The Lived Experience of New Nurses: Importance of the Clinical Preceptor

Penny Moore, PhD, RN, CNL, and Carolyn Spence Cagle, PhD, RNC

New baccalaureate nurse graduates need mentoring to become competent professionals. Creative approaches to new nurses’ practice initiation to complex, high-acuity patient care environments are needed to support workplace retention (Halfer, 2011; Halfer, Graf, & Sullivan, 2008). The high number of nurses of retirement age who continue to work because of recent global economic issues has lessened current concerns about a nursing shortage (Sephel, 2011). Several authorities, however, predict at least a 50% turnover rate for these nurses and others in the registered nurse work force as a result of retirement, improved global economic conditions, and other issues in the next decade (Auerbach, Buerhaus, & Staiger, 2012; Giallonardo, Wong, & Iwaisi, 2010; Potempa, 2012). Additional evidence from the recent Institute of Medicine (2010) study, The Future of Nursing: Leading Change, Advancing Health, suggested that, by 2020, 80% of new nurses will need a baccalaureate degree and an internship program to participate in health care reform to meet patient health needs. Because 42% of new nurses work in acute care, hospitals need evidence-based interventions, including new nurse internships and residency programs, to ensure that those nurses have the necessary competencies and role satisfaction to remain in the workplace (Bowles & Candela, 2005; Cowin, 2002; Dracup & Morris, 2007; Kramer, Maguire, Halfer, Brewer, & Schmalenberg, 2011; Lofmark, Smide, & Wikblad, 2006; Sephel, 2011).

PROBLEM AND SIGNIFICANCE

One-year nurse residency programs are an evidence-based approach to increase the recruitment, readiness...
for practice, and retention of new nurses (Halfer, 2007, 2011; Lofmark et al., 2006). Several major databases link the terms “residency” and “internship” and often use them interchangeably. Residency or internship programs generally include classroom instruction, mentors, clinical nurse exchange, and professional development support. These components help new nurses to move from the skill set learned in the academic setting to the critical thinking and team-based work required in the clinical setting (Halfer, 2007; Halfer et al., 2008; Winfield, Melo, & Myrick, 2009). Because most evidence from the United States addressing the benefits of an internship or residency has been quantitative, the experience of being a new nurse intern in today’s clinical environment has not been described in detail. Further research is needed to understand this experience, based on pleas from providers, clinical administrators, and consumers for identifying and implementing effective transition programs for new nurses, particularly during the stressful first year of employment (Hatler, Stoffers, Kelly, Redding, & Carr, 2011). This study used an appropriate qualitative method to explore this phenomenon. Data gained from such a methodological approach to assess new nurses’ experience will help nurse administrators and nurse educators to identify and address factors to improve internship and residency programs to increase new nurses’ workplace satisfaction and retention.

REVIEW OF THE LITERATURE
Consequences of Nurse Dissatisfaction

Discovering creative ways to recruit and retain new nurses benefits both patients and agency employers. Agencies experience a 35% to 50% turnover rate among new nurses during their first year of employment as a result of nurse dissatisfaction and other factors (Williams, Goode, Krsek, Bednash, & Lynn, 2007; Winfield et al., 2009). Nurse turnover interrupts the efficiency of the health care team and contributes to poor quality of care (National Quality Forum, 2007). High nurse turnover leads to poor communication within health care teams and contributes to sentinel events in acute care agencies (Joint Commission, 2007). Health care agencies assume a high cost for nurse turnover. Several authors noted a replacement cost of $44,000 to $67,000 for one nurse who chooses to leave the workplace (Halfer, 2007; Jones, 2005, 2008; Jones & Gates, 2007).

Health care agencies benefit when they have a system in place to recruit and retain new nurses and when they provide resources to support those nurses’ ability to provide quality patient- and family-centered care. One such resource is a new nurse mentoring program, which can decrease nurse turnover rates by 6% to 13% or more (Altier & Krsek, 2006; Cubit & Ryan, 2011; Halfer, 2007, 2011; Williams et al., 2007). In a study assessing new nurse job satisfaction during 12-month post-baccalaureate residency programs at six academic medical centers, Altier and Krsek (2006) found a low turnover rate (9.8%) among new nurses. Mentors played an integral role in those programs. Although new nurses showed no change in job satisfaction using the McCloskey-Mueller Satisfaction Survey at the beginning and the end of the residency, they showed decreased satisfaction scores on the variables of praise and professional opportunities by the end of the residency program (Altier & Krsek, 2006).

Based on interest in assessing the effect of a 1-year residency program on job satisfaction and retention in 12 U.S. university hospital settings, Williams et al. (2007) also measured new nurses’ job satisfaction at entry, midway, and at the end of a residency program using the McCloskey-Mueller instrument. They found that nurses’ scores on variables for professional opportunities and control-responsibility declined midway through the residency (Williams et al., 2007). Knowledge and work/job satisfaction quantitative data from a study using the Halfer-Graf Job/Work Environment Satisfaction Survey (Halfer & Graf, 2006) indicated that new nurses were significantly dissatisfied with essential job knowledge/skills, access to resources, and professional development opportunities in the first 18 months of employment. This finding supported Halfer’s (2007) implementation of a theoretically based new nurse orientation program to support the development of needed competencies and role transition of newly hired nurses in a large medical center.

