the SPANS questionnaire (0.7%), the PRES questionnaire (0.4%), and the PES questionnaire (0.7%). Cohen and Cohen (1983) suggest that missing data up to 10% on a specific variable is considered small and the variable should be retained in the analysis. Furthermore, Raymond and Roberts (1987) estimated that a variable should be retained with 40% or less missing data. Removing cases with missing data from data analysis procedures can result in reduced sample size,

compromised statistical power, and inaccurate parameter estimates (Barnard & Meng, 1999; Patrician, 2002; Tabachnick & Fidell, 2001). Due to the small percentage of missing data, the decision was made to retain all cases and use individual mean imputation for missing data points (Shrive, Stuart, Quan, & Ghali, 2006). This technique involved calculating the average of either the subscale within a questionnaire or the entire questionnaire (if questionnaire was a single factor instrument) and replacing the missing data points with this calculated average.

Descriptive statistics (frequencies, percentages, means, and standard deviations) were performed to describe the sample characteristics and NLRNs' perceived preceptor role effectiveness, psychological empowerment, and professional autonomy.

Correlational analyses were conducted to examine the relationships between NLRNs' perceived preceptor role effectiveness, psychological empowerment, and professional autonomy. In addition, Cronbach's alpha reliability coefficients were calculated to determine internal consistency reliability of the PRES, PES, and SPANS. A p value of ≤ 0.05 was considered statistically significant.

By email solicitation, 634 participants were recruited to participate in this study. Of the 634 emails addresses used, 123 email addresses were deemed invalid resulting in 511 valid email addresses. One hundred and one participants responded to the survey resulting in a 19.76% response rate. Of the 101 participants who responded to the survey 15 declined to participate, five had incomplete data sets, and 12 did not meet the inclusion criteria. A total of 69 usable questionnaires were included in the data analysis for the study.

Sample Characteristics

The majority of the NLRNs were female ($n = 59$, 85.5%) and Caucasian ($n = 51$, 73.9%) (Table 1). The participants' age ranged from 22 to 49 years with a mean age of 32.43 years ($SD = 8.10$). The number of months licensed as a registered nurse ranged from 2 to 24 months, with a mean of 12.31 months ($SD = 6.95$). The majority of NLRNs indicated that they are currently employed as a RN ($n = 63$, 91.3%), while 5.8% ($n = 4$) indicated that they were no longer employed as a RN. The majority of NLRNs ($n = 63$, 91.3%) indicated that their employers provided them a one-on-one preceptorship. The preceptorships ranged from 0.5 to 7 months with a mean of 3.25 months ($SD = 1.31$). Over three fourths of the participants ($n = 58$, 84.1%) indicated their preceptor was effective in his/her role in helping the NLRN in successfully transitioning to the professional role of nursing.

Table 1

Demographic Characteristics of NLRNs (N = 69).

| Characteristics | | |
|--------------------------------------|----------|-----------|
| | <i>M</i> | <i>SD</i> |
| Age | 32.43 | 8.10 |
| Months Licensed | 12.31 | 6.95 |
| Months Preceptorship Lasted | 3.25 | 1.31 |
| | <i>N</i> | <i>%</i> |
| Gender | | |
| Male | 10 | 14.5 |
| Female | 59 | 85.5 |
| Race/Ethnicity | | |
| White/Caucasian | 51 | 73.9 |
| Black/African American | 9 | 13.0 |
| Hispanic/Latino | 3 | 4.3 |
| Asian/Pacific Islander | 5 | 7.2 |
| Native American | 1 | 1.4 |
| Currently Employed as RN | | |
| No | 4 | 5.8 |
| Yes | 63 | 91.3 |
| Offered One-on-One Preceptorship | | |
| No | 6 | 8.7 |
| Yes | 63 | 91.3 |
| Preceptor Effective in His/Her Role | | |
| No | 5 | 7.2 |
| Yes | 58 | 84.1 |
| Currently Employed by First Employer | | |
| No | 7 | 10.1 |
| Yes | 56 | 81.2 |

Instrument Reliability

Internal consistency reliability of the PRES, PES, and SPANS was assessed by calculating Crochbach's alpha reliability coefficients. For this study, Cronbach's alpha coefficients were; PRES (0.97), PES (0.88), and SPANS (0.91) indicating that internal consistency reliability was highly acceptable for all three instruments.

Research Questions

Research question one. Research question one examined the relationship between NLRN's perception of preceptor role effectiveness. The potential score range for the PRES was 18 to 72 (Table 2). NLRNs' PRES scores ranged from 38 to 72 with a mean of 63.04 ($SD = 9.77$) indicating a moderately high perception of preceptor role effectiveness.

Research question two. Research question two examined the relationship between NLRNs' perceived level of psychological empowerment and professional autonomy among. The potential mean score for the PES scores ranged from 1 to 5 (Table 2). NLRNs' scores ranged from 2 to 5 with a mean of 3.98 ($SD = .57$) indicating NLRNs had a moderately high perceived level of psychological empowerment.

The potential score range for the SPANS was from 60 to 240 (Table 2). The NLRNs' scores ranged from 142 to 240 with a mean of 198.90 ($SD = 21.23$) indicating a moderately high level of professional autonomy. The majority of NLRNs ($n = 55$, 81.2%) fell into the high level of professional autonomy (181-240), while 18.8% ($n = 14$) fell into the mid level of professional autonomy (121-180), and none of the participants fell in the low level of professional autonomy (60-120).

