

THE IMPACT OF STRUCTURED ORIENTATION ON ROLE TRANSITION AND
TURNOVER INTENTIONS OF ADVANCED PRACTICE REGISTERED NURSES

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THE IMPACT OF STRUCTURED ORIENTATION ON ROLE TRANSITION AND
TURNOVER INTENTIONS OF ADVANCED PRACTICE REGISTERED NURSES
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by

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ABSTRACT

Background: The first year of transitioning from being an expert nurse to embracing the role as an Advanced Practice Registered Nurse (APRN) is challenging. The literature identifies a gap in APRNs transition to practice support in the new role. The impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses in their first APRN position is warranted and have not been addressed.

Purpose of the Study: The purpose of this nonexperimental, correlational study was to investigate the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses in the United States in their first APRN position.

Theoretical Framework: Meleis' Transitions Theory guided the study.

Methods: A quantitative, nonexperimental, cross-sectional, correlational research design was utilized to test the relationships among the major study variables. The subjects completed three surveys: a demographic questionnaire, the Nurse Practitioner Role Transition Scale (NPRTS), and the Transition Turnover Scale (TIS-6). Independent *t*-tests, Pearson's Product-Moment Correlation, and a simple linear regression tested the variables in the study.

Results: A two sample independent *t*-tests results supported that APRNs who received structured orientation would score higher on the NPRTS ($t(138) = 3.017, p = .0015, ES = .57$), and score lower on the TIS-6 ($t(138) = -2.231, p = .0145, ES = -.42$). Pearson Product-Moment correlation revealed a statistically significant negative relationship between the responses of the NPRTS and the TIS-6 ($r = -.51, p < .001$). A

single linear regression model was significant ($F(1, 138) = 49.039, p < .001$) and the percentage of variation in TIS-6 scores that could be determined by the NPRTS total scores was 26% ($r^2 = .26$).

Conclusions: The findings reinforced that structured orientation influenced role transition and turnover intentions. The progression and implementation of structured orientation for new APRNs remain stagnant. To date, only one-third of new APRNs have received structured orientation across the United States. By creating stronger support for new Advanced Practice Registered Nurses (APRNs) in their transition, APRNs can be a solution to the projected healthcare provider shortages and serve vulnerable populations.

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DEDICATION

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study will transform transition to practice programs for all APRNs across the United States.

TABLE OF CONTENTS

TITLE PAGE	i
SIGNATURE PAGE	ii
COPYRIGHT PAGE	iii
ABSTRACT.....	iv
ACKNOWLEDGMENTS	vi
DEDICATION.....	viii
TABLE OF CONTENTS.....	x
LIST OF TABLES.....	xv
LIST OF FIGURES	xvi
CHAPTER ONE: PROBLEM AND DOMAIN OF INQUIRY	1
Background of the Study	2
Significance of Structured Orientation	3
Role Transition as an Advanced Practice Registered Nurse.....	5
Factors Influencing Turnover Intentions of Advanced Practice Registered Nurses...	9
Problem Statement	11
Purpose of the Study	12
Definitions of Key Terms Theoretical and Operational	12
Structured Orientation.....	12
Role Transition.....	13
Turnover Intentions.....	14
Research Questions and Hypotheses	14
Philosophical Underpinnings of the Paradigm	16
Positivism.....	16
Scientific Assumptions	18
Quantitative Research.....	20
Theoretical Framework.....	23
Meleis' Transitions Theory.....	23
Nature of Transitions, Types, Patterns, and Properties.....	26

Transition Conditions, Facilitators, and Inhibitors	28
Patterns of Response	29
Relationship of Meleis' Transitions Theory to the Study	30
Assumptions.....	33
Theoretical Assumptions	33
Researcher Assumptions.....	34
Significance of the Study	35
Significance of the Study to Nursing	35
Implications for Nursing Education.....	36
Implications for Nursing Practice	37
Implications for Nursing Research	37
Implications for Health and Public Policy	38
Scope and Limitations of the Study	38
Threats to External and Internal Validity.....	39
External Validity.....	40
Internal Validity	40
Chapter Summary	41
CHAPTER TWO: REVIEW OF THE LITERATURE	42
Role Transition and Healthcare Professionals	42
Structured Orientation and Nursing.....	51
Turnover Intentions and Nursing	63
Meleis' Transitions Theory and Nursing	70
Chapter Summary	80
CHAPTER THREE: METHODS	82
Restatement of Research Questions and Hypotheses	82
Overview of the Design	83
Sample and Setting	84
Inclusion Criteria	86

Exclusion Criteria	87
Ethical Considerations	87
Access and Recruitment Procedures.....	90
Data Collection Procedures.....	91
Data Management and Storage	92
Instruments.....	93
Demographic Questionnaire	93
Nurse Practitioner Role Transition Scale.....	94
Turnover Intention Scale.....	96
Data Cleansing.....	98
Data Analysis Plan.....	98
Chapter Summary	101
CHAPTER FOUR: FINDINGS OF THE STUDY.....	102
Sample Description.....	104
Demographic Characteristics of the Sample.....	106
Exploratory Data Analysis for Measurements.....	111
Relationship Among Major Study Variables.....	112
Demographic Questionnaire	112
Nurse Practitioner Role Transition Scale (NPRTS).....	112
Turnover Intention Scale (TIS-6).....	114
Assumptions.....	116
Independence of Observations.....	116
Normality	117
Research Questions and Hypotheses Reviewed	117
Research Questions and Hypotheses Testing	118
Research Question One and Hypothesis One	118
Research Question Two and Hypothesis Two.....	119
Research Question Three and Hypothesis Three.....	120
Chapter Summary	122
CHAPTER FIVE: SUMMARY AND DISCUSSION	126

Summary of the Study	126
Summary of the Study Findings	128
Demographics and Background Characteristics	128
Relationships Among Major Study Variables	131
Research Question One, Hypothesis One	131
Research Question Two, Hypothesis Two.....	136
Research Question Three, Hypothesis Three.....	141
Relationship of Study Findings to Theoretical Framework.....	142
Significance of the Study.....	147
Significance of the Study to Nursing.....	148
Implications for Nursing Education.....	149
Implications for Nursing Practice	149
Implications for Nursing Research	150
Implications for Health and Public Policy.....	151
Strengths and Limitations of the Study.....	152
Strengths	152
Limitations	153
Recommendations for Future Study	154
Conclusions.....	154
References.....	159
APPENDIX A: BARRY UNIVERSITY INSTITUTIONAL REVIEW BOARD	
APPROVAL	172
APPENDIX B: BARRY UNIVERSITY COVER LETTER.....	
	173
APPENDIX C: BARRY UNIVERSITY ACCESS LETTERS	
	175
APPENDIX D: BARRY UNIVERSITY RESEARCH FLYER	
	180
APPENDIX E: BARRY UNIVERSITY DEMOGRAPHIC QUESTIONNAIRE.....	
	181
APPENDIX F: BARRY UNIVERSITY NURSE PRACTITIONER ROLE	
TRANSITION SCALE (NPRTS).....	189

APPENDIX G: BARRY UNIVERSITY PERMISSION TO USE NURSE PRACTITIONER ROLE TRANSITION SCALE.....	194
APPENDIX H: BARRY UNIVERSITY TURNOVER INTENTION SCALE (TIS-6) TURNOVER INTENTION SCALE (TIS-6)--SURVEYMONKEY	196 197
APPENDIX I: BARRY UNIVERSITY PERMISSION TO USE TURNOVER INTENTION SCALE (TIS-6)	199
APPENDIX J: BARRY UNIVERSITY HYPOTHESES TABLE.....	200
APPENDIX K: BARRY UNIVERSITY VITA	203

LIST OF TABLES

Table 1 <i>Demographics of the Advanced Practice Registered Nurses Sample (N=140)</i>	106
Table 2 <i>Years and Months of Employment for the Advanced Practice Registered Nurses Sample (N=140)</i>	108
Table 3 <i>Scale Reliability Coefficient (Cronbach's α) for NPRTS and Subscales and TIS-6 (N=140)</i>	116
Table 4 <i>Durbin-Watson Statistic for the Data Collected</i>	117
Table 5 <i>Advanced Practice Registered Nurses t-tests Results for Hypothesis 1 & 2</i>	120
Table 6 <i>Correlation Coefficients for the Relationship between NPRTS and TIS-6 (N = 140)</i>	121
Table 7 <i>Model for the Regression of the Relationship of NPRTS on TIS-6 (N =140)...</i>	122

LIST OF FIGURES

Figure 1 <i>Meleis et al. 's Transitions Theory (2000)</i>	31
Figure 2 <i>Conceptual Representation of the Impact of Structured Orientation on Role Transition and Job Turnover Intentions of Novice Advanced Practice Registered Nurses (Jules, 2021). Adapted from Meleis et al. 's Transitions Theory (2000).</i>	32
Figure 3 <i>Advanced Practice Registered Nurses Practice Regions Across the United States</i>	111
Figure 4 <i>Frequency of Advanced Practice Registered Nurses with Structured Orientation (Yes/No)</i>	112
Figure 5 <i>Nurse Practitioner Role Transition Scale Responses</i>	113
Figure 6 <i>Nurse Practitioner Role Transition Scale by Structured Orientation Response (Yes/No)</i>	114
Figure 7 <i>Turnover Intention Scale Responses</i>	115
Figure 8 <i>Turnover Intention Scale (TIS-6) by Structured Orientation (Yes/No)</i>	115
Figure 9 <i>Histogram of Standardized Residuals</i>	117
Figure 10 <i>Scatterplot of the Relationship Between the Predictor Variable (NPRTS) and the Criterion Variable (TIS-6)</i>	122

CHAPTER ONE

PROBLEM AND DOMAIN OF INQUIRY

Advanced Practice Registered Nurses (APRNs) play a pivotal role in today's healthcare system. The United States is projected to have a paucity of 122,000 physicians in both primary and non-primary care specialties by 2032 while the supply of physician assistants (PAs) and APRNs continues to rise (American Hospital Association, 2019; Association of American Medical Colleges, 2019). This shortage of healthcare providers will have direct impact on patient care, which gives momentum to the nursing profession and nursing leaders to support new APRNs to fill the gap of the projected healthcare provider shortages. Currently, 89.7% of APRNs are certified in an area of primary care, 69.0% of all APRNs provide primary care, and more than 28,700 new APRNs graduated in 2017-2018 (American Association of Nurse Practitioners, 2020). Advanced Practice Registered Nurses provide care in a variety of specialties and are also certified in family practice (65.4%), adult practice (12.5%), adult-gerontology primary care (7.8%), acute care (5.5%), pediatrics-primary care (3.7%), adult-gerontology acute care (3.4%), women's health (2.8%), psychiatric/mental health-family (1.8%), gerontology (1.7%), and hospice and palliative care (1.5%).

However, the first year of transition as a novice APRN is extremely challenging (Barnes, 2015a; Bush & Lowery, 2016; Flinter & Hart, 2017). The majority of APRNs struggled when leaving their expert nurse status to embrace the new role as a novice healthcare provider (Barnes, 2015a). This shift from a familiar environment to an unfamiliar one altered their ability to develop their professional identity, self-confidence, and role development (Barnes, 2015a; Meleis et al., 2000). Successful role transition for

new graduates should be prioritized in the discipline of nursing as their success in the new role would yield better patient outcomes.

The researcher conducted a correlational study to investigate the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses in their first APRN position. A study of this magnitude was justified because the availability of structured orientation for all novice APRNs was lacking in actual practice. This study revealed key factors that contributed to the well-being and success of novice APRNs in their role transition from academic settings into practice settings and mitigated job turnover intentions. It is the hope of the researcher that novice APRNs can anticipate structured orientation support during this critical period to ensure a seamless role transition and decrease job turnover intentions.

Background of the Study

Advanced Practice Registered Nurses (APRNs), previously known as Advanced Registered Nurse Practitioners (ARNPs), were renamed in 2018 by the Health Policy Committee (H.R. Rep. No. SB 1594, 2018). This bill also amended the Clinical Nurse Specialists role (CNS) and classified them as APRNs. The Nurse Practice Act defined an APRN as any person who is licensed to practice professional nursing and is certified in advanced or specialized nursing practice (Florida Nurse Practice Act, 2021). This includes Certified Registered Nurse Anesthetists, Certified Nurse Midwives, and Advanced Practice Registered Nurses. Having solely a national certification does not authorize a nurse to practice as an APRN. The nurse is also required to possess a Registered Nurse (RN) license (Nursing Licensure, 2020). Requirements for all APRNs vary by state. The practice of advanced or specialized nursing practice is characterized as

providing higher level nursing functions that the board of nursing endorses and considers to be suitable with respect to the nurses' specialized education, training, and experience (Florida Nurse Practice Act, 2021). These general tasks include:

1. Prescribe, dispense, administer, or order drugs.
2. Initiate appropriate therapies.
3. Perform additional function as determined by the board rule.
4. Order diagnostic tests and physical and occupational therapy.
5. Order any medication for administration to a patient in specified facilities (Florida Nurse Practice Act, 2021).

Advanced Practice Registered Nurses (APRNs) deliver primary, acute, and specialty health care across the life cycle by assessing, diagnosing, and treating illnesses and injuries. They also play a key role in health promotion and disease prevention. Certified Nurse Midwives render primary gynecological and reproductive health care services. Clinical Nurse Specialists diagnose, treat, and maintain ongoing management of patients; offer expertise and sustenance to nurses caring for patients, foster practice changes within the workplace and assure evidence-based care are utilized for best patient outcomes. Certified Registered Nurse Anesthetists provide anesthesia and pain management services to clients in outpatient and hospital services (American Nurses Association, 2020; Florida Nurse Practice Act, 2021).

Significance of Structured Orientation

Structured orientation is necessary for novice Advanced Practice Registered Nurses (APRNs) during their transition into practice settings (Flinter & Hart, 2017; Rugent et al., 2017). The Institute of Medicine's (2010) Future of Nursing report

emphasized that new APRNs are trained with high quality clinical and critical thinking skills to satisfy patients' needs and recommended residency programs when shifting to new clinical areas. Omidshar and Young (2001) posited the orientation period as the time when an employee starts a job until the person is part of the organization. However, while orientation focuses on attitude, training deals with the development of knowledge and skills. The authors postulated that socialization is integral in the orientation phase as it focuses on how individuals learn the beliefs, values, orientations, behaviors, and skills to carry out their new roles efficiently within an organization.

The importance of structured orientation for new APRNs had been documented in the literature. Horner (2017) asserted a mentor experience/relationship provided a sense of community for new APRNs, positively influenced job satisfaction in an encouraging environment which could reduce turnover and retain APRNs. Other authors emphasized structured transition to practice programs such as residency and/ or fellowship programs are crucial for support (Flinter & Hart, 2017; Sargent & Olmedo, 2013; Zapatka et al., 2014). Advanced Practice Registered Nurse (APRN) residents who attended a residency program described the safety net environment as aiding them in their development of "confidence, competence, and mastery in their role as primary care providers" during their first year of practice (Flinter & Hart, 2017, p. 96). In addition, a formal orientation positively influenced role transition for APRNs (Barnes, 2015a). However, structured orientation remains a disparity as it relates to ARNP role transition from the academic arena into practice settings (Fitzpatrick & Gripshover, 2016).

Kawasaki (2006) recommended the establishment of meaningful work using suitable tools to support new employees and ample dedication to orient them through

opportunities to connect with the organization in constructive environments that provide the flexibility to ask, seek information, and foster professional development. Such an environment may promote the growth and role development of novice APRNs. Moran and Nairn (2018) conducted a qualitative synthesis of literature surrounding role transition of APRN trainees. The review supported the impetus for structured orientation, appropriate mentorship, supported development of skills, clinical supervision, and an appropriate level of education as processes that could facilitate transition. In addition, this review reinforced the fact that absent, unstructured, or forced orientation, limited or inappropriate mentorship, absent or minimal skills training supervision, absent or minimal clinical supervision, and poor education quality were practices that could hinder transition. Without adequate support, novice APRNs may experience transition shock and job turnover (Fitzpatrick & Gripshover, 2016).

Role Transition as an Advanced Practice Registered Nurse

The history of Advanced Practice Registered Nurses (APRNs) transitioning from the Registered Nurse (RN) role to the APRN role underscored the daunting nature of this epoch (Brown & Olshansky, 1997). Literature that investigated the transition from the RN role to the APRN role further illuminated the current state and demands of these novice healthcare providers (Heitz et al. 2004; Kelly & Mathews, 2001; Poronsky, 2013; Roberts et al., 1997). Brown and Olshansky's (1997) longitudinal qualitative grounded theory study of 35 novice APRNs developed from *Limbo to Legitimacy* theoretical framework to characterize the different stages new APRNs go through during the first year of practice before achieving competence and confidence. The investigators identified novice APRNs as expressing feelings of anxiety, role confusion, stress, and

insecurity in the first two stages of the theoretical framework. Participants felt more comfortable in their role, experienced decreased anxiety, and increased competence, which anchored their self-confidence in the latter stages of the model. The qualitative work of Roberts et al. (1997) also reported APRN students as exhibiting complete dependence to developing independence and interdependence in the progression of their APRN clinical practicum. Kelly and Mathews (2001) conveyed family practice APRNs with emotions of distress, isolation, and a sense of disconnection.

In addition, in a descriptive, qualitative study of nine family practice APRNs, Heitz et al. (2004) examined role transition from the RN to the APRN role and delineated two phases of transition. The first phase occurred during graduate school when the APRN experienced a sense of loss and the need to relinquish the RN role. The second phase commenced after graduation and in the first position as an APRN and is marked with feelings of self-doubt, apprehension, and emotional turmoil. In effect, these classic studies supported the notion that transition was complex, multidimensional during this period of change and was a time for redefining one-self (Chick & Meleis, 1986; Meleis et al., 2000; Meleis, 2010). The studies also implied that transition is a multiphase and multistage process that can occur at any time in one's life, environment, health, or relationships and could be significant when embarking on a new role as in the case of novice APRNs (Chick & Meleis, 1986; Poronsky, 2013).

Barnes (2015b), in her concept analysis, defined APRN role transition as:

A process consisting of multiple mixed emotions that occurs over time and is a period of great personal development and learning as the APRN takes on new autonomy and responsibility for patients. This process occurs as the new APRN

moves out of the RN role and absorbs the APRN role, and is affected by personal and environmental antecedents, which can lead to a successful or unsuccessful role transition. (p. 142)

In the role, the new APRN must understand and assume the shift from provider of care to prescriber of care while maneuvering the two identities and associated mixed emotions (Barnes, 2015b). Other authors attributed the APRN role shift as being marked with uncertainty, disorientation, insecurity, loss of confidence, vulnerability, convulsion, evolution, complexity, chaos, turmoil, and confusion (Flinter & Hart, 2017; Kralik et al., 2006; MacLellan et al., 2015). This role changing period implies that individuals must abandon his or her prior role as a Registered Nurse (RN) in order to successfully embrace new beginnings as an APRN. According to Gardner et al. (2008), new APRNs immediately faced a philosophical shift in that nursing embraced a holistic model of care, whereas medicine emphasized a disease and treatment-focused model of care. As a result, APRNs must redefine their roles to incorporate both paradigms and uphold the new responsibilities of diagnosing, prescribing, and treating. During this stage, some APRNs sometimes faced significant amount of resistance from nurses and physicians which rendered their transition more arduous (MacLellan et al., 2015). Critical to the role were the personal and environmental antecedents that would determine whether APRNs were successful or not. Some of the personal antecedents identified by Barnes (2015b) consisted of a graduate level education, experience, active disengagement from the prior role, active engagement into the new role, and desire for feedback; while environmental antecedents included job novelty, support, and formal orientation. These antecedents will be delineated in the next section.

Personal Antecedents

Personal antecedents to the Advanced Practice Registered Nurse (APRN) role consisted of a graduate level education, experience, active disengagement from the prior role, engagement into the new role, and desire for feedback (Barnes, 2015b). To become an APRN, a master's or a post-master's level of education is required for entry-level practice. In addition, a Registered Nurse license is needed to be credentialed as an APRN in the state of Florida (Nursing Licensure, 2020). Novice APRN healthcare providers bring to the role their educational preparation and prior nursing experience. Benner (1982), in her novice to expert model, defined the novice as a beginner without experience who wanted to be advised what to do. The novice was also taught rules to guide their actions in respective situations. According to Heitz et al. (2004), new APRNs experienced role loss and reverted from the APRN role to the RN role in phase one and exhibited difficulty with active disengagement. It is necessary for novice healthcare providers to abandon their prior nursing role to actively engage in the new role (Meleis, 2010). A mixed method study on APRNs' perceptions of preparedness for transition into clinical practice by Hart and Bowen (2016) revealed 3.3% felt very well prepared, 38.9% were generally well prepared, 43.0% were somewhat prepared, 11.1% were minimally prepared, and 3.7% were very unprepared. This data coupled with a desire for feedback in this group supported Benner's definition of novice and suggested that novice APRNs needed nurturing to grow during the transitional phase through structured and supportive environments (Faraz, 2019; Flinter & Hart, 2017).

Environmental Antecedents

Environmental antecedents included job novelty, support, and formal orientation (Barnes, 2015b). New Advanced Practice Registered Nurses (APRNs) face higher job novelty as healthcare providers. Nicholson (1984) argued that higher job novelty put greater pressure on the individual transitioning since they could not use prior job experience to function in the new role and required greater personal and role development. Several authors identified this transitional period as being daunting and novice APRNs could experience transition shock without adequate support and orientation to the new role (Fitzpatrick & Gripshover, 2016; Flinter & Hart, 2017; Moran & Nairn, 2017). Barnes (2015a) completed a descriptive, cross-sectional survey of practicing APRNs to assess whether prior RN experience and a formal orientation influenced role transition. Only 33% of the participants received a formal orientation in their first APRN position. While prior RN experience did not influence APRN role transition in this study ($p = .12$), a formal orientation was positively correlated with APRN role transition ($p < .001$). Advanced Practice Registered Nurses (APRNs) expressed a need for “support, mentorship, autonomy, learning and professional growth and development, work-life balance, and finding meaning in work” (pp. 3-4) as facilitators of transition and identified “lack of respect, role ambiguity, lack of support, workload, and compensation” (p. 5) as inhibitors to transition (Faraz, 2019). Environmental antecedents could play a crucial role in an APRN’s role transition as it related to whether structured orientation was received or not in the new role.

Factors Influencing Turnover Intentions of Advanced Practice Registered Nurses

The transition from the academic setting to the workplace can be daunting for new Advanced Practice Registered Nurses (APRNs), and they are susceptible to experiencing transition shock (Fitzpatrick & Gripshover, 2016; Flinter & Hart, 2017).

Fitzpatrick and Gripshover (2016) delineated the pressures of transition shock as causing “anxiety, insecurity, exhaustion, role dissatisfaction, suboptimal performance, and possible failure in the workplace” (p. 419). These researchers found that few programs addressed the emotional well-being of the new Advanced Practice Registered Nurses. Issues such as “professional isolation, negativity in the work environment, non-APRN colleagues’ unfamiliarity with APRNs’ scope of practice all cause frustration for the “isolated APRN in a multidisciplinary team approach” leading to job turnover (Fitzpatrick & Gripshover, 2016, p. 420). Some physician colleagues also expected new APRNs to manage their patients independently in their new role which hinted a lack of knowledge about new APRNs transition (Sangster-Gormley et al., 2015). According to the Bureau of Labor Statistics (2015) and Cejka Search and the American Medical Group Association (2014), the national APRN turnover rate is 12.6 % as compared to 6% for physicians. It must also be realized that novice APRNs possessed varying backgrounds and diverse levels of clinical experience which warranted different clinical needs and attention (Bush & Lowery, 2016; Flinter & Hart, 2017). Wallace and Bowler (2014) asserted that attaining expertise from novice to expert took about five years or 10,000 hours for a new APRN. Therefore, without adequate support and mentorship, some APRNs may fail (Bush & Lowery, 2016). Poghosyan et al. (2015) emphasized that organizational support and productive work environment were essential to APRNs’ retention rates as poorly structured environments equated to decreased work productivity, poorer patient outcomes, and job turnover.

In the absence of adequate transitional support, APRNs have experienced transition shock due to poorly structured orientations, inadequate community resources

and organizational support, lack of APRN-physician collaboration, colleagues support, and insufficient clinical preparation leading to turnover rates that were twice that of physicians (Barnes, 2015a; Dillon et al., 2016; Fitzpatrick and Gripshover, 2016). As a solution, Flinter and Hart (2017) and Rugen et al. (2017) emphasized the importance of supporting new APRNs for independent practice in a safety net environment through residency programs. While residency programs are not mandated, the implications to support new APRNs through this critical transition would prepare competent and autonomous healthcare providers to meet the healthcare needs of underserved communities and vulnerable populations (Faraz, 2017). The quality of patient care outcomes, increased job turnover, and job satisfaction can be compromised if factors affecting role transition for novice APRNs are not addressed (Barnes, 2015a). Therefore, the purpose of this correlational study was to investigate the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses in their first APRN position.

Problem Statement

Novice Advanced Practice Registered Nurses (APRNs) should anticipate receiving a structured orientation during their role transition from the academic settings into practice settings (Flinter & Hart, 2017). The structure can promote seamless transitional support, which may lead to better patient outcomes, decreased job turnover intentions, and higher job satisfaction (Fitzpatrick & Gripshover, 2016). Only 38.9% of APRNs reported being well prepared for practice after graduation (Hart & Bowen, 2016), and approximately 33% of those APRNs received a formal orientation in their first position as a healthcare provider (Barnes, 2015a). The dearth of adequate transitional

support left new APRNs to contend with role confusion, deficiencies in self-confidence and role development, inadequate support from colleagues, lack of organizational structure, poorly structured orientation, and insufficient clinical preparation leading to transition shock (Barnes, 2015a; Fitzpatrick & Gripshover, 2016; Flinter & Hart, 2017; Poghosyan et al., 2015). These deficits have resulted in higher job turnover rates for APRNs that were approximately twice than those of physicians (Bureau of Labor Statistics, 2015; Cejka Search and the American Medical Group Association, 2014, & Nursing Solutions, 2019). The quality of patient care outcomes, increased job turnover, and job satisfaction may be compromised if factors affecting role transition and job turnover intentions for novice APRNs are not addressed.

Purpose of the Study

The purpose of this quantitative nonexperimental correlational study was to investigate the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses (APRNs) in their first APRN position.

Definitions of Key Terms Theoretical and Operational

In this study, the theoretical and operational definitions of the key terms are provided. A theoretical definition provides the meaning of the variables of interest. An operational definition defines the way the variables of interest are measured in the study. Both the theoretical and operational definitions are closely aligned (Burns & Grove, 2011; Polit & Beck, 2017).

Structured Orientation

Theoretical Definition

Structured is characterized as having a well-defined structure or organization; highly organized (American Heritage Dictionary of the English Language, 2011). Orientation is defined as measures that are undertaken to assure a new employee is accustomed with the working environment, its demands, and expectations, and to prepare newly qualified nurses to be confident and to provide safe patient care (Lindfors & Junttila, 2014). A successful orientation program comprises personal preceptorship, regular feedback from managers and preceptors, and a supportive environment (Lindfors & Junttila, 2014). Therefore, structured orientation (a mentorship, a preceptorship, or a residency experience) entails having a well-organized and supportive training that facilitates new hires into the integration of their new role.

Operational Definition

Structured orientation (a mentorship, a preceptorship, or a residency experience) was measured using a single item question, “Did you receive a structured orientation in your first Advanced Practice Registered Nurse (APRN) position?” with a “yes” and “no” response on the demographic questionnaire.

Role Transition

Theoretical Definition

The theoretical definition of role transition adapted from Meleis (2010) is defined as “a change in role relationships, expectations or abilities” (p. 15).

Operational Definition

The Nurse Practitioner Role Transition Scale (NPRTS) developed by Cusson et al. (2011) and revised by Strange (2015) was used to operationally define role transition. The 16-item, self-report questionnaire measured role transition of study

participants and consisted of three subscales: Developing Comfort and Building Competence, Understanding of the Role by Others, and Collegial Support. Each item was rated on a 5-point Likert Scale. Responses ranged from 1 = *strongly disagree* to 5 = *strongly agree*.

Turnover Intentions

Theoretical Definition

The theoretical definition of turnover intentions is defined as sentiments of resigning from one's current employment and a tendency to accept another job offer (Tongchaiprasit & Ariyabuddhiphongs, 2016).

Operational Definition

The Turnover Intention Scale (TIS-6) developed by Roodt (2004) was utilized to operationally define turnover intentions. The 6-item, self-report questionnaire measured job turnover intentions of study participants and predicted actual turnover. Depending on the question, response choices for each question varied and ranged in value on a 1 to 5 Likert scale from: 1 = *never* to 5 = *always*, 1 = *very satisfying* to 5 = *totally dissatisfying*, 1 = *highly likely* to 5 = *highly unlikely*, and 1 = *always* and 5 = *never*.

Research Questions and Hypotheses

Gaps in the literature highlighted the need to study the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses in their first APRN position. The research questions and hypotheses for the study included:

RQ₁. Do novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position have better role transition when compared to those who did not receive structured orientation?

H₀. Role transition mean scores for novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position are equal to those who did not receive structured orientation.

H₁. Role transition mean scores for novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position are higher than for those who did not receive structured orientation.

RQ₂. Do novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position have lower job turnover intentions when compared to those who did not receive orientation?

H₀. Turnover intentions mean scores for novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position are equal to those who did not receive structured orientation.

H₂. Turnover intentions mean scores for novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position are lower than for those who did not receive structured orientation.

RQ₃. Is there a negative correlation between novice Advanced Practice Registered Nurses' role transition scale scores on the Nurse Practitioner Role Transition Scale (NPRTS) and turnover intentions scale scores as measured on the Turnover Intention Scale (TIS-6)?

H₀. There is no correlation between NPRTS scores and TIS-6 scores for novice Advanced Practice Registered Nurses.

H₃. There is a negative correlation between NPRTS scores and TIS-6 scores for novice Advanced Practice Registered Nurses.

Philosophical Underpinnings of the Paradigm

Philosophical underpinnings refer to the bases and presumptions of obtaining knowledge and conducting research (Crotty, 1998). Kuhn (1962) defined paradigm as “a strong network of conceptual, theoretical, instrumental and methodological commitments” (p. 42), which comprised “the source of methods, problem-fields, and standard of solution accepted by a scientific community and is the prerequisite to the discovery of scientific laws” (Von Dietze, 2001, p. 34). The task at hand was to investigate the impact of structured orientation on role transition and turnover intentions of novice Advanced Practice Registered Nurses in their first position. The positivist paradigm assisted the researcher to obtain objective truth on this phenomenon of interest.

Positivism

Positivism, a paradigm that is based on the scientific method and objective reality, is defined as, “direct methods whereby laws can be established scientifically through observation, experiment, and comparison” (Crotty, 1998, p. 22). It can be traced back through the early writings of Francis Bacon in the late 1500s and early 1600s. Positivism captured the Spirit of Enlightenment, a self-proclaimed age of reason that commenced in England in the 17th century and offered, “assurance of unambiguous and accurate knowledge of the world” (Crotty, 1998, p. 18). The paradigm is often attributed to French philosopher Auguste Comte for popularizing the word through *Société*

Positiviste in the 1800s. Comte emphasized logic and mathematics and viewed the scientific method as a flexible approach that can be used in many contexts. In addition, he made a distinction that the search for certainty in science rather than numerical precision was of utmost importance. Positivism was also influenced by the Vienna Circle in the 20th century, which gave birth to logical positivism. There are many forms of positivism. The two most common include logical positivism and empiricism.

Logical positivism denotes that scientific knowledge is factual and rejects traditional metaphysical doctrines. While the Vienna circle dissolved in 1938, its scattered members continued to promote its impact on science as well as its central tenet: the verification principle. This principle posited that statements are only meaningful if they can be verified (Crotty, 1998). These statements are called analytic propositions, which can be verified by what is said of a subject in its definition or through mathematical statements. Crotty (1998) asserted that these statements are verifiable by “experience through our senses or by way of the instruments of science that extend the operation of our senses which is verified knowledge” (p. 25).

Logical positivism is concerned with facts and scientific role in establishing them as such. The constructs of positivism include determinism, empiricism, parsimony, and generality which guided the methodology of the study (Cohen, Manion, & Morison, 2000). Determinism infers another circumstance causes an event and can be used to explain casual links. Empiricism is defined as a collection of verifiable empirical evidence in support of theories or hypotheses. Parsimony is an explication of a phenomenon using the most economical explanation. Generality is the process of generalizing observations to the world (Cohen et al., 2000; Polit & Beck, 2017). The

constructs of positivism as well as its scientific assumptions assisted the researcher in attaining scientific knowledge that was objective, valid, certain, and accurate.

Scientific Assumptions

Scientific assumptions are a central component of research that stipulates how reality, knowledge, value, language, and methodology are construed (Creswell & Poth, 2018). They also provide direction for a study. Ontology, epistemology, axiology, rhetoric, and methodology comprise the five scientific pillars that directed the discovery of knowledge, how it was perceived and how to obtain it utilizing methodological strategies. As such, each assumption is defined based on the positivist worldview that constituted the researcher's paradigmatic stance.

Ontology denotes the nature of reality. Within the positivist paradigm, there is one reality that is “driven by real natural causes and subsequent effects and is independent of human observation” (Polit & Beck, 2017, pp. 9-10). Using a scientific approach, the researcher applied this view of reality to objectively measure and explain defined concepts. The primary aim was to obtain factual data, identify relationships, prediction, and control on the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses in their first APRN position while seeking to generalize findings through a realist lens in this study.