Readiness to Practice: Role of the Preceptor

Qualitative evidence supports new nurse residents’ higher satisfaction scores, particularly if they perceive readiness to practice. Readiness to practice correlates with new nurses’ skills, knowledge, and judgment gained through work (Berkow, Virktis, Stewart, & Conway, 2009; Hickey, 2009). However, the conceptual meaning of readiness to practice and its relationship to nurse competency, the ability to manage complex patient needs, and the role of internships/residency programs in developing readiness to practice are unclear (Wolff, Pesut, & Regan, 2010; Wolff, Regan, Pesut, & Black, 2010).

As part of nurse residency and internship models, preceptor programs increase new nurse retention (Salt, Cummings, & Profetto-McGrath, 2008). Preceptors serve as specialty experts and teachers to promote evidence-based nursing practice (Walters & Brown, 2010). Preceptors supervise and evaluate new nurses and es-
tablish strong interpersonal relationships with them to meet specific goals (Walters & Brown, 2010). Boyer (2008) added that preceptors provide a safe environment that allows new nurses to learn and develop. Like a teacher-student relationship, a strong preceptor-new nurse relationship focuses on support and professional role socialization and enhances new nurses’ transition to practice to positively affect workplace retention. In one study of new nurses working with preceptors, retention increased from 64% to 88% in 1 year (Cubit & Ryan, 2011). To achieve similar retention gains, various authors recommended structured and sustained mentoring programs during the first year of a new nurse’s practice to connect expectations of professional work life with an accurate definition of the work role (Cubit & Lopez, 2011; Duchscher, 2008, 2009; Ferguson, 2011; Halfer, 2011; Kramer et al., 2011; Wangensteen, Johansson, & Nordström, 2008).

New Nurse Perceptions

New nurses’ perceptions of the first year of practice may assist health care employers to develop ways to increase workplace satisfaction and retention (Halfer, 2011; Halfer & Graf, 2006; Williams et al., 2007; Wolff, Pesut, et al., 2010). Based on more than a decade of research to clarify the professional role transition for new nurses, Duchscher (2008, 2009) noted that new Canadian nurses often experience “transition shock” in their first months of employment. Duchscher’s theory of Transition Shock involves a nonlinear process that pushes the new nurse through developmental and professional growth, reflecting intellectual, physical, developmental, emotional, skill, and role relationship changes. These changes occur particularly during the first 4 months of employment (Duchscher, 2009). This process causes the new nurse to experience anxiety, insecurity, inadequacy, and emotional imbalance that may lead to departure from the workplace. New nurses in Australia, Norway, and Sweden experience similar feelings of imbalance, and they need support to cope with their “newness” and gain clinical competence (Cubit & Lopez, 2011; Wangensteen et al., 2008). New nurses may be supported by restricting their work hours and patient load until preceptors identify their ability to function more independently (Cowin & Hengstberger-Sims, 2006). Additional research to amplify the “voice of the new nurse” would help to define successful programs, including preceptor services, to support new nurses’ transition to practice.

Gap in the Literature

The health care system that new nurses enter in the United States may differ from that found in Canada, Norway, Australia, or Sweden. Few interpretive studies have considered the phenomenon of new nurse interns in the United States. Sensitivity to ways of one’s being in the world (Dreyfus, 1991; Streubert & Carpenter, 2011) for the new nurse in an internship program is needed. The new nurse’s sense of being a new nurse in an internship program was the focus of this study.

Conceptual Framework

Diekelmann and Diekelmann’s (2009) concernful practices (CPs) of “schooling learning teaching” provided the conceptual framework for this study. CPs define the ways that people relate to one another and form the foundation of relationships. CPs assume that a strong teacher-student relationship exists, and this guides students toward optimal learning and attainment of course goals (Diekelmann, 2003). These ideas are relevant to the internship experience because the goal is to produce a safe and informed nurse based on a strong relationship between the teacher (preceptor) and the student (new nurse). Definitions of 10 CPs evolved from data collected in a 20-year longitudinal study by Diekelmann and Diekelmann (2009) (Table 1). CPs are grounded in Heideggerian hermeneutic phenomenology, the method used for this study.

CPs consistently appear in both positive and negative ways. When a new nurse enters a clinical unit’s break room, a CP of welcoming by the other nurses may occur. Welcoming may be positive (other nurses reach out to the new nurse) or negative (other nurses ignore the new nurse). Likewise, a preceptor may show full engagement with a new nurse’s needs during management of the new nurse’s first code. Although perhaps physically present to the new nurse, the preceptor may appear more emotionally distant when a staffing shortage occurs on a busy clinical unit. CPs appear embedded in stories of novices (new nurses in an internship program) and teachers (preceptors) in many different venues where the “schooling learning teaching” process always occurs between and among individuals (Diekelmann & Diekelmann, 2009; Ironside, 2006).

Study Goals

This study had two purposes. The first was to explore the phenomenon of being a new nurse in a 12- to 18-month internship program, and the second was to identify ways that CPs provide a framework during the internship experience. The research questions were as follows: (1) What is the lived experience of new nurses during their internship program? (2) How do CPs present themselves during the new nurse internship experience?
METHOD
Phenomenology, a form of qualitative research, was the method used for this interpretive study. In particular, this study used Heideggerian phenomenology because it provides a way to study human phenomena and understand the practices that people engage in to make sense of the world (Dreyfus, 1987). Because lived experiences are so common, the meaning of those experiences may be hidden. Humans are fundamentally self-interpreting beings who attach meaning to experience. Understanding human action always includes a researcher’s interpretation of the meanings that study participants attach to experiences.

