PRECEPTORING NEW GRADUATE NURSES IN EMERGENCY CARE: THE LIVED EXPERIENCE OF THE PRECEPTORS

JUNE TAVENOR

PRECEPTORING NEW GRADUATE NURSES IN EMERGENCY CARE: THE LIVED EXPERIENCE OF THE PRECEPTORS

by

©June Tavenor

A thesis submitted to the

School of Graduate Studies

in partial fulfillment of the requirements for the degree of

Master of Nursing

School of Nursing

Memorial University of Newfoundland

April 2013

St. John's Newfoundland

Abstract

Hiring of new graduates in nursing to work in the emergency department (ED) as their first nursing position is a fairly recent phenomenon. There is a vast amount of literature describing the experience of new graduate nurses employed in critical care and their experiences in preceptorship programs. However, there is limited literature specific to the ED and a paucity of literature describing the preceptorship experience from the perspective of ED nurses who act as preceptors to new graduates in emergency care. This study was designed with the purpose of describing the experiences of ED nurses who precepted newly graduated nurses. Phenomenology as desribed by Colaizzi was used to guide the study. Eight ED preceptors were interviewed using a semi structured interview guide. The findings consisted of six main themes and a number of subthemes. The main themes that were developed describe the lived experience of these eight ED preceptors: 1) meeting the challenges of teaching; 2) double the workload; 3) balancing responsibilities; 4) preceptor fatigue; 5) a reflection of preceptor competence; and 5) professional growth and strengthening practice. This study highlighted numerous areas where change is needed for ED preceptors. One of the main findings is the need for the preparation for the teaching role involved in preceptorship in order to meet the challenges inherent in this role. In order to continue to foster the future generations of nurses, especially in emergency care, it is important that the many challenges faced by ED preceptors are addressed. Implications are presented that could help improve the experience for ED preceptors, which would eventually lead to improved ED patient care.

Acknowledgments

I would like to acknowledge the invaluable assistance, advice, and support that were provided by the supervisory committee of this thesis. This committee included Dr. Shirley Solberg and Dr. Anne Kearney, both of Memorial University of Newfoundland. Completing a qualitative study would not have been possible without their expertise and guidance. I would also like to acknowledge the support and encouragement given to me by my mentor, Dr. Lianne Jeffs of St. Michael's Hospital in Toronto. I would not have the thirst for nursing research if it were not for her inspirational influence on my life.

Table of Contents

Page

List of Tables

Chapter 1

Introduction

Since the mid-1970s emergency nursing has been organized as a specialty within nursing and nurses recruited to work in specialty areas such as the emergency department (ED) have been required to have some prior clinical experience before they began to practice in that area (Schriver, Talmadge, Chuong, & Hedges, 2003). Hiring of new graduates in nursing to work in the ED, as their first nursing position, is a fairly recent phenomenon that continues to generate debate and discussion about the appropriateness of this approach (Winslow, Almarode, Cottingham, Lowrey, & Walker, 2009). However, as the nursing shortage begins to affect all nursing positions new graduate nurses are increasingly being hired to work in critical care areas, such as intensive care units (ICUs) and the ED, as their first nursing position (Berezuik, 2010; Jarman & Newcombe, 2010). The onus is on nursing leadership to help these new graduates become safe practitioners within a challenging environment (Spivak, Smith, & Logsdon, 2011).

Many hospitals are addressing the preparation of new graduates to work in ICUs and EDs by creating preceptorship programs as part of the orientation of the nurses (Baggot, Hensinger, Parry, Valdes, & Zaim, 2005; Elmers, 2010; Glynn & Silva, 2012). Although preceptorship has been used extensively in nursing education (Billay & Myrick, 2008), within orientation programs it was specifically designed to help the novice nurse or a nurse new to a practice area make a smooth transition to that practice (Baxter, 2010). Within these orientation programs preceptorship is usually a time-limited relationship between an experienced nurse and a novice nurse for purposes of helping the novice nurse

make a successful transition to a nursing role and what that role entails (Canadian Nurses' Association [CNA], 2004). Preceptorship is a formal relationship between a new graduate nurse and a senior nurse that provides individualized support to the new nurse on how to provide nursing care within a specific context. A preceptor is a "competent, experienced nurse who serves as a nurturer and educator for the new nurse" (Finger & Pape, 2002, p. 634). No statistics or estimates were located on how many senior nurses act as preceptors to new graduates, however in my own experience I have yet to encounter a nurse with more than one year experience who has not acted as a preceptor in the ED.

The principles of preceptorship are the same across all clinical areas of nursing, however the unpredictable and critical nature of the ED makes preceptorship of new graduate nurses in this area more challenging for both teacher and learner alike (Considine & Hood, 2004). There is a growing amount of literature describing the experience of new graduate nurses employed in critical care and their experiences in preceptorship programs (Chesnutt & Everhart, 2007; Finger & Pape, 2002), however, there is limited literature specific to the ED and a paucity of literature describing the preceptorship experience from the perspective of ED nurses who act as preceptors to new graduates in emergency care. This study is designed to describe the experiences of ED nurses who precept newly graduated nurses.

Background

In 2007, the Canadian Nurses' Association (CNA) reported a national nursing shortage of 11,000 registered nurses (RNs). Further predictions put the Canadian nursing shortage at 60,000 by 2022 (CNA, 2009a). A study by the US Department of Health and Human Services predicted that by 2020 the nursing shortage in that country will be

808,000 (US Department of Health and Human Services, National Center for Health Workforce Analysis, 2002). The nursing shortage is widespread with many countries affected (Littlejohn, Collins-McNeil, & Khayile, 2012; Oulton, 2006).

The nursing shortage affects many areas of clinical practice but may affect critical care and emergency nursing more severely and differently than perhaps in other clinical areas of nursing (Morphet, Considine, & McKenna, 2011; Zolnierek & Steckel, 2010). There are a number of reasons cited for why critical care areas are more adversely affected (Cartledge, 2001; Robinson, Jagim, & Ray, 2004). Among the reasons are the increased demand for nurses in these areas because of developments in technology for treatments and procedures that increase the demand for critical care usage, the trend for greater non emergent used of EDs than previously, and the rapid turnover of nurses in these areas.

Critical care units, including EDs, have a unique environment that encompasses very sick patients and a very fast pace (Robinson et al., 2004). Many nurses are drawn to critical care and emergency nursing because of the excitement and the challenges inherent in these clinical areas and as a consequence these nursing positions would seemingly be the easiest to fill. However, Buerhaus, Staiger, and Auerbach, (2000) suggested that some specialty care units were areas where the nursing shortages were more acute than in other clinical areas. The difficulty in keeping critical care positions filled with experienced nurses might in part be because of an aging nursing workforce, and a greater number of retirements, coupled with the trend that intensive care units appear to be attracting younger RNs (Buerhaus et al., 2000). Other factors such as job satisfaction and burnout or risk of burnout are reasons why some ED nurses leave or intend to leave their positions

(Hauck, Quinn Griffin, & Fitzpatrick, 2011; Sawatzky & Enns, 2012). More than 50% of the RN workforce in the US is older than 45 years (Hill, 2011). In 2005, 36.3% of ED nurses in Canada had reached eligibility age for retirement (CNA, 2007).

A popular alternative to the unavailability of experienced nurses in critical care areas, including EDs, is hiring and orientating new graduates directly into these patient care areas (Bechtel, Butler, & Kurz, 2006; Everhart & Slate, 2004; Morphet et al., 2011). The debate regarding the suitability of new graduates beginning their practice in critical care nursing is ongoing, with some feeling that the learning curve of becoming a practicing nurse is challenging enough without the added stress of caring for critically ill patients (Bechtel et al., 2006; Duchscher, 2001; Ramritu & Barnard, 2001). However, other authors maintain that this is an effective recruitment strategy that will ensure the needs of critically ill patients will be met with eagerness, competence, and skill (Allegra, 2002; Mitiguy & Rotondi, 1991; Porte-Gendron, Simpson, Carlson, & Vande Kamp, 1997). Reports of successes of preceptorship programs for new graduate nurses in EDs from all over the world are becoming more common in the literature (Gurney, 2002; Kingsnorth-Hinrichs, 2009; Salonen, Kaunonen, Meretoja, & Tarkka, 2007; Schmidt, Giovanelli, & Palazollo, 2003).

In Canada, the number of nurses working in EDs rose from 14,884 in 2005 to 16,015 in 2007 (CNA, 2009b). Although there is no breakdown of the data to indicate how many of these ED nurses are new graduate nurses, it might indicate that ED recruitment strategies targeted towards this particular cohort of nurses in Canada are working. The use of strong preceptorship programs may be contributing to improving retention of these ED nurses (Bechtel et al., 2006; Betts, 2003; Gurney, 2002; Loiseau,

Kitchen, & Edgar, 2003; Ollier, 2004; Robin, 2006; Valdez, 2008; Wolf, 2006). However, there is a continuing loss of experienced ED nurses, whose knowledge and expertise is crucial to the successful development of new graduate emergency nurses, and critically important to the success of strong preceptorship programs.

Nursing practice environments can be described as "the organizational characteristics of a work setting that facilitate or constrain professional nursing practice" (Lake, 2002, p. 178). Critical care and emergency nursing settings have been demonstrated to have unique characteristics that contribute to higher levels of physical and emotional demands on nursing staff (Wilkin & Slevin, 2004). These characteristics include increased patient acuity, increased conflict among members of nursing staff, frequent ethical concerns and dilemmas, and increased educational requirements, including specialty knowledge when compared to nursing on other patient care units (Dunn et al., 2000; Hurst & Koplin-Baucum, 2005; Morphet et al., 2011; Robichaux & Clark, 2006; Robichaux & Parsons, 2009; Wikstrom & Larsson, 2003; Wilkin & Slevin, 2004). The ED and critical care environments have been known for some time to make nursing in these areas more susceptible to nursing staff turnover (Cartledge, 2001).

The nature of ED nursing differs from critical care in intensive care units because of the unpredictability of when patients will present to the ED, the severity of illness or injury present, and the care requirements of vulnerable patient populations (Adriaenssens, DeGucht, Van Der Doef, & Maes, 2011). Patients in the ED can include those who have unknown or undiagnosed infectious diseases, are unable to provide histories because of alcohol or illegal drug use, present with self harm issues, and who increase the risk of violence against nurses in EDs (Corbett & McGuigan, 2008; Dawood, 2008; Mills, 2008;

Palmer, Blackwell, & Hinchcliffe, 2008). These factors coupled with the fast pace and increased pressure to decrease patient wait times create uncertainty and increased stress when providing critical care nursing to patients in the ED (Arslanian-Engoren, 2000; Sedlack & Roberts, 2004).

Study Rationale

With preceptorships in the ED becoming a more common phenomenon in the workplace as a means of integrating new nurses into the ED, it is important that we understand what the experience is like for the preceptors. Because of the importance of preceptorship of new graduates for the development of future ED nurses, and the potential impact of acting as a preceptor on the retention of experienced RNs, it is equally important we understand the preceptorship experience from the point of view of the preceptors. A better understanding of the preceptorship experience in critical care, and specifically emergency nursing, may lead to the development of strategies to improve the experience of being a preceptor in this environment, and therefore improve the retention of experienced ED nurses. Insights into the preceptors' experiences in turn may improve the experience for the preceptee as well.

I took time while preparing to do this research to reflect on and examine my own presuppositions about being a new graduate nurse in emergency care, the preceptorship program at this hospital, and the experience of being a preceptor in the ED. Colaizzi (1978) described the importance of the exercise of reflection prior to beginning research on a phenomenon to identify why the phenomenon is of interest to the researcher, and uncover any hidden benefits of doing the study for the researcher. When I graduated from nursing school in 2005, I was hired by the hospital in this study to work in the ED as a

new graduate. I participated in a six month orientation preceptorship with a senior ED nurse, who had over 20 years of ED experience. Exposure to many of the dramatic life and death patient care situations of this ED, and observing the struggles of disenfranchised patient populations was challenging for me to cope with because of my lack of exposure to such human conditions but my preceptor was able to assist me in making a positive adaptation. I found the preceptorship to be a fast and steep learning curve during which I completed several self study modules and participated in classroom activities with another new graduate hired at the same time as well as two newly hired experienced nurses. I found great comfort and inspiration in the number of nurses in the department with one or two years experience who were also new graduates in the ED. I also felt support from the other new graduate who started at the same time I did. However, I also experienced occasional covert intimidation from senior nursing staff who did not entirely agree that new graduates were appropriate in the ED. I remember feeling very uncomfortable and hesitant when I would need to ask or rely on these less supportive nurses for help. The ED also had a few experienced nurses who were supportive of new graduates, including my preceptor, and I was able to complete the six month program successfully.

Approximately one year later, I was asked to be a preceptor for a student nurse in her undergraduate clinical consolidation. I was a preceptor to undergraduate nursing students on two other occasions. I enjoyed the process because I take pleasure in teaching and I feel I am able to improve my own skills and knowledge when challenged to do so because of the presence of a nursing student. When I had been a practicing ED nurse for three years, I was asked to preceptor a new graduate nurse. This experience was more

challenging than having a nursing student because of the pressure associated with knowing that I was responsible for teaching another nurse to function effectively in the emergency department. I was acutely aware of how my colleagues associated her performance and attitude with me. During the six months, I approached the educator about concerns over this new graduate, such as not picking up speed in her skills or her lack of demonstration of critical thinking. I was assured this would develop over time, but I still felt my colleagues judged me because the new graduate was not fast enough in the ED environment.

Clinical practice can be a source of research questions for nurses (Elliott, 2004), and my experience as a new graduate nurse in the ED and later my experience as a preceptor to a new graduate nurse was the source of my research question for this study. I wondered how my experience compared with that of other colleagues in the ED who had been a preceptor. Additionally I felt that although there was attention paid to the needs of new graduate nurses in this ED, the preceptor program was lacking in a number of ways because there seemed to be no obvious concern for the preceptors and what they were experiencing. Based on my personal experiences as both a preceptee and a preceptor and the available literature, I believe there is a definite need to explore and describe the lived experiences of preceptors in the ED.

Purpose of Study

The purpose of this study is to describe the lived experience of emergency nurses who preceptor new graduate nurses. In order to understand the lived experience of these preceptors, a descriptive phenomenological approach as described by Colaizzi (1978) was used.

Chapter 2

Literature Review

I performed a review of the literature to identify what research had been conducted on the experiences of nurses who have acted as preceptor to new graduate nurses in the ED. The search included critical care and acute care nursing because available research specific to the ED was limited. I used the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Embase, and PubMed databases for my literature review. The combinations of keywords I used for the literature search included "preceptorship and nursing" (1785 results), "preceptorship and new graduate nurses"(404 results), "new graduate nurses and emergency" (74 results), "new graduate nurses and critical care nursing" (148 results), "preceptorship and critical care" (170 results), and "preceptorship and emergency" (28 results).

The research on preceptorship and nursing is extensive. The majority of the research studies are related to the preceptorship of students. There is less research on preceptorship of new graduates or nurses who are new to a practice area. In much of the research on precepting new graduates, the experience of the new graduate was the focus of the study (Duchscher, 2001; Eigsti, 2009; Johnstone, Kanitsaki, & Currie, 2008; Patterson, Bayley, Burnell, & Rhoads, 2010; Ramritu & Barnard, 2001; Schumacher, 2007). However, some research was found on the experience of the staff nurse as the preceptor of the new graduate (Richards & Bowles, 2012). A few studies included nurses who had been a preceptor to both staff nurses, who were new to a clinical area, or new graduate nurses. While there seems to be a paucity of research describing the experience

of preceptorship in the ED or ICU from the point of view of the preceptors, the bulk of the literature from the ED and critical care has focused on the implementation and evaluation of new graduate nurse preceptorship programs and these articles are included in this chapter.

This chapter is divided into two main sections: (a) studies focused on the preceptor experience and (b) those focusing on both preceptor and preceptee experience. In each section, I will highlight any research in the ED setting. The literature dealing solely with precepting nursing students within their educational programs was excluded from this chapter, as was the literature on precepting new nurses in community health settings, because both of these experiences, while they might have some similarities, were thought to differ in important ways from the focus of this study (Smedley, 2008). Many of the former studies (i.e., precepting student nurses) have been included in systematic reviews of the literature (Omansky, 2010).

Research on Preceptor Experience

There were some research studies located on the preceptor experience, however there was no research that specifically addressed the experience of being a preceptor to a new graduate in the ED. There were also some studies that evaluated preceptor programs and if these studies included findings related to the preceptors' experiences they were included.

Evaluation of preceptor programs.

One Canadian evaluation study was found that evaluated new graduate nurse preceptorship program in the ED (Loiseau et al., 2003). The preceptors in this study commented on what could be considered both positive and negative aspects of the role.

While they felt being a preceptor was growth enhancing from both a professional and personal perspective, they did feel at times they were being pressured to increase their patient load.

A second evaluation study that focused on preceptors was from New Zealand (Hagerty, Holloway, & Wilson, 2012). The aim in this study was to evaluate how well preceptors in a country wide initiative, designed to integrate new nurses into practice, felt they were both prepared for and supported in this role. Key findings related to either the program design or experience as a preceptor. The preceptors felt the program did not always prepare them well for the role in that not all had the ability to attend the scheduled education sessions and those that attended did not feel the sessions prepared them to be preceptors. They would have liked more information about what was expected of them as preceptors. Furthermore the criteria for selecting preceptors were not clear and there was general agreement that not all nurses made good preceptors. Some also felt that they were precepting in an unsupportive environment. They felt their workload was increased and they did not have the time they needed to discuss issues related to practice with new nurses or complete the required documentation. They stated they would also have liked more clarity around expectations of new graduate performance.

Preceptor experience.

An early study on the experience of preceptors for new graduates was conducted by Stevenson, Doorley, Moddeman, and Benson-Landau (1995) and focused on the positive and negative aspects found in this relationship. The 30 nurses who took part came from a variety of clinical areas within a teaching hospital, including critical care. The main rewards that the preceptors identified were the satisfaction they felt from their teaching

and the observable progress of the preceptee. They believed being a preceptor contributed to their personal growth and knowledge and they appreciated the recognition of being chosen for the role. Participants in the study did experience negative aspects of taking on the preceptor role and these were mainly related to the amount of time it took to teach, the increased workload that went with the role, the stress that resulted from the additional work, less contact with their patients, and a lack of recognition in any way for being a preceptor. The nurses were asked specifically how taking on the role of preceptor affected how they practiced. They identified a growth in their knowledge, improvement in care to patients, and overall improved sense of self and particularly in that of being a role model. Preceptors included in the study had acted as preceptors to both new nurses and nursing students and so the findings were generic to both groups. It would have been helpful if the experience varied by preceptored group and in what way.

Other researchers with a focus on positive and negative aspects of the preceptor role have had similar findings to those of the study by Stevenson et al. (1995). For example, Hautala, Saylor, and O'Leary-Kelley (2007) studied both the stress and support that preceptors experienced. They studied 65 nurses in acute care areas who precepted either nursing students or new nurses, or both. Although some findings related more to nursing students, generally findings were not separated according to type of preceptee. Most of the respondents reported some degree of stress (from mild to extreme) related to preceptorship with the sources related to increased workload, a lack of clinical competence and confidence in the preceptee, and a lack of support and recognition for the preceptor at the organizational level. Despite indicating that they did feel supported at the unit level, critical care nurses in this study also indicated that the stress of being a

preceptor is increased when their patient load included a patient with an unstable condition who required extra attention and monitoring. ED was not specifically mentioned. Most of the respondents (65%) were from critical care, followed by general medicine and surgery (23%), and the remaining 12% came from specialized units.

Findings reported in other nursing research studies supports those related to preceptors that have been identified in the studies by Stevenson et al. (1995) and Hautala et al. (2007). Morris et al. (2007) asked preceptors for feedback about their experiences with new graduates in a critical care orientation program. The preceptors noted that they felt overwhelmed by several issues, including their perceptions of wasting time teaching what should have been taught in nursing school, the lack of time management skills by new graduate nurses, the variability in new graduate work ethic and competence, and a perceived lack of initiative in the new graduates. The preceptors also expressed concerns about the lack of support for preceptors at the unit level.

In two other studies, researchers explored preceptor perceptions of new graduate nurses (Hickey, 2009; McNeish, 2007). Although these studies focused more on information pertaining to the new graduate nurse, some of the findings presented revealed something of the experience of the preceptors. McNeish's (2007) phenomenological study of five labour and delivery nurse preceptors identified several concerns of preceptors about new graduate nurses. The preceptors felt that a new graduate nurse who asks questions was easier to evaluate and one that they felt was safe working in the clinical area. Hickey's (2009) study of 62 preceptors explored how these preceptors perceived the readiness for practice of new graduate nurses. The preceptors in this study expressed concern over the selection and training of preceptors, such as preceptors not

being volunteers, as well as a perception that the new graduates lacked some basic nursing skills. Although the author did not indicate how many of the preceptors were from critical care or the ED, a few of the preceptors reported that new graduates going into these areas needed stronger skills in organization, basic assessment, and time management, echoing concerns expressed in the literature by Morris et al. (2007).

In a study to identify the impact of preceptor coaching on new graduates' critical thinking Forneris and Peden-McAlpine (2009) identified some concerns of the preceptors. Their case study research followed six preceptors as they participated in preceptor training to help increase the development of critical thinking in new graduate nurses. These preceptors were afraid of giving the new graduate increased independence, and felt more comfortable about the safety of the new graduate when she or he tended to ask more questions. Asking questions was seen as positive by the preceptors because they believed the new graduates needed to build on their knowledge from undergraduate training. Preceptors were frustrated by the lack of time available to sit and discuss what they were teaching with the new graduates. They were frustrated when they perceived the new graduate to be working too slowly. However the training given to the preceptors or their experience in this case study research was seen by the preceptors as having many benefits for them. They felt that by helping a new graduate nurse develop critical thinking skills, they were able to refine their own critical thinking. In addition the open dialogue involved in this program helped the preceptors to put into words some of the more intrinsic thinking behind nursing actions. This finding is similar to that of Sorenson and Yankech's (2008) study of preceptors and their finding that preceptors demonstrated improved teaching skills in their work with new graduate nurses after receiving training. Sorensen

and Yankech implemented a program to help improve the critical thinking skills of new graduate nurses. They studied the perceptions of the 15 preceptors and revealed that nurses are often presumed to be skilled teachers, when they may not be.