Epistemology signifies how knowledge is obtained. Knowledge is based on factual data that are attained by observation through cause-and-effect generalizations. Within the positivist paradigm, knowledge is objective and can be measured with reliable and valid instruments to obtain empirical evidence. The researcher remained independent from those being investigated so that findings were not influenced (Polit & Beck, 2017).

The researcher utilized reliable and valid instruments to obtain accurate and objective data and knowledge that informed the study on the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses in their first APRN position.

Axiology denotes the role of values whereby the researcher is free from subjective bias to maintain the objectivity of the research findings (Polit & Beck, 2017). Within the positivist paradigm, researchers remain free from bias and removed themselves from the research process. Biases can create confounding variables that could obscure true reality. Therefore, the researcher remained independent of the data and impartial to ensure value-free interpretation on the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses in their first APRN position.

The *rhetorical* assumption involves the utilization of precise languages and descriptions within a study (Polit & Beck, 2017). In this quantitative study, the researcher employed statistical and mathematical terms to summarize the findings of the research objectively. The researcher remained distant from the data to ensure accurate reporting of the results of the study on the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses in their first APRN position.

Methodology denotes how the evidence is attained. Within the positivist paradigm, the scientific method is central toward knowledge development. Knowledge is created through deductive processes and hypothesis testing with an emphasis on specific concepts (Polit & Beck, 2017). These concepts are called variables, which are

operationalized and tested using reliable and valid instruments. An a priori design, large representative samples, quantifiable information, statistical analysis, and corroboration of researchers' predictions all comprise the methodology of quantitative research. Data were obtained using surveys and the aim was to generalize the findings of the study to a target population through the use prediction, explanation and understanding (Polit & Beck, 2017). The quantitative methodological approach aided the researcher to attain new objective data regarding the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses in their first APRN position.

The five scientific assumptions guided the study from the positive lens. The guiding paradigms served as the framework for the researcher. The study followed the scientific method to retain its objectivity. Quantitative research methodologies as well as the chosen method for the study is discussed in the next section.

Quantitative Research

Quantitative research seeks to explain cause and effect relationships among variables (Polit & Beck, 2017). To infer causality, a cause must precede the effect. The presumed cause is known as the independent variable, and the effect is identified as the dependent (outcome) variable. If other variables cause the effect, this is known as confounding (extraneous) variables and would not explain causality. Quantitative researchers utilize the scientific method, a step-by-step guided technique to obtain objective and measurable information. Deductive reasoning is employed to generate hypotheses for testing in real life situations. A focus on utilizing specific concepts bolstered the search for answers to the problem. The researcher's assumptions are also

verified against other credible researchers. This systematic process utilizes an a priori design, large, representative samples, quantifiable data as well as empirical evidence, and statistical analyses that would support the generalizations of the research findings to a target population (Polit & Beck, 2017).

Quantitative designs include experimental and nonexperimental. Experimental designs are considered the gold standard of quantitative research. Experimental designs involve randomized control trial (RCT) and are characterized by three properties: manipulation, control, and randomization. Manipulation involves some type of intervention to some of the participants. Control consists of the group that does not receive the intervention. Randomization of subjects with treatment and control groups ensure the researcher designates participants to a control or experimental situation at random. It is the most efficient technique of managing individual characteristics, safeguard comparable groups, and regulate all possible sources of confounding variation (Polit & Beck, 2017). Experimental designs also include posttest only, pretest-posttest, factorial, and cross-over designs. Posttest only designs involve collecting data after an intervention. With pretest-posttest, data are collected before and after an intervention. Factorial designs involve the manipulation of two or more variables to test main effects and interaction effects and crossover design exposed subjects to more than one condition in randomized order and served as their own control (Polit & Beck, 2017).

Quasi-experimental design is another experimental design that involves an intervention without randomization. These designs can support causal inferences. Quasi-experimental designs consist of nonequivalent control group pretest-post design, time series design, dose response analyses, and quasi-experimental (nonrandomized) arms of a

partially randomized patient preference (PRPP). Nonequivalent control group pretest-posttest design includes data that are collected pretreatment so that group equivalence can be evaluated. Time series design involves the collection of information on the dependent variable over a period before and after an intervention. Dose response analyses infer the outcomes of those receiving different doses of an intervention are compared and the PRPP randomization design involved groups with strong preferences.

Nonexperimental (observational) research designs do not involve interventions or randomization (Polit & Beck, 2017). They include correlational studies and descriptive research studies. Correlational studies seek to assess relationship among variables. Descriptive research studies capture the status of phenomena. Descriptive correlational studies explain how phenomena are correlated without causal justification. Correlational studies can be retrospective, prospective, or cross-sectional. Retrospective designs are previously collected data and include case control designs. Prospective designs (cohort design) are data that are collected over a period, and cross-sectional, whereby data are collected at one point in time (Polit and Beck, 2017). Other designs include natural experiments and path analytic studies. Natural experiments involve a group that are influenced by a random event such as a disaster, whereas path analytic studies evaluate causal models that are established based on a theory. On the other hand, descriptive studies consist of univariate descriptive studies seeking to describe the “frequency or occurrence of a behavior or condition” (Polit & Beck, 2017, p. 206). These include prevalence and incidence studies. Prevalence studies detail the prevalence rate of a condition at one point in time, and incidence studies demonstrate the frequency of new

cases over a given time. Relative risk of each case for two groups is calculated once incidence rates for both groups are projected.

In this study, the researcher employed a correlational design to investigate the phenomenon of interest. Structured orientation was the independent variable; role transition, and turnover intentions were the dependent variables. It was understood that some of the limitations of this design included their weakness to infer causality, selection bias involving preexisting groups, and the inability to assume similarity between groups being compared before the independent variable occurred. In addition, preexisting differences among the groups may have yielded an alternate reason for any group differences on the outcome variable. However, this design was appropriate for this study because it did not involve experimental intervention. It was effective in collecting extensive data in this study (Polit & Beck, 2017). Furthermore, the positivist paradigm helped to guide the phenomenon of interest by providing current, quantifiable data as it related to the study's variables.

Theoretical Framework

Meleis' Transitions Theory

Afaf I. Meleis is a professor of nursing and sociology and the former Margaret Bond Simon Dean of Nursing at the University of Pennsylvania School of Nursing and the former Director of the School's World Health Organization (WHO) Collaborating Center for Nursing and Midwifery Leadership. She also taught nursing at the University of California Los Angeles and the University of California San Francisco for 34 years (Smith and Parker, 2015). Meleis continues to consult on doctoral education for nurses nationally and internationally and serves on various committees. Meleis' research

scholarship was centered on the theoretical development of the nursing discipline, structure and organization of nursing knowledge, transitions and health, global immigrants, and women's health. She was the creator of transitions theory, a middle range theory that was characterized as a "passage from one life phase, condition, or status" (Meleis, 2010, p. 25). In addition, Meleis considered the theory as a central concern of nursing phenomenon (Meleis, 2010). Meleis' Transitions Theory development was influenced by three different paradigms: role theory, perceived views on the lived experience, and feminist post-colonialism. Role theory, a dynamic and interactionist paradigm, assisted in the formulation of the type and nature of questions that supported individuals who were transitioning from one role to another and how to embrace a new role or modify behaviors in a role (Smith & Parker, 2015). Meleis (2010) further conceptualized role insufficiency and role supplementation as being integral in role transition.

Role insufficiency is characterized as "any difficulty in the cognizance and or performance of a role associated with role behavior as perceived by the self or the significant others" (Meleis, 2010, p. 16). This concept considers individuals' behaviors, sentiments as it pertains to their shortcomings in fulfilling their role obligations which can occur with poor role clarification. In addition, when role insufficiency is clouded with feelings of anxiety, apathy, frustration, and powerlessness, it impedes one's progression, and adaptation toward role transition. Role insufficiency can be counteracted with role supplementation, a preventative and therapeutic tool. Role supplementation is characterized as:

a deliberate process whereby role insufficiency or potential role insufficiency is identified by the role incumbent and significant others, and the conditions and strategies of role clarification and role taking are used to develop a preventive or therapeutic intervention to decrease, ameliorate, or prevent role insufficiency.

(Meleis, 2010, p. 17)

When a preventive approach is taken, role clarification for individuals occurs in anticipation of the impending transition, whereas a therapeutic approach is employed when role insufficiency is already present. Furthermore, strategies to facilitate role clarification and role taking involve role modeling, role rehearsal, and reference groups interactions. Perceived Views on the Lived Experience was also a driving force in the development of the theory because it focused on the nature of the lived experiences of individuals undergoing transition as well as how they responded to the change. Meleis embraced the perceived view because she believed personal knowing are holistic, encompassing and complements the empirical way of knowing (Smith & Parker, 2015).

The Feminist Post-colonialism paradigm also influenced Meleis' transitions theoretical development. This worldview questioned "power relationships in societies and institutions and that links societal and political oppressions that shaped the responses to change events" (Smith & Parker, 2015, p. 363). This paradigm amplified the understanding of the transitional experience through the multiple lenses of race, ethnicity, nationality, and gender. When considering these power differentials in ascertaining how people perceived and handled transition, preventive and therapeutic interventions can be tailored to better assist them to achieve a good outcome. In effect, the three paradigms:

role theory, perceived views on the lived experience, and feminist post-colonialism transformed the progression of transitions theory (Smith & Parker, 2015).

Transition is viewed as being convoluted and multifaceted (Kralik et al., 2006). Several types, patterns, and natures of transitions, properties and transition conditions accompany the transitional experience. Meleis (2010) explicated that these conditions may have impacted role transition in ways that may have been problematic. Role transition is further complicated with a shift in role relationships, expectations, or abilities and require one to integrate new knowledge and alter one's behavior and self-redefinition within one's respective social context. The outcome of transition is measured by patterns of response and outcome indicators while nursing therapeutics can target unhealthy transitions to promote a sense of well-being. A successful transition is demonstrated with a great sense of well-being, mastery of skills, and having a new sense of identity while an unsuccessful transition is marked by negative emotions and inadequate support (Meleis, 2010). Therefore, transitions theory encompasses many facets: (a) Nature of Transitions, that is comprised of types, patterns, and properties; (b) transition conditions that include facilitators and inhibitors, (c) nursing therapeutics, and (d) patterns of response that includes process and outcome indicators (Meleis, 2010).

Nature of Transitions, Types, Patterns, and Properties

Types of Transitions

The four types of situations that can generate a transitional experience are prompted by change and include developmental, situational, health/illness, and organizational transitions (Meleis, 2010; Smith & Parker, 2015). According to Chick and Meleis (1986), the process of change is external while transition occurs internally.

Developmental transitions are characterized by life stages such as birth, adolescence, aging, and menopause or by roles (mothering, fathering, marrying, and divorcing).

Situational transitions embody experiences and reactions to situational changes.

Examples in this category include admission to or discharge from a hospital and changes a new graduate Advanced Practice Registered Nurse (APRN) experiences in learning the ropes of the new role in his or her first position. Health and illness transition involves receiving a diagnosis of an illness or undergoing interventional procedures for a diagnosis. It also includes recovery from an illness as well as coping with a new diagnosis. Organizational transitions are associated with rules and functioning and represent transition within the structural environment. Examples include the arrival of a new leader, implementation of a different system of care, educational preparation in nursing in curricular content, and modes of thinking as well as changes in nursing as a profession (Meleis, 2010; Smith & Parker, 2015).

Patterns of Transitions

According to Meleis (2010), transitions occur in patterns that can be singular, multiple, sequential, simultaneous, related, or unrelated. Individuals can experience multiple transitions concurrently as in the case of novice APRNs who are undergoing multiple transitions when leaving their expert nurse status to work as a novice APRN in new practice settings (Flinter & Hart, 2017).

Properties of Transitions

Awareness, engagement, change and difference, transition time span, and critical points and events characterize the five properties of transitions (Meleis, 2010). Awareness pertains to the “perception, knowledge, and recognition of the transitional experience”

(Meleis, 2010, p. 57). Individuals can be aware of the transition process or not.

Awareness leads to engagement, which is the “degree to which a person demonstrates involvement in the processes inherent in the transition” such as searching for information, accessing role models, and being proactive in preparing and knowing when to revise activities (Meleis, 2010, p. 57). The level of engagement depends on the level of one’s perception of the change. Change and difference are also properties of transitions.

Change involves uncovering the meaning of a situation whereas difference entails seeing the world in a different way than others perceived it. This sometimes can lead some individuals to modify their actions or insights and eventually conform to the social norm after assimilation into a new role, new workplace, or a situation. Bridges (2003)

considered transition as a time span which begins with an ending that is characterized by a period of instability, confusion and distress and ends with a new beginning or a period of stability. While transitions denote there is flow and movement over time, it is cautionary to consider “flux and variability” in the process and not complete linearity in flow especially for those experiencing long-term transitions (Meleis, 2010, p. 58).

Critical points and events occur with increasing awareness of the change or difference and being actively engaged until a sense of stabilization takes place (Meleis, 2010).

Transition Conditions, Facilitators, and Inhibitors

Transition conditions involve personal and environmental factors that can enhance or hinder a successful transition (Meleis, 2010). Personal conditions are comprised of meanings, beliefs and attitudes, socioeconomic status, and preparation and knowledge that an individual brings with them to a new role. Environmental factors include community and society conditions. These environmental factors consist of

available resources, social support and presence of supportive preceptor, mentor, or role model. All these conditions can facilitate or inhibit change depending on an individual's response when undergoing through change and transition and whether resources and support are available or not (Meleis, 2010).

Patterns of Response

Patterns of response pertains to process and outcome indicators. Process indicators involve feeling connected, interacting, being located, and situated, developing confidence, and coping; while outcome indicators include role mastery and fluid integrative identities (Meleis, 2010). The ability of an individual in transition to connect with previous colleagues, families, and other professionals provide social support and mentoring. Interacting helps one to uncover new meaning and context of a situation clearly as confidence and coping skills develop. An outcome indicator that yields to role mastery is a characteristic of a healthy transition. Role mastery is the capacity to perform required skills with comfort in a new situation. It also includes the development of competence and self-confidence. These outcomes lead to the cultivation of fluid integrative identities and success in the transitional process. Nurse mentors and professional colleagues employ promotive, preventive, and interventive therapeutics to influence the process (Meleis, 2010).

Meleis' Transitions Theory provided scientific knowledge that guided the researcher to investigate the impact of structured orientation of novice Advanced Practice Registered Nurses' (APRNs) role transition and job turnover intentions in their first APRN position. In this study, new APRNs were impacted by the four types of transitions. They experienced a developmental transition as they embraced the new role as novice

healthcare providers. A situational transition occurred as APRNs adjusted to new situations and circumstances of the role. They encountered health and illness transition as they harbored negative emotions of stress and anxiety in the new position and experienced organizational transition when neophyte APRNs left their familiar and comfortable environment to embrace an unfamiliar environment in a new organization. All these transitions were occurring simultaneously for the new provider. In this study, structured orientation (a mentorship, a preceptorship, or a residency experience) was treated as a transition condition and a nursing therapeutic that could influence role transition and job turnover intentions for novice APRN providers. Process indicators could be evaluated by the progress of new APRNs in the new role and whether they experienced transition shock or adapted to the role. Outcome indicators were appraised with APRNs' socialization into the role and the development of confidence and competence.

Relationship of Meleis' Transitions Theory to the Study

Transitioning into practice for novice Advanced Practice Registered Nurses (APRNs) is overwhelming. This role transition process related to Meleis' Transitions Theory in that novice APRNs underwent multiple transitions simultaneously while leaving a former expert role to embrace the new role. Meleis (2010) detailed transitions as an interconnected process that involved an intricate understanding of one's role and being able to navigate through. This involved conditions within the transitional experience that may have hindered or assisted a novice to succeed. The theory detailed provisions within nursing therapeutics that targeted APRNs that were not thriving (role insufficiency) and how to support them for success in the role (role supplementation).

The process was not linear, and the experience could vary individually. Hence, Meleis' Transitions Theory provided guidance as to how to better assist new APRNs through transition. Transitions theory was utilized as a guide to design the methodology of the study.

Figure 1

Meleis et al.'s Transitions Theory (2000)

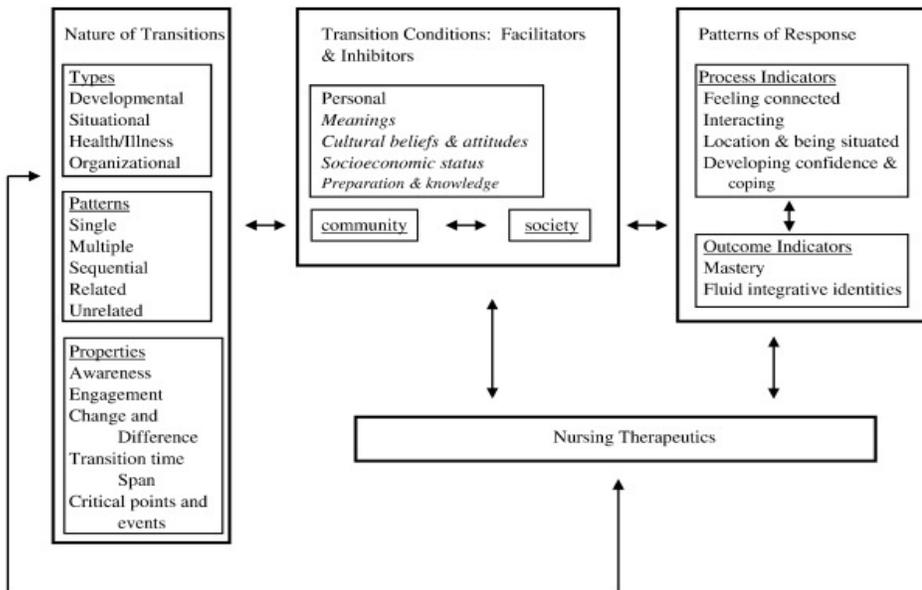
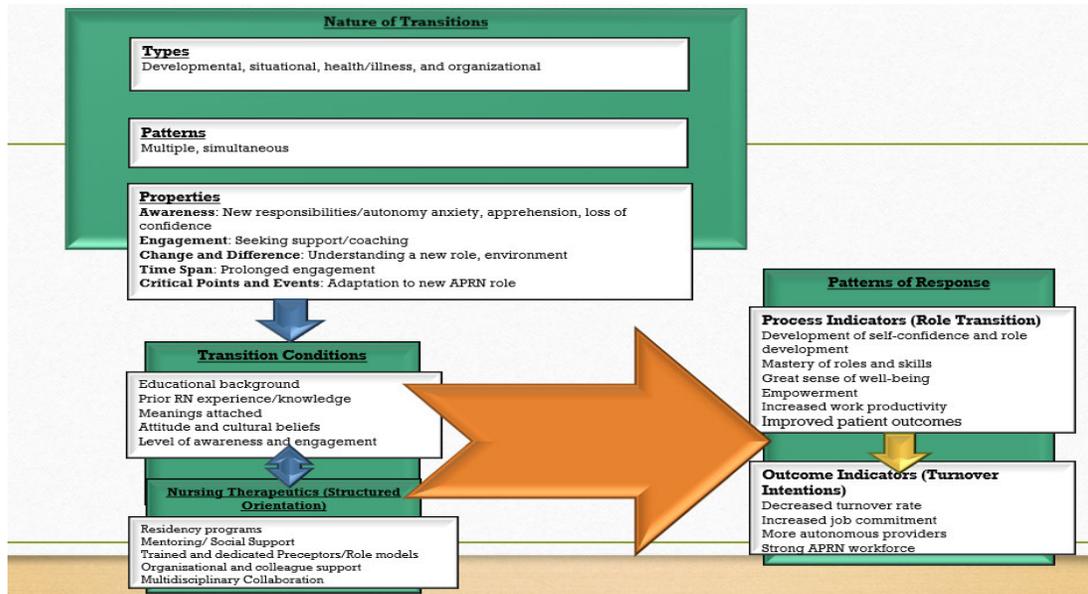


Figure 1 outlines the nature of transitions such as the types, patterns, and properties (Meleis et al., 2000). It also addressed transition conditions facilitators and inhibitors and incorporated patterns of response such as process and outcome indicators to evaluate the transitional experience. Nurse mentors and professional colleagues influenced the transition process by using promotive, preventive, and interventive therapeutics for new Advanced Practice Registered Nurses (Meleis et al., 2000).

Figure 2

Conceptual Representation of the Impact of Structured Orientation on Role Transition and Job Turnover Intentions of Novice Advanced Practice Registered Nurses (Jules, 2021). Adapted from Meleis et al.'s Transitions Theory (2000).



This study related to Meleis' Transitions Theory in many ways. Figure 2 provided a schematic depiction of a conceptual representation on the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses (APRNs). The figure highlighted the nature of transitions: types, patterns and properties, transition conditions, patterns of response, process indicators, outcome indicators, and nursing therapeutics. Novice APRNs experienced developmental, situational, health and illness, and organizational transitions simultaneously. Their transition occurred in multiple patterns. The novice APRN faced new responsibilities and autonomy as a new provider and experienced anxiety, apprehension, and loss of confidence. This propelled the novice APRN to seek support in the new role to better grasp and adapt to the new responsibilities.

Novice Advanced Practice Registered Nurses brought to the role their educational background, prior nursing experience, meanings and their cultural beliefs to the role which influenced their adaptation. Nursing therapeutics such as structured orientation provided a supportive framework and generated patterns of responses that could effectuate a successful role transition and decreased job turnover intentions for novice APRNs. In this conceptualization, structured orientation was treated as a transition condition and a nursing therapeutic.

Assumptions

An assumption is an idea or opinion that is accepted as truth without concrete validation (Cottrell & McKenzie, 2011). In a study, presumed assumptions are foundational in interpreting its results. Therefore, assumptions that are made in a study guide the reader to appraise the findings of the research. Theoretical assumptions are based on the truth derived from a theoretical framework that have been tested to guide the study. Researchers' assumptions are personal ideas that the researcher deems to be true.

Theoretical Assumptions

Meleis' theoretical assumptions are delineated below.

1. A human being's responses are shaped by interactions with significant others and reference groups.
2. Change through health and illness events and situations trigger a process that begins at or before and extends beyond the event time.
3. Whether aware or not, individuals and/or families experience a process triggered by changes with varied responses and outcomes.

4. Outcomes of the experience of the transition are shaped by the nature of the experience.
5. Preventative and therapeutic actions can influence outcomes.
6. Individuals have the capacity to learn and enact new roles influenced by their environment.
7. By producing critical and well-supported evidence, inequities in health care can be changed to more equitable systems of delivery.
8. Gender, race, culture, heritage, and sexual orientation are contexts that shape people's experiences and outcomes of health-illness events as well as health provided.
9. Nursing perspective is defined by humanism, holism, context, health, well-being, goals, and caring.
10. Environment is defined as physical, social, cultural, organizational, and societal and influences experience, interventions, and outcomes.
11. Individuals, families, and communities are partners in the care processes (Meleis, 2010; Smith & Parker, 2015, p. 363).

Researcher Assumptions

The researcher accepted the following assumptions as being true without validation: Subjects' exposure to structured orientation in their first APRN role were reflected in their role transition quality and job turnover intentions. Subjects answered to questionnaire items truthfully and accurately. In addition, Meleis' Transitions Theoretical assumptions held true that novice APRNs who were supported in their first APRN

position would experience a successful transition and decreased job turnover intentions, whereas those who were not supported would not.

Significance of the Study

The aim of conducting research was to enrich the body of current knowledge. One of the primary goals of this study was to address the gap that currently existed in the literature regarding the impact of structured orientation for novice Advanced Practice Registered Nurses (APRNs) on role transition into practice and job turnover intentions. Included in the gap were the inconsistencies in the type of support new APRNs received during the initial transition from the academic settings into practice settings. This phenomenon needed to be studied and better understood to promote a seamless transition for these group of healthcare providers. This study brought forth understanding about the challenging nature of transition for APRNs as well as the factors that promoted or hindered its process. Furthermore, this study has served as a path towards future research regarding how to better support novice APRNs nationally.

Significance of the Study to Nursing

The nursing profession has an ethical duty to promote and provide a seamless transition for novice Advanced Practiced Registered Nurses who are transitioning into practice. The first year of transition to practice for new Advanced Practice Registered Nurses (APRNs) is stressful, confusing, and challenging (Meleis, 2010; Kralik et al., 2006). Without adequate support, some APRNs leave the role. It is also known that APRNs come from varying backgrounds and differing levels of experience, which implies that their supportive needs can fluctuate (Gripshover & Fitzpatrick, 2016). Meleis and Trangenstein (1994) asserted the central focus of nursing was to enable clients,

families, and communities through life transitions because nursing is “concerned with the process and the experiences of human beings undergoing transitions where the importance of health and perceived well-being is the outcome” (p. 257). Novice APRNs’ well-being is at stake without adequate transitional support. The Institute of Medicine’s (2010) Future of Nursing report emphasized that new APRNs are trained with high-quality clinical and critical thinking skills to satisfy patients’ needs and recommended residency programs when shifting to new clinical areas or a specialty. Therefore, a study that investigated the impact of structured orientation on role transition and turnover intentions of novice Advanced Practice Registered Nurses in their first APRN position may contribute to improving nursing education, nursing practice, nursing research, health, and public policy.

Implications for Nursing Education

It is incumbent upon nursing leaders to standardize entry-level experience for enrollment into graduate programs across the board. Currently, there are many avenues to attain a master’s degree to become an Advanced Practice Registered Nurse and some programs have admitted nurses with little or no clinical experience (Barnes, 2015a; Flinter & Hart, 2017). This would be a first step in closing the loopholes and inconsistencies that currently exist within the nursing educational system. Secondly, finding ways to include structured transition to bridge practice from the academic settings into practice settings for new APRNs is another consideration. The findings of this study may serve as a guide to help facilitate the understanding of what factors promote or hinder transition to practice, leading to reform that will foster seamless transition and decrease turnover intentions for new graduates.

Implications for Nursing Practice

Advanced Practice Registered Nurses (APRNs) are in great demands to care for the aging and vulnerable populations. With the expected shortage of primary care providers, preparing and supporting new APRNs early in the role with structured orientation and mentoring can help to build their confidence and role development and abate transition shock and turnover. Supporting APRNs in practice will sustain and strengthen the nursing workforce to continue to serve the needs of the population with satisfactory patient outcomes. This study has contributed data toward the needs of new APRNs to enhance their transition into practice.

Implications for Nursing Research

Nursing research is a fundamental element that informs education, clinical practice, and policy development. This research provided new data that can direct nursing practices. Moreover, Meleis (2010) characterized the process of transition as being complicated and multidimensional. Further investigations were needed to advance the knowledge of theory development and clinical practices as it related to role transition for novice APRNs. This study might help bridge the gap that existed in the literature regarding programs that can better support new APRNs transition into practice settings and improve job satisfaction and reduce job turnover intentions. The findings from the study have added to the body of nursing science and the applicability of Meleis' Transitions theory. Furthermore, the investigation of this problem has served as a path towards the promotion of transition to practice programs for all novice APRNs.

Implications for Health and Public Policy

Health policy refers to decisions, plans and actions that are accepted to attain specific health goals within a society (World Health Organization, 2020). The American Nurses Association (ANA) (2010) refers to public policy as governmental policies that affect the whole population. Health and public policies serve as a social contract between society and the nursing profession (ANA, 2010) and the community at large relies on professionals to receive optimal care. Therefore, it is imperative that Advanced Practice Registered Nurses (APRNs) are adequately prepared. Continued structured transition to practice programs are needed to support new APRNs. Public policy development that promotes stable funding sources to support these programs are necessary. These programs can support novice APRNs to progress through the stages of transition, decrease transition shock and turnover intentions. It is hoped that the results of this study would stimulate the development of policies and interventional programs needed for improving novice APRNs' role transition into practice settings.

Scope and Limitations of the Study

The scope of the study enabled the researcher to determine the impact of structured orientation on novice Advanced Practice Registered Nurses' role transition and turnover intentions. Subjects for the study included: (a) novice APRNs with 1 month to 3 years of clinical practice in any specialty in the United States, (b) holding an active APRN license, (c) being 18 years or older, (d) able to read, write, and understand English, and (e) having access to a computer and the internet. The 3-year maximum was chosen to maintain the focus of the study and to capture the impact of how new APRNs experience transition with or without a structured orientation program. All the subjects

who volunteered to participate in the study received the designated questionnaires to complete the study. Data from those novice APRNs who voluntarily participated in the study were utilized.

The limitations of this study consisted of factors that jeopardized the external and internal validity of this study. A convenience sampling procedure was used in this study to recruit subjects. This sampling technique lacked randomization and reduced the researcher's ability to generalize results to a population at large. The accuracy of the data depended on the subjects' self-reported responses being truthful and not falsified. Furthermore, limitations of utilizing nonexperimental correlational designs included their weakness to infer causality, selection bias involving preexisting groups, and the inability to assume similarity between groups being compared before the independent variable occurred. In addition, preexisting differences among the groups may have yielded an alternate reason for any group differences on the outcome variable. The research was conducted by a novice researcher. The limited experience may have affected the conclusion of the study.

Threats to External and Internal Validity

Validity refers to the soundness of the study's evidence (Polit & Beck, 2017). Shadish and colleagues (2002) defined validity as the "approximate truth of an inference" (p. 34). It was the assumption that the outcome of the study (dependent variable) resulted from the proposed cause (independent variable). Validity of a study represents the "truth of the findings as determined by the purity of the design" (Wood & Ross-Kerr, 2011, p. 120). Therefore, it was paramount that the researcher addressed, attempted to reduce, or eradicated threats to a study's validity to maintain the study's integrity. In effect, the

greater the degree of validity of the study, the more confident one would be in the results (Wood & Ross-Kerr, 2011). When threats to external and internal validity are reduced, it is believed that the conclusion of the study would be more precise.

External Validity

External validity is the magnitude to which the results of a study are generalizable to a target population (Wood & Ross-Kerr, 2011). Threats to external validity “concern ways in which relationships between variables might interact with or be moderated by variations in people, settings, time, and conditions” (Polit & Beck, 2017, p. 230). Testing based threats include interaction effects of testing and selection (two treatments are manipulated simultaneously), reactive arrangements, and multiple treatment inferences. Threats based on participants consist of limited types of population tested, gender bias, racial bias, and cultural bias (Polit & Beck, 2017). To assure generalizability, random sampling, large representative sample that accounts for extraneous variables are necessary and preferred. However, this study was cross-sectional, and a convenience sampling method of novice Advanced Practice Registered Nurses (APRNs) was utilized. This approach may limit the ability to replicate the findings of the study as compared to longitudinal studies. In addition, a small sample size can hinder generalization to a target population. Optimal sample size for the study was calculated using power analysis to assure statistical analysis was meaningful and large enough to detect errors (Wood & Ross-Kerr, 2011). Data collected from participating subjects in the study may vary.

Internal Validity

Internal validity indicates the results of the study are the due influence of only the independent variable (Wood & Ross-Kerr, 2011). Extraneous variables can interfere with

the action of the current variables being examined, and can threaten internal validity (Polit & Beck, 2017; Wood & Ross-Kerr, 2011). Threats to internal validity include temporal ambiguity, selection bias, history, maturation, mortality, testing, and instrumentation (Polit & Beck, 2017). To control threats to internal validity, the use of established valid and reliable instruments was employed to evaluate the effects of both the independent and dependent variables. Reliable and valid instruments ensured the variables in the study were measured consistently among the study's subjects. Temporal ambiguity is a criterion for implying a causal relationship wherein the cause must precede the effect (Polit & Beck, 2017). In random controlled trials, temporal ambiguity is not an issue. However, it could be a concern in cross-sectional and correlational studies such as this one as it may be unclear whether the independent variable preceded the dependent variables being studied.

Chapter Summary

This chapter discussed the background of the study, the problem statement, and the purpose of the study. Key theoretical and operational definitions were enunciated. The research questions and hypotheses were postulated. Philosophical underpinnings of the paradigm were highlighted. The theoretical framework as well its constructs were discussed. Relationship of the Meleis' Transitions Theory to the study was presented. The significance of the study and the implications for nursing education, nursing practice, nursing research, health and public policy were delineated. Scope and limitations and scope of the study, threats to external and internal validity were summarized. Chapter Two follows with the review of the literature.

CHAPTER TWO

REVIEW OF THE LITERATURE

The purpose of this non-experimental, correlational study was to investigate the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses (APRNs) in their first APRN position. A comprehensive review of the literature was conducted to ascertain the current state of knowledge, as well as the gaps in knowledge, relevant to the study. The search involved the major electronic databases in the disciplines of nursing, medicine, psychology, sociology, and education. The Cumulative Index to Nursing and Allied Health Literature (CINAHL), Google Scholar, DeepDyve, Medline, Ovid databases, and ProQuest were accessed. The search was limited to the English language and included articles from 2012 through the present. The key search terms and phrases were *role transition*, *Advanced Practice Registered Nurses*, *turnover intentions*, *structured orientation*, *mentoring*, and *Meleis' transitions theory*. The literature review covered the following categories: role transition and healthcare professionals, structured orientation and nursing, turnover intentions and nursing, and Meleis' Transitions Theory and nursing.

Role Transition and Healthcare Professionals

This portion of the literature comprised of six articles that portrayed role transition of new Registered Nurses (RNs), novice Advanced Practice Registered Nurses (APRNs), Registered Nurse preceptors and novice Clinical Pharmacists (NCPs). Two articles highlighted the need for preceptor training and its impact on new nurses' transition and retention, one article identified the need for structured support for novice Clinical Pharmacists, two articles provided the perceptions of novice APRNs'

perceptions of the quality of their educational preparation for practice and areas for improvement and the final study delineated the facilitators and inhibitors of transition.

