Transition to Practice in Nonhospital Settings

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A survey conducted in 2001, and replicated in 2003 with the same results, found that fewer than 50% of employers thought newly licensed nurses were safe and effective in practice. These findings caused concern for boards of nursing, so in 2002 the National Council of State Boards of Nursing (NCSBN) began to examine transition to practice (TTP) in nursing, developing an evidence-based model program and studying its effectiveness in hospital and nonhospital settings. After completion of the TTP study in hospitals with registered nurses (RNs) published earlier in 2015, a study was conducted in nonhospital facilities with RNs and licensed practical nurses to determine if NCSBN's TTP program could be used effectively across settings. Sites volunteering to participate, however, faced many challenges while the study was underway. This article presents the TTP program, study design, challenges faced by nonhospital sites trying to implement a TTP program, and limited findings. These results are important because they highlight what was learned and set the groundwork for future TTP programs and studies involving nonhospital sites. The study examines factors faced by new graduates, such as work-related stress and job retention.

This study included 34 nonhospital settings in three states. The sites that volunteered were nursing homes and public health and home health settings. Twenty-three facilities hired 48 new nurses who were enrolled in the study between April 1, 2012, and October 31, 2012. Each site was randomized to either the study group (TTP group), which adopted the NCSBN's TTP program or the control group, which used its existing onboarding orientation program. Results are presented on competency assessment, reports of errors and safety practices, work stress, job satisfaction, and retention.

Two surveys found that fewer than 50% of employers thought newly licensed nurses (hereafter referred to as "new nurses") were safe and effective in practice (National Council of State Boards of Nursing [NCSBN], 2002, 2004). These concerning findings caused NCSBN to begin to examine transition to practice (TTP) in nursing, developing an evidence-based model program (see Figure 1) and studying its effectiveness in hospital and nonhospital settings. After completion of the TTP study in hospitals with registered nurses (RNs) (Spector et al., 2015), a study was conducted in nonhospital facilities with licensed practical nurses (LPNs) and RNs to determine if NCSBN's TTP program could be used effectively across settings. This article presents the findings of that study.

Literature Review

The need for an effective TTP program in nursing has been documented for more than 80 years (e.g., Townsend, 1931). Yet, comprehensive study of transition to practice in nursing did not begin until the 1970s. Marlene Kramer published her seminal work, *Reality Shock,* in which she proposed and assessed strategies to ameliorate that shock (Kramer, 1974). Patricia Benner also began studying the nurse's transition from novice to expert (Benner, 1984, 2004) based on the Dreyfus model of skill acquisi-

tion (Dreyfus & Dreyfus, 1986). More recently, there have been national calls for standardized TTP programs in nursing (Benner, Sutphen, Leonard & Day, 2010; Institute of Medicine, 2011; The Joint Commission, 2002).

Two recent reviews of TTP studies provide some insight into the quality of the TTP research (Anderson, Hair, & Todero, 2012; Theisen & Sandau, 2013). Both reviews stress the need for more well-designed studies with diverse settings and valid, reliable measurement tools; a better description of the educational intervention with more rigorous control over confounding variables; and the use of control groups for comparing outcomes. Anderson, Hair, and Todero (2012) assert that the limitations of most of the reviewed studies were the result of small sample sizes. They recommend multisite studies that would include diverse settings, so the results can be more widely generalized to new nurses.

Though the majority of new RNs work in hospitals, nearly 25% begin work in nonhospital settings. In NCSBN's RN practice analysis ($n = 2,832$), 76.2% of new RNs reported working in hospitals; 13.1% worked in long-term care settings; and 6.9% worked in community-based settings (NCSBN, 2012). In the LPN practice analysis, the majority (54.2%) of new LPNs worked in long-term care facilities; 25.2% worked in community-based or ambulatory care facilities; and 12.1% reported working in a hospital (NCSBN, 2013). Thus, in order for nursing to require

transition programs, we would need evidence from both hospital and nonhospital settings.

Yet, little literature and research exist on transition to practice in nonhospital settings. Two articles described model programs for nurses new to home care settings, both newly licensed nurses and those transferring from other practice areas (Carignan, Baker, Demers, & Samar, 2007; Meadows, 2009). Both emphasized the need for a precepted clinical experience for the new RN and added other content and experiences as a portion of their program. They both reported higher retention when employers used their programs. Carignan, Baker, Demers, and Samar (2007) also reported on preliminary outcomes from three self-report scales (satisfaction, control over practice, and the new graduate experience), finding that their new nurses consistently scored higher than those in the hospital residencies, though no statistical inferences were made.