The perspective of preceptors was explored in Nicol and Young's (2007) innovative study in Australia. The researchers developed a program that placed the preceptors, who were far removed from being new graduates themselves, in a completely unfamiliar setting and forced them to learn to sail a sailboat with the associated environmental and time challenges. Although the study did not explore the experience of preceptors and their work with new graduate nurses, the 23 preceptors who participated in this study described how they would now approach being a preceptor differently. The training gave them some transferable skills, such as a refined concept of empathy for new graduates, as well as increasing their patience level when a new graduate was taking more time with skill acquisition. The participants felt they would be more aware of letting the new graduate perform tasks without constant supervision, while ensuring the graduates knew the preceptor was still available when needed. The participants noted how they relied on regular and constructive feedback from their instructors. Clear expectations, time, and patience were all noted by the participants as virtues they would bring back to their work with new graduate nurses.

Chen, Duh, Feng, & Huang's (2011) study used a phenomenological approach with 15 preceptors to explore their experiences training new graduate nurses. The researchers identified three major themes as a result of the study. The first theme related to the identification of multiple teaching strategies that would assist new graduates. Preceptors noted that they would rehearse a situation with the new graduate prior to allowing them to

complete a procedure to increase patient safety. Additionally they discussed the importance of providing new graduate nurses with real learning opportunities to facilitate practicing clinical skills. Within the theme related to teaching strategies, preceptors noted the importance of being able to employ various methods of evaluation.

The second theme to come out of Chen et al.'s study (2011) addressed how preceptors felt burdened by their role. They experienced role conflict because they were now not only providing care to patients, but teaching new graduate nurses was added to this role of care provider. Participants reported various feelings related to this role conflict including guilt and lack of control. Preceptors felt they were unable to do an adequate job in either role because of the workload and lack of time. The burden of the preceptor role was experienced as a fear of failing as a preceptor as well as self doubt because of criticism from nurse colleagues. There was a general lack of support from colleagues noted by preceptors. Preceptors felt overloaded and unprepared to fill out paperwork related to the new graduate nurse, such as evaluations of the new graduate. Preceptors placed pressure on themselves, especially when a new graduate nurse was not progressing according to the anticipated time frame of the hospital. It was frustrating for preceptors when new nurses were taking a long time to learn concepts.

The third theme the researchers explored described the sense of achievement felt by preceptors when they saw how the new graduate improved over time (Chen et al., 2011). As the new nurse increased in confidence and competence, the preceptor felt gratified in their role. There were positive experiences such as emotional satisfaction when the preceptor knew that the new graduate trusted them. The experience of self-growth for preceptors was described as a sense of responsibility that motivated the preceptor to

prepare for teaching, as well as keeping current with nursing knowledge. The preceptors acknowledged how this knowledge improved their own patient care.

In a second and recent phenomenological study Richards and Bowles (2012) reported that the essence of the preceptors' experience they studied was the altruism that resulted as they contributed to the nursing profession through their work as preceptors. Their main themes were professional commitment, raising our young, and bridge between the book and the bedside. In the subthemes developed under each of the main themes the participants expressed how they believed they had contributed to the profession, the preceptee or new nurse, and to good patient care.

Precepting both new nurses and students.

At least one of the research studies on preceptors included both new nurses and nursing students. Hyrkas and Shoemaker (2007) compared a group of 55 nurses who mainly precepted newly hired nurses with a group of 27 nurses who precepted nursing students. However, the bulk of the study data did not separate out preceptors by type of preceptee. Regardless of type of preceptee, both groups demonstrated greater commitment to being a preceptor if they perceived a higher level of reward for the role. Nurses who acted as preceptors to nursing students reported a significantly higher level of support from nursing coordinators than their peers who were preceptors to new graduate nurses. The nurses who precepted new nurses were significantly less likely to believe their colleagues understood the goals of being a preceptor and that they had an appropriate workload when precepting than the comparison group of nurses precepting nursing students. Although not statistically significant, other trends in mean score suggested that precepting new nurses did differ from the experience involving nursing

students. Preceptors to new graduates perceived less time available for them to carry out their role, that they were less likely to have adequate preparation for the role, and that their roles as preceptors were unclear.

Within the same study, Hyrkas and Shoemaker (2007) explored preceptors' perceptions of their role. The new nurse preceptors and student nurse preceptors were compared on selected data such as attendance at preceptor workshops. This study collected data at two points, six months apart, and suggested that while preceptor perceptions of benefits improved over time, they felt less supported in the role. The authors found a positive correlation between perceived rewards of being a preceptor and commitment to the role. As well, the more support perceived by a preceptor, the more committed they were to the role. However, the authors noted that there was a relationship between those preceptors who attended the workshop and higher perceptions of support. The authors highlight an interesting point, i.e., that those preceptors who are the most enthusiastic about being preceptors are the ones who attended the training. These enthusiastic preceptors are therefore most likely also those who completed the study survey, which could be considered a limitation of the study.

Research on Preceptor and Preceptee Experience

A number of studies I explored focused on both preceptor and preceptee experience. Although these studies include data outside preceptors and specifically their experience, the findings nonetheless contribute to information about preceptorship, and therefore to the experience of preceptors. This section of the literature review will mainly focus on the preceptor's experience.

Reising's (2002) study on the socialization of new graduate nurses in critical care included interviews with two nurse preceptors to describe the orientation process more fully and comment on the readiness of the new graduate. The preceptors in this study clarified that they have a job and responsibility to ensure that the new graduate nurse is ready for practice at the end of preceptorship. The teaching strategies the preceptors used helped the new graduate move away from task-oriented work, and move them towards problem solving and prioritization. In terms of evaluation, preceptors noted that they would look for "red flags" such as overconfident or unmotivated new graduate nurses as an indication of unsafe practice (Reising, 2002, p. 23). A similar study, conducted by Reddish and Kaplan (2007), examined the transition process of new graduate nurses, and identified when these nurses were competent in critical care. Data from preceptors included their role in evaluating if a new graduate was overwhelmed versus excited in the beginning of the orientation process. This study revealed that preceptors are frequently relied upon to provide a "safe and nurturing learning environment" for the new graduate nurse, while at the same time challenging them to expand their learning (Reddish & Kaplan, 2007, p. 203).

Clark and Holmes' (2007) research involving practice development nurses, preceptors, and preceptees has examined how newly graduated nurses develop competencies over the first six months of practice. The authors did not indicate the practice area of the preceptors or preceptees. Preceptors described how they believed the new graduate nurses were not prepared for practice. Preceptors voiced a concern that the orientation program for these new graduates focused too much on forcing the new graduates to manage their workload, instead of helping them to master basic nursing care

skills. Preceptors explained that they had to adjust their teaching approach to focus on what skills the new graduate nurse could not do. They described how evaluation of new graduates was largely based on intuition, and that they would gradually afford the preceptee more independence. An interesting finding in this study was that preceptors themselves had varying opinions of what the new graduate nurses should focus on for learning or be capable of performing. The preceptors acknowledged the growing number of junior staff on the nursing unit and were concerned about knowing what to teach to the new graduates.

Another recent study focused on safety concerns of new nurses in acute care and examined these concerns from the perspective of both the preceptor and the preceptee (Myers, Reidy, French, McHale, Chisholm, & Griffin, 2010). Although this study did not focus on preceptor experience, preceptors were included in data collection, and the findings clearly highlight many concerns of preceptors of new graduate nurses. Preceptors expressed concern about the ability of new graduates to perform a thorough and accurate assessment. Findings indicated that preceptors in this study felt new graduates were poorly prepared for practice. Two concerns of preceptors were that new graduates nurses were not aware of their own knowledge deficits and also that they were not keen to ask questions. Preceptors found that teaching new graduates was stressful, and that the lack of time to provide care and to teach was a source of this stress.

Evaluation of preceptorship programs contributes to our understanding of aspects preceptorship. Evans, Boxer, and Sanber (2008) have conducted research to evaluate existing support programs for new graduate nurses. These researchers sought to determine the strengths and weaknesses of a program, and used one-on-one interviews with 9 new

graduates and 13 experienced nurse preceptors. The findings from the preceptors indicated that the workload of the nurses was too high to give adequate support to new graduate nurses. These experienced nurses expressed concern that undergraduate nursing programs are too theoretical, and perhaps not relevant to the practice nursing. The contribution of preceptors was identified as a strength of the program in this study. The preceptors were more valuable to the new graduate nurses when the preceptorship role was voluntary and when the personalities of the preceptor and preceptee were compatible. A lack of recognition and no reduction in workload for preceptors discouraged nurses from future preceptoring.

In Fox, Henderson, & Malko-Nyhan's (2006) study, the authors compared the perceptions of preceptors and the perceptions of preceptees in regards to the preceptor role. The data collection took place at two separate time intervals during the preceptorship relationship. The preceptors reported at both time intervals that they felt supported by other staff in their role as preceptor. The authors do not identify exactly who made up the category of staff, but it can be assumed that nursing colleagues would be included. The findings of this study are inconsistent with the findings of the studies reported above where preceptors felt they were criticized and judged by their colleagues. At the first time interval, more than half of the preceptors felt they were unable to meet their role expectations as preceptor. Although the demands and workload associated with the role of preceptor has been previously described, the preceptors in this study indicated that this feeling diminished over time. This improved sense of meeting their roles may have been because of the increasing independence of the new graduate nurse as time passed, or maybe more "realistic expectations" in their role as preceptor (Fox et al., 2006, p. 364).

Researchers have examined the effect of preceptorship programs on nursing turnover rates and the associated health care costs. Lee, Tzeng, Lin and Yeh's (2009) study, from Taiwan, reported on the design and evaluation of a preceptorship program. Although this study did not focus on the experience of preceptors, the data collected from preceptors indicated that when they were unable to balance the rewards of preceptorship with the associated stress, thus their loyalty to the organization was affected. The findings included decreased turnover rates, decreased cost to the organization because of the lower turnover, decreased medication errors, decreased adverse events, and preceptee satisfaction.

Summary

The current nursing literature describing the experience of being a preceptor to a new nurse indicated there are both positive and negative aspects associated with this role. Studies that have explored the role of the preceptor reported that the role can be personally fulfilling and professionally enriching. However, it can be stressful as well, and while preceptorship is identified as a source of stress for new graduate nurse preceptors, the specific causes of the stress are ambiguous in the research, and, as such, need to be examined further. Preceptors often report an increased workload leading to a feeling stressed. Furthermore, the degree of stress experienced and factors leading to a stressed state most likely vary depending on the environment.

What appears to be missing from the current published literature is a focus on the ED environment within the context of the preceptor role for new graduate nurses. Some of the studies reviewed above involved critical care nursing, and while there are similarities exist between the two environments (i.e., the acuity of patients), the ED

setting itself can create additional challenges in the preceptor role. It is worth noting too, that there are limited studies that focus on critical care, increasing the need for a specific study on the ED environment (i.e., there are limited studies available for which to make broader similar comparisons based on work environment). Noting the challenges preceptors face in non-ED environments, while insightful, may not necessarily relate to the high-pace, critical nature environment of the ED. For example, how would acting as a preceptor in the ED environment affect preceptor stress levels?

Most of the literature that does mention ED and critical care focused on the program itself (i.e., implementation and evaluation of new graduate nurse preceptorship) and not the preceptor experience. Knowing best practices for program implementation is important, but can only be successful if it takes into account the perspectives of the participants. A clear examination of preceptor experience in an ED setting, from the point of view of participating preceptors, is needed to specifically identify both current challenges felt by preceptors and recommendations that would improve the experience of being an ED preceptor. Improving the ED preceptor experience would have an overall positive effect on the overall well being of the ED environment itself.

Chapter 3

Methodology

In this study I explore the lived experience of experienced emergency nurses who preceptor new graduate nurses. A descriptive phenomenological approach as described by Colaizzi (1978) was used. Phenomenology is the study of the essence of lived experiences, where a lived experience is what an individual takes to be true in his or her own life (Chamberlain, 2009). Spiegelberg (1975) depicted descriptive phenomenology as a method that improves the understanding of lived experiences as described by individuals by emphasizing "the richness, breadth, and depth of those experiences" (p. 85). The qualitative method selected was able to assist in describing the everyday experience of emergency nurses preceptoring new graduates. Colaizzi described the importance of experience and phenomena not being defined by others. He stated that denying an experience as described by the individual who lived the experience is to not be objective, and true objectivity is "a respectful listening to what the phenomenon speaks of itself" (Colaizzi, 1978, p. 52). I interpreted Colaizzi here to mean that in order to obtain a true description of the experience, I as the researcher must listen to how the preceptors described the experience of preceptorship and present it as closely as possible to their experiences.

Study Setting and Context

The facility where this study was conducted is a hospital in Toronto, Ontario. It is a level one trauma facility with ED specific protocols for and specialization in the care of patients suffering from general trauma, neurosurgical trauma, trauma in pregnancy, acute

myocardial infarctions, and acute strokes among other varied conditions. The hospital is well recognized for its care of the inner city population of downtown Toronto and those patients experiencing acute mental health issues. Patients from other programs in the hospital, such as hemodialysis, respirology, infectious diseases, and renal transplant are frequently cared for in the ED. While there are other preceptorship programs in the hospital, the format of the new graduate nurse preceptorship program in the ED is a six month orientation program where the new graduates work a full-time schedule. Within these full time hours the new graduates spend the bulk of their time on the floor with a single designated preceptor. This preceptor is an experienced emergency nurse, generally with at least three years of experience. The time spent in the clinical area with a preceptor is divided among the three care areas of the ED at the hospital. These areas are minor, which handles the least acute injuries and illness such as extremity injuries and requests for diagnostic tests; intermediate, which treats abdominal pain, gynecological and prenatal emergencies, and mental health emergencies; and major, which treats the most acute patients, such as acute myocardial infarctions, cardiac arrests, and acute stroke. Patients experiencing trauma, which are the most severely and complexly injured patients, either as "fresh" from the scene of the trauma or as a transfer from peripheral hospitals, are covered by one nurse from the major area and a second nurse from the minor area. The time spent in the ED with a preceptor is a process that begins with the new graduate initially following the preceptor very closely. Gradually, the patient load of the new graduate is increased. New graduate independence is individualized and adjusted with time over the six month program at the discretion of the preceptor. Within the full time schedule any time not spent with the preceptor is spent in a classroom environment

with the ED clinical educator. The classroom content includes theory as well as "hands on", for example, practice with commonly used ED equipment. Experts in different aspects of emergency care, such as the geriatric emergency management nurse, also provide teaching to the new graduates during their orientation period. The clinical leader manager, clinical educator, preceptor, and new graduate nurse aim to meet every two weeks when possible to discuss the progress of the new graduate and identify concerns that any of the involved parties may have. Extra time for the new graduate in this preceptorship program is considered if near the end of the six months, it is determined that an extension of time would benefit the new graduate and the ED. This extension of time is rare, but is an option presented to a new graduate who is not ready for independent practice at the end of the scheduled preceptorship period.

Participants and Recruitment

The participants in this study were experienced ED nurses who had preceptored a new graduate nurse. Inclusion criteria for this study included those nurses who have worked in an ED for at least three years and have acted as a preceptor to a new graduate nurse in the ED in the 12 months prior to recruitment. Three years was chosen as the minimum years of experience based on a competency checklist for critical care and ED nurses that defined a nurse with three full years of experience as being ready to act as a preceptor (Bourgault & Smith, 2004). In order to obtain rich and expansive data on the phenomenon, my goal was to include eight to ten participants (Colaizzi, 1978). ED nurses working in a large Toronto academic health science hospital who met the inclusion criteria were invited to participate in the study. The nurses were purposely selected because of their intimate knowledge of the research topic. Colaizzi (1978) described how

"experience with the investigated topic and articulateness suffice as criteria for selecting subjects" (p. 58).

The ED nurses were invited to participate in the study through an invitation letter attached to their paystubs, and through posters that were placed in the nurses' lounge, encouraging interested nurses to contact me (see Appendices A and B). A consent form was attached to the paystubs. The ED at this hospital has dedicated administrative personnel who oversees payroll. This individual attached the recruitment letters to the paystubs of all registered nurses on staff in the ED of the hospital. One month later, the administrative personnel repeated this process a second time, where the same invitation letter was again attached to the paystubs of the registered nurses. At the time when potential participants contacted me, the purpose and methods of the research were explained. Over the course of three months, nine nurses contacted me to participate in the study. I was able to schedule and complete eight interviews. The ninth participant expressed regret, but was unable to participate because of scheduling conflicts and child care demands.

Data Collection

My experience and presuppositions with the phenomenon of acting as a preceptor to new graduates in emergency care provided me with a "preliminary basis by which I could formulate my research questions" (Colaizzi, 1978, p. 58). In keeping with phenomenology as method, I conducted interviews comprised of open-ended questions that were designed in an attempt to elicit descriptions of the phenomenon of acting as a nursing preceptor to new graduates in ED from those who have experienced the phenomenon firsthand. An interview guide was drafted to assist and guide discussions

(see Appendix C) if required. Data were collected using individual interviews, one per participant, scheduled for one hour each in length. The actual length of the interviews ranged from 25 minutes to one hour and 15 minutes.

The interviews were conducted in locations chosen by the participants. Most took place in my own residence, one was held at the personal residence of the participant, and two occurred in private seminar rooms on site at the hospital. Digital audio tapes were used to record the interviews. As indicated on the interview guide, a verbal identification code was assigned to each participant and was stated at the onset of the interview for ease of transcription. The month and year of the interview was stated only, and participants were assured that pseudonyms such as "nurse A" and "new graduate A" would be transcribed whenever personal names were revealed and audio taped during the interview. My name was left in the transcripts whenever it was used by the participant. "The hospital" was transcribed to indicate the institution. "The hospital" will be used in all manuscripts related to this thesis work to indicate the institution where this study took place. I took notes during the interviews to help me keep track of conversation points during the interviews, and to note any observations or thoughts I had during the interviews. The notes were de-identified using the participant code. The purpose of the note taking was explained to the participants prior to beginning the audio recording.

As soon as possible after the conclusion of the interview, I secured the consent forms in a locked box within a locked cabinet at my personal residence. The de-identified notes taken by me during the interview were secured separately from the consent forms in the locked cabinet to ensure the names on the consent forms could not be linked to the notes taken during the interview. Audiotapes were secured in the locked cabinet until

such time as I was able to have them transcribed, and they were transcribed as soon as was possible. Once the audiotapes had been transcribed and verified to be verbatim, they were destroyed by erasing as per the protocol and request of the REB at the hospital. The transcripts were kept in the locked cabinet at my personal home to which I have sole access. The transcripts will be kept secured for a period of 5 years in case of audit and to comply with ethical approval guidelines. Participants were assigned a code number so as to identify which text belonged to which participant. This was done to ensure validation of the correct text with the correct participant. These code numbers were kept electronically on my personal password protected hospital intranet account. After all interviews had been transcribed, I relocated to Newfoundland. The signed consent forms were sent via a secure courier service directly to the office of my thesis supervisor for secure storage in her office.

Data Analysis

The procedural steps as described by Colaizzi (1978) were used to guide the analysis of the data. The steps were intended by Colaizzi to be guidelines for researchers, and consist of: (1) collecting and reading all participants' descriptions of the phenomenon in order to acquire a feeling for them; (2) returning to the original transcripts and extracting significant statements pertaining directly to the phenomenon of interest; (3) trying to spell out the meaning of each significant statement; (4) organizing the aggregated formalized meanings into clusters of themes; (5) writing an exhaustive description; (6) returning to the participants for validation of the description; and (7) if new data are revealed during the validation, incorporating them into an exhaustive description. In the event of incongruence between the cluster of themes and the

transcripts, the preceding steps are repeated. Below is a detailed description of how I interpreted and applied these procedural steps. The first three steps were completed on one transcript at a time and repeated for each of the eight transcripts.

Once the interviews had been transcribed, each transcript was read twice without making any marks on the transcript in order to get an overall feeling for what was being said by the participants. After reading the transcript twice, I then read it a third time and noted statements that I felt were significant to the phenomenon in this study. As suggested by Colaizzi (1978), as I read each statement that I had selected, I would refer back to the purpose of the study and conclude that each statement I was noting did indeed pertain to the phenomenon of interest. I discussed this process with my thesis committee. The committee agreed that I was extracting statements appropriately. I decided to continue to note all statements that I felt were significant in each transcript to preserve their original context and felt confident that if I determined a statement was not significant, I would identify and disregard it during subsequent steps in the analysis. Each significant statement was recorded in a table using the Microsoft Word processing program.

Once I felt I had extracted the significant statements from all eight transcripts, I proceeded with formulating meanings for each statement. To aid in capturing the context of each significant statement, I employed two strategies. First, I ensured that when I recorded the significant statement, I included contextual information in brackets after the statement. Second, as I was formulating meanings for each statement, I would visually follow the progression of the interview with the printed transcript at the same time. That way, I was always sure of the context of the statement prior to formulating a meaning and

to ensure the likelihood that the meanings I derived reflected what the participant was saying. At this point, I wanted to be certain that I was ensuring the accuracy and validity of my results. Therefore, after writing each formulated meaning, I would read it back and then revisit the transcript where I had retrieved the significant statement to verify that I had not derived a formulated meaning that did not fit within the context of the transcript. From the eight tables, I was able to create a new table entitled "formulated meanings and cluster of themes". Using the word processing program, I was able to copy the formulated meanings from the "analysis table" file, and paste them into this new table.

The file, which contained the formulated meanings in similar groups, allowed me to view the data according to common ideas. I began my attempt at extracting themes by printing this table. I considered whether I had correctly grouped the formulated meanings, and took time to clarify any ambiguities I felt I had created in this data table. When I began to try to write broad titles for each of these groups, I discovered that although I had grouped the formulated meanings into seventeen clusters, there were still main points that were common to all the data. With the guidance of my supervisors, I took the concepts, which I had extracted from the data and found to be common throughout the transcripts, and visually placed them on post-it notes to assist in conceptualizing how the concepts fit together and to attempt to identify themes from the groups of concepts. Through a process of writing and rewriting and with much support and guidance from my supervisors, I was able to identify six themes and subthemes in each that were common to all the participant transcripts and therefore were reflective of the lived experience of being a preceptor to new graduates in the ED.

Next I wrote an exhaustive description of the six themes taking into consideration the clusters that were used to identify the theme in order to explain how the six themes fit together to describe the lived experience of the participants. A brief summarization of the themes was compiled, verified with my supervisors, and sent to the participants in the manner in which each of them had indicated they preferred to be contacted. Seven of the participants agreed with the themes as they were. One participant made notes of clarification on two of the themes and returned them to me. The points of clarification noted by the one participant were integrated into the analysis.