Table 2

Score Ranges, Means, and Standard Deviation for the PRES, PES, and SPANS (N = 69).

| Instrument | Potential Score Range | Participants' Score Range | <i>M</i> | <i>SD</i> |
|------------|-----------------------|---------------------------|----------|-----------|
| PRES | 18 – 72 | 38 – 72 | 63.04 | 9.77 |
| PES | 1 – 5 | 2 – 5 | 3.98 | .57 |
| SPANS | 60 – 240 | 142 – 240 | 198.90 | 21.23 |

Research question three. Research question three examined the relationships between NLRNs' perceptions of preceptor role effectiveness, psychological empowerment, and professional autonomy. A significant relationship was found between preceptor role effectiveness and professional autonomy, $r(69) = .326, p = .006$ (Table 3). Preceptor role effectiveness has a moderately positive relationship with professional autonomy.

A significant relationship was found between preceptor role effectiveness and psychological empowerment, $r(69) = .486, p < .001$ (Table 3). Preceptor role effectiveness has a moderately positive relationship with psychological empowerment.

A significant relationship was found between psychological empowerment and professional autonomy, $r(69) = .444, p < .001$ (Table 3). Psychological empowerment has a moderately, positive relationship with professional autonomy.

Table 3

Correlation Matrix between Preceptor Role Effectiveness, Professional Autonomy, and Psychological Empowerment (N =69).

| | Professional Autonomy | Psychological Empowerment |
|------------------------------|-----------------------|---------------------------|
| Preceptor Role Effectiveness | .326** | .486** |
| Professional Autonomy | | .444** |

** $p = .01$

CHAPTER 5: DISCUSSION

This chapter discusses the interpretation of data findings and relates those findings to theory and previous literature. Limitations to the study are also discussed. The chapter concludes with a discussion of the implications of the research findings in relation to nursing practice, nursing education, and future nursing research.

Descriptive analysis of data showed a moderately high level of perceived preceptor role effectiveness, psychological empowerment, and professional autonomy among the NLRNs surveyed. This indicated that, overall, NLRNs are experiencing effective preceptorships, feel psychologically empowered in their profession, and have a moderately high degree of autonomy in their role as a RN.

Upon examining the results of the correlational analysis, preceptor role effectiveness had significant, moderately, positive relationships with professional autonomy and psychological empowerment. This indicated that as perceived preceptor role effectiveness increased, perceived professional autonomy and psychological empowerment of the NLRN also increased. Professional autonomy had a significant, moderately, positive relationship with psychological empowerment. This indicated that as perceived professional autonomy increased, perceived psychological empowerment of the NLRN also increased.

These findings support literature that shows that effective preceptorships are essential in making the transition from novice to expert as smooth as possible (Park et al., 2011). This study's findings also supports Harrison-White & Simon's (2013) previous

research suggesting that NLRNs are more likely to provide effective care sooner and show, overall, more confidence in their nursing role with the support of an effective preceptor. Additionally, this study's findings support literature that claims NLRNs who are content with their preceptorships have a better transitional experience (Park et al., 2011), and have increased confidence and competence as they transition to practice and take on in their new professional role (Mills & Mullins, 2008).

Moreover, in this study, the majority of NLRNs were satisfied with their preceptors' role effectiveness and the majority remained in their first nursing positions within the first year of practice. These findings concur with the findings of Halfer and Graf (2006) who found that NLRNs' retention rates increased with the utilization of a preceptor. Similarly, Lee et al. (2009) found that retention rates increased by more than 50% when NLRNs had a preceptor.

Furthermore, the findings of high degrees of autonomy and its correlation with effective preceptorships and greater degrees of empowerment mimics the results of the Laschinger and Finegan (2005) study that found that higher levels of perceived professional autonomy are linked to increase job-related empowerment. Researchers have found that increased levels of autonomy are also linked with an increased ability to critically and analytically assess situations, use multiple types of knowledge, and implement acquired knowledge in the form of high quality nursing care (Mantzoukas & Watkinson, 2007). Moreover, these findings are supported by Chen-Chung, Samules, and Alexander (2003) who found that autonomy was the second most significant predictor of job satisfaction among nurses working in a hospital setting.

One of the most significant findings in this study was the degree of psychological empowerment, and its significant relationship with preceptor role effectiveness. This finding is significant because Bradbury-Jones et al. (2011) found that high degrees of psychological empowerment are linked to NLRNs feelings of being valued as a learner, valued as a team member, and valued as a person (Bradbury-Jones et al., 2011). This finding ties back to Peplau's Theory of Interpersonal Relations which asserts that these feelings are important when attempting to successfully transition a NLRN to the role of a professional nurse (Peplau, 1997; Washington, 2013). Park et al. (2011) assert that preceptors are in the best position to assess and influence the NLRNs' perceived level of professional autonomy and psychological empowerment and that a positive, supportive preceptor helps to facilitate the professional transition of the NLRN. An encouraging attitude increases feelings of satisfaction in the relationship and confidence in personal capability. (Halfer & Graf, 2006; Cho et al., 2006; Larrabee et al., 2003).

With this study's findings and additional support found in the literature (Halfer & Graf, 2006; Cho et al., 2006; Larrabee et al., 2003), it behooves preceptors to be more supportive in the areas of empowerment and encouragement. Not only have these concepts been linked to easing the NLRN transition to practice, but they have been linked to increased job satisfaction, increased work effectiveness, and better nurse retention rates (Casey, Suanders, & O'Hara, 2010; Laschinger, Wilk, Cho & Greco, 2009).

Limitations

One limitation of the study was that email solicitation was used to recruit participants. This limited the study to only students that provided the university with an email address after graduation. The study was further limited to those whose email

addresses were still valid. There was also the dependence that participants would respond to the email in a timely manner. This limited sample size and generalizability of the study findings.

A second limitation was that the study participants were recruited from one university. This university was found in the southeast United States and only graduated bachelor's prepared nurses. This limited the study to participants of the southeast United States and bachelor's prepared NLRNs only. This limited sample size, increased the possibility of response bias, and limited generalizability to diploma and associate's prepared NLRNs.