Study Participants and Setting
Study participants met the following two inclusion criteria: (1) status as a new graduate nurse and (2) engagement in a 12- to 18-month internship program. The new nurse’s unit of practice dictated the length of the internship. New graduates in the intensive care unit and emergency department participated in an 18-month internship program, whereas new graduates in other acute care areas participated in a 12-month program. Eighteen interns were invited to participate in the study. Of those, 10 responded. Participants were purposefully chosen to provide a diverse sample.

Data Collection
New nurses provided qualitative data through private audiotaped interviews with the primary author. Interviews lasted 45 to 60 minutes and were conducted in a setting of the intern’s choice. Consistent with Heideggerian hermeneutics (Allen & Jenson, 1990; Weber, 1986), the primary author engaged in an intensive dialogue (i.e., conversation) (Streubert & Carpenter, 2011) with each new nurse intern. Each conversation began with an open-ended statement, such as, “Tell me about your experiences in the internship during the past year.” Nurses presented stories that had meaning to them without investigator

<table>
<thead>
<tr>
<th>Concernful Practice</th>
<th>Dialogue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presencing: Attending and being open</td>
<td>Free, open clearing where matters of concern (care) may be experienced: being-with, engaged openness, alongside-of.</td>
</tr>
<tr>
<td>Assembling: Constructing and cultivating</td>
<td>The coming together in new, unique ways that let new possibilities: being-many-together; not to be confused with putting together preformed pieces.</td>
</tr>
<tr>
<td>Gathering: Welcoming and calling forth</td>
<td>Engaged openness, ready to accept possibilities, the happening when teachers and students (preceptors and new nurses in an internship program) connect, engage, compel (gently); always incomplete because of its openness, but attendance is mandatory.</td>
</tr>
<tr>
<td>Caring: Engendering of community</td>
<td>Engendering of community (can be safe and respected or toxic and unsafe); engendering is a reciprocal calling; what is called out is unpredictable.</td>
</tr>
<tr>
<td>Listening: Knowing and connecting</td>
<td>A kind of fusing of horizons (Gadamer, 1990); may demonstrate in small acts of conversation.</td>
</tr>
<tr>
<td>Interpreting: Unlearning and becoming</td>
<td>Allowing new becoming to happen by putting aside knowns; the action that makes listening in a new way possible.</td>
</tr>
<tr>
<td>Inviting: Waiting and letting be</td>
<td>Embedded in the sounds of silence is the being open that invites.</td>
</tr>
<tr>
<td>Questioning: Sensing and making meanings visible</td>
<td>Questions that have no answer, but stimulate thought and let knowing emerge.</td>
</tr>
<tr>
<td>Retrieving places: Keeping open a future of possibilities</td>
<td>Letting of things already pulled forward to inform things yet to be: possibilities.</td>
</tr>
<tr>
<td>Preserving: Reading, writing, thinking-saying, and dialogue</td>
<td>Dissemination that remains open and engaged.</td>
</tr>
</tbody>
</table>

Note. Data from Diekelmann and Diekelmann (2009).
influence. Probes (e.g., “Tell me more about that.”) increased the depth of the conversation to support data interpretation. Conversations continued until the author believed that data saturation was achieved and patterns essential to the purposes of the study were found.

Standards of Rigor
Standards for rigor in qualitative methods (Lincoln & Guba, 1985; Streubert & Carpenter, 2011; Wangensteen et al., 2008) were met by careful consideration of credibility, transferability, dependability, and confirmability. Two experienced phenomenological researchers (authors), individually and then collectively, engaged deeply with the raw data to analyze and synthesize a converging conversation. This conversation supported the study themes and the identification of CPs (credibility and dependability). Description of the sample, setting, and participant voices in the converging conversation supported adherence to transferability that was important for making the application to practice. An audit trail of the study process supported confirmability (Streubert & Carpenter, 2011).

Ethical Considerations
Institutional review board approval was obtained before the start of data collection. Both oral communication and written consent reinforced the right of any new nurse to refuse to participate or to withdraw from the study. All participants provided informed consent, and their confidentiality was protected by using pseudonyms on audiotapes and transcribed narratives, hiring a contracted transcriber, and storing materials in a locked file cabinet. Electronic study information was protected with a password.

Data Analysis
Transcribed conversations were analyzed with the hermeneutic approach described by Diekelmann, Allen, and Tanner (1989). The hermeneutical circle of interpretation involves moving or arching forward and backward with data to grasp and examine meanings and interpretations (Debesay, Nåden, & Slettebø, 2008). Analysis focused on interpreting the phenomenon of interest (i.e., the lived experience of being a new nurse in an internship program) and supported a deeper understanding of that phenomenon through attention to language in text (Streubert & Carpenter, 2011). Analysis of new nurses’ interview data occurred in two stages. Although the hermeneutical analysis was not linear, its steps (Streubert & Carpenter, 2011) are described here for clarity.

Stage 1: Identification of Themes Through the Hermeneutical Process. Each author examined the entire set of conversations as a whole, developed a summary, and identified possible meanings of language and connection of ideas.

Each author shared the conversation summaries with the other author, using a “back-and-forth” review of narratives.

Each author identified relational themes across all narratives and connected additional findings from the literature to support identified themes.

