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Relationship Between Emotional Intelligence and Resilience Among Newly Licensed Registered Nurses Transitioning to the Professional Role

Lee Fong-Hong

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THE RELATIONSHIP BETWEEN EMOTIONAL INTELLIGENCE AND
RESILIENCE AMONG NEWLY LICENSED REGISTERED NURSES
TRANSITIONING TO THE PROFESSIONAL ROLE

Presented in Partial Fulfillment of the
Requirements for the Degree of
Doctor of Philosophy in Nursing Education

Nova Southeastern University

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**NOVA SOUTHEASTERN UNIVERSITY
HEALTH PROFESSIONS DIVISION
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Abstract

Background: With the current nursing shortage there are fewer experienced nurses and more newly licensed registered nurses (NLRNs) in the workplace. This shortage may be due in part to inconsistencies between role expectations learned in school and the practice environment. These inconsistencies may make it challenging to transition from nursing school into professional healthcare organizations. Nurses with certain person-level traits, including resilience and emotional intelligence, may be more likely to make a successful transition into practice. Findings may improve our understanding of what person-level traits are important for making the successful transition to the workforce.

Purpose: The current study explored whether emotional intelligence (EI) and resilience influenced transition into professional roles.

Theoretical Framework: Understanding how cultural shock and adaptation are challenging for many NLRNs is important. Duchscher transition theory provided an overview of how NLRNs engaged in the professional practice role as they are confronted with the realities of the work environment.

Methods: A non-experimental research design with descriptive cross-sectional study is used to determine if EI and resilience have any effect on NLRNs transitioning into their professional roles.

Results: With a sample size of 63, there is a direct positive linear relationship between resilience and global trait EI and its subscales for NLRNs. The correlation is significant with the exception of the EI subscale emotionality. Also there was no significance with NLRNs who transitioned in a critical care setting and those in other specialty care areas.

Conclusions: There is a need for further exploration of this relationship with a larger sample size and the need to investigate person-level characteristics in NLRNs who successfully transition to their professional role.

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Chapter One

The Problem and Domain of Inquiry

The role of the nursing workforce has been constantly evolving in the United States with a greater focus on technology and complex medical conditions. Spector and colleagues (2015) indicated that a nursing shortage exists in today's healthcare environment with fewer experienced nurses and more newly licensed registered nurses (NLRNs) in the workforce. Although the literature showed there is a current shortage of nurses, according to projections by the Health Resources and Services Administration (2014), by 2025 the supply of registered nurses will exceed the demand. Newly licensed registered nurses will be the largest source of nurses entering the workforce, and they will need a supportive environment that is conducive to a positive transition process into the workplace (Phillips, Kenny, Esterman, & Smith, 2014). Although NLRNs qualified as competent based on licensure, most were concerned with the inconsistency in role expectations learned in school and those of the practicing nurse (Feng & Tsai, 2012). Transitioning to the work environment has often been a complex and difficult process that presented many obstacles and challenges to the NLRN. For example, the environment in healthcare organizations is ever changing. In addition, organizational emphasis has mostly been on operating more efficiently with declining resources. Furthermore, the existence of a lack of access to experienced nurses to precept, mentor, and coach and increased oversight and workloads in healthcare organizations have

compounded the issues NLRNs face as they transition from an academic setting to the workforce (Hofler & Thomas, 2016).

Considering the complexity of today's healthcare environment and an imminent nursing shortage perpetuated by massive nurse retirement, there are fewer experienced nurses and more novice nurses in the workplace. This has been problematic because there is a decline in the level of nursing experience which translates into a gap in nursing expertise. In healthcare systems, the focus has been on evidence-based practice, patient safety, and quality improvement. This requires practical learning and high-level thinking, qualities not typically exhibited in newly licensed registered nurses (Spector et al., 2015). In addition, it has become necessary to retain NLRNs since turnover rates often range from 16% to 67%, and there is a significant cost of \$65,000, typical salary for new nurse, the average for a nurse replacement (Bratt & Felzer, 2012). According to Bratt and Felzer (2012), within three years of NLRNs' initial positions, about 22% changed employer or position and approximately 40% planned to leave. It has been documented that there is a need for effective programs to transition NLRNs into practice settings (Spector et al., 2015). Nevertheless, nurse managers, educators, and clinical specialists find it very difficult and frustrating to provide effective programs to halt the turnover rates in acute care settings (Bratt & Felzer, 2012). While hospitals and other healthcare institutions have been challenged to create appropriate programs that support NLRNs, financial constraints within these institutions limit the availability of resources for a clinical education (Kumaran & Carney, 2014).

As frontline healthcare professionals, nurses have an important responsibility to provide high quality service. Transition into the professional role for a NLRN can be