A third limitation was the use of self-report questionnaires to survey perceived preceptor role effectiveness, psychological empowerment, and professional autonomy. Self-report questionnaires increase the opportunity for response bias due to the selection of socially desirable responses (Polit & Beck, 2012).

Implications

The findings of this study were significant in finding a positive relationship between perceived preceptor role effectiveness, psychological empowerment, and professional autonomy. These findings have significant implications in the areas of nursing practice, nursing education, and future research.

Nursing Practice. The turnover rate for NLRNs in their first year of practice is roughly 30% and increases to about 57% in the second year (Twibell et al., 2011). High turnover rates have been shown to negatively affect job satisfaction, workplace morale, and the quality of patient care (Mills & Mullins, 2008). Most NLRNs attribute their attrition to the lack of confidence needed to function autonomously in their new role and

the lack of competence needed to provide safe, effective patient care (Hodges et al., 2008). Park et al. (2011) state that preceptors are in the best position to assess and influence the NLRNs' perceived level of professional autonomy and psychological empowerment.

Despite many supportive studies (Halfer & Graf, 2006; Cho et al., 2006; Larrabee et al., 2003) related to the effectiveness of preceptorships, the extent to which NLRNs experience an effective preceptorship continues to vary (Harrison-White & Simons, 2013). If the profession of nursing is to attempt to reduce the estimated impact of the nursing shortage and decrease turnover rates, implementation of effective NLRN retention strategies is necessary. The use of effective preceptorship programs must become the goal of the profession, and not just the individual. Making orientation with an effective preceptorship a standard in the transition process of NLRNs is one way to help reduce attrition.

One orientation strategy found to be effective is the implementation use of nurse residency programs. One program utilized is the United Health Consortium/American Association of Colleges of Nurses (UHC/AACN) Nurse Residency Program. It was designed with the goals of easing the NLRN transition to practice, enhancing the expertise of the nursing workforce, reducing practice errors, and minimizing the burnout caused by the stress of being under prepared as a professional nurse. This program evaluated the retention rate of NLRNs transitioned through this program. Most recent data at that time showed a retention rate of 94.3% for the first year of employment at 28 participating organizations (AACN, 2007). Outcomes data showed that NLRNs demonstrated improvement in areas of confidence, competence, organization and

prioritization, communication, and leadership and reported a reduction in stress levels. The program was demonstrated to be effective in improving performance levels of NLRNs, preventing care omissions, and helping ensure timely, appropriate patient interventions, therefore increasing patient safety and the quality of care (AACN, 2007).

A second strategy shown to ease NLRN's transition is the implementation of post-orientation mentorship programs. Mentorship programs are designed to provide continued support for the NLRN beyond the formal orientation period. These mentorships have been shown to help decrease the stress related to being separated from staff utilized in the formal orientation period and further ease the transition to practice (Spiva et al., 2013; McDonald & Ward-Smith, 2012). Bradbury-Jones et al. (2011) found that effective mentorships and a supportive work environment were factors that significantly influenced the sense of empowerment and impacted NLRNs' learning and their commitment to continue as a nurse. Research supports that with the increased use of strategies such as nurse residency programs and the aforementioned mentorship programs, there is an increase in NLRN job satisfaction, a decrease in NLRN turnover, and an increase in the safety and quality of patient care (AACN, 2007; McDonald & Ward-Smith, 2012; Spiva et al., 2013). As the use of these programs grow in becoming a professional standard, the nursing profession can then begin to positively impact the nursing shortage.

Education. More than 57% of NLRNs state that they are simply overwhelmed by the overall responsibility of providing adequate patient care (Halfer & Graf, 2006). In a theme found by Harrison-White & Simons (2013), NLRNs stated, "You learn theory, but in practice, it is completely different" (p. 25). Kramer (1974) first coined this

inconsistency in school-bred values of theory and world values in practice as “reality shock.” The discrepancies between what the NLRN understands from their education and what they experience in practice leave them with a sense of “not knowing.” This role ambiguity and internal conflict leads to job dissatisfaction and disillusionment in relation to how they will execute patient care (Duchscher, 2003).

The burden of nurse educators lies here. To better prepare NLRNs for practice, educators must begin to actively lessen the gap between theory learning in the academic setting and what is practiced in the acute care setting. Educators must become more diligent in staying abreast to the ever-changing skills and theory utilized in the acute care setting. In addition to teaching NLRNs theory, there is a required need to present it alongside “real or realistic” nursing or that which is actually done in the acute care setting. Is it important that NLRNs learn the theory behind their actions, but it is more important that they understand that “real or realistic” nursing practice is significantly different from theory. Duchscher (2009) proposed the *Transitional Shock Theory*. This theory suggests that educational institutions should provide more preparatory theory that discusses the role transition for NLRNs and facilitating clinical placements that provide more real-world, hands on experiences that better prepare NLRNs for the “dynamic, highly intense and conflict-laden context” of nursing practice (Duchscher, 2009, p. 1111). Therefore, it is essential that in the academic setting educators give NLRNs more of the reality of nursing practice so that the “shock” experienced during transition may be lessened, even expected.

Another strategy to lessen this “shock” is the partnering of nurse educators with healthcare organizations and developing dedicated education units (DEU). DEUs are

designed to more closely connect the academic and acute care settings (Mulready-Shick, Kafel, Banister, & Mylott, 2009). DEUs facilitate stronger relationship-building of academia and practice by requiring a collaborative effort of nurse management, staff nurses, and nursing faculty in creating an atmosphere of learning and support in the acute care setting.