One study of home care (Patterson, Hart, Bishop, & Purdy, 2013) conducted in Ontario, Canada, used interpretive phenomenology to explore the experiences of eight new nurses as they transitioned into independent practice in home care over a 6-month period. Researchers found three important interrelated factors (personal factors, relational factors, and systemic factors) that either pulled new graduates into home care or pushed them away. A strong relational factor was a positive preceptor-preceptee experience, which supports the findings of Meadows (2009) and Carignan et al. (2007) and was also found with transition to hospital settings (Anderson et al., 2012; Theisen & Sandau, 2013).

Larger, nationwide studies have found that hospitals, not nonhospital settings, offer the most comprehensive TTP programs, and the programs are more prevalent for RNs than for LPNs. In 2006, a survey of new RNs and LPNs was conducted to investigate the extent of transition experiences in their first jobs (NCSBN, 2006). The new graduates (628 RNs and 519 LPNs) were employed in 1,015 facilities, including hospitals and long-term care and community-based facilities. In hospitals, 33.4% of RNs and 22.4% of LPNs had a TTP program. In long-term care facilities, 5.6% of RNs and 8.8% of LPNs had a TTP program. And in community-based agencies, 19% of RNs and 14.7% of LPNs had a TTP program. In a more recent survey of nonprofit home health care and hospice agencies (n = 56 in 2011 and n = 44 in 2013), Pittman, Bass, Hargraves, Herrera, and Thompson (2015) report that 2.5% of these agencies had nurse residencies in 2011, with that increasing to 14.7% in 2013.

Changes are taking place in health care. Inpatient admissions are falling and outpatient admissions are increasing. Compared to new RNs surveyed in 2004–2005, new RNs in 2010–2011 were less likely to be working in hospitals and more likely to be working in nursing homes, home health, and ambulatory care (Kovner, Brewer, Fatehi, & Katigbak, 2014). Further, the impact of the Affordable Care Act on prevention and Medicare's Hospital Readmission Program is likely to promote the use of outpatient and community services (Mancino & Feeg,

FIGURE 1

Transition to Practice Model
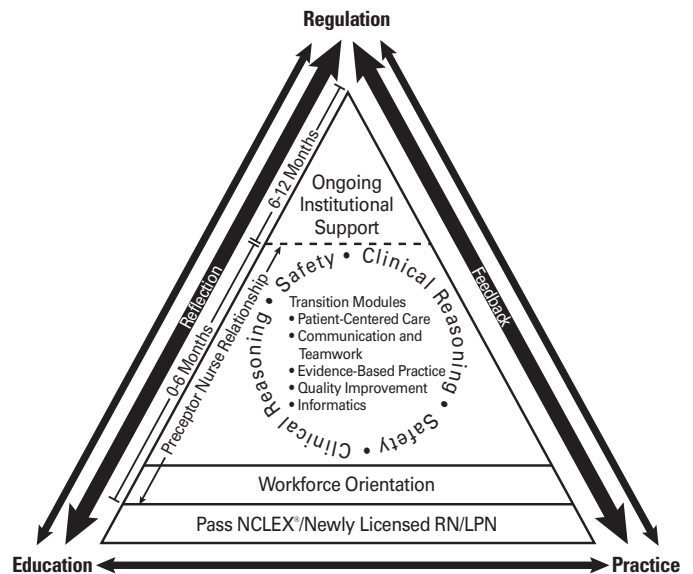
2014). As of December 31, 2012, more than 1.4 million people in the United States were living in nursing homes (Centers for Medicare & Medicaid Services, 2013), and this number is expected to rise not only because of the aging population but also because nursing homes are providing post-acute and skilled care to older adults.

TTP Study: Nonhospital Settings

The aims of the nonhospital TTP study were to:
1. study the use of an evidence-based TTP program in facilities other than hospitals, and with RNs and LPNs.
2. assess its generalizability to environments beyond the acute-care setting with only RNs.

This study provides information on transition to practice in nonhospital settings, where there is a demonstrated need for further work. It will further inform boards of nursing and managers/administrators in these settings about implementing a successful TTP program as well as inform nurse educators about preparing students for nonhospital settings.

Study Design

This was a mixed-method comparison study using a longitudinal, randomized, multisite design to examine the effects of TTP programs in assimilating new graduate nurses to the practice environment in their first professional nursing position.

The study included new nurses who were hired at nonhospital settings, including long-term care, home health, and public health. The study began on March 1, 2012, when preceptors were selected and assigned to take the NCSBN model TTP training

module. New nurses were enrolled from April 1, 2012, through October 31, 2012, and were followed for 12 months.

