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**CAN MARRIED STATE ONBOARDING CLOSE THE TRANSITION GAP TO
PROFESSIONAL PRACTICE?**

By

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Abstract

Onboarding is process of advancing the behaviors that will be the foundation of an employee's long-term success with managers involved in the process. Five themes emerged in the literature review for onboarding new Registered Nurses (RN): consistency, partnership, critical reasoning, learning style, and transition. The self-directed, or learner-driven, married-state process implies adult learning protocols in a consistent partnership between learner and coach are effective.

Key Words

consistency, retention, transition, onboarding, partnership, critical reasoning, engagement

Can Married State Onboarding Close the Transition Gap to Professional Practice?

Clearly, the one-size fits all approach to the onboarding process fails to recognize a learner-driven concept and needs and does not adequately address the development of clinical reasoning skills and engagement of new staff nurses (Davidson, Ray &Turkel, 2011).

Onboarding is a process of leaders partnering with professional development teams to develop the behaviors that will be the foundation of a new employee's engagement success with the organization. In contrast, orientation is an event, from a half day to a multi-day workshop (Jeffery & Jarvis, 2014). This evidence-based project was designed to determine if the implementation of a Married State Onboarding Process (Married State Model, MSM) would increase the retention rates of the new graduate nurse in a service line specific clinical component of an established residency. The data collected and analyzed from the evidence-based project through the established and reliable Casey-Fink tools and the Parse Lived Experience survey support the change (Table 1). The evidence-based project was deployed on selected surgical units and data analyzed for improvement and redesign before a suggested system-wide deployment throughout all of perioperative services.

Jeffery and Jarvis (2014) assert that organizations retain new employees longer and the employees are more successful when they have experienced orientation and onboarding.

According to a white paper by Freeman (2013):

- Up to 4% of new employees will resign after day one
- Most employees make up their minds to stay or leave within the first six months
- 22% of new employee turnover occurs within the first 45 days

- With a learner-driven onboarding process, 58% of employees can still be with the facility in three years.

High turnover rates within 18 months for new graduates and increased disengagement and low morale of the proficient level of nurse, informs educators and leaders that something creative and different must be done (Benner et al. 2010). A rebalanced process with an eye on nurses' development with a dedicated departure from timeline –driven analysis and programs, to feedback on development rather than ratings, will determine the success of this evidence-based project. Tools designed to support performance discussions, as reflective practice, married state coaching and interactive conversations necessary to build trust and motivate change and engagement in staff, were constructed and evaluated. Onboarding process develops the behaviors that will be the foundation of an employee's long-term engagement since the outcome of not investing in the development of a learner-driven onboarding program is grander than simply losing and replacing staff. Engagement is crucial for retention to exist in any organization. Learner-driven onboarding process, based on education, competence and experience level does not exist in healthcare today and directly impacts transition into professional practice at all levels in nursing. New graduates are particularly affected by a firmly established support system through the married-state.

Creating an effective onboarding program, can be overwhelming with what to address. The process starts with identifying how to give new hire nurses opportunities to validate that they made the determination to work at the chosen facility through engaging them prior to their first day, and each and every day after orientation. As time and encouragement are built, new staff begin the move into gratifying work relationships through the married state dyad. This

process that is competency-based will reduce turnover, increase employee satisfaction, increase morale and engagement. Figueroa et al. (2013) report a statistically significant decrease in turnover rates with the Married State Model (MSM) versus traditional precepting or mentoring. The MSM utilizes the concept of two-as-one throughout the onboarding process to support five themes identified in the literature. New graduate residencies have begun to address many of the transition gaps for new graduates, yet fall short in many specialty areas.

Longenecker and Abernathy (2013) describe actual adult learning to consist of natural motivation and level of engagement experiences in the modern workplace. Matrix, high technology organizations and nursing units, as perioperative services, require technological onboarding techniques to onboard new staff to realistically engage them in a dynamic, highly flexible environment. Preparation of scenarios for the flipped classroom approach, where assignments are prepared in advance by the learners and discussion brought back to the classroom are easily adapted for increased engagement. This type of technology takes longer prep time for the educator but is more efficient in the onboarding process in the long run.

