The Lived Experience of Newly Qualified Registered Nurse First Assistants (RNFA) Who Have Transitioned to the Hospital Operating Room Surgical Setting: A Phenomenological Perspective

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Dedication

I am truly blessed! The Lord has blessed me with the strength and faith so I was able to embark and complete this endeavor! He has blessed me with the BEST family EVER! My husband is my best friend and life-long partner through the journey of life. We are blessed with two wonderful and supportive daughters! The love and guidance provided by my family is how I reached this goal! Whenever I lost confidence or thought for a moment that I couldn't do this, Dan, Jessica and Rachel, you picked me up and reminded me that I could do this, and I would push on! To my husband and daughters- you never lost faith in me and helped me see the possibilities! This would not have been possible without your support, love and encouragement. You are all my inspiration! You helped me reach my dream! This is our success- WE DID IT! Thank you!

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2 Corinthians 9:8

And God is able to bless you abundantly, so that in all things at all times, having all that you need, you will abound in every good work.

Abstract

There is increased use of RNFAs as assistants to surgeons in surgery. It is estimated that RNFAs comprise as many as 54% of the non-physician assistants who provide patient care during the surgical event in the operating room setting (Patterson, 2012). There are research studies that focus on transitions of graduates from nursing programs but a lack of research on transitions of RNFAs to the surgical environment following education.

This qualitative interpretive hermeneutic phenomenological study explored the lived experience of newly qualified RNFAs who have transitioned to the hospital operating room surgical setting. The purpose of the study was to understand and interpret the meanings of lived experiences has provided a better understanding of the transition between the phases of the newly qualified RNFA functioning within the role of the hospital operating room setting as first assistant. Individual interviews were conducted with twenty participants. Data was analyzed for identified themes using Colaizzi's seven-step process of thematic analysis. Four major themes and thirteen subthemes emerged from the thematic analysis of data. There were identified difficulties RNFAs encountered as well as positive experiences that were beneficial to the transition were shared. There were varying degrees of support and a great deal of effort needed to complete program requirements. The educational and clinical process was viewed overall as positive and worthwhile experience. There was a sense of pride in the achievement of the new role of RNFA. There were implications for nursing practice and education.

Chapter One: Significance of the Problem

The Registered Nurse First Assistant (RNFA) is a valuable member of the surgical team whose primary foci are to provide individualized care to the surgical patient and promote optimal patient outcomes. In this advanced role, the RNFA utilizes training and skills attained through specific education and clinical rotations. The RNFA has acquired the necessary knowledge, operative skills, critical thinking skills and clinical judgment specific to the surgical environment (Kurkowski, 1999). During the surgical experience, the RNFA assists the surgeon and plans for patient care both preoperatively and postoperatively. It is estimated that RNFAs comprise as many as 54% of the non-physician assistants who provide patient care during the surgical event in the operating room setting (Patterson, 2012). The increased use of the RNFA is due to the shortage of physicians and residents who formerly served as first assistants to surgeons (Welter, 2007). Educated and clinically trained individuals acting in this role help the surgeon first hand in surgical procedures by providing exposure during surgery and assisting with the procedure as necessary. The use of the RNFA as an assistant in surgery has resulted in no reported adverse consequences and has been shown to actually improve patient safety by lowering the rate of surgical site infections (SSIs) of coronary artery bypass graft (CABG) procedures (Pear & Williamson, 2009). Pear & Williamson (2009) reported that following a 9-month study investigating the use of RNFAs in CABG surgery, the surgery time decreased to 268 minutes from the previous rate of 300 minutes and resulted in a decrease in surgical site infections of harvest graft site to a monthly mean of 43% improvement. Research findings have revealed that the use of the RNFA in surgery is a safe assistant to the surgeon in the repair of abdominal aortic aneurysms (Archie, 1992). Dall, Galio, Chakrabarti, West, Semilla and Storm (2013) reported a

substantial rise in future service demand reflective of advanced diseases and higher rates of surgery that will increase the need for specialized health care professionals.

The projected health care demands will increase between the years 2013 and 2025 as a result of the United States (US) population demographic characteristic changes and the implementation of The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA) (Dall et al., 2013). More specialists and trained professionals will be needed to meet the projected increase in demands for health care that result from the implementation of the ACA. The projected U.S. population aged 65 or greater by the year 2050 will be 89 million, more than double the population in 2010 (Dall et al., 2013). Additionally, the National Cancer Institute (NCI) estimates that there will be approximately 18.1 million cancer survivors by the year 2020 (Dall et al., 2013). A study conducted by The Census Bureau reported that by the year 2025, individuals in need of vascular surgery will increase by 31% and the demand for cardiology intervention will be 20% greater than that of 2010 (Dall et al., 2013). The Centers for Disease Control and Prevention (CDC) reported 51.4 million inpatient surgical procedures were performed in the United States in 2010 (CDC, 2013). This number has increased considerably from 40 million procedures in the year 2000 to 45 million inpatient surgical procedures performed in 2005 (CDC, 2007; CDC, 2002). The 2005 figure of inpatient surgical procedures per year constitutes a national rate of 1,522.7 procedures per 10,000 individuals (CDC, 2007).

Significant changes in health care have resulted in fewer physicians choosing specialty practices such as surgery and more of an interest in primary care. Physicians' declining interest in surgery has resulted in vacancies in surgical rotations thus creating more opportunities for RNFAs (DeCarlo, 2005). Assistants other than a second surgeon in surgery receive 85% of the

fee allowed for an assisting surgeon. The reimbursement for the RNFA varies among states due to differing state laws, scope of practice and legislative language (Becker, 2005; DeCarlo, 2005). The use of registered nurses (RNs) in the advanced role of RNFA in surgery has been a cost-effective measure as they eliminate the need for a second surgeon. The educated and clinically trained RNFA can be utilized separately in various surgical roles (assistant, circulator, scrub nurse), which further aids in decreasing health care costs. According to the Association of Perioperative Nurses (AORN) (2012), RNFAs are not used to their fullest potential, nor are they reimbursed in a consistent manner across the United States. The Institute of Medicine (IOM) Future of Nursing 2010 Report addressed these two issues of underutilization and equitable reimbursement, and identified the potential of nurses to provide unique contributions towards improving the delivery of health care through the use of innovative strategies. RNFAs are in a unique position to make such a contribution. Historical, regulatory, and policy barriers, however, limit health care delivery by RNFAs. All nurses, specifically RNFAs who are permitted to work to the full extent of their education and training can improve the delivery of health care (Poe, Bubb & Freeman, 1997 & Forsythe, 1997). The resistance to expand the roles of nurses and fully extend the use of educated nurses in advanced practice roles along with fragmentation of the health care system are identified professional barriers (IOM Future of Nursing, 2010). Fragmentation occurs when there is inconsistent reimbursement by insurances for health care (Kunic & Jackson, 2013). The value of the RNFAs' financial contributions may go unnoticed as their services are often billed as part of the physician's charges or not at all (Kunic & Jackson, 2013). In addition, insurance companies vary in the identification of eligible providers and reimbursement is inconsistent resulting in fragmentation (Kunic & Jackson, 2013). There is a wide variety of health care reimbursement among insurance companies. Nurses have the ability

to overcome barriers by advocating for and assisting in making significant changes in the health care system (McNamara, 2011). The IOM Future of Nursing Report (2010) endorses that nurses achieve higher levels of education and training through a seamless progression. The lack of consistency in reimbursement for RNFA services across the United States acts as a barrier for RNFA scope of practice (AORN, 2012). In locations where RNFAs are not reimbursed for services rendered, utilization of the advanced role may not occur. An innovative measure that can assist in reimbursement of the RNFA that resulted from the IOM Report (2010) is compensation for nurses to fill the coverage gaps that were created from the mandatory reduction of surgical resident work hours (Kunic & Jackson, 2013).

The RNFA educational requisites are similar across the nation; however, the reimbursement for RNFA services is not consistent across the United States rendering their practice utilization as variable and disproportionate (Chard, 2013). The inconsistency in utilization and reimbursement of the advanced role creates varying levels of health care costs throughout the country. Nurses are encouraged to partner with physicians and colleagues through collaboration to achieve process improvements. Collaborative efforts can take place at a local and regional level in order to promote full extent of RNFA use and eliminate the fragmented reimbursement of first assistants (Strech & Wyatt, 2013).

The health care climate is one that requires cost effective measures in all areas, including the operating room. The ACA focuses on changing the direction of health care reform for the purpose of decreasing the cost of health care while providing optimal patient care to all Americans (U.S. Department of Health & Human Services, 2013). The RNFA is a vital and beneficial team member for the surgical patient but little is known about the transition of the

newly qualified RNFA to the RNFA functioning in the active role of assistant in surgery. A review of literature reveals an absence of information pertaining to the RNFA.

Nurses represent the largest proportion of health care workers in the United States providing direct patient care (Boehm & Tse, 2013). The demand for nurses and other health care professionals to be more knowledgeable in their fields is associated with high quality patient care and positive patient outcomes. Use of the RNFA promotes continuity of care for surgical patients in the changing climate of today's efforts at health care reform (Kurkowski, 1999). The graduate RNFA must make the transition from the newly qualified RNFA role to the critical role of skilled expert RNFA, a position that holds great responsibility.

Research is nonexistent on the relationship between surgical specialty exposure during the clinical education phase and the RNFA's ability to transition to the role of surgical assistant. In order to proactively advocate for employing RNFAs in operating rooms, their transition to the role within the operating room needs to be investigated.

Identifying whether struggles or barriers exist for the RNFA transitioning to the new role of surgical assistant will assist in the development of transition interventions or the modification of programs that will enhance the transition process. Research results have indicated that a positive transition from nursing student to the role of professional nurse can be correlated with motivation to perform well, increased job satisfaction, and higher retention rates (Almada, Carafoli, Flattery, French & McNamara, 2004; Blanzola, Linderman, & King, 2004; Casey, Fink, Krugman & Propst, 2004; Cleary & Happell, 2005; O'Malley Floyd, Kretschmann & Young, 2005). Positive experiences and support during the transition of the RN from student to new RN role in other areas of nursing have been researched; however, RNFA transition experiences should be investigated in order to identify experiences that could increase retention and job

satisfaction of the RNFA (Almada et al., 2004; Blanzola et al., 2004; Cleary, Matheson & Happell, 2009; Melrose & Gordon 2011; O'Malley Floyd et al., 2005).

The RNFA is responsible for performing critical tasks during surgical procedures which are listed in Table 1 *Perioperative Behaviors of the RNFA* and Table 2 *Responsibilities of the RNFA* (Appendix A; Appendix B). The intraoperative behaviors unique to the RNFA are handling tissue specimens for laboratory examination, providing exposure by manipulating patient anatomy, using instruments to provide exposure to anatomy, dissecting tissue and organs, providing hemostasis, and suturing of the operative incision (Vaiden, 2005). The RNFA utilizes independent nursing skills and judgment that are essential to the surgical practice. Additionally, the RNFA performs interdependently and is directed by the surgeon intraoperatively (Vaiden, 2005). Due to the lack of research, there is much to learn about the transition of the newly qualified RNFA to the advanced practice role.

Background and Significance

The nurse's role as first assistant in surgery was first introduced as a result of the increased needs during wartime. Nurses were called upon to broaden their scope of practice to include advanced practice roles within their profession (Hallquist, 2005; Zarnitz & Malone, 2006). Florence Nightingale instituted the idea of nurses assisting in surgery during the Crimean War (1854-1856). Nurses assisted during surgical procedures and provided postoperative care (Lafountain, 1992). The registered nurse acting in the role of first assistant flourished during the American Civil War (1861-1865), World War I (1914-1918), and World War II (1939-1945). During World War II, nurses found themselves acting as first assistants as a result of greater numbers of injuries, increasing numbers of surgeries and shortages in health care personnel (Welter, 2007). The responsibilities of the RN as first assistant expanded to include insertion of

chest tubes, performing tracheostomies, and opening and closing of surgical wounds (Welter, 2007). The Korean War (1950-1953) was a pivotal moment in furthering the development of the role of the nurse as first assistant (Hallquist, 2005). The army nurse perfected the role of RNFA in mobile army surgical hospitals (MASH) by providing care to surgical patients in the areas of preoperative, intraoperative and postoperative care (Welter, 2007; Zarnitz & Malone, 2006). At the beginning of the Korean War in 1950, the recruitment of ancillary staff in the operating room allowed for nurses to provide specialized surgical patient care, supervise and provide patient support and educate staff, which are very similar activities associated with the current advanced nurse practitioner role (Hallquist, 2005). Military nurses who were highly experienced in perioperative nursing care were recognized as the most experienced assistants to the surgeon in the absence of an additional surgeon; however, returning as civilian nurses, they found the role without specific designation, support and acceptance. The RNFA was deemed an appropriate position as a surgical assistant in 1977 when the American College of Surgeons (ACS) provided official acceptance. Clarification of the RNFA role was first requested of AORN Association by its members in 1979. The determination of whether the role of first assisting in surgery was part of perioperative nursing practice was brought before the AORN House of Delegates (Welter, 2007). The approval was granted that in the absence of a qualified physician, the registered nurse in possession of appropriate knowledge and technical skills is the best qualified non-physician to serve as first assistant (Vaiden, 2005). In 1984 the original Association of Perioperative Registered Nurses (AORN) Official Statement of RNFA was accepted (AORN, 2013; Vaiden, 2005; Welter, 2007). In addition to the evolving perioperative nurse role, changes in health care created opportunities for the perioperative nurse. Standardized academic programs have been in

place since 1985 to educate RNFAs and offer the opportunities to augment skills; however, research on the process of the transition experience of RNFAs to the surgical field is nonexistent.

Across the country RNFA programs have been established that include didactic and clinical education. The clinical practicum phase of the RNFA training encompasses clinical rotations consisting of assisting with surgical procedures under physician-directed supervision in order to acquire hands-on skills in surgery. The physician preceptor mentors the RNFA student and provides clinical instruction and guidance in the preoperative positioning of the patient, hands-on skills during surgery and during the postoperative plan of care for the surgical patient. Mentoring by the physician preceptor has been identified as a vital component in RNFA career development. Mentors are viewed as valuable sources of support and are essential to providing opportunities to maximize learning (Myall, Levett-Jones & Lathlean, 2008).

The RNFA programs accepted by the Competency and Credentialing Institute (CCI) are those educational programs listed in the most current list of acceptable schools (Competency & Credentialing Institute, 2017). Academic requirements for RNFA training vary slightly among the programs in the United States; however, a majority of the programs require one academic year of formal, post-basic, nursing study and a clinical practicum in surgery. The RNFA student is required to complete one academic year (equivalent to six semester credit hours) of formal didactic studies in first assistant training following two years of perioperative RN training (AORN, 2014). The RNFA student is required to complete 120 hours of a clinical practicum (equivalent to three semester credit hours) for surgical assistant training (AORN, 2014). The clinical practicum is supervised and guided by a surgeon preceptor during the perioperative periods. Fifteen RNFA programs in the United States are currently accepted by CCI (Competency & Credentialing Institute, 2017). All academic programs require the RNFA student

to have an active role in patient care management throughout the perioperative, intraoperative and postoperative periods.

The RNFA provides continuity of care for patients throughout the perioperative period by coordinating the planning and delivery of patient care. In addition, the RNFA evaluates the care given and modifies the care to incorporate changes based on the patient's needs and condition. The RNFA further functions as a liaison for the patient and family in collaborating with the surgeon, anesthesia team, nursing staff, surgical schedulers and postoperative care staff to identify and address individual patient needs (Ilton, 2002).

The RNFA is a board certified perioperative nurse who has obtained perioperative certification (CNOR) and has completed RNFA education including both the didactic and clinical components. Prior to obtaining the education to become an RNFA, the perioperative RN must have a minimum of two years perioperative experience and an interest in advancing the knowledge and skills necessary to become a first assistant in surgery. The experience requirements must be met in order to function in the advanced role of RNFA. In order to be eligible for RNFA training the perioperative RN must meet specified requirements as outlined in Table 3 *RNFA Education* in Appendix C. Having strong clinical skills is imperative for the professional RNFA if the nurse is to function at the maximum potential in providing safe patient care. Skills are learned through educational experiences and mentored clinical supervision practica which focus on the performance of precise preoperative assessment and the implementation of patient-specific surgical plans of care. Additional skills which the RNFA executes are effectively utilizing surgical instrumentation techniques and devices; providing surgical exposure; handling or cutting tissue; providing hemostasis; suturing; and collaboratively assisting the surgeon in postoperative patient rounds and discharge planning (AORN Position

Statement on RN First Assistants, 2013). The RNFA practices within the scope of nursing which compiles with statutes, regulations and institutional policies related to the RNFA role (Welter, 2007). AORN standards provide a guide and framework for designing, implementing and evaluating RNFA programs and curriculum (AORN Standards for RNFA Education, 2011). The standards for RNFA education are listed in the Table 3 *RNFA Education* in Appendix C (AORN Standards for RNFA Education Programs, 2014). AORN recommends validation of competency by various tools of assessment such as, but not limited to: direct observation, physician review, evaluation of performance in different scenarios, patient health record documentation review, return demonstration and publication (AORN RNFA Competency Statement, 2007). Competency statements and measurable criteria are presented within the AORN Perioperative Nursing Data Set (PNDS) (AORN RNFA Competency Statement, 2007). The PNDS includes desired patient outcomes in the four competency domains. The domains are *Safety, Physiologic Responses, Behavioral Responses* and *Health System* (AORN RNFA Competency Statement, 2007).

The RNFA is eligible for certification following 2000 hours of clinical experience subsequent to the completion of the RNFA program. Certification is achieved following successful completion of the certification exam provided by CCI (Competency and Credentialing Institute, 2012). The certification exam *the Perceived Value of Certification Tool (PVCT ©)* was developed by CCI to identify and validate the benefits of the RNFA certification (CRNFA). The successful completion of the comprehensive examination indicates that the CRNFA has demonstrated knowledge, has attained practice standards, provided evidence of achievement and professional credibility, and confirms commitment to the highest level of patient care and safety (Competency & Credentialing Institute, 2012).

According to the Director of Credentialing and Education from CCI, as of January 1, 2017, there are 1260 nurses holding the CRNFA certification (James Stobinski, personal communication, January 28, 2017). The CRNFA certification offered through CCI is currently accredited by the National Commission for Certifying Agencies (NCCA). CCI accreditation by NCCA, is the leading agency in setting strict quality standards for credentialing organizations. Additionally, CCI is a member of the American Board of Specialty Nursing Certification (ABSNC) (Competency & Credentialing Institute, 2012). According to Stobinski (personal communication, January 28, 2017) there were approximately 800 graduates in 2016 from accepted RNFA programs in the US and there were 52 successful CRNFAs that passed the certification exam in 2016. Certification as an RNFA is voluntary and not required in all states or facilities in order to function as a first assistant. The certification requirement is a facility specific requirement. The educated and skilled RNs working in the expanded role as RNFAs in surgery who have an interest in validating their knowledge and skills may seek certification.

The RNFA provides continuity of care to the surgical patient within the preoperative, intraoperative and postoperative areas. The RNFA works with the physician in surgery for the benefit of the patient and provides both professional and technical assistance throughout the perioperative period by drawing upon scientific principles that direct clinical knowledge, critical thinking skills and judgment (AORN Position Statement, 2013). The work of the RNFA compliments that of the surgeon but the RNFA is not a substitute for the surgeon. The first assistant is not trained to conduct the entire surgery in the surgeon's absence. The collaborative care of the RNFA addresses the physical, psychological, and spiritual responses of the patient (AORN Position Statement, 2013). The RNFA behaviors are dependent upon patient populations, practice environments, specific services provided, accessible resources, hospital

policy and regulations specific to State Board of Nursing (AORN RNFA Position Statement, 2013). Table 1 in Appendix A *Perioperative Behaviors of the RNFA* displays the role of RNFA (AORN RNFA Position Statement, 2013).

Preoperatively care provided by the RNFA includes a focused nursing assessment along with communication and collaboration with the patients, their families, the surgical team and other health care providers to create an individualized plan of care for the surgical patients. The RNFA has extensive knowledge in anatomy, physiology, wound healing and is competent in performing physical assessments. Patient advocacy during surgery is critical as the patient's protective reflexes are potentially compromised rendering a patients vulnerable to injury (AORN Position Statement Patient Safety, 2011). The RNFA coordinates the positioning and prepping of the patient within the surgical suite. During the surgery, the RNFA will provide adequate exposure of the surgical site for those cases in which a first assistant is required. A first assistant uses the specialized training and education to provide adequate and safe retraction of tissue that is not able to be performed by the scrub personnel. The scrub personnel are responsible for setting up and providing instrumentation to the surgeon and first assistant. The scrub personnel work collaboratively with the team to ensure safety precautions and actions, such as surgical counts, occur. Postoperative care may include discharge planning and in some instances case management of the patient.