Preparation for the Study

Five online modules, based on the evidence-based TTP model (see Figure 1), were developed for RNs and used in NCSBN's TTP study in hospital settings (Spector et al., 2015). These same modules were used for the RNs in this study, but were modified by educators with expertise in LPN education for the LPNs in the study group (hereafter known as the TTP group). The modules were developed for general transition to practice concepts, and were not individualized to settings or specialties. The modules were completed online to control for differences in delivery methods across sites.

The following is a summary of the TTP model program:
1. A trained preceptor is key to the model and all new nurses are assigned to a seasoned nurse in the new nurse's area of practice for the first 6 months of practice. The preceptors are educated for their role through an online preceptor training module.
2. In the first 6 months the new nurse completes five online modules
   - Patient-centered care—with major subcategories such as content specialty (work with preceptor); multiple dimensions of patients; prioritizing and organizing; just culture; moral/ethical concerns; health care systems; professional boundaries
   - Communication and teamwork—with major subcategories such as transitioning from student to an accountable nurse (role socialization); communicating to ensure safe and quality care (TeamSTEPPS, 2014); delegating and decision making; work environment and conflicts; growing as a professional nurse
   - Evidence-based practice—with major subcategories such as defining evidence-based practice with scenarios; using databases; critically appraising the literature; using clinical practice guidelines; evidence-based practice models; implementing evidence-based practice in practice settings
   - Quality improvement—with major subcategories such as overview of quality improvement; identifying improvement gap opportunities; quality improvement tools; measuring and monitoring the data; using quality improvement in practice (case study); keys to successful improvement
   - Informatics—with major subcategories such as informatics as the foundation of nursing; computer and information literacy skills; information management skills with cases; informatics and the nurse's role in delivering safe patient care
3. Safety and clinical reasoning threaded throughout the modules
4. Institutional support during the second 6 months of the program. After completing the formal program, the new nurse would be encouraged and supported to participate in system activities, such as committees, unit projects, and other learning opportunities offered by the institution.
5. Feedback and reflection. These components are threaded throughout the first year of practice and facilitated by the new nurses' preceptors and managers.

Institutional Review Board

Institutional review board (IRB) approval was obtained for all 23 sites. Twenty sites used the Western Institutional Review Board, and three sites used their local IRBs. All study participants were given information about the study and were provided the opportunity to ask and have answered any questions they had. Each study participant signed consent forms.

Selection Criteria: Sites and Subjects

The study was conducted in facilities throughout Illinois, North Carolina, and Ohio. In order to participate, the following inclusion criteria were required:
- Hire new graduate RNs or LPNs between April 1, 2012, and October 31, 2012
- Allow new nurses at least 20 hours per month for 3 months during work hours to access the online TTP modules
- Allow preceptors at least 10 hours to access the online training module during scheduled work hours
- Identify an internal candidate to serve as a site coordinator to manage IRB submission and organizational research efforts for the study
- Agree to share patient site demographics, staffing, and turnover data with the investigators.
   The new nurses had to meet the following inclusion criteria:
- Be employed in their first job after graduating from a prelicensure LPN, diploma, associate-degree, bachelor's-degree, or master's-entry program
- Pass the NCLEX-PN® or NCLEX-RN®
- Be employed by the participating organization as an LPN or RN not more than 30 days before the enrollment period (April 1, 2012, through October 31, 2012)
- Be hired to fill a 0.5 full-time employee position or greater.
   Nurses were excluded from the study if they were employed by the facility before April 1, 2012, or after October 31, 2012. (An RN who had worked as an LPN before becoming an RN was eligible). Also excluded were nurses who previously worked in permanent positions as RNs or LPNs.

Sample: Sites, Subjects, and Preceptors

A total of 34 sites volunteered for the study. However, only 23 of the original sites actually hired new nurses (17 nursing homes, 3 home health agencies, and 3 public health agencies). Of the 23, 13 were study (TTP) group sites (9 nursing homes, 2 home health agencies, and 2 public health agencies) and 10 were con-

trol group sites (8 nursing homes, 1 home health agency, and 1 public health agency).

Most of the 34 sites volunteering had small TTP or onboarding programs before the study; 16 had a structured transition curriculum (13 nursing homes, 2 home health agencies, and 1 public health agency). Further, 22 had new nurses work with preceptors (16 nursing homes, 3 home health agencies, and 3 public health agencies). Only nine sites had both. The curriculum components most often present were quality improvement and patient safety.