The MSM provides consistency in the dyad throughout the onboarding process, regardless of length (learner-driven), this is essential for competency and confidence levels for all new staff nurses regardless of years of practice or education. The effective MSM dyad completes socialization and acculturation to the facility and the unit, establishing a sense of belonging and caring, essential components for retention. A nurse who feels like he belongs to a unit, in a facility and a part of the decision-making process, will intend to stay, according to the literature (Casey & Fink, 2011). The MSM will affect all of nursing, those that onboard and those that are currently employed and in transition. The theory of transition shock presented by Duchscher (2009) builds on Kramer's (1974) seminal work, in reality shock theory. Though

Duchscher describes her theory in the context of the new graduate nurse, transition shock theory can be applied at any level in nursing where transition and change are manifested together. A transition can be implemented to the experienced RN, who is stuck at the competent level without any process or practice to breach the gap to proficiency and expert level competency. The clinical coach could be that bridge to developing a new graduate's clinical imagination to help them recognize significant changes in a patient's condition and make a persuasive argument for a change in treatment or process (Benner, Sutphen, Leonard & Day, 2010). Nursing onboarding process would benefit from nursing theory as a basis for guiding initial practice. The seminal works of Benner (1984) and Parse (2001) are the basic nursing theories of choice for the implementation of this evidence-based project.

The Robert Wood Johnson (2008) Foundation's *Charting Nursing's Future* policy brief series, is designed to inform and motivate hospital executives, nurse leaders, educators and policy-makers to address the nursing shortfall and other critical issues. Among these is the issue of retention and recruitment of staff. Retention and recruitment are directly related to the quality and personalization of the onboarding process. Laurano (2013) reveals that about two-thirds of organizations are doing little or nothing to help new employees be successful or to welcome them into the organization. The nursing shortage is symptomatic of multiple underlying problems related to unaddressed policy and practice issues (Robert Wood Johnson, 2008). Purposeful, critical facts and data must be presented to governing boards, chief executives and nursing executives as they have in the business and industry sectors, to change the practice of orientation to onboarding through socialization to a role.

Methodology

After review and approval by the Institutional Review Boards of Capella University and the local approved affiliate, the evidence-based program was implemented as planned. The question asked at the initiation of this project states: “In the Perioperative orientation with onboarding process of new graduate residents, how does the learner-driven married state process compare to current time-frame sensitive orientation and affect turnover of the new graduate perioperative nurse from the evidence-based project beyond three months?” Can Married State Onboarding Process Close the Transition Gap to Professional Practice?

Implementation Process

Learning is learner-driven or self-directed and a lifelong process. Learners learn in practice and through it, and learning is based on people's experiences and knowledge. Learning leads to changes in people's behavior and is not only about knowing something but about doing something with that knowledge. Learning only happens when the learning process matches the needs and the reality of the learner. Learning requires a safe environment, in which people dare to speak up, to experiment and make mistakes (Cable, 2013). The participants in the evidence-based project in the married state were matched with a clinical coach based on learning styles assessment of both coach candidates and NGRs. The Kolb Learning Styles assessment was used in the formal new graduate residency (University Healthcare Consortium), and the same assessment was used for the coach candidates with implementation discussion following IRB approval. Learning styles are matched as exactly as possible.