There are many benefits to employing RNFAs in the surgical setting such as continuity of care, expertise in the perioperative setting and cost effectiveness (Forsythe, 1997; Poe et al., 1997). The presence of the RNFA in surgery eliminates the need for a second surgeon, thereby decreasing costs, while maintaining quality care (Forsythe, 1997; Hodson, 1998; Poe et al., 1997). When not assisting in surgery, the RNFA is flexible and can be utilized in the roles of

circulator or scrub nurse when staffing needs exist (Forsythe, 1997; Poe et al., 1997). The RNFA is able to provide care in these roles when a need exists and when not being utilized as a first assistant. This is a cost effective measure for the facility as the RNFA can assist in room turnover, preparation of the patient, acquiring necessary equipment and the ability to function in other perioperative roles (Forsythe, 1997 & Poe et al., 1997). The RNFA serves as a quality, cost-effective, health provider (Kurkowski, 1999). The perioperative nurse has developed professionally and functions in the role as a highly skilled member of the surgical team. The significant influence on patient care of the perioperative nurse has gained professional acceptance in meeting the needs of health care delivery especially during times of financial and patient care challenges (Poe et al., 1997 & Rothrock, 2015). The turnover time for operating room suites was decreased by five to ten minutes when RNFAs were utilized during surgical procedures (Forsythe, 1997). Decreasing turnover time of the surgical room will increase surgical case volume creating more revenue for the facility (Forsythe, 1997; Pear & Williamson, 2009; Poe et al., 1997). In addition, the RNFA has the knowledge and experience to assist the circulator nurse with obtaining and prepping the operating room as well as conducting surgical skin prep and patient position. The RNFA can conduct the preoperative patient interviews and assist in planning for individual patient needs with consistent application of the nursing process (Forsythe, 1997; Poe et al., 1997). Draping the patient, preparing equipment and conducting surgical wound closures has helped decrease surgical in-room times (Forsythe, 1997).

There is an increase in the use of RNFAs in surgery and their role is recognized within the scope of nursing practice in all 50 states only after obtaining specialized education and clinical experience (AORN, 2013). Patterson (2012) reported that more than 80% of operating rooms in the United States use non-physicians to assist in surgery. Among states, nursing scope

of practice regulations differ, particularly for RNFAs. Employment and practice barriers exist for the RNFA. AORN (2011) reported in the *RNFA Reimbursement Laws* and *Memo of Support for RNFAs* that reimbursement for assisting at surgery services to licensed non-physicians does not routinely and consistently include third party reimbursement for RNFA services. AORN identified RNFA utilization as cost saving measures to the health care insurance industry as their service was reimbursed at a lower rate than physician rates for surgical assisting yet the qualified RNFA was not included in all state reimbursement laws (AORN, 2011). Due to inconsistent recognition for reimbursement for first assistant services by some insurance companies and the Centers for Medicare & Medicaid Services (CMS), RNFAs are not utilized equally among states (Chard, 2013 & AORN Position Statement, 2013).

The Robert Wood Johnson Foundation (RWJF) collaboratively joined forces with the IOM by making recommendations to the nursing profession in support of health care system reform. The ACA identifies the opportunity for the US to transform its health care system in providing safer, higher-quality, more affordable and accessible care (IOM Future of Nursing, 2010). Within the IOM Report, nurses were the qualified individuals who can fill the new and expanded roles in the health care redesign. Although nurses are qualified to fill the expanded roles; they must be permitted to practice in accordance with the educational and professional training they have received (IOM Future of Nursing, 2010; Kunic & Jackson, 2013). Nurses practicing to the fullest extent of their education and training will improve the health of the US population, and initiate change to promote an improved and accessible health care system (IOM Future of Nursing, 2010). In response to the IOM report, nurses need to partake in a partnership with physicians and health care professionals in order to create a significant connection and investment in health care reform (IOM, 2010; Strech & Wyatt, 2013). The RNFA working in the

advanced practice role can advocate for health care reform and play a pivotal role in leading change within the model of care provided in the perioperative area. The role of RNFA should be further investigated to enhance and improve utilization of the RNFA role in surgery.

The transition of the newly qualified RNFA to the role of first assistant can be influenced by many things. The curriculum content can play a part in the transition as specific topics may vary among schools. Obtaining a better understanding of the transition of the newly qualified RNFA to the role of first assistant may identify opportunities for curriculum change to enhance the transition of RNFAs and standardization of educational content. The clinical model of the facility in which the new RNFA is employed may differ in relation to roles and responsibilities. The specific job duties at each facility may differ for the RNFA role within the preoperative, intraoperative and postoperative phases. Some facilities may require the RNFA to conduct preoperative assessments and have more of an involvement with the patient and family preoperatively. During surgical clinical experience, the preceptor may vary the RNFA student's involvement with such things as tissue dissection, device utilization, hemostasis and suturing. Postoperatively, involvement with postoperative care, attending surgical rounds and planning for patient discharge may differ. The RNFA in the clinical phase may only work with one surgeon and within one specialty while others may work with multiple surgeons gaining experience in various surgical specialties and procedures. This may be viewed as an advantage as the RNFA will gain experience in surgical specialties other than the mentored surgeon's specialty. Due to the varying degrees of surgical experience and degree of clinical preceptor support, the RNFA may experience differences in the ability to transition to the role of assistant in surgery. The RNFA experienced in one surgical specialty may have difficulty transitioning to a different surgical specialty once practicing in the role of surgical assistant following completion of

academic and clinical education. Exposure to one specialty in surgery may allow for confidence in the one area; however, this practice may warrant them inexperienced in other areas of specialty. For example, if the RNFA mentored in the orthopedic specialty of surgery during the clinical phase is now expected to assist in ophthalmology surgery, the RNFA will not be familiar with the different equipment and more delicate suture material.

There is no literature regarding the role of preceptors, perceptions of the RNFA, or relationships with the preceptor during the training or following the completion of training of the RNFA. Transition experiences may differ among students entering the active role of first assistants; however, no literature about this process has been published. Research identifying and describing the transition and outcomes of the newly qualified RNFA needs to be conducted as RNFAs are utilized in increasing rates. Identifying the nurse's journey, educational needs, issues, problems, dilemmas or struggles is essential. This will help in evaluating current RNFA curricula and can provide guidance in making curriculum revisions. It will also inform those who facilitate the transition experiences of the newly qualified RNFAs as they develop as first assistants who are prepared to provide quality patient care and outcomes. Findings may increase retention and job satisfaction of the RNFA. The utilization of RNFAs are among the strategies that promote cost effective health care spending while exemplifying quality patient care and outcomes.

Investigating transitional experiences of the RNFA is an important area of study that will assist in meeting the projected needs of qualified first assistants in surgery. The aim of this study was to determine the transitional processes associated with moving from the completion of RNFA training to the role of surgical assistant. Understanding the realities of the transitional period and identifying potential difficulties that these individuals encounter will heighten the levels of awareness of their needs both by the RNFA and the educational program directors.

Assumptions

The researcher has identified the following beliefs regarding the transition phase of the newly qualified RNFA to the active role of an RNFA:

1. RNFAs transition from novice practitioners to expert practitioners at different paces and achieve comfort levels in performing their new responsibilities (Benner, 1982; Benner, 1984; Benner, 2001).
2. There are common struggles and barriers experienced by the RNFA during the transition phase from the period of time when clinical and academic training is completed to the time the nurse assumes the active role of surgical assistant.
3. The ability to transition from completion of training for the RNFA role to the time the nurse assumes the active role of surgical assistant is based upon the varying surgical specialty experiences encountered within the clinical phase. Surgical specialty experiences consist of, but are not limited to, general, obstetrical, gynecological, urological, orthopedic, ophthalmology, neurological, vascular, podiatry, plastic, and ear, nose and throat surgical procedures.
4. The transition of the newly qualified RNFA to the role of surgical assistant is influenced by many variables during the transition. Among the variables influencing the transition of the RNFA are the willingness of the preceptor to provide coaching during clinical experiences, the temperament and personality of the preceptor, and overall acceptance of the RNFA by the surgical team.
5. Newly qualified RNFAs are able to share their experiences of transitioning to the role of surgical assistants.

Purpose of the Study

The primary purpose of this qualitative phenomenological study was to explore the lived experience of newly qualified RNFAs functioning in the active role of surgical assistants in the hospital operating room setting. An additional goal was to identify the barriers and struggles encountered by the new RNFAs as they transition to their new role.

Research Question

The research question addressed in this study was:

What is the lived experience of newly qualified RNFAs as they transition to the role of surgical assistant?

Definition of Terms

For the purpose of this study the following terms were defined by the researcher. The terms are supported by the literature.

1. Transition is defined as the passage or movement from one state or condition to another (Schumacher & Meleis, 1994). It is an individualized process in that there is a change of behavioral patterns in the individual. The behavioral changes are related to the individual's abilities, role, identity and relationships that have been altered to an accepted level of change (Meleis, 2010). Educational background and clinical experience are key in making a transition and changes. The time of transition investigated in this study will be within 24-months of completing an accepted CCI RNFA program. The time frame will include the 24-month period following completion of a program and working within the role of RNFA. All study participants will actively hold a position as a RNFA in the surgical assistant role within the operating room of an acute care institution.

2. Registered Nurse First Assistant (RNFA) is defined by the 2013 Position Statement of the Association of Periopeative Registered Nurses (AORN) as a perioperative registered nurse who works in collaboration with the surgeon and other health care team members to achieve optimal patient outcomes. The RNFA has acquired the necessary knowledge, judgment, and skills specific to the expanded role of RNFA clinical practice. The RNFA practices intraoperatively at the direction of the surgeon and does not concurrently function as a scrub person during surgery (See Table 4 Appendix D) (AORN RNFA Position Statement, 2013).
3. Preoperative care provided by the RNFA consists of, but is not limited to, the preoperative patient management in collaboration with other health care providers such as performing focused preoperative nursing assessments and communicating and collaborating with other health care providers regarding the patient plan of care (Table 2 Appendix B).
4. Intraoperative care provided by the RNFA consists of using instruments and medical devices, providing surgical site exposure by manipulating tissue and organs, handling or cutting tissue for specimen collection, providing hemostasis, suturing, maintaining aseptic technique, positioning patients safely, and administering medication safely (Table 2 Appendix B).
5. Postoperative care provided by the RNFA consists of the postoperative management of the surgical patient in collaboration with other health care providers in the immediate postoperative period and beyond, such as participating in postoperative rounds and assisting with patient discharge planning (Table 2 Appendix B).

6. A physician preceptor is a board-certified surgeon who is credentialed by the facility and has been granted hospital or agency privileges at the facility where the RNFA is performing the required clinical practicum in order to complete the clinical component required by the academic training program (AORN, 2014). During the clinical practicum, the RNFA works under the direct supervision of the physician preceptor during the preoperative, intraoperative and postoperative periods. The RNFA functions in the role of first assistant. The physician preceptor assesses the performance of the RNFA on a daily basis through documentation of progress and preceptor-preceptee discussion. Skill competencies are reviewed and validated with the clinical evaluation tools guided by *The Core Curriculum for RN Assistant* and academic facility. Skill assessments are performed and documented on an ongoing and regular basis by the preceptor and reviewed with the physician preceptor, student RNFA and the academic advisor (Vaiden, 2005).
7. Competency of the RNFA is defined by AORN, and is verified by the evidence of demonstrative behaviors from a continuum starting with basic competency to a level of excellence of specific clinical tasks (AORN, 2013). The competent RNFA should maintain certification as a perioperative nurse (CNOR) and is encouraged to pursue certification as CRNFA (AORN RNFA Position Statement, 2013). Refer to Appendix D (Table 4) *AORN RNFA Position Statement*.
8. Competence is the functional ability and capacity to integrate effective application of both knowledge and skills along with attitudes and values that are directly related to efficient job performance in order to successfully complete a task (Meretoja, Isoaho & Leino-Kilpi, 2004; Meretoja & Koponen, 2012). The Joint Commission defines competency as the documentation of an employee's clinical knowledge, experience, and

capabilities as being appropriate for assigned duties (The Joint Commission, 2009; The Joint Commission 2010). Competency is associated with clinical performance and is a prerequisite for performance in the clinical setting (Meretoja et al., 2004; Stobinski, 2008). RNFAs are educated and skilled individuals who assist the surgeon during surgery and are deemed competent by the physician preceptor and accredited academic program to successfully carry out the responsibilities of a surgical assistant. AORN recommends validation of competency by various tools of assessment such as, but not limited to: direct observation, physician review, evaluation of performance in different scenarios, patient health record documentation review and return demonstration. Competencies of the RNFA refer to nursing assessments, communication and collaboration with health care professionals regarding plan of care and surgical skills such as handling and cutting tissue, providing hemostasis, suturing, handling specimens, providing surgical exposure and safe patient positioning (AORN RNFA Competency Statement, 2007). Refer to Table 2 *Responsibilities of the RNFA* in Appendix B for specific responsibilities of the first assistant.

Chapter Summary

RNFAs are perioperative RNs that have furthered their education in the academic setting and obtained specific skills through clinical experience in the operating room setting preparing them to function in the advanced role as first assistants in surgery. Utilization of RNFAs in surgery is one approach to meet patient needs, provide quality patient care outcomes, and reduce health care costs. Due to the multiple roles the RNFA can perform, such as surgical assistant, circulator nurse or scrub nurse, it is speculated that the RNFA role may contribute to cost

containment. The ability for the RNFA to decrease room turnover may be viewed as a measure to save time and contain costs.

Research literature related to the transition of newly qualified RNFAs to the advanced role of RNFA is absent. This study explored the lived experience of the newly qualified RNFA functioning in the active role of surgical assistant in the hospital operating room setting. The study identified the barriers and struggles encountered by the new RNFAs as they transitioned to their new role.

Chapter Two: Review of the Literature

Chapter Two presents a review of literature on subject matter related to the research question, including the theoretical framework and concept guiding the study. In addition, the need for this health care delivery model, physician restricted hours of duty, AORN support of RNFA utilization, resistance to RNFA utilization, health care benefit of RNFA utilization in surgery and nursing transitions researched will be discussed. An integrative review of literature in nursing and medicine was conducted using the Cumulative Index to Nursing and Allied Health (CINAHL), ProQuest, Medscape and Google Scholar using the key terms "transition," "nurse," "nursing," "nursing student," "student," "new role," "faculty," "first assistant," "RNFA," "surgical assistant," "surgery," "nurse residency," and "mentor". Reference lists from related journal articles were reviewed for identification of additional related articles. The review covered from 1950 to present, because the role of the RN as first assistant was pivotal during the Korean War (1950-1953) and expansion in the role has evolved. This review included both quantitative and qualitative research studies.

Concept of Transition

Transition is a process that all individuals undergo when responding to change, which is inevitable in today's quickly advancing world. The transition process varies by individual, and the situation itself gives credence to how the transition process may take place. It is the response of human experience. Meleis (2010) declared that transition is the business of nursing and nurses are at the forefront of change throughout health care. Clinical time in nursing practice is spent at the bedside of the patient where change is seen in abundance. Some of the transitions take place as the patient progresses through the admission process, rehabilitation, recovery, and then discharge. Transition is evident in the nurse's need to adequately care for patients throughout

multiple change events such as developmental, epidemic, and world changes such as migration, illness, and coping. Amid the changes in health, culture, and response to evolving issues of mankind, the nurse must make the transition in gaining knowledge and skills to meet the ever changing needs of human existence (Meleis, 2010). The concept of transition in nursing is a central focus in the discipline (Meleis, 2010). Nursing roles and responsibilities have evolved and transitioned over time. Specialty certification in nursing has brought about changes in practice and responsibilities. Transition is significant in nursing for many reasons. Nurses spend a great deal of time caring for patients and their family. Advances in technology drive transition and the need for professionals to gain new knowledge and skills. There is a rich interest in transitioning within nursing (Blanzola et al., 2004; Almada et al., 2004; Miller & Leadingham, 2010; Houghton, 2003). Transition and its effect on newly qualified RNFAs is of critical importance in the successful process of transitioning to the role of surgical assistant in the hospital operating room surgical setting.

Understanding the concept of the transition process could establish a strong foundation in the investigation of the transition of the newly qualified RNFA to the role of first assistant in the operating room. Obtaining a better understanding of the transition process and identifying barriers and struggles in transitioning to the role of RNFA in the operating room could provide empirical data to develop transition programs for newly qualified RNFAs.

Theoretical Framework for the Study

The theory of transition as described by Meleis (2010) served as the theoretical framework for this qualitative phenomenological research study. The middle-range theory identifies four major transitions as Developmental, Situational, Health-Illness, and Organizational transitions. Situational transition theory is the best suited to guide this study and

uncover emerging themes of RNFA transition. Situational transitions are those advances made during changes in professional and educational role changes (Meleis, 2010). Several essential properties of the transition experience have been categorized as Awareness, Engagement, Change and Difference, Time Span, and Critical Points and Events. Awareness is the perception, knowledge, and recognition of a transition. The individual must have some sense of awareness that a change is occurring. Engagement is the level to which an individual is involved with the process of the transition experience. Qualities evident in engagement are use of role models, active participation, preparation and information seeking, and proactively modifying behaviors, and activities. Engagement is not present without awareness. All transitions involve a change or difference. Transitions are said to be both results of change as well as results in change. The dimensions of change explored related to this study are changes of the personal nature, societal norm, and expected changes related to an RNFA transitioning to the surgical setting. Differences are the perceived changes in behaviors or perceptions in the transition towards skill mastery. Time Span is characterized by a flow and movement over time (Meleis, 2010). Bridges (2004) identified a specific end point, followed by a period of instability, ending with a period of stability evident of a transitional experience. Critical Points and Events are characteristic of a sense of stabilization in skills, new routines, or lifestyles (Meleis, 2010).

In order to fully understand the experience of the transition, it is necessary to identify facilitators and inhibitors of progress towards successful transition. Identifying personal, community, and societal conditions such as meanings, beliefs and attitudes will allow for thorough comprehension of the experience. Meleis (2010) described patterns of response that occurred in transition experience. Process indicators are outcome indicators that are identified in the transition toward a positive outcome. Feeling connected and interacting are response patterns

identified in successful transition experiences. Individuals make contacts, communicate, and reflect about new relationships experienced in transition. Another pattern of response seen in successful transition is the ability to place oneself comfortably in terms of time, space, and relationships. Meleis (2010) demonstrated that the transition trajectory is the time period and process of developing and manifesting a level of confidence and understanding from one point to the next within the transition process. Role transition is a change in relationship, expectations, and ability of the individual. In order for successful role transition to take place, the individual incorporates new knowledge, demonstrates a change in behavior, and embraces altered definitions of the individual in a specific context (Meleis, 2010). According to Meleis (2010), the transition between roles is a pause in what was and what is to come by way of changes in identity, role, ability, relationship, and behavioral patterns**.** The properties identified in the transition experience are awareness, engagement, change and difference, time span, and critical points and events (Meleis, 2010). The acquisition of new knowledge and the completion of an educational program or the attainment of a new role are examples of critical events in the transition in education and role change. The individual's cultural beliefs and attitudes can facilitate or inhibit the pattern of response (Meleis, 2010).

In addition to the theory of transition, this study was guided by Benner's Stages of Clinical Competence. Benner (1984) used the concept to analyze the process of acquiring and developing the skills necessary to move through the five levels of proficiency. The stages of clinical competence are: novice, advanced beginner, competent, proficient, and expert (Benner, 1982; Benner, 1984; Benner, 2001). Benner's Stages of Clinical Competence are based on the Dreyfus Model of Skill Acquisition, which studied practice situations in determining the level of practice evident in the situation (Benner, 2001). The Dreyfus model reflects three changes in

general aspects of skilled performance. The first change is the movement from reliance on abstract principles to use of concrete past experience. The second change is in the learner's perception of the situation; the situation is viewed less as a collection of equally relevant bits and more as a complete whole with specific important aspects. The third and final change is of the performer from a detached observer to one who is more involved in the situation (Benner, 2001). Benner's Stages of Clinical Competence are generalized in nursing and reflect the three changes identified in the Dreyfus model and focus specifically on the five stages of proficiency. Novice is the first stage in which individuals are beginners and have no previous experience or knowledge of the situation in which they are expected to perform tasks. The learner is taught about the situation in terms of objective attributes. The novice learner is unable to use discretionary judgment and exudes a lack of confidence in demonstrating safe practice. The novice learner requires continual verbal and physical cues. In the next stage, the advanced beginner demonstrates marginally acceptable performance since a prior experience in actual situations exists. Occasional cues are required for efficient and skillful practice. Knowledge is developing and behaviors are backed up by competent level nurses. The difficulty with the advanced beginner level is that all attributes and aspects are treated with equal importance, and the individual at this level is unable to choose which is of greater importance. Competence is the next level and typically reflects individuals with two to three years experience in the specific practice. Competent nurses begin to see their actions in terms of long-range goals or plans. The competent nurse is consciously able to identify the plan or goal and dictate which attributes and aspects of the current situation are considered of greater importance than those that can be ignored. Nursing care at this level can be completed in a suitable time frame without supporting prompts. Nurses tend to remain at this level because supervisors perceive it as ideal. Proficient is

the following level, in which the individual perceives situations as a whole rather than in terms of aspects. The nurse has the perspective to determine which of the many attributes are important and can implement prioritized care. Acting at this level, the nurse has a firm understanding of the situation that enables effective decision making. Performing at the expert level no longer relies on analytical principles to connect an understanding of the situation to an appropriate action. At this level, the nurse has a significant amount of experience and is able to implement appropriate behavior based on past experiences coupled with a deep understanding and insightful grasp of the situation (Benner, 1982; Benner, 1984 & Benner, 2001).