stressful and arduous because NLRNs are concerned with inconsistencies between role expectations learned in school and those of the practicing nurse. The realities of the clinical setting were not always congruent with values taught in nursing school (Feng & Tsai, 2012). Feng and Tsai (2012) indicated that in the United States within the first year of employment there is a voluntary turnover rate of 30%. There is evidence in the literature that a gap exists between theory and practice when it comes to being a student and entering the practice setting. Additionally, NLRNs have been challenged with reality shock associated with trying to meet the needs of patients as they transition to the practice environment (Rush, Adamack, Gordon, Lilly, & Janke, 2013). According to Hatler, Stofferer, Kelly, Redding, and Carr (2011), within the first 12 months of employment, NLRNs may have had a stressful time making a connection between the knowledge learned in the academic setting with the experiences encountered in the practice setting. With hospitals employing 72% of NLRNs in the United States, it is crucial that NLRNs are oriented to the organization appropriately and given enough time to adjust to their role (NCSBN, 2015; Washington, 2013). NLRNs that have poor experiences during the transition period either leave their first job within less than a year or leave the profession altogether (Edwards, Hawker, Carrier, & Rees, 2015). According to Edwards et al. (2015) strategies that improved the transition process directly impacted NLRNs by reducing stress and anxiety. This led to the promotion of confidence and competence which influenced increased job retention in NLRNs. Since patients and the healthcare community demand high-quality services, essentially healthcare providers (particularly nurses) had the emotional intelligence to manage the events that occur during hospitalization (Hong & Lee, 2016). These providers were cognizant of

continuous changes in healthcare technology, chronic conditions of various disease processes, and many safety aspects of high reliable organizations.

Although much attention has been focused on the challenges of the workplace for NLRNs, less research has concentrated on the role of NLRNs' person-level traits in their successful transition to the workforce. To deal with the many facets of health care, providers need to possess personal attributes like emotional intelligence (EI) and resilience to increase their confidence and competence when giving care and to reduce turnover rates caused by poor job performance (Heydari, Kareshki, & Armat, 2016). However, the task of improving confidence and competence in NLRNs within one year has been daunting because of a vast, complex healthcare system. Minimal research has been done to investigate behaviors associated with EI and resilience related to high turnover rates and the small amount of time NLRNs stay within a single facility. Therefore, this research will examine the effect of emotional intelligence and resilience on how NLRNs progress and succeed as they transition to their professional roles in an acute care hospital setting.

Problem Statement

Newly licensed registered nurses encounter various stressors in their transition to the professional role within a hospital setting (Vishavdeep, Das, Prahbjot, & Ghai, 2016). Having an understanding of emotions is an important skill to manage stress and prevent burnout (Tyczkowski et al., 2015). High levels of stress and burnout contributed to poor retention of nursing staff in acute care facilities. Emotional intelligence is a predictor of resiliency, so being able to effectively manage one's own emotions in complex care settings may have important implications for role transition (Kinman &

Grant, 2011). Emotional intelligence is a personal attribute in which individuals are able to monitor their own emotions and use this to guide their thinking and actions (Heydari et al., 2016). Brennan (2017) referred to resilience as the individual's ability to cope effectively with and positively adapt to adversarial conditions. Workplace stress has been found to contribute to retention problems. To maximize retention in the nursing profession, it is necessary to understand the precise factors that enhance the well-being and success of a NLRN. Newly licensed registered nurses have to be resilient to face the dynamic changes in health care, whether they are influenced by environment, external, individual, and outcome factors (Kinman & Grant, 2011). Emotional intelligence exists in our minds and guides our behavior and judgment whether or not they match up to an objective reality. In organizational settings, individuals continually make judgments of other people's emotional abilities. Hence, emotional intelligence is judged by social perceptions or interpersonal skills and not how things really are (Elfenbein, Barsade, & Eisenkraft, 2015).

Aradilla-Herreo, Tomas-Sabado, and Gomez-Benito (2013) perceived that emotional intelligence in nursing referred to the ability to manage one's own emotions and is important in carrying out nursing duties. Therefore, emotional intelligence may have been seen as an essential skill for competent nurses (Aradilla-Herreo et al., 2013). NLRNs with higher emotional intelligence may have performed better on interpersonal tasks like being situationally aware of social dynamics and communicating well with others (Libbrecht, Lievens, Carette, & Côté, 2014). Developing emotional intelligence skills empowered NLRNs to overcome fear in their profession, improve their attitudes, and gain greater control over their emotions as they become therapeutic in the nurse-

patient relationship (Aradilla-Herreo et al., 2013). Emotional intelligence is an individual difference characteristic that affected how NLRNs communicate with other professionals and patients. NLRNs with emotional intelligence are more perceptive and emotionally aware of changes in patients' clinical status and are able to picture the therapeutic relationship in the overall plan of care. There is a reduction in risk and improvement in patient safety as individuals/nurses communicate with others (Codier & Codier, 2015).

A NLRN's ability to cope effectively despite the challenges of the current healthcare environment may also be attributable to his or her own resiliency. Some of the factors that affect how a NLRN delivers high-quality patient care are difficult working conditions and role expectations. Therefore, to be able to have the necessary skills associated with being resilient may sustain a NLRN in a challenging work environment (Brennan, 2017). Brennan (2017) indicated that contributing factors and strategies to build resilience not only enhance individual well-being but are also beneficial to an organization by increasing nurses' productivity, employee retention, and patient satisfaction.

Purpose of the Study

The purpose of this study was to assess whether emotional intelligence (EI) and resilience are positively related to NLRNs who successfully transition to their professional role. This study explored if EI and resilience could influence NLRNs' transition into their professional roles and shed light on the process of the person-level characteristics that may aid in a positive change to the work environment. Adapting to the practice environment and the shock of transitioning to the nursing culture could have been stressful for NLRNs and have a negative impact when it comes to interactions with

other medical professionals and patients. Examining EI and resilience is important to transitioning for NLRNs, so this study could possibly identify if these factors had any significance on newly licensed registered nurses as they immersed into their first professional practice work environment.