Students that participate in DEUs gain the clinical knowledge, skill, and values needed to transition from theory in the academic setting to practice in the clinical setting (Mulready-Shick et al., 2009). Students were shown to have the knowledge, skills, and attitudes associated with safe, high quality, and competent patient care (Mulready-Shick et al., 2009). There was increased teamwork and collaboration, and students were fully integrated participating as team members (Mulready-Shick et al., 2009). There were greater opportunities for “teachable moments” due to students’ increased “time-on-task” practicing nurses (Mulready-Shick et al., 2009). Other researchers have found that students were well supported during clinical placements because all staff participated in student teaching and that the use of DEUs in nursing curriculum eased NLRN transition to practice and improved satisfaction (Casey et al., 2008; Walker et al., 2012).

Additionally, Kovner, Brewer, Greene, and Fairchild (2009) found that NLRNs are increasingly assigned patients with the same acuity of more experienced nurses. To meet the needs of such patients, NLRNs must have the knowledge and skills necessary to properly assess these complex cases. Kovner et al. (2009) suggest that NLRNs are not being given adequate assessment skills for the complex, aging population that makes up the acute care setting. Again, the burden must be shared with the educator. It is no longer acceptable to only prepare the NLRN for licensure, but to prepare them for practice in

relation to the dynamics of the current patient population. This may require a remodeling of what skills, theory, and/or how health assessment techniques are presented to the NLRN in the academic setting. NLRNs must understand the complexity of the diseased body, and this teaching must be done emphasizing the impact of the disease process on the entire body, not a single organ system.

One strategy available to lessen transitional stress and increase the student's ability to assess the complex patient population is the use of simulation in nursing curriculum. Simulation is the use of "real," patient scenarios with a varying degree of fidelity, low, medium, or high fidelity, to simulate clinical situations. Simulation is an educational tool used to replicate "real" clinical practice scenarios in a safe environment (Cant & Cooper, 2010). From a systematic review of literature, simulation has been shown to be a valid teaching/learning method (Cant & Cooper, 2010). Based on their systematic review of the simulation literature, Cant and Cooper (2010) suggest that positive simulation experiences were correlated with additional gains in knowledge, increased critical thinking ability, and increased satisfaction and confidence compared with other teaching techniques. Rabia (2013) found that the use of simulation before and after the first clinical experience significantly decreased student anxiety. Decreased anxiety was paired with increased confidence, greater caring ability, and greater caring efficacy (Rabia, 2013). Additionally, a systematic review by Norman (2012) revealed similar results showing a relationship between the use of simulation and increased knowledge, skills performance, patient safety, and self-confidence.

Most importantly, and in addition to increased student education, there must be increased preceptor preparation and education. In preparing the student for nursing

practice, there is a need to also prepare the preceptors for their new role as a NLRN preceptor. Preceptor selection must become more formal and detailed. It is no longer sufficient or beneficial to select NLRN preceptors that have not been trained to do so. The ability to precept or one's precepting capability must be based on more than expertise nor even their willingness to do so, but the characteristics they possess, their dedication to advancing the profession, and their commitment to ensuring the successful transition of the NLRN.

The most important strategy, in relation to the outcomes of this study, in easing NLRN transition is the formal training and education of NLRN preceptors. American Association of Critical-Care Nurses (AACN) (2013) suggests implementing the *Preceptor Challenge* course. The *Preceptor Challenge* is a course designed to help train and assist the staff in taking on the role of preceptor. The *Preceptor Challenge* course aides in increasing the preceptors knowledge regarding best practice techniques and learning how to use such techniques to effectively integrate the NLRN. Moreover, the *Preceptor Challenge* is effective in educating the preceptor on how to transfer practical skills into theory-based precepting practice. In doing so, the preceptor is educated in relation to the role of a preceptor and is cautioned as to how this role is significantly different from the role of a staff nurse.

Additionally, throughout the *Preceptor Challenge* course, the preceptor is educated related to teaching and learning strategies to utilize with the preceptee and the importance of adequate assess of the strengths and weaknesses of the NLRN, developing a strategy to improve weaknesses and utilize strengths, and developing a plan related to how the preceptor hopes to implement these strategies. The AACN goes on to stress the

essentiality of continual assessment of the needs and goals of the preceptee and the continual modification of the proposed learning plan (AACN, 2013).

Preceptor training workshops such as the *Preceptor Challenge* more effectively prepares staff nurses to act as preceptors, boosts the preceptor's confidence and competence in the ability to assess the NLRN, and give constructive feedback (Sandau et al., 2011). The improved confidence and competence of the preceptor translates to the preceptee and results in improved retention rates for NLRN and an increased number of staff nurses desiring to precept (Sandau et al., 2011).

Future research. NLRNs involved in effective preceptorships have shown significant achievement of many qualities needed to survive the transition to a safe, competent professional (Lee, Tzeng, Lin, & Yeh, 2009; Marks-Maran et al., 2012). NLRNs, as a result of preceptorships, have more specialized knowledge and skill sets, have better communication skills, and enjoy higher levels of patient and personal satisfaction (Lee et al., 2009). Preceptorships have been shown to enable NLRNs to better manage stress and feel more supported at work.

Future research is needed that focuses on the preceptors that are perceived as effective in their role. Examining qualities and skills effective preceptors possess will enable researchers to identify qualities and skills that are different from those thought to be ineffective. Also, research is needed to assess what preceptor characteristics are linked with high levels of perceived preceptor effectiveness, and if the two are linked with NLRN retention. Future research needs to include an assessment of how factors such as the preceptor's education level, years in practice, commitment to practice, and preceptor training effect NLRN psychological empowerment and professional autonomy. It may

even behoove researchers to again assess NLRNs for what qualities they perceive as necessary for an effective preceptor, and focus research toward methods and strategies useful in developing these qualities in those looking to be utilized as a future NLRN preceptor.