Need for Health Care Delivery Model

The United States health care delivery model needs extensive redesign in order to meet patient care needs (IOM 2010 Report, n.d.). The delivery of safe patient care in a cost conscience manner is vital. Business practices have been introduced into health care with the goal of improving efficiency, decreasing expenses, and improving the quality of health care delivery (Hartzband & Groopman, 2009). Attention has also been directed at creating cost effective measures and reimbursement (Hartzband & Groopman, 2009). Identifying and understanding the value and contribution of each member of the health care will provide evidence in supporting a redesign of the health care system (Wyatt, 2013). Implementing innovative models of health care will allow for nurses' full contribution to health care (Wyatt, 2013). Nurses will play an important role in assisting in the redesign of health care while meeting the IOM request for nurse involvement in reform (AORN activities, 2013). RNFAs are essential members of the perioperative team, enhancing communication, demonstrating teamwork, connecting with positive patient outcomes, and providing superior quality care (Chard, 2013).

Physician Restricted Hours of Duty

In 2002 the Accreditation Council for Graduate Medical Education (n.d.) (ACGME) implemented Code 405 regulation guidelines that restricted the number of hours residents were permitted to work as a result of a 16-month study on resident sleep-related issues, resident training, and patient safety (Accreditation Council of Graduate Medical Education, n.d.). The regulation was the first national comprehensive plan to address prolonged work hours involving physician training and the detrimental effects prolonged work hours have on patient care. The impetus for mandated changes reflected the performance dangers of sleep-deprived practicing residents, the growing concern of compromised patient safety, the well-being of residents, and the increased comorbidities of patients requiring a greater amount of care (Zonia, LaBaere, Stommel, & Tomaszewski, 2005). The duty hour restriction went into effect in July 2003, with the goal of enhancing patient safety and improving the quality of life for the resident trainees (Damadi, Davis, Saxe, & Apelgren, 2007; Mir, Cannada, Murray, Black, & Wolf, 2011). The restriction limited residents to no more than an 80-hour week with a 24-hour maximum limit per shift. In addition, each shift was to be followed by a 10-hour minimum break between shifts. Medical residents were required a minimum of one, 24-hour break in work per week. This is averaged on a 4-week evaluation period. In-house call assignments for residents cannot occur more than once every third night (Baskies, Ruchelsman, Capeci, Zuckerman, & Egol, 2008; Kerfoot, Nabha, & Hafler, 2005; Occhino, Hannigan, Baggish, & Gebhart, 2011). The restrictions were further refined following an investigation conducted by the IOM in 2008 (Accreditation Council of Graduate Medical Education, n.d). The revisions that limited interns to a maximum of 16 hours per shift were accepted and implemented in 2011 (Fletcher, Reed, & Arora, 2011). This led to vacancies in surgical assistants in the operating room. Methods to fill

vacancies within hospitals as a result of physician hour restrictions were investigated; one of the methods was the use of RNFAs. The role of RNFA was accepted by the ACS and AORN in the late 1970s and the utilization of RNFAs in surgery increased thereafter.

Physician assistants (PA) also were used to fill physician vacancies in the hospital setting. Cawley and Hooker (2006) reported a 50% increase in PA use in critical care units and in inpatient settings between 2003 and 2006, but use in the operating room fell from 9% to 6.7%. The increase of PAs working in the inpatient setting as house officers resulted in their decreased use in the operating room. The decrease in physicians and PAs as second assistants in surgery further supported the need for greater use of RNFAs as surgical assistants in operating rooms.

AORN Support of RNFA Utilization

The RNFA was deemed appropriate as a surgical assistant in 1977 when the ACS provided official acceptance (AORN, 2013). AORN members requested that the association clarify the role of RNFA (Welter, 2007). In 1979, the AORN House of Delegates adopted the agreement that specially trained nurses with appropriate skills and knowledge were the best qualified non-physicians to serve as surgical first assistants (Welter, 2007). The original AORN "Official Statement of RNFA" was accepted in 1984, and the AORN House of Delegates in 1989 approved the official generic curriculum for training RNFAs in 1989 (AORN, 2013; Vaiden, 2005). The first structured RNFA education program was implemented at Delaware County Community College in Pennsylvania under the guidance of Dr. Jane C. Rothrock (Rothrock, 2005; Welter, 2007). By 1993, RNFAs were recognized nationally by the American College of Surgeons, the American Nurses Association (ANA), AORN, the National League for Nursing (NLN), the National Association of Orthopaedic Nurses, and by all state boards of nursing (Kurkowski, 1999; Welter, 2007). The ACS recognizes RNFAs as RNs with specialized training

who assist the surgeon in providing exposure and controlling hemostasis, as well as other duties in the perioperative process, performing duties within the level of responsibility as defined in their state nursing practice act (American College of Surgeons, 2008). Patterson & Miller (2011) surveyed 353 operating rooms to determine first assistant use, which was reported as 67% in community hospitals and 53% in teaching facilities. In addition, hospitals reported daily use of first assistants and several stated using RNFAs exclusively as assistants in surgery (Patterson & Miller, 2011).

AORN supports use of RNFAs by collaborating with various state action coalitions and declaring services of the RNFA as equitable across the country and consequently eligible for reimbursement recognized by the CMS (Chard, 2013; Kunic & Jackson, 2013; Schroeder, 2013). Advocating for utilization of RNFA supports the IOM Report (2010) with regards to the future of nursing (Kunic & Jackson, 2013).

Resistance to RNFA Utilization

The resistance to expand roles of nurses and fully extend operational use of trained nurses along with fragmentation of the health care system is one of the identified professional barriers (IOM Future of Nursing, 2010). The lack of reimbursement for RNFA services across the United States acts as a barrier for RNFA scope of care practice (AORN, 2012). Inconsistencies exist in insurance companies' recognition of qualified providers and reimbursable services (Kunic & Jackson, 2013). There are inconsistencies in policies with private and governmental payers as well as from state to state (Kunic & Jackson, 2013). The Government Affairs Department of AORN supports RNFA utilization and advocates for reimbursement for their services (AORN, n.d.; AORN, 2011; Kunic & Jackson, 2013).

Health Care Benefit of RNFA Utilization in Surgery

Health care in the United States is in an economic crisis and great need of system redesign to decrease costs and effectively provide quality care. Costs are increasing at such a rapid pace that even the government is having difficulty meeting the financial demand (Kubin, 2012). In the year 2012, U.S. health care spending has increased by 3.7 percent, which reflects $2.8 trillion. This hike resulted in $8,915 per individual in increased health care expenditures. The rate increase of health care spending was 3.6 percent in 2011. One area of increased spending was from personal health care costs influenced by hospital services. This increase was 4.9 percent in 2012, an $882.3 billion expenditure. A demand exists for lower cost health care models (Martin, Hartman, Whitle, Catlin & the National Health Expenditure Accounts Team, 2014). Models of care have changed over time to meet the demands for cost cutting measures. In addition, the health care field and practices have evolved during the past three decades to meet changes in patient culture, patient needs, financial demands, and advances in technology. With financial health care constraints, the need to enhance cost-effective care is monumental; the operating room is not immune to such cost cutting needs (Weeks, 2002). According to the IOM Report (2010), nurses represent the largest population of the nation's health care workforce. Over time, the role of the nurse has expanded to take on a multitude of responsibilities. RNFAs have been trained and utilized to fill vacancies in surgical assistant roles and are versatile, educated, and skilled to function in various independent roles within surgery aiding in the cost effective measures for the facility, and thereby decreasing health care costs.

Transitions to New Nursing Roles

In the field of nursing, transition has been researched and has been found to be an important aspect of assuming a new role. Although new RNFAs go through a transition period,

no literature exists detailing the experience. Conducting research in order to discover important aspects to this transition would prove beneficial to nurses in this role. Literature about mentoring during the transition of new nurses has been researched extensively, focusing specifically on the mentoring role itself, the nursing students' perspectives on the mentoring programs, and the mentors' perspectives of the mentoring experience (Blanzola et al., 2004; Almada et al., 2004; Miller & Leadingham, 2010; Houghton, 2003). Clinical competency levels of the nurse have been investigated to determine the nurse's ability to perform clinical skills necessary to provide competent patient care. The core clinical competencies were defined as assessment of the patient, development and implementation of an individualized plan of care, and the evaluation of the plan in response to patient status (Blanzola et al., 2004). The levels of satisfaction of graduates from nursing residency programs, job satisfaction, and retention rates of nurses have been examined (Almada et al., 2004; Casey et al., 2004; O'Malley Floyd et al., 2005). Nurse educators' perspectives have been explored in relation to mentorship roles. In addition, educators' views on support, retention rates, and satisfaction rates within mentoring programs were investigated (Sawatzky & Enns, 2009). Research findings revealed specific factors that influence the relationship between the mentor and mentee (Darling, 1984; Hodges, 2009). Additionally, specific characteristics of "good mentors" have been identified as well as requirements for successful mentoring (Sawatzky & Enns, 2009). Earnshaw (1995) identified and described students' views of mentors, mentor's roles and the mentor/mentee relationship.

A clinical partnership model was researched to investigate the effectiveness of enhancing transition of the student nurse. Newton, Cross, White, Ockerby & Billett (2011) conducted a mixed method study investigating the effect of implementing a clinical partnership placement model in workplace learning for undergraduate students that promoted and enhanced their

transition to graduate nurses. The longitudinal mixed methods approach consisted of interviews, observation of clinical workplace, surveys, and participant workshops. Data were collected over a 3-year period. Twenty-eight students attending a bachelor of nursing program participated. Three themes that influenced preparedness for work and enhanced workplace transition emerged: organizational familiarity, continuity, and social participation. Organizational familiarity allowed for student preparation for work. Students felt prepared when gaining a familiarity with paperwork, documentation, and policies and procedures. Student graduates experienced social participation and continuity when they were greeted by health care workers they had previously encountered during clinical placement. This welcoming promoted a sense of belonging for the newly graduated nurse and secured their work place readiness (Newton et al., 2011).

Kaihlanen, Lakanmaa & Salminen (2013) conducted a qualitative descriptive study with a modulated narrative method to examine how the students rate the significance of the final clinical practice mentor as a supporter in the role changes from student nurses to graduates to their new roles as RNs. The convenience sample of 16 graduating nursing students studying in a Finnish nursing education program were asked to write an essay related to the transition from student nurse to registered nurse and the significance the clinical practice mentor played with supporting the nurse in the role change (Kaihlanen et al., 2013). The student-mentor relationship was viewed as a crucially important relationship in the role change of the student. The study found that the relationship between student and mentor greatly affected student self-confidence and enthusiasm in the beginning phases of the new RN role. This impact could be either a positive effect or a negative effect on the role change. Motivation to learn and the ability to adapt were also affected by the student-mentor relationship. The mentor's ability to provide support

during the transition was divided into three categories: role change support, the mentor's actions, and qualities of a good mentor (Kaihlanen et al., 2013).

Phillips, Esterman, Smith & Kenny (2013) conducted a cross-sectional study using descriptive questionnaire survey via the internet to identify predictors of successful transition from undergraduate student to registered nurse and whether transition was affected by pre-registration paid employment. The sample consisted of 392 newly graduated nurses from bachelor of nursing programs throughout Australia. Transition scores were identified for the four categorized respondent groups. Categories of pre-registration employment were hospitality/retail, enrolled nurse, other health care worker, and non-worker. Results revealed that transition scores were higher for employed undergraduates than those unemployed (p=0.043). Institutional factors during post-registration were found to be higher predictors of successful transition than pre-registration employment factors (Phillips et al., 2013). The strongest predictors of successful transition were assistance in dealing with complex patients, orientation to surroundings, and respect from colleagues. It was suggested that a paid employment experience during the final year of education would be most beneficial for the students as they transition to the new role of RN.

Casey et al., (2004) performed a descriptive, comparative study to identify stress and challenges experienced by graduate nurses in six acute care hospitals in Denver, CO. The study was implemented at five specific time periods of baseline, three months, six months, twelve months and at an additional time period. Comfort and confidence levels of new graduate nurses in regards to specific job duties were assessed. In addition, open-ended questions were utilized to identify difficulties with role transition of the new nurse. The participant group consisted of a convenience sample of 270 new graduate nurses in the Denver area. The Casey-Fink Graduate

Nurse Experience Survey © was utilized following development, pilot, and revision of the tool. New nurse responses reflected less confidence in communicating with interns and residents initially; a higher confidence level was found during the time period between 6 months and 1 year (p =.001). Communicating with attending physicians reflected greater confidence levels in nurses at the 6-month and 1-year interval than the initial survey (p =.003). Comfort and confidence increased significantly between 6 months and 1 year of experience in regard to delegating to ancillary personnel (p =.005). In addition, significant improvement in nurses comfort and confidence levels was found between 6 months and 1 year as compared to initial survey in areas of prioritizing and organizing patient care needs (p =.002) and suggesting changes in patient plan of care (p <.001). Themes identified from the open-ended questions used to identify difficulties with role transition were lack of confidence in skill performance, relationships with peers and preceptors, struggles with dependence on others, frustrations with work environments, organization and priority-setting skills, and communication with physicians. Stress, feelings of inadequacy, and deficits in skill and knowledge were identified as difficulties with transition. Nurses stated that it took 12 months to feel comfortable and confident in their roles. Nurses reported the importance the preceptor role played in nurses' job satisfaction and the developing competency. Consistent support, professional development and a close partnership between academia and practice settings would facilitate the transition of new nurses from student to professional nurse (Casey et al., 2004).

A study by Gerrish (2000) sought to identify perceptions of newly qualified nurses of the transition from student to qualified nurse. A grounded theory approach was utilized to examine the process of transition as compared with two study groups. The first study was conducted in 1985 with 10 newly qualified nurses and later repeated and compared to a sample of 25 newly

qualified nurses in 1998. Interviews were individually conducted with a sample from nurses working in medical or surgical areas from two acute hospitals in England. The study found nurses' perceptions of differences in the role of student and staff nurse. New role preparation and learning techniques of new role were viewed differently. There were diverse nurse perceptions regarding relationships with others in the profession and how they interacted with patients and their families. Feedback and support through the transition, and positive and negative aspects of the new role reflected in varying views of nurses. Findings revealed that nurses "fumbled along" as they learned to perform in a haphazard manner in the first cohort; however, the follow up study identified benefits from providing support to newly qualified nurses as they transitioned to the new role (Gerrish, 2000, p. 475). A "bridging period" was suggested in order to support new nurses through the transition phase (Gerrish, 2000, p. 480). This period of time would allow the new nurse to adjust with support to the new role during the transition from educational environment to the new role of nurse (Gerrish, 2000).

McKenna & Newton (2008) conducted a qualitative study utilizing focus groups aimed at exploring how new graduate nurses develop skills and knowledge over the first 18 months after completion of nursing school. Participants were asked questions directed at their perceptions of what was the most influential impact on their skills and knowledge development as well as what influenced their development as registered nurses (McKenna & Newton, 2008). Three main themes emerged: sense of belonging, independence, and moving on. Nurse participants experienced feelings of acceptance by peers and a sense of equality among them only after the 18-month time period. A sense of belonging fostered workplace confidence and socialization (Mc Kenna & Newton, 2008). In addition, the nurses felt more independent in their work following the 18-month period following graduation as the support was no longer there from

nursing school. A sense of moving on was felt by the nurses as early as 12 to 18 months following training as they began to think beyond their current role and explore possibilities in specialty areas of nursing. Although the sample size was small and the ability to generalize was not present, researchers stated the findings are of importance and warrant a need for future research with a larger population and more specific studies (McKenna & Newton, 2008).

Chang and Hancock (2003) researched role stress and role ambiguity in new nursing graduates in Australia. The first few months as a nurse following completion of nursing education are identified as potentially challenging and stressful. Chang and Hancock (2003) examined role stress at 2-3 months after employment in a new nursing role and again at 11-12 months following the first survey. They also investigated the relationship between job satisfaction and role stress. There were 154 participants in the first survey selected from tertiary graduates of 13 institutions in New South Wales, Australia. The second round of surveys was conducted 10-11 months after the first survey with 110 of the 154 original participants. A questionnaire was used to explore sources of role stress and changes in role stress at two periods. A five-point Likert scale was used to measure role ambiguity and role overload. The most prominent factor of role stress in the first few months was identified as role ambiguity, and role overload was the leading factor in role stress. Job satisfaction was found to have a significantly negative correlation with role ambiguity and role stress in both surveys. The researchers concluded that understanding role transition effects on the graduate is beneficial for future graduates, program directors, educators and administrators. Education programs can use barriers to transition in redesigning curricula to address the barriers and better prepare students for employment (Chang & Hancock, 2003).

Tastan, Unver and Hatipoglu (2013) conducted a research study on identifying factors that affected the transition of newly graduated nurses in Turkey. A descriptive and cross-sectional study of newly graduated nursing students was conducted with three cohort groups between May 2009 and December 2011. The groups of new nurses were employed at a military education and research hospital in Ankara, Turkey. The sample size was 234 (89% response rate) nurses who were considered newly graduated having graduated within the past 3 years. Data collection consisted of a survey questionnaire and use of a visual analogue scale (VAS). The VAS scale consisted of two poles of which the number 0 represented "it was very difficult for me" and 10 represented "it was not difficult for me" (Tastan et al., 2013, p. 407). The participants were asked to indicate on the VAS the number that represented for them the perception during transition for selected questions. The point for each response was measured and a score was determined. Results revealed that 57.8% of responses indicated that the orientation training met their expectations by working with a preceptor. New nurses working under supervision of a nurse scored their transition period during the first 6 months as 5.78 ± 2.66 (median=6) and the last 6-month period was scored as 6.65 ± 2.77 (median=8). The difference between the two scores was statistically significant (t=-3.207, $p < 0.05$) (Tastan et al., 2013). Stress factors and feelings of newly graduated nurses were investigated. The two most significant factors of contributing causes of stressful experiences were not getting enough rest (57.7%) and working with nurses unwilling to help (50%) (Tastan et al., 2013). Professional socialization was viewed as a significant factor in new nurse transition to the role of nurse (Tastan et al., 2013).

Dyess & Sherman (2009) examined transition experiences and learning needs of novice nurses through a qualitative research study with pre-program and post-program focus groups.

Participants included 81 new nurses with less than 12 months of practice experience. The nurses possessed either an associate's degree or a baccalaureate degree in nursing. Participants were enrolled in the Novice Nurse Leadership Institute (NNLI) in South Florida. The program did not replace regular orientation or transition programs but acted more as a recruitment tool for new nurses. The focus groups took place before the program and 12 months after its completion. Seven key themes evolved from the focus groups: Confidence, fear, less than ideal communication, experiencing horizontal violence, perception of professional isolation, complex units require complex critical decision-making, and contradictory information. Nurses felt confident yet fearful as a result of all the information they had learned along with the uncertainty of what to expect. Nurses said that communication was less than ideal with physicians and interdisciplinary members. Horizontal violence was reported frequently within the workplace. Horizontal violence was described as any act of aggression by a colleague. It included criticism and innuendos as well as emotional, physical and verbal threats (Dyess & Sherman, 2009). The professional workplace was viewed as chaotic and nurses felt isolated and often on their own. Complex specialty units were employed by many of the participants (77%), and nurses reported often being placed in critical situations in which quick decision-making was necessary. The nurses reported not having sufficient time to think through and respond. And lastly, nurses reported that questions asked of colleagues were often answered with contradictory information. The study suggested that transition support should take place in order to assist new graduates in taking on the professional role. This support should take place throughout the first year, link the new nurses with leadership professionals and promote interdisciplinary communication and skills, and offer a strategy for proper responses to horizontal violence (Dyess & Sherman, 2009).

Doody, Tuohy & Deasy (2012) investigated final year nursing students' perceptions of role transition at an Irish university. The sample consisted of 116 (84% response rate) fourth-year nursing students. A 28-item survey with a 5-point Likert rating and closed questions were used to explore demographic data, role preparation, and competence, along with organization and support issues. Results indicated that 53% of the participants agreed that they received adequate preparation for the role of the nurse. More than half (63%) reported having provided opportunities to develop skills required to be a nurse; however, only 29.6% were provided opportunities to develop managerial skills. In relation to role competence, many reported an effective work relationship with multidisciplinary teams (85.7%), successful management of workload (75.5%), and good time management skills (80.3%), yet only half reported feeling competent in providing health information and education to patients and families. As a result of this study, the researchers suggested that new nurses should be provided with transition support and that national guidelines for graduate nurse transition programs should be established (Doody et al., 2012).