The 23 sites hired 48 new nurses (16 LPNs and 32 RNs). Nursing homes hired all 16 LPNs and 21 of the RNs. Public health agencies hired 4 RNs, and home health agencies hired 7 RNs. Of these new nurses, 30 from 20 sites responded to the demographic survey and were on average 30.4 years of age (range, 20 to 54). The majority were RNs with baccalaureate or graduate-entry degrees (43%); 30% were RNs with associate degrees; and 27% were LPNs. The new nurses were mostly female (93%) and white (73%); 17% were African American, and 10% were Asian.

There were 57 preceptors from 20 sites (21 from nursing homes, 23 from home health agencies, and 13 from public health agencies), though not all were assigned a new nurse. Of the preceptors who were assigned to new nurses and completed surveys, 12 were from TTP sites and 6 from control sites. Six preceptors evaluated LPNs, and 12 evaluated RNs. Four of the preceptors were themselves LPNs, and 14 were RNs. All were female; 13 were white (72%), 4 were African American (22%), and 1 was Asian (6%). Their average age was 39 in a range of 26 to 47.

All sites provided demographic data via an online instrument at the start of the study and at 12 and 18 months. The site coordinators provided data on the organization's ownership and control, staffing, rotation of students through the agency, description of the current transition program, numbers of patients served, and retention data on the new nurses hired between April 1, 2012, and October 31, 2012.

At this point, we noted that the facilities participating in the study did not hire as many new graduate nurses as they predicted and we began realizing the challenges facing nonhospital facilities. We were aware that the number of participants did not meet the number the power analysis indicated we would need for inferential analysis; however, because there is so little information on transition to practice in the groups we targeted for this study, we decided to move forward and see what we could learn and possibly set the groundwork for future investigation.

Procedure

The sites were randomized based on the type of nonhospital setting (nursing homes, home health agencies, or public health agencies) and the number of new nurses expected to be hired. Sites were randomly assigned to the TTP or control group for 1 year. Settings in the study group were to adopt the entire NCSBN TTP program for the study duration, while nonhospital settings

in the control group maintained their usual onboarding program. Preceptors were assigned to new nurses in the TTP group and provided data about their new nurses' performance. In the control group, preceptors, or managers if their program had no preceptors, were asked to participate in the study and to provide data on their new nurses. Each setting assigned a site coordinator to enroll the new nurses and preceptors into the study, manage the study protocol, and enter data about the particular facility. Additionally, for each state the NCSBN hired a state coordinator who connected on a daily basis with the site coordinators, answering questions and maintaining the integrity of the study.

TTP Group

Within the first month after the start date, demographic data were collected from the new nurses, and they were expected to start the online TTP modules as well as attend the organization's existing orientation program. The TTP group could complete the modules at their own pace, though the modules were to be completed by month 6 after the employment start date.

The new nurses were partnered with a preceptor who worked in the same unit or department as the new nurse. The new nurse and preceptor were expected to participate in the TTP program for a 6-month period. This involved the new nurse and the preceptor meeting to review the program and then meeting at least weekly throughout the 6-month transition period for the preceptor to provide feedback and to discuss questions or any areas of concern.

At baseline (within 30 days of hire) and at 6, 9, and 12 months, the nurses in the TTP group completed online surveys about their reports of errors, use of safety practices, competency, work stress, and job satisfaction. As an incentive for participating in the study, the new nurses in the TTP group received 20 contact hours of continuing education for completing the modules. At the end of the study, they were invited to participate in a telephone interview to gather qualitative data.

The preceptors assigned to new graduates in the TTP group completed the preceptor training module before working with a new nurse. Before starting the module, they were expected to complete a demographics form via an online survey within 1 month after the enrollment date. At 6, 9, and 12 months, the TTP preceptors completed surveys about their new nurses' competency. Throughout the 6-month preceptorship, the preceptor was expected to be available to the new graduate. TTP preceptors received 20 contact hours of continuing education for completing the module and participating in a preceptorship, and they were invited to participate in a telephone interview at the end of the study.

Control Group

The new nurses in the control group went through the institution's usual orientation and onboarding program. Within the first month after the start date, they entered demographic data via

the electronic database. At baseline and at 6, 9, and 12 months, they completed surveys about their reports of errors, use of safety practices, competency, work stress, and job satisfaction.

The preceptors or managers completed a demographic online survey within 1 month of the enrollment date and provided data at 6, 9, and 12 months, assessing the new nurse.