Miller et al. (2017) conducted a basic interpretive qualitative study in Northeastern U.S. to explore the experiences, growth, and development of nurses transitioning to the nurse preceptor role in a variety of healthcare settings. Work Role Transition Theory and Benner's application of the Dreyfus Model of Skill Acquisition guided this inquiry to examine the preparation and training of preceptors. Research questions included, how do nurses describe their preparations for and experiences in their preceptor role? How do nurses describe their evolution after transitioning in and out of the preceptor role? Twenty nurses who met criteria were recruited through purposive and snowball sampling and participated in the study. After approval from the university's institutional review board was obtained, 20 face-to-face interviews were conducted and audio-recorded over a period of five months ranging from 45 to 90 minutes. Data were coded and themes were identified and conceptualized. Findings consisted of three emergent themes and subthemes.

Major themes included transfer of learning and clinical expert to novice again. Subthemes included the preceptorship experience, formal training, informal training, deconstruction, and construction. Participants found meaning through their teaching and learning encounters with novice nurses, developed identity development in their roles as nurses and preceptors. Recommendations included the criteria for additional administrative support, guidelines, and standards for preceptor training and preparation and those preparation geared towards adult learning as well. Additional time and support for transitioning to the preceptor role were also noted.

In a similar study, Clipper and Cherry (2015) conducted a descriptive correlational study within central Texas to examine the effectiveness of a structured preceptor development program by measuring perceptions of transition to practice and first-year retention of two groups of former graduate nurses with less than 1 year experience as a nurse: the first comprising of preceptors trained through a preceptor development program, and the second comprising of preceptors who did not participate in structured training. Boychuk Kutscher's (2009) Theory of Transition Shock guided this study. One hundred thirty-eight new graduate Registered Nurses (NGRNs) from seven acute care hospitals within central Texas were recruited through an online survey. First cohort consisted of former NGRNs ($n = 62$) who had untrained preceptors, and the second cohort of former NGRNs ($n = 76$) had trained preceptors. Fifty-nine subjects responded. Demographics data included an age range of 21-50 years for the total sample, ages 21-25 years accounted for 43.9%, 44% of NGRNs with untrained preceptor had Bachelor of Science in Nursing (BSN) level compared with 89% of NGRNs with trained preceptors at the BSN level.

A 16-item, investigator-developed survey with attributes of Transition Shock Theory was employed to assess NGRNs' perceptions of the transition process and their preceptors' effectiveness. The survey included seven demographic items, eight questions, a 7-point Likert scale, ranging from 1 = *strongly agree* to 7 = *strongly disagree* and one open-ended qualitative question about their perception of the overall orientation and transition process. The Mann-Whitney U-test was utilized for data analysis. Two questions revealed significant results. The first question, "My preceptor helped me develop collegial working relationships and promote a positive work environment in my

new unit/ department” had a significance level of ($p = .038$) and the second question, “My preceptor took adequate time with me to ensure a smooth transition from my role as student nurse to that of an independent, professional nurse” revealed a level of ($p = .016$). The NGRNs who had trained preceptors scored these two questions significantly higher than the NGRNs with preceptors who were not trained. The survey tool had a Cronbach alpha of 0.954 suggesting strong internal reality. Findings revealed NGRNs with trained preceptors had a slightly higher 1-year retention rate at 89.5% compared with 82.7% for NGRNs with untrained preceptors.

Recommendations included a need for more research on which facilitators and inhibitors can affect transition and what can counteract the negative effects of the nursing shortage that was identified in this study. Communication with physicians and relationships with experienced nurses were inhibitors in this study and must be explored. In addition, research was recommended on the retention of nurses in the study and recruitment efforts for future cohorts.

Magola et al. (2018) conducted a qualitative study to identify the challenges novice Clinical Pharmacists (NCPs) faced during transition to independent practice and perceptions of the importance of these challenges. Meleis’ Transitions Theory and Karesek’s Job Demand Control model guided the authors in this study. Nominal group technique (NGT) was utilized for data collection. Twenty-five participants were recruited using a purposive sampling of four populations, of which there were seven novice Community Pharmacists (NCPs) (up to 12 months); four early Career Pharmacists (ECPs): 2-3 years; five preregistration tutors (PRTs); and six pharmacy support staff. Inductive thematic analysis was used to derive data-driven themes in this study through

NVIVO 10. The findings revealed that the workplace environment produce challenges for the NCPs. Emerging challenges included relationship management, confidence, decision-making, being in charge and accountable and adapting to the workplace. All the groups identified relationship management as problematic. Fear of being perceived as being incompetent deterred NCPs from delegating to support staff, while pharmacists and pharmacy support staffs viewed NCPs as being passive in managing others creating friction among them. As a result, NCPs experienced “emotional stress, low self-esteem, and distress in response to professional accountability” (p. 856). On day one of independent practice, the dearth of tutor support, supervision, and structural support also hindered their transition and promoted isolation. Recommendations included social support structure from professional colleagues that were aimed at targeting job strain for NCPs and supportive environment for learning. Future research included exploring factors that enhanced transition for NCPs, insights into the role of the environment and their challenges, as well as interpersonal and leadership skill-building.

Hart and Bowen (2016) conducted a mixed study via an electronic Web-based survey assessing new Advanced Practice Registered Nurses’ (APRNs) perceptions of preparation for clinical practice and transition into practice for APRNs who graduated between 2006 and 2011. A convenience sample of 698 licensed APRNs who rendered care to patients in the United States completed the survey. The demographics consisted of a majority non-Hispanic and white (86.4%). The majority (90.2%) completed a master’s APRN program, and 69.4% were prepared as family APRNs.

The survey included two sets of 21 items. In set 1, the participants rated the “importance of preparation” for specific practice-related skills, and in set 2, they rated the

same items based on “how prepared they felt” at the beginning of practicing. Five themes emerged: managing health concerns, basics of health assessment and diagnosis, diversity and teaching, procedures, and evidence-based practice and collaboration. Based on the results, only 3.3% reported feeling very well prepared, 38.9% were generally well prepared, 43.0% were somewhat prepared, 11.1% were minimally prepared, and 3.7% were very unprepared. The Advanced Practice Registered Nurses (APRNs) specified feeling most prepared for practice in core areas (health assessment, pathophysiology, pharmacotherapy, differential diagnosis, evidence-based practice, health teaching) and least prepared in mental health management, coding and billing, EKG and X-ray interpretation, and office procedures. Participants lacked formal mentors, desired help to transition into practice, and demonstrated interest in postgraduate residency programs. Physicians mostly served as mentors for this group despite the difference in educational background and roles compared to APRNs. The authors suggested recommendations to improve the transitional experience for new APRNs to include the development of evidence-based recommendations for transitioning into practice, mentoring and formal orientation, guides for mentors of APRNs (both for mentors who are APRNs and for mentors who are not APRNs), and postgraduate residency programs, as well as for APRN educators to strengthen curriculum and evaluation in areas APRNs proposed in this study.

Faraz (2019) conducted a descriptive, cross-sectional study via online survey administered to a national sample of 177 Advanced Practice Registered Nurses (APRNs) who graduated from an accredited APRN program and was practicing in a primary care (PC) setting for 3-12 months. The purpose of the study was to assess facilitators and barriers to transition for novice APRNs through open-ended responses. A convenience sample of APRNs practicing in PC settings was recruited through all Commission on Collegiate

Nursing Education (CCNE)-accredited master's nursing programs, social media sites, and snowballing. An e-mail was sent to the contact administrator listed on the CCNE website for each of the accredited master's nursing programs in the United States ($N = 431$) and to the contact administrator listed for all primary care focused APRN residency or fellowship programs ($N = 8$) found on the GraduateNursingEDU.org website that described the purpose of the study and benefits of the research and a request to dispatch a recruitment e-mail on behalf of the researcher to their APRN graduates. Twenty-nine APRN educational programs from all regions of the United States and five APRN residency/fellowship programs disseminated the e-mail to their graduates. Additional recruitment methods simultaneously used to increase participation included posting the recruitment letter for the study and a link to the survey on APRN group pages via the social media site Facebook and the professional networking site LinkedIn.

Data were analyzed using Krippendorff content analysis method to examine qualitative themes of open-ended. Five open-ended questions included: "What factor has been most influential in your job satisfaction/dissatisfaction to date?"; "Is there an issue not included in the survey that you feel is important to your job satisfaction?"; "Do you have any further comments about your transition to your first APRN role?"; and "Please provide any additional information that may help to understand your responses (i.e., relocating for family reasons or starting a family)" were included to assess aspects of the workforce transition that were not captured through the Likert-type questions. Advanced Practice Registered Nurses expressed a need for "support, mentorship, autonomy, learning and professional growth and development, work-life balance, and finding meaning in work" (pp. 3-4) as facilitators of transition and identified "lack of respect,

role ambiguity, lack of support, workload, and compensation” (p. 5) as inhibitors to transition. Recommendations included to improve transitions between the educational and work arena to promote novice ARNP role development, increase retention, continuity of care and improved patient outcomes.

Jones et al. (2015) conducted a descriptive qualitative study to explore Advanced Practice Registered Nurse (APRN) graduate perceptions on the quality of their education and their preparedness to care for the geriatric community. The purpose of this study was to describe the success and limitations of APRN programs in preparing graduates to care for older adults and identify strategies and direction to enhance gerontologic curriculum in APRN programs. A convenience sample of 23 graduates of an APRN program from 2 universities in the western United States from the same parent system participated in focus group discussions or interviews. Both programs had adult APRNs and family APRNs. All students were invited to participate in the interviews. Four main themes emerged from the analysis of qualitative data. The first theme entailed, “Getting your boots on and getting into the role.” Graduates expressed feelings of insecurity and a lack preparation to care for the complex needs of the older adults as well as a dearth of preparation for their new role.

Having available mentors and using technology to fill gaps not provided in their APRN education, and training about caring for older adults facilitated confidence. The second theme identified was, “Older people are more complex than we were prepared to care for.” Graduates felt a need for greater exposure to meaningful clinical experiences with older adults. The third theme identified was, “It is very different as a provider, but I am so glad I was a nurse with experience first.” Advanced Practice Registered Nurses

(APRNs) had varying levels of prior RN experience and APRNs utilized that experience to care for elderly patients to fill the gaps in their APRN education. The fourth theme identified was, “APRNs have a scope of practice, physician assistants (PAs) have a job description—but I wish we had their procedural preparation.” Some of the participants shared the perception that Physician Assistant (PA) education was superior to APRN education because of their procedural skills and because APRNs taught from nursing models and find themselves having to adapt to the medical model in actual practice. Recommendations consisted of a need for more educational content and clinical experiences specific to the care of older adults, in addition, a postgraduate residency or mentoring to assist APRN role transition and progress was suggested.

In the articles previously mentioned, Miller et al. (2017) discussed role transition for nurses that were transitioning in the role of preceptors for novice nurses. Preceptors reported feeling like novice again as well before reverting to an expert status as a preceptor. Preceptors grew in their role simultaneously as they taught new nurses. The recommendations for more administrative support, preceptor training and preparation, and additional time for the transition to the preceptor role spoke volume about where the gap lied and the importance for this study. Similarly, Clipper and Cherry (2015) explored transition to practice and the retention rate of two groups of graduate nurses with respect to having preceptors that were trained and those that were not. Those with trained preceptors tended to have a slightly higher retention rate. Novice Clinical Pharmacists experienced transition shock due to the dearth of support and structure in their working environment leading to job strain and poor transition (Magola et al., 2018). Both Hart and Bowen (2016) and Jones et al. (2015) identified areas of APRNs education that needed

strengthening, and Faraz (2019) identified facilitators and barriers for new APRNs and recommended improving transitions between the educational and work arena to foster role development and improve retention. All these studies emphasized the need for transitional training for all professionals in transition, time for transition, and structured support as a gap in the literature.

Structured Orientation and Nursing

This portion of the literature contained five articles that highlighted the importance of structured orientation on Registered Nurses (RNs) and Advanced Practice Registered Nurses (APRNs) in their new role. Two articles covered structured support programs for nurses. Two articles portrayed the influence of residency programs on novice Advanced Practice Registered Nurses' (APRNs) success. One article discussed the role of mentoring in fostering job satisfaction as a retention strategy.

Hussein et al. (2017) conducted a convergent mixed method study to examine change in new graduate nurses' (NGNs) perception over the 12-month Transitional Support Program (TSP) and identify how organizational factors and elements of clinical supervision altered the confidence levels and satisfaction with the orientation program. The study also explored their experiences and identified change between baseline and follow up at a teaching hospital in Sydney, Australia. A convenience sample of 124 nurses ($N = 124$) participated in the program. All the participants completed the baseline survey (81%), and 87 of them (76%) completed the follow-up survey. The mean age was 23 years ranging from 20 to 53 and three-quarter of the sample were females (78%). Over half of the subjects worked previously as nursing assistants. Two-thirds (63%) of the new graduates worked in non-critical areas and the other third were placed in critical

care settings during the internship. The Manchester Clinical Supervision (MCSS-26) assessed NGNs' perceptions of the quality of clinical supervision, and the Practice Environment Scale-Australia (PES-AUS) evaluated satisfaction with their clinical practice environment. Cronbach's alpha for both instruments were 0.90 and 0.91.

Pearson's chi-square, and paired *t*-test were employed to analyze for change in the subjects' responses between baseline and follow up. A *p*-value of < 0.05 was considered statistically significant. For the open-ended questions, a conventional content analysis (CCA) was utilized. Data were coded and themes were identified and conceptualized. The first theme included orientation and transitional support program as a foundation for success which included three subthemes: instrumental support during transition, understanding the clinical capabilities of the new graduate, and becoming one of the team. The second theme included developing competence with appropriate workload/working within scope of practice, inadequate skill mix, and building clinical confidence and competence.

Findings revealed no statistically significant changes in new graduates' satisfaction with clinical supervision (mean (*M*) MCSS-26 scores = 73.2 vs. 72.2, *p* = 0.503), satisfaction with clinical practice environment (mean (*M*) PES-AUS scores = 112.4 vs 110.7, *p* = 0.298), overall satisfaction with the transitional support program (*M* = 7.6 vs 7.5, *p* = 0.337), satisfaction with the number of study days received, orientation days received (*M* = 6.4 vs. 3.5, *p* = 0.933), and not practicing beyond personal clinical capability (*M* = 3.9 vs 4.0, *p* = 0.629). On the other hand, qualitative data revealed increased workload and mismatch in the level of support against clinical demands and expectations. Two emerging themes included orientation and transitional support

program as foundation for success and developing clinical competence. Five subthemes included instrumental support during transition, understanding the clinical capabilities of the new graduate, becoming one of the team or part of the team, appropriate workload and working within scope of practice, adequate skill mix, building clinical confidence, and competence. Recommendations included the need to consider unmet needs for clinical, social, and emotional support of new graduate nurses and to focus on interventions to ensure effective skill-mix.

Strauss et al. (2015) conducted a cross-sectional quantitative study in Israel at three hospitals and a nursing school with a bridge program to determine whether the transition of the graduates into their working place included a structured orientation program and to assess the effectiveness of the program from the graduate's perspective. A convenience sample of 79 Registered Nurses (RNs) participated in the study. Demographic data included: female graduates (89%), age range 20 to 50 years ($M = 31.01$; $SD = 8.70$); single (26%), married (68%), divorced (7%). Thirty-three percent of the graduates were childless; others had between one (23%) to more than four (13%) children. As for religiosity, 17% were ultra-orthodox, 33% were religious, 19% were traditional, and 30% were secular. Graduates were composed of registered nurses (51%), nurses with a bachelor's degree (41%), and nurses which have a master's degree (4%). Seventy-eight percent (78%) of the graduates had up to 2 years of experience on the job and 22% had between 3 and 5 years of experience.

The participants completed a questionnaire that included closed and open questions. The closed questions were evaluated using a 5-point Likert scale on each item and measured knowledge, being introduced to the staff and their roles, being introduced

to the structure of the department, being introduced to department procedures, and required skills, being introduced to entities in the community and outside the department and general evaluation of the program by the graduate. Cronbach's alpha = 0.91 met the reliability standards for the constructs in this questionnaire. The open-ended question was evaluated utilizing a single item question to answer whether there was a structured program in the department.

Independent *t*-tests were assessed to examine the relationship between retention on the ward and other indices: having an orientation program, satisfaction on the ward, adaptation to the ward, and support. A total number of 50.6% received a structured orientation. A structured orientation program was highly correlated with satisfaction ($r(77) = .86, p < .001$), adaptation ($r(77) = .82, p < .001$), and support ($r(77) = .86, p < .001$). The more the nursing graduates felt they had a structured orientation program, the more satisfied they were on the ward, the more adapted they felt to the ward, and they perceived more support ($r(77) = .75, p < .001$). Retention on the ward was highly correlated with having a program ($t(46) = 3.93, p < .001$), satisfaction ($t(46) = 4.03, p < .001$), adaptation ($t(46) = 4.06, p < .001$) and support ($t(46) = 4.44, p < .001$). No significant correlations emerged between age and retention on the job with all other indices: age ($r = .15$), support and age ($r = .05$) support and retention ($r = -.03$), adaptation and age ($r = -.10$), adaptation and retention ($r = .02$), satisfaction and age ($r = -.03$) satisfaction and retention ($r = .03$) and program and age ($r = .07$), program and retention ($r = .05$).

On the open-ended questions of the questionnaire, graduates identified several factors that assisted them to adapt in their new department. These included: a structured

program that was gradual and accompanied by a preceptor, a professional preceptor who was accessible and available whenever needed, had patience, was not part of the staff when instructing the graduate, gave constructive criticism, gave a sense of security, communicated well, was supportive, humane, and kind, was knowledgeable, was a role model and a caring nurse to her patients. Factors, cited by graduates, that made adaptation more difficult, included (a) lack of a structured orientation program; (b) a preceptor, which was part of the staff while training the new graduate; (c) having different preceptors which caused a lack of continuity in training; (d) heavy ward pressure load and department density; (e) organizational culture, and (f) unrealistic expectations of the graduate.

Regression analysis demonstrated satisfaction and support were highly predictive of having a structured orientation program (satisfaction ($R^2 = .28$, $F(4, 43) = 56.67$, $p < .05$) and support ($R^2 = .46$, $F(4, 43) = 56.67$, $p < .001$). The investigators tested to see if there was an effect for demographical variables: gender, marital status, and number of children, place of birth, religiosity, and education. A significant inverse association was found between religiosity and all the acclimation indices: support, adaptation, and satisfaction. Recommendations included to further research the influence of religion on the acclimation of new nurse graduates (NGNs).

Horner (2017) conducted a nonexperimental, mixed method study to determine whether mentoring, based on Watson's Caring model positively influenced Advanced Practice Registered Nurses' (APRNs) job satisfaction. Watson's Caring model guided the inquiry. A convenience sample of 37 practicing APRNs from a large urban health care setting in Central Indiana participated in the study. The demographics were as followed:

mean age: 49 years of age, years of registered nurse (RN) experience: 2-40 years. Years of experience as an APRN: 27.03%: 3-5 years, 21.62%: 1-2 years and 6-10 years of experience, 13.5%: more than 15 years, 8.11%: 7-10 months, 5.11%: 1-6 months and 2.70% of respondents had 11-15 years within the current organization.

Sixty-nine subjects met criteria and were sent the survey link through an anonymous online survey platform Qualtrics. However, only 54% of the subjects responded ($N = 37$). The survey contained three sections: demographics, mentoring, and the Misener Nurse Practitioner Job Satisfaction Scale (MNPJSS). The demographic survey consisted of 17 questions. The mentor survey consisted of five questions with subsets based on “yes” or “no” response, including open text and questions specific to additional comments. Variables in the survey included: presence of a mentor, gender of mentor, formal or informal, length of time, forms of interaction, and influence on job satisfaction and whether it was beneficial. In addition, the MNPJSS 44-items, 6-point Likert scale was utilized to evaluate APRNs’ satisfaction ($\alpha: .96$).

A one-way analysis of variance with .05 level of significance for cross tabulations were used. Most of the subjects (51.35%) reported not having a mentor while preparing as an APRN. Seventy two percent of the respondents did not have a mentor upon hire, 61.54% reported they would have preferred to have a mentor. Those who reported having mentors were mentored by APRNs. The mentor-mentee relationship was described as informal by 60% of the subjects, 30% had a formal relationship and 10% had a mixture of both. Length of mentorship varied: 30% had 1-3 months of mentorship, 20% had 3-6 months, and 10% had 12 months. Mentoring modalities included: face-to-face mentoring (100%), phone call (30%), text (20%), and e-mail (20%).

Participants reported the mentor experience/relationship positively influenced job satisfaction. Scores from the MNPJSS ranged from 141-246 with a mean of 195.26 ($SD = 28.29$). Retention of APRNs was linked to job satisfaction. Those respondents who were assigned mentors upon hire had higher mean scores than those who did not. Any length of time and all forms of interactions were found beneficial. Ninety-seven percent (97%) of the respondents were willing to serve as mentors. Emerging themes from open-ended questions about mentoring included providing feedback, ability to ask questions and talk with, share/pass knowledge and availability. Recommendations included research with a mentorship focus, use of electronic or e-mentoring especially in rural areas where face to face mentoring was not available. Additional studies that assessed the value and impact of cost-effective mentorships and support programs within hospitals and other health care systems were warranted. Furthermore, the author suggested the need for more qualitative or mixed method studies to be conducted to increase awareness and understanding about barriers APRNs experienced as it related to job satisfaction.

Rugent et al. (2017) conducted a quantitative study to describe the aggregate Nurse Practitioner (NP), now known as Advanced Practice Registered Nurses (APRNs) resident outcomes after attending a 1-year full-time residency program. The residents were evaluated across 69 items in seven competency domains established by the Veterans Affairs Centers of Excellence in Primary Care Education (VA CoEPCE). Evaluation of APRN resident competencies focused on (a) APRN progress (self and mentor evaluation) over the 12-month program using mean scores, (b) the identification of the aggregate highest and lowest scores at 1 and 12 months, and (c) differences between aggregate mean self and mentor scores at 1, 6, and 12 months. A convenience sample of all 38

APRN residents who enrolled in the CoEPCE APRN primary care residency program and their mentors at five sites from 2012 to 2015 were analyzed. Thirty-six APRN residents completed the yearlong program. Two left early for nonperformance-related issues.

Advanced Practice Registered Nurse (APRN) residency enrollment and site participation increased over time, 2012-2013: eight APRN residents across three sites; 2013-2014: 11 APRN residents across four sites; and 2014-2015: 19 APRN residents across five sites.

The demographics consisted of females (84.2%), and 50% had prior training in a CoEPCE as an APRN student; graduates of either a Bachelor of Science in Nursing to Master of Science in Nursing (MSN) program (55.2%) or a graduate entry to advanced practice nursing program (44.8%).

The VA CoEPCE APRN resident 69-items competency assessment tool with seven domains were utilized. The domains include clinical, leadership, interprofessional collaboration, patient-centered care, shared decision-making, sustained relationships, and performance improvement/population management. The rating scale is based on the level of supervision needed to carry out professional activities. The levels are as follows: 0 (not performed/not observed), 1 (observes task only), 2 (needs full supervision), 3 (needs supervision periodically), 4 (is able to perform without supervision), and 5 (able to supervise others). Advanced Practice Registered Nurse (APRN) residents were expected to show proficient independent practice in all domains by the completion of the program. The APRN resident and his and/or her designated mentor independently completed the competency tool at 1, 6, and 12 months. The mentor had direct knowledge of residents' performance as APRN residents presented patients' cases to them. Mentors also gathered information about performance from electronic medical record review and feedback from

other providers and clinic staff. After completion of 1, 6, and 12 months, the APRN resident and mentor discussed their competency ratings (Rugen et al., 2017). Preliminary psychometric analysis demonstrated high internal consistency (among the items) for each of the seven domains when scored by the APRN resident and mentor (Cronbach alpha: 0.86-0.95).

A two-tailed standardized *t*-test was used to assess for statistically significant mean differences between APRN resident and mentor mean scores for each domain at each time point. Generalized linear models were used to statistically test (for each domain) whether APRN residents (when assessed by either themselves or by their mentors) progressed with increasing score values over the 12 months. Mean APRN resident self-ratings and mean mentor ratings demonstrated statistically significant improvement in all domains ($p < .0001$). At 12 months, APRN residents were rated by their mentors as able to practice without supervision in all competency domains. The average mean scores for the seven categories for both APRN residents and mentors at 1 month and 12 months were as followed. Clinical competency: APRN residents at 1 month $M = 2.7$ ($SD = 0.81$), APRN Mentors $M = 2.78$ ($SD = 0.86$) and at 12 months APRN residents $M = 4.2$ ($SD = 0.65$), APRN mentors $M = 4.3$ ($SD = 0.71$). Leadership mean scores at 1 month for APRN residents were $M = 1.6$ ($SD = 1.57$) and $M = 1.58$ ($SD = 1.57$) for APRN mentors; at 12 months, $M = 4.0$ ($SD = 1.20$) for APRN residents and $M = 4.3$ ($SD = 1.08$) for APRN mentors. The mean scores for interprofessional team collaboration at 1 month for APRN residents were $M = 3.47$ ($SD = 0.90$); APRN mentors $M = 3.43$ ($SD = 1.06$) and at 12 months APRN residents mean scores were $M = 4.64$ ($SD = 0.47$), and APRN mentors $M = 4.57$ ($SD = 0.55$). The mean scores for patient-centered

care at 1 month for APRN residents were $M = 3.2$ ($SD = 0.89$) and $M = 3.2$ ($SD = 1.07$) for APRN mentors; at 12 months $M = 4.58$ ($SD = 0.51$) for APRN residents and $M = 4.57$ ($SD = 0.53$) for APRN mentors.

The mean scores for shared decision-making at 1 month for APRN residents were $M = 3.17$ ($SD = 0.93$) and $M = 3.2$ ($SD = 1.05$) for APRN mentors; at 12 months $M = 4.47$ ($SD = 0.48$) for APRN residents and $M = 4.6$ ($SD = 0.64$) for APRN mentors. The mean scores for sustained relationships at 1 month for APRN residents were $M = 3.45$ ($SD = 0.92$) and for APRN mentors $M = 3.48$ ($SD = 0.94$); at 12 months $M = 4.55$ ($SD = 0.51$) for APRN residents and $M = 4.65$ ($SD = 0.57$). The mean scores for performance improvement for APRN residents at 1 month were $M = 2.14$ ($SD = 1.58$) and $M = 1.7$ ($SD = 1.54$) for APRN mentors; at 12 months $M = 3.98$ ($SD = 0.98$) for APRN residents and $M = 3.94$ ($SD = 1.32$) for APRN mentors. At 1 and 12 months, clinical, leadership, and quality improvement/population management competencies were the lowest scored domains while patient-centered care, interprofessional team collaboration, shared decision-making and sustained relationships competencies were highest. The results provided evidence for the effectiveness of VA CoEPCE APRN residency programs and underscored areas that required improvement. Recommendations for faculty development needed to be done to standardize mentor assessment, potentially through increased direct observation and portfolios, to make the competency tool as relevant as possible to objectively measure competency achievement.

Flinter and Hart (2017) conducted a qualitative study utilizing Krippendorff's content analysis. The research was completed to evaluate 1200 reflective journal entries of 24 residents from five cohorts of residents starting with the 2008-2009 cohort and

ending with the 2012-2013 cohort who completed a year-long residency program in the first primary care Advanced Practice Registered Nurse (APRN) residency in the United States. The purpose of the study was to understand the experience of Advanced Practice Registered Nurses (APRNs) in a residency program in the United States and how the program facilitated their transition to the role of primary care provider. Theoretical frameworks of the Transitions Theory and Dreyfus' five stage model of Adult Skill Acquisition guided the inquiry.

The demographics included: female, aged from 24-51 years ($M = 30$ years), completed the master's degree in nursing less than 18 months prior to starting the residency, and secured board certification as family Advanced Practice Registered Nurses (APRNs) no later than one month after starting the residency. Residents had 0 to 6 years of nursing experience prior to the residency, with an average of two years; eight of them had no prior experience working as RNs, and one had practiced as an APRN for one year. Journals were analyzed through content analysis. Data were coded and themes were identified month by month with chronologic ordering of the major themes that emerged across the journals of all 24 Residents, which was merged into major quarterly themes.

The quarterly themes included: First quarter (September–November) from euphoria to shock and awe; Second quarter (December–February) from exhaustion to heads above water; third quarter (March–May) managing complexity to awareness of emerging competency; fourth quarter (June–August) comfort with APRN role and commitment to primary care for the underserved and anticipating the future. The final themes included of a sense of being transformed into a confident primary care provider who can cope with challenges. Residents expressed a deep appreciation for the residency

program, preceptors, and each other. They also felt more capable of caring for their own panel of patients and were ready to embrace the role. Core facilitators in the program comprised engaged preceptors, didactics, specialty rotations, procedures, building a patient panel and special community events. Whereas persistent stressors involved managing chronic pain and request for opioids, insufficient clinical support staff and impact of poverty and social determinants of health on health and health care.

Recommendations for program improvement included the residents' request for more feedback, more assignments, and testing throughout the year of residency and dedicated support staff such as medical assistants and Registered Nurses specifically assigned for the residents. In addition, further study to include other postgraduate APRN training programs across the United States would be valuable to establish if the organizations that are hosting APRN residencies to invest on new APRNs and determine whether potential national investments were necessary.

In the articles, Hussein et al. (2017) identified unmet needs for clinical, social, and emotional support of new graduate nurses and to focus on interventions to ensure effective skill-mix as areas of improvement for transitional programs. Strauss et al. (2015) reported structured orientation as aiding new graduate nurses to feel supported in their new role. Both Rugent et al. (2017) and Flinter and Hart (2017) depicted the reality of the first year of transition for new Advanced Practice Registered Nurses (APRNs) and how the safety net environment assisted new APRNs in their role development and competence at the end of the residency. Furthermore, Horner (2017) reiterated the importance of mentoring in determining new APRNs' job satisfaction and retention when supported. Hussein et al. (2017) provided key elements to consider when structuring

orientation programs for new graduates, while the other four studies highlighted the benefits of structured orientation.

Turnover Intentions and Nursing

This portion of the literature contained five articles that identified several factors that could propel turnover intentions in new graduate nurses and Advanced Practice Registered Nurses (APRNs). Two articles concerned factors leading to APRNs' turnover intent. Three articles featured Registered Nurses' (RNs) turnover intent. All five articles showcased aspects of organizational practices that can affect turnover intentions.

Faraz (2017) conducted a descriptive cross-sectional study through an online survey utilizing a convenience sample of 177 Advanced Practice Registered Nurses (APRNs) practicing in primary care (PC) settings. The purpose of the study was to assess workforce transition and turnover intention of novice APRNs in primary care (PC). Through a thorough review of the literature, the primary investigator delineated individual characteristics, role acquisition and job satisfaction of novice APRNs, and distinguished factors leading to their successful transition and turnover intention in the first year of PC. Participants were recruited through all Commission on Collegiate Nursing Education (CCNE) accredited master's nursing programs, social media sites and snowballing. Twenty-nine APRN educational programs from all regions of the United States and five APRN residency/fellowship programs redirected the e-mail to their graduates.

A total of 293 surveys were started, and 177 completed the surveys and met inclusion criteria. The sample contained 92.9% ($n = 158$) women with an average age of 35 ($SD = 8.2$), 79.7% ($n = 141$) held a master's degree in nursing. The survey and

questionnaire included six previously established scales and investigator-developed demographic questions. The scales focused on role acquisition, job satisfaction, turnover intention, self-confidence, social support, educational background, and prior work experience. Likert scales were utilized for the questionnaire except for demographic data, educational background, and prior work experience questions.

The research revealed greater professional autonomy in the workplace decreased turnover intention in novice APRNs in primary care and promoted job satisfaction for APRNs in the study. Based on the data from the standard multiple regression model, professional autonomy ($p = .001$) and role ambiguity ($p = .03$) were two variables that mostly predicted APRNs' intention to leave their new positions as APRNs. The model accounted for approximately 48% of the variance in turnover intention ($R^2 = .476$). Professional autonomy remained significant ($\beta = -.44, t = -3.42, p = .001$) and role ambiguity was significant ($\beta = -.20, t = -2.14, p = .03$). Self-confidence and perceived competence were a significant predictor of turnover ($\beta = -.29, t = 3.95, p < .001$). Recommendations for practice included finding solutions to provide adequate professional autonomy and support APRNs during the transitional period of their first year of employment.

Buffington et al. (2012) conducted a mixed method descriptive survey study involving Registered Nurses (RNs) with 1 or more years of experience that provided direct patient care in inpatient and ambulatory settings in an acute care academic magnet hospital in Colorado. The purpose of the study was to examine factors affecting Registered Nurses' retention and to validate the revised Casey-Fink Nurse Retention Survey (2009). Six hundred and seventy-seven nurses met inclusion criteria of which

91% of them were female ($n = 657$) and 40 years of age. Inpatient RNs consisted of 72% ($n = 477$) and 28% of the nurses comprised of ambulatory RNs ($n = 185$). Subjects had an average of 13 years as a nurse with about 7.5 years employed.

Nurses completed the survey consisting of 33 items related to work environment, support, and encouragement using a Likert scale; of which an exploratory factor analysis of all the completed surveys using the Kaiser criterion was completed. Four factors set of correlated subscales emerged: recognition/rewards, professional nursing role, mentorship, and scheduling flexibility. The fifth item consisted of demographic data. Subjects chose 1 item from a preconstructed list to state the top reason for continuing to work in their current job. The final section consisted of four open-ended questions related to praise, recognition, and retention. Quantitative data were entered into SPSS version 19. Survey items and demographics were summarized using descriptive statistics, tests of difference and association, and t -test were used. Qualitative data were managed using a general inductive approach to identify themes.