Boychuk Duchscher (2009) identified the feelings of anxiety, insecurity, inadequacy, and instability of new graduate nurses transitioning to the role of RN in the theory of transition shock. The professional adjustment initially experienced by new RNs could be best met by preparatory theory regarding role transition for senior nursing students (Boychuck Duchsher, 2009). Additionally, they noted the importance of aligning curricula in undergraduate studies to workplace expectations. This claim is made following a 10-year accumulation of four qualitative research studies of new nursing graduates and their transition experiences. The first study was a 6-month phenomenological investigation of five new nursing graduates as they transitioned to professional nurses in 1998. The following study was a 12-month research study in 2001 that

explored the transition of four new nursing students and five experienced nurses to emergency room nursing. The third was a retrospective analysis conducted by Dr. Leanne Cowin on self-concept and retention plans. The last study was an 18-month investigation of 15 newly graduated nurses and their transitions to the nursing profession (Boychuck Duchsher, 2009). The investigation determined that as a result of the transition from nursing student to professional nurse, a change in roles took place with evidence of differences in relationships, roles, responsibilities, knowledge, and performance expectations. These differences occurred during moves from the familiar environment of academia to an unfamiliar environment of professional nursing; the theory of transition shock transpired from the student's initial reactions (Boychuck Duchsher, 2009). Feelings of loss of control, doubt, confusion, and disorientation are experienced when the new graduate moved from the familiar environment to an unfamiliar environment of professional nursing, with changes in responsibilities, roles, relationships and knowledge.

Chapter Summary

RNFAs new to the role have an adjustment phase as do newly graduated RNs. The literature is rich in the transition experience of new RNs; however, there is a gap in the literature when focusing on the RNFA transition to new roles in surgery. One can rely on the vast findings of new RN transition; however, research should be conducted in this area in order to better understand the experiences of RNFAs transitioning to the surgical environment. Understanding role transitions of new RNFAs could assist with facilitating and supporting them during this process. Research in this area would be valuable to future RNFA students, clinical mentors and the academia community. A review of the literature in the field of nursing demonstrated that transition is an important aspect in the adjustment to new roles. Transitioning to an RN is related

to feelings of anxiety, altered comfort level, stress, and instability. Mentors and mentor relationships affect the ability of the new RN to successfully transition to the new role. Research is abundant on various transitions in the field of nursing but is lacking on the transition experience of RNFAs to the role of surgical assistant in the operating room. As the use of RNFAs in the surgical area is expanding, research regarding their transition experiences is critical.

Chapter Three: Methodology

Research on the lived experience of newly qualified RNFAs working as surgical assistants in the hospital operating room setting is significant for the health care arena because of the increased use of the role in nursing and the vital role they play in contributing to surgical patient care. Chapter Three discusses the methodology used in this qualitative research study and presents an overview of phenomenology. This chapter also provides sampling, setting, recruitment of participants, protection of human subjects, data collection procedure, and data analysis, and details the components of rigor and trustworthiness.

Overview of Phenomenology

Phenomenology is the study of phenomena. It is the study of an individual's life as it is experienced and focuses on identifying a deep understanding of the nature or meaning of daily experiences and promotes human understanding (Morse & Field, 1995; Munhall, 2007). Phenomenological research is the study of essences of experiences. When posing a question to investigate a phenomenon, the researcher chooses a philosopher and process that best answers the posed question and provides meaning. As an approach, phenomenology is used for the purpose of understanding, making sense, and eliciting the meaning of the phenomenon (Morse & Field, 1995). The lived experience can be investigated under the direction of phenomenological initiators such as Edmund Husserl or Martin Heidegger. Selecting a method in phenomenology to best fit a research study and answering a specific question requires a process of distinguishing between approaches.

Phenomenology has its roots in the late 18th century. German philosopher Immanuel Kant claimed that phenomena exist in the human mind and are separate in reality (Converse, 2012). Every experience was first a human experience that creates a relationship between living subjects

and the world; it identifies how we perceive and understand them (Kant, Pluhar & Kitcher, 1996; Pollio, Henley & Thompson, 1997). Phenomenology assists the researcher to explore experiences without having preexisting knowledge of the phenomenon (Converse, 2012). Edmund Husserl (1859-1938), revered as the father of phenomenology, emphasized that researchers remove their biases in order to experience the pure essence of the phenomenon and understand human thought (Converse, 2012).

Philosopher Martin Heidegger (1889-1976) was a student of Husserl, but took his teachings from a different point of view and believed that the phenomenon investigated the meaning of being (Converse, 2012; Wojnar & Swanson, 2007). Classifications of phenomenological methods can be further grouped by similar focuses such as transcendental phenomenology, existential phenomenology, hermeneutical phenomenology, and linguistic phenomenology (Munhall, 2007: Richards & Morse, 2013). Hermeneutical phenomenology is connected with Heidegger. In this view, knowledge from the phenomenon comes through language and understanding. The interpretation of the phenomenon is an evolving process and uses cultural components such as, symbols, religions, art, and languages in the interpretation process (Richard & Morse, 2013).

Husserl and Heidegger both stressed views of phenomenology; however, they expressed differences. Husserl's transcendental phenomenology is based on description of the phenomenon; whereas, Heidegger's hermeneutic view went a step further towards interpretation of the phenomenon and identifying the meaning of being (McConnell-Henry, Chapman, & Francis, 2009). Husserl developed a descriptive psychology that was noted as an early form of phenomenology. He presented a systematic approach to the investigation of knowledge in the consciousness and used phenomenology to describe the experience or awareness of things.

Husserl described the investigation of things as they appear to consciousness as being pure (Munhall, 2007). He stated that the process consisted of transcending to the reality of the underlying experience.

Husserl's work was labeled as transcendental phenomenology. He attempted to explore and identify the reality of humans within a lived experience (Munhall, 2007). The lived experience was explored as it was experienced within the life-world or *Lebenswelt* (McConnell-Henry et al., 2009). Knowledge was believed to stem from conscious awareness and that the mind was directed towards objects known as intentionality.

Transcendental phenomenology aims to expose the absolute truth via description and focuses on the experience itself (Dowling & Cooney, 2012; McConnell-Henry et al., 2009). The underpinning of Husserl's belief involves the thought that the experiences within the mind and body are separate (McConnell-Henry et al., 2009). Husserl's Cartesian duality declared that the mind and body were mutually exclusive and assumed the existence of a mind-body split. The mind was directed towards objects, and the phenomenon existed only if there was a subject that experienced it (Dowling & Cooney, 2012; McConnell-Henry et al., 2009). His view included the need for *epoche* (the Greek work for a check or cessation), the methodology of bracketing, setting aside preconceptions, or reduction of the researcher's preconceived ideas about whether something exists or can exist (Pollio et al., 1997). One could only experience the true essence of the phenomenon or lived experience if these preconceived ideas of the related question were set aside (McConnell-Henry et al., 2009; Pollio et al., 1997). Bracketing prior knowledge or experience with the phenomenon allows for the researcher to experience and report the encounter as it is perceived in its original state (McConnell-Henry et al., 2009; Richards & Morse, 2013).

It was expected that Heidegger would carry on Husserl's work; however, Heidegger's work of hermeneutical phenomenology took him away from Husserl's beliefs of transcendental philosophy (McConnell-Henry et al., 2009). Heidegger's work explored beyond the descriptive nature of phenomenology to an interpretive manner of uncovering the meaning of lived experiences (McConnell-Henry et al., 2009; Smythe, 2012). Hermeneutics derives from the Greek work *hermeneusin,* which means to understand or interpret (McConnell-Henry et al., 2009). Heidegger moved from Husserl's description of the phenomenon with an aim towards identifying meaning and uncovering the interpretation of the phenomenon, ultimately exposing a greater meaning of *being* (Dowling & Cooney, 2012; McConnell-Henry et al., 2009; Wojnar & Swanson, 2007). Heidegger's view of being included *being in the world,* which was influenced by the individual's social, cultural, and historical being (Chinn, 1986). Gaining an understanding of the lived experience was not a thing or object but rather an event, one that would produce a deeper meaning to the event (Dowling & Cooney, 2012; Figal, 2007). Heidegger was interested in studying all human activities and their interpretation as they provide information about being in the world and how it is expressed in *language* (Munhall, 2007). Language allows the hidden nature of being to be revealed (Munhall, 2007). Take for example, a hammer; one sees its metal head and wooden handle and feels its weight and interprets it as a tool for building or a weapon. The presence of a thing is determined not only by its characteristics but is interpreted by those who have encountered it (Harman, 2007).

Heidegger rejected Husserl's mind-body duality of human existence and promoted a concept termed *dasein,* and described what it means (McConnell-Henry et al., 2009). We conceive ourselves as being there, which is dasein (Wojnar & Swanson, 2007). This takes place before anything else (Figal, 2007; McConnell-Henry et al., 2009). The wonder and question of

our existence and being is dasein (McConnell-Henry et al., 2009). The concept of dasein introduced the human way of being in the world (McConnell-Henry et al., 2009; Wojnar & Swanson, 2007). Heidegger identified that a forestructure of understanding exists from an individual's familiarity, previous experiences, and sociocultural background. Forestructure is associated with how one understands and interprets reality (Wojnar & Swanson, 2007).

Heidegger stated that it is not possible to live without interpretations and that understanding is rooted in our definitions (McConnell-Henry et al., 2009). His aim was to allow the information to speak for itself, which provides for greater meaning or understanding of the phenomenon (McConnell-Henry et al., 2009). Human beings are influenced by their environments, cultures, and past experiences. Humans do not exist without being in the environment (Munhall, 2007). The world holds great meaning with its vast interaction, communication, relationships, languages and experiences (Figal, 2007). Time and space are major concepts of Heidegger's philosophy (Munhall, 2007).

Heidegger rejected Husserl's belief of the need for bracketing prior knowledge and experience of the phenomenon. He declared that the researcher is as much a part of the research as the participant and the ability to interpret data is dependent on previous knowledge and understanding of the experience (McConnell-Henry et al., 2009). Heidegger believed that the researcher must be open with his or her viewpoint when obtaining data. Understanding and interpretation cannot take place unless the researcher has preconceived knowledge and experience in the phenomenon. This preconceived knowledge and experience lends to richness in the interpretation process. Heidegger believed that our understanding is always present and already exists; therefore, it cannot be removed by way of bracketing (Smythe, Ironside, Sims, Swenson & Spence, 2008). In order to obtain neutrality or transcendental subjectivity, the

researcher should set aside prior understandings and preconceptions by using field notes to collected observations and assumptions (Wojnar & Swanson, 2007). For the purpose of this research study, the researcher bracketed previous knowledge, experiences and emotions related to the transition of the newly qualified RNFA to the hospital operating room surgical setting in order to achieve neutrality. The researcher bracketed due to the close nature of the issue being studied. The researcher has completed RNFA training and occasionally functions in the role of RNFA. In addition, the researcher works directly with RNFAs in the operating room. Bracketing allowed for easier data analysis as previous knowledge, experiences and emotions related to the issue were separated.

The hermeneutic circle identified by Heidegger consists of an interpretive process of relating parts of information to the whole and its parts in a continuous manner (Pollio et al., 1997; Wojnar & Swanson., 2007). Rather than a linear process, the hermeneutic circle consists of a back-and-forth movement within the examining, questioning, and re-examining of text; the findings are an ever expanding circle of thoughts about the meaning of the phenomenon (McConnell-Henry et al., 2009; Pollio et al., 1997; Wojnar & Swanson, 2007). The researcher investigated the lived experience of participants by obtaining their stories and listening intently. Heidegger's hermeneutical phenomenology assisted the researcher in obtaining data through interviews and interpreting the shared meaning of the phenomenon rather than just describing the experience (Crist & Tanner, 2003; Lopez & Willis, 2004). The interpretive process with Heidegger's hermeneutics looks deeper into human experience rather than just the conscious description of Husserl's method (Lopez & Willis, 2004).

Research Design

The research design used in this study was a qualitative interpretive hermeneutic phenomenological method. The qualitative research method was used due to lack of knowledge related to the phenomenon of the lived experience of newly qualified RNFAs who have transitioned to the hospital operating room surgical setting. The purpose of a phenomenological study is to describe the essence of behaviors, human understanding and general explanations related to the phenomenon (Creswell, 2009; Morse & Field, 1995). The focus of this study was to understand the lived experience of RNFAs as they transitioned from newly qualified RNFAs to the hospital operating room surgical setting. The interpretation of the meanings of the lived experiences has provided a better understanding of the transition between the phases of the newly qualified RNFA functioning within the role of the hospital operating room setting as first assistant. Data was analyzed for identified themes using Colaizzi's seven-step process of thematic analysis.

Sample

A purposive convenience sample was used for this study; participants were selected based on their knowledge, direct exposure, and expertise with the phenomenon under investigation (Holly, Salmond, & Saimbert, 2012; Sandelowski, 1995). The study's sample included RNFAs who had transitioned to the hospital operating room surgical setting within 24 months of successful completion of an acceptable RNFA training program and not with receipt of certification as a CRNFA. The subjects were graduates from a CCI acceptable RNFA program within the past 24 months and had not yet obtained certification as a CRNFA. For this study, the researcher recruited RNFAs who successfully completed the RNFA training from the AORN professional association RNFA database.

The sample size was determined by data saturation. Saturation was achieved when no new information was obtained from additional sample participants and collected data were viewed as sufficient to create the intended product (Munhall, 2007; Rubin & Rubin, 2012; Sandelowski, 1995). The narratives of new participants were added to the database after each interview. The information was analyzed as it was added to the study database (Munhall, 2007). The quality of information is by far more important than the number of participants (Munhall, 2007; Sandelowski, 1995). Upon data saturation, interviews were concluded. Twenty participants were interviewed.

Setting

Interviews on a one-to-one basis were conducted via telephone interview. Interviews took place via telephone that promoted privacy and eliminated interruptions. The interviews included only the researcher and participant.

Recruitment of Population Participants

Approval from the Institutional Review Board (IRB) at Villanova University was obtained prior to recruiting participants. Approval was also obtained from the IRB at AORN prior to participant recruitment through the AORN RNFA database. The researcher recruited participants by initially contacting the AORN professional association via email introducing the request to obtain participants from among RNFA members. The letter introduced the researcher and purpose of the study (Appendix E). Following approval, prospective participants were contacted via email and postal mail with a letter of explanation of study purpose (Appendix F). Informed consent was obtained from each prospective participant (Appendix G). After informed consent and demographic information were obtained from each participant, the researcher asked

questions about his or her transition as an RNFA to the hospital operating setting. Each participant received a $20 VISA gift card incentive after validation of data was returned to the researcher. The gift card was mailed to the participants. Interviews conducted via telephone were audio recorded.

Protection of Human Subjects

Institutional Review Board (IRB) approval was obtained from both Villanova University and AORN prior to conducting the study. Human subject issues were protected by use of informed consent and confidentiality (Brink & Wood, 1998). Participants were recruited on a voluntary purposive method and were provided a letter of explanation of study purpose (Appendix F). In order to protect human subjects, individuals participating in the study additionally received an informed consent letter (Appendix G). Informed consent and demographic data form were completed prior to conducting interviews. Participants were notified of the potential risks of participating in the study. Individuals had the ability to decline participation at any point during the study without penalty. The participant interviews were captured on two digital recorders. The recordings were downloaded immediately by the researcher following the interview onto the researcher's computer and external flash drive, both with password protection. The researcher conducted the transcriptions. The taped audio files and transcripts are kept in a password-protected file in a locked file cabinet in the researcher's home office. Consent forms with participants' signatures are stored separately from interview data. Participants' names were not used in order to preserve their anonymity. All documents and recordings will be kept in a locked file cabinet for five years and then permanently destroyed.

Data Collection Procedure

Each participant signed an informed consent (Appendix G) and completed a brief demographic data form (Appendix H). Interviews were conducted after informed consent was obtained and the demographic data form was completed. Telephone interviews were scheduled after the researcher received returned informed consent and demographic data form. Interviews that are generally open-ended and few in numbers were used to elicit opinions and insight from the participants (Creswell, 2009). The interviewer asked predetermined questions in a manner to solicit answers without contaminating the participants' responses (Holstein & Gubrium, 1995). Data were collected through the use of an open-ended semi-structured interview in order to learn about the lived experience (Rubin & Rubin, 2012). Prepared questions developed for the interviews were broad with probing questions (Appendix I) for further exploration and understanding that did not influence the content (Holstein & Gubrium, 1995). The interviews were audiotaped with two digital audio recorders. The researcher used field notes to add to the information provided by the participants. Two recorders were used to provide a backup in case of malfunction during the interview. The researcher listened and asked questions. Information was preserved in field notes following the interview to avoid decreasing communication during the interview (Mellon, 1990). Upon completion of each interview, the recordings were downloaded by the researcher, from the recorders directly to the researcher's computer and external flash drive, both with password protection. The downloads were then transcribed directly into NVivo software on the researcher's computer by the researcher following each interview. Data were analyzed by the researcher after each interview. Each interview was identified by alphanumeric code.

Data Analysis

The demographic data and audio recordings were uploaded to the NVivo software program. Identification was documented by alphanumeric coding. The data was analyzed by using Colaizzi's method of thematic analysis. The seven steps of thematic analysis identified by Colaizzi (1978) consist of:

1. Read and re-read the transcripts of the participants' descriptions of the experiences to understand or acquire a feeling for the phenomenon.
2. Return to each transcript to identify and extract significant statements that directly relate to the investigated phenomenon.
3. Formulate significant meanings from the extracted statements.
4. Cluster the formulated meanings to form the common themes of all participants. Clusters made by the researcher will be validated by referring to the original stories. Information that may not fit will not be ignored.
5. All significant statements and clusters will be used to describe the phenomenon in an exhaustive description.
6. Themes and descriptions of phenomenon will be validated by referring back to participants to compare their experiences with the findings.
7. Any changes or additional information offered from the participants will be incorporated into the findings.

The use of thematic analysis allowed the researcher to reflect on the collected data and identify themes. It is imperative that the researcher reviews the information collected from the interviews multiple times to clearly understand the information and accurately interpret the data (Creswell, 2009; Morse & Field, 1995).

Rigor and Trustworthiness

Rigor and trustworthiness are of great importance in qualitative research studies as they are implemented to prevent error (Morse & Field, 1995). Lincoln and Guba (1985) identify four criteria that need to be met for qualitative research, met early, and continued throughout the study: truth value or credibility, applicability, consistency, and neutrality or confirmability (Morse & Field, 1995).

Truth value or credibility is defined by Morse & Field (1995) as subject oriented and not predefined by the researcher. The researcher reported the perspectives of the participants as clearly as possible (Morse & Field, 1995). The researcher's actions are aimed at establishing confidence that the truth of the context is reflected in the reported findings (Lincoln & Guba, 1985). The study is viewed as credible when the findings highlight faithful interpretations of the human experience to a degree that the participants are able to recognize the descriptions as their own (Sandelowski, 1986). Prolonged engagement and persistent observation provide certainty of credibility of the data and analysis (Lincoln & Guba, 1985). Member validation as described by Sandelowski (1993) is a process by which the participant validates the data collected and its interpretation. Validating the accurate description of the phenomenon confirms the credibility of the description. The transcripts were returned to the participant via email or mail for validation and then returned to the researcher with approval or further information input. This process allowed for the additional opportunity of data collection and increased the time of engagement. The researcher reported clearly the participants' perspectives with the use of audio taped interviews, transcriptions, and field notes. Consultation with two doctorally prepared researchers with experience in qualitative research was incorporated to review the audit trail.

Applicability of a qualitative study is demonstrated when the experiences of the participants are accurately described or interpreted findings provide a rich description of the phenomenon being studied (Lincoln & Guba, 1985; Sandelowski, 1986). Interviews were transcribed word for word and returned to each participant for validation. Quotes were reported to illustrate the findings.

Consistency is defined by Morse & Field (1995) as experiences or findings that are similar in nature when replicated. Qualitative research is identified by Morse and Field (1995) as having variation in replicated studies due to the uniqueness of human experiences. An audit trail was used to describe the researcher's decisions and insights during the study and how the data were interpreted (Morse & Field, 1995). The audit trail was reviewed by two doctorally prepared nurse researchers with expertise in qualitative research.

Neutrality or confirmability is defined by Morse & Field (1995) as having freedom from bias. Researchers identify and bracket their own biases and avoid researchers' motivations, interests, and perspectives from contaminating the findings (Lincoln & Guba, 1985). In addition, the researcher consulted with two experienced researchers and an additional external research reviewer with expertise in qualitative research. Rigor was met by ensuring accurate transcription and repeated review of the transcripts by the researcher. Bracketing was implemented to ensure neutrality (Lincoln & Guba, 1985).

Chapter Summary

This chapter discussed the qualitative interpretive hermeneutic phenomenology method that was used to guide the study of the lived experiences of newly qualified RNFAs transitioning to the role of RNFA in the operating room. Interviews were conducted with participants from a purposive convenience sample. The researcher collected data via the use of an audio recorder,

and it was transcribed into NVivo software. The data were analyzed using Colaizzi's thematic analysis. The researcher identified themes on the meaning of the phenomenon. Rigor and trustworthiness of the study were maintained through truth value or credibility, applicability, consistency, and neutrality or confirmability.