Stage 2: Development of a Converging Conversation With Concernful Practices. Sequential transcript analysis allowed the authors to link excerpts from individual new nurse interns’ narratives to form a converging conversation that supported the new nurses’ lived experience. The process of converging conversation involved presenting narratives from individual new nurse interns as if they occurred as a group discussion. A converging conversation linked evolving themes and patterns (CPs) found in each interview to define a framework for the new nurses’ experience and possibilities for practice and education (Diekelmann & Diekelmann, 2009; Ironside, 2001, 2006). Converging conversations are at the core of phenomenological interpretation, and they allow the reader to engage in analysis with each reading (Diekelmann & Diekelmann, 2009). In this study, a converging conversation highlighted the CPs of preceptors (teachers), as shown in themes describing new nurses’ first year of practice.

RESULTS
Sample
The sample included seven participants—six female and one male. Both nurses with an associate’s degree and those with a baccalaureate degree who were working in their first professional nursing job were represented. Four nurses were 20 to 30 years, two were 31 to 40 years, and one was older than 41 years. One participant was hired to work in the emergency department, two were hired to work on the intensive care unit, and the remaining four were hired to work on general medical-surgical units. Two of the seven participants were from rural facilities.

Themes
Analysis of new nurse narrative data produced three themes defining the phenomenon of being a new nurse in an internship program. Data focused predominantly on new nurses’ relationship with their preceptors. Themes presented in the converging conversation included the following: (1) feeling the fit, (2) mentoring to push and pull growth, and (3) proving competency: losing the apron strings. Themes and patterns (CPs) show multiple understandings of the experience of the new nurse in an internship program and consistency with the work of Diekelmann and Diekelmann (2009).
**Feeling the Fit.** Many new nurses in this internship program noted the supreme and foundational importance of the relationship with their preceptor. Perception of a positive relationship occurred “when we spent a lot of time talking about my comfort level and my progress. . . . She would help me if I needed her. We clicked.” New nurses noted that it was not “where” they worked but “who” they worked with that was important to “feeling the fit” with the preceptor. Staff acceptance of new nurses’ needs and demonstration of respect also contributed to new nurses’ experience of “feeling the fit” in their assigned unit. One nurse noted, “If you are respected there [the clinical unit], you get along with the management.” Relevant CPs congruent with “feeling the fit” included gathering, questioning, caring, and preserving. On the other hand, a lack of fit occurred when the health care system promised to systematically evaluate the internship experience but neglected to do so. “When staff showed disrespect or made fun of you and asked you questions to make you feel bad,” and when new nurses had so many preceptors that a relationship could not be developed to meet their needs, “feeling the fit” did not happen. Several new nurses mentioned peers who were not “feeling the fit” and became ill, dreaded work, and made plans to leave the health care system. When new nurses did not experience “feeling the fit,” a negative expression of the CPs occurred.

**Mentoring to Push and Pull Growth.** New nurses valued preceptors who “jump-started their learning” by giving them homework and quizzing them on critical content and skills needed for safe and quality practice. Preceptors who served as good mentors kept the new nurses “on track” and encouraged their evolving accountability for care decisions. Quality preceptors assessed new nurses early and throughout the relationship to identify their learning needs. They also determined when they might need assistance and engaged other staff to build unit support for them. Preceptors helped new nurses to balance work and life issues and develop the time management skills needed for clinical practice. CPs relevant to this theme appeared to be retrieving places, interpreting, and caring. These CPs operated negatively when new nurses noted, “I don’t know where to start,” or “I feel like she doesn’t want to be there. She’s not there to teach.” CPs also operated negatively when preceptors were absent physically or emotionally and were unable to meet new nurses’ needs or when preceptors did not trust new nurses to provide needed care.

**Proving Competency: Losing the Apron Strings.** While depending on preceptors for skill development, new nurses slowly assumed responsibility for independent care. New nurses were grateful to preceptors who assessed their care abilities, particularly for critically ill patients, before the new nurses implemented care alone. One new nurse noted that her preceptor always checked on her “around 9” to clarify whether she had followed the plan of care and to offer help if she had not. One new nurse noted her growing competence by stating, “She is always there, but it is me pretty much running the show.” Another new nurse noted, “She’s not there all the time, and that really helps because I have to learn to do it myself.” New nurses appreciated a preceptor’s presence and lack of hovering, a behavior that some new nurses believed facilitated their assumption of a more independent role. The lack of preceptor presence when a new nurse was “overwhelmed and did not understand what to do in an urgent situation without help and was feeling lost” led to negative new nurse perceptions. With limited preceptor or staff assistance or presence, new nurses had to prove their competency by believing in themselves alone. One new nurse said, “Be strong, and don’t let them run you off. You can do this. But it was hard the first few months.” In cases like this, CPs of caring and presencing operated negatively.

**Converging Conversation Connected to Themes and Relevant Concernful Practices**

A converging conversation made up of new nurses’ stories illustrated how the “schooling learning teaching” process defined by Diekelmann and Diekelmann (2009) is a dynamic, evolving phenomenon occurring between teacher (preceptor) and student (new nurse intern). According to Diekelmann and Diekelmann (2009), “Themes and patterns (CPs) interrelate. . . . and they do not occur in isolation. They are always narratives, historically and temporally situated” (p. 386). This process of interconnection of themes and patterns (CPs) is centered on the learner and includes an inseparable integration of literature, experience, interaction, and cycles of interpretation (Ironside, 2006). A converging conversation, presented in tabular format, shows consistency with the integration and interpretation suggested by Diekelmann and Diekelmann (2009) and Ironside (2006). The converging conversation provides rich evidence of the experience of being a new nurse in an internship program for seven nurse interns (Table 2, with references, is available as supplemental material in the online version of this article).

