



Preceptor Support in Hospital Transition to Practice Programs

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OBJECTIVE: The aim of this study was to describe newly licensed RN (NLRN) preceptorships and the effects on competency and retention.

BACKGROUND: Preceptors are widely used, but little is known about the benefit from the perspective of the NLRN or about the models of the relationships. The National Council of State Boards of Nursing added questions about the preceptor experience in a study of transition-to-practice programs.

METHOD: Hospitals were coded as having high or low preceptor support in regard to scheduling NLRN on the same shifts as their preceptors, assignment sharing, and preceptor release time and a low number of preceptors per preceptee.

RESULTS: Half of the 82 hospitals were classified as high, and half as low preceptor support. NLRNs and their preceptors in high-support hospitals evaluated the preceptor experience and NLRN competence higher. In addition, NLRN retention was higher in the high-support hospitals.

CONCLUSION: To improve NLRN competence and retention, preceptors should have adequate time

with each NLRN, share shift and patient assignments, and have few preceptees assigned to each preceptor concurrently.

Newly licensed RNs (NLRNs) face challenges when applying recently learned knowledge and skills in the complex world of modern hospitals. To assist in

be structured to include 1 day each month together or all shifts for 6 months.⁸ A review of strategies to increase NLRN retention found that between 71% and 82% of studies used a clinical preceptor program of some kind.^{12,13}

Given the recognized importance of preceptors to the successful transition of NLRNs, the characteristics of a good preceptor, methods to train preceptors, rewards and recognition for preceptors, evaluation of preceptors, and the satisfaction and stress of preceptors have been evaluated.^{8,13-21} After reviewing the literature, Moore^{20(p250)} listed 6 problem areas: (a) preceptorships being too short, (b) mismatch between the work schedules of the preceptee and preceptor, (c) little opportunity to discuss expectation and goals, (d) preceptee spending too little time with the preceptor, (e) a general lack of time, and (f) failure to adjust preceptor's patient load.

The length of time preceptees spend with preceptors varies greatly, and most reports do not include specifics about release time for preceptors, the ratio of preceptees a6(train)-2pears6TDO Tc-308.7ceptor62(p)2-400.9(es0)294.8(ra)7(,)e]TJ/F(tra04.)0(u)1 p4(t ag#287765

of the NLRN competencies scores were performed

activities higher in HPS hospitals than in LPS hos-

T 4. *NLRN Competence— rated by NLRNs*

	LPS Hospitals	HPS Hospitals	Significance of Difference
	Mean	Mean	
Survey 6 mo	n = 266	n = 278	
Overall competence	3.10	3.12	NS
Patient-centered care	4.16	4.20	NS
Quality improvement/evidence-based practice	3.98	4.01	NS
Technology	4.27	4.36	NS
Teamwork/communication	4.08	4.08	NS
Survey 9 mo	n = 240	n = 253	
Overall competence	3.10	3.13	NS
Patient-centered care	4.21	4.23	NS
Quality improvement/evidence-based practice	4.04	4.03	NS
Technology	4.29	4.36	NS
Teamwork/communication	4.12	4.12	NS
Survey 12 mo	n = 104	n = 134	
Overall competence	3.18	3.22	NS
Patient-centered care	4.33	4.36	NS
Quality improvement/evidence-based practice	4.13	4.17	NS
Technology	4.39	4.45	NS
Teamwork/communication	4.19	4.25	NS

patient assignments, and keeping the number of preceptees for each preceptor low. There were only small differences between these 2 groups of hospitals other than their preceptor support. Furthermore, the characteristics of preceptors and NLRNs differed only slightly between HPS and LPS hospitals.

NLRNs in HPS hospitals were significantly more likely to be retained at the end of the 1st year, 86% in HPS hospitals versus 80% in LPS hospitals. Both preceptors and NLRNs evaluated their preceptor

experiences higher in HPS hospitals. This included an evaluation of the preceptor context: time, support, continuity, and adjusted patient assignment; and preceptor activities such as feedback, determining patient priorities, providing information, using evidence-based practice, staff communication, learning from errors, developing clinical reasoning, and using technology.

The competence of NLRNs increased over time as expected with more experience; this included the overall competence and the specific competencies of

T 5. *NLRN Competence – rated by Preceptors*

	LPS Hospitals	HPS Hospitals	Significance of Difference
	Mean	Mean	
Survey at 6 mo	n = 300	n = 378	
Overall competence	3.26	3.31	NS
Patient-centered care	4.17	4.20	NS
Quality improvement/evidence-based practice	3.98	3.98	NS
Technology	4.26	4.32	NS
Teamwork/communication	4.02	4.06	NS
Survey at 9 mo	n = 376	n = 280	
Overall competence	3.23	3.36	.001
Patient-centered care	4.23	4.32	.029
Quality improvement/evidence-based practice	4.03	4.10	NS
Technology	4.30	4.37	NS
Teamwork/communication	4.06	4.14	.054
Survey at 12 mo	n = 162	n = 167	
Overall competence	3.36	3.43	NS
Patient-centered care	4.30	4.39	NS
Quality improvement/evidence-based practice	4.10	4.29	.004
Technology	4.34	4.47	.031
Teamwork/communication	4.13	4.30	.009

patient-centered care, quality improvement/evidence-based practice, use of technology, and teamwork/communication. NLRNs and their preceptors in HPS hospitals assessed their competence higher than did those in LPS hospitals, although only the differences in preceptor scores were statistically significant. In

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