New Nurse and Preceptor Tools

Two instruments were used to evaluate new nurse competence: the Overall Competence Tool and the Specific Competency Tool. The Overall Competence Tool has previously been used by NCSBN, and the new nurses and their preceptors rate the new nurses on six items. The Specific Competency Tool was developed by modifying the Nursing Executive Center's Critical Thinking Diagnostic (Berkow, Virkstis, Stewart, Aronson, & Donohue, 2011) tool (with permission). The Critical Thinking Diagnostic instrument has previously established validity and reliability. In collaboration with experts from the Quality and Safety Education for Nurses (QSEN) initiative (Sullivan, Hirst, & Cronenwett, 2009), the tool was modified to include QSEN competencies; then the tool was piloted in three Chicago hospitals before the study. This tool was developed for RN scope of practice and was modified by experts for LPN scope of practice. As with the Overall Competence Tool, the new nurses and their preceptors evaluated the new nurses' competence with the Specific Competence Tool.

The Work Stress Tool consists of four questions and was developed by NCSBN staff. The members of an advisory panel confirmed the questions had face validity. The Brayfield & Rothe Index of Job Satisfaction (Brayfield & Rothe, 1951) was used to measure job satisfaction. Validity and reliability have been well established in numerous studies for this instrument.

The NCSBN Practice Issues Index was revised from a previous NCSBN instrument and was used for collecting the number of self-reported errors made and positive ("I was the first to recognize a change") and negative ("I violated standard precautions") safety practices identified by the new nurses. The errors and safety practices were reported as a mean percentage of those listed. Because this was a simple tool for self-reporting errors and safety practices, no psychometric testing was required, though experts agreed that there was face validity.

L. C. Williams and Associates conducted and analyzed telephone interviews with 6 new nurses, 13 preceptors, and 8 site coordinators. These interviews were conducted between June 6, 2013, and November 13, 2013. Additionally, a state coordinator focus group was held in Chicago on August 9, 2013. Even though a $100 incentive was provided to subjects recruited, the firm reported having significantly more challenges than usual in recruitment.

Data Analysis

Automatic e-mail reminders were sent to the new nurses and preceptors about due dates and past due dates for completing their surveys. Additionally, the site coordinators received reminders and were expected to notify the new nurses and preceptors. The state coordinators logged into the system daily and viewed the status of survey completion for their sites, and notified the site coordinators of outstanding surveys. Even with this system, there were not enough data for empirical analysis of the quantitative data so those data are reported here descriptively.

The new nurse survey tools on errors and safety practices contained open-ended questions that would provide qualitative data. Qualitative comments from the surveys on errors and safety practices by the new nurses at baseline and at 6, 9, and 12 months were analyzed by using NVivo software (QSR International Pty Ltd, Doncaster, Victoria, Australia). The comment data were imported into NVivo, and all analysis and memos were created within this database. Using a systematic and dynamic content analysis approach, the data were examined for patterns and themes.

Results

Observations of the quantitative data are presented. The qualitative data presented here provide explanations about the challenges of implementing TTP programs in nonhospital sites and about opportunities for future programs and study.

Patient Care Errors and Safety Practices

The NCSBN Practice Issues Index was used by the new nurses to report errors they made within 2 weeks of answering the survey and the positive or negative safety practices they used. Interestingly, when we compared these data to those of the larger TTP study done in hospital settings, we found a much higher number of new nurses in nonhospital settings report making an error than new nurses employed in hospital settings (Spector et al., 2015). However, the reports of positive and negative safety practices were similar to those reported in the hospital study. While conclusions can't be made with these limited data, it would be interesting in future research to investigate the higher reports of errors by new nurses in nonhospital settings.

Competency

For the Overall Competency Tool, the new nurses reported how they and others (preceptor or manager, supervisor, patients, nurses, and others from the health care profession) would rate their competence with ratings of 1 = poor and 4 = excellent. Examination of the pattern of new nurse scores showed increases in overall and specific competency scores from baseline to 9 months. The scores at 12 months dropped but the number of responses also dropped for the study group at 12 months.

In the Specific Competency Tool, patient-centered care, quality improvement/evidence-based practice, use of technology, and communication and teamwork were assessed. For this tool, the ratings were 1 = low and 5 = high. For the most part, increases from baseline to 9 months were similar to the overall competency reports. Interestingly, as in hospital settings, the pre-

ceptors tended to rate the new graduates higher than the graduates rated themselves on the competency scales.

Work Stress and Job Satisfaction

Work stress was rated on a scale of 1 to 3 with 0 = low stress and 3 = high stress. Job satisfaction was scored from 1 = low to 5 = high. Stress was higher in the study nurses than in the control nurses initially and at 6 months but the pattern reversed at 9 months when the control nurses showed more work stress. Job satisfaction was scored from 1 = low to 5 = high, and it declined in the study nurses, though remained about the same in the control group.