Findings revealed no statistically significant relationships between nurse respondents' perceptions of work environment, support, encouragement and age or years of experience. Inpatient, $n = 454$, $M = 27.14$ ($SD = 3.50$), $p = .785$; Ambulatory, $n = 178$, $M = 27.27$ ($SD = 4.21$), $p = .785$. There were significant differences between inpatient and ambulatory nurse responses in several key areas including job satisfaction, mentorship, and educational support. The results were as followed. Recognition and Rewards: Inpatient, $n = 445$, $M = 39.28$ ($SD = 7.03$), $p = .032$; Ambulatory, $n = 164$, $M = 37.84$ ($SD = 8.07$), $p = .032$. Mentoring: Inpatient, $n = 435$, $M = 24.91$ ($SD = 3.27$), $p = .000$; Ambulatory, $n = 148$, $M = 22.90$ ($SD = 4.00$), $p = .000$. Scheduling flexibility:

Inpatient, $n = 471$, $M = 4.91$ ($SD = 1.58$), $p = .002$; Ambulatory, $n = 176$, $M = 5.30$ ($SD = 1.33$), $p = .002$. Nurses reported feeling lack of support and a dearth of mentorship and recognition from managers and educators. While only 3% of nurses left this magnet hospital, the hospital leadership incorporated the findings of this study to foster better nurse retention strategies. Future recommendations suggested utilizing this survey in other hospital settings to enhance the validity of the data.

Abubakar et al. (2015) conducted a cross-sectional study to investigate the mediating effect of organizational trust on training and development and turnover intention as well as compensation practices and turnover intention among Registered Nurses (RNs) in Nigerian public hospitals. The Social Exchange Theory guided this study. A convenience sample of 175 RNs was utilized of which 47 were males and 128 were females. Subjects were between 21-30 years of age (11.43%), 62 of them ranked between 31-40 (35.43%) years of age. Majority of the subjects were between 41-50 years of age (42.86%) and the remaining 18 were 51 years of age and above (10.29%). The participating nurses held varying positions in nursing administration.

The subjects completed a self-administered questionnaire to include demographic variables. A three-item Turnover Intention Scale ($\alpha = .87$) included an item on the likelihood that an employee would resign from the hospital. A six-item Organizational Trust Subscale ($\alpha = .90$) had an item whether management can be trusted to make sensible decisions for the hospital's future. A six-item Human Resource Management (HRM) Practice Scale ($\alpha = .88$) was employed, and a sample item discussed whether amount and duration of training program in their hospital were satisfactory. Preacher and Hayes' (2008; 2004) bootstrapping resampling technique was applied to estimate indirect

effects in simple mediation model because of its suitability for mediation analyses with small sample size. Total and direct effects of Human Resources Management (HRM) practices on turnover intention are ($-0.6323, p < .01$, and $-0.6651, p < .01$). The analysis revealed organizational trust play a role in between HRM practices and predicted turnover intention. Recommendations included considerations of a longitudinal study and to collect data from diverse populations.

Poghosyan, Lui, Shang and D'Aunno (2017) completed a cross-sectional survey design on practicing Advanced Practice Registered Nurses (APRNs) in 163 primary care organizations in Massachusetts in 2012. The purpose of the study was to examine APRN practice environments in primary care organizations and the extent to which they were associated with APRN retention measures. Conceptual underpinnings were based on theoretical and empirical research in organizational studies demonstrating that employees' view of their work atmosphere influence their behaviors, performance, and outcomes. The convenience sample consisted of 314 Advanced Practice Registered Nurses (APRNs). Most of the demographics consisted of women (97.3%), White (93.3%), and a master's degree (92.1%). The mean age of the participants was 50 years old. Organizational level was measured utilizing the 29-items, 4-point Likert scale Nurse Practitioner Care Organizational Climate Questionnaire (NP-PCOCQ) to assess practice environments in primary care. The tool had four subscales: NP-Physician Relations ($\alpha: .90$), NP-Administration Relations ($\alpha: .95$), Independent Practice and Support ($\alpha: .89$) and Professional Visibility ($\alpha: .87$). Advanced Practice Registered Nurses' Job satisfaction level was measured using a single item with 4-point Likert scale to rate their satisfaction from "very satisfied to very dissatisfied and their intent to leave the job was measured

with a yes/no item: “Do you plan to leave your current position in the coming year?” This item was used previously in surveys of nurses but not with APRNs. Cronbach’s alphas met the reliability standards for the constructs in the NP-PCOCQ scale.

Multilevel logistic regression models were utilized to investigate the relationship between APRN practice environment and the outcome variables. The four NP-PCOCQ subscales were measures of APRN practice. Pearson’s correlation coefficients among them were significant. Findings revealed APRNs rated the relationship between APRNs and physicians favorably, contrary to the relationship between APRNs and administrators. All subscales measuring APRN practice environment had similar influence on the outcome variables. With every unit increase in each standardized subscale score, the odds of job satisfaction factors increased about 20% whereas the odds of intention turnover decreased about 20%. Advanced Practice Registered Nurses (APRNs) from organizations with higher mean scores on the NP-administration subscale had higher satisfaction with their jobs ($OR = 1.24$, 95% CI (1.12, 1.39)) and had lower intent to leave ($OR = 0.79$, 95% CI (0.70, 0.90)). Recommendations suggested examining the impact of APRN job satisfaction and intent to leave on patient outcomes in future studies.

Church et al. (2018) conducted a retrospective correlational study to determine the effect of autonomy, competence, group cohesion, structural empowerment, and job satisfaction on organizational commitment, turnover intent, and actual job turnover using secondary data of 1,498 new licensed Registered Nurse (NLRN) residents. A convenience sample of 1498 (95%) NLRNs from the 2011 cohort participated in a residency program in general acute care hospitals across the United States. Data were

collected over the course of the 1-year residency and annually up to 5 years. The demographics consisted of female: 1278 (86.5%), male: 200 (13.5%); age range in years: 20-25 (40.6%), 26-30 (26.4%), 31-35 (14.7%), >36 (18.2%); most of the subjects were White (69.6%); educational level included associate (42.2%), baccalaureate (56.2%), and Master's (1.2%).

The variables in the study were measured using appropriate scales. Autonomy was measured using Schutzenhofer Professional Nursing Autonomy (SPNA) Scale (α : .91), Group Judgment Scale (GJS) (α : .90) measured group cohesion, Slater Nursing Competencies Rating Scale (α : .99) measured competence, Nursing Job Satisfaction Scale (NJSS) (α : .77) measured job satisfaction. Structural empowerment was measured using Conditions for Work Effectiveness Questionnaire-II (CWEQ-II), Job Activities Scale (JAS), and Organizational Relationships Scale (QRS) (α : .83, .77, .88), organizational commitment was measured using Organizational Commitment Questionnaire (OCQ) (α : .91) and turnover intent and actual job turnover was measured utilizing a single-item scale, "Do you plan to leave this facility in the next year?"

To conduct analysis of the hypothesized path model in actual turnover the Mplus 7.4 was employed. Descriptive statistics of and correlations between the variables in the path model were analyzed. The results demonstrated that participants experienced higher levels of total structural empowerment, job satisfaction, and competence in their work, moderate levels of autonomy and commitment, and lower group cohesion. Turnover intent at 1 year from the start of the residency was low with a mean score of 2.00 of 6 ($SD = 1.36$). At 2 years, 91.7% ($n = 1373$) of the sample remained employed whereas 8.3% ($n = 125$) resigned from the organization. The proposed path model was not a good

fit for this sample of X data. The R^2 statistics demonstrated that a 14.7 % variance in organization commitment was explained by the antecedent variables ($p < .001$) as well as 14.7% of the variance in turnover intent ($p < .001$). Therefore, the findings of the study showed that individuals who experienced higher levels of organizational commitment have decreased intent to leave their organization. Recommendations included the impetus for nurse administrators to support the development and effectiveness of nurse residency programs in their organizations.

The studies in this section of the literature review considered of factors leading to turnover intentions. Faraz (2017) identified professional autonomy, role ambiguity, self-confidence, and perceived competence as predictors of turnover. Buffington et al. (2012) reported feeling lack of support, mentorship, and recognition from managers and educators as factors. Abubakar et al. (2015) reported organization trust and human resources practices decreased turnover intention. Poghosyan et al. (2017) cited APRNs' poor relationships with management as a factor for job turnover, while accentuating organizational support as being crucial for retention. In addition, Church et al. (2018) found individuals with higher levels of organizational commitment exhibited decreased turnover intent. All five studies were interrelated as many factors led to turnover intentions. While all five studies differed in focus, the gap existed that those without adequate support in their position are more likely to leave their current job.

Meleis' Transitions Theory and Nursing

Meleis' transitions theory has had a profound impact on nursing practice. Studies among healthcare professionals that have utilized this theory in practice are presented in this section.

Wildermuth et al. (2019) conducted a transcendental phenomenological qualitative study at a small Midwestern college of nursing and an affiliate hospital to explore the lived experiences of a cohort of nurses as students and new graduate nurses during transition in a collaborative nurse residency program. Meleis' Transitions Theory guided this inquiry. A convenience sample of 15 participants who were part of the first collaborative nurse residency program and met inclusion criteria were recruited; nine participants agreed to partake in the study. Participants had face-to-face interviews lasting 45-90 minutes in a private room at the college of nursing. Data were analyzed, grouped into themes, both textual and structural descriptions, and confirmed.

Findings consisted of three major themes and subthemes. Major themes included: feeling overwhelmed, feeling supported, and feeling confident. Subthemes included: communication with physicians, relationships with experience nurses, jumping in, and learning. Results of this study were consistent with Meleis' five essential properties of transition as evidenced by participants' expression of awareness of the transition and feelings of being overwhelmed in difficult clinical situations to engaging with their preceptors and feeling supported. Defining moments included positive feedback from patients and being able to help their colleagues. Engaging in learning with their preceptor and learning from experienced nurses were personal factors that facilitated transition. Community factors included the overwhelming support from preceptors, which built their confidence. Society conditions that hindered transition for new nurses were the negative attitude of experienced nurses toward them.

Recommendations for practice included the ongoing need to continue to understand the transition experience of new graduate nurses and identified strategies that

could facilitate transition. It was advised for faculty to collaborate with managers to identify preceptors that students would work with in their clinical immersion and when they began their practice as a new nurse. Prolonged engagement with a preceptor that began in a clinical immersion experience during nursing school and extended through orientation as a new graduate nurse was a model that could facilitate transition. Hospitals should consider partnerships with schools of nursing where relationships between preceptors and students can develop and grow resulting in retention and recruitment.

Kim and Shin (2020) conducted a cross-sectional, correlational quantitative study in Korea using the transitions theory. The purpose of the study was to develop a theoretical model that assesses factors affecting professional socialization using Transitions Theory as the theoretical framework and to verify the effects of the relationships among the variables used in the model. The objectives of this study were to verify the suitability of the professional socialization model of nursing students based on Meleis' Transitions Theory, clarify the direct and indirect effects of related factors, and delineate the differences between third- and fourth-year nursing students. A structural model study was used.

A convenience sample consisted of 412 third- and fourth-year nursing students who completed at least one semester of clinical practice or completion of a clinical course within 4 weeks prior to the study at one of seven nursing colleges in a hospital setting in Korea. The demographics consisted of 220 (53.4%) third-year students and 192 (46.6%) fourth-year students. Average age of subjects were 23.9 years of age; 344 (83.5%) subjects were females, and 68 (16.5%) subjects were males. In this study, clinical practice competency and the clinical learning environment were treated as transition

conditions. Process indicators included transition shock and adaptation to clinical practice while professional socialization comprised outcome indicators.

The students completed demographic questionnaires. Several measurements were utilized to assess clinical practice competency, clinical learning environment, transition shock, adaptation to the clinical practicum, and professional socialization. A 19-item, 5-point Likert scale Clinical Practice Competency by Joo and Sohng (2014) measured clinical practice competency. The scale measured communication skills, core nursing skills, integrated nursing through critical thinking, nursing leadership and stress management. Cronbach's alpha = 0.93 met the reliability standards and validity of subfactors was good ($\beta = .56 \sim .84$). Clinical learning environment was evaluated using an adapted version of Saarikoski and Leino-Kilpi (2002)'s 19-item, 5-point Likert scale Korean version of the Clinical Learning Environment, Supervision and Nurse Teacher Evaluation Scale. This scale measured learning environment in wards, leadership styles of ward managers, students' relationships with supervisors, and nursing care on the wards. Cronbach's alpha = 0.93 met the reliability standards and validity of subfactors was good ($\beta = .60 \sim .76$).

Transition shock was measured by Kim and Shin (2018)'s 14-item, 4-point Likert scale. The scale assessed the domination of an overwhelming workload, confusion in professional nursing values, daunting relationships, loss of social support, and disharmony between personal life and practice. Cronbach's alpha = 0.83 met the reliability standards and validity of subfactors was acceptable ($\beta = .49 \sim .67$). Adaptation to the clinical practicum was measured using Yi (2007) measurement scale, which included three factors: adaptation to assignments (seven items), adaptation to the

environment (three items), and satisfaction with clinical practice (four items) using a 5-point Likert scale. Cronbach's alpha = 0.85 met the reliability standards and validity of subfactors which was nearly acceptable ($\beta = .38 \sim .81$). Professional socialization was measured using Toit (1995)'s 34-item, 5-point Likert scale and assessed the domain of a calling, maturity, independence and decision making. Cronbach's alpha = 0.92 met the reliability standards and validity of subfactors was acceptable ($\beta = .48 \sim .79$). Exploratory and confirmatory factor analyses were performed for the scales except for the clinical practice competency scale.

Data were analyzed using SPSS version 24.0 and AMOS version 24.0. Pearson's correlation coefficient determined multicollinearity between the variables. The model was verified for goodness of fit and multiple group analysis assisted to ascertaining the differences between third- and fourth-year students. Theoretical model suitability and measurement model homogeneity were appropriate: $X^2 = 475.162$, $df = 176$, $X^2/df = 2.70$, $GFI = .903$, $TLI = .891$, $CFI = .909$, and $RMSEA = .064$. Homogeneity tests assessed for differences between education years of the two groups by evaluating a constrained (model ($X^2 = 683.635$, $df = 368$, $X^2/df = 1.858$, $GFI = .866$, $TLI = .890$, $CFI = .904$, and $RMSEA = .046$) and an unconstrained model ($X^2 = 660.584$, $df = 352$, $X^2/df = 1.877$, $GFI = .870$, $TLI = .888$, $CFI = .906$, and $RMSEA = .046$). The difference in the degrees of freedom between the two models was insignificant ($\Delta X^2 = 23.051$), which established cross-validity. The investigators established and verified a theoretical framework that promoted the understanding of nursing students' professional socialization based on Meleis' Transitions Theory. A multiple group analysis revealed the clinical learning environment had no significant impact on third-year students' adaptation to the clinical

practicum ($\beta = -.17, p < .064$) but had a significant impact on fourth-year students ($\beta = .10, p < .024$). Third-year nursing students require active interventions to support them with transition shock and the path to professional socialization through adaptation to clinical practice because this group only had one semester of exposure to the clinical environment.

The impact of transition shock on adaptation was more significant for third year students ($\beta = -.72, p < .001$) than fourth-year students ($\beta = .82, p < .001$). Clinical practice competency on professional socialization was only significant for fourth-year students ($\beta = .82, p < .001$), underscoring the necessity to further improve clinical practice competency. Recommendations proposed that nursing programs enhanced the educational environment of clinical practice and support students to develop clinical competency.

Pilat and Merriam (2019) conducted a transcendental, phenomenological study in an acute hospital in New York State (NYS) to develop a broader understanding of the perceptions of nurse managers' lived experience of transitioning from a staff nurse into a leadership role. Meleis' Transitions Theory provided the theoretical framework for the study. Ten nurse managers: eight female and two male participants, who met sample criteria participated in the study. Semi-structured interviews were conducted with the leading question "What is it like to transition from staff nurse to leadership role?" Interviews were audio recorded and transcribed verbatim. Data were coded, and themes were identified and conceptualized. Colaizzi's seven procedural steps to data analysis were used to explore, analyze, and describe their experiences.

Findings consisted of major themes and subthemes. The first theme included expectations, with the subthemes: expectations were not clear and not providing onboarding. The second theme consisted of essential knowledge and skills, with the subthemes: finance, balance, and emotional intelligence. The third theme included graduate education prepared, with the subthemes: connection, teaches skills. The final themes were sought support and mentoring from colleagues, role mastery not possible. Each major theme was correlated to Meleis' Transitions Theory and transition conditions. New nurse managers were expected to be competent and high performers immediately. Participants did not receive proper onboarding to the role, had unclear role expectations, and expressed uncertainty in their knowledge and skills to be successful as managers. The nurse managers who had master's degree preparation felt it assisted them to relate to staff nurses. There was no formal mentoring program at the organizational level leaving nurse managers to rely on their comanagers for support. All 10 nurse managers expressed they could not achieve role mastery.

Recommendations for practice included implementing a nurse manager onboarding process, supporting, and mentoring to mitigate challenge that staff nurses faced during transition to a leadership role, and facilitating achievement of mastery in the role. Recommendations also included developing a support role transition program that was geared toward new nurse managers' skill attainment and needs. A follow-up study on nurse managers perceptions of how the program aided them and how to facilitate the achievement of role mastery was needed. In addition, exploring the impact of nurse manager turnover on staff, patient, organizational, and financial outcomes may substantiate the significance of providing support and resources during the transition.

Barnes (2015) conducted a descriptive, cross-sectional quantitative study of practicing Advanced Practice Registered Nurses (APRNs) to examine whether prior Registered Nurse (RN) experience and a formal orientation influence role transition. Meleis' Transitions Theory guided the research. Prior RN experience was examined as a personal-level transition condition, and receiving a formal orientation was examined as a community- or environmental-level transition condition. The theory stipulated that a successful transition was characterized by a subjective sense of well-being, increased confidence and competence, mastery of skills, and autonomous practice, whereas an unsuccessful transition was characterized by negative emotions, a lack of confidence, turnover, and limited support.

The convenience sample consisted of 352 participants at a national APRN conference. Inclusion criteria were APRNs who were practicing in direct patient care within the U.S., held a graduate degree to practice as an APRN, were able to speak and read English, and had been working as an APRN for at least 6 months in the first APRN position. Demographics included mostly females (88.6%), White (81.8%), with a mean age of 47 years. A majority (86.6%) held a Master of Science in nursing as their highest nursing degree. Years of APRN experience ranged from 6 months to 23 years, with a mean of 7.7 years. The most frequently cited population focus was family (47.9%), and almost 60% of the sample practiced in an outpatient/ private practice office setting.

A 16-item, 5-point Likert Scale Nurse Practitioner Role Transition Scale (NPRTS) measured participants' perceptions of their own APRN role transition experience. Measured concepts in the NPRTS scale included feelings of support versus isolation, understanding of their role by patients, physicians, and other staff, and feeling

prepared to manage patients and time. Exploratory factor analysis identified developing comfort and building competence in the role, understanding of the role by others, and collegial support as three dimensions that explained role transition. Single-item questions measured prior RN experience and receiving a formal orientation in the first APRN role. Cronbach's alpha = 0.87 met the reliability standard for the NPRTS scale.

Pearson correlations between the variables were evaluated, and an independent *t*-test was used to compare the mean scores on the NPRTS between those participants who reported receiving a formal orientation and those who did not. A multiple regression analysis was used to test if prior RN experience and a formal orientation explained APRN role transition. Findings indicated prior experience had a nonsignificant relationship with the APRN role transition ($p = .12$). Thirty-three percent of the participants received a formal orientation in their first APRN position and was positively correlated with APRN role transition ($p < .001$). This supports Meleis' Transitions Theory that formal orientation promoted APRN role transition. The multiple regression model did not explain much of the variance in the dependent variable (9%), and only a formal orientation contributed significantly. Therefore, the possibility that 91% of APRN role transition is explained by other unidentified factors must be considered. Recommendations in this study suggested that APRN educators tailor clinical requirements and placements in preparing APRNs for practice especially because schools of nursing currently admit students into Master of Science in nursing and Doctor of Nursing practice programs with no prior practice requirements. Additionally, knowledge that formal orientation facilitates role transition can encourage administrators to explore hiring and orientation policies that can provide the essential support for wider development of these programs.

Future research was needed to investigate the relationships of the variables further as well as additional factors that could best support new APRNs.

Kumaran and Carney (2014) conducted a Heideggerian hermeneutic phenomenology study to present a holistic picture of what is being experienced by newly qualified nurses during their role transition. The aim of the research was to identify and understand the experiences of role transition from student nurse to newly qualified registered general nurse in an Irish context and to identify strategies that promote and support role transition. Meleis' Transitions Theory was used to guide the inquiry. Ten newly qualified nurses from one of Dublin's Academic Teaching Hospitals were interviewed. Data collection was retrospective in nature. A single interview that lasted about 45-60 minutes was used to explore the role transition of each student nurse participant. Data were coded and themes were identified and conceptualized. Van Manen's (1990) thematic analysis of data was used.

Findings consisted of two major themes and subthemes. Major themes included initial feelings and experiences and inherent highs and lows of qualification and standing on their own two feet. Subthemes included initial feelings and experiences, becoming visible, mounting confidence, assimilation anxiety and associated stress and being responsible and accountable. The themes had relevance to Meleis' Transitions Theory in relation to the absence of familiar reference points for students and new difficulties in unfamiliar roles, confidence issues, and need for greater supervision. The study also identified independent responsibility as an integral step in the transition process as well as the need for support and time to adjust to new responsibilities. Strong supportive

preceptorship from experienced staff can facilitate the transition process.

Recommendations included the need to perform this study with a larger sample size.

The studies presented in this section of the literature review utilized Meleis' Transitions Theory as a theoretical framework. Wildermuth et al. (2019) demonstrated how graduating nurses could be supported through prolonged engagement with a preceptor in their clinical practicum and after graduation and provided a stable environment that facilitated their role development despite the lack of support from other colleagues. Kim and Shim (2020) utilized Meleis' Transitions Theory to demonstrate how to enhance the educational environment of clinical practice and support students to develop clinical competency. Pilat and Merriam (2019) identified a need to develop a nurse manager's support role transition program. Barnes (2015) demonstrated formal orientation as a predictor of successful role transition and Kumaran and Carney (2014) explored the lived experiences of new nurses in transition. All five studies identified the need for structured orientation for those in transition to promote success in the role.

Chapter Summary

This chapter presented a review of the body of literature relevant to structured orientation and its impact on role transition and turnover intentions of healthcare professionals. It examined four areas pertinent to the study: role transition and healthcare professionals, structured orientation and nursing, turnover intentions and nursing, and the utilization of Meleis' Transitions Theory in the practice of nurses. The review revealed that novice healthcare professionals require structured support as they transition into their new role. Scholars demonstrated that structured orientation enhances role transition, improves self-confidence, job satisfaction and patient

outcomes and decreased turnover intentions. Furthermore, this chapter presented Meleis' Transitions Theory as a framework that can be utilized for research and practice. Although there was an abundance of scholarly work on structured orientation, the review identified a gap in practice as it related to the availability of structured orientation and support for all novice Advanced Practice Registered Nurses (APRNs). This positioned the need for the study at hand. It is hoped that the study findings would add to the body of nursing knowledge about the impact of structured orientation on role transition and turnover intentions on novice APRNs in their first position. Chapter Three follows with the methodology that was used to conduct the study.

CHAPTER THREE

METHODS

The purpose of this correlational study was to investigate the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses (APRNs) in their first APRN position. It is the hope that the findings of the study would stimulate the institution of structured orientation for all new APRNs so that they experience a seamless role transition and decrease job turnover intentions. The following areas are delineated in this chapter: restatement of research questions and hypotheses, overview of the design, sample and setting, inclusion and exclusion criteria, ethical considerations, access and recruitment procedures, data collection procedures, instrumentation, data management and storage, validity and reliability, data cleansing, and data analysis plan.

Restatement of Research Questions and Hypotheses

The research questions and hypotheses were as followed:

RQ₁. Do novice Advanced Practice Registered Nurses (APRNs) who received structured orientation in their first APRN position have better role transition when compared to those who did not receive structured orientation?

H₀. Role transition mean scores for novice Advanced Practice Registered Nurses who received structured orientation in their first position are equal to those who did not receive structured orientation.

H₁. Role transition mean scores for novice Advanced Practice Registered Nurses who received structured orientation in their first position are higher than for those who did not receive structured orientation.

RQ₂. Do novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position have lower job turnover intentions when compared to those who did not receive structured orientation.

H₀. Turnover intentions mean scores for novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position are equal to those who did not receive structured orientation.

H₂. Turnover intentions mean scores for novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position are lower than for those who did not receive structured orientation.

RQ₃. Is there a negative correlation between novice Advanced Practice Registered Nurses' role transition scale scores on the Nurse Practitioner Role Transition Scale (NPRTS) and turnover intentions scale scores as measured on the Turnover Intention Scale (TIS-6)?

H₀. There is no correlation between NPRTS scores and TIS-6 scores for novice Advanced Practice Registered Nurses.

H₃. There is a negative correlation between NPRTS scores and TIS-6 scores for novice Advanced Practice Registered Nurses.

Overview of the Design

The study was positioned within the positivist paradigm. Positivists affirmed that knowledge attainment should be objective and free of bias (Polit & Beck, 2017). Within this paradigm, research is deductive, scientific, and conventional. As such, the positivist paradigm was best suited to investigate the impact of structured orientation (a

mentorship, a preceptorship, or a residency experience) on role transition and turnover intentions of novice Advanced Practice Registered Nurses (APRNs) in their first APRN position. This study utilized a cross-sectional correlational research design. A non-experimental design was fitting to test the hypotheses because the researcher did not manipulate the variables or the environment in the study (Polit & Beck, 2017). A cross-sectional method enabled the researcher to investigate the variables of interest at a single point in time within the target population. The researcher did not seek to establish a cause-and-effect relationship in this study. Rather, a correlational design was employed to examine relationship between variables (Polit & Beck, 2017).

Sample and Setting

A sample is defined as a subset of a population (Polit & Beck, 2017). A sample was used because it was easier to collect data in this way than from the entire population. There are two types of sampling methods: probability and nonprobability (Wood & Ross-Kerr, 2011). Probability sampling denotes that every component in the population has a known probability of being included in the sample. Probability sampling includes systematic sampling with a random start, simple random sampling, stratified random sampling, and cluster (multistage) sampling. Systematic sampling with a random start involves access to a list of the population, begin sampling randomly, and then choose every *n*th person from the list until a prearranged number has been achieved. Simple random sampling affords every subject in the population an equal opportunity of being chosen for the study. Stratified random sampling divides the population into groups based on the sample measures, and then a fixed number from each stratum is drawn using a simple random sampling technique. Cluster (multistage) sampling involves having a list

of relevant geographic locations of the populations included in the study, and a simple random sample from that list is drawn until a set number is reached. The process is repeated with a sample according to the next relevant criteria, then a simple random sample from the new list is generated until the desired number is achieved. The same step is repeated until all relevant criteria have been exhausted. During the final stage, all the members of the population are listed, and a simple random sample is selected to the prespecified number (Wood & Ross-Kerr, 2011).

In nonprobability sampling, some subjects may not be included in the sample and therefore may not accurately represent the population (Wood & Ross-Kerr, 2011).

Nonprobability sampling consists of convenience sampling, snowball (network) sampling, quota sampling, and consecutive and purposive sampling (Polit & Beck, 2017).

Convenience sampling involves utilizing available subjects at the time the data is being collected. Snowball (network) sampling uses referral to obtain other qualified subjects from previous sample members. Quota sampling applies a list of criteria to appropriate the sample into groups. A preset number of subjects is taken from each group, and then a convenience sample is chosen from each set until each quota was filled. Consecutive sampling involves the recruitment of all eligible members who meet criteria for a study over a specified timeframe to achieve a set sample size from an available population.

Purposive sampling involves choosing a population that possesses the eligibility criteria for a sample to select subjects (Polit & Beck, 2017; Wood & Ross-Kerr, 2011).

In this study, the target population comprised of Advanced Practice Registered Nurses (APRNs) who were actively working in the United States in any specialty from 1 month up to 3 years. A nonprobability sampling approach utilizing convenience and

network sampling techniques allowed the researcher to have access to available subjects that met criteria for the study (Wood & Ross-Kerr, 2011). A power analysis employing G*Power 3.1, a common statistical power analyses tool, was used to determine a priori sample size (Faul et al., 2009). It calculated sample size based on alpha, power, and effect sizes. Power analysis estimated that the sample was “large enough to assume statistical analysis is meaningful and large enough to detect error” (Wood & Ross-Kerr, 2011, pp. 164-165). A power analysis was conducted to determine the appropriate sample size for *t*-tests model to ascertain the difference between two independent means (two groups). The sample size was determined to be 114, based on a significance level (α) of .05, power ($1 - \beta$) of .80, to detect a medium effect size (*ES*) of 0.50. It was estimated that some surveys would be excluded due to incomplete data, therefore, the required sample size for the study was adjusted to 136 (Israel, 1992; Nilima, 2017). In addition, a sample size needed for correlation using power ($1 - \beta$) of 0.80, alpha (α) .05, and effect size (*ES*) of 0.30 on a one-tailed correlation (*r*) yielded a sample size of 64. Therefore, a sample size of 140 was adequate for the study. The study was administered to novice APRNs across the United States.

Inclusion Criteria

The inclusion criteria for subject selection included the following: (a) novice Advanced Practice Registered Nurses (APRNs) with 1 month to 3 years of clinical practice in any specialty in the United States, (b) held an active APRN license, (c) were 18 years or older, (d) were able to read, write and understand English, and (e) had access to a computer, internet, and email.

Exclusion Criteria

The exclusion criteria for the study included the following: (a) not practicing as a novice advanced practice registered nurse, (b) did not hold an active APRN license, (c) were less than 18 years of age, (d) were not able to read, write, or understand English, and (e) did not have access to a computer, internet, and email.

Ethical Considerations

When conducting scientific research, researchers must adhere to three ethical standards to protect human subjects. The ethical principles include respect for persons, beneficence, and justice (Polit & Beck, 2017). Respect for persons ensures participants' right to self-determination and the right to full disclosure. This means that subjects could voluntarily participate in the study free from coercion, ask question(s), and were made aware of all the risks and benefits involved and may withdraw from the study at any time without any penalty. This constituted the process of informed consent. Beneficence entails minimizing harm and maximizing benefits for those involved. There were no known risks associated with this study. There were no direct benefits associated with this study. However, the information gathered may assist in developing interventions to benefit novice Advanced Practice Registered Nurses (APRNs). The findings in this study could contribute to nursing and society. It may also be used to enhance nursing education, transition to practice programs, nursing research, and health and public policy developments that may improve role transition quality and decrease job turnover intentions for novice APRNs.

Justice involves the right to fair, equitable treatment, and the right for privacy (Polit & Beck, 2017). This principle entails choosing subjects based on the study's

criteria without discrimination, treating subjects who choose not to participate or withdraw from the study fairly, and providing proper access to research team for questions and concerns. The researcher ensured anonymity by safeguarding the names or other identifiers of the subjects, which were not collected from the subjects and maintained confidentiality of the data. In addition, the researcher completed the Collaborative Institutional Training Initiative (CITI) research ethics training to better prepare to conduct the study. Moreover, approval was sought and obtained from Barry University's Institutional Review Board (IRB) prior to recruiting potential subjects.

The study was announced with a research flyer that had a link to access SurveyMonkey®, a secure online survey software that allowed researchers to host anonymous professional surveys for data collection to participating subjects (Finley, 1999). In addition, social networking websites such as LinkedIn, Facebook, Twitter, and WhatsApp were utilized to disseminate the flyer. LinkedIn is a business-oriented social networking medium that empowered users to connect with other associates (Hoffman, 2003). Facebook is an online social networking site that is used by people to create and share information with others (Zuckerberg et al., 2004). Twitter is a social networking outlet that enables users to post short messages that can be seen by other users (Dorsey et al., 2006). WhatsApp is a social network outlet that provided secure, simple, reliable messaging that supported the dissemination of a variety of media, text, photos, videos, documents with a secure end-to-end encryption (Acton et al., 2009).

When subjects accessed the link that was listed on the flyer, an electronic cover letter addressed the ethical components. These components in the electronic cover letter

described the purpose of the study, the voluntary nature of the study, the inclusion criteria and that there were no known risks or direct benefits associated with the study. To preserve anonymity, names or other identifiers of the subjects were not collected. SurveyMonkey® suppressed internal protocol (IP) addresses, and as such, they were not visible or available to the researcher at any time. Confidentiality of the data was maintained. In addition to completing a demographic survey, subjects were asked to rate how much they agreed or disagreed with various statements on two questionnaires. The three surveys contained a total of 37 items. The process took a maximum of 10 minutes to complete. Subjects could omit any question(s) they chose not to answer and may withdraw from the study at any time without any penalties.

In addition, the researcher, faculty sponsor, and Institutional Review Board (IRB) point of contact information were provided in the cover letter. Use of password-protected encrypted computer and a back-up flash drive to ensure against potential loss were utilized to store all electronic data and will be kept locked in the researcher's home office. Access to the electronic data is restricted to the researcher and the dissertation committee. Data will be stored for a minimum of 5 years upon completion of the study and then kept indefinitely by the researcher. Once data collection was completed, the IBM® Statistical Package for Social Sciences (SPSS®) Statistics Version 27, a powerful statistical software platform, was utilized by the researcher to input electronic data collected for analysis and perform statistical procedures to help understand and solve research problems in this study (IBM Corp., 2020). This software made it feasible to visualize data, run reports, manage large data sets more efficiently, and run a comprehensive set of statistical tests.