Research Questions

There have been no studies found to date that have provided a quantitative viewpoint of both EI and resilience in NLRNs. Therefore research questions that guided this study were:

1. What is the relationship between emotional intelligence and resilience among newly licensed registered nurses transitioning to their professional role?
2. What is the difference in emotional intelligence and resilience between NLRNs who transition in critical care nursing specialty and those who do not?

Hypotheses

H1: There will be no statistically significant relationship between emotional intelligence and resilience among newly licensed registered nurses transitioning to their professional role.

H1a: There will be a statistically significant relationship between emotional intelligence and resilience among newly licensed registered nurses transitioning to their professional role.

H2: There will be no statistically significant difference in emotional intelligence and resilience between NLRNs who transition in critical care nursing specialty and those who do not.

H2a: There will be a statistically significant difference in emotional intelligence and resilience between NLRNs who transition in critical care nursing specialty and those who do not.

Significance of the Study

Nurses who work in hospitals face many complexities that require interactions from the varying professionals that work in this high stress environment (Montes-Berges & Augusto, 2007). Often in those high demand healthcare settings, nurses are challenged to maintain restraint in response to varying acts of hostility from other clinicians and patients. Their responses to innumerable emotions like anger, fear, and sadness can affect the quality of patient care and can continue a cycle of hostility (Nosek, 2015). Emotional intelligence and resilience may affect how a newly licensed registered nurse adapts and functions in situations that are often stressful. By looking at the correlation between resilience and emotional intelligence, one may be able to understand the personality profile of NLRNs and whether they are equipped to handle transitioning into the workforce. Also it is important to see if these traits have an impact on those who participate in a residency program and those who do not.

Nursing Education

The projected need for nurses over the next 10 years will increase. This is attributed to an increased need for nursing care as the number of older adults rise, nurses in the workforce aging, and high attrition of new nurses (Cochran, 2017). The American Association of Colleges of Nursing (2017) indicates that enrollment in nursing programs is not growing fast enough to meet the projected demand. There is a shortage of nursing faculty and changing models of care for which the nursing curriculum is not keeping up.

Health care has become so complex that it is imperative to align education with the practice environment (American Association of Colleges of Nursing [AACN], 2017). Therefore NLRNs need to have the necessary knowledge and skills to perform in the workplace.

The significance of this study to nursing education relates to creating standardized methods to transition NLRNs during the first year of practice. Dramatic changes in today's healthcare industry have resulted in transformation of nursing roles, which has provided new opportunities in nursing (Amos, 2016). These changes, for instance advances in technology, have generated important changes in nursing education (Allen, 2013). As a result, current and future nursing students require more information to function and care for patients in the healthcare system (Amos, 2016). With these demands in the future of nursing care, nurse educators are challenged with adapting a curriculum that meets these changes. In today's complex healthcare system, the principles of quality and safety are essential components that need to be integrated into nursing curricula (Lewis, Stephens, & Ciak, 2016). These principles add rigor to nursing programs and create additional stressors when it comes to clinical requirements and adaptation to the nursing culture. Having emotional intelligence and building resiliency may benefit nursing students in completing their nursing programs and assist them with the culture shock as they enter practice as licensed clinicians (Boardman, 2016). Emotional intelligence is a relatively new concept in nursing education and how it affects the nursing profession is still being explored (Yekta & Abdolrahimi, 2016). Resilience and academic stress have been studied; however, resilience development and NLRNs is still being hypothesized (Wahab, Mordiffi, Ang, & Lopez, 2017). This study may show

that EI and resilience are significant for NLRNs and there may need to be interventions in the workplace to enhance these qualities and support their adaptation to a new environment

Nursing Practice

This study has the capacity to provide significant information to the profession by correlating an objective measure of EI and resilience. This has the potential to increase understanding of the importance of person-level characteristics of the NLRNs themselves as they transition into the workforce. Practice readiness of NLRNs in today's environment has been problematic and has led to healthcare agencies making efforts to develop evidence-based programs to improve the orientation process for transitioning NLRNs into the practice environment. Approaches to NLRNs' orientation into the workforce are being re-examined with the learning needs of the NLRNs and by taking into account the preceptors who work with the NLRNs. Nursing leaders are concerned that NLRNs are not fully prepared to provide safe patient care (Dyess & Sherman, 2009). According to Jones and colleagues (Jones et al., 2017), depending on the nursing specialty, a 12 to 16 week intense transition program followed by a yearlong program that supports and mentors NLRNs would facilitate the development of the critical thinking skills and nursing practices that are necessary to provide safe patient care. This is inconsistent with Dyess and Sherman's (2009) recommendation of a transition program to be completed within 3 to 6 months. Transition or residency programs would build on what NLRNs have learned from their education programs; however, these varying programs may lack the support needed to sustain the NLRN through the transition during their first year of practice (Dyess & Sherman, 2009).

Nursing Research

The information generated from this study can be tested in various other settings like other geographical areas. This study is relevant, as further research on NLRNs' transition from new graduate to professional nurse is needed. Even though it has been documented that there is a gap between being a student nurse and a licensed professional nurse entering the work environment, it may be beneficial to have studies further investigate the initial transition period into the work environment between these two phases (Rush et al., 2013). The evidence supporting NLRNs' transition process and outcomes has been variable when it comes to identifying benefits, so this study has the potential to develop an evidence-based strategy that may possibly be constructive for NLRNs to improve the work environments by providing directions and interventions designed to better integrate the NLRN into practice. Continued studies regarding the structure of the transition period and available support would benefit NLRNs during this challenging period that is often stressful (Rush et al., 2013).