Conclusion

The aim of this research study was to examine the relationship between NLRNs' perceived preceptor role effectiveness and NLRNs' perceived level of psychological empowerment and professional autonomy. This study's results indicated that, overall, NLRNs had a high degree of perceived preceptor role effectiveness, psychological empowerment, and professional autonomy with the various preceptorships they have been offered. In addition, perceived preceptor role effectiveness had moderately, positively relationships with perceived psychological empowerment and professional autonomy in NLRNs. This indicates that preceptor role effectiveness is an important element in the successful transition of the NLRN to nursing practice. Therefore, effective preceptorships are a necessary requirement in easing the NLRNs' transition to practice and retention within the nursing workforce.

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Appendix A
Informed Consent

**Kennesaw State University
Informed Consent**

Title: The Effect of Preceptor Role Effectiveness on Newly Licensed Registered Nurses' Perceived Psychological Empowerment and Professional Autonomy

Principal Investigator: Chanell Watkins, BSN, RN

Faculty Advisor: Patricia Hart, PhD, RN

I am seeking 85 newly licensed registered nurses (NLRN) to participate in this research study. The purpose of the study is to:

1. Examine the perceived level of preceptor role effectiveness among NLRNs.
2. Examine the perceived level of psychological empowerment and professional autonomy among NLRNs.
3. Examine the relationships between NLRNs' perceived preceptor role effectiveness and perceived levels of psychological empowerment and professional autonomy.

Participants inclusion criteria include: 1) must be 18 years or older, 2) able to speak and read English, and 3) licensed as a registered nurse for 24 months or less.

Procedures: If you decide to participate, you will be asked to complete a short demographic questionnaire consisting of nine questions, the Preceptor Role Effectiveness Scale (PRES) consisting of 18 questions, the Psychological Empowerment Scale (PES) consisting of 12 questions, and the Schutzenhofer Professional Autonomy Nursing Scale (SPANS) consisting of 30 questions. It should take you approximately 15 minutes to complete the four questionnaires. The demographic questionnaire will consist of questions that pertain to your gender, age, race/ethnicity, months licensed as a registered nurse, orientation received with your first employer after graduation, the time spent in orientation with your first employer after graduation, the effectiveness of the orientation received in helping you transition into practice, your current employment status, and your current place of employment. The PRES will contain items that measure preceptor role effectiveness of the preceptor involved in your first preceptorship experience. The PES will contain questions that measure your degree of psychological empowerment. The SPANS will contain questions that measure your degree of professional autonomy. Your completion of the questionnaires is your consent to participate.

Risks: There are no known physical risks for participating in this study. You may experience some uneasy feelings thinking about your orientation process and the relationship with your preceptor.

Benefits: There are no direct benefits to you for participating in this study. It is possible that with your information, the researcher will identify areas that will advance knowledge and understanding regarding the preceptor-NLRN relationship.

Incentives: There are no incentives for participating in this study.

Confidentiality: Participant confidentiality is assured by not collecting IP addresses or any other participant identifying information. The information that you provide will only be shared with the individuals that are directly involved with the research study. You maintain all of your rights while participating in the study.

Voluntary Participation/Withdrawal: Participation in research is voluntary. You have the right to refuse to be in this study. If you decide to be in the study and change your mind, you have the right to drop out at any time.

Data Security: The survey responses and any data collected will be stored via Survey Monkey. Access to the responses will be password protected and only the researcher will have access to survey responses. Data will be shared with the researcher's faculty and those directly involved in data analysis. An SPSS database will be used for data analysis. The SPSS file will be stored on a jump drive and secured in a locked file cabinet when not in use. All data related to the study will be secured and stored for a minimum of five years and then destroyed.

Contact Person: If you have any questions or concerns regarding this study, you may contact the investigator: Chanell Watkins, BSN, RN @ nellnicole00@aol.com

Institutional Review Board: Research at Kennesaw State University that involves human participants is carried out under the oversight of their Institutional Review Board. You may contact the Institutional Review Board with any questions or concerns regarding the protection of your rights. The address is as follows: Institutional Review Board, Kennesaw State University, 1000 Chastain Road, Kennesaw, GA, 30144, (678)797-2268.

PLEASE PRINT A COPY OF THIS CONSENT DOCUMENT FOR YOUR RECORDS.
IF YOU DO NOT HAVE PRINT CAPABILITIES, YOU MAY CONTACT THE
RESEARCHER TO OBTAIN A COPY

I agree and give my consent to participate in this research project. I understand that participation is voluntary and that I may withdraw my consent at any time without penalty.

I do not agree to participate and will be excluded from the remainder of the questions.

Appendix B
Demographic Form

Demographic Questionnaire

1. What is your gender? Male Female
2. What is your age, in years? _____
3. What race/ethnicity group do you most identify with?
 - White/Caucasian Black/African-American
 - Hispanic/Latino Asian or Pacific Islander
 - Native American Arabic
 - Other
4. How many **months** have you been *licensed* as a Registered Nurse (RN)? _____
5. Are you currently *employed* as a RN?
 - Yes No
6. Did the first employer whom hired you after you were licensed offer you a one-on-one preceptorship with an experienced nurse (preceptor)?
 - Yes No
7. How long, in **months**, did the preceptorship last? _____
8. In your opinion, was the preceptor effective in his/her role in helping you successfully transition into practice?
 - Yes No
9. If you are currently employed as a RN, are you currently employed by the first employer whom hired you after you were licensed?
 - Yes No

Thank You!

Appendix C

Preceptor Role Effectiveness Scale

(Clinical Instructor Characteristic Ranking Scale-Revised)

Preceptor Role Effectiveness Scale

The following items describe preceptor role characteristics. They are designed to determine the effectiveness of the preceptorship you experienced from the first employer by whom you were hired. The statements are to be applied to the first preceptor you were assigned during this preceptorship period only. You are asked to respond to each item according to how you would rank the presence of each characteristic in your first preceptor during your first preceptorship only.