**DISCUSSION**

**Themes of the New Nurse-Preceptor Relationship**

This study focused on understanding the phenomenon of being a new nurse in a 12- to 18-month internship program. Both the quality and the “fit” of relationships...
between the new nurse and the preceptor were founda-
tional and meaningful to the new nurses’ positive inter-
pretation of the experience. This finding is similar to that of Wangensteen et al. (2008), who described new nurses’ appreciation of experienced nurses who “mapped out what I could manage . . . and we found together we could manage most situations” (p. 1880). The experience of “feeling the fit” met new nurses’ desire to establish secure social bonds, allowing maximal learning so that the nurse could become clinically competent (Malouf & West, 2011). New nurses perceived a positive relational experience with preceptors when they saw those preceptors practicing nursing as idealized by the new nurses (Ferguson, 2011). This experience fostered new nurses’ experience of “feeling the fit,” leading to fewer challenges in the transition to practice.

Themes of “mentoring to push and pull growth” and “proving competency: losing the apron strings” also correspond with the findings of Duchscher (2009), Wangensteen et al. (2008), and Cubit and Lopez (2011). Duchscher (2009) identified the process of “becoming” among new nurses in Canada who were transitioning to practice. Wangensteen et al. (2008) also found that new nurses in Norway reported gaining experience and competence during the first year of practice. The sample of 12 graduate nurses reported by Wangensteen et al. (2008) experienced uncertainty, the need for support and recognition, and struggles with becoming aware of more responsibility during the first year. Personal reflection showed that these nurses benefited from managing the challenging initial year of practice. Cubit and Lopez (2011) also noted that first-year nurses needed to “step out of their comfort zone” to later excel in their role. In those three studies, new nurses eventually experienced “feeling the fit” and confirmed the findings of the current study.

Concernful Practices Inherent in the New Nurse-Preceptor Relationship

New nurses’ consistent identification of preceptor behaviors and three data-derived study themes opened understanding and presentation of several CPs to define the new nurse internship experience (Diekelmann & Diekelmann, 2009). The CP of presencing: attending and being open seemed paramount in many stories, suggesting that a “free, open clearing” and “engaged openness” (Diekelmann & Diekelmann, 2009) might be a prerequisite for many, if not all, CPs for an effective new nurse-preceptor relationship. CPs found within the data and linked to study themes validate other findings that indicate that supportive practice environments nurture the effective transition of new nurses to their professional role, significantly influencing new nurse retention (Schumacher, 2007; Wolff, Pesut, et al., 2010; Zinsmeister & Schafer, 2009).

The new nurse narratives and converging conversation reported in this study also confirm the importance of a quality preceptor-new nurse relationship for new nurse retention. The study highlights new possibilities for practice and education of both preceptors and new nurses in an internship program, based on their respective roles (Ironside, 2006). Diekelmann and Diekelmann (2009) and others who use narrative pedagogy (stories) would support that, through a process of sharing and collective interpretation, preceptors and new nurses co-create and transform knowledge to respond to previously held assumptions and ways of being (Ironside, 2001, 2006; Kawasaki, 2005). Nurses who exhibit CPs of gathering: welcoming and calling forth and listening: knowing and connecting have the potential to increase new nurse satisfaction, leading to better workplace retention and enhancing new nurses’ efficiency and quality of work (Cubit & Ryan, 2011; Pinkerton, 2003; Rudel, 2007).

Preceptor-new nurse relationships are powerful determinants of new nurse satisfaction and success. How do health care managers select preceptors to help new nurse interns navigate toward safe and quality nursing practice and a positive experience of being a new nurse in an internship program? New nurse stories provide insight into critical qualities of preceptors and contextual factors that influence the “fit” of preceptor (teacher) and new nurse (student). These factors support a new nurse’s growth to gain readiness to practice and transition to functioning as a member of the health care team (Diekelmann, 2003; Williams, 2010; Wolff, Regan, et al., 2010). A good “fit” of preceptor and new nurse allows the new nurse to feel safe, think, and offer ideas for practice, illustrating the CP of caring: engendering of community. In this sense, community is a network of carers who benefit one another and the patients they serve (Williams, 2010). Recent research indicated that a perceived support system of carers extended community and facilitated the new nurse’s effective transition to practice in various health care systems (Cubit & Ryan, 2011; Ferguson, 2011; Kramer et al., 2011).

Although the focus in this study was on the lived experiences of new nurses in an internship program and, in particular, their experience with preceptors, the perceptions of preceptors assigned to the new nurses were not explored. Most narratives illustrated positive CPs in preceptors’ interactions with new nurses in an internship program. However, an occasional narrative identified a new nurse’s perception of an encounter that illustrated a negative expression of a CP (e.g., absence of presenc-
ing; attending and being open). Smythe (2002) provided insight into this situation:

It is often not that the person does not want to care, but that the systems of practice have stripped the word “care” of its meaning. In a climate of economic rationalism, doing will always take precedence over caring, for doing brings measurable outputs. Perhaps it is the responsibility of researchers to bring to the light the consequences of care that is not caring. (p. 197)

Are there factors in the health care system (facilities) that are causing the breakdown of embodied intelligence and hindering the use of CPs in a positive way? Heidegger (1927/1995) said that every person defines and becomes through the course of living. When embodied intelligence works well, it is rapid and unconscious. When system breakdown occurs, such intelligence loses that taken-for-granted quality and might behave in an unusual way that blocks positive expression of CPs during personal interactions.