Parse humanbecoming school of thought (HBST) is one the theories of choice for this project. “Humanbecoming is freely choosing personal meaning in a situation in the intersubjective process of living value priorities” (Parse, 2010). The foundation of professional

fortitude and retention is initiated through trust. Through the unique dyad relationship, reflection generates a sense of relaxed connection, and opportunities to know nursing in a way that caring practice can thrive in any environment. The evidence-based project involves eight perioperative new graduate residents with five clinical coaches, in the clinical component of an established residency. Three of the NGRs experienced orientation in the traditional fashion with varied and inconsistent preceptors. The MSM evidence-based project will demonstrate increased satisfaction and persistence of the five new graduates (NGR) onboarded through the married state with clinical coach program (MSM). The project data will enhance and support the earlier data by Figueroa et al. (2013) that consistency in support methods and enrichment of the knowledge base for experienced nurse coaches, maintains their expertise and experiences in the facility to enhance the experience of transition to professional practice during onboarding process. The contextual learning interventions of the married state dyad provide a teaching structure that facilitates questioning to develop all nurses' critical reasoning and coach lifelong learning. The advanced beginner to competent level nurse has the potential to create an excellent novice coach having just progressed through that level of competency themselves.

Parse's humanbecoming school of thought (HBST), "a method of dynamic relational synchrony", provides an appropriate framework with which to promote retention by purposefully engaging new staff members within onboarding dyads to explore personal meanings and; "recognize that each person has a unique story, knowing that one size does not fit all to create, strong professional identities" (Parse, 2015, p.171-172). Methodological triangulation involving the use of multiple qualitative and quantitative methods was used to study the program. The evidence-based project used Parse interviewing, observation and survey analysis, to assess the changes, themes or new phenomena, related to the married state onboarding process and learner-

driven methodology (Table 2). The purpose of triangulation is not necessarily to cross-validate data but rather to capture different dimensions of the same phenomenon. This evidence-based project data can increase the validity of conclusions by collecting different kinds of data impact on the same phenomenon. Triangulation will also capture more complete, holistic and contextual portrayal of the environments used for the evidence-based project.

The Married State Process of Onboarding (MSM) ensures a safe, advanced-beginner to competent level nurse (Figueroa, 2013) following onboarding and transition into a relationship that will develop socialization and professionalism in practice. Compared with the traditional preceptorship model, the married state model uses a clinical coach role instead of a preceptor, the task increases over time, not the patient load. Working closely together allows the coach to teach, coach, assess and give learning opportunities to the new graduate while maintaining patient and NGR safety at all times. The married state model allows the new graduate to watch and become directly involved in the delivery of care to the patient, paying attention to the critical thinking, clinical reasoning, and judgment shown by the clinical coach and reflecting on the observations through journaling. The married state model has a guideline, following 1-2 days of orientation and a flexible timeline that clinical coaches (CC) and new graduate residents (NGR) can follow in the onboarding process over three to six months, and that can be individualized according to the NGR's pace of learning.

Discussion of Results

The Casey-Fink Readiness for Practice Surveys identified four subscales in the 20 questions used as clinical problem solving, teaching and learning techniques, trials and tribulations and professional identity. Themes identified from the two onboarding questions with both coaches and NGR emerged as more time needed for preceptor feedback, the number of

preceptors in six weeks, comfort level asking for help, belonging to a team, learner-driven versus time-framed process and engagement of staff on units with residents. The three residents that went directly to the non-married state unit did not experience the MSM and had many new preceptors. The bi-weekly feedback from the educator had little reflection and presented a rigid orientation schedule with little or no engagement of unit based staff with the residents. In comparison to the MSM residents who met with the educator and their coach every week, participated in reflective journaling with a flexible, supportive schedule and participated in bi-weekly chat meetings with staff and educator.

Cronbach's alpha is not a statistical test; it is a coefficient of reliability. In the evidence-based project design, the survey items of the Casey-Fink Readiness for Practice (CFRFP) and Nurse Retention (CFNR) Surveys were rated for reliability by the designers (Casey & Fink, 2011). The CFRFP survey was divided into four subscales; clinical problem solving, learning techniques, trials and tribulations and professional identity.