Please select the number that represents the degree to which you agree or disagree with each statement.

| | Strongly Disagree | Disagree | Agree | Strongly Agree |
|---|--------------------------|-----------------|--------------|-----------------------|
| 1. Was available for help when I needed guidance | 1 | 2 | 3 | 4 |
| 2. Demonstrated knowledge of scientific principles relative to patient care | 1 | 2 | 3 | 4 |
| 3. Showed genuine interest in me as an individual | 1 | 2 | 3 | 4 |
| 4. Gave assignments that helped me transfer theoretical concepts to actual patient care | 1 | 2 | 3 | 4 |
| 5. Demonstrated ability to do nursing skills (such as nursing procedures) | 1 | 2 | 3 | 4 |
| 6. Encouraged me to be "open" thereby respecting my opinions and feelings. | 1 | 2 | 3 | 4 |
| 7. Demonstrated honesty to me and others | 1 | 2 | 3 | 4 |
| 8. Demonstrated ability to use scientific principles relative to patient care. | 1 | 2 | 3 | 4 |
| 9. Suggested helpful resources when I have questions. | 1 | 2 | 3 | 4 |
| 10. Demonstrated how to function in a real nursing situation. | 1 | 2 | 3 | 4 |
| 11. Avoided embarrassing me. | 1 | 2 | 3 | 4 |
| 12. Encouraged me to think for myself. | 1 | 2 | 3 | 4 |
| 13. Showed a contagious enthusiasm for giving quality patient care | 1 | 2 | 3 | 4 |

| | Strongly Disagree | Disagree | Agree | Strongly Agree |
|--|--------------------------|-----------------|--------------|-----------------------|
| 14. Evaluated my progress in nursing in a fair manner. | 1 | 2 | 3 | 4 |
| 15. Rewarded my efforts to give quality nursing care. | 1 | 2 | 3 | 4 |
| 16. Showed empathy to others and me. | 1 | 2 | 3 | 4 |
| 17. Demonstrated kindness during daily interactions with people. | 1 | 2 | 3 | 4 |
| 18. Showed a continued interest in applying improved methods of giving nursing care. | 1 | 2 | 3 | 4 |

***Original tool: Rauen, K. (1974). The clinical instructor as role model. *Journal of Nursing Education*, 13(3), 33-40.

Modified with permission from Karen Rauen.

Appendix D

Psychological Empowerment Scale (PES)

Psychological Empowerment Scale (PES)

Listed below are a series of statements that represents conditions of psychological empowerment. Please indicate the degree of your agreement or disagreement with each statement by selecting one of the five alternatives.

| | Strongly Disagree | Disagree | Neither Agree or Disagree | Agree | Strongly Agree |
|---|--------------------------|-----------------|----------------------------------|--------------|-----------------------|
| 1. The work I do is important to me. | 1 | 2 | 3 | 4 | 5 |
| 2. My job activities are personally meaningful to me. | 1 | 2 | 3 | 4 | 5 |
| 3. The work I do is meaningful to me. | 1 | 2 | 3 | 4 | 5 |
| 4. I am confident about my ability to do my job. | 1 | 2 | 3 | 4 | 5 |
| 5. I am self-assured about my capabilities to perform my work activities. | 1 | 2 | 3 | 4 | 5 |
| 6. I have mastered the skills necessary for my job. | 1 | 2 | 3 | 4 | 5 |
| 7. I have significant autonomy in determining how I do my job. | 1 | 2 | 3 | 4 | 5 |
| 8. I can decide on my own how to go about doing my work. | 1 | 2 | 3 | 4 | 5 |
| 9. I have considerable opportunity for independence and freedom in how I do my job. | 1 | 2 | 3 | 4 | 5 |
| 10. My impact on what happens in the department is large. | 1 | 2 | 3 | 4 | 5 |
| 11. I have a great deal of control over what happens in my department. | 1 | 2 | 3 | 4 | 5 |
| 12. I have significant influence over what happens in my department. | 1 | 2 | 3 | 4 | 5 |

Appendix E

Schutzenhofer Professional Nursing Autonomy Scale

Schutzenhofer Professional Nursing Autonomy Scale

The following items describe situations in which a nurse must take some action that requires the exercise of professional nursing judgment. You are asked to respond to each item according to how likely you would be to carry out the action in each item. Please respond to each item even if you have not encountered such a situation before. Use the following scale in responding to the items:

1 = Very unlikely of me to act in this manner

2 = Unlikely of me to act in this manner

3 = Likely of me to act in this manner

4 = Very likely of me to act in this manner

Select the number after each situation that best describes how you would act as a nurse. There is no right or wrong answer.

| | Very unlikely | Unlikely | Likely | Very likely |
|---|--------------------------|-----------------|---------------|------------------------|
| 1. Develop a career plan for myself and regularly review it for achievement of steps in the plan. | 1 | 2 | 3 | 4 |
| 2. Consider entry into independent nursing practice with the appropriate education and experience. | 1 | 2 | 3 | 4 |
| 3. Voice opposition to any medical order to discharge a patient without an opportunity for nursing follow-up. | 1 | 2 | 3 | 4 |
| 4. Initiate clinical research to investigate a recurrent clinical nursing problem. | 1 | 2 | 3 | 4 |
| 5. Refuse to administer a contraindicated drug despite the physician's insistence that the drug be given. | 1 | 2 | 3 | 4 |
| 6. Consult with the patient's physician if the patient is not responding to the treatment plan. | 1 | 2 | 3 | 4 |
| 7. Depend upon the profession of nursing and not on physicians for the ultimate determination of what I do as a nurse. | 1 | 2 | 3 | 4 |
| 8. Evaluate the hospitalized patient's need for home nursing care and determine the need for such a referral without a medical order. | 1 | 2 | 3 | 4 |
| 9. Propose changes in my job description to my supervisor in order to develop the position | 1 | 2 | 3 | 4 |