Limitations

Although this study offers rich data to inform new nurses’ transition to practice and the critical role of preceptors in that transition, it also had limitations. No data were collected about whether the nurses in the study sample had previous patient care experience that might have influenced their lived experience as interns. The study used a convenience sample from one health care system and included nurses with diverse educational preparation. Hermeneutical analysis (Diekelmann & Diekelmann, 2009) is always tentative and reflects the contextual and temporal history of the study participants. Continued analysis provides opportunities for new understanding, meaningfulness, and significance of themes and patterns of a phenomenon (Ironside, 2006). Although efforts were made to address elements of the rigor of the study, as outlined earlier, no member checking to confirm the validity of the findings/themes with the participant nurses occurred.

IMPLICATIONS FOR PRACTICE

Recommendations for Preceptors and Clinical Educators

New nurses’ stories show that, despite significant education, new nurses come to the workplace needing support and socialization to the nursing role in a complex and multifaceted health care setting. Perhaps clinical educators and preceptors have focused too heavily on the orientation of new nurses to functional skills and too little on new nurses’ need for personal preceptors (Cubit & Ryan, 2011; Malouf & West, 2011). Increased awareness by both groups of the relevancy of CPs (e.g., caring, questioning, listening) to support a personal new nurse-preceptor relationship could increase new nurses’ experience of “feeling the fit” to connect to the workplace community during their internship (Ferguson, 2011). Responsive and effective preceptors provide systematic and sequential feedback to new nurses on “what and how to” complete patient care and demonstrate “mentoring to push and pull growth” of new nurses. These outcomes result when preceptors and new nurses work together closely on short-term and long-term goals early in their relationship and evaluate the attainment of those goals as the new nurse progresses toward competency (Morgan, Mattison, Stephens, & Meadows, 2012). Preceptors’ responsiveness to these goals facilitates new nurses’ acquisition of clinical skills, critical thinking skills, and perceived competency, and also diminishes their feelings of self-doubt. These are urgent needs, particularly in the first 4 months of employment (Duchscher, 2009; Hatler et al., 2011; Malouf & West, 2011; Wangensteen et al., 2008).

Preceptors who have a passion for teaching, show optimal listening skills and respect for new nurses’ learning, know workplace resources to help new nurses to transition to the clinical role, and possess expert clinical practice and thinking skills serve as optimal preceptors. These preceptors help new nurses to perceive the study theme of “feeling the fit.” Several studies have noted that preceptors also hold new nurses accountable for learning and encourage their self-reflection to become competent nurses who meet standards of care (Cook & Leathard, 2004; Giallonardo et al., 2010; Gustafsson & Fagerberg, 2004). These preceptors illustrate the study themes of “mentoring to push and pull growth” and “proving competency: losing the apron strings.” The best preceptors show authentic leadership, characterized by self-awareness, relationship transparency, internalized moral vision, and the ability to think critically through a variety of data and opinions to reach a decision. These qualities may ultimately improve workplace retention of new nurses (Giallonardo et al., 2010).

Recommendations for Health Care Agencies and Nurse Administrators

Hospitals pursuing Magnet® status widely use preceptors and new nurse transition programs, including new nurse reflection, to significantly increase nurse satisfaction and retention (Hatler et al., 2011; Kelly, McHugh, & Aiken, 2011). However, several authors have voiced concern that insufficient numbers of nurse residency programs exist to help new nurses transition to the workplace (Duvall & Andrews, 2010; Sephel, 2011). Thus, health care agencies, through the leadership of nurse
administrators, must advocate for funding of nurse residency programs and training programs for nurse preceptors who are committed to the role. Evidence shows that these programs are cost effective and improve new nurse retention (Jeffries, 2006; Jones, 2008). In one clinical center, a preceptor training program provided a cost savings of $800,000, based on an initial cost of $150,000, and also improved overall patient satisfaction, nurse retention, and outcomes of patients with acute myocardial infarction and congestive heart failure (Hatler et al., 2011).

Health care agencies have an obligation to support preceptors who affirm, model, and engage in dialogue and outcomes of patients with acute myocardial infarction and congestive heart failure (Hatler et al., 2011). and high-acuity clinical situations. The quality of the preceptor-new nurse relationship could be compromised under such circumstances.

Because CPs are relatively new concepts and have not been subjected to thorough exploration, several questions must be asked. Are CPs universal to all caring or professional relationships? What changes might occur in the preceptor-new nurse relationship if preceptors were oriented to the CPs before they establish the relationship? How would CPs be reflected in nurse-patient relationships or the relationships between nonprofessional caregivers and care recipients? Further research might identify “practices that engender communities that are safe, fair, and respectful” (Diekelmann & Diekelmann, 2009, p. 504). Such communities could increase new nurses’ perceptions of secure and optimal learning environments for developing needed clinical competence, becoming part of the clinical team, and assuming readiness to practice. This study did not differentiate between the internship experiences of nurses with an associate’s degree and the experiences of those with a baccalaureate degree. Further studies might examine whether different educational preparation of nurses might yield a different preceptor-new nurse relationship. This relationship might lead to sufficient preparation of new nurses to work effectively in clinical units where high patient acuity increasingly is the norm.