Access and Recruitment Procedures

Following approval from Barry University's Institutional Review Board (IRB) (see Appendix A), electronic access letters (see Appendix C) were sent to gatekeepers (president or director) of various professional nursing organizations such as State Boards of Nursing across the U.S., American Association of Nurse Practitioners (AANP), American Nurses Credentialing Center (ANCC), American Nurses Association (ANA), Florida Nurses Association (FNA), Haitian American Nurses Association (HANA), Lambda Chi Chapter of Sigma Theta Tau International of Nursing, Hispanic Nurses Association (HNA), Black Nurses Association (BNA), South Florida Council of Advanced Practice Nurses, Nurse Practitioner Council of Miami-Dade, and the ENP Network. The researcher asked the president and or director of the aforementioned agencies to forward a research flyer (see Appendix D) to members of their association on behalf of the researcher and to post the flyer in their designated areas for recruitment of potential subjects. In addition, the researcher sent an access letter to social networking websites (e.g., LinkedIn, Facebook, Twitter, and WhatsApp) seeking permission to publicize the study on their website. Furthermore, access letters were emailed to Chief Nursing Officers (CNO) of hospitals, and church leaders across the United States requesting permission for them to post the research flyer in designated areas of their facilities to recruit potential subjects for the study. The researcher's APRN pool of acquaintances/colleagues were accessed for recruitment of subjects via email and telephone. Recruitment of subjects for the study was achieved utilizing the research flyer in addition to convenience and network sampling techniques.

Data Collection Procedures

Data collection commenced upon approval from Barry University Institutional Review Board (see Appendix A). The subjects interested in participating in the study used a direct link on the research flyer to access the online surveys via SurveyMonkey®. Once subjects entered the URL into their browser and clicked on the direct link provided, a cover letter (see Appendix B) was presented. The electronic cover letter described the purpose of the study, the voluntary nature of the study, the inclusion criteria, and that there were no known risks or direct benefits associated with the study. However, the information gathered may assist in developing interventions to benefit novice Advanced Practice Registered Nurses (APRNs). The findings of this study could contribute to nursing and society. It may also be used to enhance nursing education, transition to practice programs, nursing research, and health and public policy developments that may improve role transition quality and decrease job turnover intentions for novice APRNs.

Clicking the “Next” button at the bottom of the cover letter indicated consent for participation in the study. Subjects could omit any question(s) they chose not to answer and could withdraw from the study at any time without any penalty. To preserve anonymity, names or other identifiers of the subjects were not collected. SurveyMonkey® suppressed internal protocol (IP) addresses and as such were not visible or available to the researcher at any time. Confidentiality of the data was and will be maintained. Subjects who took part in the research were directed to click the “Next” button at the bottom of the cover letter, which indicated consent for participation in the study. Subjects were given the option to return to the previous section to review or modify their selection by clicking the “Previous” button located at

the lower left-hand corner of each page or move forward by clicking the “Next” button. Subjects were permitted to skip question(s) they opted not to answer. They had the right to withdraw from the study at any time without any penalties, by clicking the “Exit” button located in the upper right-hand corner of each page.

Each subject was then asked to complete three separate surveys. Each survey had its own section on SurveyMonkey®. The “Next” prompt at the bottom of the cover page led to the next section: the demographic survey that contained 15 items. Once completed, the “Next” prompt at the bottom of the demographic survey led to the Nurse Practitioner Role Transition Scale (NPRTS) survey that contained 16 items. Once completed, the “Next” prompt at the bottom of the NPRTS survey led to the Turnover Intention Scale (TIS-6) survey that contained six items. Once completed, the prompt “Done” presented on the bottom of the TIS-6 survey. Clicking the "Done" button submitted all the responses and subjects were greeted with a thank you screen for participating in the study. The three surveys contained a total of 37 items. Completion time was a maximum of 10 minutes. Reminders were sent every 2 weeks via email to the gatekeepers (president or directors) of professional APRNs, nursing organizations, social networking websites (Linked in, Facebook, Twitter, and WhatsApp), researcher’s APRN pool, CNOs of hospitals, and church leaders to continue to announce the study. Data collection was completed over a five-week period and a total number of 162 subjects responded, of which 140 met inclusion criteria for the study. Therefore, a sample size of $N = 140$ was achieved.

Data Management and Storage

All electronic data were exported by the researcher directly from

SurveyMonkey® to her password-protected, encrypted personal home office computer and a back-up flash drive to ensure against potential loss of data. The computer and flash drive are kept in the researcher's locked home office. The data are only accessible to the researcher and the dissertation committee. The data will be stored for a minimum of 5 years upon completion of the study and then kept indefinitely by the researcher. In the future, usage of the data will be done solely by the researcher, and de-identified data will not be shared.

Instruments

A total of three instruments was utilized to collect data in this study. These included a researcher-developed demographic questionnaire (see Appendix E), the Nurse Practitioner Role Transition Scale (NPRTS) (see Appendix F), and the Turnover Intention Scale (TIS-6) (see Appendix H). The demographic questionnaire was used to collect characteristics of the sample. In addition, the independent variable (structured orientation) was measured by a single item question with a yes or no response on the demographic questionnaire. The NPRTS was employed to measure the first dependent variable (role transition), and the TIS-6 measured the second dependent variable (turnover intentions). Written permission to use the NPRTS and TIS-6 scales were obtained from Dr. Regina Cusson and Professor Gert Roodt (see Appendix G and Appendix I).

Demographic Questionnaire

The characteristics of the sample was captured in a researcher-developed, 15-item demographic questionnaire (see Appendix E). The demographic questionnaire inquired about each subject's gender, age, ethnicity, marital status, APRN specialty,

practice region, practice setting, APRN program of completion, degrees earned, prior non-RN health related employment, months and years of RN employment, time in months and years in current position, and a single item question on structured orientation, any change of employment organization to assume new role as APRN, if change of employment organization as APRN in the new role, how many mentors were provided.

Nurse Practitioner Role Transition Scale

The revised 16-item, 5-point Likert Scale Nurse Practitioner Role Transition Scale (NPRTS) (see Appendix G) was used to assess novice Advanced Practice Registered Nurses (APRNs) role transition quality. The Nurse Practitioner Role Transition Scale (NPRTS) is a self-report survey that is designed to measure APRNs' perceptions of role transition experiences during the first year of practice and consisted of three subscales: developing comfort and building competence, understanding of the role by others, and collegial support (Strange, 2015). The subjects were asked to rate their agreement (1 = *strongly disagree* to 5 = *strongly agree*) with statements regarding concepts such as feelings of support versus isolation and feeling prepared to manage patients and time and understanding of their role by patients, physicians, and other staff. The possible range of scores is 16 to 80, with 80 being the highest score. A higher total score indicated a more successful transition, with lower scores indicating a less successful transition (Cusson et al., 2011; Strange 2015). This scale was chosen because it has been used in previous studies (Cusson et al., 2011; Strange, 2015). Permission was obtained from the instrument' first corresponding author, Dr. Regina Cusson to utilize the scale in this study (see Appendix F).

Reliability

Reliability refers to the accuracy and consistency of information obtained in the study (Polit & Beck, 2017). Statistical reliability refers to the probability that results are generalizable to a wider group and ensured measurement of constructs were stable, homogeneous (internal consistency), and equivalent. The Kaiser-Meyer-Olkin measure of the Nurse Practitioner Role Transition Scale was 0.80, and the Bartlett test of sphericity demonstrated a chi square of 2158.81, with $df = 465$, and $p < .001$ (Strange 2015). The exploratory factor employed principal component analysis in concert with the varimax and oblique rotation and the minimum loading level was set at 0.4. Extraction loadings between 0.53 and 0.82 on all the variables supported the 16 survey items. The content reliability and validity for the 16-item scale had a Cronbach's alpha of 0.87, indicating high internal consistency for measuring APRN role transition (Strange, 2015).

Validity

Validity refers to soundness of the study's evidence (Polit & Beck, 2017). Strange (2015), in her dissertation on the development and psychometric testing of the Nurse Practitioner Role Transition Scale (NPRTS), reported a Cronbach's alpha ranging from 0.88-0.92 for the NPRTS, indicating a high internal consistency. Thompson (2019) in a nonrandomized, pretest-posttest, and single group quantitative study assessed whether an educational intervention enhanced Advanced Practice Registered Nurses (APRNs) role transition. The Nurse Practitioner Role Transition Scale (NPRTS) was used and the content reliability and validity for the 16-item NPRTS in a sample of ($N = 30$) had a Cronbach's alpha of 0.77. Furthermore, Barnes (2015) in a quantitative study on exploring the factors that influence role transition for APRNs, also utilized the NPRTS in

a sample of ($N = 352$). Internal consistency reliability for the total 16-item NPRST was .87. Thus, the studies support the validity of the NPRTS in measuring role transition.

Turnover Intention Scale

The Turnover Intention Scale (TIS-6) (see Appendix H) is another self-report survey that is geared toward assessing employees' turnover intentions (Bothma & Roodt, 2013). The TIS-6 is a revised version from the previous 14 items, 5-point Turnover Intention Scale, first developed by Roodt (2004) in an unpublished document. A few years later, the instrument was made public and had a Cronbach's alpha of 0.91 (Jacobs & Roodt, 2008). In addition, Jacobs and Roodt (2008) updated the 14 items, 5-point scale instrument to 15 items, 5-point scale in a study on predicting the turnover intentions of professional nurses. The 15 items turnover intention scale was later condensed to six items, 5-point scale (Bothma & Roodt, 2013). Based on the Turnover Intention Scale (TIS-6), subjects were asked to rate their agreement on a scale of 1-5 (1 = *never* to 5 = *always*, 1 = *very satisfying* to 5 = *totally dissatisfying*, 1 = *highly unlikely* to 5 = *highly likely*, and 1 = *always* to 5 = *never*). The possible range of scores were 6-30. The midpoint of the scale was 18. If the total score was below 18, then it indicated a desire to stay. If the scores were above 18, it indicated a desire to leave the organization (G. Roodt, personal communication, October 22, 2019). Permission was obtained from the instrument's first corresponding author, Professor Gert Roodt to utilize the scale in this study (see Appendix F).

Reliability

Bothma and Roodt (2013) conducted a correlational, cross-sectional study to validate the Turnover Intention Scale (TIS-6) on a census-based sample ($N = 2429$) of

employees in an information, communication, and technology (ICT) sector company ($N = 23,134$) where the TIS-6 was used as one of the criterion variables. A Cronbach's alpha of 0.80 supported the internal consistency of the scale in the study. Criterion predictive validity revealed the mean score differences for those employees who resigned and those who stayed in the company. Comparison of the mean difference scores were significant and had a large effect size. This signified that the Turnover Intention Scale could predict actual turnover (Bothma & Roodt, 2013).

Validity

Mxenge et al. (2014) in a correlational study assessed organizational stress and employees' intention to quit amongst administrative personnel at the University of Fort Hare ($N = 225$) and reported a significant positive relationship between organization stress and intention to quit ($r = 0.203$; $p = 0.0178$). In addition, Roodt's 2004 14-item, 7-point Likert Turnover Intention Scale yielded a Cronbach's alpha of 0.81. Similarly, Malik and Khalid (2016) in a correlational study examined the impact of psychological contract breach on employees' turnover intentions with the mediating role of work engagement in a sample of 302 employees ($N = 302$) in private and public banks reported work engagement partially mediated the relationship between psychological contract breach and employees' turnover intention. A Cronbach alpha of 0.79 was reported for the Turnover Intention Scale. Furthermore, Taboli (2015) utilized Roodt's (2004) Turnover Intention Scale (TIS-6) in a correlational, cross-sectional study to assess the relationship between the work engagement and burnout and turnover of 210 employees ($N = 210$) in universities across Kerman, Iran and authenticated the validity and reliability of the

instrument with Cronbach alphas of .89 and 0.91. Based on these studies' results, the validity of the TIS-6 scale was supported.

Data Cleansing

Data cleansing was a crucial step in data analysis as it ensured data accuracy. Failure to do so may jeopardize the generalizability of the results of the study (Polit & Beck, 2017). After data collection, the researcher exported the data electronically into IBM® Statistical Package for Social Sciences (SPSS®) Version 27 and reviewed all the distributions for each variable to assess for missing or invalid data (Fowler, 2014; Polit and Beck, 2017). Surveys that contained 30% missing values on any single predictor (structured orientation) or the outcome variables (role transition and turnover intentions) were not included (Fox-Wasylyshyn & El-Masri, 2005). Outliers were evaluated by a standard deviation greater than 3 (Polit & Beck, 2017).

Data Analysis Plan

All electronic data were exported from SurveyMonkey directly to IBM® SPSS® Version 27, which were employed to perform the statistical analyses (IBM Corp., 2020). Data analyses included descriptive statistics (measures of central tendency and dispersion) and inferential statistics comprised independent *t*-tests and Pearson's Product-Moment Correlation, and simple linear regression. Descriptive statistics were used to describe the attributes of the sample. Frequency distributions assisted with identifying outliers in the data as well as symmetry of the distributions. Inferential statistical testing such as independent *t*-tests is a standard procedure for analyzing the differences between the means of two groups (Wood & Ross-Kerr,

2011). This powerful parametric test involves measurements on at least an interval scale and assumes four assumptions:

1. The dependent variables are normally distributed in the population.
2. There are equal variances between the two groups.
3. Interval data are being used.
4. The two groups are independent. (Wood & Ross-Kerr, 2011, p. 264)

Pearson's product-moment correlation was performed to examine the correlation between variables. It was used to ascertain the direction and strength of the relationship between the variables. Correlation coefficient (r) number ranges from -1.00 to 1.00 (Polit & Beck, 2017). In addition, a simple linear regression was utilized to assess whether the independent variable predicted the dependent variable whereby $Y' = a + bX$. It was also used to create a direct line that runs through to the data thereby decreasing deviations from it. Therefore, correlation coefficients expressed in (r^2) demonstrated how variability in the predictor variable led to variability in the outcome variable. The strength of the correlation determined the quality of the prediction as well as the strength of the percentage of the variance (Polit & Beck, 2017).

In this study, independent t -tests compared the mean scores between those subjects who received structured orientation to those who did not on their role transition and job turnover intentions to test for differences between them. Pearson's Product-Moment Correlation assessed the associations for novice Advanced Practice Registered Nurses between Nurse Practitioner Role Transition Scale (NPRTS) scores and turnover intentions as measured on the Turnover Intention Scale (TIS-6). It was followed by a simple linear regression to predict the outcome and assessed for variations.

The first research question—Do novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position have better role transition when compared to those who did receive structured orientation? —was answered utilizing a single item question on the demographic questionnaire and the Nurse Practitioner Role Transition Scale (NPRTS) to assess whether subjects received a structured orientation or not. An independent *t*-test tested the difference between the two groups. The second research question—Do novice Advanced Practice Registered Nurses who received structured orientation in their first position have lower job turnover intentions when compared to those who did not receive structured orientation? —was answered using a single question item question on the demographic questionnaire and the Turnover Intention Scale (TIS-6) to assess impact of structured orientation on job turnover intentions. The independent *t*-test examined the difference between the groups.

The third research question—Is there a negative correlation between Novice Advanced Practice Registered Nurses' role transition scale scores on the Nurse Practitioner Role Transition Scale (NPRTS) and turnover intentions scale scores as measured on the Turnover Intention Scale (TIS-6)? —was answered utilizing Pearson's Product-Moment Correlation followed by a simple linear regression. Data are stored on the researcher's password-protected, encrypted personal home office computer and back-up flash drive to secure data in the researcher's locked home office. The data is only accessible to the researcher and the dissertation committee and will be kept for a minimum of 5 years upon completion of the study and then indefinitely.

Chapter Summary

This chapter delineated the methods that were employed to conduct the study. The chapter contained restatement of research questions and hypotheses, overview of the design, sample and setting, inclusion, and exclusion criteria. Ethical considerations and the protection of human subjects were also discussed. The chapter culminated with the access and recruitment and data collection procedures, data management and storage, instruments, data cleansing, and data analysis plan. Chapter Four follows with the results of the study.

CHAPTER FOUR

FINDINGS OF THE STUDY

The purpose of this non-experimental, cross-sectional, correlational study was to investigate the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses (APRNs) in their first APRN position. The significant findings supporting the hypotheses underscored the need for structured orientation to be given by the administrations of responsible employers and organizations. This chapter highlights the characteristics of the sample and reliability estimates for each of the instruments and explores the data to determine whether assumptions for statistical tests were met. The results of descriptive and inferential analyses are delineated. Statistical analytics employed for hypotheses testing comprised independent *t*-tests and Pearson Product-Moment Correlation followed by a simple linear regression analysis. Data were analyzed using IBM® SPSS® Version 27.

Data were collected from a convenience sample of 162 Advanced Practice Registered Nurses (APRNs) over a 5-week period, of which 140 subjects met inclusion criteria for the study. Subjects were recruited from various professional nursing organizations such as State Boards of Nursing across the U.S., American Association of Nurse Practitioners (AANP), American Nurses Credentialing Center (ANCC), American Nurses Association (ANA), Florida Nurses Association (FNA), Haitian American Nurses Association (HANA), Lambda Chi Chapter of Sigma Theta Tau International of Nursing, Hispanic Nurses Association (HNA), Black Nurses Association (BNA), South Florida Council of Advanced Practice Nurses, Nurse

Practitioner Council of Miami-Dade, and the ENP Network by email and social media through LinkedIn, Facebook, Twitter and WhatsApp. Access letters were also emailed to Chief Nursing Officers (CNO) of hospitals and church leaders across the United States to recruit potential subjects for the study.

The researcher's APRN pool of acquaintances and colleagues were accessed for recruitment of subjects via email and telephone through convenience and network sampling techniques. However, the subjects came from the following 21 Facebook groups and organizations: The Black Nurse Practitioner Network, Nurse Practitioner Networking, Ohio Nurse Practitioners, Nurse Practitioner New Grads and Students, Urgent Care Nurse Practitioners, Nurse Practitioner (NP) Networking Group, Women's Health Nurse Practitioners, Northwest Nurse Practitioner Group of Connecticut, New Nurse Practitioner (NP) Life Support, Nurse Practitioner Faith Community, Black Nurse Practitioners of Palm Beach County, Family Nurse Practitioner (FNP)/Psychiatric Mental Health Nurse Practitioner (PMHNP) Collaborative Group, Nurse Practitioners Only, Nurse Practitioner Community for Students and Credentialed, Colorado Society of Advanced Practice Nurses, Certified Registered Nurse Anesthetists (CRNAs) and Students Registered Nurse Anesthetists (SRNAs) Uncensored, Nurse Practitioner Community Support, Nurse Practitioner (NP) House Calls, Family Nurse Practitioners of the Federal Qualified Health Centers (FQHCs), New Graduate Family Nurse Practitioner, Certified Nurse Practitioners, Florida Nurse Practitioners, Life of a Psych Nurse Practitioner (NP)/Psychiatric Mental Health Nurse Practitioner (PMHNP) Student and New Grad Resource Group, Haitian American Nurses Association (HANA), LinkedIn, and the researcher's

convenience sample of APRN pool of acquaintances and colleagues with associated network sampling.

The 37-item survey was hosted online by SurveyMonkey and included three surveys: a demographic questionnaire, the Nurse Practitioner Role Transition Scale (NPRTS), and the Turnover Intention Scale (TIS-6). A single-item question on the demographic questionnaire assessed whether APRNs received structured orientation with a yes and no response. The Nurse Practitioner Role Transition Scale (NPRTS) was used to measure role transition and the TIS-6 was utilized to measure job turnover intentions.

Sample Description

Convenience sampling yielded 162 online subjects of which 140 subjects met inclusion criteria for the study. Therefore, 22 subjects were excluded from the study because they were practicing in their current position for more than 3 years. The subjects were Advanced Practice Registered Nurses (APRNs) with 1 month to 3 years of clinical practice in any specialty in the United States. The criteria for participation were that they held an active APRN license and were at least 18 years or older, were able to read, write, and understand English, and had access to a computer, internet, and email. The subjects were recruited from various professional nursing organizations such as State Boards of Nursing across the U.S., American Association of Nurse Practitioners (AANP), American Nurses Credentialing Center (ANCC), American Nurses Association (ANA), Florida Nurses Association (FNA), Haitian American Nurses Association (HANA), Lambda Chi Chapter of Sigma Theta Tau International of Nursing, Hispanic Nurses Association (HNA), Black Nurses Association (BNA), South Florida Council of Advanced Practice

Nurses, Nurse Practitioner Council of Miami-Dade, and the ENP Network by email and social media through Linked In, Facebook, Twitter and WhatsApp. Access letters were also emailed to Chief Nursing Officers (CNO) of hospitals, and church leaders across the United States to recruit potential subjects for the study. The researcher's APRN pool of acquaintances and colleagues were accessed for recruitment of subjects via email and telephone through convenience and network sampling techniques. However, the sample came from the aforementioned 21 Facebook Advanced Practice Registered Nurses (APRN) groups, Haitian American Nurses Association (HANA), LinkedIn, and the researcher's convenience sample of APRN pool of acquaintances and colleagues and network sampling.

The *a priori* power analysis using G*Power 3.1 (Faul et al., 2009) indicated the minimum sample size needed for *t*-tests model to ascertain the difference between two independent means (two groups) was 114, based on a significance level (α) of .05, power ($1 - \beta$) of .80, to detect a medium effect size (*ES*) of 0.50. In addition, a sample size needed for correlation using power ($1 - \beta$) of 0.80, alpha (α) .05, and effect size (*ES*) of 0.30 on a one-tailed correlation (*r*) yielded a sample size of 64. Therefore, the actual sample size ($N = 140$) was adequate for the study. The data was analyzed for missing or invalid data. One subject did not answer the question of how to manage case load on the NPRTS scale. That answer was replaced with the average number 3. Subject number 38 also skipped the number of years worked as an RN; that number was also replaced with the average number of 11.3 years. Therefore, both cases were included in the study. No other essential data was missing. Walker and Almond (2010) indicated that self-report questionnaires may have missing data because

participants fail to respond when they are tired, or they choose not to answer for some reason.

Demographic Characteristics of the Sample

Demographic data included gender, age, ethnicity, marital status, APRN specialty, practice region, practice setting, APRN program of completion, degrees earned, prior non-RN health related employment, months and years of RN employment, time in months and years in current position, and a single-item question on structured orientation, any change of employment organization to assume new role as APRN and number of mentors in new environment were collected.

Table 1

Demographics of the Advanced Practice Registered Nurses Sample (N =140)

Category	Subset	n	%
1. Gender	Male	8	5.7%
	Female	129	92.1%
	Non-Binary	1	0.7%
	Other	2	1.4%
2. Age	21-30	25	17.9%
	31-40	65	46.4%
	41-50	30	21.4%
	Over 50	20	14.3%
3. Ethnicity	White or Caucasian	82	58.6%
	Black or African American	37	26.4%
	Hispanic or Latino	16	11.4%
	Asian, Middle Eastern, Biracial, other	5	3.5%
4. Marital Status	Married or Civil Union	104	74%
	Single	24	17%

5. APRN Specialty	Family Practice	91	65%
	Acute Care Facility	22	16%
	Adult, Gerontology, Anesthesia, Community Health, Family & Psych Pediatrics, Telehealth, Women's Health, & Palliative	27	19%
6. Practice Regions			
	Southeast	47	33.6%
	Southwest	19	13.6%
	Northeast	15	10.7%
	Northwest	16	11.4%
	Midwest	18	12.9%
	Unspecified	25	17.9%
7. Practice Settings			
	Hospital Inpatient Acute Care	35	25%
	Private Practice Primary Care	28	20%
	Private Practice Specialty	23	16.4%
	Community Health Clinic	16	11.4%
	Federal Qualified Health Center	16	11.4%
	Urgent Care Center	8	5.7%
	Long-Term Care Facility, Home Health and Palliative	8	5.7%
	Hospital Outpatient Clinic or Specialty, Telehealth or unspecified	6	4.4%
8. APRN Program of Completion			
	Master's Program	99	71%
	Doctorate Program	15	11%
	Accelerated, BSN, Non-nursing or Post Masters Certificate	26	18%
9. Degrees Earned			
	Master's Degree	115	82%
	Doctorate Degree	23	16%
	Associate or Non-Nursing Master	2	2%
10. Prior non-RN Health Related Employment			
	Non-RN Health Related	58	41%
	RN Health Related	82	59%
11. Years of RN Employment (see Table 2)			

12. Months in APRN Position (see Table 2)			
13. Structured Orientation (a mentorship, a preceptorship, or a residency experience)			
	Yes	39	28%
	No	101	72%
14. Changed in Work Organization in new APRN Role			
	Yes	92	66%
	No	48	34%
15. a. Mentors (in a New Work Organization/Environment) *			
	Yes, One	35	25%
	Yes, Two	15	11%
	Yes, Three or more	21	15%
	No	40	29%
	Skipped	29	21%
b. Mentors (in New Work Organization/Environment) **			
	Yes, One	31	33.7%
	Yes, Two	14	15.2%
	Yes, Three	15	16.3%
	No	32	34.8%

*Included results from all the APRNs in the study who answered question 15a (n = 111).

**Results from only the APRNs who changed work organization/environment in question 15b (n = 92).

Table 2

Years and Months of Employment for the Advanced Practice Registered Nurses Sample (N =140)

Category	<i>M</i>	<i>SD</i>
Years of RN Employment	11.36 years	7.30
Months in APRN Position	15.84 months	10.18

The sample comprised of 140 subjects as illustrated in Table 1: 92.1% females ($n = 129$), 5.7% males ($n = 8$), 0.7% non-binary ($n = 1$), and 1.4% other ($n = 2$). The ages of the subjects were collected in four categories in Table 1: 21-30 (17.9%, $n = 25$), 31-40 (46.4%, $n = 65$), 41-50 (21.4%, $n = 30$), and over 50 (14.3%, $n = 20$). The ethnicity of this group was collected using six categories: 58.6% were White or Caucasian ($n = 82$), 26.4% were Black or African American ($n = 37$), 11.4% were Hispanic or Latino ($n = 16$), and 3.5% were Asian, Middle Eastern, Biracial, or other ($n = 5$). The number of Advanced Practice Registered Nurses (APRNs) who were married or in a civil union was 74% ($n = 104$), 17% of them were single ($n = 24$), and 9% of APRNs were divorced or separated ($n = 12$). The subjects came from five regions of the United States as noted in Table 1 and Figure 3: Southeast (33.6%, $n = 47$), Southwest (13.6%, $n = 19$), Northeast (10.7%, $n = 15$), Northwest (11.4%, $n = 16$), and Midwest (12.9%, $n = 18$). The remaining 17.9% of the subjects did not specify their practice region ($n = 25$). Their practice settings included hospital inpatient acute care, private practice primary care, private practice specialty, community health clinic, federal qualified health center, urgent care center, long-term care facility (home health/palliative), and hospital outpatient clinic or specialty, telehealth or other.

The majority (65%) of the APRNs specialized in family practice ($n = 91$), followed by 16% in acute care ($n = 22$), and the remaining 19% had a specialty in adult, adult gerontology, anesthesia, family and psych, community health, telehealth, pediatrics, women's health, and palliative ($n = 27$). With respect to the Advanced Practice Registered Nurse program of completion, 71% of the subjects completed a master's program ($n = 99$), 11% completed a doctorate program ($n = 15$), and the remaining 18%

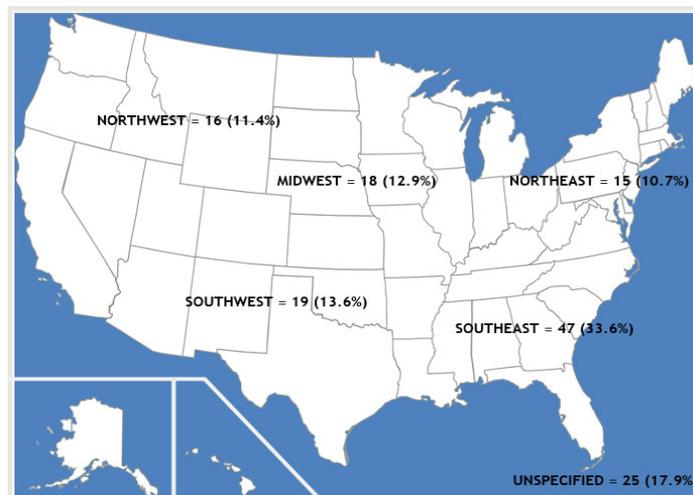
completed either an Accelerated Master, BSN Master, Non-Nursing Master or Post Masters Certificate programs ($n = 26$). As it pertains to the degrees earned, 82% of the subjects held a master's degree ($n = 115$), 16% held a doctorate degree ($n = 23$), the remaining 2% comprised of 1 subject with an associate degree and 1 with a non-nursing master. Of the 140 subjects, 41% previously worked in a non-RN health related employment ($n = 58$) and while 59% did not ($n = 82$).

The mean number of years of practice as a Registered Nurse (RN) was 11.36 years ($SD = 7.30$, $skew = 1.3$) as shown in Table 2. One subject reported 0 years worked as a RN. The mean number of months in their current position as an APRN was 15.84 months ($SD = 10.18$, $skew = .287$) in Table 2 with a range of 1 month to 36 months. Of the 140 subjects, 101 (72%) did not receive a structured orientation (a mentorship, a preceptorship, or a residency experience), leaving 39 (28%) who received structured orientation in their new APRN position. Most of the subjects 66% ($n = 92$) changed work environment in their new role, while 34% ($n = 48$) remained within the same organization. As far as the number of mentors (informal go-to person (s) for support) in their new environment, 21% ($n = 29$) skipped the answer, 29% ($n = 40$) reported having no mentors, 25 % ($n = 35$) had one mentor, 11% ($n = 15$) had two mentors, and 15% ($n = 21$) reported having three or more mentors for a total of 51% (see Table 1, 15a). These numbers in question 15a represent those Advanced Practice Registered Nurses (APRNs) ($n = 111$) who changed work environment as well as some of the APRNs who did not change work environment but chose to answer question 15 in the study as this question was meant to only address those who changed work environment. However, to account for the number of APRNs who changed work

organization/environment that had mentors, the researcher went back to the data and manually counted the numbers. Of the Advanced Practice Registered Nurses (APRNs) ($n = 92$) who changed work organization/environment, 65.2% of the APRNs ($n = 60$) APRNs had a mentor or mentors while 34.8% of APRNs ($n = 32$) reported not having had mentors (see Table 1, 15b).

Figure 3

Advanced Practice Registered Nurses Practice Regions Across the United States



Exploratory Data Analysis for Measurements

Descriptive statistics such as frequency distributions and histograms were utilized to ascertain the degree to which the data were normally distributed for each instrument. The demographic questionnaire included 15 items that highlighted the sample characteristics of the subjects in the study. Reliability estimates were computed for the Nurse Practitioner Role Transition Scale (NPRTS) total score and for each subscale (Developing Comfort and Building Competence in the Role subscale, Understanding of the Role by Others subscale, and Collegial Support subscale) and for the Turnover Intention Scale (TIS-6). Basic assumptions for

independent *t*-tests, Pearson Product-Moment Correlation, and linear regression were tested.

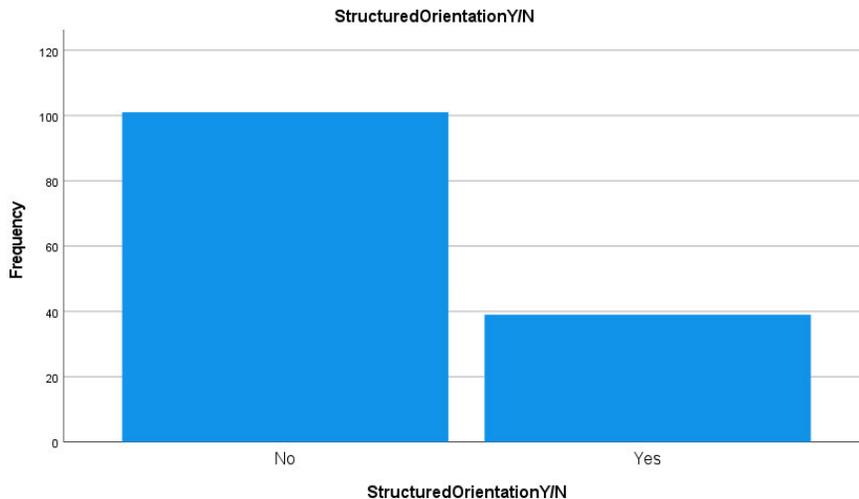
Relationship Among Major Study Variables

Demographic Questionnaire

A single-item question on the demographic questionnaire measured whether Advanced Practice Registered Nurses (APRNs) received structured orientation (a mentorship, a preceptorship, or a residency experience) in their first APRN position with a “yes” and “no” response. Of the 140 APRNs, 101 (72%) did not receive a structured orientation, leaving 39 (28%) who received structured orientation upon commencement of their new APRN position as shown in Figure 4.