Ethical Considerations

Ethical approval was requested and obtained from both the Human Investigation Committee of Memorial University (see Appendix D) and the Research Ethics Board (REB) of the hospital (see Appendix E), as both research ethics boards are guided by the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (2010).

Participants were asked to sign an informed consent form and were provided with a signed copy of the form. Once I had contacted a participant to take part in the research an electronic copy of the consent form was emailed at least a week in advance at an email address provided by the participant in case the original consent form had been misplaced. The participants were asked to bring the consent form with them to the interview for signing and participants were provided with dedicated time prior to beginning the interview to explain the study in detail, clarify any issues related to the study or the consent form, to allow participants to ask any questions, and to ensure they understood the study. Considering I was a practicing nurse in this ED at the time of participant recruitment and to minimize bias, participants were asked to contact me through email or

phone, and I did not personally ask any nurse to participate in the study. This prevented any coercion of participants.

There was a potential risk in this study for a participant to become distressed because we were discussing mutual colleagues and that the participant would have been aware that I may have known about any incident they were discussing in the interviews. Participants could have also become distressed through fear of being recognized as a participant in the study, and therefore being linked to any negative findings. Participants therefore may have feared repercussions in the workplace as a result of participating in this study. Therefore, as per the request of the REB of the hospital, it was decided that should any participant become distressed during the interview, the cause of the distress would be addressed at that time and I would offer to either discuss the issue further or end the interview. Should the distress have continued, I was prepared to suggest the participant contact the Employee Assistance Program (EAP) for further counseling. There was no incident where any participant became distressed during an interview.

Debriefing of participants occurred in two steps. The first step occurred with the sending of the summarized version of the themes to the study participants for validation and feedback from the participants. There will be a follow up telephone call at the conclusion of the study, once the process of thesis approval has been met to ensure the information I share with them is final and complete. I hope this will bring a sense of completeness to the participants, and help them realize their participation in this study will contribute to the body of knowledge concerning new graduate nurse preceptorships.

Rigor of the Research

Colaizzi (1978) in his methodological considerations does not directly address the question of rigor but does stress both a rigorous attempt to validate themes that are identified from the data as well as asking participants to validate the themes. In order to validate the themes I worked with my supervisors as we carefully checked the data to ensure that the themes could be supported by the interview material that formed the data. A number of refinements in the themes and subthemes took place through this process. I also checked the themes developed with the participants in the study as described above.

Mackey (2012) suggests a number of evaluative criteria for a phenomenological study and these consist of resonancy, reasonableness, representativeness, recognizability, raised consciousness, readability, relevance, revelations, and responsibility (p. 524). Working with my supervisors and participants I believe that my themes and subthemes "resonate" with experiences of nurses in the clinical area that take on the preceptorship of new graduate nurses. The finding resonate with some of my past experiences as a preceptor, yet go beyond these experiences to give a more varied and more representative experience of being a preceptor. These finding certainly resonate with what has been reported in the literature as my discussion illustrates. I also believe that I meet the criteria of relevance in that the findings present a good understanding of what nurses experience in their day to day work as preceptors and that the findings of this research may add to the work on preceptorship and how to improve that process for both preceptor and preceptee.

Chapter 4

Findings

The findings of this study reflect the lived experience of eight ED preceptors (seven female and one male) who ranged in age from 28 to 50 years and in years of nursing experience from 3 to over 20. Although there was one male participant I will use "she" throughout in the presentation of findings to maintain confidentiality.

Six themes were developed that describe the lived experience of these eight ED preceptors: (1) meeting the challenges of teaching, (2) double the workload, (3) balancing responsibilities, (4) preceptor fatigue, (5) a reflection of preceptor competence, and (6) professional growth and strengthening practice. Each of the themes had a number of subthemes and these are presented in Table 1. This chapter will present the findings of the study by these themes.

Theme #1: Meeting the Challenges of Teaching

The first theme, meeting the challenges of teaching, captured the role of the ED preceptor as "teacher." Teaching a new graduate nurse how to be a competent practitioner and fully functional member of the nursing team is the essence of a preceptorship program and can be quite challenging. The participants provided many descriptions of the challenges inherent in the role of teacher and implications for ED nurses. Subthemes under this theme were 1) lack of preparation for the teaching role; 2) lack of choice in taking on the teaching role; 3) lack of feedback and support from colleagues and administration; 4) preceptors' teaching experience and self-confidence levels; 5) putting tacit knowledge into teaching; and 6) The ED environment is not always conductive to teaching.

Table 1: Themes and subthemes: Experiences of preceptors in the ED

Themes	Subthemes
1. Meeting the challenges of teaching	1) Lack of preparation for the teaching role; 2) Lack of choice in taking on the teaching role; 3) Lack of feedback and support from colleagues and administration; 4) Preceptors' teaching experience and self-confidence levels; 5) Putting tacit knowledge into teaching; and 6) The ED environment is not always conducive to teaching
2. Double the workload	1) Dual role (teacher + ED nurse) = Double the workload; 2) ED nurses are already over tasked; 3) Preceptee's existing nursing skills entering the program; and 4) The ED environment
3. Balancing responsibilities	1) Primary caregiver vs. teacher; 2) Colleague vs. preceptor; and 3) Preceptoring vs. the ED environment
4. Preceptor fatigue	1) Constant observation; 2) Preceptor–preceptee relationship; 3) Textbook practice v. normal routine; 4) Pressure of the role; 5) Personality conflicts; and 6) Lack of incentives for preceptors.
5. A reflection of preceptor competence	1) Preceptee performance as a negative reflection of preceptors; and 2) Preceptee performance as a positive reflection of preceptors
6. Professional growth and strengthening practice	1) Seeing nursing through a preceptee's eyes; 2) Continuing education; and 3) Learning from the preceptee

Lack of preparation for the teaching role.

A common thread throughout the data and subtheme of meeting the challenge of teaching was the lack of established guidelines for preceptors to prepare them for the teaching role. As one participant stated:

> *There was no, like, this is where they are coming from, this is their experience, these are the expectations. It was just sort of like, teach them to be an emergency nurse, go. Um, and especially, like, the first time I did it, it was like, honestly, I didn't know what I was doing.*

The experience of being a preceptor was described as "more stressful" because of the lack of guidelines. Furthermore, ED preceptors believed that a lack of formal guidelines created more pressure for the new graduate to perform to unspecified goals, a situation that can make them "harder to teach." As one preceptor summarized, "so now you have two stressed people."

Many participants stated that, in order for a preceptor to feel prepared to teach a new graduate nurse, the preceptorship program needed formalized guidelines. These guidelines should include fundamentals, or "general rules of work," for the new graduate nurse such as the hours of work, when shift change occurs, and what the new graduate nurse should do if she or he has to call in sick. Other suggestions for formalized guidelines included outlining learning expectations and addressing what skills are expected of the new graduate nurse within the six-month program (e.g., how long it should reasonably take for a new graduate nurse to master arterial line monitoring). Guidelines help set parameters for the preceptor-preceptee relationship, as well as identify the expectations of everyone in the preceptorship.

The preceptors in this study also identified a training gap with respect to having "difficult conversations" with the preceptee. Preceptors indicated their lack of training in having such potentially volatile and awkward conversations with the preceptee about expectations or evaluation contributed to them feeling unprepared. Although difficult conversations with others are common for nurses in the ED, facing the challenge of teaching involves knowing how to have a difficult conversation with a new graduate nurse and doing so in a professional manner. As one participate stated,

> *Managing difficult behaviours [of preceptees] was another [concern of preceptors], which I found absolutely astounding given the amount of difficult behaviours that they manage here in a day. But I think it was because [other preceptors] wanted to be more considerate. They wanted to be more careful, because this was a colleague and a new nurse and they didn't want to, you know. I was like, are you kidding? Didn't I just see you yell at the guy at triage? I'm like, you guys, that's all you do all day. And they said, well no, we want to make sure, you know like, 'how would you say that', or 'how would you frame that?*

Overall, participants stressed repeatedly that preparing ED preceptors is necessary because of the critical nature of patient care in the ED and the large amount of ongoing education required.

Preceptors also felt unprepared to teach because they were unsure of expectations. At the time of this study, there was no formal process in place to become a preceptor. Many participants noted inconsistent descriptions of preceptor training programs and resources available in the hospital. One participant noted, while laughing, "I got a booklet." One nurse described how this lack of preparation led to feelings of insecurity and anxiety:

> *Very little formal teaching was provided prior to me receiving this new grad ... I think there's probably workshops out there that I haven't availed myself*

of, but ... in my experience, it was just a note in the mailbox that said your student slash new grad is starting on such and such a date.

Partly due to and inconsistent level of preparation participants received from administration prior to receiving a new graduate student, participants experienced a range of confidence levels in meeting the challenges of teaching.

Lack of choice in taking on the teaching role.

A subtheme I identified was the felt lack of choice that the preceptors were given to take on the teaching role. The preceptor was simply notified by the manager that a new graduate nurse would be starting with the preceptor on an assigned date. A common complaint from all preceptors in this study involved the lack of selection criteria for becoming a preceptor. Oftentimes, preceptors had not volunteered for the position, but were, instead, assigned to the role. While some ED preceptors described "not minding" being asked to be a preceptor and explained that they enjoyed teaching, preceptors did state that the automatic association of nurse with teacher was not appropriate and believed that nurses need to be supported and given preparation for the additional role of teacher. Often, ED preceptors felt "pressured" into being a preceptor, explaining why some ED preceptors approached the situation "with a negative attitude." Preceptors did not appreciate being expected to teach and described feeling "a bit of resentment, actually, towards the organization" when they were assigned to precept a new graduate nurse.

Lack of feedback and support from colleagues and administration.

A third subtheme was the lack of feedback and support for the preceptor role. Many of the preceptors in this study felt isolated and left on their own while helping to create a competent ED nurse in six months. They felt that their colleagues could have contributed

more to the learning needs of a new graduate nurse by providing early feedback on the new graduate. Preceptors felt disheartened when they learned their colleagues had concerns about their new graduate and did not voice them until the end of the preceptorship period:

> *And [I] also would have appreciated a little bit of feedback from my colleagues sooner. So I think everyone panics right before they find out someone's coming off orientation, and then all the crap starts coming out. And then you're like, um, okay, well I was off for vacation that one week, why didn't you tell me she was running around, you know, pinching the patients or whatever [laughs]. You feel a little helpless.*

ED preceptors felt helpless and that their efforts with a new graduate had been compromised because they could have benefited from timely feedback from others.

ED preceptors indicated that they would have more support if they felt that their colleagues were more involved in helping to teach the new graduate. Several participants described scenarios they felt would be ideal where the new graduate would be split between two preceptors so as to "give the preceptor a break." Beyond formal arrangements such as this, ED preceptors believed there are day-to-day ways their colleagues can help "share the load":

> *[Colleagues] have to be involved too, like if you're not around or, you know everybody kind of helps out even though the preceptee might be with me primarily. But if they see them doing something as well that they can kind of step in and, you know, for like a learning experience, come and get them for a learning experience, or if they see them doing something that they think might be wrong, that they are also kind of helping out with, like, a team kind of learning experience.*

Preceptors also described feeling as though management did not include them enough in the evaluation of new graduate nurses. The ED preceptors felt as though their input into the performance of the new graduate was scrutinized and not taken seriously.

As one participant stated, "take what I say as fact." The experience for preceptors was challenging because they felt they had to work to convince management that a new graduate was either performing well or was struggling. Due to the fact that ED preceptors felt management and their colleagues were less than supportive during the preceptorship period, it was challenging to teach effectively. The preceptors felt isolated when they were teaching a new graduate nurse and this hampered their ability to teach.

Preceptors' teaching experience and self-confidence levels.

Another subtheme was the preceptors' teaching experience and self-confidence. Teaching adults involves being able to assess the learning style of the learner. Preceptors described their lack of familiarity with teaching methods and strategies as contributing to a "lack of confidence" with their role as teachers. The act of teaching itself is not something that comes naturally to all nurses. One preceptor described teaching as "a very close, personal interaction that can be uncomfortable." For someone who feels his or her teaching ability is not strong, acting as a preceptor to a new graduate nurse in the ED can be a source of stress. One participant stated, "I know how to nurse, I don't know how to teach, I don't necessarily know how to mentor. Um, and yeah, anxiety, am I going to do a good enough job [teaching]?" One of the preceptors described her discomfort with teaching and why having a new graduate nurse was an awkward experience:

> *I don't do well with someone over my shoulder. I don't feel that I'm a strong teacher. I don't enjoy teaching. And it's hard for me to, sort of, I can answer questions, but it's hard for me to sort of just plow ahead, like, you know, assessing a patient, you need to do this you need to do that . . . I know how to nurse, I don't know how to teach.*

A preceptor's level of personal confidence in her or his teaching ability is, therefore, pivotal to feeling prepared to teach a preceptee. Preceptors described the

individuality of learning needs for each new graduate and how they felt unprepared to "find [their] own style" of teaching. Nursing education prepares nurses for patient education, but not necessarily how to teach other health professionals. One preceptor pointed out the lack of instruction regarding how to teach other nurses in undergraduate education:

> *I guess I compare it with med school, where ... teaching is an integral part of their education. As you're learning, you're being instructed on how to teach somebody else. Whereas in nursing education it's almost nonexistent. But we're expected to come out and be able to function, and then sometimes in a fairly short turnaround time, be expected to teach someone else. ... but whether nursing education needs to change to include more of the teaching, you know, the preceptorship and the mentoring in the, like, from the undergrad level, I guess as you come in, make that part of the education.*

Additionally, preceptors were aware that their years of nursing experience had an impact on their professional readiness to teach. The more experienced the preceptor, the more knowledge "they [had] to pull from." A solid knowledge base is something a preceptor needs in order to feel comfortable with teaching. ED preceptors who felt uncertain in their skills and knowledge expressed being uncomfortable relaying their knowledge. One less experienced preceptor stated, "I lack confidence as well," while another, more experienced, preceptor noted "because I have more confidence in my own practice . . . I actually like to have new grads." The difference between these two participants highlights how some of the preceptors felt more prepared personally to teach than others.

The ability to evaluate a preceptee became easier with additional years of nursing experience and an increased self-confidence about the preceptor role. The level of nursing experience contributed to both a preceptor's confidence in relaying information to a new

graduate, and the ability to give feedback to the novice learner. One preceptor, with five years' experience, described how she felt as a more junior preceptor, and what that meant for her experience and the experience of her new graduate:

> *I think the fact that I've only been doing this for 5 plus years, I think that, like, this, the culture of nursing has made that a senior nurse, where that is not a senior nurse. And I think that as much as they say, okay you have enough time, here's someone to work with you, it's still like, well you've only been doing this for five years, what do you know, when you're giving them feedback ... I just think that work can be done on teaching the preceptor and especially, like, a young preceptor ... I feel bad for the preceptees. I feel bad that they are looking at me as a senior nurse. And they have no idea what they're missing out on not being with a nurse of 16 years plus. I think that a senior nurse by my definition can offer them a lot more than I can offer them, but they don't know the difference.*

The less experienced ED preceptors described feeling as though senior nurses were more equipped to teach because of their years of experience; they were more familiar with some of the more infrequent ED presentations (e.g., patients requiring thoracotomies). As one participant stated, "they have more [experience] to draw from." This perception may indicate that less experienced ED preceptors are more challenged to teach. Senior ED preceptors acknowledge that being a young preceptor must be "a little nerve-racking."

Putting tacit knowledge into teaching.

A fifth subtheme described the difficulty preceptors experienced in putting tacit knowledge into teaching. Despite the level of confidence a preceptor has in her own skill or ability to teach a new nurse, explaining why nurses do what they do is one of the more challenging aspects of teaching in nursing. A large component of nursing, and ED nursing in particular, is "gut instinct" or intuition. One of the challenges of teaching new graduate nurses is helping them develop their own intuition. How does one teach what they

intuitively know? How does one articulate what they do naturally and then teach that to someone else? These questions arose throughout the course of this study, and ED preceptors noted that they felt unprepared in their role when, fundamentally, they were unable to teach what they simply knew. One preceptor noted:

> *I know it's happening, but I can't articulate what I know, why I know it, why I'm doing what I'm doing necessarily. Like, it's just hard for me to articulate. So, that's one of the challenges I found.*

One of the preceptors who, at the time of the study, was also in an educator role and helping to prepare other preceptors, offered a comforting and innovative solution for preceptors:

> *A lot of people were worried about how they wouldn't be able to articulate what they did. And I said, you don't have to, it's a verbal-nonverbal mix.... They just need to see you do it. I know you know how to do it. But most people were worried about having to say out loud, like, this is why I'm doing it. And it's, that's okay, you just take your time, and you go back and you think.*

The challenge for ED preceptors to teach what they intuitively know contributed to an awkward feeling for the preceptors. This uncomfortable feeling affected the experience of being an ED preceptor because it was an aspect of nursing that they were expected to teach, and it was as not as easy to relay to a learner as information from a text book.

The ED environment is not always conductive to teaching.

Another subtheme described how the ED environment is not always conductive to teaching. As emphasized throughout this study, ED nursing presents a unique skill set. The critically ill nature of the patients dictates that teaching in the ED environment requires special attention. Preceptors in this study felt that "critical care is very different," due to the varied and fluctuating needs of the patients, and after hospital orientation of the new graduate nurse, "most of our training that we do is in-house." The level of acuity of the patients in the ED made some preceptors feel logistically challenged, just by the nature of the environment. For example, it is often not possible to take the time to stop and teach in the middle of a cardiac arrest. However, teaching in such scenarios does eventually have to occur or else the new graduate nurse would never be able to function as an independent member of the code team. The preceptors in this study felt that the necessity to teach in these critical situations was something that they were unprepared to do. Guidance was not provided to preceptors as to how to teach in these critical care situations, despite the importance. As one preceptor put it, "How you do teach in a trauma? It's not possible."

Theme #2: Double the Workload

A second and related theme mentioned by participants was the increased workload a preceptor had by virtue of adding the teaching role to their existing caregiving role. This theme was identified as "double the workload" because that is how it felt to many preceptors and how they expressed what being a preceptor was like in an already busy, hectic environment. Participants described how the existing workload of an ED nurse was being doubled when they took on the role of a preceptor: Not only were they expected to

fulfill their regular duties, but, within the same 12-hour shift, they were expected to teach a preceptee. ED preceptors noted the amount of time they spent on teaching, indicating that this teaching time would normally be when they performed their other responsibilities (such as direct patient care) and, therefore, their workload increased. There were many factors that contributed to this sense of doubled workload, including the attitude of both preceptor and preceptee before the preceptor program even began, the already busy lives of ED nurses, the level of basic nursing skills preceptees possessed entering the program, and the ED environment itself. Subthemes under this theme were 1) dual role = double the workload; 2) ED nurses are already over tasked; 3) preceptees' existing nursing skills entering the program; and 4) the ED environment.

Dual role (teacher + ED nurse) = Double the workload.

The first subtheme identified described how the dual role of the preceptor doubled the workload. A nurse who acts as a preceptor to a new graduate nurse is literally fulfilling two roles: nurse and teacher. ED preceptors described how having a new graduate nurse with them "actually slows [them] down," and how tasks "can take double the time" that it would normally take. As one preceptor described, "you're trying to manage your own workload, and then you're trying to manage their learning and then their workload, which contributes to your workload." Workload, therefore, is doubled because the ED preceptor already has an assigned amount of work, but is now also responsible for the work of the preceptee.

Preceptors described the increased workload associated with teaching as the "extracurricular stuff" they do outside of work, (e.g., looking up a clinical issue to better

explain a concept that a new graduate is struggling with) to ensure the new graduate is learning. One nurse explains:

> *When you have a new grad, you ... you have more work than you usually would. Because you're just, you're doing your job, but you're also teaching at the same time. And sometimes, how you explain things may not, as I've learned, they don't understand it that way, so you've got to come back and explain it another way. And sometimes you got to say, okay, tomorrow I'm going to come back and explain it to you another way because you got to go look it up. ... So it's, you'd like to say that with preceptorship there's no extra work, I don't think that's right. Because it's a lot of work.*

Beyond teaching the hands-on skills associated with ED nursing, preceptors described how the work of teaching a new nurse often includes a socialization role, "general rules of showing up to work every day," and overall appropriate behaviour, as well as the "professional conduct" the preceptors expected the new graduates to be able to show other nurses and health care professionals. Teaching these social skills adds to the teaching requirements of the ED preceptor and, therefore, adds to their overall workload during their 12-hour shift.

The workload associated with teaching in nursing is often underestimated. One preceptor described the workload associated with her early experience with new graduate nurses as "unmanageable." Even the most organized preceptor is still challenged to manage the workload associated with having another nurse working under them. As one ED preceptor recalled: "I think it kind of takes a little bit of skill to manage your workload and then work with somebody else." ED preceptors felt that, on top of the already existing multiple demands for their time, it is "stressful" to have double the workload associated with teaching a new graduate nurse, who has less hands-on skills, the large amount of ED-specific knowledge they have to learn.

ED nurses are already over tasked.

A second subtheme was ED nurses are already over tasked. Nurses in the ED have a heavy workload and participants described a sense of feeling continuously over worked. Therefore, before the preceptorship even begins, there were a number of factors that contributed to ED preceptors feeling that their workload was doubled. A national nursing shortage has contributed to most ED nurses already feeling over worked; therefore, adding any extra responsibility increases the workload and ED nurses feel their duties are being doubled because they are already working beyond normal capacity.

As noted earlier, the existing national nursing shortage influences and increases the workload of all nurses. On occasion, when a sick call cannot be filled, a new graduate nurse may be called upon to be "an extra set of hands" and essentially are treated as a fully functioning staff member for that shift. This creates a situation for the ED preceptor where teaching is non-existent and the workload is still doubled because the ED preceptor is essentially carrying the assignment of two fully functioning ED registered nurses. The ED preceptors believe it is "unsafe" for them to assume the workload associated with the new graduate being counted as staff and "unfair" to the preceptee who is now not in a situation to learn. The assumption that an ED preceptor and a new graduate will, in fact, help with workload is something that makes preceptors upset with management:

> *Like, not replacing a sick call to save money. Those things may seem like a good idea to someone, I'm guessing management, um, but it's a bad idea to my preceptee when I have to take care of three critically ill patients because they're not going to replace a sick call to save money and their preceptee, my preceptee who is, you know, going to be on their own a couple of months, is not getting any experience because they can't. Because it's not safe.*

The nursing shortage was referenced by preceptors as "impacting [their] practice" and their ability to be preceptors. Their own workload was already increased because the ED was short of experienced nurses, even before the workload associated with the preceptee was taken into consideration.