Chapter Four: Findings

This chapter presents the results of this qualitative phenomenological study that explored the lived experience of newly qualified RNFAs functioning in the active role of surgical assistants in the hospital operating room setting. In addition, it addressed barriers and struggles encountered by the new RNFAs as they transitioned to their new role. Real life accounts were described as related to the lived experiences of participants.

Description of the Sample

Twenty RNFAs participated in this study. The researcher conducted twenty audiotaped interviews following receipt of consent form (Appendix G) and the completion of the demographic data form (Appendix H). The demographic data form was used to identify additional information about the participants. The demographic data form was designed by the researcher. Sixteen participants were female and four were males. Participant ages ranged from 32 to 67 years old with the average age being 50 years old. Sixteen participants were Caucasian, two were Hispanic/Latino and two identified themselves as other. Sixteen participants were married, two divorced and two identified themselves as in a committed relationship. Fifteen of the participants held a BSN degree, two held an MSN degree, one each held a Diploma, Associate's Degree and other degree. The other degree was identified as an MS in Healthcare Administration. Four academic facilities provided participants' RNFA education. Nine participants attended a national institute, seven attended a community college, and four attended professional seminars. The number of years as an RN was between 3 and 44 years with an average of 22 years. The number of years of operating room experience fell between 9 and 37 years with the average of 22 years of experience noted. The number of preceptors in clinical internship varied from zero to 10 preceptors. All participants had primary specialties in which

they gained clinical experience. Four participants had one primary specialty and sixteen had more than one primary specialty during their clinical rotation. Nineteen participants received experience in more than one specialty and one participant received experience in only one specialty during clinical internship. Half of participants expressed having a specific surgical specialty interest after course completion. Three participants are currently working in specialties outside of the specialty areas in which training was experienced. At the time of the study, seventeen participants were working within the specialties they experienced during their clinical internship. Thirteen of the twenty participants were mentored as an RNFA following course completion of the RNFA program. For those nurses mentored following course completion, the amount of time mentored in the new role varied between two months and one year. Regarding employment settings, 19 of the participants were employed in the hospital setting and one worked in both hospital and ambulatory surgical settings.

Analysis of Data

This study was guided by this question: What is the lived experience of newly qualified RNFAs as they transition to the role of surgical assistant? Participants were encouraged to share information as they answered the interview questions (Appendix I). Data from each interview transcript were analyzed using Colaizzi's method of thematic analysis. The seven steps of thematic analysis identified by Colaizzi (1978) consist of the following:

1. Read and re-read the transcripts of the participants' descriptions of the experiences to understand or acquire a feeling for the phenomenon.
2. Return to each transcript to identify and extract significant statements that directly relate to the investigated phenomenon.
3. Formulate significant meanings from the extracted statements.

4. Cluster the formulated meanings to form the common themes of all participants. Clusters made by the researcher will be validated by referring to the original stories. Information that may not fit will not be ignored.
5. All significant statements and clusters will be used to describe the phenomenon in an exhaustive description.
6. Themes and descriptions of phenomenon will be validated by referring back to participants to compare their experiences with the findings.
7. Any changes or additional information offered from the participants will be incorporated into the findings.

The researcher listened to the audiotapes and read through the interview transcripts multiple times to obtain an understanding and sense of the content of the interviews. The researcher made notations in the margins of each transcript and highlighted significant statements. In addition, NVivo software was used to assist in categorizing significant statements. Significant statements were then separated and categorized into formulated meanings. Common themes emerged from the formulated meanings. Field notes were integrated into the data analysis. The use of thematic analysis allowed the researcher to reflect on the collected data and identify themes. It is imperative that the researcher reviews the information collected from the interviews multiple times to clearly understand the information and accurately interpret the data (Creswell, 2009; Morse & Field, 1995). Thematic analysis resulted in four main themes and thirteen subthemes. The four main themes were personal challenge to obtain requirements for the certificate, health care providers' attitudes and actions towards RNFAs, satisfaction from the new role of RNFA, and engagement in an on-going learning process. Thirteen subthemes emerged from the four main themes as presented in Appendix J.

Theme One Personal Challenge to Obtain Requirements for the Certificate

Many of the participants stated there was an element of challenge in completing the requirements of academic studies and clinical obligations. Participants described various challenges that made the academic and clinical experiences difficult. Some participants shared the personal sacrifices that were made to complete both clinical hours and academic studies. As one participant noted:

> I did a lot of self seeking for myself. Experiences, I sought them out. I put myself into situations where I wasn't always comfortable, so that I made myself learn. I knew I wasn't really good at laparoscopic stuff but I volunteered to go in. And you do have to push yourself, you can't be afraid; you just have to keep trying.

The above statement expressed a participant's challenge in seeking out experiences to help in the learning process as requirements for the program were completed. The participant described the courage and perseverance essential in reaching the overall goal of program completion. Although challenges were experienced in obtaining requirements, there was an overall sense of worth in the process and education. Two participants described their overall experience as "challenging but well worth it," and "it was not a bad experience, it was just kind of strenuous on my life."

From the first theme of personal challenge to obtain requirements for the certificate, four subthemes emerged: needed to be self-directed in seeking out learning experience, struggle to obtain required clinical hours, time-consuming process, and involved rigorous and extensive work. Research participants' rich descriptions of the subthemes are included.

Subtheme One: Needed to be self-directed in seeking out learning experiences

The participants in this study shared that they often needed to be self-directed in seeking out learning experiences in order to complete their course work and obtain useful clinical experiences. Participants expressed that a great deal of their time was invested in preparing for the classroom and for surgical procedures. The value that classroom and clinical learning had in preparing participants for the role of RNFA was communicated by many; however, there was the necessity to be self-directed in learning to supplement the academic component of the program. In addition, the need to practice on one's own was necessary to supplement the skill acquisition component to learning. One participant shared, "For the curriculum for the RNFA, you sought out your own cases. You had to pursue the hours that you needed to finish up the RNFA…you had to be self-motivated."

There was a great deal of self-directed learning that took place as described by many of the participants. One participant explained that self-directed learning of some educational material occurred and explained it as, "do your theory portion on your own" and "the book work and all that was pretty much on my own." Another participant described that there was actually a preference in learning the material autonomously:

> Give me the material and what I need to know, and I will read it and take the test and do it on my own…what I don't like is to sit in the classroom and they go over what you were supposed to have read the night before or reading from slides up on the wall, it drives me insane.

Participants also explained the need to seek out learning experiences in order to plan and prepare for surgical procedures. Many discussed the process of researching surgical procedures in order to better prepare them for upcoming procedures in the operating room. One participant

described the self-directed preparation as “I did it all, a lot of it at the kitchen table on pigs’ feet”. This participant spoke of practicing suturing technique and suture manipulation of a pig’s foot in order to gain dexterity and control of the suture material and instrumentation as well as enhancing the precision of skin approximation when closing a wound.

Not only did participants describe the need to seek out their own experiences in academic studies and gain experience with skills for surgical procedures, but they also had to be self-directed in learning in other phases of care such as preoperative and postoperative care of the surgical patient. Often times, this experience was not fully covered in the academic or clinical settings.

Subtheme Two: Struggle to obtain required clinical hours

Overwhelmingly, most participants described the struggle in obtaining required clinical hours in the operating room. One struggle described by many participants in obtaining required clinical hours was reflective of the competitive nature of the operating room among those seeking clinical case experiences. Participants described the struggle as a competition with others in the profession and favoritism or politics in obtaining time in surgery within the assistant role. It was often difficult to receive the approval to participate in surgical procedures in the role as surgical assistant. On occasion, approval was granted to other student RNFA and PA assistants in need of similar exposure and experience as a surgical assistant, which resulted in missed opportunities for the RNFA student. On other occasions, participants perceived the inability to gain exposure to surgical procedures as a result of politics or favoritism. Some established assistants were protective of their attachment to surgeons and were not welcoming to the learner, while others felt unaccepted by surgeons themselves. One participant shared that:

> It was hard, I felt like I was constantly scrambling to get my hours because I felt politics really played into what was going on in the OR because nobody wants to give up their surgeon and especially since mine had his nurse practitioner.

This last statement was shared by an RNFA who felt a great presence of political conflict when attempting to obtain exposure to the RNFA assistant role in the operating room. Often times it was the director, supervisor or charge nurse that restricted the RNFA in obtaining time in the assistant role in surgery. Other times, it was competition with others needing that same time in the role of RNFA during surgical procedures. Participants described their feelings in attempting to obtain those valuable clinical hours as "disheartening," "challenging," and "frustrating." One described the feeling of general "resentment." Another described the experience as, "It was hard to be patient and get your hours in. I thought the hours would just fall into my lap; but not so much."

Participants expressed genuine concern of how the challenge in obtaining the required clinical hours affected both their professional and personal lives. There was a great deal of personal time invested in obtaining clinical hours. Participants shared how they invested personal time in the operating rooms on their days off to gain the necessary experience in surgery. In addition, some participants utilized valuable time after working a full-time job to obtain necessary clinical hours and experience in surgery as a first assistant. The sacrifice of free time was made to gain the experience necessary to complete the requirement of clinical hours in surgery. One participant described this difficulty as "the hardest challenge I had. I had to give up my day off, some weekends, and my evenings to get my clinical hours in." Another participant described how the semester needed to be extended in order to obtain the required clinical hours. Clinical time in the OR was delayed and took place during an extended academic semester, "I

had to extend my time because I was unable to actually get my hours between doing my full-time job and my home life."

Subtheme Three: Time-consuming process

Many described the task of obtaining clinical hours, paper work and the academic component as time-consuming. One participant described the act of tallying all the clinical hours as "burdensome." Another participant expressed the process of putting together the clinical affiliations as a time-consuming process. While yet another participant explained the time involved in obtaining all the requirements as being "more time intensive than you realize."

Participants described the challenges of obtaining clinical hours and the time-consuming process in completing requirements. A few participants mentioned that personal time was required to obtain their clinical hour requirement. For some this meant sacrificing time with family and friends in order to be in the operating room on days off, evenings, and weekends which resulted both in their time-consuming views as well as challenges in obtaining clinical hours. The academic work required, in addition to the number of surgical clinical hours, was seen as a time-consuming process.

Subtheme Four: Involved rigorous and extensive work

Many participants expressed classroom work requirements and clinical hours in the operating room as rigorous and extensive. Many described the overall experience in acquiring information and valuable clinical experience towards becoming an RNFA as "hard," "challenging," "a lot of work," and "strenuous." Some found the classroom didactic portion, homework, and requirements of the program to be difficult but overall, worthwhile. A participant described the perception of extensive work as "challenging, but it was fulfilling because I learned a lot."

Some participants described the process of becoming an RNFA as "a little nerve racking," and "it was not a bad experience, it was just kind of strenuous on my life." One participant expressed that the learning process was, "more labor intensive than you think" and "the training part of itself was great, extremely rigorous." Overall, the participants felt the academic and clinical portions were of value to their learning and beneficial to them as new RNFAs but many did feel that it was labor intensive and difficult: "The clinical portion of it was actually pretty difficult…getting that aspect of it done was very, very difficult and grueling." Two additional participants described the coursework requirement as too much information presented at one time during the academic didactic phase, "It was a bit overwhelming" and "During my class, the education part, I found the actual lab helpful. I think what I didn't find helpful was all the systems being crammed into a week, an intense week of reviewing systems and anatomy." Participants reflected on views of their experiences of personal challenges encountered while obtaining requirements in completing academic studies and clinical obligations. Although, many described challenges encountered while in the academic and clinical phase of becoming an RNFA, participants also identified the benefits and values of learning opportunities in the pursuit of becoming a first assistant.

Theme Two - Health Care Providers' Attitudes and Actions towards RNFAs

The participants in this research study expressed both positive and negative experiences they encountered while gaining knowledge and valuable clinical experiences in becoming RNFAs in surgery. Participants also expressed concern toward health care providers' attitudes and actions regarding RNFAs that were encountered during the educational and clinical process. Participants shared contrasting views in the two subthemes that emerged: process of integration

and acceptance by the patient care team and encounters that the RNFA experienced with colleagues while learning the RNFA role.

Subtheme One: Process of integration and acceptance by the patient care team

It was evident that a large number of participants in this study had an enormous amount of support from various sources such as encouragement from surgeons, instructors, RNFA colleagues, PAs, and others in the field of surgery. Participants described support from others in the field such as anesthesia staff, ancillary health care team members, and senior leadership within the organization. The participants reported that surgeons were willing to teach and help the participants as they learned the skills necessary in becoming RNFAs. Participants explained how beneficial the support from surgeons and others was in their transition to the new role of RNFA. The guidance and patience provided by preceptors was also valuable to RNFAs. One research participant described the beneficial clinical encounter: "They [entire team] knew I had limited experience but the staff and the surgeon and everybody had been very helpful with teaching me their routines and what happens at the new hospital."

A participant passionately described how the encouragement and optimism encountered by the anesthesia team during skin closure helped to encourage the RNFA and provided a comfortable atmosphere for stepping into the role:

> I even had anesthesia cheering me on from behind the drapes. I mean, they were like 'oh that looks great' and I just feel like I have a good rapport with the people I work with and so there weren't a lot of problems. They were very eager to help me out and it was just positive all around.

Participants described how the support they received had a positive effect on them and promoted their learning experience. Having the acceptance of the surgical team was monumental

in feeling like a functional part of the team and a sense of belonging. One participant explained how the trust from the surgical team helped with the transition and learning process, "A trust relationship…when you gain their trust…the transition will be much easier because they will teach you a lot of things and they will let you do a lot of things as well."

Some participants rationalized how the support they received was reflective of their past experiences in the operating rooms as well as their familiarity with the environment and staff. Building up a rapport and the respect between health care workers promotes acceptance and integration. Many participants described how the integration and acceptance were believed to be the result of establishing themselves as good circulators and scrub nurses prior to entering the RNFA program as well as having prior relationships with the team members. The following statement expresses the acceptance of the RNFA by the anesthesia team that most likely is reflective of the past experience of being an OR nurse:

> Anesthesia wrote a note to the director supporting the program because of the surprise that somebody in the assistant role would do things like open and set up an a-line, help with insertion of a central line, standby for induction…the need for assistive devices as well…a difficult intubation and I just run and go get a glide scope. And, personally, that came from my experience. That came from being in the operating room for as many years as I was. So anesthesia was very supportive.

Participants described the support they received from their facilities in allowing them to complete their clinical hours within the surgical department in addition to encouragement and financial support for expenses related to academic studies. The encouragement and support was helpful in the process of integration and acceptance by the patient care team. The hospital provided financial support to the student RNFA and allowed ease in pursuit of academics.

Additionally, one participant shared the ease of integration to the role of RNFA due to the facility's overall acceptance of the RNFA role.

Additional components that fostered the process of integration and acceptance reside in knowing your scope of practice which helps in the integration of the RNFA and ultimately maintains a safe practice. One participant described this in the following statement:

> I found the scope of practice section, that we were doing to be very helpful. To actually find where my lines were, what I could and couldn't do, or at least have an idea of where I needed to be careful.

The welcoming, understanding and helpful manner in which RNFAs were accepted by the patient care team was most beneficial and allowed the RNFA to be perceived as having value and worth. Feelings of belonging and being part of the health care team promoted and fostered learning for the RNFA. Acceptance of the team was rewarding and beneficial, "the support….I couldn't have asked for anything more."

In contrast to the many examples of positive experiences that assisted in the process of integration and acceptance by the patient care team, there were negative experiences shared that hindered the process of integration and acceptance. Participants shared feelings of frustration and hopes for greater support and better reception from those in the profession. One participant stated, "I wished that they would have had a manager in place that would've been the liaison." The presence of a liaison was thought to help in the integration of the RNFA to the operating room setting and would have assisted in the assimilation to this new role.

A negative experience was detailed in which a charge nurse played favorites when it came to surgical assistant assignments. The participant believed that the charge nurse purposefully withheld surgical exposure for an RNFA in need of particular experiences. Another

participant shared frustrations with experiences being taken away from an assistant and instead bestowed upon PAs:

> I felt like my experience was being taken away from me to give it to them [PAs] so they could get on par; so they could start working and do their job. So I was kind of pushed aside a little bit because we needed to get those people up and going rather than RNFA students and train them to be employed and work at my facility…I really wanted to take on more of an RNFA role but it was taken away at my facility by PAs because we just hired two PAs to come in and basically do all the assisting. So that left me looking to other venues like surgi-centers, which I work at two other surgi-centers now, just to try to fill in that role as the RNFA.

Another participant shared the experience of staffing issues that negatively affected the process of integration and acceptance by the patient care team: "Switching back and forth really divides your focus." Being frequently and unexpectedly assigned to roles other than that of assistant created frustration for some RNFAs because their "hands were tied" and rendered them unavailable "to function consistently as an RNFA." Staffing issues demanded the RNFA function in circulator and scrub nurse roles which limited the exposure to the RNFA role.

Another obstacle to the process of integration and acceptance by the patient care team is the unfamiliarity of the benefits and value of the RNFA. Participants expressed a genuine concern that hospitals, surgeons, patients, and politicians do not have an understanding of the significance and importance the RNFA role offers. A participant revealed the struggle in receiving acceptance from surgeons in the statement:

> There were still some surgeons not really ready to accept the RNFA because they believed they didn't have the aptitude to take on the role…some surgeons and the PAs definitely believed that they were better prepared for the role of the surgical assistant.

The participants spoke to the benefits of the RNFA role. Recognition and benefit of the role of RNFA was a struggle for some patient care teams to accept, as one RNFA pointed out:

> It was still a big struggle getting recognition for the role and how to credential the role because no one knew at the time…for me personally; it was probably hard in that I was the first RNFA that the hospital had ever heard of and one of the first nurses to ever assist.

Subtheme Two: Encounters with colleagues while learning the RNFA role

Research participants described both beneficial and problematic encounters with colleagues during their learning process. From a positive perspective, many participants spoke of the willingness of colleagues to accept them into the environment and role of the RNFA. There was a helpful response to the RNFA as a team member from those in the roles of anesthesiologist, CRNA, surgeon, circulating nurse, scrub nurse, and others in the assistant role. Many participants felt well received by others. One participant shared how the willingness of others to accept and teach during the time of learning held great significance. "…It had a lot of value because they were speaking from experience."

The encouragement and support received during closing a wound, for example, was seen as beneficial by participants in the role. Closing a surgical wound with sutures is a stressful time for those learning the skill. This is a critical time when precision and detail are of great importance in order to approximate the incision adequately to promote healing. It is also a time of independent performance while onlookers, forming perceptions of your work, are waiting for

the RNFA to complete the task. The encouragement and support received during closing a surgical wound was beneficial to participants in the role. During this task, it appeared that many felt that attention was focused on them while managing the suturing and maintaining proper and secure closure of the wound. Such supportive encounters were described by one participant like this, "I had many who were just very supportive of me. They would just talk and tell jokes and things like that while I was busy trying to close the patient," and:

> They've all been very positive. Nobody rushed me when I was closing or anything like that…they offered words of encouragement. When I was closing incisions, they'd say that 'it looked great' and 'you're doing such a great job'. That was all the way around, from the nurse anesthetists to the circulator and also, to the scrub. I think they appreciated what I could bring.

The supportive nature of willing surgeons encountered by one participant was genuinely expressed in the statement:

> I've actually found the doctors far more helpful and educational than I expected them to be…they were more nurturing…I was taken under the doctor's wings…that little bit of faith in me, even though I didn't know what I was doing, was huge. That there was a certain level of confidence that they had in me…saying 'you're doing a great job,' 'keep it up,' and 'we're so proud of you.' That was definitely a great support.

This same participant spoke of another surgeon that was "empowering, this surgeon totally pushed me and stayed with me and encouraged me." Another encounter that was advantageous for this individual was a memorable event with an experienced RNFA in the field:

> While in suture lab, the RNFA instructor provided helpful information that stuck out in my mind. While sharing instruction specific to vascular surgery, demonstration of the

> amount of pressure to apply when experiencing a vascular bleeder, was performed as the instructor applied pressure to my hand to demonstrate the amount needed to occlude the bleeder.

Meaningful and positive learning experiences like these are important to the learner. RNFAs expressed the importance of how beneficial the supportive encouragement is when seeking efficiency and confidence:

> I was very fortunate because I was well received….there were so many people willing to mentor me…if you have people helping you along, you do pick up the pace, you build your confidence, it is going to be okay, you are not alone at that field, you can always ask for help. It really did make my experience a lot better.

In contrast to the many positive encounters experienced by the research participants, there were an equally large number of negative and destructive encounters that were reported. Participants discussed the unwelcoming and somewhat competitive nature of the operating room setting. RNFAs learning in clinical settings perceived a territorial component related to the unwelcoming nature of current RNFAs. RNFAs in the learning phase felt a sense of rejection from other incumbent RNFAs. The impression was that important information regarding responsibilities of RNFAs was withheld intentionally from those learning the roles and responsibilities. Two participants explained the need to prove themselves to other RNFAs in order to acquire their acceptance within the surgical team.