New Nurse Turnover

Over the first year in practice, the retention rate of new nurses hired in nonhospital settings (see Table 1) was only 45.8%, TTP sites retained 55% of their new hires after 1 year, and control sites retained only 30%. Involuntary turnover (terminations and left due to injury) was 6% in the study sites and 12% in the control sites. These retention rates are much lower than the retention rate of hospital-based nurses, which had an average across all groups of 83% in the hospital-based study (Spector et al., 2015).

Much of the turnover was in nursing homes, which retained only 35% of their nurses over 1 year. However, the rate varied widely between TTP sites and control sites (40% versus 29%). (See Table 2). Further, the retention rate for RNs (53%) was higher than that for LPNs (31%). Of the RNs, 6% left nonhospital settings involuntarily; of the LPNs, 12.5% left involuntarily. By contrast, home health and public health facilities had retention rates of 85% and 75%, respectively. Because of the low number of these facilities, however, the percentages should be viewed with caution.

Qualitative Data

We collected qualitative data two ways. TTP and control group nurses provided comments on their experiences with patient safety on electronic surveys. Secondly, phone interviews were conducted with the TTP new nurses, preceptors, and site coordinators after the study, and a focus group was held with the state coordinators. These data were collected to learn more about the specific needs of nurses in nonhospital sites. The following information is typical of the themes or patterns that were identified.

Surveys

At baseline and at 6, 9, and 12 months, the new nurses provided information on their experiences with errors and near misses, reasons they might leave the organization, and recommendations regarding the TTP program.

The following were themes related to patient safety and errors:
- Identified errors (self or others)
- Preceptor as safety net

TABLE 1

New Nurse Turnover

N = 48 RNs and LPNs	Retained	Left Voluntarily	Left Involuntarily
Overall	45.8%	45.8%	8.3%
Group			
Study (TTP)	55%	39%	6%
Control	30%	59%	12%
License type			
RNs	53%	41%	6%
LPNs	31%	56%	12.5%
Facility type			
Nursing home	35%	54%	10.8%
Home health	86%	14%	0%
Public health	75%	25%	0%

- Expressions of confidence
- Perceived adverse event as "unavoidable"
- Poor communication with physicians.

Examples of when nurses perceived an unavoidable event included, "… patient noncompliance in taking medications in their home" and "… patient refusal of treatment."

The themes related to reasons for considering leaving the institutions included:
- Change specialty
- Professional growth
- Geographic location
- Better work environment.

Related to generalizing the TTP program to nonhospital sites, one nurse provided this positive comment: "I really appreciate this program and the way it enhanced my entry into this new nurse position." Another nurse stated: "Preceptor was very supportive and informative." However, there were issues with the TTP program. One nurse commented that "the program activities seem to be focused on hospital floor nursing when the patient-to-nurse ratio is 5 to 7 and the health care team is present. In the nursing home, the ratio is much higher, and the health care team is available only by phone."

Telephone Interviews and Focus Group

All groups tended to agree that the TTP program had the potential to be effective for onboarding new graduates in nonhospital sites. All were excited about having the opportunity to shift the nursing culture by improving transition programs. They recommended that the components of the program be more tailored to fit diverse settings. The participants acknowledged the importance of preceptors being actively engaged in transitioning new nurses. A major concern for the nursing homes was the need for

TABLE 2			
Turnover of Nursing Home New Nurses by Group			
	Retained	Left Voluntarily	Left Involuntarily
Study (TTP) group	40%	52%	9%
Control group	29%	57%	14%

buy-in from the administrators and adequate resources to be able to implement the program.

New Nurses

Generally, new nurses found that the TTP program:
- Increased their overall confidence and competence
- Alleviated some fears that come with being less experienced
- Served as a reference that they went back to
- Provided structure and guidance related to effective communication with physicians and nurses.

New nurses reported completing the modules in the office, in the field, at home, or in some combination of the three. Some of the new nurses found the TTP program experience to be overwhelming because of all their other responsibilities. For example, one new nurse reported, "It's hard to sit down for long periods and not have to get up constantly for distractions and someone falling and things like that."

Some other limitations of the TTP program or barriers perceived by new nurses included:
- Added extra work/stress to the workday
- Modules were geared toward hospital nursing
- Modules needed more specialty content, such as care of dementia patients in the home.