Participants noted that adding the responsibility of preceptor to their duties was adding more work to an already full workload. One preceptor described how the increased workload was attributable to the preexisting extra demands on ED nurses and why that in turn influenced their preceptor experience:

> *It's just another role on a, of an overtaxed, sort of, generally workload from a nurse, right? So, given the chance, if we had just to do our nursing role, which includes precepting, we could probably do it with less stress. But because we're doing everything else, generally as a system, that support is not there, to support the nurse just to do nursing stuff.*

This quote illustrates the feeling by preceptors that they would enjoy being a preceptor more if they could focus more on that role, instead of having to balance nursing and non-nursing demands in addition to teaching.

Preceptees' existing nursing skills entering the program.

Another subtheme identified was the preceptees' existing nursing skills entering the program. There are a variety of ways a preceptee adds to the preceptors' workload, such as poor preparation of the preceptee. Preceptors felt that some new graduates had less basic preparation and weaker nursing skills, so therefore needed more teaching and supervision. Thus the previous experience, skill, and knowledge of the new graduate nurse can either increase or decrease the workload of the preceptor depending on the preceptees' individual learning needs.

If a new graduate has poor basic nursing skills, the preceptor perceives the workload to be doubled because they have to teach these basic skills before being able to teach the more intricate ED-specific skills and knowledge. ED preceptors generally felt new graduate nurses were beginning work in the ED with an insufficient knowledge and skill background. ED preceptors cited this lack of prior skill as "frustrating" and "disappointing." Many preceptors believed this lack of preparation of the new graduate created more work for them because they were unable to focus on ED-specific learning content. For this reason, some ED preceptors believed the ED is not an appropriate place for new graduates to begin their nursing careers. As one preceptor described:

> *They don't [have basic nursing skills]. And some of it might be their fault or not. Some of it is stuff you learn as you're a new grad, but I don't know if emergency is the place for them to be actually learning it. They should be learning on the floor . . . I think that's a good place to learn.*

Some preceptors stated that the beginning of the preceptorship period is more work because the preceptor had to determine the level of knowledge and skill of the new graduate. Preceptors needed to establish the learning needs of each new graduate in order to successfully supervise a new graduate, as well as ascertain what skills the new graduate already possessed and what tasks he or she could perform independently. One preceptor described the workload associated with her role as time intensive: "some [new graduates] come in, don't know anything, you have to literally start from the ground up." Therefore, if a new graduate nurse has poor basic nursing skill and knowledge before being assigned to a preceptor, the workload for the ED preceptor is increased. The previous experience of the new graduate nurse has such an immense impact on the experience of being a

preceptor that if a preceptee has good basic nursing skills before starting in the ED, the preceptor considers her or himself "lucky."

The ED environment.

A fourth subtheme was the ED environment. Considering the workload associated with teaching in general, it is no surprise that ED preceptors felt that the nature of ED nursing and the large specific body of ED nursing knowledge contributed to their already heavy workload. The pace of the ED, coupled with high patient acuity, can create a negative experience for a nurse when he or she also has to act as a preceptor. As one nurse described, "This is the most stressful thing [about being an ED preceptor]. Because it's busy." One preceptor described teaching in the fast pace of the ED: "It's difficult to transmit all those quick things." The implications of poor learning in the ED can mean "life or death" for patients, and ensuring the new graduate has learned in an acute situation is "critical." The workload associated with the time commitment of teaching illustrates why ED preceptors find it "stressful" when their new graduate is slow to pick up a concept or requires something to be explained multiple times before learning occurs. One participant summarized this feeling of frustration nicely:

> *Sometimes it's very frustrating because you don't move as fast as you think you should move. And you don't quite think they're making the bar or, the bar that you've set out. And I think my bar is high whereas other people's bar is not high. They just, not, they're just not at that level. It's just, it's frustrating.*

ED preceptors noted that they work extra hard to teach in the midst of critical situations while fulfilling their workload and duties to the patient, and that they do so to foster "a future colleague" in their new graduate. The workload of ED preceptors is especially increased as they attempt to provide good learning opportunities during acute

patient situations. The importance of the preceptee learning how to perform in similar situations is always on the mind of preceptors, but as one ED preceptor described, it is not always possible to teach:

> *You can't maybe teach as much as you want to, or if someone is acutely ill it's good for that new grad to get that experience, but they don't get it fully because the patient is so ill they can't be a, maybe like, as active as a member of like a code team or something like that as you would need them to be. So, it's hard because they need that experience with acutely ill patients, but it's hard to get because the situation is so critical.*

The workload associated with teaching the specific knowledge of ED nursing partially lies in the "unpredictable" nature of the ED. The unique and unpredictable ED environment means the preceptor may have to seek out learning opportunities for the preceptee to ensure they have been exposed to key concepts. This pressure creates an increased workload towards the end of the preceptorship when the ED preceptor starts to worry that they may not have been able to expose the new graduate to all relevant patient conditions.

Theme #3: Balancing Responsibilities

Often, preceptors felt caught in a balancing act when the responsibilities associated with their multiple roles (ED practitioner/caregiver, teacher, and colleague) competing for their time. Nurses have a responsibility to their patients to deliver quality care, as well as a responsibility to their colleagues to make sure the workload in the department is distributed equally. However, as preceptors in the ED, there was now the added responsibility to ensure a successful learning experience for the new graduate by letting him or her provide hands-on care. How do ED preceptors experience the pressure of all of these responsibilities and cope with such a balancing act? Unfortunately, ED preceptors

largely indicated that their inability to balance their responsibilities has a negative impact on their experience as preceptors. Preceptors in this study so frequently mentioned the various implications of balancing these multiple roles that it warranted a separate theme. Subthemes under this theme were 1) Primary caregiver vs. teacher; 2) Colleague vs. preceptor; and 3) Preceptoring vs. the ED environment.

Primary caregiver vs. teacher.

The first subtheme was primary caregiver vs. teacher. As the primary caregivers to ED patients, ED preceptors maintain their own standards of patient care while teaching a new graduate nurse how to do the same. This environment may mean there are times when the preceptee can only observe a situation. Even though ED preceptors were being asked to teach a new graduate how to eventually provide competent care independently to patients, many participants in this study reinforced their role as caregivers to their patients and described how they initially "establish boundaries" and then gradually "let the leash out a little further" on their new graduate nurse as a means of ensuring their patients were receiving the best possible care. The most common descriptor of good patient care for ED preceptors is safe patient care. Certain procedures and medications were described as more "worrisome" than others; however, the critical care environment of the ED made all teaching a concern for patient safety and patient survival. ED preceptors described having to balance patient care and teaching as "frightening," and how having to trust the new graduate to "not do something stupid" was worrisome. One of the preceptors described feeling challenged to teach her new graduate nurse in an acute patient care situation, as she would not compromise patient care in the interest of teaching:

> *I feel like I'm really letting [the new graduate] down because . . . I can't let them do things and they just have to stand there and watch me do stuff, and maybe I could explain it to them after. But, like, in my practice my patient safety and my patient survival is, like, the number one thing that I do my job for. And unfortunately if, you know, my preceptee has to suffer because of it, then they do. And there's really nothing I can do about that.*

Some preceptors tended to assign their new graduate "off on menial tasks," such as taking vital signs, because these were less labour intensive teaching activities but ones that still needed to be completed. Although it can be tempting to have the preceptee help out when the ED is particularly busy by doing basic care, the ED preceptors in this study felt strongly about providing good learning experiences, such as being able to participate in a cardiac arrest or trauma. While they did understand the importance of preparing the preceptee to work in the ED in a relatively short period of time, some preceptors found balancing between patient care and teaching difficult because they felt "if someone's really sick . . . I'm not good at dividing my attention." The experience for ED preceptors was ethically challenging when they felt they could not teach because the patient was too ill.

Colleague vs. preceptor.

The second subtheme was colleague vs. preceptor. Preceptors were well aware that their teaching duties took away from their ability to "contribute to the team," and that this, in turn, increased the workload of their colleagues. One preceptor stated, "I need to be with them when, yeah, I could be with another patient and taking the load off my colleagues. But that's not really going to help anybody." Increasing the workload of colleagues may in turn negatively affect the teaching practices of the ED preceptors. The preceptors are distracted by the knowledge that they are inadvertently increasing the

workload of their colleagues, and this impacts how effectively they are able to teach to the new graduate.

Preceptors experienced a sense of being torn between helping their colleagues in the ED and taking the time to teach their new graduates. Also, preceptors believed they were fulfilling a responsibility to their colleagues because by acting as a preceptor, they were, in fact, helping to foster a "future colleague." The ED preceptors felt they were able to balance their responsibility to their current colleagues by ensuring they were creating future competent colleagues. When ED preceptors were teaching new graduate nurses, they did so with "a set of goals" because they wanted to help this preceptee be someone who will work well with the other ED nurses. One of the ED preceptors explained: "You have to look at it as, okay, down the road this is going to be one of the nurses that I'm going to be working with. They're going to be my equal."

Some of the concern felt by preceptors in creating future colleagues was ensuring the new graduate nurse was competent. Preceptors identified the following as being the most significant indicators of competence in a new graduate nurse: strong assessment skills, basic nursing skills, and the ability to work quickly and safely in the ED. One participant elaborated:

> *Number one would be assessment skills. You know, are they able to do a, um, nice primary and secondary assessment, um, with all the adjuncts that go with that. Can they insert Foley's, are they competent with IV skills, are they competent with phlebotomy skills? Also their pace. Are they fast enough, like, can they work with another nurse with a seven load of patients and can they carry their weight? It's one thing to be really efficient and hit all the markers, but, you know, can you also weed out what's not important and focus on what is important and then get that done in a timely fashion. So it's, I mean, it's skill, but it's also being quick on your feet with that skill . . . that to me is competent.*

As mentioned previously in the context of teaching, a common concern for all new graduate nurses during their transition into a practicing nurse was socialization. The ED preceptors felt it was their responsibility to help the new nurse socialize into the culture of the ED. One ED preceptor described the importance of balancing teaching nursing skills and facilitating socialization:

> *I think it's my role to educate, and to make somebody comfortable. And I think preceptoring goes beyond, like, okay, you can do task a and b and you can critically think through this, you know, I need to sort of make you welcome in the society of where I'm working. You know, like, we are there 12 hours a day. I see people I work with more than I see my family and I need to make sure that, you know, I introduce the preceptee in a way that they will have the same experience, that they'll have a positive experience with the people they work with, not just their job.*

Increasing the workload of your colleagues because of the preceptor role was something that ED preceptors worked hard to avoid. The increase in work for others was a potential source of friction in the workplace in an already challenging ED environment.

Preceptoring vs. the ED environment.

The last subtheme was preceptoring vs. the ED environment. ED preceptors acknowledged that the ED can be an intimidating place for a new graduate nurse. The ED preceptor, therefore, needs to balance his or her ED workload with teaching a preceptee how to work in the ED and how to cope with what they experience in the ED. As one preceptor put it, "the fact that they show up day after day is an amazement to me some days." ED preceptors felt that part of their responsibility to the new graduate nurse is to support them emotionally, not be "abrupt or abrasive," and help the preceptee cope with some of the tragedy they witness in the ED environment.

> *I remember one girl saying, well this woman came in and she'd been smoking crack and she was pregnant and we were giving her nebulizers because she was short of breath. And then we were like, well we'll see you next week, and she was like, [gasp], she was mortified. They don't have a place for all this stuff. They don't have a place for the violence, they don't have a place for the poverty, for the, you know, the sort of, the bad things that happen to people.*

The balancing act of responsibility experienced by ED preceptors is challenging. Unfortunately, there are times when ED preceptors were unable to maintain a balance, and either their colleagues or the new graduate suffered. In an effort to meet the challenges, the ED preceptor may have unreasonable expectations for themselves, which can lead to preceptor fatigue.

Theme #4: Preceptor Fatigue

A fourth theme that permeated much of the interview material was preceptor fatigue. It is not surprising that preceptors frequently experience fatigue, given their increased workload and responsibility brought about by being an ED nurse and a teacher. The preceptors felt there was no mental break when they had a new graduate with them; there was "someone always on you." Additionally, preceptors felt that they had to maintain some ideal of nursing and they were under pressure to create a competent ED nurse in six months. Moreover, personality conflicts and the lack of incentives also influenced the level of enthusiasm a preceptor felt at the role. These factors often culminated into preceptors feeling worn out. The time, energy, stress, and workload associated with being an ED preceptor are contributors to preceptor fatigue and are readily identified in the data. Subthemes under this theme are 1) constant observation; 2) preceptor-preceptee relationship; 3) textbook practice vs. normal routine; 4) pressure of the role; 5) personality conflicts; and 6) lack of incentives for preceptors.

Constant observation.

Participants noted that the presence of the preceptee and the feeling of being constantly under observation, or being shadowed, was quite tiring; yet, that is what often happens when preceptors are assigned a preceptee, especially in the beginning of the relationship. As one participant expressed, "It's certainly a drain on the people who are teaching." Preceptors stated that they had no mental break; there was a constant presence when a new graduate was with them, and preceptors indicated they "just [wanted] five minutes" of their own time.

One participant described preceptorship as "an invasion of your privacy" and two participants described actual scenarios where preceptees were following them so closely that they followed them into the washroom. The six-month program can feel extra long for the ED preceptor because "it's a drag to be around somebody for six months."

The lack of a mental break from new graduates is also evident in the description of the large numbers of new graduates introduced into the ED at once. Preceptors are not given a chance to practice independently before being assigned another new preceptee. There are constantly new learners being introduced into the department. One preceptor stated "almost everybody has a preceptee with them. And it's hard. Like, it's just hard."

Preceptor–preceptee relationship.

A second subtheme was the preceptor-preceptee relationship. The mental commitment to get to know the new graduate as a person was cited as a source of fatigue for many of the preceptors. Time was spent chatting and socializing with the new graduate even during breaks in order to develop a relationship between teacher and learner. ED preceptors wanted to have good relationships with their new graduate nurse to

be able to provide helpful feedback so that the new graduate was "motivated instead of . . . disheartened."

Part of the necessity of developing a positive relationship was making sure the new graduate nurse felt comfortable approaching the preceptor with emotionally difficult cases. During the preceptorship program, ED preceptors indicated that they became emotionally attached on some level to their new graduate and felt "protective" of them. They acknowledged this relationship was a basis to help the new graduate develop a coping mechanism for the ED environment and the necessary "thick skin."

The expectation to have a good relationship with the new graduate nurse carries over into the behaviour and professional conduct of the ED preceptor. Not only did the preceptors feel they should be exposing the new graduate to the best possible procedures and behaviours in practice, but they also felt they needed to maintain the highest level of interpersonal relationships because they were in the spotlight as preceptors. One of the preceptors described how she was constantly aware of this feeling:

> *So sometimes it's nice to get a break, and go, okay, phew. Like, I can just go and do my assessments by myself, nobody's judging me, nobody's, you know, like, I don't have to feel like I'm on my best behaviour all the time, or on the ball with everything. Because you want to be when you have a preceptee. ... So, I think it's nice sometimes just to have a break because you can just kind of relax. Because I think you're on edge as much as they are sometimes.*

Family responsibilities took a toll on some of the ED nurses as they often pointed to the fact that there are forces outside their work life (e.g., children, family, and finances) that contributed to how they approached each shift. One preceptor described how she would like to shut down any unnecessary tasks at work and focus on her patients:

> *Everybody has things going on in their lives and I don't want to have to talk to people all day long. I want to talk to my patients, and I want to do my job, and that's it.*

The preceptors acknowledge that "[their] life is not this job," indicating that preceptors may be experiencing fatigue in balancing work and family responsibilities.

It is also "taxing" to spend time just thinking about and planning the best way to communicate with new graduate nurses. The ED preceptors described how there was a lack of experienced ED nurses in the department. This gap, coupled with short time between rounds of hiring, meant that the same nurses were continuously being used as preceptors. There was never any time off between preceptees, so the much-needed breaks did not occur. A preceptor would often complete her role with one preceptee only to immediately start another six-month rotation with another incoming preceptee.

Textbook practice vs. normal routine.

A third subtheme was textbook practice vs. normal routine. Another source of fatigue noted by ED preceptors was feeling as though they "[could] not practice the way [they] normally would." There was an unofficial expectation that the ED preceptor had to portray an ideal of nursing during the entire six-month preceptorship program. Practicing in a different way than what they were used to for such a long period of time added to their fatigue. Part of the reason for this apparent pressure, ED preceptors acknowledged, is that this is the first exposure a new graduate nurse is going to have to the profession, and, regardless of the outcome of the preceptorship, these new nurses will always remember what they learned when they started. To this end, ED preceptors felt compelled to perform all their tasks "the textbook way of doing things" and not use any of the "shortcuts" that all nurses develop over the course of their careers. These ED preceptors have spent their

careers taking what they learned in nursing school and adapting it to real-life patient care scenarios. This pressure to do everything the textbook way all the time leads to fatigue because pressures in care delivery can limit what is achievable at times. In other words, textbook practice doesn't always apply to real-life settings. As one preceptor described, ED preceptors feel there is a large amount of "extra reading" required to prepare yourself to effectively teach a new graduate nurse.

Pressure of the role.

Another subtheme was pressure of the role. Preceptor fatigue partially emanates from the fact that the ED preceptors in this study felt pressured to create a competent nurse in the six month program. At the onset, the preceptors felt pressure to "have all the answers" for the new graduate nurse. As the preceptorship approached the end, the preceptors felt anxious over whether they had provided the new graduate with all the information and skills he or she needed to work independently. It is tiring and "frustrating" for ED preceptors when, after spending considerable time and energy on teaching and fostering a new nurse, the new graduate seems disinterested or lacks initiative as a learner in the ED. Feeling as though time and energy had been wasted contributed to preceptor fatigue.

Fatigue was also evident when ED preceptors described having to role model appropriate behaviours. One preceptor pointed out how upholding this ideal behaviour is especially challenging on a night shift:

> *I have to, you know, it's like I can't, you can't keep to yourself. You can't, I can't be a b***h because I want to be a b***h today. Like [laughs], I have to try to be nice all day long, and be patient and I find sometimes at three o'clock in the morning on a nightshift I don't want to be patient. I want to get things done. I want to make sure my patients are safe, and I find that, you*

> *know, being patient, for me, is one of the hardest things and one of the biggest things that I find really difficult when I'm tired, and when I'm just tired of talking all day. So yeah, that would probably be why I don't want to [be a preceptor*].

It's worth noting that the fatigue expressed by the participant above may also be compounded by existing weariness inherent in the fact that it was during the night shift.

Personality conflicts.

The next subtheme was personality conflicts. The frustration associated with a new graduate who seems uninterested was amplified when the new graduate has a challenging or difficult personality. ED preceptors felt these "arrogant" or "cocky" new graduates were tiring because they felt they always had to follow up on the actions of the new graduate, such as ensuring a medication was given or that a procedure was documented correctly. Some ED preceptors noted having to carefully supervise or "hover" over the preceptee to ensure that the new graduate nurse was not going to compromise patient safety in any way.

Personality incompatibilities, which can occur between the new graduate nurse and the preceptor can be taxing if they continue for the duration of the six months. Even when preceptors identified being able to address negative behaviour early on in the relationship, it was still noted that the effects lingered for the preceptor:

> *There may be personality incompatibilities. I've had good luck so far, um, but I had students where I felt uncomfortable with who just, we didn't gel and that's, um, very uncomfortable. And if you do that for six months that can be very hard.*

Working in a close relationship with a preceptee you do not get along with is a source of fatigue for ED preceptors. In some working relationships, you could limit

contact as much as possible. However, with a new graduate nurse, that individual is at your side for six months.

Lack of incentives for preceptors.

The last subtheme is lack of incentives for preceptors. Preceptors identified few rewards for their efforts. As one ED preceptor stated, "the only thing that's in place that would make me want to precept is that I don't mind doing it." Overall, the preceptors in this study did not see that they were receiving adequate reward for being a preceptor. This lack of recognition may explain why ED preceptors experienced fatigue in their roles.

The participants in this study noted a lack of financial compensation for those who invested their time and coped with the responsibilities of being ED preceptors. Preceptors felt that more experienced nurses would volunteer if they were paid for their efforts. One preceptor simply stated, "Money. They need to pay us more," in response to being asked what, if anything, would motivate nurses to continue taking on the preceptor role.

Theme #5: A Reflection of Preceptor Competence

The preceptors in this study perceived that how the preceptee performed reflected on them and their competence. They described the preceptorship experience as not only developing the skills of a new graduate nurse, but also being a reflection of their own competence as nurses. Preceptors wanted their new graduate nurse to be perceived as competent in order to maintain their own reputation as a competent ED nurse. The subthemes identified under this theme were 1) preceptee performance as a negative reflection of preceptors; and 2) preceptee performance as a positive reflection of preceptors.

Preceptee performance as a negative reflection of preceptors.

The first subtheme identified was preceptee performance as a negative reflection of preceptors. Preceptors readily acknowledged that the performance of the new nurse was frequently viewed by nurse colleagues as a reflection of the skills and knowledge of the preceptor. This perception had an impact on the experience of being a preceptor, as noted by one participate:

> *I absolutely want them to do well because they're going to be part of the team, and for me to work alongside them, and for others to work alongside them, like, they need to be up to scratch in terms of at least being competent and safe. But at the end of the day, you know, I don't want it, I would hate for, it does reflect on me because it's well, you know, she never told me that, she never told me to do this, she never told me to do that. Absolutely I think it would reflect poorly on me and I want my colleagues to have respect for me and all that. So, definitely it's a combination of both.*

All of the junior preceptors and the majority of the more experienced preceptors in this study described feeling pressure associated with the performance of the new graduate nurse. Only one preceptor (who had the most years of experience) failed to describe internalizing the performance of her new graduate nurse as a reflection of her own competence. She did, however, note how the performance of her new graduate "sometimes gets turned around on you." In this scenario, the preceptor related how her new graduate nurse was instructed on how to perform a task, yet proceeded to complete the task in another way. In this instance, the preceptor was made to feel that the actions of the new graduate nurse was her fault.

Although the preceptors readily described how the success of new graduates was truly individualized to the new nurse on a "case-by-case basis," the competence of the preceptor remained associated with the performance of the new graduate. ED preceptors

found the insinuation that the performance of the new graduate nurse was a direct result of their influence "difficult." The negative innuendos associated with an unfavorable new graduate nurse performance led to a poor preceptorship experience for some ED preceptors and left them "frustrated with ... the comments [from colleagues]." The preceptors felt strongly that this comparison was "unfair."