Cronbach's alpha for the obtained subscales ranged from .50 (for the three-item learning techniques subscale) to .80 (for the seven-item clinical problem-solving scale). The other two subscales had results in the .60 - .70 range, which is not ideal but is acceptable for research use (Burns & Grove, 2011). Correlations between subscales in this orthogonal solution ranged from $r = .04$ to $.51$, with significant inter-correlations among the clinical problem-solving, professional identity, and trials and tribulations scales, all three of which had significant relationships with the learning techniques subscale (Casey & Fink, 2011). Casey-Fink Readiness for Practice Surveys are divided into three sections.

Section 1: Survey demographic

Section 2: Comfort level with clinical & relative performance (Likert scale 1 -> 4)

Section 3: Two open-ended questions (specific to onboarding experience).

Cronbach's alpha for the evidence-based project revealed problem-solving 0.88, professional identity 0.10 and trials and tribulations 0.766 with the learning techniques rated 1.72. Based on these ratings and the triangulation comparison with Parse dialogical experience stories, the learning techniques greatly affected the way the NGR "saw themselves" as a nurse.

Analysis of subsequent CFRFP surveys for recurrent themes comparing married state dyad group to non-married state group revealed engagement in learner-driven process increased belonging and team building in MSM group. Non-MSM group voiced the desire to have a "coach", someone they could always depend upon for support, someone consistently assigned or partnered with them. The NGR that cross-trained the first ten weeks in the MSM and then transferred to the non-MSM unit expressed confidence in basic perioperative skills and advanced communication skills, with onboarding competencies met two weeks earlier than anticipated. This participant stated that the clinical coach and journaling were aspects of the onboarding process that was a valuable life tool and not available after transfer to the non-MSM unit.

Casey-Fink Nurse Retention (CFNR) survey analyzed for themes and trends with retention goals 83% of residents and 90% coaches' plan to remain at the facility for three years. Two coaches were planning to retire within a year and "will stay" if MSM continues. Evidence-based project group retention rates increased compared to facility retention trends, 83% plan to stay for three years or more. Non-MSM residents revealed they have plans to leave that are currently in progress. Currently, 20% will remain at facility less than 18 months without the MSM with a current turnover rate that correlates with the facility-wide turnover rate of 15%.

Parse dialogical experience recordings were one-on-one discussions with the evidence-based project coordinator and recorded on a personal recording device. “Descriptions of lived experiences enhance knowledge of human becoming that shed light on the meaning of the experience(s). Dialogical engagement discovers the meaning of phenomena as humanly lived” (Parse, 2001, p.52-53). In presence with the participant, the evidence-based project coordinator (PC) can elicit authentic information about each person’s experiences related to the evidence-based phenomena (Parse, 2001). The PC creates structures of lived experiences and weaves the structure with the theory in ways that enhance the knowledge base of nursing (Parse, 2001). This creates the stories from the dialogical discussions recorded. The discussions threads were all identical and were devoted to the identified themes from the literature search related to retention of new nurses in a facility (Table 1). Support for the desired themes of belonging to something greater than they, engagement with peers and physicians, ability to think on their feet most of the time (4 days out of 5) and need for consistency in the support system, especially their coach and manager was acknowledged and discussed by each participant. Seven of eight stories revealed a need for courage to defend themselves against aggression and rudeness and developing these skills from modeling behaviors around their clinical coaches.

Recommendation and Discussion

The most critical lesson learned was to differentiate clearly between clinical coaches and preceptors, especially if the organization has created and utilized a preceptor training and enrichment program. Married State Model clinical coaches serve as mentors, advisors, coaches, teachers, role models and facilitators of resources for the new graduate cohorts (Mijares, Baxley, & Bond, 2013). Preceptors, according to Jeffery & Jarvis (2014) are defined as a more experienced nurse who provides training and observation time for the less experienced trainee,