Public Policy

Findings from this study can provide beginning data for identification of interventions to be included in policies regarding NLRNs in the work environment. The successful transition of a NLRN into practice is crucial; however, many healthcare organizations have not implemented programs to facilitate the transition of the NLRN into the work environment. The research done here could provide evidence-based support for NLRNs and provide them with strategies to cope and be constructive in their work environment during this critical transition period. Implementing the evidence into policy

within healthcare institutions can provide the structure needed to support the NLRN (Silvestre, Ulrich, Johnson, Spector, & Blegan, 2017).

Philosophical Underpinning

The philosophical underpinning of this dissertation incorporates the scientific paradigm. The assumption is that NLRNs are expected to use skills with minimal knowledge learned in academia and practice with expertise in the work environment. In this paradigm, knowledge is developed objectively by successfully completing high stakes tests rather than from human experiences (Pratt, 2012). The scientific paradigm was first applied by Comte in the 1900s as he attempted to associate the social and natural sciences using one philosophy and methodology. The scientific paradigm seeks conjectures and makes generalizations (Scotland, 2012; Winit-Watjana, 2016). Over time positivism has been questioned and challenged, resulting in several approaches to the positivist philosophy that fall in distinct generations (Crossan, 2003).

The first generation following the period of Enlightenment includes an aggregation of scientific knowledge. In the 18th and 19th centuries, Comte, Hume, and Locke are some of the philosophers associated with the early practice of positivism (Crossan, 2003). August Comte is the central theorist of positivism, and his position is that a ubiquitous method of inquiry is required for all sciences (Breen & Darlaston-Jones, 2010; Winit-Watjana, 2016). The next phase is the generation associated with logical positivism in the early 20th century that identifies with philosophers generally known as the Vienna Circle (Crossan, 2003). The Vienna Circle included philosophers, physicists, mathematicians, and logicians whose ideas merged formal logic with empiricism resulting in logical positivism. Ultimately the verification principle, knowledge verified

became facts, emerged from this period (Breen & Darlaston-Jones, 2010). Finally, there is the generation developed in the post-war era frequently affiliated with Karl Hempel (Crossan, 2003). As members of Circle sought flight overseas, logical positivism became global. Its premises proliferated and dominated research in many disciplines (Breen & Darlaston-Jones, 2010).

According to Crossan (2003), the essential thinking with positivism was the ontological position of realism in which knowledge derived from the accumulation of data that were measurable. Independent of human behavior an objective reality existed; therefore, it is not created by the human mind. Real knowledge is derived from humans investigating objective reality (Crossan, 2003). Positivist epistemology asserts objectivism and that knowledge procured through the scientific method is neutral. Positivism aims to identify, predict, control, and explain with the overall goal of producing universal laws. In positivist research, the fundamental methodology is experiment. Deductive reasoning is used to carry out theory-based research as part of the scientific method in which a pattern can be confirmed with generalization (Breen & Darlaston-Jones, 2010; Winit-Watjana, 2016). Using Crossan's (2003) explanation of positivism, NLRNs' emotional intelligence and resilience can be examined to see if a relationship exists.

Theoretical Framework

When seeking to understand if emotional intelligence and resilience have an influence on the transition experiences of NLRNs to the workplace, it is important to understand how cultural shock and cultural adaptation are challenging for many NLRNs. Duchscher transition theory provides an overview of how NLRNs engage in the

professional practice role as they are confronted with the realities of the work environment (Duchscher, 2008).

Duchscher Transition Shock Theory

Judy Boychuk Duchscher (2008) introduced a transition theory on newly graduated nurses' experiences in their role transition from school to professional nursing practice. For the purpose of this study, newly graduated nurses are referred to as NLRNs. Duchscher's theory of transition was based on the results from four qualitative research studies over a 10-year period. The focus was on understanding the transition process of novice practitioners through different stages of knowledge development – doing, being and knowing - that expanded their scope of practice and contributed to their personal and professional progression. The emergence of the concept theory of transition stages intends to be a standard for successful integration of new nurses into the workplace by those who recruit, orient, and mentor (Duchscher, 2008; Nursing the Future, 2016). The theory is a framework for understanding how a NLRN's transition experience is nonlinear and moves through various stages and phases (Duchscher, 2008; Duchscher, 2009). The process “moves the new practitioner through developmental and professional, intellectual and emotive, skill and role-relationship changes, and contains within it experiences, meanings and expectations” (Duchscher, 2009, p. 1105).

Originally, Kramer (1974) characterized transition of new nurses to the professional work environment as *reality shock* (Duchscher, 2008; Duchscher, 2009; Martin & Wilson, 2011). Kramer (1974) asserts that for most new graduate nurses, the assimilation into professional nursing practice has particular phases. These phases include the following: the honeymoon phase, which is filled with optimism and

enthusiasm and where the perception of reality is distorted; the shock phase, characterized by disillusion in which professional values are questioned; and the resolution phase in which a decision is made whether to adapt or leave (Duchscher, 2008; Martin & Wilson, 2011). Duchscher (2008) suggests that for NLRNs, practical nursing experiences are limited. That is, NLRNs lack the social and cognitive skills that are necessary to handle basic clinical practices like communication, delegation, and time management (Duchscher, 2008).