| | Very unlikely | Unlikely | Likely | Very likely |
|---|----------------------|-----------------|---------------|--------------------|
| further. | | | | |
| 10. Answer the patient's questions about a new medication or a change in medication before administering a drug, whether or not this has been done previously by the physician. | 1 | 2 | 3 | 4 |
| 11. Institute nursing rounds. | 1 | 2 | 3 | 4 |
| 12. Withhold a medicine that is contraindicated for a patient despite pressure from nursing peers to carry out the medical order. | 1 | 2 | 3 | 4 |
| 13. Consult with other nurses when a patient is not responding to the plan of nursing care. | 1 | 2 | 3 | 4 |
| 14. Routinely implement innovations in patient care identified in the current nursing literature. | 1 | 2 | 3 | 4 |
| 15. Initiate a request for a psychiatric consult with the patient's physician if my assessment of the patient indicated such a need. | 1 | 2 | 3 | 4 |
| 16. Promote innovative nursing activities, like follow-up phone calls to recently discharged patients, to evaluate the effectiveness of patient teaching. | 1 | 2 | 3 | 4 |
| 17. Assess the patient's level of understanding concerning a diagnostic procedure and its risks before consulting with the patient's physician if a patient has questions about the risks of the procedure. | 1 | 2 | 3 | 4 |
| 18. Assume complete responsibility for my own professional actions without expecting to be protected by the physician or hospital in the case of a malpractice suit. | 1 | 2 | 3 | 4 |
| 19. Develop effective communication channels in my employing institution for nurses' input regarding the policies that affect patient care. | 1 | 2 | 3 | 4 |
| 20. Develop and refine assessment tools appropriate to my area of clinical practice. | 1 | 2 | 3 | 4 |
| 21. Record in the chart the data from my physical assessment of the patient to use in planning and implementing nursing care. | 1 | 2 | 3 | 4 |

| | Very unlikely | Unlikely | Likely | Very likely |
|--|----------------------|-----------------|---------------|--------------------|
| 22. Initiate discharge planning concerning the nursing care of the patient, even in the absence of medical discharge planning. | 1 | 2 | 3 | 4 |
| 23. Report incidents of physician harassment to the appropriate manager or administrator. | 1 | 2 | 3 | 4 |
| 24. Offer input to administrators concerning the design of a new nursing unit or the purchase of new equipment to be used by nurses. | 1 | 2 | 3 | 4 |
| 25. Complete a psychosocial assessment on each patient and use this data in formulating nursing care. | 1 | 2 | 3 | 4 |
| 26. Adapt assessment tools from other disciplines to use in my clinical area. | 1 | 2 | 3 | 4 |
| 27. Carry out patient care procedures utilizing my professional judgment to meet the individual patient's needs even when this means deviating from the "cookbook" description in the hospital procedure manual. | 1 | 2 | 3 | 4 |
| 28. Decline a temporary reassignment to a specialty unit when I lack the education and experience to carry out the demands of the assignment. | 1 | 2 | 3 | 4 |
| 29. Initiate referrals to social service and dietary at the patient's request. | 1 | 2 | 3 | 4 |
| 30. Write nursing orders to increase the frequency of vital signs of a patient whose condition is deteriorating even in the absence of a medical order to increase the frequency of such monitoring. | 1 | 2 | 3 | 4 |

Appendix F

Permission Letter from Associate Director of Undergraduate Program

From: "Janice B. Flynn" <jflynn@kennesaw.edu>

To: "Chanell Watkins" <cwatki29@students.kennesaw.edu>

Cc: "Tommie Nelms" <tnelms1@kennesaw.edu>, "Cynthia D. Elery" <celery@kennesaw.edu>, "Patricia Hart" <phart@kennesaw.edu>, "Nicole Mareno" <nmareno@kennesaw.edu>, "Marilyn King" <mking71@kennesaw.edu>

Sent: Wednesday, July 31, 2013 4:27:08 PM

Subject: Re: Permission to Use Recent Graduate Email Addresses

Chanell,

I enjoyed your presentation today. You have done meaningful work on your thesis proposal. I do give you permission to use the email addresses of our BSN graduates from Spring 2010 to Spring 2013. As I mentioned to you some time ago, I did discuss your use of the addresses with Dr. Nelms. She was in agreement with me to allow you to use the email addresses. From your presentation today, I can conclude that you will protect the participants by obtaining IRB approval and building informed consent into your survey packet. The best method to obtain the addresses is to request the lists of graduates that goes to the Georgia Board of Nursing each semester. You can obtain these files from Ms. Cynthia Elery who has the spreadsheets in her electronic files. I will ask you to destroy the email addresses after use. This spreadsheet will also have the confidential data of birth dates as well, so please hold all the information in a confidential file. I wish you the best with your thesis. Let me know if I can be of additional assistance.

Dr. Flynn

----- Original Message -----

From: "Chanell Watkins" <cwatki29@students.kennesaw.edu>

To: jflynn@kennesaw.edu

Sent: Wednesday, July 31, 2013 2:53:34 PM

Subject: Permission to Use Recent Graduate Email Addresses

Dr. Flynn,

I am writing to request permission to use recent graduate email addresses as a method for recruitment for my thesis research. I would like to obtain email addresses starting with students graduating Spring 2010 through Spring 2013.

Please let me know if I have your permission to access these email addresses.

Thank you for your consideration,

Chanell Watkins, BSN, RN

Appendix G
First Email Solicitation

**Kennesaw State University
Wellstar School of Nursing
1000 Chastain Rd
Kennesaw, GA 30144**

Email Title: Kennesaw State University Graduate Student Request

Dear Colleague

My name is Chanell Watkins. I am a graduate student at Kennesaw State University. I am currently conducting a research study for my thesis requirement. My thesis advisors are Drs. Patricia Hart and Nicole Mareno.