One participant shared competitive encounters with others that existed in the surgical arena when attempting to gain experience and acceptance of the surgical team: “There were a couple of nurses that I was colliding with for quite some time. Circulators were unappreciative of provided assistance as a result of fear that their jobs would be taken from them.” One participant

indicated that sometimes "when receiving direction from the surgeon, the other RNFA member will give you conflicting information in order to compete with you," and this was perceived by the participant as disruptive and intentional in order to sabotage the learner's performance.

Many participants spoke of a level of competition or intentional divisions developed among the team. This is expressed in statements such as, "There is competition between the RNFA and the PA. The belief, there is still the belief, it still exists that the PA is the better clinician than the RNFA." Another participant spoke of the same belief about the RNFA and PA saying "In the beginning it divided some of us and them…they [PAs] don't want me there and I don't want to be part of something that's dysfunctional like that."

The competition discussed in the following statement was thought to be reflective of "jealously" and perhaps "fear":

> …some of it is they're a little territorial. We have one of the RNFAs, all she does is robotics so she doesn't want anybody else taking over that or coming into her territory. Some of it has to do with that we've brought in PAs as well. And they're intimidated by the PAs or they're afraid the PAs are going to take over their jobs.

Another participant described similar experiences with competition within the surgical area as "That's my surgeon phenomenon," meaning there is a possessiveness to holding onto their surgeon and not allowing others into the procedure. This participant further explained this as "some people make sure you don't get in there. That is the job they've decided they are entitled to do." This participant went on to explain the sense of intimidation felt by others and perhaps the feelings of "here's one more person that's going to take away my opportunity to do this job."

Participants also discussed the challenge of previous experiences and rapport as a circulator nurse that led to an expectation of similar proficiency in the new role of RNFA. As one participant noted, “I felt it was very challenging because sometimes more was expected of me because I was the expert circulating nurse and now I’m learning to be the RNFA, so that was a little more challenging.” Having a previous relationship with colleagues in the operating room and being identified as an experienced circulator, in some cases, created a similar expectation of the individual now functioning in the novice role of RNFA.

Another challenge for the RNFA attempting to acclimate to the team while learning are the interactions with other health care providers that are unpleasant and unwelcoming “They just expected you to know everything and they weren’t very nice to you when you were trying to learn.” Another participant shared, “There was really no support from my peers…it was pretty much a cut throat environment.” Unwelcoming and negative behaviors of colleagues were described like this, “Some people with negative attitudes toward the learner would easily and for no reason, bite your head off.” In addition, one participant expressed her change in behavior as a result of unfavorable and unsupportive behavior exhibited from the surgical team, “I find myself apologizing when I feel the eye rolling, real or imagined, even though I shouldn’t. No need to apologize when I’m only trying to do the best I possibly can for each patient.”

One participant described adaptive behaviors that were accredited to her success as an RNFA, “I came to the OR with a thick skin and a sense of humor. I firmly believe it’s why I’ve been successful. I can brush these behaviors off because I know I am doing my very best for my patients.” This participant described how an adjustment had to take place in order to adapt to the environment to acclimate successfully.

Statements shared by research participants were divided among positive and negative experiences encountered by health care providers' attitudes and actions towards RNFAs. The attitudes and actions were influential to the participants' experiences. Overall, support and encouragement were among the largest stated positive attitudes or actions encountered by participants.

Theme Three - Satisfaction in the New Role of RNFA

Participants openly and eagerly shared a satisfaction in the new role of RNFA. There were many statements that detailed the satisfaction in the three subthemes that emerged: RNFAs make a difference in patient care, RNFAs have the ability to advocate for the patient and the patient care team, and transformation into a leadership role. Statements supporting the three subthemes are discussed.

Subtheme One: RNFAs make a difference in patient care

Participants shared their feelings that being an RNFA allowed them to do more for the patient by having more direct involvement with the surgery, providing a more complex level of care, and helping in ways that they could not before becoming an RNFA. Participants shared how "The RNFA always is involved from start to finish," and they are able to assist in a greater capacity due to their level of knowledge and skill in all phases of surgical care. One participant explained, "It's just phenomenal what I actually can do during surgery to help the doctors in the actual procedure." Participants explained that they are able to work in roles of circulator, scrub nurse and RNFA that can help with the overall flow of the room and care of the patient. The role of RNFA was compared to the PA assistant in that "surgical assistants can only hold retractors, RNFAs can do more. They can hold the circulating job, they can do the RN job or they can do

the scrub tech job." The RNFA assists anesthesia with intubation as well as during extubation. They provide a higher level of standardized care:

> It's the all around care for the patient; I can work in all aspects of the room…it's the total encompassing of that care. And it's exciting to actually be able to suture somebody closed. To actually have your hands on…providing the actual care other than passing the instruments and doing the paperwork.

Participants felt their role and involvement helps the overall flow of the room, "I will get those cases done more quickly. I'm in the room helping turn over. I will do whatever it takes to keep the day moving," and "from the time they [surgeons] leave until the time they start their next case, is significantly diminished because the turnover is so much faster." An expedited room turnover limits delays for subsequent patients awaiting surgery.

Participants also explained that they are able to do more for patients as they spend time with the patient preoperatively and postoperatively. There was an overwhelmingly positive view of their ability to work in a multifaceted manner. RNFAs are able to work in multiple roles (circulator, scrub personnel, or assistant) within the operating room as well as in different phases of care:

> I usually make myself visible before surgery and after surgery, kind of like the circulator would be, just to make sure they see me from beginning to end and know that I'm there with them. And I like to explain...I'm still very verbal with the patient and I think it's important to them.

Another participant shared thoughts about how the RNFA makes a difference in patient care:

> I treat every patient the same. I think that they deserve the best care, no matter who they are, where they're from, if they have insurance or not. It doesn't matter. When I take a

> patient that I am providing their care, I take it very seriously. I give them everything I have, the knowledge and the experience that goes along with that. And that's something that I pride myself in. Being an RNFA and being able to work at the table is just the spot where I wanted to be.

Subtheme Two: RNFAs have the ability to advocate for the patient and the patient care team

There was a genuine pride and sense of worth in that participants felt that RNFAs advocate for patients and the patient care team, which adds great value to their role in the operating room. One participant shared the importance of advocating for patients under anesthesia, "Knowing how much I mean to the patient at the bedside. Even though they are asleep under general anesthesia, just a comfort with them knowing that I'm there. It's huge for them." Being a part of the team is meaningful, "It means being a vital part of the OR team." The RNFA is able to prepare patients for surgery by explaining expectations and outcomes and plan for their individualized care and help the team prepare for those needs, "We can help support whether they are doing something, whether they [surgical team] have everything they need." RNFAs are able to provide this enhanced preparation when they prepare before the procedure and meet with the patient. RNFAs are able to provide specific information about the surgical procedure, expected outcomes of surgery, and answer detailed questions related to the surgical process. One participant expressed this level of involvement in the following statement:

> I had the time to go through charts of my patients, and have a good handle of what was going to be going on in the OR. So I could go back to the room and speak to the techs, speak to the circulator, and even talk to anesthesia and tell them what the story was.

> One participant stated that having the ability to prepare and speak with the patient before the surgery assisted in the ability to plan and care for the patients in a manner that actually helps the patients…getting them out of surgery quicker.

Limiting the risk of anesthesia is a goal promoted by decreasing the amount of time under anesthesia. There was a great sense of worth and value in the ability to do more for patients. The significance of their involvement with patient care has great meaning for the RNFA.

The following statements made by participants revealed the passion and pride experienced by the ability to advocate for the surgical patient: "It's personal pride. It's satisfying to know that I am making a difference in somebody's life and I am able to function on my own, and be a patient advocate by helping them with whatever they need done." One participant described, "Being able to advocate for the patient on a much finer level, once the patient goes to sleep in surgery. Advocating by protecting them, being so careful about where their arms and legs are placed, it's very, very rewarding." Another participant explained, "It is advocacy not only for the patient but for the nursing profession."

Subtheme Three: Transformation into a leadership role

Some of the participants described the transformation into a leadership role as the "ability to share knowledge and empower other people," and "the use of leadership qualities and the performance of an expanded role." Giving back and having the ability to teach others were described by participants as valuable attributes in the RNFA role. One participant detailed this interest as "I like being a preceptor, and I like teaching other nurses to scrub; I like teaching them to circulate." Another participant shared, "I was teaching them what the instruments were." One participant explained having the leadership role now to teach other physicians how to first assist was appealing:

> I was actually able to proctor the new physician in retina surgery. He had never done that but he is a seasoned physician. He is actually a physician from another country, so he's working in the assistant role, first assistant to the surgeon. I actually taught him.

An RNFA participant explained an intrinsic reward within the leadership role, which involves providing insight in a collaborative manner to the surgical team, "Giving recommendations to the surgeons and then your surgeon will take what you said and try what you recommended and it works."

Some participants described the leadership role of the RNFA with expressions like responsibility, self-government, autonomy, and freedom. Participants spoke of being able to choose what cases they want to be involved with and the autonomy in setting their own schedules following completion of the program. Another reward of the leadership role is having the freedom to do the thing they love while having financial freedom and independence. One participant shared that "It means more responsibility and the staff look to you for direction." Another participant views the leadership role as being the individual to mentor and lead by example:

> My goal is to promote teamwork, promote following the appropriate chain of command. I feel that as the RNFA I have to be the example, this is how we behave. This is how we interpret and follow the policy. This is how we speak up if somebody is trying to do something that is a work around, or a short cut, or something that's not safe.

Many participants described the gratification of the new expanded role of RNFA in the following statements, "It enhanced me more as an RNFA because I have the right tools (skills and knowledge); all I have to do is transform that tool into action," and "I find it extremely rewarding…I am in a leadership role…people look to me for answers to different things that are

happening in the operating room…it is very rewarding," and "It is very challenging. I find that I am really excited about work again."

Some described the leadership role as an "expanded role", "empowering", and "giving to the next generation". There was an overwhelming sense of responsibility and as one participant stated, "Who's going to take care of us someday?" as an obligation to give back to our next generation of RNFAs. There is a sense of ownership for our profession and future RNFAs.

The knowledge, expertise and worth of the RNFA were passionately displayed by many RNFAs. There is a strong sense of value to the role. One participant felt so avidly about the level of advanced care and stressed that is should be a degree and not just a certificate:

> When I found out that it was a certificate as opposed to a degree, I was kind of a little bit disappointed because there is a huge educational component that is required. Being an RNFA, I feel that when I'm in a room, aside from the surgeon and the anesthesiologist, I'm the next in line of command.

Theme Four - Engagement in an On-Going Learning Process

Participants in this study shared their experiences and views of engagement and the on-going learning process required to acclimate to the role of RNFA. Four subthemes emerged from this theme and are depicted in the rich statements provided. The four subthemes are handling personal fears and developing a level of professional well-being, learning the elements of the role, building the necessary skill set, and maturing in the RNFA role.

Subtheme One: Handling personal fears and developing a level of professional well-being

Many participants described a deep desire or intrinsic passion to become an RNFA and have the ability to do more for the patient through their expanded skills in the perioperative

setting. Education was an important aspect for many of the participants. Some explained the interest in becoming and RNFA as "My dream job to have and that it is like a dream that I was chasing after two years and finally the dream came true," and "I developed this innate desire to be able to do this as a nurse in the future." Many described that being at the surgical table and working in the capacity of the RNFA was the ideal position for them, "…just the spot where I wanted to be," and "I just can't imagine doing anything else. There was nothing that was going to deter me from doing what I wanted to do." One participant described robust interest and comfort in the surgical setting. The comfort experienced in the operating room for this participant was felt so deeply that it was compared to being in one's own home. This familiarity and comfort limited some of the personal fears:

> The OR is like walking in my house. I know where everything is, how things go, where, you know, it's just like being in my house. It's like a second home away from home for me being in the OR.

Although many described the enthusiasm in living out their dreams and goals in becoming an RNFA, there were many participants that described fears and concern about stepping into the role of RNFA. Some descriptions of participants' feelings are "excited," "scared," and "intimidated." Some participants shared feelings of uncertainty and lack of confidence. Some questioned their ability in first assisting in the RNFA role, "Am I capable, can I do this? I mean, think about it, you're tying someone's artery; you're tying someone's vein. What if that comes loose? I could hurt somebody." Another participant described the experience and initial feelings as "humbling." There were concerns regarding degree of confidence as a result of not always being proctored on all specialty cases prior to working in the role of RNFA

in surgery. This participant explained the experience as humbling because the process was slow at first and:

> You have to keep in mind you are a novice. One of the most important things and I still say to this day, is what the surgeon taught me, no one is born knowing. I'm smart and I can figure this out…I really need to rely upon my critical thinking skills and know when to ask for help. Those are some of the things that really are the most important tools you have when you transition. You have to remember you are a beginner again. It is humbling.

Comfort level within the new role of RNFA varied among participants. Some felt their level of comfort was lacking due to the need for more time with their proctor in surgery and others felt more confident. One participant described the level of comfort after academic and clinical completion as 120%, while others felt confident in some specialties "I felt confident to do orthopedic procedures." And another participant explained that "even though I felt like maybe I'm not as ready as I thought I was, I was."

Research participants described that although there were fears and initial concerns of preparedness, their overwhelming passion and perseverance in becoming an RNFA resulted in satisfaction and a sense of achievement, "For me it was a huge accomplishment," and "It was well worth all of my time and effort and I'm very glad I did it."

Subtheme Two: Learning the elements of the role

Many participants spoke of how their past experiences in the operating room as circulators and scrub personnel prepared them in the learning process for becoming an RNFA. Having a past experience with the equipment and even an understanding of anatomy and the

procedures was beneficial. The RNFA utilizes past experiences, anatomy knowledge and learned skills and expands upon that knowledge when working within the assistant role:

> Being able to apply the knowledge that I had, and as I went through the various modules in there, being able to be in that environment and actually put it to use from past experience and take the new knowledge and skills and start to use those in the day to day practice, I think was the best part of it.

Another research participant shared how past experiences were beneficial, yet as an RNFA there is deeper understanding built upon the basics of perioperative nursing:

> I had been a surgical tech years ago and I knew instruments and the basics. You learn more intricate anatomy in the program. You know your basic anatomy as a nurse but you don't really get into the layers of the tissue and the different fascia, so it is interesting to go through all that and be able to really get into the more detailed anatomy…I do a lot of Whipple procedures and liver surgeries and you don't realize how close you are to the vena cava and the different large vessels.

Several participants echoed this same idea that previous experience in the OR proved beneficial as they transitioned into the RNFA role.

Although some participants felt prepared in the knowledge and clinical components of the RNFA role, there were still aspects applied to the RNFA role that needed more instruction. Financial billing for assistive procedures and credentialing of the RNFA role are areas that were lacking in instruction according to many participants. A participant explained this belief in the following:

> I felt prepared from a clinical standpoint and probably because I had been doing it for so long ahead of time. I was very unprepared for all of the credentialing. I did not feel that I was prepared for that. Definitely was not prepared for the billing situation.

Participants also spoke of wanting more time in simulation and lab. They were gaining experience in clinical; however, not all specialties were covered within the academic setting. For example, one participant noted, "I would've liked more practice time, actually in a classroom, probably at least another week to work on mannequins, equipment, and suturing." Billing, credentialing, and simulations emerged as three specific elements of the RNFA role for which some participants did not feel adequately prepared.

An element of the role of becoming and RNFA that was expressed in more negative terms was the exposure to the politics of the hospital. A few participants discussed how dealing with hospital politics was a difficult and unsolicited component in the process of becoming and RNFA: "The bureaucracy portion of it was actually the hardest hurdle to go through or jump through." Some individuals spoke of the difficulties in arranging affiliations with organizations or acquiring approval to perform clinical hours within a particular facility. Receiving recognition and acknowledgement for the role of RNFA in the health care community was another obstacle. As is clearly evidenced, participants found prior experience helpful, discovered gaps in their knowledge, and also ran into political obstacles as they learned the elements of the RNFA role.

Subtheme Three: Building the necessary skill set

Participants shared feelings of appreciation for the program and clinical rotation towards broadening their abilities and knowledge base; however, many shared that additional time was necessary in building their skill set and gaining self-confidence. Participants discussed how the

basics were covered in their education and confidence built over time with practice and exposure to other procedures and specialties:

> So many cases today are laparoscopic and they did not provide much instruction regarding laparoscopic surgery…I don't really do any major vascular…I think there was one small workshop for some vascular. If all you are going to do is tie and hold retractors and maybe a minor suturing, the program was great but I think it probably needs a little bit more, other than practicing on foam. It's a great concept but that's nothing like what skin or tissue is like. Knowing how much tension to put on the sutures, like when you are suturing a liver or tying the liver, you know, when you tie the skin you pull that suture tight but when you're tying the liver if you pull that suture that tight you are just going to rip through the liver.

Another participant shared how practice at home was necessary to build the suturing skills required in the operating room:

> I do wish there was more time learning suturing and those kinds of things. I didn't get a lot of experience doing that in the course. Probably, we practiced suturing for about two days and then we went home and practiced. I worked on it by myself for several months, learning how to suture, trying to do better and learning how to tie and do all those things…I wished it would've been more.

Confidence was built from practice as stated by many participants: "I'm much more confident now but I've been practicing." One participant shared how confidence grew even though practice was limited:

> My classroom was educational but a lot was crammed into two weeks. I do wish we had more time with lab and suturing, and things like that initially. I didn't feel like I was

> prepared to transition over but as I did my clinical, I got more confidence and more secure and was able to go into the role.

Several participants shared the same experiences that confidence and skills grew through practice.

Participants also shared their experiences of working closely with surgeons and how it helped them understand the procedures in greater depth, the potential complications of the surgery, as well as rationale and consequences for actions taken:

> It was so interesting to kind of delve into the mind of the surgeon and to be able to understand what the plan of, basically their plan of attack or plan for surgery is. And knowing to anticipate, learning how to anticipate that.

Experience and confidence grew while working with various surgeons and comparing the various approaches for a particular surgery:

> It was so useful because the doctor actually got to work with you and you got to experience all the different doctors doing things a little bit different. And seeing how everything was working out; doing a hysterectomy one way versus doing a hysterectomy another way.

Spending time in physicians' offices both preoperatively and postoperatively was also a beneficial component to refining knowledge and skills of the RNFA as expressed by one participant: "I got to see a different side of what the patient was experiencing and how the doctor handled telling patients what the plan was. I saw different ways of doing it through physicians."

Subtheme Four: Maturing in the RNFA role

Maturing in the role of RNFA was viewed as an ongoing process that enhanced skills and aptitude over time and through experiences. Maintaining life-long learning, seeking

continued educational offerings, and networking aided the RNFAs in working towards full potential and promoted evolution within the role. Attending workshops and seeking new methods through attending conferences and learning from others was beneficial to the RNFAs.

Networking with other RNFAs and discussing procedures, devices and methods in first assisting helped expand aptitude and advanced skill sets. Two participants shared views of their continued growth in the following way, “Learning from other people’s experiences,” and “You’re going to learn something from everybody.” Being open, receptive, and willing to share experiences is an important component to maturing in the role. Learning from surgeons and “actually working with the surgeons, you will learn their idiosyncrasies and how they like to do things and how they approach different situations.” Another part of the maturation process of the RNFA is reflective of growth over a period of time. One participant shared overall feelings of the program and shared how growth took place through varying experiences: “It was a good year of learning and the week-long course was informative. Then having the projects throughout the year helped me grow in depth.”

Exhaustive Description of the Phenomenon

Colaizzi’s method of data analysis includes the integration of results into an exhaustive description and the identification of the fundamental structure of the investigated phenomenon (Colaizzi, 1978). Integration of significant statements, formulated meanings and themes into a comprehensive and exhaustive description of the phenomenon of the lived experience of newly qualified registered nurse first assistants (RNFAs) who have transitioned to the hospital operating room surgical setting is presented. The exhaustive description portrays the essence of the phenomenon and the view of the participants’ experiences.

The participants in this study described their experiences of transitioning to the hospital operating room surgical setting as newly qualified RNFAs with great passion. In most instances, participants stated an overall sense of worth and satisfaction in the pursuit of becoming RNFAs. All participants were proud of becoming RNFAs and possess strong enthusiasm in their work as RNFAs. They described pride in overcoming the challenging work and perseverance through the struggles they met while in educational and clinical components of learning. Participants viewed their new role and responsibilities as leadership roles and valued their new responsibilities as RNFAs. Having the ability to do more for the patient and the team was of great value and benefit to RNFA participants. Integrating new skill sets and educational knowledge in making significant differences in patient care was respected and held with great value. Participants shared the significance and importance in having more responsibility in patient care and advocating for patients and their families. There was a great deal of discussion around support during the educational component and clinical aspect. The support participants received during education and clinical settings was most appreciated by participants and beneficial to learning. Most stated that patience and guidance provided by surgeons was exceptional and beneficial to the ability to successfully transition into the role of RNFAs.