over a short term. Preceptors are deployed by shift, by the week or day, depending upon staffing needs and lack the consistency of a clinical coach, married to the new nurse until completion of onboarding process. In comparison, shared experiences between clinical coach and new graduate nurse provide unique opportunities for building efficient identification and developing passionate engagement with perioperative nursing. As transition-to-practice programs are designed and implemented by hospitals, more consideration needs to be given to the support for the clinical coaches. To provide the best transition experiences for NGRs, clinical coaches should share shift and patient assignments with the new graduate; have the time to spend assessing, guiding, and evaluating each new graduate; and have limited or no concurrent new staff members in training. Clinical coaches should also be prepared and trained before the start of each cohort and with ongoing regular workshops, in the MSM of coaching and the principles of adult learning, giving and receiving feedback, reflective practice and journaling, difficult conversations and crucial accountability. Open lines of communication, early in the planning stages, with professional development specialist, managers, recent new graduates and clinical coaches, are essential for a successful onboarding process. Creating an onboarding process that is competency-based and learner-driven, with an ample amount of flexibility that will successfully accommodate a variety of new graduates. The learning techniques used in the MSM are simulations, reflective journaling and regular (weekly) meetings with coaches and educator. These techniques are supported by the work of Jeffery and Jarvis, (2015), and are a substantial part of the MSM program and clinical coach training workshops.

Clinical Coaches are experienced and competent (Benner, 1984) staff members that have received formal preparation to function effectively and serve as role models and resources for new nursing staff at any level. A competency-based onboarding approach initiates competency

assessment, verification and advancement processes to maintain safety in practice. The married state model connects a clinical coach and a new graduate nurse in a clearly defined relationship and process necessary for the successful transition to professional practice.

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Table 1 Pre-intervention Surveys

Characteristic		Results
Survey Date	July 2015	September 2015
No. of Residents Surveyed	8	8
No. of Clinical Coaches Surveyed	0	5
Response Rate %	100	62.5
Major Themes*	Need more preceptor feedback	Need more time for preceptor feedback
	Number of Preceptors	Number of Preceptors
	Comfort asking for help	Comfortable asking for help
	Teamwork/Part of Team	Belonging/Connectedness
	Time frame Focus	Learner Driven vs Time-Stamped
	Engagement with Staff	Engagement with Staff
	Leadership Visibility	Leadership Visibility

Note. July Survey administered to all new graduate residents that participate in the UHC/AACN consortium program. *Themes identified by both clinical coaches and residents in September Surveys only

Table 2 Parse Themes

Characteristics	Residents	Clinical Coaches
Sample Size	8	5
Emerging Themes	Stories Analyzed	Stories Analyzed
Belonging	5	5
Courage	6	5
Engagement	5	4
Safety/Partnership	5	5
Consistency	5	4
Thinking & Reasoning	5	4
Intention to Stay	6	5

Note: n=8 Residents, n= 5 Clinical Coaches

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Capella University's Academic Honesty Policy ([3.01.01](#)) holds learners accountable for the integrity of work they submit, which includes but is not limited to discussion postings, assignments, comprehensive exams, and the dissertation or capstone project.

Established in the Policy are the expectations for original work, rationale for the policy, definition of terms that pertain to academic honesty and original work, and disciplinary consequences of academic dishonesty. Also stated in the Policy is the expectation that learners will follow APA rules for citing another person's ideas or works.

The following standards for original work and definition of *plagiarism* are discussed in the Policy:

Learners are expected to be the sole authors of their work and to acknowledge the authorship of others' work through proper citation and reference. Use of another person's ideas, including another learner's, without proper reference or citation constitutes plagiarism and academic dishonesty and is prohibited conduct. (p. 1)

Plagiarism is one example of academic dishonesty. Plagiarism is presenting someone else's ideas or work as your own. Plagiarism also includes copying verbatim or rephrasing ideas without properly acknowledging the source by author, date, and publication medium. (p. 2)

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Statement of Original Work and Signature

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I attest that this dissertation or capstone project is my own work. Where I have used the ideas or words of others, I have paraphrased, summarized, or used direct quotes following the guidelines set forth in the *APA Publication Manual*.

Learner name
and date

Sueanne Wright Cantamessa 12/18/2015

Mentor name
and school

Catherine Suttle, PhD, School of Nursing and Health Sciences