I am investigating the relationships between preceptor's role effective and newly licensed RNs' perceived level of psychological empowerment and professional autonomy.

I am seeking 85 newly licensed registered nurses to participate in a survey. The entire survey will take approximately 15 minutes to complete.

If you are interested in being a participant in this study, please click on the link below to be taken to the survey.

[LINK GOES HERE](#)

If you have questions about the study, please feel free to contact me at the email address below. Thank you for considering this request.

Chanell Watkins, BSN, RN

nellnicole00@aol.com

Appendix H
Second and Third Email Solicitation

**Kennesaw State University
Wellstar School of Nursing
1000 Chastain Rd
Kennesaw, GA 30144**

Email Title: Kennesaw State University Graduate Student Request

Dear Colleague,

I am writing to remind you of the opportunity for you as a newly licensed RN to participate in my research study. I am a graduate student at Kennesaw State University. I am currently conducting a research study for my thesis requirement. My thesis advisors are Drs. Patricia Hart and Nicole Mareno.

I am investigating the relationships between preceptor's role effective and newly licensed RNs' perceived level of psychological empowerment and professional autonomy.

If you have already completed the survey, thank you. If not, you still have time to participate!

REMEMBER: it only takes about 15 MINUTES to complete the survey. If you are interested in participating in the study, click on the link below!

[LINK GOES HERE](#)

If you have questions about the study, please feel free to contact me at the email address below. Thank you for considering this request.

Chanell Watkins, BSN, RN

nellnicole00@aol.com

Appendix I

Permission to Use and Revise Clinical Instructor Characteristic Ranking Scale

From: "Rauen, Karen" <KRauen@chw.org>
To: "nellnicole00@aol.com" <nellnicole00@aol.com>
Subject: Permission Request
Date: Sun, Feb 3, 2013 8:18 PM

Hi Chanell,

You have permission to use the CICRS and adapt it for your research study, as long as you credit me as the original author. Good luck with your thesis. I would be interested in your findings.

Best Wishes, Karen Rauen, CNS

From: nellnicole00@aol.com [nellnicole00@aol.com]
Sent: Saturday, February 02, 2013 4:31 PM
To: Rauen, Karen
Cc: phart@kennesaw.edu; nellnicole00@aol.com
Subject: Permission Request

Hi Ms. Rauen,

I am conducting a research study for my thesis requirements, and I am seeking permission to use the Clinical Instructor Characteristics Ranking Scale in my research study. I would also like to have permission to adapt the instrument for use in my study. I will be sure and credit you as the instrument's author in my study. Please let me know if I have your permission to use the scale in my study.

Thank you for your consideration and time with this request.

Sincerely,
Chanell

Appendix J

Permission to Use the Psychosocial Empowerment Scale

From: "Gretchen Spreitzer" <spreitze@umich.edu>
To: <nellnicole00@aol.com>
Subject: Permission Request
Date: Sun, Feb 3, 2013 7:46 AM

Hello Chanell, yes you have permission to use the psychological empowerment instrument. Best wishes on your research.

On Sat, Feb 2, 2013 at 5:29 PM, <nellnicole00@aol.com> wrote:
Hi Dr. Spreitzer,

I am conducting a research study for my thesis requirements and I am seeking permission to use the Psychological Empowerment Scale in my research study. I will be sure and credit you as the instrument's author in my study. Please let me know if I have your permission to use the scale in my study.

Thank you for your consideration and time with this request.

Sincerely,
Chanell

Gretchen Spreitzer
Keith E. and Valerie J. Alessi Professor of Business Administration
Professor of Management and Organizations
Ross School of Business
Ann Arbor, MI 48109-1234
(734) 936.2835
<http://webuser.bus.umich.edu/spreitze/>

Appendix K

Permission to Use the Schutzenhofer Professional Nursing Autonomy Scale

From: mconmy@springerpub.com
To: "nellnicole00@aol.com" <nellnicole00@aol.com>
Subject: Permission Request
Date: Sat, Feb 2, 2013 8:03 PM

Dear Chanell,

Thank you for the request. You have our permission to use the scale in your thesis. All we require is you reference our title name, author, year published, and Springer Publishing Company, LLC.

Best regards,
Matt Conmy
Senior Sales Director
Springer Publishing Company. LLC.
Sent via BlackBerry by AT&T

From: "nellnicole00@aol.com" <nellnicole00@aol.com>
Date: Sat, 2 Feb 2013 17:26:39 -0500
To: sales<sales@springerpub.com>
Cc: phart@kennesaw.edu<phart@kennesaw.edu>;
nellnicole00@aol.com<nellnicole00@aol.com>
Subject: Permission Request

To Whom It May Concern,

I am conducting a research study for my thesis requirements and I am seeking permission to use the Schutzenhofer Professional Nursing Autonomy Scale in my research study. Please let me know if I have your permission to use the scale in my study.

- 1) Contact Name: Chanell Watkins
- 2) Email Address: nellnicole00@aol.com
- 3) Complete Mailing Address: 3780 Towne Xing NW Apt# 304, Kennesaw, GA 30144
- 4) Book Title You Are Requesting to Use: Waltz CF & Strickland OL (1990).
Measurement of nursing outcomes. (4 vols). New York, NY: Springer.
- 5) Author: Karen Kelly Schutzenhofer
- 6) All Pages You Are Requesting Permission to Use: 3-18
- 7) Reason for Permission Request: I am a graduate student conducting a research study for my thesis requirement.
- 8) ISBN: 0826152724

Thank you for your consideration and time with this request.

Sincerely,
Chanell