Although ED preceptors in this study felt their colleagues were the primary source of comparison, they did acknowledge that preceptors themselves can internalize this reflection of the new graduate performance. One nurse explained:

> *It is also a reflection of yourself; you are putting yourself out there a bit, um. Other colleagues will judge you by how your preceptee is doing, and so it can be even an embarrassing and humbling experience.*

ED preceptors often felt it was their "problem" and their "fault" when a preceptee was unable to perform to expectation. The following quote highlights how uncomfortable it can be when an ED preceptor internalized the poorer performance of a preceptee:

> *Recently one of the people I have precepted as a new grad had somebody with a tachycardia. The educator was asking some questions and I was getting more embarrassed by the minute because my former preceptee couldn't answer the questions, and so I felt that that reflected poorly on me.*

Preceptee performance as a positive reflection of preceptors.

The second subtheme was preceptee performance as a positive reflection of preceptors. While preceptors considered the link between poor performance of the new graduate and preceptor competence to be "unfair," preceptors seemed happy to take advantage of the association made between themselves and a good preceptee. Nurses were proud when they are able to tutor a preceptee and help them develop into a

competent beginner. As one of the preceptors noted, nurse colleagues credited ED preceptors with the success of a new graduate nurse:

> *But altogether I think it, in the end it probably gives you a certain amount of self-confidence that you have taught somebody, and especially if they turn out well, if they're good nurses, you kind of get that Halo effect, that you were their preceptor. And it's not as bad for the negative side. I think you get more positive credit for turning out, in quotation marks, turning out a good nurse as the preceptor, then you get negative feedback for turning out a bad nurse. So far, as I have said I've had good luck. The new grads that I've preceptors were all very good and very nice, so.*

There was a positive association for ED preceptors when a new graduate nurse became independent and performed above their own expectations and those of nurse colleagues. ED preceptors were "happy" and felt "pride" associated with the success of new graduate nurses that they had precepted.

Theme #6: Professional Growth and Strengthening Practice

The sixth and final theme identified speaks to what the preceptorship may give to the preceptor and why she continues in the role. In essence, being a preceptor allowed the ED nurse to experience professional growth as a nurse, in spite of the many challenges and stressors associated with taking on the role and, therefore, strengthened her or his own practice. The theme of professional growth was very strong throughout the data. The nurses readily acknowledged this aspect of the experience and described the professional growth in a myriad of ways. For some, it was a "strengthening of their practice"; for others, it was through "becoming a more reflective practitioner"; for many, it was simply described as "making them a better nurse" or "a better practitioner." Participants grew professionally by getting back to "the roots of nursing" and focusing more on therapeutic relationships, increasing their knowledge, and learning from the new graduates. The

subthemes within this theme were 1) seeing nursing through a preceptee's eyes; 2) increased knowledge; 3) continuing education; and 4) learning from the preceptee.

Seeing nursing through a preceptee's eyes.

The first subtheme was seeing nursing through the preceptee's eyes. For ED nurses, it is common to focus on clinical assessment and hands-on care required by the number of emergencies, uncertainty of conditions, and many life and death situations they encounter in the clinical area. ED nurses can become so caught up with these critical occurrences and required actions, or the "what" of nursing, that they lose sight of the "why," or the reason they came into nursing in the first place. Actions associated with stabilizing the patient often take precedent over psychological aspects of care. As the ED preceptors in this study observed the new graduate nurses reacting to urgent situations and saw their reaction to the situation (and especially to the patient), it made the preceptors see their practice differently. They could see how their practice had evolved over time and through exposure in the ED. This revelation was noted as being one of the positive aspects of being a preceptor and contributed to the preceptors' professional growth. As one of the more experienced preceptors recounted:

> *There was a patient the other day and the new [preceptee] and I were in there and we were doing something, and she was like I've never seen that. And I was seeing her reaction and thinking about, oh yeah, that is pretty horrific, whereas I had many years ago gone 'that's horrific' and then stopped labeling it as horrific anymore because it sort of, like, commonplace. So it was kind of nice to see it through fresh eyes because it sort of reminds you that there's humanizing, sort of you know, components that we need to all focus on at times, not just the tasks.*

Seeing a patient situation through the experiences of preceptees reminded the more experienced preceptor that sometimes it was important to step back and even slow down

the pace a little, whenever possible, and not always be caught up in the fast pace of the ED:

> *But sometimes I find that we get so tired and so overworked, that even on days when we're all sitting down at the nursing station and we're not doing anything, I can still be doing stuff with my patients, make their experience a better experience. And I know that, and that's what new grads tend to do, right? . . . That's a way that you build a, that's the way you build a therapeutic relationship with a patient. So, it kind of reminds me that I should, that I could be out there sitting with my patient for an extra five minutes and just chit chat, you know, pay more attention to them.*

The quote above illustrates how the dividends to the professional growth for the preceptor and the wellbeing of a patient could be substantial.

Increased knowledge.

A second subtheme was increased knowledge. Besides the humanizing aspect or being, once again, more aware of the patient as a person, professional growth was also experienced in terms of increased knowledge for the preceptor. Being a preceptor is about both acquiring and transmitting knowledge. The preceptors understood that to help prepare the preceptee for work in the ED, they, too, needed to read and prepare so they could be knowledgeable and current. This preparation was crucial because they were required to explain to, or were questioned by, the preceptee about patient conditions, underlying pathophysiology, and various treatments options—why the preceptor did what they did in particular situations. One of the nurses explained how this happens:

> *Oh, I think it strengthens my practice because it makes me revisit a lot of, like, old things. They are asking questions all the time that, um, I don't always know the answers to. But then I have to look it up and get back to them. So, I think it definitely makes me like a little more sharper. And then it kind of renews my interest in nursing again as well because then I'm like, oh, I forgot about that.*

Because of the tacit knowledge experienced ED nurses have acquired from practice, it can be easy for them to act more on intuition or at least not to make the knowledge behind their actions explicit. As the experienced preceptors in this study admitted, they have learned efficient and effective ways to deliver care that may vary from how it was taught in nursing school. However, when confronted by a preceptee who did not have the same knowledge and experience as the preceptor has and who needed to know how to handle certain situations, the preceptor needed to pull back and reflect on the situation and make the knowledge required for the situation more explicit.

> *I think it makes you a better practitioner because you have to explain what you're doing. And by that I think you develop a better judgment, and I think you make better decisions because you have to justify why, and um, you're kind of going beyond the gut instinct. Now you're explaining your gut instinct, you're explaining a lot of things that you're doing. So, I think that it makes you a much more reflective practitioner.*

Continuing education.

A third subtheme was continuing education. Part of being a preceptor was to engage on a more regular basis in continued education. Not only did some preceptors acknowledge that they needed to be more reflective about their practice and what they were doing, they also recognized that they were required to engage in extra preparation so that they could be a good preceptor. Some of the professional growth required was, therefore, self imposed and necessitated engaging in continuing education. The preceptors viewed this continuing education component as essential to their ability to be a preceptor in the first place because of the knowledge they were required to transmit. One of the nurses described both the positive outcome and the complexity of what was required of a preceptor:

> *Keeps me on my toes, keeps me on top of things, knowing recent research, really knowing your hospital policies, um. Taking courses outside of the hospital that, you know, eventually that they're going to have to take. Um, because, you know, you have to dictate the ACLS [Advanced Cardiac Life Support] guidelines, ATCN [Advanced Trauma Care for Nurses], and all those things that they're going to run into. So, yeah, it's basically keeping myself updated. Like, that to me, that's really important. That's what I do for myself, so that I could be a good preceptor, because if I, if I don't update myself, then really I shouldn't be a preceptor, you know what I mean?*

The preceptors noted that they had to be aware of and know certain things in order to teach others.

Learning from the preceptee.

The next subtheme was learning from the preceptee. The new graduate nurse brings certain benefits to the relationship and experience of the preceptor, and part of this benefit is that the new nurse comes with comprehensive knowledge of the nursing literature. The experienced preceptors certainly recognized this facet of the relationship and how knowledge transmission "goes both ways." Thus, professional growth also resulted from what the preceptor learned from the preceptee. This is not surprising, given that the preceptees had just completed an educational program, would have current knowledge, and understood the importance of questioning and exploring. The ED preceptors recognized that the new graduate has much to contribute to the experienced nurses' professional growth:

> *They can teach, like, new grads can teach you. Teaching is like a two way street. They can teach you things, they go, well you can do it like this. And you go, oh. "You know how to do that". So, you go, like, oh, "I didn't think of doing it like this". So it's like, I guess it's, it can be a two-way street. Like, because there's some things that change as time goes on, or they're just, they're thinking outside the box.*

Growing professionally has many positive outcomes for the preceptor. Participants felt it made them understand their work better, conduct more thorough assessments, enabled them to make better judgments, reinforced knowledge, renewed interest, increased their confidence, and allowed them to become more assertive. They experienced these aspects of their experience as "exciting and new," "rewarding," and, above all, "strengthened" them as ED nurses.

Conclusion

The lived experience of being a preceptor to a new graduate nurse in the ED is rich with descriptors. There is anxiety about being able to meet the challenges of teaching, feeling burdened by the extra workload, being challenged to balance all of the various responsibilities, and coping with preceptor fatigue, all the while feeling pressure that the performance of the new graduate reflects on the preceptor her or himself. The descriptors provided by the participants in this study highlight the depth of the experience of being an ED preceptor. Fortunately, even with all the many challenges and some of the negative experiences described by ED preceptors, preceptorship is not entirely one-sided, and there were many benefits experienced by the ED preceptors as well. These benefits were mainly intrinsic and speak to a natural tendency among many nurses who want to see others succeed. As these study findings indicate, there is much to learn from the experience of those who have been preceptors in the ED. The descriptors of what the experience is like for ED preceptors can be used to improve the experience for them as well as the preceptee, thus enhancing the preceptorship program.

Chapter 5

Discussion

Precepting a new graduate nurse in the ED is both a complex and challenging phenomenon for both junior and experienced nurses. Through my research, I have been able to describe what that experience is like. This study is the sole one that has examined the experience of being a preceptor in the ED, and can therefore be used to help understand some of the complexities of the ED preceptor role and what it means for an experienced ED nurse to take on the teaching of a new graduate nurse in a formal relationship (such as is the case in being a preceptor). Through the participant interviews I identified six themes regarding the experience of being an ED preceptor: (1) meeting the challenges of teaching, (2) double the workload, (3) balancing responsibilities, (4) preceptor fatigue, (5) a reflection of preceptor competence, and (6) professional growth and strengthening practice. In this chapter I will explore the literature and how my findings relate to the literature, and what may be some new understandings of this role.

Challenges of Teaching Associated with the Preceptor Role

The teaching role of the preceptor was definitely challenging; some even mentioned feeling uncomfortable with their teaching ability. This feeling of discomfort explains some of the variation that is captured when researchers measure satisfaction with preceptorship on the part of preceptors. While Stevenson et al. (1995) found that, overall, preceptors reported a sense of satisfaction in their role as teacher not all the participants in my study felt the same way. These nurses stated that their ability to meet the challenge of

teaching was hindered by the lack of training provided to nurses on how to teach other nurses, a finding supported by Hyrkas and Shoemaker (2007). Because one is an experienced ED nurse and very competent in that role does not necessarily translate into being a competent teacher.

Selection process of preceptors.

The selection process for preceptors can be challenging. Often, nurses selected to be ED preceptors are not given adequate consideration of their qualifications (e.g., nursing experience, teaching experience, and previous preceptor experience). The selection criteria for preceptors are not stringent enough (Blozen, 2010). For ED preceptorship programs to be successful, careful selection and training of preceptors through such methods as peer review and recommendations, strong performance appraisals, and a series of courses aimed at teaching others how to teach, are pivotal for success (Elmers, 2010; Kollman et al., 2007; Solheim & Papa, 2010). If these measures are not put in place, both the preceptor and the preceptee can become wary about the quality of teaching experienced.

The voluntary nature of selection for preceptorship has support from other researchers (Billay & Yonge, 2004; Evans, et al., 2008; Graham, Hall, & Sigurdson, 2008; Kauflin, Castro, Babb, & Carpenter, 2009). Making the preceptor role a voluntary one would allow for much-needed breaks between training sessions and lessen the likelihood of preceptor fatigue. Moreover, a voluntary process would help to ensure that enthusiasm for the program remains high, since only those who really want to participate would be chosen for the role. The current reality of a nation-wide nursing staff shortage

may preclude the ability to transform the role of preceptor into a voluntary one; however, the benefits of such a process should be noted.

Preparatory training for preceptors.

Ideally, ED preceptors are nurses with sufficient knowledge and experience to help a new graduate nurse learn the skills of ED nursing. While preceptors are experienced nurses, there is still a need for necessary training to be an effective teacher and participants emphasized this. Preceptors are usually far removed from the experience of being a new graduate nurse and may not know how to relate to a novice nurse much less teach one (Nicol & Young, 2007). The ED preceptor, therefore, is left to her or his own devices and now must determine how to teach "gut instinct" and what they intuitively know, a challenging process. This intuition of ED preceptors that has developed over time must also be taught in the challenging environment presented by the ED, where the critical nature of patients dictates that new graduates learn quickly in order to ensure the delivery of safe patient care. Participants in this study stressed the importance the role the ED environment itself played on the ability to teach effectively, a relationship that currently is not thoroughly explained in the current literature. This lack of research on the effects of high acuity situations indicates that the ED preceptors in this study have highlighted a potentially significant component of critical care preceptorship that warrants further investigation.

Preceptor as teacher.

The third challenge noted by participants had to do with the teaching role itself (i.e., the idea of themselves as "teacher"). They stated that being a competent nurse did not automatically correlate to being a good teacher. There were many aspects of the

teaching role that pertained to knowledge and comfort in educational practices and not to nursing. That is, preceptors were strong ED nurses, but lacked confidence in their teaching skills. Preceptors are uncomfortable with certain aspects of teaching, particularly if this is not part of their customary role, such as evaluating preceptees (Luhanga, Yonge, & Myrick, 2008b), a process that is often described as being intuitive (Clark & Holmes, 2007). The observation that preceptors need better guidance in teaching has been suggested by others (Sorenson & Yankech, 2008). Nurses do not have a formal education background and it should not be assumed they are familiar with teaching methods and strategies.

Participants often expressed self-doubt in clinical and/or teaching abilities, a finding not found in the literature. This research gap may be due to the limited research available on the lived experience of preceptors or the fact that most research on preceptorships focuses on outcomes of preceptorship programs. Also, as noted in the literature review, even when preceptors were asked for feedback on preceptorship programs, many did not offer any opinions, and no explanation was given as to why preceptors did not provide feedback (Morris et al., 2009).

The concern over providing appropriate feedback to new graduates has been noted previously (McNeish, 2007). It can be challenging for many ED preceptors to teach new graduate nurses (regardless of years of experience or comfort level with teaching) when they are not given the necessary guidelines or expectations with regards to preceptoring the new graduate nurse. The ED preceptor is challenged to teach without a template of how to approach the preceptor-preceptee relationship, and also to what level to expect the new graduate nurse to perform.

Lack of established guidelines.

Overall, the lack of established guidelines contributed to participants feeling unprepared as a preceptor. While preceptorship programs are operating despite not having established guidelines and expectations (Hautala et al., 2007; Valdez, 2008), these studies do not include feedback from preceptors on what qualifies as "success" in a preceptorship program. This study helps to support the argument for established guidelines and expectations to ensure preceptors feel prepared in terms of what they will be expected to teach the new graduate nurse. ED administration has documented that guidelines and skills checklists of preceptees contribute to successful ED and critical care preceptorship programs (Charleston & Happell, 2005a; Chestnutt & Everhart, 2007; Elmers, 2010; Kingsnorth-Hinrichs, 2009; Ramli, 2009; Rose, 2008; Solheim & Papa, 2010). Already established guidelines include a competency checklist for acute care and critical care nurses, tools for measuring the development of critical thinking skills, and timelines for the attainment of clinical skills. In addition, adequate notice prior to receiving a new graduate nurse would facilitate at least a psychological readiness for teaching. This concern of preceptors has been documented by one other researcher, who described how preceptors felt frustrated when they received a new graduate nurse unexpectedly (Blozen, 2010). Both current literature and this study highlight how advanced notice and clear preceptee expectations would help preceptors prepare for their role of teaching a new graduate nurse. Moreover, being prepared would contribute to the preceptor having the resources to meet the challenges of teaching, and experience a more positive preceptor experience, overall.

Effects on Nursing Workload

Evans et al. (2008) indicated that the workload of nurses is too high to adequately support new graduate nurses, a finding found in this study. Almost all participants experienced an increased workload associated with having a new graduate nurse. Research has shown that preceptors feel overloaded with evaluation related to the new graduate nurse (Chen et al., 2011) and echoes the sentiment of preceptors that the time constraints of trying to teach within the allotted time on a shift contributes to an increased workload of preceptors (Blozen, 2010; Hautala et al., 2007; Stevenson et al., 1995; Yonge, Myrick, Ferguson & Luhanga, 2005).

ED environment and workload.

ED preceptors in this study specifically noted that their workload was increased simply because of the ED environment. Preceptors felt that the unique skill set required to work effectively in the ED is not factored in when addressing preceptor workload. An advanced nursing skill set is required to work in critical care units (Reddish & Kaplan, 2007); preceptorships in specialty care units require extensive focus on teaching unit-specific knowledge and skill (Duvall, 2009; Kumpf, Privitere, Latimore, & Mombrea 2009). Having to teach these advanced skills in a critical environment is often cited as stressful. The stress experienced by critical care preceptors has been shown to increase as the acuity of patients increases (Hautala et al., 2007).

Although current literature does suggest that the nature of critical care requires specialized preceptorship content (Duvall, 2009; Kumpf et al., 2009), there is no literature supporting this position for ED nursing in particular. ED nursing holds many similarities to critical care nursing in terms of patient acuity and complexity; however, one issue not

addressed in the literature is the unpredictability of the ED and how that affects the workload and ability of ED preceptors to teach. This study offers a unique perspective of the preceptorship program in the context of the ED environment, an essential perspective when evaluating ED-specific preceptorship programs and subsequent workload (i.e., it is more helpful to compare like with like—ED preceptorship programs with ED preceptorship programs—, rather than trying to force standardizations and best practices of preceptorship programs on other units on an ED specific program).

Preceptees' preparation levels and workload.

The new graduate's level of preparation prior to beginning work in the ED influenced the workload associated with the preceptorship experience. Current research indicates that preceptors feel nursing programs are too theoretical and not relevant to practice (Evans et al., 2008) and that new graduates often lack basic nursing skills (Hickey, 2009; Luhanga, Yonge, & Myrick, 2008a; Morris et al., 2007). One of the ED preceptors in this study was particularly clear about the inadequacies of undergraduate nursing programs in preparing new graduate nurses for practice. Participants in this study noted that often, new graduate nurses lacked basic nursing skills, meaning that instead of focusing on more advanced ED-specific skills, preceptors had to step back and teach basic skills. Preceptors therefore had double the amount of skills to teach, contributing to an already heavy workload.

Kumpf et al. (2009) found preceptors in specialty care areas were more satisfied in their role when they were able to focus teaching on unit-specific content than when they also had to teach basic nursing skills. A recent study found that nurse managers felt new graduates begin practice with adequate theoretical knowledge (Chernomas, Care,

McKenzie, Guse, & Currie, 2010), however, it was not discussed if the managers felt the new graduates had adequate hands-on nursing skills. More emphasis needs to be placed on assessing new graduate nurses' basic nursing skills before the program begins and accommodating for that possible gap in situations where preceptees may need to be taught these basic skills. This knowledge gap needs to be considered when evaluating the workload of the preceptor.

Current nursing shortage, preceptorship, and workload.

Staff shortages and increased workload related to preceptorships can have an impact on the success of new graduate preceptor programs (Chernomas et al., 2010). ED preceptors in this study noted how the nursing shortage resulted in new graduate nurses being placed in situations where they were expected to act as fully functioning staff. Filling a nursing vacancy with a preceptee can double the workload of a preceptor and also greatly diminish the amount of teaching during that shift. Although Chernomas et al. (2010) described how new graduates on acute care units were given a full complement of patients earlier than was preferred because of staffing demands on the unit, there is no literature available that describes the specific practice of using a new graduate preceptee to fill a nursing vacancy. This lack of literature may be because studies involving evaluation of new graduate programs are often written by those involved in implementing the programs, which could bias the information shared by the authors.

Balancing of Responsibilities

Preceptors are often challenged to balance their responsibility to patients, colleagues, and their preceptee. This triad of responsibilities (to their primary care duties, to their colleagues, and to their preceptee) often results in ED preceptors feeling torn

between multiple roles. The first priority for any nurse in clinical practice is the care of their patients, and this priority sometimes conflicts with their teaching role. Current research supports the finding that preceptors are often frustrated by the lack of time to teach (Chen et al., 20011; Forneris & Peden-McAlpine, 2009) because their primary, and most important role, remains that of patient care provider. The participants in this study believed patient safety to be paramount and accepted that this sometimes resulted in poor learning experiences for the preceptee. Current research highlights a sense of fear associated with allowing the new graduate to practice more independently (Forneris & Peden-McAlpine, 2009), as preceptors always keep patient care and safety as their primary concern (Luhanga, Yonge, & Myrick, 2008a; Yonge, 2009; Yonge et al., 2005). Although the participants in this study admitted that their need to focus on patient care could diminish the learning opportunities of the new graduate nurse, this specific outcome was not found in other research studies. This may be specific to preceptorship in the ED and, therefore, an important finding in this study. The diminished learning opportunities of new graduate nurses needs to be further investigated because of the importance of new graduate programs to the development of future nurses, especially in specialty nursing areas.

Additionally, ED preceptors felt a responsibility to maintain a level of functioning to avoid burdening their colleagues. This feeling of being torn between their colleagues and their preceptees was previously noted in the literature (Proulx & Bourcier, 2008). One of the dilemmas faced by ED preceptors in this study was feeling as though they were increasing the workload of their colleagues because they were unable to perform to their normal capacity of patient care and teach a new graduate at the same time. ED

preceptors felt they must work extra hard to ensure they did not burden their colleagues with extra tasks.