Further investigation is needed to clarify other factors that influence new nurses’ experience during initial practice and their relevance to workplace retention. Studies on the experiences of new nurses in other countries (Cubit & Ryan, 2011; Duchscher, 2008, 2009; Wangensteen et al., 2008) and with different health care systems in the United States offer opportunities to reflect on ways that various health care systems may affect the experiences and retention of new nurses. In the United States, structured 12-month mentoring programs increase new nurse retention in the first year of employment. Less is known about factors that increase nurse retention beyond the initial year of employment to support nurses’ career development as leaders (Halfer, 2011; Hatler et al., 2011).

CONCLUSION

In this study, new nurses shared their internship experiences. Although the initial plan was to explore the experiences of new nurses. An exploration of the experiences of preceptors would provide further evidence of the important dynamics of the new nurse-preceptor relationship to increase new nurses’ transition/readiness to practice as well as workplace satisfaction for both new nurses and preceptors. Future studies could explore how this relationship might change when preceptors are involved with several nurse interns simultaneously in high-stress and high-acuity clinical situations. The quality of the preceptor-new nurse relationship could be compromised under such circumstances.
key points

**Preceptors**

1. The preceptor-new nurse relationship significantly influences new nurses’ transition into practice.
2. Concernful practices define the ways in which individuals relate to one another and form the foundation of relationships.
3. New nurses value the foundational relationship with a preceptor who pushes but mentors them to become competent health care providers.
4. Health care agencies have an obligation to support preceptors who affirm, model, and engage in dialogue with new nurses to support their future success and retention in the profession.

new nurse internship experience as a whole, the role of the preceptor-new nurse relationship so dominated the data that it became the central focus. New nurses’ narratives influenced the value of preceptor behaviors. Three themes emerged that are consistent with manifestations of CPs, as defined by Diekelmann and Diekelmann (2009). These themes amplify the importance of preceptor behaviors in facilitating new nurses’ acquisition of critical nursing skills by “doing, knowing, and thinking” (Wolff, Regan, et al., 2010, p. 6). Evidence from new nurses in an internship program indicates that positive preceptor behaviors increase new nurse satisfaction. Health care agencies can benefit by implementing evidence-based preceptor and mentoring programs to improve nurse workplace retention and support cost-effective, quality patient care.

CPs were demonstrated in many ways, validating their usefulness as a framework for caring relationships between preceptors and new nurses. A converging conversation was used to connect themes and patterns. This narrative offers cycles of interpretation, unifying themes and CPs, and provides a useful understanding of the lived experience of new nurses.

**REFERENCES**


### Converging Conversation: Being a New Nurse in an Internship Program

| Gina: We are paired up with preceptors and I was lucky enough to get one that ... we match pretty well, we clicked right away so we didn’t have a personality conflict and things like that and she is really good about teaching me as well as letting me do my own thing. But, if I needed help, she would be willing to show me instead of just like “no, you have to do this.” I know there are some new grads that got stuck with people they didn’t click with, a bad mesh in personality and they absolutely hated coming to work every day. (CP: Gathering: Welcoming and Calling Forth) (Theme: “feeling the fit”) |
| John: Um, my preceptor is wonderful. His name is Sam and has been a nurse for 4 years and some of the neat things that he does that kind of sets him apart is that he has homework for me every week so, like, he gives me, he writes out a list of questions, like, “compare this drug to this drug, like metoprolol XL vs. regular metoprolol” and, also, like, um, situation type questions. He has a patient that comes back with these types of symptoms, “what would you do; what would you look for, what is the doctor ordering?” He is also good about giving me feedback. (CP: Retrieving Places: Keeping Open to Possibilities) (Theme: “mentoring to push and pull growth”) |
The understanding of John’s narrative and his connection to his preceptor is further explained by Hyde (2006). “The teaching environment is energized and actualized by the emotional involvement that people have with each other and with their subjects of study. If engagement is to have priority over diversion, ideas need to be presented in an interesting way so that they will be taken seriously by students who await acknowledgment from a teacher who is obliged to give it. Teaching requires a commitment to being-for others” (Hyde, p. 164).

In The Life-giving Gift of Acknowledgment (1997), Hyde quotes Rabbi Abraham Heschel: “What we need more than anything else is not textbooks but text people. It is the personality of the teacher which is the text that the pupils read; the text that they will never forget” (p. 162).

Linda: I think it is pretty good if you are matched up with somebody, a preceptor who you like and who you click with because if you are getting paired up with someone who is just babying you or leaving you alone too much, you know, not fitting your needs, it could be a void in the whole situation, but for me, I got somebody that we hit it off right away. (CP: Questioning: Sensing and Making Meanings Visible) (Themes: “feeling the fit;” “mentoring to push and pull growth”)

Marsha: Like I said, my preceptor was really great. She was really good about me sort of letting her know what I needed help with and what I didn’t. And even now, she has taken patients today, a few, but otherwise when I am there it is pretty much me running the show, but she is
always there if I have questions.  (CP: **Presencing**: Attending and Being Open; **Listening**: Knowing and Connecting) (Theme: “proving competency: losing the apron strings”)