Figure 4

Frequency of Advanced Practice Registered Nurses with Structured Orientation (Yes/No)



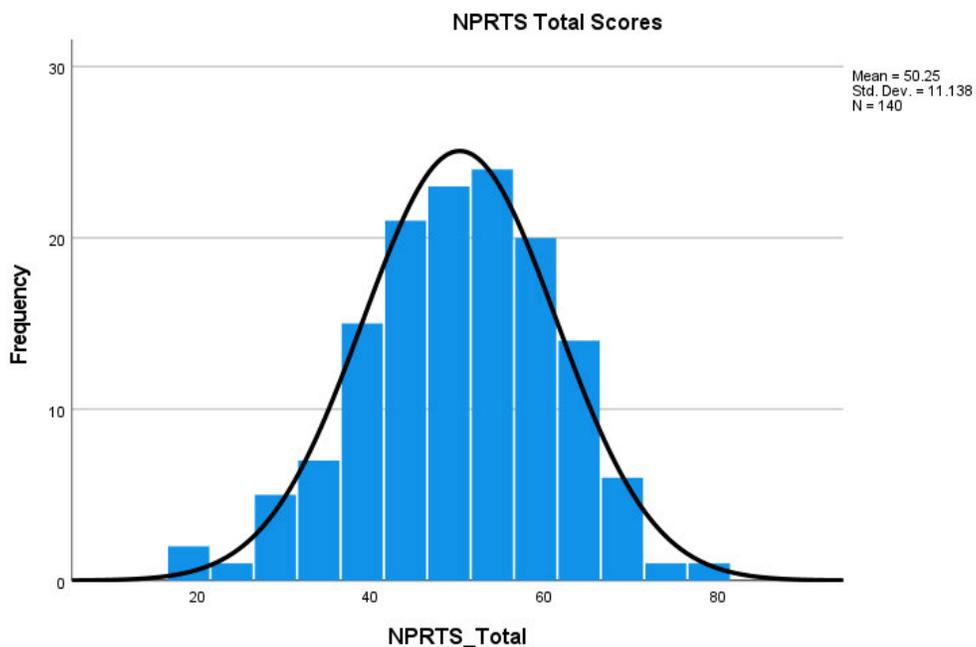
Nurse Practitioner Role Transition Scale (NPRTS)

The Nurse Practitioner Role Transition Scale (NPRTS) was used to measure Advanced Practice Registered Nurses’ (APRNs) self-reported perceptions of their role transition experiences. The instrument contained 16 items on a 5-point Likert scale with

responses ranging from 1 = *strongly disagree* to 5 = *strongly agree* and consisted of three subscales (Developing Comfort and Building Competence in the Role, Understanding of the Role by Others, and Collegial Support). Items 6, 8, 14, and 15 were reverse-scored and recoded (i.e., a score of 5 was recoded as a 1, a score of 4 was recoded as 2, a score of 3 was recoded as 3, a score of 2 was recorded as 4, and a score of 1 was recoded as 5). The total score for the NPRTS was established by tallying the scores of the responses of the 16 items with appropriate reverse scoring corrections. Summated scores ranged from 16, signifying a less successful transition, to 80, implying a more successful transition. Figure 5 displayed that the distribution of these scores for the entire group followed a normal distribution ($M = 50.25$, $SD = 11.138$, $skew = -.25$).

Figure 5

Nurse Practitioner Role Transition Scale Responses

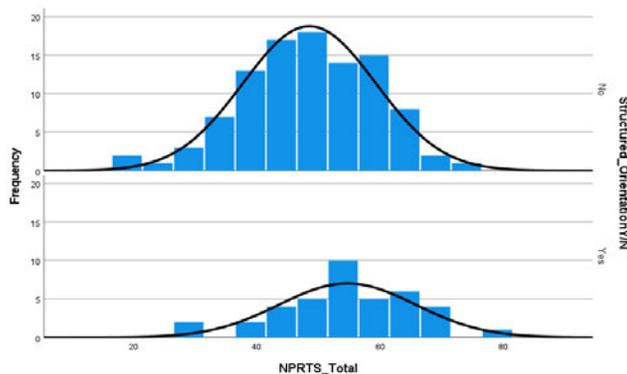


The histogram for each group of the Nurse Practitioner Role Transition Scale (NPRTS) total scores by Advanced Practice Registered Nurses (APRNs) and the

structured orientation responses (Yes/No) are presented in Figure 6 and followed symmetrical normal distributions. Cronbach's alpha for the NPRTS total scores was acceptable ($\alpha = .89$). The alpha for each subscale (Developing Comfort and Building 'Competence in the Role subscale, Understanding of the Role by Others subscale, and Collegial Support subscale) was also acceptable ($\alpha = .85, .84, \text{ and } .79$, respectively) as illustrated in Table 3.

Figure 6

Nurse Practitioner Role Transition Scale by Structured Orientation Response (Yes/No)



Turnover Intention Scale (TIS-6)

The Turnover Intention Scale (TIS-6) was utilized to measure Advanced Practice Registered Nurses' (APRNs) self-reported job turnover intentions. The instrument consisted of six items on a 5-point scale with responses ranging from (1 = *never* to 5 = *always*, 1 = *very satisfying* to 5 = *totally dissatisfying*, 1 = *highly unlikely* to 5 = *highly likely*, and 1 = *always* to 5 = *never*). The overall score for the TIS-6 was derived by adding the scores of the responses of the six items. Summated scores ranged from 6-30 with a midpoint of 18. A score below 18 indicated a desire to stay, while a score above 18, implied a desire to leave the organization. Figure 7 shows that the distribution of

these scores for the entire group followed a normal distribution ($M = 17.27$, $SD = 6.22$, $skew = .08$). Cronbach's alpha for the TIS-6 total scores was acceptable ($\alpha = .90$) as demonstrated in Table 5. The histogram for each group of the TIS-6 scores is presented in Figure 8 and follows normal symmetrical distributions.

Figure 7

Turnover Intention Scale Responses

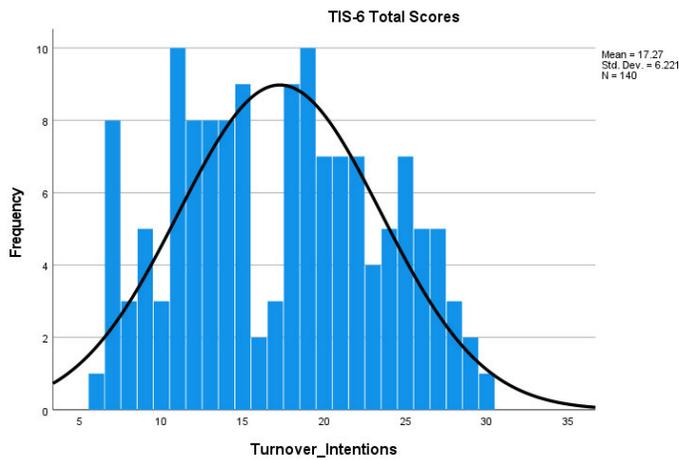


Figure 8

Turnover Intention Scale (TIS-6) by Structured Orientation (Yes/No)

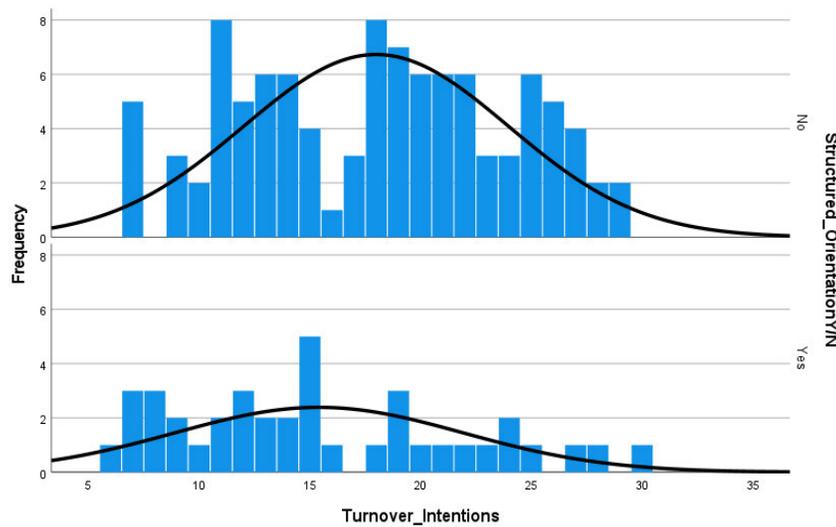


Table 3

Scale Reliability Coefficient (Cronbach's α) for NPRTS and Subscales and TIS-6 (N =140)

Scale	Subscale	Cronbach's α
Nurse Practitioner Role Transition Scale (NPRTS)		.89
	Developing Comfort & Building Competence in the Role	.85
	Understanding of the Role by Others	.84
	Collegial Support	.79
Turnover Intention Scale (TIS-6)		.90

Assumptions

Valid conclusions concerning regression parameters when based on this sample required that the assumptions be satisfied. Spicer (2005) specified that, to avoid over or under-estimation of significance, observations must be independent, data from each variable must be normally distributed, and that there should be a linear relationship.

Independence of Observations

The design of the data collection where the Advanced Practice Registered Nurses were not collaborating while completing the surveys determined that each score was independent. The statistic that provided evidence of independence of observation was the Durbin-Watson (DW) statistic, which in this case was 2.153 as illustrated in Table 4. The assumption is that this statistic be close to 2.0, and this assumption was therefore satisfied (Spicer, 2005).

Table 4

Durbin-Watson Statistic for the Data Collected

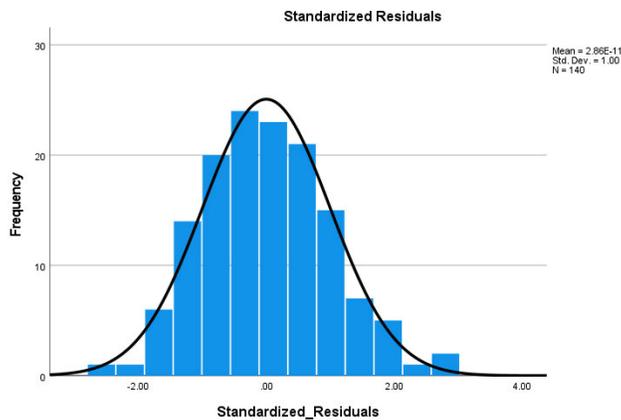
Predictor	Criterion	Durbin-Watson Statistic
NPRTS Total Score	TIS-6	2.153

Normality

Normality is a property of a data distribution that follows a symmetrical curve and the distribution of residuals of the regression are assumed to be normally distributed (Polit & Beck, 2017). This assumption was tested by creating a histogram of the standardized residuals. The histogram of the distribution of the standardized residuals in this relationship was presented in Figure 9 indicating that the assumption of normality of standardized residuals was met.

Figure 9

Histogram of Standardized Residuals



Research Questions and Hypotheses Reviewed

Research questions one and two were answered using independent *t*-tests. The basic assumptions for conducting independent *t*-tests were tested and satisfied. The

third research question was answered using Pearson Product-Moment Correlation followed by a simple linear regression.

Research Questions and Hypotheses Testing

Research Question One and Hypothesis One

RQ₁. Do novice Advanced Practice Registered Nurses (APRNs) who received structured orientation in their first APRN position have better role transition when compared to those who did not receive structured orientation?

H₀. Role transition mean scores for novice Advanced Practice Registered Nurses who received structured orientation in their first position are equal to those who did not receive structured orientation.

H₁. Role transition mean scores for novice Advanced Practice Registered Nurses who received structured orientation in their first position are higher than for those who did not receive structured orientation.

In keeping with the first hypothesis, a two-sample independent *t*-test was carried out to determine whether the mean NPRTS total scores for the Advanced Practice Registered Nurses (APRNs) who had received structured orientation were higher than the mean NPRTS total scores for those who did not receive structured orientation. The assumptions for independent *t*-tests were tested and were satisfied. Hypothesis one was supported, and the null hypothesis was rejected. The independent *t*-test output demonstrated a statistically significant difference was found ($t(138) = 3.017, p = .0015, ES = .57$) in Table 5 between the mean scores for the APRNs without structured orientation ($M = 48.53, SD = 10.73$) and the mean scores for those with structured orientation ($M = 54.69, SD = 11.07$), which supported the alternative

hypothesis that APRNs who received structured orientation would score higher on the NPRTS.

Research Question Two and Hypothesis Two

RQ₂. Do novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position have lower job turnover intentions when compared to those who did not receive structured orientation?

H₀. Turnover intentions mean scores for novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position are equal to those who did not receive structured orientation

H₂. Turnover intentions mean scores for novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position are lower than for those who did not receive structured orientation.

In keeping with the second hypothesis, a two-sample independent *t*-test was carried out to determine whether the mean TIS-6 scores for the Advanced Practice Registered Nurses (APRNs) who had received structured orientation were lower than the mean TIS-6 scores for those who did not receive structured orientation. Hypothesis two was supported and the null hypothesis was rejected. Again, a statistically significant difference for APRNs without structured orientation ($M = 17.99$, $SD = 5.98$) and those with structured orientation ($M = 15.41$, $SD = 6.51$) was established ($t(137) = -2.231$, $p = .0145$, $ES = -.42$), which supported hypothesis two that APRNs who received structured orientation will score lower on the TIS-6 than those who did not receive structured orientation (see Table 5).

Table 5*Advanced Practice Registered Nurses t-tests Results for Hypothesis 1 & 2*

H	<i>M</i> (No*)	<i>SD</i>	<i>M</i> (Yes**)	<i>SD</i>	df	<i>t</i>	<i>p</i>	<i>ES</i>
1	48.53	10.43	54.69	11.07	138	3.017	.0015	.57
2	17.99	5.98	15.41	6.51	138	-2.231	.0145	-.42

Did not receive structured orientation** Received structured orientation**H = Hypothesis***Research Question Three and Hypothesis Three**

RQ₃. Is there a negative correlation between novice Advanced Practice Registered Nurses' role transition scale scores on the Nurse Practitioner Role Transition Scale (NPRTS) and turnover intentions scale scores as measured on the Turnover Intention Scale (TIS-6)?

H₀. There is no correlation between NPRTS scores and TIS-6 scores for novice Advanced Practice Registered Nurses.

H₃. There is a negative correlation between NPRTS scores and TIS-6 scores for novice Advanced Practice Registered Nurses.

Hypothesis three indicated that there would be a statistically significant negative correlation between the NPRTS total scores and the TIS-6 scores, so a Pearson Product-Moment Correlation was carried out. As hypothesized, the relationship was significant and negative ($r = -.51, p < .001$), which supported alternative hypothesis three that there would be a statistically significant negative relationship between the responses of the NPRTS and the TIS-6 (see Table 6). It must

be noted that in Table 6, the subscales of the NPRTS (Developing Comfort and Building Competence in the Role, Understanding of the Role by Others, and Collegial Comfort) each correlated independently and were statistically significant with the TIS-6 scores ($r = -.412, -.303, -.598$, respectively).

Table 6

Correlation Coefficients for the Relationship between NPRTS and TIS-6 (N = 140)

Predictor	Criterion	<i>r</i> statistic	<i>p</i> - value
NPRTS Total Score	TIS-6	-.51	<.001
Developing Comfort and Building Competence in the Role	TIS-6	-.412	<.001
Understanding of the Role by Others	TIS-6	-.303	<.001
Collegial Comfort	TIS-6	-.598	<.001

Since a significant negative correlation was revealed, it was appropriate to carry out a regression analysis to establish the linear relationship discovered. The model for the regression in Table 7 was significant ($F(1, 138) = 49.039, p < .001$) and the coefficient of determination indicated the percentage of variation in TIS-6 scores that could be determined by the NPRTS total scores as 26% ($r^2 = .26$). The regression equation obtained was $y = -.286x + 31.644$ where x represents the NPRTS total scores, and y represents the TIS-6 scores in Figure 10.

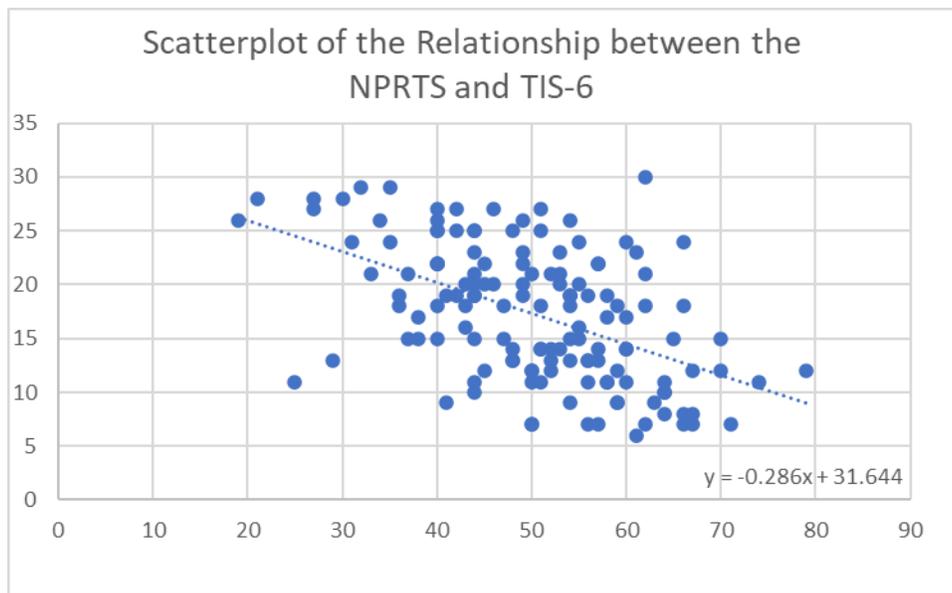
Table 7

Model for the Regression of the Relationship of NPRTS on TIS-6 (N =140)

Model	SS	Degree of Freedom	MS	F Statistic	p-value
Regression	1410.471	1	1410.471	49.039	<.001
Residual	3969.215	138	28.762		
Total	5379.686	139			

Figure 10

Scatterplot of the Relationship Between the Predictor Variable (NPRTS) and the Criterion Variable (TIS-6)



Chapter Summary

This chapter provides the findings of the study. The sample description, reliability estimates for the instruments, exploratory data analysis for the measurements, including assumptions, descriptive findings of the major variables,

research questions and hypotheses, and statistical analyses employed to answer the research questions and the results are presented. The 37-item survey was hosted online by SurveyMonkey and included three instruments: a demographic questionnaire, the Nurse Practitioner Role Transition Scale (NPRTS), and the Turnover Intention Scale (TIS-6). A single item on the demographic questionnaire measured the independent variable (structured orientation), the outcome variables role transition and turnover intentions were measured by the Nurse Practitioner Role Transition Scale (NPRTS) and the Turnover Intention Scale (TIS-6). Convenience sampling yielded 162 Advanced Practice Registered Nurses with completed surveys, of which 140 subjects met the inclusion criteria.

Most of the subjects were females (92.1%, $n = 129$). More than half of the subjects fell within the age range of 31-40 (46.4%, $n = 65$) and identified themselves as white, non-Hispanic (58.6%, $n = 82$). Most of them were married or in a civil domestic union (74%, $n = 104$). Geographically, the subjects came from all regions of the United States. They worked in various practice settings. The majority of the Advanced Practice Registered Nurses (APRNs) specialized in family practice (65%, $n = 91$), followed by acute care (15%, $n = 22$). Most APRNs held a master's degree, followed by a doctorate (84%, $n = 117$, 16%, $n = 23$, respectively). The mean number of years of practice as a Registered Nurse (RN) was 11.36 years ($SD = 7.30$, $skew = 1.3$) and the mean number of months in their current position was 15.84 months ($SD = 10.18$, $skew = .287$) with a range of 1 month to 36 months. In response to question 13 on the demographic questionnaire, approximately 28% of the subjects reported that yes, they received structured orientation (a mentorship, a preceptorship, or a residency

experience) in their new role ($n = 39$). About 51% ($n = 111$) all the APRNs in the study including those APRNs who changed work environment as well as some of the APRNs who did not change work environment, but chose to answer question 15a in the study, reported having had a mentor (an informal go-to person for support). However, to account for the number of APRNs in question 15b ($n = 92$) who changed work environment/organization that had mentors, the researcher manually counted the numbers and found 65.2% of the APRNs ($n = 60$) had a mentor or mentors.

Hypothesis One suggested that there was a significantly higher role transition mean scores for novice Advanced Practice Registered Nurses (APRNs) who received structured orientation in their first position than for those who did not receive structured orientation was supported. It was tested using independent t -tests. The results showed that a statistically significant difference was found ($t(138) = 3.017, p = .0015, ES = .57$). Hypothesis Two stated that there were significantly lower turnover intentions mean scores for novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position than for those who did not receive structured orientation was supported. It was tested using independent t -tests. The results demonstrated that a statistically significant difference was found ($t(138) = -2.231, p = .0145, ES = -.42$). Hypothesis Three indicated that there would be significant negative relationship between the NPRTS total scores, and the TIS-6 scores was supported. It was tested utilizing Pearson product-moment correlation. The relationship was statistically significant and negative ($r = -.51, p < .001$). A linear regression analysis established the relationship discovered. The model for the regression was significant ($F(1, 138) = 49.039, p < .001$) and the coefficient of determination indicated the percentage of

variation in TIS-6 scores that could be determined by the NPRTS total scores as 26% ($r^2 = .26$). Chapter Five follows with a summary and discussion of the study.

CHAPTER FIVE

SUMMARY AND DISCUSSION

The purpose of this non-experimental, cross-sectional, correlational study was designed to investigate the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses (APRNs) in their first APRN position. Chapter Five provides a synopsis of the research problem, purpose of the study, research questions, hypotheses, data collection, and appropriate analytic methods that were utilized. This is followed by a review of the demographic and background characteristics of the subjects and a discussion of the results of the statistical analyses. The significance of the study, significance of the study to nursing and the implications as it related to nursing education, nursing research, nursing practice, health and public policy are delineated. Furthermore, the strengths and weaknesses of the study are highlighted, and suggestions for future studies are recommended followed by the conclusions reached in the analysis.

Summary of the Study

A cross-sectional, correlational design was used to investigate the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses (APRNs) in their first APRN position. This study sought to answer the two research questions about whether APRNs who received compared to those who did not receive structured orientation had a better role transition and lower job turnover intentions and a third research question asking whether the relationship between role transition and turnover intentions was

negatively related for these APRNs. The hypotheses that were tested to answer these questions were:

H₁. Role transition mean scores for novice Advanced Practice Registered Nurses who received structured orientation in their first position are higher than for those who did not receive structured orientation.

H₂. Turnover intentions mean scores for novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position are lower than for those who did not receive structured orientation.

H₃. There is a negative correlation between NPRTS scores and TIS-6 scores for novice Advanced Practice Registered Nurses.

A convenience sample of 162 Advanced Practice Registered Nurses of which 140 subjects met inclusion criteria were recruited over a five-week period from various professional nursing organizations such as State Boards of Nursing across the U.S., American Association of Nurse Practitioners (AANP), American Nurses Credentialing Center (ANCC), American Nurses Association (ANA), Florida Nurses Association (FNA), Haitian American Nurses Association (HANA), Lambda Chi Chapter of Sigma Theta Tau International of Nursing, Hispanic Nurses Association (HNA), Black Nurses Association (BNA), South Florida Council of Advanced Practice Nurses, Nurse Practitioner Council of Miami-Dade, and the ENP Network by email and social media through Linked In, Facebook, Twitter and WhatsApp. Access letters were also emailed to Chief Nursing Officers (CNO) of hospitals, and church leaders across the United States to recruit potential subjects for the study. The researcher's APRN pool of acquaintances and colleagues were accessed for

recruitment of subjects via email and telephone through convenience and network sampling techniques. However, the sample came from the 21 Facebook Advanced Practice Registered Nurses (APRNs) groups, Haitian American Nurses Association (HANA), LinkedIn, and the researcher's convenience sample of APRN pool of acquaintances and colleagues and network sampling. A 37-item survey was hosted online by SurveyMonkey and included three surveys: a demographic questionnaire, the Nurse Practitioner Role Transition Scale (NPRTS) to measure role transition, and the Turnover Intention Scale (TIS-6) to measure job turnover intentions. A single-item question on the demographic questionnaire assessed whether APRNs received structured orientation with a yes and no response.

Summary of the Study Findings

Research related to structured orientation and role transition as predictors of role transition and job turnover intentions in Advanced Practice Registered Nurses has been studied in previous research but not with this focus. The results of the study are discussed with the intent to highlight these differences.

Demographics and Background Characteristics

In this study, most of the subjects were females, which is a common phenomenon for most studies related to nursing, since nursing remains a female dominated profession. The age ranges by decades were evenly represented (14% to 46%) and the distribution of this sample's ethnicity correlated with the United States (U.S.) population diversity statistics. Geographically, the subjects came from all five regions of the United States uniformly with four areas representing 10.7% to 13.6% and the Southeast representing 33.6% of the sample. Therefore, the sample was representative of Advanced Practice

Registered Nurses (APRNs) across the country. The subjects in this study worked in a variety of practice settings and embodied the many practice locations of many APRNs today. This sample correlated with the American Association of Nurse Practitioners (AANP) (2020) fact sheet in that most of the Advanced Practice Registered Nurses specialized in family practice (65%). Most APRNs held a master's degree, and the next most frequent degree was a doctorate (84% and 16%, respectively). Many of the subjects had a reasonable number of years of practice as a Registered Nurse (RN) ($M = 11.36$, $SD = 7.30$) except for one subject who reported zero years of prior RN experience. According to Jones et al. (2015) and Owens (2018), prior RN experience aided new APRNs to build upon their role transition in concert with a supportive environment. Based on the authors' assertion, a new APRN without prior RN experience may be subjected to a tougher role transition.

The APRNs in this sample had a mean number of 15.84 months in their new role ($SD = 10.18$, $skew = .287$), with a range of 1 month to 36 months in their current position. This data offered timely information of the status of new APRNs' role transition and job turnover intentions. Furthermore, the statistical percentages have not improved. As mentioned, only 28% of the sampled APRNs in this study acknowledged having had a formal structured orientation; In so far as a change in workplace, about 51% ($n = 111$) of all the APRNs in the study including those APRNs who changed work environment as well as some of the APRNs who did not change work environment, but chose to answer question 15a in the study as this question was meant to address only those who changed work environment, reported having had a mentor (an informal go-to person for support). However, to account for the number of APRNs in question 15b ($n = 92$) who changed

work organization/environment that had mentors, the researcher manually counted the numbers and found 65.2% of the APRNs ($n = 60$) APRNs reported having had a mentor or mentors.

Auffermann et al. (2020), in a quantitative study, assessed new APRNs' transition period during the first 6 months to 2 years of practice by exploring the influence of demographics (practice setting, formal orientation programs and intent to leave current position) and job satisfaction. The authors reported approximately 33.6% of the subjects received formal orientation. Bryant and Parker (2019) in another quantitative study evaluated APRNs' responses who completed a fellowship program to those who did not on the Misener Nurse Practitioner Job Satisfaction Scale (MNPJSS) and revealed only 19% of subjects completed a fellowship program. Additionally, Park et al. (2021) assessed the outcomes of a postgraduate residency or fellowship program on primary care APRNs' role perception, practice autonomy, team collaboration, job satisfaction, and intent to leave their current position and discovered only 10% of the subjects completed a post-graduate training program.

Furthermore, a quantitative study by Barnes (2015a) assessed whether prior RN role and formal orientation influenced role transition also reported 33% of APRNs received formal orientation. Based on the percentage of APRNs who received structured orientation in this current study, the numbers have not progressed. In so far as a change in workplace, 66% of the subjects changed work environment in their new APRN role. About 51% of all the APRNs ($n = 111$) who answered question 15a in this study reported having had a mentor or mentors, 29% did not have a mentor, and 21% ($n = 29$) skipped the question as this question was meant to only address those who

changed work environment. However, of the Advanced Practice Registered Nurses (APRNs) in question 15b ($n = 92$) who changed work organization/environment, 65.2% of the APRNs ($n = 60$) had a mentor or mentors while 34.8% of APRNs ($n = 32$) reported not having had mentors. Having a mentor is highly regarded as a necessity to assist new APRNs in their transition into the new role and to promote personal and professional growth, familiarity with the organization and a supportive environment (Robeano et al., 2019; Horner, 2017).

Relationships Among Major Study Variables

The objective of this study was to determine whether the role transition and job turnover intentions differed between those who had or did not have structured orientation and whether role transition was negatively related to turnover intentions. Significant findings were obtained when testing the hypotheses developed for this study. The findings, from this study, mirrored previous findings from past studies on this topic in that those who received structured orientation obtained significantly higher scores on both measures of role transition and job turnover intentions and the measures were negatively related in some studies. Other research articles presented studied different variables that were related and supported the current study's findings.

Research Question One, Hypothesis One

To test hypothesis one that those who received structured orientation would have higher role transition scores than those who did not receive structured orientation, a one-sample independent t -test was conducted. The results revealed that the Nurse Practitioner Role Transition (NPRTS) mean scores for the yes group of 54.69 compared to the NPRTS mean scores for the no group of 48.53 was statistically

significant ($t(138) = 3.017, p = .0015, ES = .57$), which supported the alternative hypothesis that APRNs who received structured orientation would score higher on the NPRTS. The effect size for this test was moderate. This indicated that structured orientation would promote improved role transition for APRNs entering a new position. Studies that were conducted by Auffermann et al. (2020), Park et al. (2021), Bryant and Parker (2019), and Owens (2018) supported this finding.

In a quantitative study that sought to comprehend the transition period of new Advanced Practice Registered Nurses (APRNs) by exploring the impact of demographics (practice setting, formal orientation programs and intent to leave current position) and job satisfaction during the first 6 months to 2 years of practice, Auffermann et al. (2020) reported about 33.6% subjects received formal orientation. Subjects who received a formal orientation were more satisfied with their job ($M = 189.82, SD = 47.07$) than those who did not receive one ($M = 172.19, SD = 42.33$); $t(114) = 2.04, p = .04$. Those APRNs who were trained also took advantage of the opportunities to grow in their profession ($M = 20.64, SD = 6.78$) in comparison to those who were not trained ($M = 17.72, SD = 6.78$; $t(114), p = .02$). This finding was relevant to hypothesis one as formal orientation (a mentorship, a preceptorship, or a residency experience) promoted job gratification and professional growth which are components of enhanced role transition.

Park et al. (2021) assessed the outcomes of a postgraduate residency or fellowship program on primary care APRNs' role perception, practice autonomy, team collaboration, job satisfaction, and intent to leave their current position on a subset of ($n = 8,400$) primary care providers from the 2018 National Sample Survey of Registered Nurses ($N = 75,996$) and found only 19% of subjects completed the fellowship program.

Multivariate logistic regression analyses revealed APRNs who attended a postgraduate training program had a better role experience, were able to perform more independently, worked better in teams, exuded greater pleasure in their role, and expressed a lesser intent to leave their position than those who did not attend a residency training. However, role perception was not statistically significant between the group with residency training (85%, $n = 6364$) and those without training (82%, $n = 55,992$). Both groups said they were able to practice to the full extent of their education. As it relates to practice autonomy, the subjects with training (69%, $n = 5,127$) were more apt to bill under their national provider identification (NPI) than those without (64%, $n = 43,215$). While the bivariate analysis was not statistically significant between the groups ($p = .14$), once personal and practice attributes were managed, the significance was minimal. As it pertains to team collaboration, training post-graduation was positively correlated with working better in team-based care ($OR = 1.28$; 95% CI , 1.01–1.62; $p = .04$), and those participants felt more comfortable to perform in multidisciplinary teams ($OR = 1.69$; 95% CI , 1.28–2.23; $p < .001$). The findings in the Park et al. (2021) study correlates well with the tested results of hypothesis one of this study. According to Park et al. (2021), those who completed a postgraduate training exhibited more autonomy in practice, valued working in team-based care, demonstrated more commitment to remain in their role, and experienced a better role transition.

Bryant and Parker (2019) conducted a quantitative study on 258 Advanced Practice Registered Nurses (APRNs) to evaluate the response of those APRNs who completed a fellowship program to those who did not on the Misener Nurse Practitioner Job Satisfaction Scale (MNPJSS). In this study, 19% ($n = 49$) of the subjects received the

training while 81% (209) did not. Mean scores for the different measures of the MNPJSS were computed. Mean scores on sense of accomplishment were marginally increased for those who did the fellowship program ($M = 5.20, SD = 1.02$) as compared to those who did not ($M = 5.01, SD = 1.03$); opportunity to expand scope of practice ($M = 4.69, SD = 1.19$) versus ($M = 4.38, SD = 1.32$), opportunity for change in the work setting or office practice ($M = 4.45, SD = 1.32$) versus ($M = 4.34, SD = 1.45$) freedom to question decisions and practices ($M = 4.47, SD = 1.32$) vs ($M = 4.34, SD = 1.42$), the ability to deliver quality care ($M = 5.16, SD = 1.03$) vs ($M = 5.11, SD = 0.88$), respect for opinion ($M = 4.49, SD = 1.40$) versus ($M = 4.29, SD = 1.44$), and acceptance and attitudes of physicians outside of practice ($M = 4.63, SD = 1.16$) vs ($M = 4.45, SD = 1.10$). Mean scores were moderately increased for those who achieved the fellowship program than those who did not. Mean scores for opportunity for professional growth were ($M = 4.69, SD = 1.19$) vs ($M = 4.38, SD = 1.32$), input into organizational policy ($M = 4.20, SD = 1.29$) versus ($M = 3.88, SD = 1.48$), a sense of value for what is done ($M = 5.02, SD = 1.09$) versus ($M = 4.65, SD = 1.37$), flexibility in practice protocols ($M = 4.78, SD = 1.10$) vs ($M = 4.51, SD = 1.23$), monetary bonuses that are available in addition to salary ($M = 3.94, SD = 1.74$) vs ($M = 3.16, SD = 1.65$), and compensation for services outside of normal duties ($M = 3.69, SD = 1.50$) versus ($M = 3.08, SD = 1.60$). There were similar means found with respect to recognition for work from superiors ($M = 4.31, SD = 1.56$) vs ($M = 4.33, SD = 1.41$) and level of autonomy ($M = 5.14, SD = 1.10$) versus ($M = 5.14, SD = 1.00$).