Another responsibility ED preceptors had to balance was their obligation to the new graduate nurse against their responsibility to provide safe patient care. The main responsibilities as a preceptor to the new graduate nurse are to provide good learning opportunities and experiences to allow them to become competent ED nurses, as well as help new graduate nurses to cope with the difficult situations they are exposed to in the ED. Previous research studies have also found that preceptors emphasize the importance of providing good learning opportunities (Reddish & Kaplan, 2007; Reising, 2002). Preceptors stress that the goal of critical care preceptorship programs is to create a competent critical care nurse (Chen et al., 2011; Elmers, 2010; Kowalski & Cross, 2010; Morris et al., 2009). Many of the participants in this study discussed concerns over the emotional wellbeing of the preceptee and felt a sense of protectiveness over their new graduates. Preceptors often described wanting to protect their preceptees from emotional abuse from patients and colleagues (Charleston & Happell, 2005; Schumacher, 2007). Nursing is a caring profession, and this study reinforces what is already evident in the literature that preceptors feel connected to new learners. It is unclear if preceptors are more concerned about the success and wellbeing of new graduate nurses than other, non-teaching, experienced nurses.

Preceptor Fatigue

ED preceptors felt as though they had no mental break for each 12-hour shift they worked for 6 months. Other preceptors have described always being "on guard" and were burdened by their role (Chen et al., 2011). They often felt worn out from not being able to

be "themselves," having to always maintain some ideal of nursing behaviour, and always being in the presence of their preceptee (i.e., never having any time to themselves). Although only one participant used the term "preceptor fatigue," all of the participants described how different components of the preceptorship experience were tiring, taxing, or stressful. Many of the factors ED preceptors in this study described are similar to those described in current literature, such as feeling unsupported or unprepared in the role of teacher (Blozen, 2010; Charleston & Happell, 2005; Myrick et al., 2006; Solheim & Papa, 2010), the mental commitment involved in being a preceptor with dealing with unmotivated preceptees and role modeling ideal nursing behaviour (Luhanga, Yonge, & Myrick, 2008a; Myrick & Yonge, 2004; Yonge, 2009), and the increased workload of being a preceptor (Luhanga, Yonge, & Myrick, 2008a). Participants also expressed a common complaint that they were not getting a break between preceptees and that there were too many new graduates in critical care departments at once (Morris et al., 2009).

The mental energy involved in giving critical feedback was a further source of fatigue. Chernomas et al. (2010) found that nurse managers felt new graduate nurses were receptive to feedback, and did not find that giving feedback is challenging for nurse managers. However, this study's focus on preceptors (and not nurse managers) and new graduates in critical care or ED (and not medical surgical units) offers a contrasting perspective, as preceptors often noted the challenging aspect of providing clear, useful feedback to preceptees. This is a significant finding because preceptors are the people who more readily observe the new graduate nurse in action, not the nurse manager.

The participants in this study felt the financial compensation for being an ED preceptor is inadequate, a concern of preceptors that is backed up by Blozen (2010), who

suggested that insufficient pay may be a cause of preceptor burnout. Other research has also demonstrated how preceptors felt there should be more financial compensation (Charleston & Happell, 2005) and recognition (Morris et al., 2007; Stevenson et al., 1995) for being a preceptor, and that successful improvements in existing preceptorship programs have included increasing financial incentives for preceptors (Lee et al., 2009). The more preceptors perceived there are benefits and rewards to being preceptors, the more committed they were to the role of preceptor (Hyrkas & Shoemaker, 2007; Usher, Nolan, Reser, Owens, & Tollefson,, 1999). This study indicates that financial and other rewards would improve the experience for preceptors.

A Reflection of Preceptor Competence

Often, the clinical performance of the new graduate nurse was interpreted by ED nurse colleagues to be a reflection of the skill and competence of the ED preceptor. As well, when a new graduate nurse did not adapt well to the role of ED nurse, the inadequacies of that preceptee were internalized and were taken to be a reflection of their own competence. Current literature has explored preceptors' feelings of self-doubt when they receive criticism from nurse colleagues (Chen et. al, 2011), preceptors becoming frustrated when they perceived the new graduate as working too slowly (Forneris & Peden-McAlpine, 2009), and how preceptors feel pressure when the new graduate is not progressing according to the orientation schedule (Chen et al., 2011; Richards & Bowles, 2012). However, the preceptors in this study also noted that when a new graduate nurse performs well, that this creates a positive reflection on them and their knowledge and skill.

The perceived correlation between preceptee performance and preceptor competence added to participants' stress levels, a finding supported by Lee et al. (2009). Richards and Bowles (2012) found that preceptors feel accountable for the actions of new graduates, and also feel that they have done something wrong if the new graduate nurse is not showing progress in a timely fashion. Many preceptorship programs focus on the competence of the new graduate nurse as an indicator of success of the program (Elmers, 2010; Kowalski & Cross, 2010; Morris et al., 2009), and preceptors are described as being pivotal in developing clinical competence in new graduate nurses (Bratt, 2009).

Although it is felt by ED preceptors in this study that they were judged on the performance of their preceptees, the reviewed literature does not specifically identify instances where the performance of a new graduate nurse is equated with the competence of their preceptor. Therefore, this current study might highlight a new concept within preceptorship. The lack of data may again be due to limited research on the preceptorship experience from the viewpoint of the preceptors. In fact, available studies offer contradictory evidence that preceptors actually felt supported by their colleagues in their role as preceptor (Fox et al., 2006; Hautala et al., 2007). More recent contradictory literature and the results of this study may indicate that feeling less supported by colleagues is a more recent phenomenon (Chen et al., 2011). This finding may be related to increasing demands placed on nurses with rising patient acuity, fiscal constraints caused by global economic changes, or the ongoing nursing shortage. The environment of this ED at the time of this study was such that tension was high between nurses caused in part by a lack of experienced ED nurses. The results of Chen et al. (2011), who found

support for preceptors, and this study, however, indicate that the experience of preceptors may vary from time to time, and from institution to institution.

The source of the connection between new graduate performance and preceptor competence is unclear. Although all of the participants were able to describe scenarios where they had overheard their colleagues discuss new graduate performance and who their preceptor was, there was no description of specific accusations that a new graduate was performing poorly because the preceptor was incapable. This indicates that the perception that new graduate performance is a reflection of competence of the preceptor is not openly discussed within nursing. It would appear that nurses may believe this to be true, but would never discuss it with the preceptor.

Professional Growth and Strengthening Practice

The main benefits of preceptorship described in this study were twofold: (1) being an avenue to strengthen practice because of the amount of time spent reflecting on their practice and examining why they practice in a certain way, and (2) feeling a sense of satisfaction from their teaching when there was observable progress of the new graduate. Examining and expanding one's own knowledge base is also found in current literature (Hyrkas & Shoemaker, 2007; Stevenson et al., 1995). Chen et al. (2011) found that preceptors enjoyed being encouraged to keep up-to-date on current literature because they were preceptors. It is noted that preceptors enjoy watching a new graduate nurse succeed (Chen et al., 2011; Stevenson et al., 1995). This study helps add to recent literature by identifying how preceptors felt preceptorship strengthened their practice—specifically, how preceptees help preceptors grow their practice. Essentially, preceptees challenge preceptors to be more reflective and examine the care they provide in their practice. ED

preceptors felt preceptees encouraged them to keep up-to-date with nursing skills and knowledge, either by taking courses that they knew their preceptees would also have to take, or learning from the new graduate because of their knowledge of current nursing literature. Preceptorship is evidently an excellent source of knowledge acquisition, both for the new graduate nurse and the preceptor.

Conclusion

Many of the findings from my study are in congruence with current nursing knowledge on preceptorship; other findings present new information and insight into the experience of being a preceptor. This study fills a gap in the current literature pertaining to the challenges and needs of ED preceptors. ED preceptors face unique challenges because of the critical care nature of the patients that present to the ED, as well as the unpredictability of the ED environment.

If preceptorship programs are not better planned and coordinated, including offering preceptor training, preceptor fatigue becomes a real threat. ED preceptors are already experiencing heavy and stressful workloads, and increased demands on ED nurses that are not adequately supported can have negative implications for the whole health care system. As will be discussed in the next chapter, there are many implications of this study's findings that should be addressed and considered to improve the preceptorship program.

Chapter 6

Study Implications, Limitations, and Conclusions

This study has highlighted the experience of being a preceptor to a new graduate nurse in the ED. While some of the findings were supported by previous studies and literature on preceptorship and helped to validate current nursing knowledge, other findings identified new insights into the experience of being an ED preceptor. Since this study focuses on the lived experiences of preceptors in the ED, there are many potential implications of the findings. Specially, implications in the four domains of nursing (e.g., administration, nursing practice, education, and research) will be addressed in this chapter. This qualitative study highlighted numerous areas where change is needed in the ED preceptor program; changes which, if acted upon, could lead to the implementation of successful strategies to improve the current ED preceptor program.

Implications for Nursing Administration

The role of nursing administration in improving the experience of ED nurses in the role as preceptor is very important. ED managers and educators are challenged to assess the preparation programs and make changes, where necessary and possible. The role of preceptor was thought to be easier for a more experienced ED nurse. An important implication is that if this is the case what could be done to entice senior level nurses to take on this role? Or, is administration limited by existing personnel and the nation wide nursing shortage? These questions are institution specific, but worth noting nonetheless. This study showed that it can be challenging to maintain a pool of experienced nurses to

act as preceptors. ED administration should, therefore, address the issue of why so many ED preceptors are junior nurses.

While it would be ideal to include more experienced nurses as preceptors, as noted above, this may not always be possible. Therefore, ED nursing management needs to focus first and foremost on ensuring ED preceptors are willing participants and do not feel coerced into taking on a role that they are uncomfortable with, or not adequately prepared for. Feeling pressured into the role can lead to a negative association with the role of preceptor right from the start, lessening the chances for a positive experience. Participants voiced a clear need to establish standardized selection criteria for ED preceptors, criteria that should include enthusiasm on the part of the ED nurse, good performance reviews, a minimum level of nursing experience, and recommendations from nurse colleagues

This research also identified an existing inconsistency related to preparation of preceptors, resulting in many of the ED preceptors in this study feeling unable to meet the challenges of teaching. A lack of preceptor training has a direct consequence on the preceptor, the preceptee, the patient, other nursing staff, and the hospital itself. Although there may be existing preceptor preparation courses within the hospital, it would be beneficial for the ED nurse manager and educator to go beyond ensuring there is ED specific content in such courses and implement their own training program for preceptors. This training could be adapted to be supplementary to any hospital based preparation courses to help contain costs associated with training ED preceptors. Preparation of ED preceptors should include information on how to teach other nurses become competent

ED nurses, as well as adult learning theories, how to assess the learning style of the preceptee, and how to identify and adapt teaching styles.

Study participants also identified a gap in preparation with respect to the ED environment itself. The preceptorship program would benefit significantly if ED administration also considered teaching in critical acute situations, such as trauma and cardiac arrest, and how ED preceptors can be prepared for, and feel confident with, teaching in these situations. Past ED preceptors can be a resource for ED managers and educators to help formulate possible solutions to this teaching challenge.

The more thoroughly a preceptor is prepared for the role, the higher the chance will be for the preceptor-preceptee relationship to be successful. The preceptor is likely to feel less stressed taking on the teaching role with a professional attitude more conducive to learning. The preceptee is likely to recognize his or her preceptor's experience and will feel encouraged to learn and not panic in a situation. All in all, the relationship will be more effective than one where one party feels ill-equip, creating a more positive environment for coworkers and patients. Better prepared preceptors would enhance the overall preceptorship program: Both preceptors and preceptees would feel less stress, the program would be more regulated (meaning all preceptees would receive the same level of training), the preceptorship program overall would run more smoothly (creating easier transitions between programs), and more preceptors might volunteer for the role.

Another significant implication for ED nursing administration pertains to the format of ED preceptorships and how they are currently implemented. When too many new graduates are admitted to the program at once without added support resources, it can overburden current staff, causing stress and a negative work environment. There are a

few adjustments that could be made to alleviate the strain of too many graduates entering the program. While this is a situation that is time and institution specific, these suggestions mentioned above would help balance workload, reduce the stress that comes with being overworked, ensure that each preceptee is given adequate learning opportunities, and generally help create a more positive work environment with less burnout and more focus on learning and critical care.

Because of the staffing demands at the time of this study, it was common practice at this hospital to hire upwards of ten new graduate nurses at a time. ED management should consider limiting the number of new graduates introduced into the department at a single time, or if that isn't possible, assign a particular calendar date when new graduates would begin in the unit. This strategy would ensure that ED preceptors were never given a new graduate nurse unexpectedly.

One possible scenario that warrants investigation is assigning a new graduate nurse to two preceptors. Although this may be more challenging because of a limited supply of willing preceptors and the cost associated with preparing twice as many preceptors, it may be a strategy to help ensure greater preceptor satisfaction. The strategy could help decrease the pressure associated with being a preceptor. This strategy could, therefore, help to keep a group of ED nurses who are willing and able to be ED preceptors.

Without added supports in place, preceptors will feel less able to cope with the influx of new graduates. At the time of this study, the ED would have the same number of nurses assigned to an area regardless of if a new graduate nurse was also working that day. If ED administration took into consideration base nursing staff levels, ED preceptors would be able to effectively teach new graduate nurses. One possible strategy that could

be considered is the use of a "float nurse" or "resource nurse" within the department to assist with teaching or help with the ED preceptors' workload, so that the preceptor can spend more time teaching.

Aside from preparation programs and environmental considerations, participants also voiced a clear need for established guidelines and expectations developed by ED administration to ensure the preceptor and the preceptee are aware of how the preceptorship is expected to proceed. It helps establish a teaching and learning routine if both parties are aware of what is being taught throughout the program. Without these guidelines, the preceptor may overlook a key learning objective. Guidelines would ensure that neither party would question if all topics that were supposed to be covered actually were. Additionally, guidelines would standardize the program, ensuring that each preceptee completes the program with similar levels of knowledge, a finding that has a direct effect on the ED and the hospital overall. Suggested guidelines would include learning objectives and respective timeframes for completion; however, the timelines would have to be flexible because of the unpredictability of the ED, since there can be no guarantee that the new graduate nurse is given opportunity to complete certain objectives if patients do not present requiring specific interventions.

Participants also noted that often they felt isolated and not very well supported during their preceptor experience. Adding measures to create a more positive teaching environment would help ensure the success of the preceptor-preceptee program. The teaching environment can be enhanced by taking time to develop the preceptor-preceptee relationship. Currently, the ED preceptor and the new graduate often find themselves thrown into a teaching and learning environment, where trust is integral to the success of

the program, without any prior relationship. If the relationship between the two parties is strengthened, the likelihood of a successful teaching–learning relationship is increased. Potential strategies could include "preceptorship days," where a retreat-style approach is taken, with preceptors and preceptees spending a day participating in team-building activities. The cost-effectiveness of such a strategy would have to be considered, and managers would have to be creative with financing if they were to pilot such an approach. Participants mentioned a need for ongoing support of both the preceptor and the preceptee, such as an appropriate avenue for venting frustrations or support with developing learning plans—this is something that would have to be addressed and formalized by ED administration. ED administration needs to ensure an open relationship with both the ED preceptors and the preceptees through formal and informal meetings to encourage any unforeseen issues that arise to be addressed.

Implications for Nursing Practice

This research highlights nursing practice implications for those who currently act as ED preceptors. While ideal preceptorship does involve making changes at the senior administration level, there are changes that can be made at "ground level" by ED preceptors themselves. This study has identified gaps in the program, and if ED preceptors are aware of these gaps, they can work together along with administration to enhance the program. Participants in the study noted many benefits of being a preceptor, in addition to all the challenges. Recognizing that there are benefits will help create a more positive learning environment. If a preceptor does not take the time to self-reflect, she may enter the relationship with a negative attitude or not really knowing why she is taking on this role at all. Being aware of one's own perceptions towards a role can also

enhance the teaching experience in that certain basics would be recognized ahead of time. For example, if a preceptor felt overworked, but had realized that this might be an eventual outcome of the preceptor role ahead of time, she would be more likely to seek help and not take out her stress on others. The student would learn about the nature of the ED environment, but also what resources are available at times of work crises.

ED preceptors also need to consider what it is about being a preceptor that they find frustrating and advocate for better working conditions. Self advocating could include getting involved in the review and further development of the existing preceptorship program, becoming involved in the hospital preceptor training program, or helping to develop ED-specific preceptor training that would complement the program of the hospital. The preceptorship program stands a better chance of being successfully enhanced if those participating in the program get involved.

The participants in this study specifically expressed a lack of support from colleagues—a source where one might expect more of a natural supporting role. Feeling unsupported can heighten stress levels and decrease levels of self-confidence, leading to a less than ideal situation. ED preceptors, especially those with more years of nursing experience, should offer support and guidance to junior ED preceptors. Although it would be challenging for the senior nurses to find the time for this guidance and support, a simple word of encouragement when a junior preceptor is seen teaching well, or gently helping to correct a junior preceptor when she may be giving inaccurate information to a preceptee, may be just what a junior preceptor needs to feel as though she has resources to help her teach.

At the time of this study, there were a limited number of ED nurses who did not act as preceptors. The reason certain nurses did not participate in the preceptorship program was unclear; however, ED nurses who are not preceptors need to be aware of their own actions and attitudes and how they affect not only their current colleagues, but also the preceptees who will be colleagues in six months. This support needs to include a level of understanding toward their colleague and the preceptee who may take a longer time to complete certain ED tasks and skills. The support also needs to be in the form of facilitating socialization of the new graduate nurse into the culture of the ED.

Participants noted an ongoing perception that linked preceptee performance with preceptor competence. ED nurses need to be aware of how an off handed comment about the performance of a new graduate nurse is often equated with the competence and knowledge of the preceptor who is their ED nurse colleague, and consider how they would feel if their practice or knowledge were being called into question because of the performance of another nurse. Also, ED nurses need to consider that new graduate nurses are in the ED to learn how to become competent ED nurses, which means ED colleagues should be encouraging good learning experiences and not expecting the new graduate nurse to complete menial tasks.

Implications for Nursing Education

While there are many tangible implications for nursing administrators, preceptors, and nursing colleagues, this study has also highlighted a need to critically examine nursing education. The participants in this study noted how incoming preceptees often lacked necessary basic nursing skills. If a major challenge for ED preceptors is an existing gap of knowledge in their preceptees, then either the undergraduate curriculum

warrants evaluating or current practice needs revisiting. Additionally, it should be recognized that education does not stop at the university level, and that a responsibility exists for both preceptors and preceptees to take advantage of continuing education opportunities when possible.

Participants noted several times that the undergraduate curriculum could benefit from a reexamination of the content by nursing educators. Analyzing the undergraduate curriculum would identify why practicing nurses continue to have concerns about the preparation of new nurses and where any deficits in teaching basic nursing skills may lie. Undergraduate nursing students, who are preparing to graduate, need to know how to identify their own learning styles and needs, and how to relay that information to their future preceptor. Pre-graduate nurses also need to identify how to be proactive in their own learning as a new graduate nurse without being overconfident or arrogant. Additionally, undergraduate nurses would benefit from learning how to teach. If the undergraduate nursing curriculum encouraged peer tutoring and support programs, the challenge of teaching each other as registered nurses could be less foreign and awkward for nurses.

ED clinical nurse educators are also able to draw on the information in this study to address continuing education deficits and opportunities with the ED preceptors. Considering the heavy workload and fatigue experienced and reported by ED preceptors, ED clinical educators are also poised to experiment with creative new teaching strategies with new graduate nurses in the ED, such as simulators or actors posing as standardized patients. ED clinical educators need to be aware that ED preceptors may be in need of further educational support, such as how to accurately teach electrocardiogram rhythms or

how to interpret the results of an arterial blood gas. ED preceptors and new graduate nurses need to be individually approached to have their learning needs assessed.

Study Limitations

The main limitation of this study is that it took place at one specific location. It's important to realize that while this study only focused on one specific hospital, many of the situations expressed by the participants are found in various EDs throughout the country. Moreover, many of the concerns voiced by the participants were also found in previous research, albeit sometimes from nurses in other critical care departments, showing that it is the ED environment itself that is the focus and not specific teaching hospitals. While I do argue that one ED environment can act as a microcosm for others, it is true that the format of different ED preceptorship programs may lead to different results in other institutions. Each ED consists of staff with unique skill sets, personalities, and teaching experience, making every ED environment slightly different. Preceptorship programs are directly affected by these interpersonal characteristics. Therefore, a cross-institutional study would yield results that could be applied outside one specific institution and provide a broad overview of the preceptor-preceptee relationship. It would be especially helpful to conduct such further research in rural and urban centres, as well as include varying preceptor experience levels, to really dig deep into the preceptorship program from the perspective of the preceptor.

My role as the researcher also limited this study. Since I was a neophyte, qualitative researcher, my strategy for data collection was somewhat rigid. My interview process was quite structured, and I opted to follow the "guiding questions" as a script. Additionally, my role as both data collector and colleague could have been seen as a limitation.

Although I took strategies to ensure there was no coercion felt by study participants, these ED preceptors were my nursing colleagues and still may have felt obligated to assist me with my research. The data itself may have also been limited because I was a colleague, with participants potentially holding back in divulging information for fear of appearing as though they were "gossiping" about new graduates or fellow ED colleagues. The fact that I was conducting research in my own clinical setting may have influenced the relationship participants may have otherwise had with an independent researcher. Conducting research in your own clinical area has been found to be generally accepted by colleagues (Woodward, Webb, & Prowse, 2007). Richardson (2005) described the successful implementation of a clinical nurse researcher in the ED who spent half her time as a clinical nurse and the other half as a clinical researcher. Nevertheless, my dual role is still worth noting.

Areas for Further Research

In order for these findings to be applied more widely across various settings, further research needs to be done to support this research in different settings. As identified in the literature review and the discussion chapter, the majority of current literature pertaining to preceptorship is from the viewpoint of the preceptee and not the preceptor (Eigsti, 2009; Lee et al., 2009; Moore, 2009; Nugent, 2008; Romp & Kiehl, 2009; Zinsmeister & Schafer, 2009). Therefore, there is a need to address the paucity of qualitative studies with preceptors of any kind, but specifically those working in critical care and the ED. Conducting a similar study in other ED settings is necessary to validate this study's results, as well as to compare other ED preceptorship programs across Canada and around the world. There is also potential for quantitative research with ED preceptorships, such

as identifying the current skill mix in critical care and ED nursing, and how that environment has an impact on the preceptorship programs. Further research could also identify the difference in years of nursing experience, as well as years of ED specific nursing experience of ED preceptors and what this means for preceptorship programs.