*Marsha shares a story that is filled with a preceptor who understands the two types of concern that Heidegger (1995) discusses as “leaping-in and leaping-ahead” (p. 158). “Leaping-in” is a taking over of a situation. This might be appropriate if there could be serious consequences if intervention was not immediate, but many times the wise choice might be “leaping-ahead.” This is the action that empowers: it facilitates and anticipates. Benner and Wrubel (1989) explain the “leaping-in” and “leaping-ahead” very well and note one potential problem with “leaping-in” (a taking over) is that the recipient becomes dependent and taking up again may be difficult. This is a slippery slope to domination or even oppression. Evidence of this appears in parts of some new nurses’ stories.*

Marsha: One of the new grads they hired she cried every day, she got sick because she didn’t want to come to work, she even talked about leaving, you know real soon, but now that she has been switched off to somebody else it is completely different, her experience is completely different. I really think just right off the bat – whoever you are working with – it doesn’t really matter where you are working, it’s who you are doing with and whether the staff is accepting of you, if you are respected there, you get along with the management.  (CP:
Gathering: Welcoming and Calling Forth) *(Theme: “feeling the fit”)*

Patti: But, I came to the ICU and I thought I would really enjoy it. I liked the patients and the department, I just did not have a good fit with my preceptor and really did not receive any feedback whatsoever from her despite all paperwork they are supposed to fill out and all that stuff. In my first 4 days as an intern, I had 4 different preceptors, which was just very overwhelming because then every day you just kind of have to start over, they don’t know anything about you and so I was there for a couple of months and finally just decided something has to change because I was already dreading going to work and that is not a good feeling. And, so, um, I had asked for a different preceptor but was basically denied one because, I guess, there wasn’t enough to go around. *(CP: Gathering: Welcoming and Calling Forth)* was in the negative. Possibilities were closed. *(CP: Caring:)* Engendering of Community. Openness did not happen and concern was not expressed. *(CP: Interpreting:)* Unlearning and Becoming requires time and consistency not found in this situation. *(CP: Inviting:)* Waiting and Letting Be, as a process of engaged openness, became futile to this new nurse) *(Theme: “feeling the fit”)* [negative expression])

Patti’s story elicits thoughts of Maslow’s Hierarchy of Needs. Lower level needs (belonging, safety, etc.) must be met, or a person feels vulnerable and cannot reach higher levels that would include the ability to learn. Benson &
Dundis (2003) examine the role that security and freedom from stress might have in motivating health care employees to learn. Preceptors who “welcome and call forth” their new nurses facilitate learning and, growth. Hyde (2006) validates the preceptor’s duty in this area: “there is at least one obligation that must be met by any and all who would call themselves teachers: acknowledgment” (p. 159).

Pam: I felt like she doesn’t want to be here and another thing, she had to move up, she’s from 10 and she had to move up to 11 just for me and . . . so that, “I thought you agreed to do it”. . . . she’s a great nurse but teaching wise, I mean I have learned a lot from her, but she isn’t just, she’s not there to teach. (CP: Assembling: Constructing and Cultivating)

(Theme: “mentoring to push and pull growth” [negative expression])

Susan: I remember the first day, it was pretty scary. When the vent alarms went off, I really didn’t know what to do. I remember my heart beating really fast, saying “oh my God are they going to stop breathing” or, you know, “now what do I do,” and that was pretty scary and, um, um, the first few days. That was another thing – it was very overwhelming to hear all the different sounds and alarms and not being able to tell what it was, you know, what was beeping. Was it the heart rate monitor, or was it the vent? I remember my preceptor telling me that “after a while you will be able to tell what the alarm means, you know – you will be able to tell the sounds.” I remember kind of being overwhelmed with everything that was going on. I was really more doing things in emotion. Everything was
just overwhelming, you know. I remember taking somebody’s
temperature and not hearing it beep and my preceptor telling me that
“after a while you will be able to hear it beep.” I was like “how, you
can’t hardly hear it.” I guess I was so overwhelmed with everything I
couldn’t focus on that. (CP: Presencing: Attending and Being Open)
(Theme: “proving competency: losing the apron strings”)

Susan: I admit that there were many times I did consider leaving. “I can’t do
this,” I was not prepared to deal with somebody this sick – and to do this.
There were many times I would go home crying. “I can’t do this” - I
would feel bad if, for example, the blood pressure monitor went off and I
didn’t catch that the blood pressure was really high and not know what to
do with that, I would feel like really dumb. My preceptor was not always
there for me and I would feel alone. (CP: Presencing: Attending and
Being Open were not present CP: Preserving: Reading, Writing,
Thinking-Saying and Dialogue) (Theme: “mentoring to push and pull
growth” [negative expression]).

Pam: I felt people made fun of you a lot when, you know they would talk about
you, or ask you questions to just try to make you feel bad and there were
many times I thought there is no way I can work with these people and as
time goes by, it seems like they would leave me alone and move on to the
next group that was coming on but some of those people have been
leaving. But that was really hard on me, like every day I would feel like
“be strong, don’t let them run you off, you can do this” – but it was hard,
Pam’s narrative is interesting. Is Pam experiencing a type of oppression or violence? Smythe (2002) presents a study in which she explores the phenomenon of the “violence of everyday” (p. 166). Based on Heidegger’s explanation of a phenomenon as “that which shows itself in itself” (1995, p. 5), Smythe looks for that which may show itself as a “semblance.” She says, “For example, there may be a semblance of ‘being professional’ hiding what is in itself uncaring, unthoughtful behavior.” The opposite phenomenon may occur or maybe co-occur: a “semblance of violence that is, in fact, inflicting pain for ‘the good of,’ that is not in itself violence but care” (p. 166).
References