Preceptors

The new nurses placed high value on the preceptor's role in their transition program. Generally, they described effective preceptors as supportive, and the nurses stated that the preceptors provided useful feedback and established long-term relationships with them. The home health nurses felt the most positive about the preceptors because they often found themselves alone during the day, so the support and reassurance provided by the preceptor was quite valuable. The new nurses described effective preceptors as:
- encouraging, engaged, emotionally supportive and reassuring
- facilitating a new nurse's early experiences with administering care
- offering insight and valuable wisdom
- leading by example.

When the preceptor experience was positive, the new nurses said it reduced their fear and anxiety and increased their confidence and clinical knowledge. One new nurse said, "… She was great about showing me how to do it or walking me through it.

She pushed me so that I would have to learn things sometimes that I was scared to learn…."

The negative comments tended to be about being too busy in their workplaces or having overwhelming patient loads. An exemplar comment from a preceptor was, "I apologize to say, but I had negative thoughts in the beginning … but once we were introduced to the modules … I was a lot more passionate about it. So I went from negative feelings to positive."

The preceptors did have varying opinions about the usefulness of the preceptor module, and some would have liked more information about the new nurses' modules. Preceptors found the following parts of the preceptor modules most helpful:
- Delegation and prioritizing
- Assessment
- Concept mapping
- Different learning styles
- Conflict resolution
- Communication.

The preceptors also mentioned factors they thought ensured a strong bond with the new nurse:
- Providing open, encouraging communication
- Being patient and allowing sufficient time for nurses to learn
- Not being punitive
- Not being judgmental
- Always remaining friendly and approachable.

Overall, the preceptors felt positive about the TTP program; one comment stated, "… what I love best about the TTP program is it allowed for us to be a partner with the nurse …." Whereas the new nurse not in the TTP program said, "… it just felt like a basic textbook orientation, here's your checklist, go at it and you were done …." One preceptor thought it improved patient safety: "In the facility where we are, I think the TTP program decreased the error rate and increased the ability to know what they're doing and understand what they're not doing." However, the preceptorship did add to the stress of some of the preceptors because there was not enough institutional support. One preceptor noted, "It can be a little stressful for the preceptor because they're trying to do their job and precept at the same time, especially to a new nurse that has lots of questions."

The preceptors were creative about connecting with their new nurses and providing feedback. One provided feedback, after doing chart reviews, via e-mail. Another would meet the new nurse in her car. They also described impromptu discussions when they were able to work side by side.

A few preceptors actually scheduled recurring blocks of time to sit down with their preceptees either in person or over the phone to provide feedback.

Some comments were less positive, indicating new nurse preceptors weren't knowledgeable enough. One new nurse described her preceptor as "confused" about the TTP material and in need of "more education" about TTP. Another nurse commented, "The only issue I ever had with the program I guess

was my preceptor and management not knowing really too much about it ....."

Site Coordinators

In general, site coordinators describe TTP as an exciting, positive, innovative, helpful program that has the potential for positive change in nursing. However, a few described the program as overwhelming, partly because of technical issues with the modules (no access to e-mails, logging-in problems, and delivery issues).

Site coordinators faced a lack of resources, particularly in nursing homes, as illustrated by this comment: "And the barrier I had was, not all our computers are equipped to receive modules like that. So I had to have them use different computers so that they could access the modules." Site coordinators said the preceptors often did not have enough time to contribute to the preceptorship, as is apparent from this comment: "... you're seeing eighty to ninety patients a day. And we just don't have the staff to give the new nurse and preceptor a reduced load." Yet, the site coordinators thought the preceptorship was key to the program. They said the biggest challenge in the program was preceptors not having enough time to spend with the new nurses.

Another major challenge was a lack of buy-in from the organization, which impacted several facets of the TTP program. Lack of employer support was exemplified by the following comment: "They had to have time to do modules on work time. They had to have extra time set aside with their preceptor to discuss the modules. They had to have this much extra time from their education budget devoted to onboarding a new nurse resident. And we struggle with that. I think just because of the financial aspect of it."

State Coordinators

Discussions with the state coordinators provide insight into why it has been difficult to implement the TTP program into nonhospital sites. One state coordinator remarked that "it's just a different world [from hospitals]. With the clinical ladders there [in hospitals], learning and improving your skills is very much encouraged, whereas I don't get that sense from long-term care facilities. They're more like 'come and do your job and leave.'" Many of the nursing homes did not view a TTP program as a priority, according to the state coordinators: "... Looking to do this into the long-term care, extended care, I think it's doable, but they have limited resources."