More research needs to be done on teaching in the ED and how patient care conditions can have an impact on teaching in the moment. More data is needed measuring exactly how much more time is being consumed with teaching in the ED and how much longer it takes an ED preceptor to complete certain ED specific tasks because they have a preceptee. This research would help identify ED specific teaching issues, as well as potentially identify strategies for teaching in high acuity situations such as trauma or cardiac arrests. Considering the available literature describing successful critical care and ED preceptorship programs, further research needs to be conducted to evaluate these frameworks against each other. This could potentially lead to the development of new models or frameworks for preceptorships and ED specific preceptorships. Pre- and post-studies, measuring knowledge retention or development of critical thinking skills of new graduates, could be indicated for research on preceptorship framework

Conclusion

My goal for this study was to examine the lived experience of nurses who act as preceptors to new graduate nurses in the ED. Although there is a vast amount of research on the experience of new graduate nurses, there is very limited data on the experience for preceptors themselves. In particular, there is a lack of research describing what it means to be a preceptor to new graduate nurses in the ED.

Based on the findings resulting from participant interviews, the average preceptor in the ED environment at the hospital in this study feels unprepared and challenged. She is frustrated at the lack of preparation and choice given to her before taking on this new role and the process itself, including lack of expectations for the new graduate nurse and guidelines for teaching. She is often torn between multiple responsibilities and feels unable to complete either of her jobs 100%. She is either not giving her full attention to her preceptee because of her attention to patient care, or not devoting the desired amount of time to her patients because she is busy teaching the new graduate nurse. She often feels her workload is doubled as she tries to fulfill all her roles. The preceptor is tired and frustrated that she is not supported by her nurse colleagues and by her manager in her role as preceptor. She feels that although the new graduate nurse is her own clinician, that the positive and negative performance of the new graduate nurse is equated with her own competence. Although there are many struggles and challenges experienced by the ED preceptor, she still finds many rewards and benefits to being a preceptor to new graduate nurses. The joy of seeing a new nurse grow and the continual improvement of her own practice are positive aspects of being an ED preceptor that help her to get some enjoyment out of the role.

Little research has been done on the preceptor experience in the ED environment. This study is, therefore, significant because it is the first to shed light on what it means to be a preceptor to new graduate nurses in the ED. The implications of the findings of this study identify the need for a review of ED preceptorship programs. This review would address who is currently a preceptor, and who should be selected to be a preceptor. The benefits of being a preceptor need to be addressed in the planning of programs and

promoted among preceptors. Continuing education needs to be a pivotal part of the program for the preceptors themselves. Nursing academia is also indicated as needing to address the building of teaching skills among nursing students for their future role as nurse preceptors. However, considering the time lapse between nursing school and when one becomes a preceptor, institutions should also encourage those in academia to build on positive preceptor teaching programs for students. Examining this study in the context of the preceptor experience could strengthen preceptorship programs and create a more positive environment for ED preceptors. As indicated at the beginning of this thesis, happier ED preceptors will help create a happier ER nursing staff, and therefore improve not only the care delivered in the ED, but would also facilitate a better health care system for everyone.

References

Adriaenssens, J., De Gucht, V., Van Der Doef, M., & Maes, S. (2011). Exploring the burden of emergency care: Predictors of stress-health outcomes in emergency nurses. *Journal of Advanced Nursing, 67,* 1317-1328. doi:10.1111/j.1365-2648.2010.05599.x

Allegra, M.T. (2002). Retain nurses through mentoring. *Nursing Spectrum, 6*(8NE), 22. Retrieved from http://community.nursingspectrum.com/MagazineArticles/index.cfm

Arslanian-Engoren, C. (2000). Gender and age bias in triage decisions. *Journal of Emergency Nursing*, *26*, 117-124. doi:10.1067/men.2000.105643

Baggot, D.M., Hensinger, B., Parry, J., Valdes, M.S., & Zaim, S. (2005). The new hire/preceptor experience: Cost-benefit analysis of one retention strategy. *Journal of Nursing Administration,* 35, 138-145.

Baxter, P.E. (2010). Providing orientation programs to new graduate nurses: Points to consider. *Journal for Nurses in Staff Development,*26(4), E12-E19. doi:10.1097/NND.0bo13e3181d80319

Bechtel, D., Butler, C., & Kurz, P. (2006). Development and implementation of an ED residency program for graduate nurses. *Journal of Emergency Nursing*, *32*, 213. doi:10.1016/j.jen.2005.07.025

Berezuik, S. (2010). Mentoring in emergency care: Growing our own. *Emergency Nurse*, *18*(7), 12-15. Retrieved from http://www.nursing-standard.co.uk/emergencynurse/index.asp

Betts, L. (2003). An emergency department recruitment strategy. *Canadian Nurse*, *99*(9), 28-30. Retrieved from http://search.proquest.com/docview/232042922?accountid=12378

Billay, D., & Myrick, F. (2008). Preceptorship: An integrative review of the literature. *Nurse Education in Practice*,8, 258-266. Retrieved from www.elsevier.com/nepr

Billay, D., & Yonge, O. (2004). Contributing to the theory development of preceptorship. *Nurse Education Today*, *24*, 566-574. doi:10.1016/j.nedt.2004.07.010

Blozen, B. (2010). Avoiding preceptor burnout. *American Nurse Today*, *5*(11), 41-42.

Bourgault, A.M., & Smith, S. (2004). The development of multi-level critical care competency statements for self-assessment by ICU nurses. *Dynamics*, *15*(4), 15-18. Retrieved from http://www.caccn.ca/

Bratt, M. (2009). Retaining the next generation of nurses: The Wisconsin Nurse Residency Program provides a continuum of support. *Journal of Continuing Education in Nursing*, *40*, 416-425. doi:10.3928/00220124-20090824-05

Buerhaus, P.I., Staiger, D.O., & Auerbach, D.I. (2000). Why are shortages of hospital RNs concentrated in specialty care units? *Nursing Economics*, *18*, 111-116. Retrieved from http://www.ajj.com/services/pblshng/nej/default.htm

Canadian Nurses' Association (2004). *Achieving excellence in professional practice: A guide to preceptorship and mentoring*. Retrieved from http://www.cna-aiic.ca

Canadian Nurses' Association (2007). *RN workforce profiles by area of responsibility: Year 2005*. Retrieved November 11, 2009, from http://www.cna-aiic.ca/CNA/documents/pdf/publications/RN-Specialty-Profiles-2005-e.pdf

Canadian Nurses' Association (2009a). *Tested solutions for eliminating Canada's registered nurse shortage.* Retrieved November 11, 2009, from http://www.cna-aiic.ca/CNA/documents/pdf/publications/RN_Highlights_e.pdf

Canadian Nurses' Association (2009b). *RN workforce profiles by area of responsibility: Year 2007.* Retrieved November 11, 2009, from http://www.cna-aiic.ca/CNA/documents/pdf/publications/2007_RN_Profiles_e.pdf

Cartledge, S. (2001). Factors influencing the turnover of intensive care nurses. *Intensive and Critical Care Nursing, 17,* 348-355. doi:10.1054/iccn.2001.1599

Chamberlain, B. (2009). Phenomenology: A qualitative method. *Clinical Nurse Specialist: The Journal for Advanced Nursing Practice*, *23*(2), 52-53. doi:10.1097/NUR.0b013e3181996ae5

Chen, Y., Duh, Y., Feng, Y., & Huang, Y. (2011). Preceptors' experiences training new graduate nurses: A hermeneutic phenomenological approach. *Journal of Nursing Research, 19,* 132-140. doi:10.1097/JNR.0b013e31821aa155

Charleston, R., & Happell, B. (2005). Attempting to accomplish connectedness within the preceptorship experience: The perceptions of mental health nurses. *International Journal of Mental Health Nursing*, *14*(1), 54-61. Retrieved from http://www.wiley.com.qe2a-proxy.mun.ca/WileyCDA/

Chernomas, W.M., Care, W.D., McKenzie, J.l.., Guse, L., & Currie, J. (2010). "Hit the ground running": Perspectives of new nurses and nurse managers on role transition and integration of new graduates. *Canadian Journal of Nursing Leadership, 22*(4), 70-86. Retrieved from http://www.nursingleadership.net.qe2a-proxy.mun.ca/

Chesnutt, B., & Everhart, B. (2007). Meeting the needs of graduate nurses in critical care orientation: Staged orientation program in surgical intensive care. *Critical Care Nurse, 27*(3), 36. Retrieved from http://ccn.aacnjournals.org

Clark, T., & Holmes, S. (2007). Fit for practice? An exploration of the development of newly qualified nurses using focus groups. *International Journal of Nursing Studies, 44*, 1210-1220. doi:10.1016/j.ijnurstu.2006.05.010

Colaizzi, P.F. (1978). Psychological research as the phenomenologist views it. In R. Valle & M. Kings (Eds.), *Existential phenomenology alternative for psychology* (pp.48-71). New York, NY: Oxford University Press.

Considine, J., & Hood, K. (2004). Career development year in emergency nursing: Using specific educational preparation and clinical support to transition to specialist practice. *Nurse Education in Practice*, 4, 168-176. doi: 10.1016/S1471-5953(03)00076-3

Corbett, G., & McGuigan, T. (2008). Patient satisfaction. *Emergency Nurse, 16*(3), 26-35. Retrieved from http://www.nursing-standard.co.uk/emergencynurse/index.asp

Dawood, M. (2008). Alcohol-related presentations in the emergency department. *Nursing Standard, 36,* 50-60. Retrieved from http://www.nursing-standard.co.uk/

Duchscher, J.E.B. (2001). Out in the real world. Newly graduated nurses in acute-care speak out. *Journal of Nursing Administration, 31,* 426-439. Retrieved from http://search.ebscohost.com

Dunn, S.V., Lawson, D., Robertson, S., Underwood, M., Clark, R., Valentine, T., Walker, N., Wilson-Row, C., Crowder, K., & Herewane, D. (2000). The development of

competency standards for specialist critical care nurses. *Journal of Advanced Nursing, 31,* 339-346. doi:10.1046/j.1365-2648.2000.01292.x

Duvall, J. (2009). From novice to advanced beginner: The critical care internship. *Journal for Nurses in Staff Development*, *25*(1), 25-27. doi:10.1097/NND.0b013e318194b4fc

Eigsti, J. (2009). Graduate nurses' perceptions of a critical care nurse internship program. *Journal for Nurses in Staff Development*, *25*, 191-198. doi:10.1097/NND.0b013e3181ae1450

Elliott, M. (2004). Reflective thinking: turning a critical incident into a topic for research. *Professional Nurse*, *19*(5), 281-283. Retrieved from http://search.ebscohost.com

Elmers, C. (2010). The role of preceptor and nurse leader in developing intensive care unit competency. *Critical Care Nursing Quarterly, 33*(1), 10-18. doi:10.1097/CNQ.0b013e3181c8e0a9

Evans, J., Boxer, E., & Sanber, S. (2008). The strengths and weaknesses of transitional support programs for newly registered nurses. *Australian Journal of Advanced Nursing, 25*(4), 16-22. Retrieved from http://www.anf.org.au/

Everhart, B., & Slate, M. (2004). New graduates in the burn unit. *Critical Care Nursing Clinics of North America, 16*(1), 51-59. Retrieved from http://search.ebscohost.com

Finger, S., & Pape, T. (2002). Invitational theory and perioperative nursing preceptorships. *AORN Journal*, *76*, 630. doi:10.1016/S0001-2092(06)60938-1

Forneris, S., & Peden-McAlpine, C. (2009). Creating context for critical thinking in practice: The role of the preceptor. *Journal of Advanced Nursing, 65,* 1715-1724. doi:10.1111/j.1365-2648.2009.05031.x

Fox, R., Henderson, A., & Malko-Nyhan, K. (2006). A comparison of preceptor and preceptees' perceptions of how the preceptors' role is operationalized. *Journal of Clinical Nursing, 15,* 361-364. doi:10.1111/j.1365-2702.2006.01329.x

Glynn, P., & Silva, S. (2012). Meeting the needs of new graduates in the emergency department: A qualitative study evaluating a new graduate internship program. *Journal of Emergency Nursing.* On-line Journal. doi: 10.1016/j.jen2011.10.007

Graham, P., Hall, P., & Sigurdson, S. (2008). ICU survival guide: A nurse manager, preceptor, and novice explore what it takes to cut it in critical care. *Nursing Management*, *39*(1), 41-46. Retrieved from http://www.nursingmanagement.com

Gurney, D. (2002). Developing a successful 16-week "transition ED nursing" program: One busy community hospital's experience. *Journal of Emergency Nursing*, *28*, 505-514. doi:10.1067/men.2002.129707

Haggerty, C., Holloway, K., & Wilson, D. (2012). Entry to nursing practice preceptor education and support: Could we do it better? *Nursing Praxis in New Zealand*, 28(1), 30-39. Retrieved from http://web.ebscohost.com/ehost/detail?vid

Hauck, A., Quinn Griffin, M.T., & Fitzpatrick, J.J. (2011). Structural empowerment and anticipated turnover among critical care nurses. *Journal of Nursing Management, 19,* 269-276. doi:10.1111/j.1365-2834.2011.01205.x

Hautala, K., Saylor, C., & O'Leary-Kelley, C. (2007). Nurses' perceptions of stress and support in the preceptor role. *Journal for Nurses in Staff Development*, *23*(2), 64-72. Retrieved from http://search.ebscohost.com

Hickey, M. (2009). Preceptor perceptions of new graduate nurse readiness for practice. *Journal for Nurses in Staff Development*, *25*(1), 35-41. doi:10.1097/NND.0b013e318194b5bb

Hill, K. (2011). Nursing and the aging workforce: Myths and reality, what do we really know? *Nursing Clinics of North America, 46*(1), 1-9. doi:10.1016/j.cnur.2010.10.001

Hurst, S., & Koplin-Baucum, S. (2005). A pilot qualitative study relating to hardiness in ICU nurses. *Dimensions of Critical Care Nursing, 24,* 97-100. Retrieved from http://search.ebscohost.com

Hyrkas, K., & Shoemaker, M. (2007). Changes in the preceptor role: Re-visiting preceptors' perceptions of benefits, rewards, support and commitment to the role. *Journal of Advanced Nursing, 60,* 513-524. doi:10.1111/j.1365-2648.2007.04441.x

Jarman,H., & Newcombe, P. (2010). Support for nurses who are new to emergency care. *Emergency Nurse,* 17(9), 16-19. Retrieved from http://web.ebscohost.com

Johnstone, M. J., Kanitsaki, O., & Currie, T. (2008). The nature and implications of support in graduate nurse transition programs: An Australian study. *Journal of Professional Nursing, 24*(1), 46-53. doi:10.1016/j.profnurs.2007.06.003

Kauflin, K., Castro, K., Babb, R., & Carpenter, A. (2009). Improving outcomes of a nursing orientation program on a hematology oncology transplant unit using an

evidence based practice model to increase preceptor support. *Oncology Nursing Forum*, *36*(3), 43-44. Retrieved from http://www.ons.org/

Kingsnorth-Hinrichs, J. (2009). Growing new graduates... it takes a village. *RN*, *72*(1), 40. Retrieved from http://www.advanstar.com/index%5Fallpubs.html

Kollman, S., Liedl, C., Johnson, L., Elwood, T., Mundy, L., & Shue, J. (2007). Rookies of the year: Successfully orienting new graduate registered nurses to the cardiovascular surgical intensive care unit. *Critical Care Nursing Clinics of North America*, *19*, 417-426. Retrieved from http://search.ebscohost.com

Kowalski, S., & Cross, C. (2010). Preliminary outcomes of a local residency programme for new graduate registered nurses. *Journal of Nursing Management, 18,* 96-104. doi: 10.1111/j.1365-2834.2009.01056.x

Kumpf, R., Privitere, L., Latimore, C., & Mombrea, B. (2009). Development of an orientation program in a BMT unit: Integrating a large group of GNS while retaining existing staff nurses. *Oncology Nursing Forum*, *36*(3), 43. Retrieved from http://www.ons.org/

Lake, E.T. (2002). Development of the practice environment scale of the nursing work index. *Research in Nursing & Health*, 25, 176–188. Retrieved from http://www.wiley.com.qe2a-proxy.mun.ca

Lee, T., Tzeng, W., Lin, C., & Yeh, M. (2009). Effects of a preceptorship programme on turnover rate, cost, quality and professional development. *Journal of Clinical Nursing*, *18*, 1217-1225. doi:10.1111/j.1365-2702.2008.02662.x

Littlejohn, L., Campbell, J., Collins-McNeil, J., & Khaylie, T. (2012). Nursing shortage: A comparative analysis. *International Journal of Nursing,* 1(1), 22-27. Retrieved from wwww.ijnonline.com

Loiseau, D., Kitchen, K., & Edgar, L. (2003). A comprehensive ED orientation for new graduates in the emergency department: The 4-year experience of one Canadian teaching hospital. *Journal of Emergency Nursing*, *29*, 522. doi:10.1016/j.jen.2003.09.010

Luhanga, F., Yonge, O., & Myrick, F. (2008a). Hallmarks of unsafe practice: What preceptors know. *Journal for Nurses in Staff Development*, *24*, 257-266. Retrieved from http://search.ebscohost.com

Luhanga, F., Yonge, O., & Myrick, F. (2008b). Precepting an unsafe student: The role of the faculty. *Nurse Education Today*, *28*, 227-231. Retrieved from http://www.elsevier.com/

Mackey M.C. Evaluation of qualitative research. In P.L. Munhall (Ed) *Nursing research: A qualitative perspective (5th ed.) (pp. 517-531). Sudbury, MA: Jones and Bartlett Learning.*

McNiesh, S. (2007). Demonstrating holistic clinical judgement. Preceptors perceptions of new graduate nurses. *Holistic Nursing Practice, 21*(2), 72-78. Retrieved from http://www.aspenpublishers.com/

Mills, M. (2008). Practice makes perfect: Scabies. *Emergency Nurse, 16*(2), 18-19. Retrieved from http://www.nursing-standard.co.uk/emergencynurse/index.asp

Mitiguy, J.S., & Rotondi, P. (1991). Overcoming resistance to new graduates in critical care. *Recruitment and Retention Report, 4,* 6-8. Retrieved from http://search.ebscohost.com

Moore, M. (2009). Developing the preceptorship evaluation survey: A multifaceted approach including cognitive interviews. *Journal for Nurses in Staff Development, 25,* 249-253. doi:10.1097/NND.0b013e3181ae2eba

Morphet, J., Considine, J., & McKenna, L. (2011). Transition to specialty practice programs in emergency nursing - A review of the literature. *Australasian Emergency Nursing Journal, 14*(1), 45-49. doi:10.1016/j.aenj.2010.11.001

Morris, L., Pfeifer, P., Catalano, R., Fortney, R., Hilton, E., McLaughlin, J., Nelson, G., Palamone, J., Rabito, R., Wetzel, R., & Goldstein, L. (2007). Designing a comprehensive model for critical care orientation. *Critical Care Nurse*, *27*(6), 37-60. Retrieved from http://ccn.aacnjournals.org.qe2a-proxy.mun.ca/

Morris, L., Pfeifer, P., Catalano, R., Fortney, R., Nelson, G., Rabito, R., & Harap, R. (2009). Outcome evaluation of a new model of critical care orientation. *American Journal of Critical Care*, *18*, 252-259. doi:10.4037/ajcc2009355

Myers, S., Reidy, P., French, B., McHale, J., Chisholm, M., & Griffin, M. (2010). Safety concerns of hospital-based new-to-practice registered nurses and their preceptors. *Journal of Continuing Education in Nursing, 41*, 163-171. doi:10.3928/00220124-20100326-02

Myrick, F., Sawa, R., Phelan, A., Rogers, G., Barlow, C., & Hurlock, D. (2006). Conflict in the preceptorship or field experience: A rippling tide of silence. *International*

Journal of Nursing Education Scholarship, 3(1), 1-14. Retrieved from http://www.bepress.com.qe2a-proxy.mun.ca/

Myrick, F., & Yonge, O. (2004). Enhancing critical thinking in the preceptorship experience in nursing education. *Journal of Advanced Nursing, 45*, 371-380. doi:10.1046/j.1365-2648.2003.02920.x

Nicol, P., & Young, M. (2007). Sail training: An innovative approach to graduate nurse preceptor development. *Journal for Nurses in Staff Development, 23,* 298-202. Retrieved from http://search.ebscohost.com

Nugent, E. (2008). Implementing changes in educational strategies based on orientation experiences of the new graduate. *Journal for Nurses in Staff Development, 24*, 13-18. Retrieved from http://search.ebscohost.com

Ollier, C. (2004). Straw into gold: Barnes Jewish Hospital staffs its bustling ED with new nursing grads trained on-site as trauma and emergency nursing fellows. *Patient Care Staffing Report, 4*(4), 6-8. Retrieved from http://search.ebscohost.com

Omansky, G. (2010). Staff nurses' experiences as preceptors and mentors: An integrative review. *Journal of Nursing Management, 18*, 697-703. doi: 10.1111/j.1365-2834.2010.01145.x

Oulton, J. (2006). The global nursing shortage: An overview of issues and actions. *Policy, Politics and Nursing Practice, 7*(3), 34S-39S. doi: 10.1177/1527154062893968

Palmer, L., Blackwell, H., & Hinchcliffe, G. (2008). Helping people who self harm. *Emergency Nurse, 16*(3), 14-17. Retrieved from http://www.nursing-standard.co.uk/emergencynurse/index.asp

Patterson, B., Bayley, E.W., Burnell, K., & Rhoads, J. (2010). Orientation to emergency nursing: Perceptions of new graduate nurses. *Journal of Emergency Nursing, 36,* 203-211. doi:10.1016/j.jen.2009.07.006

Porte-Gendron, R., Simpson, T., Carlson, K.K., & Vande Kamp, M.E. (1997). Baccalaureate nurse educators' and critical care nurse managers' perceptions of clinical competencies necessary for new graduate baccalaureate critical care nurses. *American Journal of Critical Care, 6,* 147-158. Retrieved from http://www.ajcconline.org

Proulx, D., & Bourcier, B. (2008). Graduate nurses in the intensive care unit: An orientation model. *Critical Care Nurse*, *28*(4), 44-53. Retrieved from http://ccn.aacnjournals.org.qe2a-proxy.mun.ca/

Ramli, S. (2009). A preceptor's reflections: Lessons learnt. *Singapore Nursing Journal*, *36*(2), 47-48. Retrieved from http://www.sna.org.sg