Participants expressed many challenges and barriers in the educational and clinical process of becoming RNFAs. The many sacrifices made in completing clinical hours and the strenuous coursework required was a large component of the challenges experienced by participant RNFAs. Participants viewed the personal time devoted to completing clinical requirements in the operating room and completing the rigorous coursework was an impediment to their personal life. The need to be self-directed in seeking practice time in simulation and time required in surgery as proctored RNFA students were arduous processes. Another challenge to

RNFAs in training was the struggle to obtain operating room exposure and learning opportunities in surgery. The operating room setting can be a complicated area with politics, favoritism, and competition to obtain clinical time with the surgeon in surgery. Many participants understood the complexity to seize time with surgeons in surgery to gain clinical exposure and it was viewed as a challenge among colleagues. Many felt the unnecessary effort required to arrange for time in the operating room with surgeons was unwarranted and destructive to the learners' self image and sense of belonging.

While several participants experienced support from health care providers, instructors, and colleagues, there was still the need to self-advocate. Participants stated numerous times the need to pursue their own experiences in the operating room. Often times, there was the need to request entry into surgery to work with physicians that had prearranged agreements with other RNFAs. Time spent in clinical was not only a necessary requirement but a valuable component to the preparation of RNFAs. Many felt well prepared and supported the academic curriculum and clinical exposure; however, a desire to have additional time preparing in simulation and gaining experience within specialty surgeries existed during clinical internships. Much of this comfort and aptitude came after continued exposure in surgery as RNFAs. Numerous participants described the benefit and value that past operating room experiences as circulating nurses and scrub nurses played in the pursuit in becoming RNFAs; however, building the necessary skill sets of RNFAs was still a process that required engagement and dedication. There was a sense of maturation in the role which took time. Ultimately, all participants overcame their initial feelings of fear and developed a sense of professional well-being.

In most instances, participants supported the view of RNFAs as leaders and fully promoted the advancement and use of RNFAs in the medical field. The integration of their role

in surgery was believed to be a benefit to the entire surgical team and patient; however, the acknowledgement of their role is lacking in health care administration and policy. Participants view themselves as advocators for their role and spoke of the need to lobby with governmental affairs and health care administrators about the full use and recognition of RNFAs.

Chapter Summary

This chapter presented a summary of demographic characteristics of the twenty participants interviewed and the results of the analysis of interview transcripts. During the thematic analysis using Colaizzi's method for phenomenological research, 487 significant statements emerged with four major themes and thirteen subthemes. Participants' perceptions of experiences and thoughts expressed during the interviews were analyzed and presented as illustrations in an exhaustive description of the phenomenon.

Chapter Five: Conclusions and Implications

The primary purpose of this phenomenological study was to explore the lived experiences of newly qualified RNFAs functioning in the role of RNFAs in the hospital operating room setting and to answer this question: What is the lived experience of newly qualified RNFAs as they transition to the role of surgical assistant? An additional goal was to identify barriers and struggles encountered by new RNFAs as they transition to their new role. Perceptions of participants can aid in better understanding the experiences of RNFAs who have transitioned to the surgical operating room environments. Shared experiences of participants can provide valuable information for future RNFA students, clinical mentors and the academic community. Four major themes and thirteen subthemes emerged from the thematic analysis of data. This chapter presents a discussion of the findings, limitations of the study, implications for nursing practice and education, and recommendations for future research.

Discussion of Findings

Theme One: Personal Challenge to Obtain Requirement for the Certificate

Participants in this study revealed multiple personal challenges that were experienced during acquisition of academic and clinical requirements. Although many obstacles were identified, all participants described an overwhelming value, worth, and personal pride in completing the program requirements and obtaining the credentials of RNFA. Personal sacrifices experienced in completing the obligations and arranging time to practice were shared. Four subthemes emerged in identifying the personal challenge to obtain requirements for the certificate. The need to be self-directed in seeking learning experiences was discussed by many of the participants. Whether it was seeking experiences in academic studies, preparation for surgery, or exposure to surgical procedures, self direction was necessary. Many participants

shared various reasons for the struggle in obtaining clinical hours in the operating setting. Struggles identified included competition among professionals or favoritism and politics experienced with having the ability to gain exposure to surgical procedures. Feelings of favoritism were experienced by RNFAs when assignments were made. In some instances, participants felt they were deprived of needed experiences in certain specialties because other RNFAs were assigned to those cases. Participants described the need to compete with others due to territorial reasons or because others were unwilling to give up their normal assignment or surgeon. The competitive nature to gain access to surgical procedures was undesirable to the student RNFA. Participants found it difficult and unpleasant to compete with fellow RNFAs or PAs that were assigned to surgical procedures. Established RNFAs were unwilling to offer the role of assistant or that particular assignment to the student RNFA. In other words, the RNFA would not give up their assignment of assisting in a particular surgery for the student RNFA to have the experience. In some instances, participants described these behaviors as possessive and unprofessional. In addition to the struggle to obtain clinical hours and need to be self-directed in seeking out learning experiences, participants expressed that the educational and clinical process was time-consuming and involved extensive work. There was no literature that identified the challenges that occurred while meeting the requirements for the RNFA; however, in an integrative literature review conducted by Tower, Cooke, Watson, Buys and Wilson (2015), the most frequently cited challenge of students entering nursing degree programs was finding time to attend academic classes and complete the study requirements.

Theme Two: Health Care Providers' Attitudes and Actions towards RNFAs

Study participants spoke of the process of integration and acceptance by the health care team members and encounters with colleagues while learning the RNFA role. Some expressed

their experiences as beneficial, while others described theirs as problematic. Several RNFA experiences in the operating room setting were described as positive and supportive in nature. The participants described their preceptors' encouragement and willingness to teach as beneficial to their learning experiences**.** Student RNFAs found that obtaining trust within the team and achieving a sense of belonging were helpful in their acceptance and integration into the surgical team**.** Some participants recognized benefits from working within the surgical team as circulators or scrub nurses. Having past experience and knowledge of the operating room setting, surgical team, and surgical procedure itself was felt to be a benefit to the newly qualified RNFA in the operating room.

In contrast to the positive encounters of RNFAs as they transitioned to their new role, there were unfavorable learning situations as well. The competition that was experienced with other RNFAs was viewed as an obstacle within the learning atmosphere. The unexpected competition that existed in order for student RNFAs to gain surgical experience was viewed as undesirable. Participants expressed the need to adjust to the negative and unpleasant situations by becoming resilient and developing a sense of humor in order to acclimate to the negative or uncomfortable event. Another obstacle to acceptance and acknowledgement of the value of RNFAs in surgery was the previous association of RNFAs and PAs with surgeons and health care facilities. A challenge to the integration and acceptance of RNFAs in clinical settings or operating rooms was the inconsistent recognition or value of the role of RNFAs. Health care administration and government officials' lack of awareness of the RNFA role and of the overall benefit of their service to health care were viewed as hurdles by many participants.

Although there is no research on health care providers' attitudes and actions toward RNFAs, there is evidence for the benefits and importance of orientation, transition programs, and

support systems in the successful transition of new graduates in nursing. Supportive programs must recognize the stages of transition and the various learning and clinical support needs for the successful transition of new graduate nurses (Lea & Cruickshank, 2014; Morales, 2013). The new RNFA could benefit from transition programs that bridge the gap between the completion of program requirements and the active role of RNFAs in surgery. Transition programs are necessary in creating working environments that support new nurses, as transition programs new nurses were noted to increase job satisfaction and retention rates (Missen, McKennas, & Beauchamp, 2014).

Theme Three: Satisfaction in the New Role of RNFA

Participants shared an overwhelming satisfaction in the RNFA's ability to provide more for the patient and team as a result of their skills and enhanced education. Satisfaction from being directly involved during surgery factored into their view of fulfilling the new RNFA role. Participants felt that their ability to provide a higher level of standardized care in all phases of the perioperative setting was gratifying. They felt, as RNFAs in surgery, that there was a greater sense of patient advocacy and a greater ability to better assist the entire surgical team than in their roles as perioperative RNs. They were able to provide more diversified care as assistants in surgery. As described by one participant, "being an RNFA means being a vital part of the OR team." Giving back through leadership and mentoring others was an important concept for participants. There was a great sense of pride and self-worth in the role as RNFA as well as great intrinsic value in being part of the surgical team. Participants expressed a strong sense of professionalism within nursing. There is no literature on the satisfaction of the RNFA; however, there is research that identified a strong and significant correlation between professional image and job satisfaction (Kagan, Biran, Telem, Steinovitz, Alboer, Ovadia & Melnikov, 2015).

Theme Four: Engagement in an On-Going Learning Process

Participants felt the deep desire to become an RNFA. As one participant described "I just can't imagine doing anything else." Many participants had aspirations towards career advancement and furthering their knowledge and skills to become RNFAs. However, varying comfort levels working in the RNFA role were described, and many participants relied upon past experiences to acclimate to the new role. Familiarity with the operating room itself and knowing the surgeons were helpful to new RNFAs. Previous experiences of the circulator and scrub role helped newly qualified RNFAs to transition to the role of RNFAs in surgery. Several participants questioned their ability to proficiently work within the role as RNFA, yet the overall decision and investment in becoming an RNFA was seen as rewarding and beneficial. Education was viewed as an important aspect of becoming an RNFA as well as personal maturation in the role. Networking, learning from others, and attending conferences are imperative to the development of the RNFA role. Networking and working collaboratively with others in the health care field enable the RNFA to mature within the role.

There is no research regarding the importance of workplace engagement of RNFAs. However, there is research on new nursing graduates' job satisfaction and their engagement in the workplace. Increased access to work structures such as resources and support enabled nurses to accomplish their tasks in meaningful ways. There was a strong relationship between empowerment and job satisfaction of the new nursing graduates (Stam, Laschinger, Regan, & Wong, 2015). Engagement was linked to interpersonal relationships and turnover. Employee turnover was consistently predicted by the level of nursing engagement (Collini, Gyidroz, & Perez, 2015).

A strong affiliation of Meleis' (2010) theory of transition and Benner's (1984) Stages of Clinical Competence corresponds with the themes identified in this study. The theory of transition as described by Afaf Meleis (2010) served as the theoretical guide for this qualitative phenomenological research study. The essential properties of awareness, engagement, change and differences, time span, critical points and events were identified within the findings. RNFAs are involved with the process of transition through engagement and awareness that occurs through education and clinical training. Use of role models, active participation, preparation and information seeking in order to obtain requirements for the certificate are affiliated with Meleis' theory. RNFAs assumed the role of student with great passion while obtaining their RNFA credential. They actively took part in the educational and clinical components of the academic requirements, assuming the role of patient advocate and surgical assistants. There was engagement in the quest to seek new knowledge throughout the process of becoming RNFAs. Findings are consistent with Meleis' (2010) theory of transition. Changes occur in the transition of student RNFAs to the hospital operating room setting. Learning the elements of the role and building necessary skill sets are reflective of engagement, change and differences and time span. Maturing in the RNFA role requires awareness that a change is occurring and critical points and events are evident in the sense of stabilization of skills, new routines, growth, and maturation in the new role of RNFA. In addition to the relationship of Meleis' (2010) theory of transition to the study findings, there is also a connection with Benner's (1984) Stages of Clinical Competence.

Benner's (1984) Stages of Clinical Competence discussed the process of acquiring and developing the skills necessary to move through the five levels of proficiency. These competencies were noted when the participants discussed the challenges and struggles in meeting RNFA requirements. The time-consuming process and rigorous work were identified during the

transition from novice through completion of the academic and clinical requirements. The on-going and evolving maturation process of RNFAs is affiliated with Benner's (1984) Stages of Clinical Competence. The level of competence will evolve through the stages of competence as RNFAs continue to learn and acquire new skills.

Limitations of the Study

There were limitations identified with this study. The first limitation was the majority (80%) of the sample were female. There was the possibility that perceptions of lived experiences of RNFAs may be different between genders. Another limitation was the diversity of RNFA programs represented by participants. The sample consisted of RNFAs who completed program requirements from four different RNFA programs within the United States. Although the sample consisted of participants from across the nation, only four of the 15 nationwide programs were represented. AORN RNFA database was used to recruit potential study participants; however, this limits access to those with computer accessibility and membership with AORN.

Implications for Nursing Practice

The RNFA is a vital and beneficial member of the surgical team and provides a cost-effective measure to health care (Kunic & Jackson, 2013; Kurkowski, 1999). The findings of the lived experience of newly qualified RNFAs functioning in the active role of surgical assistants in the hospital operating room setting have implications for nursing practice and education. Some implications have strong relevance in the area of nursing practice.

There are a number of implications for nursing practice in terms of OR nursing positions, experiences and exposure to RNFAs. First, administrators in nursing could make valuable surgical experiences available to student RNFAs who need them. Similarly, chief nursing officers, directors, and operating room managers could help newly qualified RNFAs transition to

the RNFA role once they have completed the program of education. The health care administrators may also advocate for the role of RNFAs to legislative authorities. Nursing professionals and legislators could support and advocate for the marketing ability of RNFAs both on a local and national level. Additionally, increased use and reimbursement of RNFAs could be better promoted by nursing practice through advocating for the full use of RNFAs in surgical settings. Use of RNFAs in surgery promotes continuity of care for surgical patients in the changing climate of today's efforts at health care reform (Kurkowski, 1999). RNFAs are professionals with skills and expertise who hold great responsibility during surgical procedures. In the operating room, RNFAs assume the role of surgical assistant to the surgeon with required tasks like tissue manipulation, retraction and suturing of human anatomy. Nursing professionals should collaborate and join efforts with other health care professionals. Nursing professionals are identified as those in practice and in educational settings. Legislators are also identified as potential collaborators for increased support and promotion of RNFA utilization.

The preparation phase towards becoming an RNFA is vital for the learner. The clinical component and amount of preparation in skills lab were noted as imperative to the RNFA's ability to work confidently within the role. This added time for support and guidance may serve to benefit and support RNFAs following course completion. Support programs to assist newly qualified RNFAs' transitions following course completion is an important implication for nursing practice. Support from health care professionals during this phase is also an important component to transition experiences of RNFAs. Although there is no literature on the effects of positive transitions of RNFAs, there is research findings that have indicated that a positive transition from nursing student to the role of professional nurse can be correlated with motivation to perform well, increased job satisfaction, and higher retention rates (Almada et al., 2004;

Blanzola et al., 2004; Casey et al., 2004; Cleary & Happell, 2005; O'Malley Floyd et al., 2005). This research suggests that improving the transition experience of RNFAs could increase retention and job satisfaction of RNFAs. It is important that health care professionals in both practice and educational settings collaborate and work together to share information regarding RNFA transition.

Implication for Nursing Education

There are a number of implications for nursing education to promote RNFAs. Academic facilities and educators have the opportunity to promote the academic success of students. The National League for Nursing (NLN) and The Joint Commission believe it is important to facilitate and inspire a seamless academic progression for nursing students and nurses in order to produce a well-educated and diverse nursing workforce to advance the nation's health (National League for Nursing, 2017). The same focus can be applied to the RNFA academic progression (Kunic & Jackson, 2013).

Several measures can be taken to enhance the academic progression of RNFAs. For example, undergraduate curricula should consider operating room observations within the curriculum. Students interested in the operating room should be provided guidance in seeking out learning opportunities and working with nursing mentors in the operating room. In addition, academic settings should provide information about the RNFA to nursing students in pre-licensure programs. Nurses entering the profession should receive full descriptions of all potential advanced positions available. Undergraduate nursing students with OR clinical experience will have exposure to RNFAs which may generate interest in becoming operating room nurses and RNFAs.

Academic facilities and employers may have the opportunity to assist RNFAs during transition to their new role by investigating and enhancing the level of support provided to student RNFAs. Academic facilities could assist in the development of transition interventions such as residency programs or the modification of programs that will enhance the transition process for RNFAs. Transition interventions are methods implemented to assist RNFA transition to practice as an RNFA. A residency program with continued support and guidance could aid new RNFAs. Additional support with technical skills such as simulation labs or cohorts to discuss ongoing struggles or barriers could be arranged through education and hospital settings. Researchers revealed that there is a need for transition programs in order to promote work environments that support new nurses and that these programs ultimately resulted in increased job satisfaction and retention rates (Missen et al., 2014). Similar research should be conducted to investigate job satisfaction and retention rates of RNFAs. While research on transition programs for RNFA roles does not exist, the benefit of transition programs may be applied to the RNFA population to investigate job satisfaction and retention rates. Providing support and modification of academic curriculum may require more exposure in the simulation lab to assist in psychomotor skills such as handling specialty instruments and skin closure technique. Modifying programs may mean employers taking a more active role in promoting adaptation of the new role in the surgical environment.

To enhance both nursing programs and hospital settings, nursing professionals and education communities must communicate to ensure information sharing takes place. The collaboration of shared information must take place among education professionals working within RNFA programs and administrators in the hospital setting. The nursing profession and those who educate RNFAs should collaborate regarding issues and improvement measures that

could benefit RNFAs in both areas. When measures have been identified in either nursing practice or in the education setting that need to be changed, communication should take place. Clinical educators employed by the health care agencies could help facilitate the RNFAs' transition. Communication between clinical educators and academic educators should take place to assist in the didactic and clinical preparation of RNFAs. Frequent collaboration between clinical educators and academic educators may help to enhance the quality of the program experiences. Education facilities and the health care facilities, working together, could promote the utilization of RNFAs in surgery. Academic settings and hospital facilities should join forces in the promotion of RNFA practice. Finally, both nursing administration and clinical nurse educators must work collaboratively to implement support programs, such as residency programs, that are focused on supporting the newly qualified RNFA throughout the educational process and following course completion. Making necessary changes to education and implementing transition programs for RNFAs may increase retention, decrease turnover rate, increase job satisfaction, and support utilization of RNFAs.

Recommendations for Future Research

Qualitative research findings are not generalizable; however, the findings from this research study may serve as the catalyst for future studies as they relate to RNFAs in the hospital setting. Given the importance of the RNFA role, further research is needed to explore and investigate current ideas and practices. Current academic curriculum and clinical internships should be investigated. Future research could focus on the benefits of RNFAs as mentors during clinical internships. Surgical patients' perspectives of RNFA presence during the phases of surgery could be investigated. Future research topics related to this research study would include faculty and employer perceptions of preparedness of RNFA students. It would be helpful to

identify the types of communication and networking that help facilitate the transition of RNFAs to their new roles. Research could be focused on professional organizations' influence on RNFA transition to the new role and leadership within the profession. Further research is needed to determine job satisfaction, retention rate, and factors influencing retention of RNFAs. The transition of newly qualified RNFAs to this specific role can be influenced by many things. Another focus for future research is in the area of mentor programs for RNFAs.

Conclusions

The primary purpose of this qualitative phenomenological study was to explore the lived experience of newly qualified RNFAs functioning in the active role of surgical assistants in the hospital operating room setting. It investigated the transitional processes associated with moving from the completion of RNFA training to the role of RNFA in the operating room setting based upon the descriptions provided by participants in this study. The identified difficulties RNFAs encountered as well as the positive experiences that were beneficial to the transition were shared. Participant RNFAs felt there was a varying degree of support and that the program requirements entailed a great deal of effort to complete. Overall, the process was positive and viewed as a worthwhile and beneficial experience. RNFAs expressed a sense of pride in their new achievement and described a significant amount of engagement in promoting the role and its value to the health care network. Despite the varying degrees of support and efforts required to complete requirements, participants were overwhelmingly positive that they endured the strenuous demands to become RNFAs in the operating room setting.

Chapter Summary

This chapter presented a discussion of the findings while also relating findings to the relevant literature. The personal challenge to obtain requirements for the RNFA certificate,

health care providers' attitudes and actions towards RNFAs, satisfaction in the new role of RNFA and engagement in an on-going learning process were further described. The affiliation and potential relevance to Afaf Meleis' theory of transition and Patricia Benner's theory of competency were described in the study findings. Implications for nursing practice and education along with limitations of the research study were presented. Recommendations for future research were discussed.

The data provided knowledge that is useful for the preparation and integration of newly qualified RNFAs that transitioned to the new role of RNFAs in hospital operating room. There are opportunities to enhance the transition of RNFAs; however, more information is needed related to benefits of similar programs for RNFAs. The recommended research would advance the practice of nursing and provide transition programs for RNFAs. Understanding the process of RNFA integration and transition has provided valuable information about the barriers and struggles these professionals face when transitioning to the hospital operating room setting. Future findings related to the utilization of RNFAs and integration may increase retention rates and job satisfaction of RNFAs. Identifying and raising the levels of awareness of RNFAs' needs will aid in successful preparation, transition, and utilization of RNFAs in hospital operating room settings.