Expanding on Kramer's concept, Duchscher (2008) identifies three stages of transition experienced by NLRNs as they go from a graduate to staff nurse. The stages identified are "doing," "being," and "knowing." They are on a continuum as new nurses learn, discover, and adjust to their own practice (Duchscher, 2008). The stage of doing refers to the stage in which NLRNs have idealistic expectations at the initial period of role transition into professional practice. This time lasts up to five months as new nurses move from a structured environment to one in which they may feel unprepared for the new responsibilities and expectations of the work environment. The realization that what is expected is not reality affects their personal and professional selves (Duchscher, 2008). The next stage—being—refers to NLRNs' post-orientation transition experiences. It involves the next four to five months. In this stage, NLRNs are more aware of their professional role with other healthcare professionals as they try to find a balance between their personal and professional lives (Duchscher, 2008). The third stage, referred to as knowing, is the NLRNs' final stage during the initial 12 months of practice in which they are satisfied and confident with their roles, responsibilities, and work routines. They feel

more established and start to take notice of what is happening in the work environment (Duchscher, 2008).

Duchscher's (2008) theory explained that there are certain issues such as a lack of clinical experience or lack of social maturity inherent in NLRNs based on where they are on the continuum of the transition experience. However, there was not any discussion on whether the stages of transition were affected by personality traits such as emotional intelligence and resilience.

Transition Shock

New graduate nurses often experience transition shock within the first stage of professional role transition (Duchscher, 2009). Duchscher (2009) described transition shock as a phenomenon in which NLRNs have a difficult time moving from the well-known role of nursing student to the less familiar role in professional practice. This transition shock is inherent in the first stage. The transition experience is influenced by history and situational context that generate certain expectations about the professional role, responsibilities, work culture, and principles. Initially, role transition experience varies for professionals and is impacted by individual fundamental issues—physical, intellectual, and emotional—that affect their welfare. Transition shock develops as the experience of an individual moves from the known role to a somewhat less familiar role, in this case student to professional practicing nurse (Duchscher, 2009). Duchscher's study explained the significance of this experience for the new graduate as the contrast between the required expectations of the familiar academic environment and those of the professional practice setting when it comes to knowledge, performance, relationships, responsibilities, and roles. The process is not linear or prescriptive, and adjustments to

both personal and professional well-being are most intense the first one to four months post orientation. Experiencing transition shock upon fully entering the professional practice put strain and stress on the initial socialization period. By the end of this time, feelings of fatigue and isolation resulted in confusion, disorientation, and doubt, and loss represents reality. There are certain expressions of the transition shock experience, which include the following emotional, intellectual, physical, and sociocultural/developmental forms of expression (Duchscher, 2009).

Emotional

There was a wide range of emotions expressed by NLRNs during the initial stage of transition. This was an intense and overwhelming period in which reassurances and validation were sought. For the new professional, response to role transition stress is influenced by interactions with individuals in post orientation. The level of adjustment experience depends on certain dynamics including emotional and functional support; confidence and practice experience; communication with new colleagues; control and support for personifying the anticipated professional practice values and roles; exhaustion, whether emotional, intellectual, or physical; and institution, colleague, or even self-performance expectations. The new professionals spend a lot of energy attempting to stabilize their emotions and feelings as they transition (Duchscher, 2009).

Intellectual

The initial introduction of nursing graduates into their new roles as professional practitioners begins with an orientation to the workplace, nursing role, and practice context. Still in the learning role, NLRNs are eager and excited about practicing. The nursing workload and full professional practice responsibilities are not apparent until the

orientation is over and the experience is no longer exciting but overwhelming and stressful. The transition from limited to full responsibility is unexpected and often difficult as certain experiences or capabilities of new graduates are not accounted for in the process of initiation into the professional role. Not wanting to seem inexperienced or ignorant, the new professional often does not reach out to senior practitioners when in clinical situations that are above their comfort level (Duchscher, 2009).

Physical

New graduates' physical response to transition shock experience monopolizes all their energy in trying to perform a new role seamlessly with a certain level of expectation. The physical demands of adjusting to new personal life pattern routines, professional accountability while feeling inadequate, and role relationship with colleagues may consume both waking hours and sleep time (Duchscher, 2009).

Duchscher (2009) indicated that NLRNs' doubts and insecurities led to physical exhaustion as their waking hours were consumed with thoughts of what transpired during the last shift worked and mentally preparing for the possibilities on the upcoming shift.

Sociocultural and Developmental

For new graduates, the primary sociocultural and developmental undertakings are to discern their professional role and be confident, balance personal life and professional work, achieve acceptance into the professional nursing culture, merge academic education with what is seen in practice, and foster collegial relationships with colleagues (Duchscher, 2009).

Both Benner's (1992) novice to expert model and Duchscher's (2008) transition theory explore the basic level of nursing experiences. When the novice, specifically the

NLRN, experiences the transition process, having an understanding of how EI and resilience affect mood or attitude in the work environment is necessary to understand what is happening in the change process. Therefore, these theories are significant in interpreting the association between emotional intelligence, resilience, and the NLRN transitioning into the work environment.

Theoretical Assumptions

The theoretical assumptions brought to this study are substantiated in the existing literature such as Duchscher (2008) and Dyess and Sherman (2009) and in the researcher's own professional experience as a registered nurse and nurse educator. The assumptions are as follows:

- Newly licensed registered nurses are the future nursing workforce.
- Newly licensed registered nurses are stressed during their initial year on the job.
- Newly licensed registered nurses are dissatisfied with their job, and job satisfaction is correlated to retention.
- Quality of care is affected by high turnover and dissatisfied nurses.
- A gap exists between newly licensed registered nurses' perception and what is expected of a registered nurse.
- Newly licensed registered nurses face many challenges as they transition to the workforce.
- Newly licensed registered nurses need a variety of supports to transition into practice.
- Newly licensed registered nurses' individual traits play a role in the positive transition to the workforce.