Independent *t*-tests reported a statistically significant difference in sense of value for what is done ($t(87.561) = -2.054, p = .05$), monetary bonuses that are available in

addition to salary ($t(256) = -2.938, p = .01$), and compensation for services outside of normal duties ($t(256) = -2.433, p = .05$) in those who attended the fellowship program in comparison to those who did not. There was no significant mean difference in the other measures. This study supported hypothesis one in that the APRNs who attended a fellowship program exhibited greater sense of comfort and acceptance in the role, felt valued and accepted by other professionals, were able to voice their opinion and gave their input within the organization. They also expressed the ability to achieve growth and independence in the role and being compensated for their work. These responses are positive components that promote a successful role transition.

In a qualitative phenomenological study, Owens (2018) investigated 10 Family Advanced Practice Registered Nurses' (APRNs) assessments of their role transition professional identities from Registered Nurse (RN) to being an APRN in their first year of primary care practice in a rural setting. Five themes emerged: Learning new skills, knowledge, and roles; interactions and relationships with patients, nursing staff, and providers; desire to practice in rural health; role transition to APRN professional identity, and professional identity and work satisfaction. All participants expressed feeling uneasy, worried, and overwhelmed in their new role. Building upon their prior RN role as well as the acquisition of new skills and learning the new role aided them to successfully transition in their new APRN scope of practice as it differed from that of an RN. They also advocated for the inclusion of rural health in the APRN curriculum prior to working in a rural environment. Connecting and interacting with patients and collaboratively working in a team effort with nursing and medical teams while rendering care in a supportive environment anchored their professional identities as APRN providers.

In addition, they felt their role was supported by others which favor the Understanding of the Role by Others subscale of the NPRTS scale. Participants expressed the value of mentoring and structured orientation. One participant in this group attended a residency training with an assigned mentor and attributed it as being integral in succeeding, feeling confident and competent in the role. Others sought mentors in respective or remote rural facilities. The outcomes from the Owens (2018) study supported hypothesis one in that structured orientation and mentoring facilitated the new APRNs' desire to grow their professional identities and obtain new skills in a supportive environment. The understanding of their role by patients, nurses, and physicians also boosted their sense of worth, inclusion, work satisfaction and commitment.

Overall, the studies in this section advocated for the need for structured orientation for new Advanced Practice Registered Nurses (APRNs) in their first APRN position. In addition, the results of the studies supported the components of the Nurse Practitioner Role Transition Scale (NPRTS) as well as its three subscales. In addition, the findings elicited that structured orientation, residency or fellowship program and mentorship supported new APRNs to achieve comfort, proficiency, and satisfaction in their role transition. Furthermore, the structured environment offered APRNs a sense of collegiality which promoted team building, collaboration, and support. This ultimately aided the new APRNs to feel valued and built self-confidence and competence.

Research Question Two, Hypothesis Two

To test hypothesis two that those who received structured orientation would have lower turnover intentions scores than those who did not receive structured orientation, a one-sample independent *t*-test was conducted. The data results of this

study revealed that the TIS-6 mean scores for the yes group of 15.41 compared to the TIS-6 mean scores for the no group of 17.99 was statistically significant ($t(138) = -2.231, p = .0145, ES = -.42$), which supported the alternative hypothesis that APRNs who received structured orientation would score lower on the TIS-6. The effect size for this test was also moderate. This indicated that structured orientation would decrease job turnover intentions for APRNs during the early stages of their new employment. For an employer to be able to alter the average job turnover intentions of novice APRNs to a more acceptable level and remain with an organization would make financial sense for cost containment since the average salary for APRNs in the United States (U.S.) is \$ 105,220 (Bureau of Labor Statistics, 2020).

G. Roodt (personal communication, October 22, 2019) suggested that any score below 18 on the TIS-6 scale indicated a desire to stay in the position of employment and a score of 18 or above indicated a desire to leave the organization. The mean score of 17.99 in this study indicated that approximately 50% of those who did not receive structured orientation had a desire to leave their employment. This finding correlated with the low percentage of APRNs that received structured orientation in this study. In effect, job turnover intentions had an inverse relationship when compared to those who received structured orientation or not. Any efforts at changing this percentage would benefit that organization. The notion that job turnover intentions for APRNs is decreased when structured orientation is received, was partially supported in the literature. The study findings of Park et al. (2021) and Auffermann et al. (2020) correlated with the results obtained in this study's second

hypothesis; while the studies by Brom et al. (2016), Mahoney et al. (2018), and Hagan and Curtis (2018) did not.

In a quantitative study assessing the impact of residency on new APRNs, Park et al. (2021) asserted that 57% ($n = 3704$) primary care APRNs who completed a residency were 0.65 times less prone to contemplate leaving their position (95% *CI*, 1.51–0.83; $p < .001$); on the contrary, 45% ($n = 27,404$) of the APRNs who did not receive training had planned to leave their job ($p < .001$). Auffermann et al. (2020) in a quantitative study assessed the transition period of new APRNs with respect to practice settings, formal orientation programs, and intent to leave their current position and job satisfaction, postulated that formal orientation increased job satisfaction in new APRNs. Those who wanted to leave their job, had lower job satisfaction, and comprised nearly one-third of their study's subjects (34.5%, $n = 40$). According to Nursing Solutions (2019), this number exceeded the yearly turnover rate (11%) for APRNs threefold. In this current study, the findings revealed a job turnover intention to be as high as 50%. This frightening statistic emphasizes the need for all employers to provide structured orientation for novice APRNs starting in their organization.

Brom et al. (2016) conducted a study on Advanced Practice Registered Nurses (APRNs) at a Midwestern American Medical Center ($N = 181$) to measure their role perception and satisfaction as it relates to their relationships to stress and intent to stay. The APRNs demonstrated moderate role perception ($M = 4.30$, $SD = 1.23$) and were satisfied to some extent with their job ($M = 4.23$, $SD = 0.74$). More than a third (39.4%) of subjects in the study expressed skepticism about remaining in their current role or planned to leave. Intent to stay and stress demonstrated a moderate relationship

with overall satisfaction and a weak relationship with role perception. Significant differences were detected in the intra-practice and professional components of job satisfaction as was measured on the MNPJSS based on who was providing the supervision. Advanced Practice Registered Nurses (APRNs) who were supervised by another APRN exhibited higher satisfactory scores with intra-practice than those received supervision from a nurse executive/administrator.

This is an important finding as APRN preceptors, supervisors, or mentors must be familiar with their scope of practice (MacLellan et al., 2015); whereas APRNs experienced greater levels of contentment with the professional subscales when they reported to a non-clinician administrator (managers) than a nurse executive/administrator. Of greater importance, the researchers also stressed that new APRNs practice in their new role to promote growth as new APRNs often struggle with role development and may revert to the RN role (Heinz et al., 2004). The variables in this article differed from that in the current study, as it investigated role perception and satisfaction as it related to stress and intent to stay. Therefore, the findings from the Brom et al. (2016) research study did not correlate with the data results from hypothesis two that structured orientation decrease job turnover intentions. However, it must be noted that new APRNs who were precepted by an APRN preceptor were more satisfied with their practice. In addition, recommendations also included that new APRNs practice within their new role and not revert to the previous role, which can affect turnover.

Mahoney et al. (2018) conducted a study analyzing data from a 2012 national sample of ($N = 7,944$) Advanced Practice Registered Nurses (APRNs) to comprehend

factors leading to job turnover from four different practice regions (primary care, internal medicine, surgical and other). The factors that contributed to increased turnover intentions included patient workload (primary care: $r = 0.62, p < .001$; internal medicine: $r = 0.60, p < .001$; surgical: $r = 0.72, p < .001$; other: $r = 0.53, p < .001$), professional treatment (primary care: $r = 0.53, p < .001$; internal medicine: $r = 0.54, p < .001$; surgical: $r = 0.88, p < .001$; other: $r = 0.46, p < .001$), organizational administration (primary care: $r = 0.69, p < .001$; internal medicine: $r = 0.71, p < .001$; surgical: $r = 0.81, p < .001$; other: $r = 0.83, p < .001$), and salary and benefits (primary care: $r = 0.50, p < .001$; internal medicine: $r = 0.33, p < .001$; surgical: $r = 0.31, p < .001$; other: $r = 0.28, p < .001$). The findings were positive and had a statistically significant correlation to increased turnover intentions. The researchers asserted that the APRNs were dissatisfied with the lack of administrative support, the inability to grow professionally, and not having a voice into organizational practice, which had a great impact on turnover intentions. The results of the Mahoney et al (2018) research study did not correlate with the survey results for hypothesis two as it highlighted other factors such as patient workload, professional treatment, organizational administration, salary, and benefits as causative agents for increased job turnover intentions in this group.

Hagan and Curtis (2018), in a quantitative study of 315 Advanced Practice Registered Nurses (APRNs), set out to develop statistical models using Misener Nurse Practitioner Job Satisfaction Scale (MNPJSS) factors and nurse demographic characteristics to identify factors that predict length of Texas APRNs' employment and intention to leave. In this study, 39% ($n = 114$) expressed the intention to leave

their current role within 0-5 years. While age ($r = 0.355, p < .001$), years of APRN experience ($r = 0.438, p < .001$), annual salary ($r = 0.119, p = .046$), and benefits ($r = 0.204, p = .001$) demonstrated a statistically significant positive correlation with the number years of employment in the current role, only the challenge and autonomy subscale score reduced APRNs' turnover intentions within 5 years by 57% (odds ratio = 0.43, 95% confidence interval: 0.21–0.85, $p = .016$). In addition, a salary increase for each \$25,000 also diminished that intent within 5 years by 33% (odds ratio = 0.67, 95% confidence interval: 0.47–0.97, $p = .032$). The results in the Hagan and Curtis (2018) study differed from this study in that Hagan and Curtis cited challenge and autonomy as strong variables for decreasing turnover within 5 years by 57% and substantial salary increase to inhibit attrition by 33%. In addition, 39% of new APRNs within 0-5 years expressed the intention to leave their current role. Therefore, the Hagan and Curtis (2018) study did not correlate with the research results of hypothesis two in this study.

Research Question Three, Hypothesis Three

To test hypothesis three that a negative correlation existed between the NPRTS scores and the TIS-6 scores for novice Advanced Practice Registered Nurses, a Pearson Product-Moment Correlation was conducted. The output showed a statistically significant negative correlation between the NPRTS total scores and the TIS-6 scores ($r = -.51, p < .001$), which supported alternative hypothesis three. This signified that as scores measuring role transition increased, the scores measuring turnover intentions decreased and vice versa. For an organization, this means that any attempt to improve the

transitional experience for APRNs would decrease the chances that the APRN would want to leave the organization.

Information from the regression analysis indicated that a regression equation of $y = -.286x + 31.644$ where x represented the NPRTS total scores, and y represented the TIS-6 scores could be used to determine the probability that an APRN would have the intention to leave his or her job with the understanding that 26% of the variation in the measurement of job turnover intentions can be determined by the measurement of role transition. According to Polit and Beck (2017), the quality of any prediction made from the regression formula and the percentage of the variance in the scores from the dependent variable that could be determined using scores from the independent variable would come from the strength of the correlation which, in this case, was moderate. Auffermann et al. (2020), Park et al. (2021), and Bryant and Parker (2019) supported the correlation that was discovered in this study that structured orientation decreased turnover intentions. However, it can be inferred that 74% of the variations that were unaccounted for in the regression analysis can be attributed to other variables as previously reported in the latter studies.

Relationship of Study Findings to Theoretical Framework

Meleis' Transitions theory provided a blueprint to guide the development of this study. The conceptual representation of the impact of structured orientation on role transition and turnover intentions on Advanced Practice Registered Nurses adapted from Meleis et al.'s Transitions Theory (2000) was supported by the findings of the study. Structured orientation, which served as a transition condition and a nursing therapeutic, was positively correlated to better role transition and decreased

job turnover intentions in new Advanced Practice Registered Nurses (APRNs). The findings are partially supported in the literature as evidenced by Nacht and Martin (2020), Bumby and Litwack (2021), and Hallaran et al. (2020).

Nacht and Martin (2020) assessed the University of Colorado College of Nursing's Midwifery 12-month fellowship program with the purpose to recruit new nurse midwives in an academic center by integrating interprofessional education as part of the clinical training in concert with the School of Medicine. Five new graduate nurse midwives' fellows were paired with medical students and residents as part of the interprofessional experience over a 4-year period. Meleis' Transitions Theory and Jean Watson's Theory of Human Caring guided the study. The aim was to comprehend whether the fellowship program aided the new nurse midwives fellows' transitions to develop enhanced confidence and competence and a better appreciation for interprofessional team-based practice. The fellows were evaluated in seven competency areas, which included clinical, professional, intrapersonal, mentorship, interprofessional, low-resource setting, and leadership.

Emerging themes from their reflective journals underscored how mentorship supported their clinical and professional growth as nurse midwives. In addition, two of the fellows became faculty members in the practice and four of them were offered faculty positions at the completion of the program. This article supported Meleis' theoretical framework as well as the findings in the study in that the fellowship promoted the nurse midwives to succeed in their new role. The fellowship served as a transition condition and a nursing therapeutic that led to a successful transition. In this study, the Advanced Practice Registered Nurses (APRNs) who had structured

orientation had higher mean scores on the Nurse Practitioner Role Transition Scale (NPRTS) and lower mean scores on the Turnover Intention Scale (TIS-6).

Bumby and Litwack (2021) conducted a qualitative, phenomenographic study in a Midwestern United States research university's college of nursing to assess the effectiveness of Nurse Endeavor Program (NEP) interventions to support first generation, underrepresented, and/or low-income nursing major students in the first 2 years of their preliminary courses (pre-nursing) to increase their success to nursing students. Meleis' theoretical framework also guided this study. Purposive sampling of 11 students who graduated as well as eight students who withdrew from the program were evaluated for facilitating and hindering factors of transition.

Facilitating factors of transition as enumerated by the participants who succeeded included the requirement to utilize available resources (professors, supplemental instruction, and tutoring), the provision of orientation and additional counseling and coaching, rigorous and invasive guidance, cohort scheduling through weekly study hall, grade monitoring, student group and monthly meetings, and leadership development. Inhibiting factors of transition included feelings of isolation by all the participants. Those who dropped out cited the inability to adapt to the program's difficulty level, their family's difficulty to understand the demands of their new role as students. Findings also included two students with health issues, which once mediated, one student returned to the program. Five of the dropouts went back to obtain their nursing degree at the institution or another which scored the program success rate to 82%. This article supported Meleis' Transitions Theory as well as the findings in the study in that it modeled facilitating as well as inhibiting factors of

transition. In addition, when nursing therapeutics are applied to those that are not progressing in the transition process, positive outcomes can still occur as in the case of the student nurses' dropouts discussed in the article. This notion is very applicable to new APRNs in this study as it relates to those who scored lower on the NPRTS scale and higher on the TIS-6 scale and had intentions to leave their current APRN position.

Hallaran et al. (2020) conducted a predictive, non-experimental study on 217 Ontario Registered Nurses who graduated within 2 years to evaluate Meleis et al.'s Transitions Theory's association between transition and intent to leave (ITL) their job in addition to personal, community and societal conditions. The two hypotheses in this study were that personal conditions, community conditions, and societal conditions would positively affect new nurses' transition and decrease intention to leave, and that transition mediated between new nurse's perception of personal, community and societal conditions and their intent to leave. The model was tested utilizing structural equation modeling. The measures for personal conditions included self-efficacy, work/family conflict and role stress (role ambiguity and role overload) scales and associated subscales). Organization commitment, job satisfaction, work environment total score (nurse participation, nursing foundations, staffing and resource adequacy, collegial relationships, nurse manager), and empowerment (perceived control, perceived competence, goal internalization) and Becoming part of the team scales and subscales measured community conditions. Casey-Fink Graduate Nurse Experience Survey total score scale and associated subscales (professional satisfaction, communication/leadership, support, and patient safety) measured transition. Societal conditions were measured with attending a transition program for more than 12 weeks

with a yes and no response. Turnover Intention (TI) scale and Nurse Retention Index scales measured intention to leave.

In this study, the theoretical model was not supported, and role transition did not hinder intention to leave as 44% of the nurses reported intent to leave and 1% left the nursing profession ($\beta = .89, p = .95$). On the other hand, lower role stress demonstrated a positive transition and partially supported the first hypothesis ($\beta = -.58, p < 0.01$). High self-efficacy ($\beta = -.73, p < 0.01$) and work environment ($\beta = -.37, p < 0.05$) yielded a negative role transition that rejected the second hypothesis. The findings in this article failed to support Meleis' theoretical framework as well as the findings in this study.

Both Nacht and Martin (2020) and Bumby and Litwack (2021) emphasized a supportive environment as a central component that Meleis (2010) identified as being an essential aspect in developing self-confidence and success during role transition. While these studies featured nurse midwives and nurses, the findings are applicable to all novice Advanced Practice Registered Nurses (APRNs) to promote success in the new role and minimize job turnover rates. Contrary to the latter investigators, Hallaran et al. (2020) found only lower role stress contributed to a successful transition in new nurses in Ontario. This is an important finding as role development improved self-confidence in new graduates. Although a correlation between transition and turnover intentions was not found in the study by Hallaran et al. (2020), supporting new APRNs was found to lower job turnover intent. Flinter (2011) in a multiple case study with cross-case synthesis of 16 APRN residents on bridging transition from federally qualified health care (FQHC) based 1-year residency training in 2007 utilized Meleis' theoretical framework as a guide to

evaluate the transition from APRN to competent primary care provider. All the residents completed the program successfully and reported increased confidence in caring for complex patients. At the completion of the program 15 residents were practicing in FQHC primary care settings. Robeano et al. (2019) asserted that role transition from RN to novice APRN involved all aspects of the healthcare system and highlighted a robust onboarding process that supported and maximized new providers' well-being through mentorship from the recruitment phase throughout the first year of the transitional period.

Significance of the Study

This study achieved its aim of enriching the body of current nursing knowledge. The findings elucidated the paucity of structured orientation for novice Advanced Practice Registered Nurses (APRNs) as a continual gap in nursing practice throughout the United States. It was evident that structured orientation positively impacted role transition mean scores and turnover intentions mean scores, which in turn, solidified the significance for the provisions of structured orientation to promote a seamless transition for new APRNs. Inconsistencies in the type of support new APRNs received remain a gap as structured orientation such as a mentorship, a preceptorship, or a residency experience, is not mandated and is not widely available for these groups of providers. In addition, this study demonstrated the challenging nature of role transition for new APRNs as well as what facilitated and inhibited the process for the subjects that were studied. It is the hope that this study's findings can revolutionize a change for consistency in the way novice APRNs are supported in their new role going forward nationally.

Significance of the Study to Nursing

The results of this study invoked ethical implications for the nursing profession in its duty to provide a seamless transition for novice Advanced Practiced Registered Nurses (APRNs) who are transitioning into practice. As predicted, the APRNs in the study had varying backgrounds and prior level of experience as Registered Nurses (RN) including one APRN with no prior RN experience. This finding summoned for the provision of a supportive environment that tailor to the different needs of the APRNs in the new role. Furthermore, only 28% of APRNs received structured orientation in this study, the remaining 72% did not receive structured orientation and as a result approximately 50% of APRNs had intent to leave their position. Therefore, the well-being of new APRNs through transitional support must be prioritized to offset these numbers that far exceeded the national turnover rate for APRNs.

According to the Future of Nursing 2020-2030 report (National Academies of Sciences, Engineering, and Medicine, 2021), there is a mandate to augment the availability of APRNs to support the growing health care needs of the population, provide APRNs in different specialties, allocate more APRNs to areas of greatest need, and ensure there are a diverse group of APRNs that are well prepared and competent to care for the population. The nursing profession also has a responsibility to address the paucity of structured orientation among new APRNs in a new role as an identified barrier to role transition and job turnover intentions as well an impediment to the growth of the nursing workforce. The continual viability of the nursing workforce is crucial as the health of the population is further complicated with long-term effects of the COVID-19 pandemic. Furthermore, the study's results may contribute to improving nursing education, nursing

practice, nursing research, health, and public policy for all new APRNs and strengthen the APRN workforce, improve patient outcomes, and fill the projected healthcare provider shortage gap for vulnerable populations.

Implications for Nursing Education

The findings of the study supported the stipulation for the standardization of entry level experience for enrollment of applicants into Advanced Practice Programs (APP). Most of the subjects worked as Registered Nurses (RN) prior to practicing as an APRN apart from one subject who had no prior RN employment. As such, the sad fact that some programs admitted nurses without prior RN experience was apparent in this study and could be viewed as a future hindrance to role transition. This must be addressed to ensure uniformity across the Advanced Practice Programs nationally regarding having set guidelines for admission to overcome the inconsistencies that currently exist across all APRN programs. In addition, structured orientation was found to facilitate role transition and decrease job turnover intentions. Therefore, finding ways to foster a partnership and a liaison for new APRNs in transition after graduation between schools of nursing and practice settings that include structured transition to bridge the academic and practice gap should be considered. In that way, reforms for the establishment of structured orientation can be promoted to ensure a seamless transition and decrease turnover intentions for new graduates.

Implications for Nursing Practice

The Future of Nursing 2020-2030 report advocated that Advanced Practice Registered Nurses (APRNs) are supported in their nursing capability and proficiency to provide equitable healthcare to everyone in addition to the added long-term impacts of

COVID-19 on the population (National Academies of Sciences, Engineering, and Medicine, 2021). As it relates to nursing practice, the results of this study have demonstrated that structured orientation is lacking in actual practice for new APRNs and impacts job turnover. With the expected shortage of primary care providers, the findings favor that new APRNs are prepared and supported early in the role with structured orientation to foster self-confidence and role development and decrease transition shock and turnover. In this way, their success in the role can sustain and strengthen the nursing workforce to serve the needs of the growing population with satisfactory patient outcomes. In addition, this study contributed data toward the needs of new APRNs to enhance their transition into practice.

Implications for Nursing Research

The findings of this research reinforced prior studies related to the topic that structured orientation enhanced role transition and decreased turnover intentions. This study is a call to action for all medical institutions to institute a formalized mandatory structured orientation for all novice Advanced Practice Registered Nurses (APRNs) that they hire. The results also backed Meleis' Transitions Theory as a resourceful guide that can help bridge the academic to practice gap to support new APRNs in transition. In addition, the theoretical framework also proposed a pathway to assist those in transition within a structured setting. Furthermore, the results of the study further augmented nursing's body of knowledge by promoting positive change for new APRNs in all aspects of their role transition to promote support, cohesion, team collaboration, proper role development, confidence, and competence in a nurtured and supportive environment.

Implications for Health and Public Policy

The findings of the study elucidate the need for health and public policy to support and strengthen existing programs for new APRNs in their successful role transition. The Commission on Collegiate Nursing Education (CCNE) Board of Commissioners (2020) recently approved national accepted standards for accrediting residency or fellowship programs for the private sector and federally funded programs for new Advanced Practice Registered Nurses starting a new role or entering a specialty. Currently, available residency and or fellowship programs are not accredited. While the option to accredit these programs is voluntary, all stakeholders should welcome and embrace this initiative.

As part of its objective to ameliorate public health and keeping with the recommendations of the Institute of Medicine (2010) and the Future of Nursing 2020-2030 report (National Academies of Sciences, Engineering, and Medicine, 2021), CCNE accreditation would ensure that these structured programs meet quality standards to support the needs of new APRNs in transition across the United States. Furthermore, the results advocate for the allocation of stable funding that can support the provision of structured orientation for all new Advanced Practice Registered Nurses (APRNs) in their new role. Currently, structured orientation such as a mentorship, a preceptorship, or a residency experience are not widely available for all APRNs. Flinter (2011) asserted that there was a lack of funds available to support transition to practice programs for new APRNs. As such, appropriated funds to support the transition of new APRNs within a supportive environment to succeed in the role are crucial to aim for a seamless transition

and decreased job turnover rate. In this way, new APRNs can be best positioned to serve the community at large.

Strengths and Limitations of the Study

Strengths

The strengths of the study added value to the significance of the research findings and are delineated as follows:

1. In this study, there were a total of 162 subjects, of which 140 met inclusion criteria for the study. The sample size was deemed to have sufficient power to achieve statistical significance and detect error.
2. The sample was geographically dispersed across the United States and represented Advanced Practice Registered Nurses (APRNs) from various specialties with family practice being predominant as reported by the American Association of Nurse Practitioners (AANP) fact sheet.
3. The reliability and validity of the instruments utilized in the study were established as satisfactory for data collection.
4. The researcher received guidance and support from experienced researchers and statistician.
5. The researcher has been a registered nurse for 19 years, has taught nursing students as an adjunct clinical instructor, and briefly worked as an Advanced Practice Registered Nurse for 11 months in the role. She subsequently left the APRN role because of the issues faced by novice APRNs which brings awareness to this study.

6. The study's concentration on the paucity of structured orientation availability to novice Advanced Registered Nurses (APRNs) in their new role highlighted a gap in practice and augmented the body of knowledge in the nursing profession.

Limitations

The limitations of the study have impacted how the results of the study could be generalized to the target population. Limitations were as follows:

1. Utilization of a convenience sample was employed.
2. The researcher relied on the truthfulness of the subjects' self-reported responses.
3. The study was correlational in nature and therefore could not infer causality between the independent and the dependent variables.
4. Men were poorly represented in the study sample despite males being the minority in terms of gender in the profession.
5. The question regarding available mentors to the subjects in their new Advanced Practice Registered Nurse (APRN) role on the demographic questionnaire should have been addressed to all subjects in the study, not just those who changed work environment to gain a true sense of how many APRNs were mentored.
6. The COVID-19 pandemic might have affected available resources to support new APRNs in transition.
7. A novice researcher conducted the study.

Recommendations for Future Study

The researcher hopes that the findings of this study can solidify the imminent need for the implementation for structured orientation for all novice Advanced Practice Registered Nurses (APRNs). The literature review also suggested other reasons such as job satisfaction, monetary compensation, organizational support, and autonomous practice as factors that aided role transition and decreased job turnover intentions and should be further investigated. Moreover, Advanced Practice Registered Nurse (APRN) programs should consider partnerships with practice settings for student APRNs that include clinical immersions consisting of prolonged engagement with a preceptor during graduate school that extend through orientation in the role as a graduate APRN to facilitate a seamless transition. Given that this study was correlational, other antecedents that could have had effects on the dependent variables should be considered. In addition, a grounded theory study can be explored to possibly arrive at a theoretical framework that support new APRNs transitioning into advanced nursing practice or a social process that can explain the phenomenon of new APRNs that are transitioning into practice and its impact on their job turnover intentions.

Conclusions

The purpose of this non-experimental, cross-sectional, correlational study was to investigate the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses in their first APRN position. A convenience sample of 162 Advanced Practice Registered Nurses of which 140 subjects met inclusion criteria were recruited over a 5-week period from various professional nursing organizations such as State Boards of Nursing across the U.S.,

American Association of Nurse Practitioners (AANP), American Nurses Credentialing Center (ANCC), American Nurses Association (ANA), Florida Nurses Association (FNA), Haitian American Nurses Association (HANA), Lambda Chi Chapter of Sigma Theta Tau International of Nursing, Hispanic Nurses Association (HNA), Black Nurses Association (HNA), South Florida Council of Advanced Practice Nurses, Nurse Practitioner Council of Miami-Dade, and the ENP Network by email and social media through Linked In, Facebook, Twitter and WhatsApp. Access letters were also emailed to Chief Nursing Officers (CNO) of hospitals, and church leaders across the United States to recruit potential subjects for the study.

The researcher's APRN pool of acquaintances/colleagues were accessed for recruitment of subjects via email and telephone through convenience and network sampling techniques. However, the sample came from the 21 Facebook Advanced Practice Registered Nurses (APRN) groups, Haitian American Nurses Association (HANA), LinkedIn, and the researcher's convenience sample of APRN pool of acquaintances and colleagues and network sampling. A 37-item survey was hosted online by SurveyMonkey and included three surveys: a demographic questionnaire, the Nurse Practitioner Role Transition Scale (NPRTS) to measure role transition, and the Turnover Intention Scale (TIS-6) to measure job turnover intentions. A single-item question on the demographic questionnaire assessed whether APRNs received structured orientation with a yes and no response. Subjects were recruited via nursing and Advanced Practice Registered Nurses (APRNs) organizations by email and social media through Linked In, Facebook, Twitter, and WhatsApp. The researcher's APRN pool were also accessed with associated network sampling.

Many of the subjects were females (92.1%, $n = 129$). More than half of the subjects fell within the age range of 31-40 (46.4%, $n = 65$) and identified themselves as white, non-Hispanic (58.6%, $n = 82$). Most of them were married or in a civil domestic union (74%, $n = 104$). Geographically, the subjects came from all regions of the United States. They worked in various practice settings. Majority of the Advanced Practice Registered Nurses (APRNs) specialized in family practice (65%, $n = 91$), followed by acute care (15%, $n = 22$). Most APRNs held a master's degree, followed by a doctorate (84%, $n = 117$, 16%, $n = 23$, respectively). The mean number of years of practice as a Registered Nurse (RN) was 11.36 years ($SD = 7.30$, $skew = 1.3$) and the mean number of months in their current position was 15.84 months ($SD = 10.18$, $skew = .287$) with a range of 1 month to 36 months.

In response to question 13 on the demographic questionnaire, approximately 28% of the subjects reported that yes, they received structured orientation (a mentorship, a preceptorship, or a residency experience) in their new role ($n = 39$). About 51% all the APRNs in the study including those APRNs who changed work environment as well as some of the APRNs who did not change work environment but chose to answer question 15a in the study as this question was meant to address only those who changed work environment, reported having had a mentor (an informal go-to person for support). However, to account for the number of the APRNs in question 15b ($n = 92$) who changed work environment/organization that had mentors, the researcher manually counted the numbers and found 65.2% of the APRNs ($n = 60$) reported having had a mentor or mentors.

There were three research questions and associated hypotheses. Hypothesis One was supported through a two-sample independent *t*-tests, which revealed a statistically significant difference ($t(138) = 3.017, p = .0015, ES = .57$). Hypothesis Two was also supported utilizing a two-sample independent *t*-tests, which demonstrated a statistically significant difference was found ($t(138) = -2.231, p = .0145, ES = -.42$). Hypothesis Three also revealed statistically significant negative relationship between the NPRTS total scores and the TIS-6 scores and was supported through Pearson Product-Moment Correlation ($r = -.51, p < .001$). A linear regression analysis established the relationship discovered. The model for the regression was significant ($F(1, 138) = 49.039, p < .001$), and the coefficient of determination indicated the percentage of variation in TIS-6 scores that can be determined by the NPRTS total scores as 26% ($r^2 = .26$).

The findings of the study supported that structured orientation influenced role transition and turnover intentions. They also revealed a paucity of structured orientation for novice Advanced Practice Registered Nurses (APRNs) and a direct link to job turnover intentions. This adds to the body of nursing knowledge and sheds light on this essential intervention for new APRNs as it relates to nursing education, nursing practice, nursing research, and health and public policy for new APRNs. Meleis' Transitions Theory served as a theoretical framework for the study. The theory stipulates that the natures of transitions, transition conditions, patterns of response such as outcome and process indications as well as nursing therapeutics, all influence how novice APRNs transition in a new role. The theory was supported by

the results of the study. Structured orientation enhanced role transition and decreased job turnover intentions.

Although this topic had been studied from different lenses in previous studies, the progression and implementation of structured orientation for new APRNs remain stagnant. As compared with previously mentioned studies, only one-third of new APRNs have received structured orientation even though the literature provided evidence that early support in the role promoted better socialization, adaptation, and success. Advanced Practice Registered Nurses (APRNs) can be a solution to the projected healthcare shortages as well as to vulnerable populations. By creating stronger support for new healthcare providers in their transition period, Advanced Practice Registered Nurses (APRNs) can be a solution to the projected healthcare provider shortages as well as improving care to large vulnerable populations. Providing a strong APRN onboarding orientations has the potential to strengthen the nursing workforce with competent caregivers, improve APRN job satisfaction/confidence, reduce APRN job attrition rate, promote healthcare cost containment, and improve national patient health outcomes.

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Appendix A

BARRY UNIVERSITY

INSTITUTIONAL REVIEW BOARD APPROVAL



Division of Academic Affairs

Institutional Review Board
11300 NE 2nd Avenue, Miami, FL 33161
P: 305.899.3020 or 1.800.756.6000, ext. 3020
F: 305.899.3026
www.barry.edu

**Research with Human Subjects
Protocol Review**

LETTER OF APPROVAL AS EXEMPT

Date: 02/19/2021
Protocol Number: 1717759
Study Title: The Impact of Structured Orientation on Role Transition and Turnover Intentions on Advanced Practice Registered Nurses
Principal Investigator: Nadege Jules
Faculty Sponsor: Dr. Claudette Chin

Dear Researcher:

On behalf of the Barry University Institutional Review Board (IRB), I have granted final approval for this study as exempt from further review. As an exempt study, there is no expiration date and no annual report requirement. However, any modifications to the protocol or consent form, initiated by you or by the faculty sponsor, will require prior approval, which you may request by submitting a protocol Modification Form. You can download the most current version of the form from the IRBNet library (Forms and Templates).

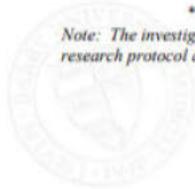
As principal investigator of this protocol, it is your responsibility to ensure that this study is conducted as approved by the IRB.

Even as an exempt protocol, you must promptly report to the IRB any serious, unanticipated adverse events experienced by participants in the course of this research, whether or not they are directly related to the study protocol.