However, that culture was not seen in the public health or home health settings. One state coordinator said: "The public health sites were very focused on this; they just don't have the budget for many new nurses, if any." A similar comment was made about home health: "Home health took it and ran." On the other hand, the state coordinators concurred that "... long-term care facilities had the potential to benefit most from TTP; but disappointingly, these sites seemed to struggle the most with implementation."

Discussion

The NCSBN Transition to Practice Program was implemented by 13 nonhospital sites, and the new nurse and preceptor responses were compared to the responses from participants in 10 nonhospital control sites (home health, public health, and nursing homes). In nursing homes it was implemented for LPNs as well as RNs. All sites were able to implement the program so, to that extent, it was generalizable. The challenges that arose from this study relate to the feasibility of implementing the program, and the qualitative data helped in understanding the feasibility issues. While they may be generalized to RNs and LPNs in nonhospital settings, transition programs in these settings all need tailoring to be feasible. Further, more research, resources, and administrative support in these settings are needed to implement transition programs.

Nursing home sites were reluctant to participate in the study, and ongoing engagement with them was challenging. Part of this reluctance to join the study was that when the study began, there were some additional Centers for Medicare & Medicaid Services requirements, which would add to their already overwhelmed workplaces. Further, lack of resources was a major challenge for nursing homes. Though the home health and public health sites were more engaged, they only enrolled seven and four new nurses, respectively, even after a 6-month enrollment period. Because of the lack of responses to our surveys, the results are presented as descriptive results only.

The study provides nursing with some new and unique information on the diverse settings that hire new graduate nurses and their transition to practice in nonhospital settings. This is a beginning effort to report on the feasibility of nonhospital facilities implementing TTP programs. We are seeing more new graduates going into nonhospital settings (Kovner et al., 2014; NCSBN, 2012, 2013), and Mancino and Feeg (2014) have predicted this trend will continue because of health care reform. Therefore, studies on transition to practice in nonhospital settings fill a very important gap.

What We Learned

Despite the low participation rate, this study provides information for continued work and development of a TTP program for nonhospital sites. These lessons include:

- One size does not fit all. TTP programs need to be tailored to the type of facility where they will be used.
- Specialty content related to long-term care, home health, and public health needs to be incorporated into the program because facilities do not have the resources to add or supply this information to new employees, much less new graduates.
- Preceptorships are important and add significant value to a TTP program in nonhospital settings.
- Buy-in from the facility administration is essential. Though we supported and trained the site coordinators, we did not

focus on the facility administration, which is necessary for success of the program.

- The modules were burdensome to new nurses in settings that could not allot time for them to complete the modules during working hours.
- The TTP program may have had some impact on the retention of new nurses in the participating facilities.
- Further studies are needed to learn more about the impact of TTP programs on safety, competence, work stress, and job satisfaction.

Even though nursing homes were the least-engaged sites in the study, the state coordinators thought they had the greatest need for standardized transition programs. The low retention data were remarkable and support the state coordinators' conclusions. In the TTP group, the retention rate was 40% over the 12-month period; in the control group, it was 29%. This does reflect the overall high turnover rate in nursing homes, reported to be up to 62.8% for RNs and 43% for LPNs (American Health Care Association, 2011). The turnover rate for all licensed nurses in nursing homes has been reported to be 47% (Trinkoff et al., 2013). If there is support for implementing a standardized TTP program and preceptorship in nursing homes, it is likely the retention rate would increase.

The public health and home health sites in the TTP group reported more positive experiences with the program, and the site and state coordinators reported more administrative support from these sites. In the phone interview data, there were many comments about the importance of the preceptor at these sites because often the nurse is alone and needs feedback. Similarly, at these sites as well as in nursing homes, preceptors are not just down the hall as they are in some hospitals. The preceptors often found creative ways to connect with their new nurses in these types of sites, including meeting in their cars, talking on the phone, and setting up blocks of time.

Conclusion

The descriptive data indicated that nonhospital sites, particularly nursing homes, could benefit from TTP programs. The high error rate and low retention rates compared with hospital settings speak to the pressing need for a standardized TTP program. Although the nursing home TTP group did not fare nearly as well as the hospitals in turnover rates, they had a much better retention rate (40%) than the control group (29%).

The climate is better for public health and home health, and for the most part, these settings were able to implement a program. There was more support and enthusiasm for a TTP program at these sites. However, because they do not hire many new nurses, these sites provided us very little data.

Because of lack of participant response in the study, we were only able to present descriptive data. Future research using

quality and safety outcomes and return on investment to make a case for transition to practice should be a priority.

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