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Appendices

Appendix A

Table 1

Perioperative Behaviors of the RNFA

Preoperative Behaviors of the RNFA RNFA behaviors in the perioperative area include, but not limited to the following:
Preoperative patient management in collaboration with other health care providers such as: • Performing focused preoperative nursing assessments and • Communicating and collaborating with other health care providers regarding the patient plan of care
Intraoperative Behaviors of the RNFA RNFA behaviors in the intraoperative area include, but not limited to the following:
Intraoperative performance of surgical first assistants techniques as in: • Using instruments and medical devices, • Providing surgical site exposure • Handling and/or cutting tissue • Providing hemostasis, and • Suturing and wound management
Postoperative Behaviors of the RNFA RNFA behaviors in the postoperative area include, but not limited to the following:
Postoperative patient management in collaboration with other health care providers in the immediate postoperative period and beyond, such as: • Participating in postoperative rounds and • Assisting with patient discharge planning and identifying appropriate community resources as needed

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Appendix B

Table 2

Responsibilities of the RNFA

Responsibilities of the RNFA Include but are not limited to:	
Preoperatively	Preoperative patient management in collaboration with other health care providers such as: • Performing focused preoperative nursing assessments and • Communicating and collaborating with other health care providers regarding the patient plan of care
Intraoperatively	Intraoperative performance of surgical first assistants techniques as in: • Using instruments and medical devices, • Providing surgical site exposure • Handling and/or cutting tissue • Providing hemostasis, and • Suturing • Aseptic technique • Scrubbing, gowning and gloving • Safe patient positioning • Use of positioning devices • Patient skin preparation • Surgical draping of patient • Safe usage of electrocautery, laser and other devices • Proper and safe usage of drains and implantable devices • Safe and proper administration of medications • Safe handling of specimens • Appropriate sterilization and disinfection • Maintaining a sterile environment
Postoperatively	Postoperative patient management in collaboration with other health care providers in the immediate postoperative period and beyond, such as: • Participating in postoperative rounds and • Assisting with patient discharge planning and identifying appropriate community resources as needed

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Appendix C

Table 3
RNFA Education

AORN Standards for RN First Assistant Education Programs
Standard I Requirements for RNFA education programs shall include the following:
Program shall: A. Be at a minimum equivalent to six (6) semester credit hours of formal, post-basic RN education; B. Award college credits and degrees or certificates of RNFA status upon satisfactory completion of all requirements; C. Be associated with schools of nursing at universities or colleges that are accredited for higher education by an accrediting agency that is nationally recognized by the Secretary of the US Department of Education. The schools of nursing shall be approved by a state licensing jurisdiction for nursing programs at the university, college, or community college level or by another agency that is nationally recognized by the Secretary of the US Department of Education as a specialized accrediting agency for nursing programs. D. Recognize the "AORN position statement on RN first assistants" E. Address all of the content in the *Core Curriculum for the RN First Assistant"*
Standard II Admission requirements for RNFA education Programs shall include the following:
A. General admission requirements as determined by each educational institution. B. Proof of licensure to practice as an RN in the state in which the clinical internship will be undertaken C. Verification of certification as one of the following: 1. CNOR or CNOR eligible. If the student is not certified at time of admission, certification must be submitted before program completion. 2. Board Certified or board eligible as an advanced practice registered nurse (APRN). APRNs without experience in intraoperative patient care must undergo an assessment regarding clinical skills and knowledge. Assessment should be completed by the program instructor or perioperative educator at the facility where the clinical experience will be completed. Assessment should include aseptic technique, scrubbing, gowning, gloving, creating and maintaining a sterile field, and positioning the patient. If it is determined that skills or knowledge are deficient, faculty members in the educational institution shall develop a plan to remediate identified deficiencies.

D. Cardiopulmonary resuscitation (CPR) or basic cardiac life support certification (BCLS) is required; advanced cardiac life support (ACLS) is preferred.
E. Letters of recommendation attesting to the years of experience as an RN and knowledge, judgment, and skills specific to surgical patient care.

Standard III
The program shall include a didactic component

A. Course content shall emphasize the expanded functions unique to the RNFA during operative and other invasive procedures, including, but not limited to,
   1. Preoperative patient management in collaboration with other health care providers, such as
      -performing focused preoperative nursing assessment and
      -communicating and collaborating with other health care providers regarding the patient's plan of care;
   2. Intraoperative performance of surgical first-assisting techniques such as
      -using instruments and medical devices,
      -providing surgical site exposure,
      -handling and/or cutting tissue,
      -providing hemostasis, and
      -suturing; and
   3. Postoperative patient management in collaboration with other health care providers in the immediate postoperative period and beyond, such as,
      -participating in postoperative rounds, and
      -assisting with discharge planning and identifying appropriate community resources as needed.
B. The APRN who does not have sufficient perioperative experience shall have remediation in basic concepts of perioperative skills and knowledge including surgical conscience, instrument and equipment use and safety, general concepts of anesthesia, use of perioperative medications, and competencies described in Standard IIC.
C. The course didactic portion shall be a minimum equivalent to three (3) semester credit hours of study, including assignments, classroom instruction and practicums.
D. A multidisciplinary faculty shall include a minimum of
   1. A perioperative nurse with a graduate degree in nursing;
   2. An RNFA or, preferably, a certified registered nurse first assistant (CRNFA ®); and
   3. A board-certified surgeon.
E. Instructional methodologies shall include, but not be limited to, lecture, interactive discussion, independent study, instructional media, demonstration/return demonstration, and laboratory practicums.
F. Evaluation methodologies shall include, but not be limited to, written examinations, laboratory practicums, and independent critical thinking assignments.
G. Instructional resources shall include
   1. The *Core Curriculum for the RN First Assistant* and
   2. Texts or other instructional media that include anatomy and physiology, operative and

other invasive procedures, and preoperative and postoperative patient assessment and management.

Standard IV
Successful completion of all requirements of the didactic component shall be required for matriculation into the clinical component.

Standard V
The program shall include a clinical component

A. Course content shall emphasize the expanded functions unique to the RNFA intern during operative and other invasive procedures, including but not limited to,
   1. Preoperative patient management in collaboration with other health care providers, such as
      -performing focused preoperative nursing assessments,
      -communicating and collaborating with other health care providers regarding the patient plan of care;
   2. Validated documentation of the intraoperative surgical first-assisting clinical experience, including, but not limited to,
      -using instruments and medical devices,
      -providing surgical site exposure,
      -handling and/or cutting tissue,
      -providing hemostasis, and
      -suturing and wound management
   3. Postoperative patient management in collaboration with other health care providers in the immediate postoperative period and beyond, such as
      -participating in postoperative rounds and
      -assisting with discharge planning and identifying appropriate community resources as needed.

B. The clinical course shall be a minimum equivalent to three (3) semester hours and shall include, but not limited to,
   - A minimum of 120 hours of intraoperative first assisting hours

C. A clinical on-site preceptors shall include
   1. A board-certified surgeon in the RNFA intern's primary area of practice,
   2. An RNFA/CRNFA mentor if available and /or desired by the student.

D. Instructional methodologies shall include, but not be limited to, physician-supervised clinical activities, assigned independent learning activities, a self-evaluative learning diary, a clinical case study project, and a surgical intervention participation log.

E. Evaluation methodologies shall include, but not be limited to, completion of assigned independent learning activities, a self-evaluative learning diary, a clinical case study project, preceptor evaluations, a surgical interventions participation log, and mentor evaluations when applicable. Students must satisfactorily complete all requirements. The RNFA program faculty members shall review all documentation. The surgeon preceptor shall provide a summative evaluation of achievement of competence and a

letter of recommendation based on all required learning activities, as shall the RNFA/CRNFA mentor when applicable. The faculty members shall be responsible for the final determination of successful course completion.

F. Instructional resources shall include
   1. *Core Curriculum of the RNFA First Assistant*
   2. Texts or other instructional media, and
   3. Consultation and collaboration with other health care providers.

AORN. (2014). *AORN Standards for RN First Assistant Education Programs.* Retrieved November 17, 2015 from http://www.aorn.org/Clinical_Practice/RNFA_Resources/First_Assisting_(RNFA).aspx

Appendix D

Table 4

AORN RNFA Position Statement

AORN Position Statement on RN First Assistants
POSITION STATEMENT This AORN position statement delineates the definition, scope of practice, and educational requirements for the perioperative registered nurse (RN) who practices as a registered nurse first assistant (RNFA). The qualifications to be met and components of the clinical privileging process are also described. Definition of RN First Assistant The RNFA is a perioperative registered nurse who: • works in collaboration with the surgeon and other health care team members to achieve optimal patient outcomes; • has acquired the necessary knowledge, judgment, and skills specific to the expanded role of RNFA clinical practice; • intraoperatively practices at the direction of the surgeon; and • does not concurrently function as a scrub person. SCOPE OF PRACTICE Perioperative nursing is a specialized area of practice. Registered nurses practicing as first assistants in surgery are functioning in an expanded perioperative nursing role. First assisting behaviors are further refinements of perioperative nursing practice and are executed within the context of the nursing process. These behaviors include certain delegated medical functions that can be assumed by the RN who is qualified to practice as an RNFA. Registered nurse first assistant behaviors may vary depending on patient populations, practice environments, service provided, accessibility of human and fiscal resources, institutional policy, and state nursing regulations. Registered nurse first assistant behaviors in the perioperative arena include, but are not limited to: • preoperative patient management in collaboration with other health care providers, such as: o performing focused preoperative nursing assessments and o communicating and collaborating with other health care providers regarding the patient plan of care; and • intraoperative performance of surgical first assistant techniques such as: o using instruments and medical devices, o providing surgical site exposure,

  - handling and/or cutting tissue,
  - providing hemostasis,
  - suturing, and
  - wound management; and
- postoperative patient management in collaboration with other health care providers in the immediate postoperative period and beyond, such as:
  - participating in postoperative rounds and
  - assisting with patient discharge planning and identifying appropriate community resources as needed.

Preparation of the RNFA

The complexity of knowledge and skill required to effectively care for recipients of perioperative nursing services necessitates nurses to be specialized and to continue their education beyond generic nursing programs.

Effective January 1, 2020 the education level for entry into an RNFA program and, subsequently, RNFA practice will be the baccalaureate degree. AORN recommends that RNs who were practicing as RNFAs prior to January 1, 2020 and do not have a baccalaureate degree be permitted to continue to practice as RNFAs.

Perioperative nurses who wish to practice as RNFAs should develop a set of cognitive, psychomotor, and affective behaviors that demonstrate accountability and responsibility for identifying and meeting the needs of their perioperative patients. This set of behaviors:

- begins with and builds on the education program leading to licensure as an RN, which teaches basic knowledge, skills, and attitudes essential to the practice of perioperative nursing;
- includes diversified clinical experience in perioperative nursing; and
- includes achievement of certification in perioperative nursing (CNOR).

Further preparation to assume the role of RNFA is then attained by completion of an RNFA program that:

- is equivalent to six (6) semester credit hours of formal, post-basic nursing study;
- meets the "AORN standards for RN first assistant education programs"1; and
- requires a baccalaureate degree for entry into the program after January 1, 2020.

Qualifications for RNFA Practice

The minimum qualifications to practice as an RNFA include:

- certification in perioperative nursing (CNOR);
- successful completion of an RNFA program that meets the "AORN standards for RN first assistant education programs";
- compliance with all statutes, regulations, and institutional policies relevant to RNFAs; and
- a baccalaureate degree, with the exception that the RNFA practicing prior to January 1, 2020, may continue to practice at his or her existing level of education.

Continued Competency

The RNFA:

- demonstrates behaviors that progress on a continuum from basic competency to excellence,
- maintains CNOR status, and
- is encouraged to achieve and maintain CRNFA certification when educational and experiential requirements have been met.

Clinical Privileging for the RNFA

The facility(ies) in which the individual practices should establish a process to grant clinical privileges to the RNFA. This process should include mechanisms for:

- verifying individual RNFA qualifications with the primary source,
- evaluating current and continued competency in the RNFA role,
- assessing compliance with relevant institutional and departmental policies,
- defining lines of accountability,
- incorporating peer and/or faculty review,
- validating continuing education relevant to RNFA practice, and
- verifying physical ability to perform the role.

RATIONALE

Historically, perioperative nursing practice has included the role of the registered professional nurse as an assistant during surgery. As early as 1977, documents issued by the American College of Surgeons supported the appropriateness of qualified RNs to first assist. The American College of Surgeons continues to support the role as evidenced in a study on assistants at surgery in 2011. AORN officially recognized this role as a component of perioperative nursing in 1983 and adopted the first "Official statement on RN first assistants (RNFA)" in 1984. All state boards of nursing recognize the role of the RNFA as being within the scope of nursing practice.

The decision by an RN to practice as a first assistant is to be made voluntarily and deliberately with an understanding of the professional accountability that the role entails.

AORN. (2013). *AORN Position Statement on RN First Assistants.* Retrieved November 17, 2013 from http://www.aorn.org/Clinical_Practice/RNFA_Resources/First_Assisting_(RNFA).aspx

Appendix E

AORN Professional Association Participant Request Letter

Name
Address
City, State, Zip Code

Dear Sir/Madam,

I am a PhD candidate at Villanova University currently working on a qualitative research study to complete my dissertation. My dissertation study is titled: *The Lived Experience of Newly Qualified Registered Nurse First Assistants (RNFAs) Who Have Transitioned to the Hospital Operating Room Surgical Setting: A Phenomenological Perspective.* This study aims to investigate the experiences of newly qualified RNFAs who have recently transitioned to the operating room setting within 24 months of academic and clinical completion and have not obtained certification.

With your permission, I would like to recruit interested participants who have completed the RNFA program from an accredited RNFA training program that are members of AORN. The research study will include an interview about their transition experiences from the academic setting to the operating room setting in the role of RNFA and completion of a demographic form. The interviews will take place on a one-to-one researcher/participant basis either in person or by online technology such as Skype. Could you provide me with a list of AORN members that are members of the RNFA Assembly who have completed your program within the past 24 months? Please also include with the list the names, phone numbers, addresses, and emails so I may contact potential participants? The interviews will take place in a quiet and comfortable location determined by both the researcher and participant. If the participant wishes to use online technology such as Skype for the interview, this will be granted. If the interview is by online Skype program, the informed consent and demographic form will be returned prior to scheduled interview.

In addition to completing my dissertation through the study for doctoral study requirements, I intend to disseminate the findings to the nursing profession through presentations, and future studies. The experiences of newly qualified RNFAs who have transitioned to the hospital operating room surgical setting will assist in facilitating role transition and implications for education.

Thank you very much for your consideration in allowing me to recruit AORN members listed in the RNFA Assembly in order to contribute to research needed to better understand the experience of newly qualified RNFAs who have transitioned to the operating room setting.

Please feel free to contact me with any questions regarding the study.

Regards,

Villanova University College of Nursing-Doctoral Student

Appendix F
Participant Request Letter

Email and Postal Mail

Dear Sir/Madam,

I am a PhD candidate and Villanova University doctoral student currently working on a qualitative research study to complete dissertation requirements. My study is titled: *The Lived Experience of Newly Qualified Registered Nurse First Assistants (RNFAs) Who Have Transitioned to the Hospital Operating Room Surgical Setting: A Phenomenological Perspective.*

The purpose of this study is to gain an understanding of the experiences of a newly qualified RNFA who has completed the academic and clinical requirements and the transition to the operating room setting in the role of RNFA. The experiences of newly qualified RNFAs who have transitioned to the hospital operating room surgical setting will assist in facilitating role transition and implications for education.

This study is a phenomenological qualitative study using one-on-one interviews. The interview should last approximately 45 minutes and include completion of a demographic form. The interview will take place in-person in a quiet location determined both by the researcher and participant. If the participant is located a great distance from the researcher, the interview can take place by the online Skype program. If the interview is by online Skype program, the informed consent and demographic form will be returned prior to scheduled interview. The interview will be audio taped. The information will be kept secure and coded for privacy. The researcher will be available via email or telephone should there be questions, concerns, or the need for additional information prior to and following the interview. In addition to the interview, there will be a short demographic form to complete. All information will be kept private and secure. After validation of the data, you will be mailed a $20 VISA card as a token of my appreciation. Please provide your mailing address with the informed consent.

Thank you for your consideration!

Regards,

Villanova University Doctoral Student

Appendix G

Informed Consent

Informed Consent: The Lived Experience of Newly Qualified Registered Nurse First Assistants (RNFAs) Who Have Transitioned to the Hospital Operating Room Surgical Setting: A Phenomenological Perspective.
Researcher Name: SUSAN LYNCH

This is a research study concerned with learning about the transition experiences of newly qualified RNFAs who have transitioned to the hospital operating room surgical setting. The interview will last approximately 45 minutes. This time estimate may vary for some participants. You will complete a demographic form prior to the one-to-one interview. The interviews will be audio taped.

The risks to you in this study are, at most, minimal, and do not differ in any way from those you might experience in everyday life. There will be no direct cost to any of the participants for their participation in the study other than their time. Your participation will help to further our knowledge of the transition from the newly qualified RNFA to the hospital operating room surgical setting.

Your participation in this study is completely voluntary. You will have the right to have any questions answered prior to, during, and after the interview. You will be given a $20 VISA card after data validation is returned. You may refuse to participate at any time during the study without any consequences. However, you will only receive the $20 VISA card if you complete the demographic form, interview and validate the data.

All data collected in this study will be kept entirely confidential. Your name will never be publicly associated with this study and your participation is kept confidential. Personal demographic information is non-identifying. Direct quotations of participants may be used but not identified. Data obtained during this study may be used for further research. All information will be kept in a secured, encrypted file on the researcher's computer with only coded alphanumeric identification used for participants.

If you have any questions concerning your participation in this project or your rights as a research participant, you should contact Susan Lynch

If you agree to participate in this study, please sign below. Please also provide the address to which you would like the VISA card mailed upon final validation of data.

Name (print)_____ Signature_____

Date_____Address_____

Appendix H

Demographic Data Form

Please mark an X next to the appropriate response or fill in the appropriate information. If you choose to write in an answer that is not provided, please do so on the line following the option "Other."

1. Gender: Male_____ Female_____
2. Age in Years:_____
3. Race: Caucasian_____ African American_____ Hispanic/Latino_____ Other_____
4. Marital Status: Single_____ Married _____ Divorced_____ Widowed_____

   In a Committed Relationship_____
5. Highest Level of Nursing Education:
   a. Diploma_____
   b. AD_____
   c. BSN_____
   d. MSN_____
   e. DNP_____
   f. DNS_____
   g. EdD_____
   h. PhD_____
   i. Other_____
6. What academic facility did you complete the RNFA program?:_____
7. Number of Years as RN:_____
8. Number of Years Operating Room Experience:_____
9. Number of Formal Preceptors in Clinical Internship: _____

10. Primary Specialty in which you received training:

    General _____ Orthopedic_____

    Plastics_____ Gynecology_____ Urology_____ Neurology_____

    Ophthalmology_____ Bariatrics_____ Other_____

11. Which surgical specialties did you gain experience in during your clinical rotation?:

    (check all specialties that you experienced during your clinical rotation)

    General _____ Orthopedic_____ Plastics_____ Gynecology_____

    Urology_____ Neurology_____ Ophthalmology _____ Bariatrics_____

    Other_____

12. After course completion, did you have a surgery specialty interest?:

    Yes_____ No_____

    If yes, what surgery specialty did you prefer?:_____

13. What specialty (if any) are you currently working in?:

    (if more than one, check all that apply)

    General _____ Orthopedic_____ Plastics_____ Gynecology_____

    Urology_____ Neurology_____ Ophthalmology _____ Bariatrics_____

    Other_____

14. Were you mentored in the role of RNFA when you began working?:

    Yes_____ No_____

    If yes, how long were you mentored?:_____

15. What type of setting do you work in?

    Hospital_____ Ambulatory Surgery Center_____

    Other_____

Appendix I

Interview Questions

1. What was the experience like for you to become an RNFA?
2. What does being an RNFA mean to you?
3. As you reflect on your formal education, what were the useful educational experiences?
4. As you reflect on your clinical training, what were the useful clinical experiences?
5. How prepared to practice did you feel after completing the RNFA program?
6. Describe the positive aspects of your RNFA learning experience.
7. Describe any negative aspects of your RNFA learning experience.
8. Describe any issues, concerns, or problems you may have encountered during your educational experiences.
9. Describe any issues, concerns, or problems you may have encountered during your clinical experiences.
10. Describe positive aspects of your transition to the hospital operating room.
11. Describe any issues, concerns, or problems you may have encountered during the time of your transition to the role of RNFA.
12. Is there anything else that you would like to tell me about your experience?

Additional Probe Questions:

1. Can you say more about that?
2. What do you mean by _____?
3. Can you tell me more about what that means to you?
4. Can you describe that for me?

Appendix J

Themes and Subthemes

Theme One: Personal challenge to obtain requirements for the certificate

Subthemes:
Needed to be self-directed in seeking out learning experiences
Struggle to obtain required clinical hours
Time-consuming process
Involved rigorous and extensive work

Theme Two: Health care providers' attitudes and actions towards RNFAs

Subthemes:
Process of integration and acceptance by the patient care team
Encounters with colleagues while learning the RNFA role

Theme Three: Satisfaction from the new role of RNFA

Subthemes:
RNFAs make a difference in patient care
RNFAs have the ability to advocate for the patient and the patient care team
Transformation into a leadership role

Theme Four: Engagement in an on-going learning process

Subthemes:
Handling personal fears and developing a level of professional well-being
Learning the elements of the role
Building the necessary skill set
Maturing in the RNFA role