Ramritu, P.L, & Barnard, A. (2001). New nurse graduates' understanding of competence. *International Nursing Review, 48,* 47-57. Retrieved from http://www.wiley.com.qe2a-proxy.mun.ca/WileyCDA/

Reddish, M.V., & Kaplan, L.J. (2007). When are new graduate nurses competent in the intensive care unit? *Critical Care Nursing Quarterly, 30,* 199-205. Retrieved from http://www.aspenpublishers.com/

Reising, D. (2002). Early socialization of new critical care nurses. *American Journal of Critical Care, 11,* 19-26. Retrieved from http://www.ajcconline.org

Richards, J., & Bowles, C. (2012). The meaning of being a primary nurse preceptor for newly graduated nurses. *Journal for Nurses in Staff development*,28, 208-215. doi: 10.1097/NND.Ob013e318269/de8

Richardson, S. (2005). Incorporation of research into clinical practice the development of a clinical nurse researcher position. *Nursing Praxis in New Zealand, 21*(1), 33-42. Retrieved from http://www.natlib.govt.nz/en/services/6innzcurrent.html

Robichaux, C., & Clark, A. (2006). Practice of expert critical care nurses in situations of prognostic conflict at the end of life. *American Journal of Critical Care, 15,* 480-489. Retrieved from http://www.ajcconline.org

Robichaux, C., & Parsons, M. (2009). An ethical framework for developing and sustaining a healthy workplace. *Critical Care Nursing Quarterly, 32,* 199-207. doi:10.1097/CNQ.0b013e3181ab91ff

Robin, N. (2006). Establishing an ED orientation program for newly licensed nurses. *Journal of Emergency Nursing, 32,* 216. Retrieved from http://www.elsevier.com/

Robinson, K., Jagim, M., & Ray, C. (2004). Nursing workforce issues and trends affecting emergency departments. *Nursing Management, 36*(9), 46. Retrieved from http://www.nursingmanagement.com

Romp, C., & Kiehl, E. (2009). Applying the Stetler Model of Research Utilization in staff development: Revitalizing a preceptor program. *Journal for Nurses in Staff Development, 25,* 278-286. doi:10.1097/NND.0b013e3181c2654a

Rose, S. (2008). The utilization and role of the preceptor in undergraduate nursing programs. *Teaching & Learning in Nursing, 3,* 105-107. Retrieved from http://www.elsevier.com/

Salonen, A.H., Kaunonen, M., Meretoja, R., & Tarkka, M.T. (2007). Competence profiles of recently registered nurses working in intensive and emergency settings. *Journal of Nursing Management, 15,* 792-800. doi:10.1111/j.1365-2934.2007.00768.x

Schmidt, L., Giovanelli, M., & Palazollo, P. (2003). Success stories. Teaming to a new dimension: Cost and quality go hand in hand. *Nursing Economics*, *21*, 194. Retrieved from http://www.ajj.com/services/pblshng/nej/default.htm

Schriver, J., Talmadge, R., Chuong, R., & Hedges, J. (2003). Emergency nursing: Historical current, and future roles. *Journal of Emergency Nursing*, *29*, 431-439. Retrieved from http://www.wiley.com.qe2a-proxy.mun.ca/bw/journal.asp?ref=1069-6563&site=1

Schumacher, D. (2007). Caring behaviors of preceptors as perceived by new nursing graduate orientees. *Journal for Nurses in Staff Development*, *23*, 186-192. Retrieved from http://search.ebscohost.com

Sedlak, S.K., & Roberts, A. (2004). Implementation of best practices to reduce overall emergency department length of stay. *Topics in Emergency Medicine, 26,* 312-321. Retrieved from http://www.lww.com/

Smedley, A. M. (2008). Becoming and being a preceptor: A phenomenological study. *The Journal of Continuing Education in Nursing, 39*, 185-191. doi:10.3928/00220124-20080401-08

Solheim, J., & Papa, A. (2010). Cutting edge discussions of management, policy, and program issues in emergency care. *Journal of Emergency Nursing, 36*, 367-369. doi:10.1016/j.jen.2010.10.006

Sorensen, H.A.J., & Yankech, L.R. (2008). Precepting in the fast lane: Improving critical thinking in new graduate nurses. *The Journal of Continuing Education in Nursing, 39*, 208-216. doi:10.3928/00220124-20080501-07

Spiegelberg, H. (1975). *Doing phenomenology.* Dordrecht, The Netherlands: Martinus Nijhoff.

Spivak, M., Smith, A., & Logsdon, M. (2011). Developing expert clinical nurses: Grow them, hold them and let them walk away. *Journal of Nursing Management*, *19*(1), 92-97. doi:10.1111/j.1365-2834.2010.01194

Stevenson, B., Doorley, J., Moddeman, G., & Benson-Landau, M. (1995). The preceptor experience. A qualitative study of perceptions of nurse preceptors regarding the preceptor role. *Journal of Nursing Staff Development*, *11*(3), 160-165. Retrieved from http://search.ebscohost.com

Sawatzky, J.V., & Enns, C.L. (2012). Exploring the key predictors of retention in emergency nurses. *Journal of Nursing Management,* 20, 696-707. doi: 10.1111/j.1365-2834.2012.01355.x

Tri-Council Policy Statement (2010). Ethical conduct for research involving humans. Retrieved from http:// *www.ethics.gc.ca/pdf/eng/tcps2/TCPS_2_FINAL_Web.pdf*

US Department of Health and Human Services, National Center for Health Workforce Analysis. (2002). *Projected supply, demand and shortages of registered nurses: 2000-2020*. Retrieved from http://www.ahcancal.org/research_data/staffing/Documents/Registered_Nurse_Supply_Demand.pdf

Usher, K., Nolan, C., Reser, P., Owens, J., & Tollefson, J. (1999). An exploration of the preceptor role: Preceptors' perceptions of benefits, rewards, supports and

commitment to the preceptor role. *Journal of Advanced Nursing*, *29*, 506-514. doi:10.1046/j.1365-2648.1999.00914.x

Valdez, A.M. (2008). Transitioning from novice to competent: What can we learn from the literature about graduate nurses in the emergency setting? *Journal of Emergency Nursing 34*, 435-440. doi:10.1016/j.jen.2007.07.008

Wikstrom, A.C., & Larsson, U.S. (2003). Patient on display: A study of everyday practice in intensive care. *Journal of Advanced Nursing, 43,* 376-383. doi:10.1046/j.1365-2648.2003.02726.x

Wilkin, K., & Slevin, E. (2004). The meaning of caring to nurses: An investigation into the nature of caring work in an intensive care unit. *Journal of Clinical Nursing, 13,* 50-59. doi:10.1111/j.1365-2702.2004.00814.x

Winslow, S., Almarode, M., Cottingham, S., Lowry, K., & Walker, K. (2009). New graduates in the emergency department: Could you, would you, should you? *Journal of Emergency Nursing, 35,* 521-524. doi:10.1016/j.jen.2008.12.016

Wolf, L. (2006). An experiment in process-oriented training: Learning to think like an ED nurse. *Journal of Emergency Nursing*, *32*, 213-214. doi:10.1016/j.jen.2005.04.018

Woodward, V., Webb, C., & Prowse, M. (2007). The perceptions and experiences of nurses undertaking research in the clinical setting. *Journal of Research in Nursing, 12,* 227-244. Retrieved from http://search.ebscohost.com

Yonge, O. (2009). Meaning of boundaries to rural preceptors. *Online Journal of Rural Nursing & Health Care*, *9*(1), 15-22. Retrieved from http://www.rno.org.qe2a-proxy.mun.ca/journal/index.php/online-journal

Yonge, O., Myrick, F., Ferguson, L., & Luhanga, F. (2005). Promoting effective preceptorship experiences. *Journal of Wound, Ostomy & Continence Nursing*, *32*, 407-412. Retrieved from http://www.lww.com/product/?0273-8481

Zinsmeister, L., & Schafer, D. (2009). The exploration of the lived experience of the graduate nurse making the transition to registered nurse during the first year of practice. *Journal for Nurses in Staff Development, 25*, 28-34. doi:10.1097/NND.0b013e318194b58c

Zolnierek, C., & Steckel, C. (2010). Negotiating safety when staffing falls short. *Critical Care Nursing Clinics Of North America*, *22*, 261-269. doi:10.1016/j.ccell.2010.03.014

Appendix A

Letter of Introduction for Study Participant Recruitment

Dear Colleagues,

My name is June Tavenor-Brake, RN, and I am a staff nurse at St. Michael's Hospital Emergency Department. I am completing my Masters of Nursing degree at Memorial University of Newfoundland. As part of this degree, I am required to complete a nursing research project for a thesis. I am interested in studying the lived experience of senior nurses who act as preceptors to new graduate nurses in the emergency department.

We are seeing an increase in the number of new graduate nurses with little or no experience in nursing practice hired directly into emergency departments all over the world. More experienced nurses are being requested to act as preceptors to new graduate nurses in the emergency department. Although we have some understanding of what new nurses experience with these types of experiences, we do not know what this is like for the experienced nurse who is required to give the guidance. Through my proposed research and with your assistance I hope to fill that gap in our knowledge. The literature has shown how new graduates feel about this (in critical care only), but there is no data that describe preceptorship from the point of view of the senior emergency nurses who act as preceptors to the new graduates.

I plan a qualitative study comprised of audio-taped individual interviews to discover and describe what it means for senior nurses to preceptor new graduate nurses. If you have been an emergency nurse for 3 or more years, and have been a preceptor to a new graduate in the last 12 months, I ask you to consider participating in this study, entitled 'Preceptoring New Graduate Nurses in Emergency Care: The Lived Experience of the

Preceptors'. Please find attached a copy of the consent form. This study has been reviewed by the Research Ethics Board here at St. Michael's Hospital as well as the Human Investigation Committee at Memorial University of Newfoundland. The utmost importance will be placed on confidentiality. My thesis co-supervisors for this study are Drs. Shirley Solberg and Anne Kearney, nursing faculty at the School of Nursing, Memorial University. Dr. Solberg can be reached at (709) 777-7493, and Dr. Kearney can be reached at (709) 777-7333. Feel free to contact my co- supervisors with any specific questions you may have about the study. For any questions you may have about your rights as a research participant, you may contact the St. Michael's Hospital Research Ethics Board at (416) 864-6060, ext. 2557, or the Human Investigation Committee at Memorial University at (709) 777-6974.

If you are interested in participating or would like to have more details about the study, please contact me by phone or email within the next couple of weeks. I appreciate your interest.

June Tavenor-Brake

Telephone: (416) 243-7737

E-mail: jtavenorbrake@mun.ca

* as with any email communication, please be reminded of the potential risk of interception/ potential limits of confidentiality.

Appendix B

Recruitment Poster

30 June 2009 REB # 09-114

Preceptoring New Graduate Nurses in Emergency Care: The Lived Experience of the Preceptors

If you have been an emergency nurse for three or more years and have acted as a preceptor to a new graduate nurse in the last 12 months:

You are being asked to consider participating in a research study that will look to describe the preceptorship experience from the preceptor's point of view.

The research will involve an audio-taped interview session lasting approximately one hour to be held at a location convenient to you. Two to three follow up telephone conversations will take place to discuss study results.

For more information or to discuss being part of this study, please contact the researcher, June Tavenor-Brake, at 416-243-7737.

For any questions regarding this study, please feel free to contact the thesis supervisors of the researcher, Drs. Shirley Solberg and Anne Kearney at the School of Nursing, Memorial University. Dr. Solberg can be reached at (709) 777-7493, and Dr. Kearney can be reached at (709) 777-7333.

Leading with Innovation
Serving with Compassion

ST. MICHAEL'S HOSPITAL
A teaching hospital affiliated with the University of Toronto

Appendix C

Interview Guide

Pre-amble

Thank-you for agreeing to speak to me today. As you know, we are conducting this study to identify and describe the experience of emergency nurses who preceptor new graduates.

This is purely a voluntary activity. You may stop the interview at any time. If any question I ask makes you uncomfortable, tell me and we can skip it, or just say "pass". If any question doesn't make sense, let me know and I can rephrase it. Please do not give your name or the names of anyone else or other institutions on the tape. Your real name or the names of anyone else or any institutions will not appear anywhere in the written transcripts of, or reports concerning, your interview. We are audio taping the interview so that we do not lose any details of the conversation. Any identifying information that may be recorded from the interview will be substituted with pseudonyms or codes in any report or publication coming from this evaluation. Please be assured that the information provided by you will be kept strictly confidential. We hope you will feel comfortable to speak freely.

The interview will likely last about 60 minutes. However the amount of time we spend and what you choose to say is entirely up to you. Do you have any questions or concerns about the process?

Let's begin.

Turn on the tape and start audio-recording.

Record the Subject ID (Code) Number

Record the Month and Year of Interview

Study Participant Demographic Information: Years of experience in the emergency both at St. Michael's Hospital and other institutions using the ranges of 3 to 5 years ED experience, 5 to 10 years ED experience, 10 to 15 years ED experience, or more than 15 years ED experience. Participant will be asked to write down mailing address, telephone number, and email address for follow up purposes at the conclusion of the interview.

Research Questions: The following questions and/or prompts have been developed for individual interviews.

1) Tell me (describe for me) what having a new graduate preceptee means (has meant) for you.

2) Describe for me what it is like to be a preceptor to a new nurse in the Emergency Department (ED)?

Prompts:

Can you give me an example of an experience you have had with a new graduate that was positive?

Can you give me an example of an experience you have had with a new graduate that was negative?

Describe how having a new graduate preceptee has had an impact upon your practice in the ED?

3) Based on your experience describe what you feel is important for others to understand about nurses like yourself precepting new graduates in the emergency room?

Prompts:

What should nursing administration understand?

What should new graduates understand?

What should your colleagues understand?

4) Tell me about (describe for me) the support you were given as a preceptor in the emergency department.

Prompts:

Give me an example of a time you felt supported as a preceptor.

Give me an example of a time you did not feel supported as a preceptor.

5) Please add anything else about your experience as a preceptor to a new graduate so that I may understand this experience more fully.

End of Interview. Thank interviewee for participating in this interview component of the study. Have participant record pertinent contact information for follow up purposes. *Turn off audio-recording.*

Appendix D

MEMORIAL

Faculty of Medicine

Human Investigation Committee
2nd Floor, Eastern Trust Bldg.
95 Bonaventure Avenue
St. John's, NL Canada A1B 2X5
Tel: 709 777 6974 Fax: 709 777 8776
hic@mun.ca www.med.mun.ca/hic

May 26, 2009

Reference #09.78

Ms. June Tavenor-Brake
C/o Dr. Shirley Solberg
School of Nursing

Dear Ms. Tavenor-Brake:

RE: **"Preceptoring the new graduate nurses in emergency care: the Lived experience of the preceptors"**

This will acknowledge your correspondence dated May 22, 2009. This correspondence and the revised consent form, verson dated February 2, 2009 has been reviewed by the Co-Chair and ***full approval*** of this research study is granted for one year effective May 25, 2009.

This approval will lapse on May 25, 2010. It is your responsibility to ensure that the Ethics Renewal form is forwarded to the HIC office prior to the renewal date. *The information provided in this form must be **current to the time of submission** and submitted to HIC **not less than 30 nor more than 45 days** of the anniversary of your approval date.* The Ethics Renewal form can be downloaded from the HIC website http://www.med.mun.ca/hic/downloads/Annual%20Update%20Form.doc

The Human Investigation Committee advises THAT IF YOU DO NOT return the completed Ethics Renewal form prior to date of renewal:

- *Your ethics approval will lapse*
- *You will be required to stop research activity immediately*
- *You may not be permitted to restart the study until you reapply for and receive approval to undertake the study again*

Lapse in ethics approval may result in interruption or termination of funding

For a hospital-based study, it is **your responsibility to seek the necessary approval from Eastern Health and/or other hospital boards as appropriate.**

Modifications of the protocol/consent are not permitted without prior approval from the Human Investigation Committee. Implementing changes in the protocol/consent without HIC approval may result in the approval of your research study being revoked, necessitating cessation of all related research activity. Request for modification to the protocol/consent must be outlined on an amendment form (available on the HIC website) and submitted to the HIC for review.

This research ethics board (the HIC) has reviewed and approved the research protocol and documentation as noted above for the study which is to be conducted by you as the qualified investigator named above at the specified site. This approval and the views of this Research Ethics Board have been documented in writing. In addition, please be advised that the Human Investigation Committee currently operates according to *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* and applicable laws and regulations. The membership of this research ethics board is constituted in compliance with the membership requirements for research ethics boards as per these guidelines.

Notwithstanding the approval of the HIC, the primary responsibility for the ethical conduct of the investigation remains with you.

We wish you every success with your study.

Sincerely,

John D. Harnett, MD, FRCPC
Co-Chair
Human Investigation Committee

Fern Brunger, PhD
Co-Chair
Human Investigation Committee

CC Dr. R. Gosine, c/o Office of Research, MUN
Mr. W. Miller, c/o Patient Research Centre, Eastern Health
HIC meeting date: May 28, 2009

Research Ethics Office
Telephone: (416) 864-6060 Ext. 2557
Facsimile: (416) 864-6043
E-mail: pateld@smh.toronto.on.ca

July 07, 2009

Appendix E

Leading with Innovation
Serving with Compassion

ST. MICHAEL'S HOSPITAL
A teaching hospital affiliated with the University of Toronto

Mrs. June Tavenor-Brake,
Department of Emergency Medicine,
St Michael's Hospital

Dear Mrs. Tavenor-Brake,

Re: REB# 09-114[C] - Preceptoring New Graduate Nurses in Emergency Care: The Lived Experience of the Preceptors

REB APPROVAL:	**Original Approval Date**	**July 07, 2009**
	Annual/Interval Review Date	**July 07, 2010**

Thank you for your application submitted on **May 07, 2009**. The above noted study has been reviewed through an expedited/delegated process (not by Full Board review). The views of the St. Michael's Hospital (SMH) Research Ethics Board (REB) have been documented and resolved.

The REB approves the study as it is found to comply with relevant research ethics guidelines, as well as the Ontario Personal Health Information Protection Act (PHIPA), 2004. The REB hereby issues approval for the above named study for a period of 12 months from the date of this letter. Continuation beyond that date will require further review of REB approval. In addition, the following documents have been reviewed and are hereby approved:

1. Protocol, as submitted on 06 June 2009
2. Consent Form, version date: 06 July 2009
3. Poster/Advertisement, version date: 30 June 2009
4. Letter of introduction for study participant recruitment, version date: 30 June 2009
5. Interview Guide, version date: 30 June 2009

During the course of this investigation, any significant deviations from the approved protocol and/or unanticipated developments or significant adverse events should immediately be brought to the attention of the REB.

This letter serves as approval by the SMH REB for conduct of this study; however, additional approvals are required as outlined on the Office of Research Administration Authorization Check List form. Enclosed is a copy of this check list and REB authorization is in the appropriate space. Also, the Clinical Trial Agreements have to be submitted to the Office of Research Administration for review and approval. The remainder of the approvals **must be** coordinated through the Office of Research Administration prior to initiation of this research. All drug dispensing must be coordinated through the Research Pharmacy at 416-864-5413.

The St. Michael's Hospital (SMH) Research Ethics Board (REB) operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans, the Ontario Personal Health Information Protection Act, 2004, and ICH Good Clinical Practice Consolidated Guideline E6, Health Canada Part C Division 5 of the Food and Drug Regulations, Part 4 of the Natural Health Product Regulations, and the Medical Devices regulations. Furthermore, all investigational drug trials at SMH are conducted by Qualified Investigators (as defined in the latter document).

With best wishes

☐ Dr. Julie Spence
Chair, Research Ethics Board

☒ Dr. Brenda McDowell
Vice Chair, Research Ethics Board

JS/BJM/kc

30 Bond Street
Toronto, Ontario
M5B 1W8
416-360-4000
www.stmichaelshospital.com

ST MICHAEL'S HOSPITAL HEALTH SCIENCES RESEARCH PROGRAM
OFFICE OF RESEARCH ADMINISTRATION
Authorization Check List for Submission of Research Proposals and Grant Requests

Applicant(s): Mrs. June Tavenor-Brake
Department: Department of Emergency Medicine,

Date: July 07, 2009

Funding Agency _____ Is this proposal: New ____ Renewal ____

Type of Grant: Operating _____, Equipment _____, Personnel _____, Other _____

Full Title of Study: REB# 09-114 - Preceptoring New Graduate Nurses in Emergency Care: The Lived Experience of the Preceptors

Proposal:	**Yes**	**No**	**If Yes, Reviewed by:**	**Pending Approval**	**Approved**	**Authorized By**
Human Subjects to be used	√	___	Research Ethics Board	_____	√	
Biohazard Risk	___	___	Safety Review Form	_____	_____	_____
Radioactive Material	___	___	Radiation Safety Officer	_____	_____	_____
Animal Subjects to be used	___	___	Inst Animal Care Committee	_____	_____	_____
			Research Vivarium Fee	_____	_____	_____
Does the Budget include:						
Salaries/Benefits	___	___	If Yes, Human Resource Review	_____	_____	_____
Is space available to do this Research?	___	___	If No, Space Allocation Committee Review	_____	_____	_____

Will the Proposed Research Involve the Following:	**Yes**	**No**	**If Yes, Dept Head Review:**		**Yes**	**No**	**If Yes, Dept Head Review:**
Nursing Services	___	___	_____	Hematology Dept	___	___	_____
Biochemistry Dept	___	___	_____	Anaesthesia Dept	___	___	_____
Pathology Dept	___	___	_____	Pharmacy Dept	___	___	_____
Med Art & Photography	___	___	_____	Respiratory Services	___	___	_____
Other	___	___	_____	Other	___	___	_____
Equipment Purchases:	___	___	If Yes, attach Quotations				
Equipment Maintenance:	___	___	If Yes, attach Quotations				

SMH RESEARCH PROGRAM ADMINISTRATION:

HOSPITAL OVERHEAD CHARGES: YES___ NO___

_____
MANAGER, OFFICE OF RESEARCH ADMINISTRATION

PLEASE SUBMIT ALL CONTRACTUAL AGREEMENTS FOR INSTITUTIONAL APPROVAL

DATE OF AUTHORIZATION: _____

FINANCE ACCOUNTS WILL NOT BE AUTHORIZED FOR RESEARCH PROPOSALS AND GRANT REQUESTS WITHOUT PRIOR COMPLETION OF THIS FORM.

THIS APPROVAL WILL BE VALID FOR A PERIOD OF 12 MONTHS FROM THE DATE OF AUTHORIZATION