Definition of Terms

The following section provides operational definitions of key terms in this study, including emotional intelligence, resilience, newly licensed registered nurses, transition, and workplace.

Emotional Intelligence

Emotional intelligence is “the nurse’s constructive ability to demonstrate and facilitate self-awareness, self-management, social awareness, and social relationship management” (Yekta & Abdolrahimi, 2016, p. 159). This is an individual trait with one’s perceptions relating to one’s emotions. A person has the ability to understand, express and control not only one’s own emotions but that of others (Yekta & Abdolrahimi, 2016). For the purpose of this study, emotional intelligence is measured using the Trait Emotional Intelligence Questionnaire Short Form (TEIQue-SF) (Petrides, 2009).

Resilience

Resilience is one’s ability to recover from adversity during a dynamic process influenced by various factors: environment, external, individual, and the outcome (Garcia-Dia, DiNapoli, Garcia-Ona, Jakubowski, & O’Flaherty, 2013). For the purpose of the study, resilience will be measured using the Connor-Davidson Resilience Scale (CD-RISC).

Newly Licensed Registered Nurses

Newly licensed registered nurse (NLRN) is a term appearing more recently in the literature. In accordance with Benner’s (1982) definition of a novice or beginner, a newly licensed registered nurse is unable to perform a task because of a lack of experience in that particular situation. For the purpose of this study, newly licensed registered nurses

denotes registered nurses who have graduated from an associate, diploma, or baccalaureate program and have possessed a registered nurse license to practice for less than 18 months.

Transition

In nursing, the concept of transition refers to the “movement from a place of comfortable familiarity to new, previously unknown experiences. It requires a passage of time and adjustment of self to roles, functions, relationships, and patterns of behavior” (MacLellan, Levett-Jones, & Higgins, 2015, p. 3). For the purpose of this study, Duchscher’s (2008) description of transition for new graduate nurses is a process of learning specific thoughts and actions as they change from student to staff nurse.

Workplace

Workplace refers to professional practice in acute care nursing settings in healthcare institutions.

Chapter Summary

Nurses are in short supply in today’s healthcare environment (Cochran, 2017). Healthcare organizations are affected by factors, usually financial in nature. There is considerable cost associated with recruiting, hiring, and training a NLRN such that organizations may choose not to invest in hiring new nurses. This restricts the numbers of available staff; consequently, nurses are often burdened with an increased demand to do more with fewer resources. Considering the cost of transitioning a NLRN to the professional role, which is a significant negative fiscal impact especially if they leave, it is important to retain the NLRN. Additionally, patient care is not just physical; it has emotional and spiritual components that need to be met. A lack of time is often the

greatest constraint in providing emotional care (Shanta & Connolly, 2013). Shanta and Connolly (2013) indicate that by understanding their own emotional intelligence abilities, nurses may be able to effectively respond to their patients and coworkers' emotional responses in a vast complex healthcare environment that can often be chaotic and stressful.

It has been well documented that transitioning from an undergraduate nursing student to a registered nurse is a difficult and tumultuous process (Duchscher, 2008). Having organizational interventions and support for NLRNs in their working environment may facilitate a positive transition which is often times made difficult by burnout, the aging workforce, and increasing levels of job dissatisfaction. How nurses are socialized and supported into the profession influences job satisfaction and retention (Phillips et al., 2014). The physical and emotional demands of the profession can be highly stressful; however, the NLRNs' resiliency and emotional intelligence may help them to cope effectively with the high level of stress in the workplace (Brennan, 2017). For this study, transition shock theory is used as a theoretical framework to understand how NLRNs transition to the professional role and how their person-level traits may help them succeed in their transition. Using quantitative methodology to elicit information about EI and resilience will provide information on how NLRNs transition to their new environment. For this chapter, the problem is identified as well as direction for the study given. Additional support related to NLRNs, transitioning, EI, and resilience is provided in chapter two.

Chapter Two

Literature Review

The study of newly licensed registered nurses' transitions into their professional role is not new (Silvestre et al., 2017). There have been many investigative studies that have described what NLRNs experience and need as they begin working in their professional roles (Crimlisk et al., 2017; Silvestre et al., 2017). Crimlisk and colleagues (2017) indicate that, traditionally, NLRNs are hired into acute care hospital settings with theoretical knowledge but not enough clinical practice skills. The adjustment to the expectations of the new professional nurse role and the lack of confidence in the required skill set make the transition difficult for the NLRN (Crimlisk et al., 2017). Therefore, it is important to understand what affects the NLRNs' well-being as they familiarize themselves with the work environment. This will increase the awareness of how NLRNs function in the work environment that is often stressful.

The purpose of this chapter is to discuss historical and current literature to better understand the importance of EI and resilience among NLRNs as they transition to the work environment. The literature focuses on key concepts such as role transition, clinical competency, and orientation. However, certain characteristics demonstrated by NLRNs affect their ability to successfully transition to professional role. A search of the literature included the Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed (MEDLINE), PsycARTICLES, Social Science Database, and Educational Resources Information Center (ERIC) databases for studies from 2000 to 2017. Search

terms include emotional intelligence, resilience, transition, transition shock, transition to practice, newly licensed registered nurses, new graduate nurses, novice nurses, novice to expert, and positivism. Multiple articles are evaluated to determine if they meet the following inclusion criteria: (a) acute care setting; (b) new graduate nurses in a transition program; (c) empirical research; (d) transition programs; (e) published in English.