If you have questions about these procedures, or need any additional assistance from the IRB, please contact the IRB point of contact, Ms. Jasmine Trana (305-899-3020 or jtrana@barry.edu). Finally, if you are required to carry professional liability insurance, please review your policy to make sure your coverage includes the activities in this study.

Sincerely,

Tan Fung-Ivan Chan, EdD, OTD, OTR/L
Chair, Institutional Review Board (IRB)
Barry University
College of Nursing and Health Sciences (CNHS)



Note: The investigator will be solely responsible and strictly accountable for any deviation from or failure to follow the research protocol as approved. Barry University has no liability related to claims arising from said deviation or failure.

Appendix B

BARRY UNIVERSITY

COVER LETTER

Dear Research Participant,

Your participation in a research project is requested. The title of the study is, “*The Impact of Structured Orientation on Role Transition and Turnover Intentions of Advanced Practice Registered Nurses.*” Structured orientation refers to a mentorship, a preceptorship, or a residency experience. The research is being conducted by Nadege Jules, a doctoral student in the College of Nursing and Health Sciences at Barry University and is seeking information that will be useful in the field of nursing, nursing education and healthcare. The purpose of this correlational study is to investigate the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses in their first APRN position.

Upon approval from Barry University Institutional Review Board (IRB), the following inclusion criteria will be sought. A) novice Advanced Practice Registered Nurses (APRNs) with 1 month to 3 years of clinical practice in any specialty in the United States, b) hold an active APRN license, c) aged 18 years or older, d) can read, write, and understand English, and f) have access to a computer, email, and the internet will be sought after. The number of subjects that are anticipated for this study are 136.

If you decide to participate in this research, you will be asked to complete 3 separate surveys: a demographic questionnaire, the Nurse Practitioner Role Transition Scale (NPRTS) and the Turnover Intention Scale (TIS-6) via SurveyMonkey online for a maximum completion time of 10 minutes. Your consent to be a research subject is strictly voluntary and should you decline to participate or choose to withdraw at any time during the study, there will be no penalties. There are no known risks or direct benefits associated with this study.

However, the information gathered may assist in developing interventions to benefit novice Advanced Practice Registered Nurses (APRNs). The findings of this study could contribute to nursing and society. It may also be used to enhance nursing education, transition to practice programs, nursing research, and health and public policy developments that may improve role transition quality and decrease job turnover intentions for novice APRNs.

As a research subject, the information you provide is anonymous whereby names or other identifiers will not be collected. SurveyMonkey.com allows researchers to suppress the delivery of internal protocol (IP) addresses during the downloading of data, and in this study no IP addresses will be delivered to the researcher. However, SurveyMonkey.com collects IP addresses for its own purposes. If you have concerns about this, you should review the privacy policy of SurveyMonkey.com before you begin.

By completing and submitting this electronic survey, you are acknowledging that you are at least 18 years old and that you voluntarily agree to participate. If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Nadege Jules at (86) 357-9264, or [REDACTED] and my Faculty sponsor, Dr. Claudette Chin at (05) 899-4716 or [REDACTED]. You may also contact Barry University’s Institutional Review Board point of contact person, Jasmine Trana, at (305) 899-3020 or jtrana@barry.edu.

Thank you for your participation.

Sincerely,
Nadege Jules, MSN, APRN, FNP-
BC
Barry University Doctoral Student

Approved by Barry University
IRB: 1681820
Date: 07/20/2021
Signature: Emilie A. Ney, Ph.D.

Appendix B

BARRY UNIVERSITY

COVER LETTER – SURVEYMONKEY

Cover Letter

Dear Research Participant,

Your participation in a research project is requested. The title of the study is "The Impact of Structured Orientation on Role Transition and Turnover Intentions of Advanced Practice Registered Nurses." The research is being conducted by Nadege Jules, a doctoral student in the College of Nursing and Health Sciences at Barry University, and is seeking information that will be useful in the field of nursing, nursing education and healthcare. The purpose of this correlational study is to investigate the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses (APRNs) in their first APRN position. Structured orientation refers to a mentorship, a preceptorship or a residency experience. Upon approval from Barry University Institutional Review Board (IRB), the following inclusion criteria will be sought:

- a) Novice Advanced Practice Registered Nurses (APRNs) with 1 month to 3 years of clinical practice in any specialty in the United States
- b) Hold an active APRN license
- c) Age 18 years or older
- d) Able to read, write and understand English
- f) Have access to a computer, email, and the Internet.

The number of subjects that are anticipated for this study are 136.

You will be asked to complete 3 separate surveys: a demographic questionnaire, the Nurse Practitioner Role Transition Scale (NPRTS) and the Turnover Intention Scale (TIS-6) via SurveyMonkey online for a maximum completion time of 10 minutes. Your consent to be a research subject is strictly voluntary and you may choose to withdraw at any time during the study with no adverse effects. There are no known risks or direct benefits associated with this study. However, the information gathered may assist in developing interventions to benefit novice APRNs. The findings of this study could contribute to nursing and society. It may also be used to enhance nursing education, transition to practice programs, nursing research, and health and public policy developments that may improve role transition quality and decrease job turnover intentions for novice APRNs.

As a research subject, the information you provide is anonymous whereby names or other identifiers will not be collected. SurveyMonkey.com allows researchers to suppress the delivery of internal protocol (IP) addresses during the downloading of data, and in this study no IP addresses will be delivered to the researcher. However, SurveyMonkey.com collects IP addresses for its own purposes. If you have concerns about this, you should review the privacy policy of SurveyMonkey.com before you begin. By completing and submitting this electronic survey, you are acknowledging that you are at least 18 years old and that you voluntarily agree to participate.

If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Nadege Jules at [REDACTED], and my Faculty sponsor, Dr. Claudette Chin at [REDACTED] or Barry University's Institutional Review Board point of contact person, Jasmine [REDACTED] at (305) 899-3020 or jtrana@barry.edu.

Appendix C
BARRY UNIVERSITY
ACCESS LETTERS

This section contains the Access Letters

Appendix C

BARRY UNIVERSITY

ACCESS LETTER

Letter of Access Request to Professional Organizations

Name and address

Dear _____,

My name is Nadege Jules. I am a doctoral student at Barry University, College of Nursing and Health Sciences. I am conducting a study titled, "*The Impact of Structured Orientation on Role Transition and Turnover Intentions of Advanced Practice Registered Nurses,*" in partial fulfillment of the requirements for a PhD in nursing. Structured orientation refers to a mentorship, a preceptorship, or a residency experience. The purpose of this correlational study is to investigate the impact of structured orientation on role transition and turnover intentions of novice Advanced Practice Registered Nurses in their first APRN position.

I am requesting your assistance to forward the attached research flyer to members of your association, on my behalf and to post the flyer in your designated areas to recruit potential research subjects. SurveyMonkey, a secure online environment, will be used to administer 3 separate surveys with a maximum completion time of 10 minutes. The study is anonymous; no names or other identifiers will be collected. Internal protocol (IP) addresses will be suppressed by SurveyMonkey and will not be visible or accessible to the researcher at any time. The study is voluntary, and the subjects may withdraw from the study at any time without penalties. There are no known risks or direct benefits associated with this study. The information gathered may assist in developing interventions to benefit novice Advanced Practice Registered Nurses (APRNs). The findings of this study could contribute to nursing and society. It may also be used to enhance nursing education, transition to practice programs, nursing research, and health and public policy developments that may improve role transition quality and decrease job turnover intentions for novice APRNs.

If you have any questions or concerns, please contact me, Nadege Jules, the researcher, at [REDACTED]. You may also contact my faculty advisor, Dr. Claudette Chin, at [REDACTED]. You may also contact Barry University's Institutional Review Board point of contact person, Jasmine Trana, at (305) 899-3020 or jtrana@barry.edu.

Please let me know, at your earliest convenience, whether you can assist me with my recruitment efforts.

Thank you for your time,

Nadege Jules, MSN, APRN, FNP-BC

Barry University Doctoral Student

Appendix C

BARRY UNIVERSITY

ACCESS LETTER

Letter of Access Request to Social Networking Websites

Name and address

Dear _____,

My name is Nadege Jules. I am a doctoral student at Barry University, College of Nursing and Health Sciences. I am conducting a study titled, "*The Impact of Structured Orientation on Role Transition and Turnover Intentions of Advanced Practice Registered Nurses,*" in partial fulfillment of the requirements for a PhD in nursing. Structured orientation refers to a mentorship, a preceptorship, or a residency experience. The purpose of this correlational study is to investigate the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses in their first APRN position.

I am seeking permission to announce the study on your website. SurveyMonkey, a secure online environment, will be used to administer 3 separate surveys with a maximum completion time of 10 minutes. The study is anonymous; no names or other identifiers will be collected. Internal protocol (IP) addresses will be suppressed by SurveyMonkey and will not be visible or accessible to the researcher at any time. The study is voluntary, and the subjects may withdraw from the study at any time without penalties. There are no known risks or direct benefits associated with this study. The information gathered may assist in developing interventions to benefit novice Advanced Practice Registered Nurses (APRNs). The findings of this study could contribute to nursing and society. It may also be used to enhance nursing education, transition to practice programs, nursing research, and health and public policy developments that may improve role transition quality and decrease job turnover intentions for novice APRNs.

If you have any questions or concerns, please contact me, Nadege Jules, the researcher, at [REDACTED]. You may also contact my faculty sponsor, Dr. Claudette Chin, at [REDACTED]. You may also contact Barry University's Institutional Review Board point of contact person, Jasmine Trana, at (305) 899-3020 or jtrana@barry.edu.

Please let me know, at your earliest convenience, whether you can assist me with my recruitment efforts.

Thank you for your time,

Nadege Jules, MSN, APRN, FNP-BC

Barry University Doctoral Student

Appendix C

BARRY UNIVERSITY ACCESS LETTER

Letter of Access Request to Chief Nursing Officers of Hospitals

Name and address

Dear _____,

My name is Nadege Jules. I am a doctoral student at Barry University, College of Nursing and Health Sciences. I am conducting a study titled, "*The Impact of Structured Orientation on Role Transition and Turnover Intentions of Advanced Practice Registered Nurses,*" in partial fulfillment of the requirements for a PhD in nursing. Structured orientation refers to a mentorship, a preceptorship, or a residency experience. The purpose of this correlational study is to investigate the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses in their first APRN position.

I am requesting your assistance to forward the attached research flyer to members of your organization on my behalf and post the flyer in your designated areas to recruit potential subjects for the study. SurveyMonkey, a secure online environment, will be used to administer 3 separate surveys with a maximum completion time of 10 minutes. The study is anonymous; no names or other identifiers will be collected. Internal protocol (IP) addresses will be suppressed by SurveyMonkey and will not be visible or accessible to the researcher at any time. The study is voluntary, and the subjects may withdraw from the study at any time without penalties. There are no known risks or direct benefits associated with this study. The information gathered may assist in developing interventions to benefit novice Advanced Practice Registered Nurses (APRNs). The findings of this study could contribute to nursing and society. It may also be used to enhance nursing education, transition to practice programs, nursing research, and health and public policy developments that may improve role transition quality and decrease job turnover intentions for novice APRNs.

If you have any questions or concerns, please contact me, Nadege Jules, the researcher, at [REDACTED]. You may also contact my faculty advisor, Dr. Claudette Chin, at [REDACTED]. You may also contact Barry University's Institutional Review Board point of contact person, Jasmine Trana, at (305) 899-3020 or jtrana@barry.edu.

Please let me know, at your earliest convenience, whether you can assist me with my recruitment efforts.

Thank you for your time.

Nadege Jules, MSN, APRN,
FNP-BC Barry University
Doctoral Student

Appendix C

BARRY UNIVERSITY

ACCESS LETTER

Letter of Access Request to Church Leaders

Name and address

Dear _____,

My name is Nadege Jules. I am a doctoral student at Barry University, College of Nursing and Health Sciences. I am conducting a study titled, "*The Impact of Structured Orientation on Role Transition and Turnover Intentions of Advanced Practice Registered Nurses*," in partial fulfillment of the requirements for a PhD in nursing. Structured orientation refers to mentorship, a preceptorship, or a residency experience. The purpose of this correlational study is to investigate the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses in their first APRN position.

I am requesting your assistance to forward the attached research flyer to members of your congregation on my behalf and post the flyer in your designated areas to recruit potential subjects for the study. SurveyMonkey, a secure online environment, will be used to administer 3 separate surveys with a maximum completion time of 10 minutes. The study is anonymous; no names or other identifiers will be collected. Internal protocol (IP) addresses will be suppressed by SurveyMonkey and will not be visible or accessible to the researcher at any time. The study is voluntary, and the subjects may withdraw from the study at any time without penalties. There are no known risks or direct benefits associated with this study. The information gathered may assist in developing interventions to benefit novice Advanced Practice Registered Nurses (APRNs). The findings of this study could contribute to nursing and society. It may also be used to enhance nursing education, transition to practice programs, nursing research, and health and public policy developments that may improve role transition quality and decrease job turnover intentions for novice APRNs.

If you have any questions or concerns, please contact me, Nadege Jules, the researcher, at [REDACTED]. You may also contact my faculty advisor, Dr. Claudette Chin, at [REDACTED]. You may also contact Barry University's Institutional Review Board point of contact person, Jasmine Trana, at (305) 899-3020 or jtrana@barry.edu.

Please let me know, at your earliest convenience, whether you can assist me with my recruitment efforts.

Thank you for your time.

Nadege Jules, MSN, APRN, FNP-BC

Barry University Doctoral Student

Appendix D
BARRY UNIVERSITY
RESEARCH FLYER



Purpose of the Study: The purpose of this correlational study is to investigate the impact of structured orientation on role transition and job turnover intentions of novice Advanced Practice Registered Nurses in the United States in their first APRN position.

INCLUSION CRITERIA

- a) Novice Advanced Practice Registered Nurses (APRNs) with 1 month to 3 years of clinical practice in any specialty in the United States.
- b) Hold an active APRN license.
- c) 18 years or older.
- d) Able to read, write and understand English.
- e) Have access to a computer, email and the internet, MAXIMUM 10 minutes of your time.
- f) Weblink:
<https://www.surveymonkey.com/r/GOAPRNS>

Researcher:

Nadege Jules, MSN, APRN, FNP-BC

Ph#: [REDACTED]

Email: [REDACTED]

Barry University Faculty Sponsor:

Claudette R. Chin, PhD, APRN

Ph#: [REDACTED]

Email: [REDACTED]

Barry University IRB point of contact person:

Jasmine Trana

Ph#: 305-399-3020

Email: jtrana@barry.edu

Appendix E

BARRY UNIVERSITY

DEMOGRAPHIC QUESTIONNAIRE

Please provide a response to the items below that best describes you. Please select all that apply and fill in your answers.

1. Gender

1. Male
2. Female
3. Other

2. Age

1. 21-30 years
2. 31-40 years
3. 41-50 years
4. >50 years

3. Race/Ethnicity

1. White/Caucasian
2. Black or African American
3. Hispanic or Latino
4. Asian
5. American Indian or Alaska Native
6. Native Hawaiian and other Pacific Islander
7. Middle Eastern
8. Other

4. Marital Status

1. Married, in a civil union or domestic partnership
2. Single
3. Divorced or separated

5. APRN Specialty

1. Family
2. Adult
3. Pediatrics
4. Acute care
5. Gerontology
6. Psych (adult and family)
7. Other

6. Practice Region

1. Fill in _____

7. Practice Setting

1. Federal Qualified Health Care Center
2. Private Practice Primary Care
3. Private Practice Specialty
4. Hospital Inpatient Acute Care
5. Long Term Care Facility
6. Other, Fill in _____

8. APRN Program Completion

1. Traditional Master
2. Accelerated Master
3. BSN Master
4. DNP
5. Other, fill in _____

9. Degrees Earned

1. Doctorate in Nursing (PHD, DNP, DNS, ScD, ND)
2. MSN
3. ADN
4. Non-nursing masters
5. Non-nursing bachelors
6. Non-nursing associate

10. Prior non-RN health-related employment

1. Yes
2. No

11. Years and Months of RN employment.

1. Fill in answer _____ -

12. Years and Months in current position

2. Fill in answer _____

13. Did you receive a structured orientation (a mentorship, a preceptorship, or a residency experience) in your first APRN position?

1. Yes
2. No

14. Did you change your employment organization when you assumed your new role as an APRN?

1. Yes
2. No

15. If you answer yes to question 14, how many mentors did you have in your new environment?

1. 1
2. 2
3. 3 or more

Appendix E

BARRY UNIVERSITY

DEMOGRAPHIC QUESTIONNAIRE – SURVEYMONKEY

Demographic Questionnaire

Please provide a response to the items below that best describes you. Please check all that apply and fill in your answers.

1. Gender

Male

Female

Other (please specify)

2. Age

21-30

31-40

41-50

>50

3. Race/Ethnicity

White or Caucasian

Black or African American

Hispanic or Latino

Asian or Asian American

American Indian or Alaska Native

Native Hawaiian or other Pacific Islander

Middle Eastern

Another race (please specify)

4. Marital Status

Married, in a civil union or domestic partnership

Single

Divorced or separated

Appendix E
BARRY UNIVERSITY
DEMOGRAPHIC QUESTIONNAIRE—SURVEYMONKEY CONT'D

5. APRN Specialty

- Family
- Adult
- Pediatrics
- Acute Care
- Gerontology
- Psych (Adult and Family)
- Other (please specify)

6. Practice Region (Fill in answer)

7. Practice Setting

- Federal Qualified Health Care Center
- Private Practice Primary Care
- Private Practice Specialty
- Hospital Inpatient Acute Care
- Long Term Care Facility
- Other (please fill in answer)

8. APRN Program of Completion

- Traditional Master
- Accelerated Master
- BSN Master
- DNP
- Other (please specify)

Appendix E
BARRY UNIVERSITY
DEMOGRAPHIC QUESTIONNAIRE—SURVEYMONKEY CONT'D

9. Degrees Earned

Doctorate in Nursing (PhD, DNP, DNS, ScD, ND)

MSN

ADN

Non-nursing masters

Non-nursing bachelors

Non-nursing associate

10. Prior non-RN health-related employment

Yes

No

11. Months and Years of RN employment (fill in answer)

12. Months and Years in current position (fill in answer)

13. Did you receive a structured orientation (a mentorship, a preceptorship, or a residency experience) in your first APRN position?

Yes

No

14. Did you change your employment organization when you assumed your new role as an APRN?

Yes

No

15. If you answer yes to question 14, how many mentors did you have in your new environment?

0

1

2

3 or more

Appendix F

BARRY UNIVERSITY

NURSE PRACTITIONER ROLE TRANSITION SCALE (NPRTS)

Part A - Directions: First, you will be asked to respond to statements about your transition to the NP (APRN) role. Please think back to your **first NP (APRN) position** and answer the following questions based on that experience. Please read each statement carefully and respond by expressing the extent to which you agree or disagree with it. Please answer **ALL** questions.

Please choose your responses based on the following scale:

1	2	3	4	5
Strongly Disagree	Disagree	Neither Disagree nor Agree	Agree	Strongly Agree

1.	I was very comfortable managing my patients.	1	2	3	4	5
2.	I felt very competent managing my patient case load.	1	2	3	4	5
3.	I was comfortable in my role.	1	2	3	4	5
4.	I felt it was easy to transition from nurse to NP.	1	2	3	4	5
5.	I felt I had the skills to deal with the role transition.	1	2	3	4	5
6.	I felt less confident than I did before becoming a NP.	1	2	3	4	5
7.	My NP program prepared me for a smooth role transition.	1	2	3	4	5
8.	I felt that I needed extra time to complete my responsibilities.	1	2	3	4	5
9.	My NP role was very well understood by the public.	1	2	3	4	5
10.	My NP role was very well understood by my patients/families.	1	2	3	4	5
11.	My NP role was very well understood by management.	1	2	3	4	5
12.	My NP role was well understood by my physician colleagues	1	2	3	4	5
13.	My NP role was well understood by my nurse colleagues	1	2	3	4	5
14.	I felt that I got very little support.	1	2	3	4	5
15.	I felt that I was isolated.	1	2	3	4	5
16.	I was treated as a professional by my colleagues.	1	2	3	4	5

Appendix F

BARRY UNIVERSITY

NURSE PRACTITIONER ROLE TRANSITION SCALE (NPRTS)--

SURVEYMONKEY

Nurse Practitioner Role Transition Scale (NPRTS)

Part A - Directions: First, you will be asked to respond to statements about your transition to the NP (APRN) role. Please think back to your first NP (APRN) position and answer the following questions based on that experience. Please read each statement carefully and respond by expressing the extent to which you agree or disagree with it. Please answer ALL questions.

16. I was very comfortable managing my patients

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

17. I felt very competent managing my case load

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

18. I was comfortable in my role

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

Appendix F

BARRY UNIVERSITY

NURSE PRACTITIONER ROLE TRANSITION SCALE (NPRTS)— SURVEYMONKEY

CONT'D

<p>19. I felt it was easy to transition from nurse to NP</p> <p><input type="radio"/> Strongly disagree</p> <p><input type="radio"/> Disagree</p> <p><input type="radio"/> Neither agree nor disagree</p> <p><input type="radio"/> Agree</p> <p><input type="radio"/> Strongly agree</p>
<p>20. I felt I had the skills to deal with the role transition</p> <p><input type="radio"/> Strongly disagree</p> <p><input type="radio"/> Disagree</p> <p><input type="radio"/> Neither agree nor disagree</p> <p><input type="radio"/> Agree</p> <p><input type="radio"/> Strongly agree</p>
<p>21. I felt less confident than I did before becoming a NP</p> <p><input type="radio"/> Strongly disagree</p> <p><input type="radio"/> Disagree</p> <p><input type="radio"/> Neither agree nor disagree</p> <p><input type="radio"/> Agree</p> <p><input type="radio"/> Strongly agree</p>
<p>22. My NP program prepared me for a smooth role transition</p> <p><input type="radio"/> Strongly disagree</p> <p><input type="radio"/> Disagree</p> <p><input type="radio"/> Neither agree nor disagree</p> <p><input type="radio"/> Agree</p> <p><input type="radio"/> Strongly agree</p>
<p>23. I felt that I needed extra time to complete my responsibilities</p> <p><input type="radio"/> Strongly disagree</p> <p><input type="radio"/> Disagree</p> <p><input type="radio"/> Neither agree nor disagree</p> <p><input type="radio"/> Agree</p> <p><input type="radio"/> Strongly agree</p>

Appendix F

BARRY UNIVERSITY

NURSE PRACTITIONER ROLE TRANSITION SCALE (NPRTS)— SURVEYMONKEY

CONT'D

24. My NP role was very well understood by the public

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly agree

25. My NP role was very well understood by my patients/families

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly agree

26. My NP role was very well understood by management

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly agree

27. My NP role was very well understood by my physician colleagues

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly agree

28. My NP role was very well understood by my nurse colleagues

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly agree

Appendix F

BARRY UNIVERSITY

**NURSE PRACTITIONER ROLE TRANSITION SCALE (NPRTS)—
SURVEYMONKEY**

CONT'D

29. I felt that I got very little support

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly agree

30. I felt that I was isolated

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly agree

31. I was treated as a professional by my colleagues

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly agree

Appendix G

BARRY UNIVERSITY

PERMISSION TO USE NURSE PRACTITIONER ROLE TRANSITION SCALE

October 21, 2019

Good evening Dr. Regina Cusson,

I hope this message finds you well. My name is Nadege Jules. I am a doctoral student at Barry University in Miami Shores, Florida. I am conducting a study entitled, " Impact of structured orientation on novice nurse practitioners' role transition and job turnover." I find the nurse practitioner role transition survey will be helpful for my study and wanted to obtain permission to utilize your scale.

I appreciate your assistance in this matter and thank you for your contributions to nursing research. I look forward to receiving your approval.

Best regards,
Nadege Jules, MSN, FNP-BC, PHD student

Dear Nadege,

I fully support your using the role transition scale for your doctoral studies. Our results indicate that it is valid with different types of NPs, since I believe the concepts it captures are universal amongst novice NPs. I'd appreciate a summary of your results when your work is complete. Best wishes with your research.

Sincerely,

Regina M. Cusson PhD, RN, NNP-BC, FAAN
Professor Emeritus
UConn School of Nursing
U-4026
Storrs, CT 06269-4026
10/21/2019

Dear Nadege,

I am including the scale for your use in your research. I believe the research reports include scoring instructions.

Regina M. Cusson, PhD, NNP-BC, APRN, FAAN

Professor Emeritus

U of Connecticut, School of Nursing

Appendix G

BARRY UNIVERSITY

PERMISSION TO USE NURSE PRACTITIONER ROLE TRANSITION SCALE

CONT'D

Help Needed with NPRTS Scoring Instructions

On Mar 31, 2021, at 5:31 PM, Jules, Nadege (Barry Student) <nadege.jules@mymail.barry.edu> wrote:

Message sent from a system outside of UConn.

Good afternoon Dr. Regina Cusson,

Happy Wednesday! I hope this message finds you well and that you are doing well during the pandemic.

My name is Nadege Jules, a doctoral student at Barry University. I obtained permission from you to utilize the Nurse Practitioner Role Transition Scale (NPRTS), the 16-scale items for my dissertation topic entitled, "The Impact of Structured Orientation on Role Transition and Turnover Intentions of Advanced Practice Registered Nurses" back in October 2019. I am currently in data analysis phase and am working with a statistician. I need access to the scoring instructions for the NPRTS scale as per the statistician to assess for reverse scoring etc. We have looked through the papers and the dissertation by Dr. Sally Strange and have not found the information that we need.

I am reaching out to you for assistance to access that information. I thank you in advance for your help so I can proceed with the data analysis portion of my Dissertation. I look forward to hearing from you soon.

Warm regards,

Nadege Jules, MSN, APRN, FNP-BC
Barry University Doctoral Student



Cusson, Regina <regina.cusson@uconn.edu>

Thu 4/1/2021 6:25 AM

To: Jules, Nadege (Barry Student)

Cc: Chin, Claudette



[EXTERNAL SENDER]

Items 18,19,20&28 were reverse scored. I will send you two unpublished manuscripts that describe further.

Regina M. Cusson PhD, RN, NCC-E, FAAN
Professor Emeritus
UConn School of Nursing
U-4026
Storrs, CT 06269-4026

Appendix H

BARRY UNIVERSITY

TURNOVER INTENTION SCALE (TIS-6)

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The following section aims to ascertain the extent to which you intend to stay at the organization.

Please read each question and indicate your response using the scale provided for each question:

During the past 9 months:

1	How often have you considered leaving your job?	Never	1-----2-----3-----4-----5	Always
2	How satisfying is your job in fulfilling your personal needs?	Very satisfying	1-----2-----3-----4-----5	Totally dissatisfying
3	How often are you frustrated when not given the opportunity at work to achieve your personal work-related goals?	Never	1-----2-----3-----4-----5	Always
4	How often do you dream about getting another job that will better suit your personal needs?	Never	1-----2-----3-----4-----5	Always
5	How likely are you to accept another job at the same compensation level should it be offered to you?	Highly unlikely	1-----2-----3-----4-----5	Highly likely
6	How often do you look forward to another day at work?	Always	1-----2-----3-----4-----5	Never

Appendix H

BARRY UNIVERSITY

TURNOVER INTENTION SCALE (TIS-6)--SURVEYMONKEY

Turnover Intention Scale (TIS-6)

The following section aims to ascertain the extent to which you intend to stay at the organization. Please read each question and indicate your response using the scale provided for each question:

DURING THE PAST 9 MONTHS.....

32. How often have you considered leaving your job?

- Never
- Rarely
- Sometimes
- Usually
- Always

33. How satisfying is your job in fulfilling your personal needs?

- Very satisfied
- Satisfied
- Neither satisfied nor dissatisfied
- Dissatisfied
- Very dissatisfied

34. How often are you frustrated when not given the opportunity at work to achieve your personal work-related goals?

- Never
- Rarely
- Sometimes
- Usually
- Always

Appendix H
BARRY UNIVERSITY
TURNOVER INTENTION SCALE (TIS-6)—SURVEYMONKEY CONT'D

35. How often do you dream about getting another job that will better suit your personal needs?

Never

Rarely

Sometimes

Usually

Always

36. How likely are you to accept another job at the same compensation level should it be offered to you?

Very unlikely

Unlikely

Neither likely nor unlikely

Likely

Very likely

37. How often do you look forward to another day at work?

Always

Usually

Sometimes

Rarely

Never

Appendix I

BARRY UNIVERSITY

PERMISSION TO USE TURNOVER INTENTION SCALE (TIS-6)

October 21, 2019

Good evening Professor Gert Roodt,

I hope this message finds you well. My name is Nadege Jules. I am a doctoral student at Barry University in Miami Shores, Florida. I am conducting a study entitled, " Impact of structured orientation on novice nurse practitioners' role transition and job turnover." I find your six-item turnover intention scale will be helpful for my study and wanted to obtain permission to utilize your scale.

I appreciate your assistance in this matter, and I look forward to receiving your approval.

Best regards,
Nadege Jules, MSN, FNP-BC, PHD student

Dear Nadege

You are welcome to use the TIS for your research. For this purpose, please find the TIS-15 attached for your convenience. This TIS-6 consists (version 4) of the first six items high-lighted in yellow. The TIS-6 is based on the Theory of Planned Behaviour.

It is easy to score the TIS-6. Merely add the item scores to get a total score. The midpoint of the scale is 18 (3 x 6). If the total score is below 18 then it indicates a desire to stay. If the scores are above 18 it indicates a desire to leave the organization. The minimum a person can get is 6 (6 x 1) and the maximum is 30 (5 x 6). No item scores need to be reflected (reverse scored).

It is recommended that you conduct a CFA on the item scores to assess the dimensionality of the scale. We found that respondents with a matric (grade 12) tertiary school qualification tend to understand the items better and consequently an uni-dimensional factor structure is obtained.

If you wish to translate the TIS in a local language, you are welcome to do so. It is recommended that a language expert is used in the translate –back translate method.

I wish you all the best with your research!

Best regards

Prof Gert Roodt

10/22/2019

Appendix J

BARRY UNIVERSITY HYPOTHESES TABLE

	Research Questions	Hypotheses	Instruments	Analysis	Results
1.	Do novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position have better role transition when compared to those who had no orientation?	<p>H₀. Role transition mean scores for novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position are equal to those who did not receive structured orientation.</p> <p>H₁. Role transition mean scores for novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position are higher than for those who did not receive structured orientation.</p>	<p>A single item question, “Did you receive a structured orientation in your first advanced practice registered nurse (APRN) position?” with a “yes” and “no” answer on the demographic questionnaire</p> <p>The Nurse Practitioner Role Transition Scale (NPRTS)</p>	Independent <i>t</i> -test	A statistically significant difference was found ($t(138) = 3.017$, $p = .0015$, $ES = .57$), which supports the alternative hypothesis that APRNs who received structured orientation will score higher on the NPRTS.

2.	Do novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position have lower job turnover intentions when compared to those who had no orientation?	<p>H₀. Turnover intentions mean scores for novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position are equal to those who did not receive structured orientation.</p> <p>H₂. Turnover intentions mean scores for novice Advanced Practice Registered Nurses who received structured orientation in their first APRN position are lower than for those who did not receive structured orientation.</p>	<p>A single item question, “Did you receive a structured orientation in your first Advanced Practice Registered Nurse (APRN) position?” with a “yes” and “no” answer on the demographic questionnaire</p> <p>Turnover Intention Scale (TIS-6)</p>	Independent <i>t</i> - test	A statistically significant difference was found ($t(138) = -2.231, p = .0145, ES = -.42$), which supports hypothesis two that APRNs who received structured orientation will score lower on the TIS-6 than those who do not receive structured orientation.
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3.	Is there a negative correlation between novice Advanced Practice Registered Nurses role transition scale scores on the Nurse Practitioner Role Transition Scale (NPRTS) and turnover intentions scale scores as measured on the Turnover Intention Scale (TIS)?	<p>H₀. There is no correlation between NPRTS scores and TIS-6 scores for novice Advanced Practice Registered Nurses.</p> <p>H₃. There is a negative correlation between NPRTS scores and TIS-6 scores for novice Advanced Practice Registered Nurses.</p>	<p>The Nurse Practitioner Role Transition Scale (NPRTS)</p> <p>Turnover Intention Scale (TIS-6)</p>	<p>Pearson's Product-Moment Correlation</p> <p>Followed by Simple Linear Regression</p>	<p>A statistically significant negative relationship between the responses of the NPRTS and the TIS-6 was found ($r = -.51, p < .001$), which supports alternative hypothesis three. The model for the regression was significant ($F(1, 138) = 49.039, p < .001$) and the coefficient of determination indicated the percentage of variation in TIS-6 scores that can be determined by the NPRTS total scores as 26% ($r^2 = .26$).</p>
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Appendix K

BARRY UNIVERSITY

VITA

1979	Born – Haiti
1998–2002	Bachelor of Science in Nursing Florida International University Miami, FL
2002– 2016	Clinical Staff Nurse/Charge Nurse/ICU Jackson Health System Miami, FL
2012– 2015	Master of Science in Nursing Family Advanced Practice Registered Nurse Barry University Miami, FL
2016 – 2017	Advanced Practice Registered Nurse Nobhill Medical Center Tamarac, FL
2017– Present	Clinical Staff Nurse/ICU Memorial Hospital West Pembroke Pines, FL
2018 –2021	Doctor of Philosophy in Nursing Science Barry University Miami, FL
2019 – Present	Adjunct Clinical Professor Barry University Miami, FL

PUBLICATIONS

2018

Letter To The Editor, Re: Wilbur
et al. (2018), Assessing and
addressing cardiovascular risk in
young women published in Nursing
Outlook