Articles were excluded for one or more of the following reasons: (a) the articles included nurses working in areas that do not provide training; (b) the articles included samples other than newly licensed registered nurses. A total of 80 articles were identified in the literature search, and all were examined. Finally 28 articles are included in this review.

A review of the literature revealed that a variety of topics has been investigated about the experiences of newly licensed registered nurses or, as referred to in most cases, new graduate nurses. The following topics have been discussed in the literature: new graduate nurses role transition in an acute care setting (Duchscher, 2008), new graduate nurses transition to practice programs and cost benefit (Crimlisk et al., 2017; Silvestre et al., 2017). However there have been only a few studies that have examined factors pertaining to NLRNs' EI and resilience.

Transition

Transition refers to a process in which there is change from one condition to another. For NLRNs, transitions occur during the progression of a period of learning to adjust and socialize to a new culture, specifically the work or practice environment (Phillips et al., 2014). Nursing is a demanding profession, and it is challenging to transition from a student to a newly licensed registered nurse (Gardiner & Sheen, 2016). Rush and colleagues (2013) point out that there is plenty of literature on transitioning of

NLRNs to practice. Studies have looked at various facets of the transition process including a NLRN's competence, job satisfaction, experiences and perspectives, and retention (Rush et al., 2013).

There have been several theories of socialization that are useful frameworks for studying transition in nursing. Transitioning successfully into the work environment has been described as effectively being socialized into and supported by the health system. The quality of the NLRN's transition is mainly related to how effectively employers welcome and support the NLRNs during the initial weeks of work. Assumptions made about prior workplace experience can influence the amount of support offered by other staff members (Phillips, Esterman, & Kenny, 2015). Phillips and colleagues (2015) assert that socializing NLRNs is essential to support transition to practice. Organizations can accomplish this by having a formal socialization process in which employees learn the behaviors, knowledge, and skills needed for a successful transition (Phillips et al., 2015).

Phillips and colleagues (2015) explain, "organizational socialization is a process where a new employee learns the processes and rules of a particular job, thereby acquiring the necessary knowledge and skills to function in that role" (p. 120). During this organizational socialization that occurs during the onboarding process, NLRNs move from being outsiders to organizational insiders. Onboarding refers to the period in which the organization helps NLRNs learn the necessary behaviors, knowledge, and skills they need to succeed in their new role. Newly licensed registered nurses bring their life experiences with them to the new role. Healthcare institutions need to recognize that NLRNs have a variety of backgrounds, experiences, and personal characteristics and that

how NLRNs are socialized and accepted into the work environment is key to the adaptation of their new role (Phillips et al., 2015).

Professionalism or professional formation is acculturation (Strouse & Nickerson, 2016). Strouse and Nickerson (2016) suggest that as a layperson enters a professional culture, over time a new identity is formed. Professional socialization encompasses the formation of the professional identity. Professional socialization is internalizing the influential interactions of attitudes, behaviors, knowledge, norms, and skills of the nursing profession, which leads to the development of a professional identity. This complex developmental process immersed in the culture of professionalism over time exposes NLRNs to the nursing culture, which is considered to be essential to the formation of their identities as professional/working nurses (Strouse & Nickerson, 2016). Strouse and Nickerson (2016) suggest that an approach to professional formation is from the viewpoint of culture, specifically enculturation. Enculturation looks at organizational, societal, and other cultural aspects of the processes that are considered as the professional culture of nursing. For NLRNs that have been socialized to the professional nursing culture through enculturation, there is mitigation of culture shock during transition process (Strouse & Nickerson, 2016).

Transitioning from the classroom to the professional practice role is multifaceted and is affected by several factors, including the values and practices of the educational institutions that NLRNs attended and the employers and clinical practitioners encountered in their new work environment. Nurses' concerns about socialization into the nursing profession often arise from discrepancies of the nursing schools idealistic values and the realities of the clinical area such as progress in medical technology leads to

greater demands for nursing skills and knowledge not taught in schools (Feng & Tsai, 2012). The professional nurse's stress comes from both organizational and professional factors. Organizational factors include the inability to reach physicians, high job demand, insufficient support from peers and the organization as a whole, shift rotations, unfamiliar situations, lack of resources, and work overload. Professional factors that are stressors are becoming aware of one's accountability, an increase in responsibility, a lack of knowledge and skills, and role ambiguity. These stress factors affect the outcomes of socialization and, for a NLRN, these are professional and organizational commitments (Feng & Tsai, 2012).

Socialization is probably a mechanism that facilitates the transition of newly licensed registered nurses into their professional roles in the workplace. However, it is important to note that the transition may not be entirely explained by socialization, as there are many other contributors to the success of the transition like personal, professional, emotive, intellectual, and skills-related factors. The NLRN's first work experience comprises an array of emotions, intellect, physical, developmental and sociocultural issues that sustain a continuous pattern of personal and professional evolution. As NLRNs go through the transition period, they experience a period of adjustment to the role of a licensed professional (Duchscher, 2008).

Martin and Wilson (2011) indicate that the literature presents two theoretical models as recurring themes with the NLRNs' transitioning to practice: Benner's novice to expert and Kramer's reality shock. The theme of novice to expert refers to progression levels of nursing practice clinical and professional expertise from a novice to being competent and eventually an expert practitioner. Reality shock is described in nursing

practice as the process of professional acculturation. The different phases of reality shock include the following: honeymoon, shock, recovery, and resolution (Martin & Wilson, 2011). Each of these phases tends to be present to some degree in all NLRNs (Martin & Wilson, 2011).

Within a NLRN's first year of professional nursing practice, he or she may struggle with high levels of dissatisfaction and stress. As novices to the workforce, NLRNs are still learning as they try to reconcile their knowledge with clinical events (Teoh, Pua, & Cham, 2013). Kramer uses the term reality shock to describe NLRNs' responses when they realized that the practice environment is not congruent with initially perceived ideals and values (Teoh, Pua, & Cham, 2013). Kramer, Brewer and Maguire (2011) define reality shock as "expectation-reality generated stress" (p. 349). Newly licensed registered nurses experience this reality shock when they try to operationalize their academic learning into their first professional practice role. This is due to the discrepancy in the role conception (Kramer et al., 2011). What is learned in school is not what is being practiced in the work environment. Newly licensed registered nurses experience reality shock in four sequential phases. Phase one is the honeymoon phase, in which NLRNs are excited about getting their first paying nursing job. Phase two is shock, which involves the NLRNs beginning to realize that their expectations do not match the reality of the clinical work. In addition, the NLRNs' expectations may not match the institution's expectations. This is due to the NLRN's lack of experience with work environment requirements and regulations. The third phase is recovery, whereby the NLRNs start to consider their work environment from a more objective standpoint. Their stress and anxiety levels pertaining to their initial shock may lessen at this point in the

process. The fourth phase is resolution, which can be either positive or negative for NLRNs depending on whether they learn to effectively cope with the new role or whether the stress continues and leads to eventual job burnout (Cheng, Tsai, Chang, & Liou, 2014).

Over the last 40 years, the literature has shown that this role discrepancy has been used to measure NLRN transition difficulties. As a result, programs have been developed between academic and practice settings to increase collaboration between the students' experiences and practicing nurses supervising and teaching student nurses (Kramer et al., 2011). Kramer and colleagues (2011) indicate that even though reality shock continues to be problematic, the nurses' work environment is a major factor in role perception. The focal point is not only on how the professional role is conceived; it now includes the professional practice work environment misalignment of expectations and perceptions. This has shifted the focus to what is now termed environmental reality shock (Kramer et al., 2011). Healthcare environments, being complex and interactive systems, have a tendency to influence and modify how one lives and works. This interdependent system of people, practices, and structures promotes and supports the organization in which nursing is practiced. Hence, NLRNs effectively learn their roles by sharing tasks through cooperating and interacting with others in the natural work environment. This natural work environment is what impacts a NLRN's development and performance in his or her role as a working medical care professional (Kramer et al., 2011).

To overcome the discrepancy between what is taught in schools and what is happening in reality, many organizations offer programs that comprise a variety of support and opportunities for NLRNs. The goal of these programs is to build competence

and confidence as the NLRN develops professionally. Even with these programs in place, NLRNs continue to report disillusionment with their chosen career path (Gardiner & Sheen, 2016). Even though Gardiner and Sheen (2016) indicate that there are programs that offer varying support and opportunities to build competence and confidence, there is no specific mention that these programs focus on teaching methods to increase emotional intelligence and resilience.

Newly Licensed Registered Nurses

A review of the literature reveals examination of a variety of factors being investigated with NLRNs and their future in the nursing workforce. The education of nurses moved from training schools that were hospital based to institutes of higher learning. Basically, what could have been seen as an apprenticeship model has now become a practical experience through universities and colleges with less amount of time being spent in different healthcare settings. As a result, most often nursing students seek out employment in healthcare settings to gain increased clinical experience in areas similar to what their future work may be. The aim is to seek assistance in making the transition to the professional role since they are able to learn some transferable generic skills such as communication, handling conflicts, teamwork, and time management (Phillips et al., 2015).

With acute care settings seeing more patients with complex and chronic conditions and with their experienced nurses leaving the industry for varying reasons such as retirement or opportunities in other settings, NLRNs face many challenges as they transition to the work environment (Hofler & Thomas, 2016). Newly licensed registered nurses are one of the largest sources of nurses entering the workforce. Whether

the NLRNs are generation Y, millennials, or mature aged people entering the nursing profession, they all have demands, expectations, and needs. They expect certain necessities to be afforded to them by the future employer (Phillips et al., 2015).

According to Hofler and Thomas (2016), NLRNs, particularly with millennials, it is imperative they have coaches in order to have a successful transition process. Healthcare organizations need to have experienced coaches and mentors who are cognizant of the generational diversity in age of the NLRNs. Millennials expect an environment that is structured. Knowing that the NLRNs are stressed and fatigued during the transition to the professional role, organizations can expect turnover if their needs are not met (Hofler & Thomas, 2016).

The concepts of professional acculturation and development of professional responsibility have been two themes identified in the literature when it comes to the NLRN experience. The first theme, professional acculturation, includes socialization and acculturation (Martin & Wilson, 2011). With the aspect of socialization, the process has three categories, “anticipation and entry, surprise and reality shock, and status passage to describe the socialization of the newly licensed nurse” (Martin & Wilson, 2011, p. 22). The aspect of acculturation deals with whether or not the practice environment is caring. Professional acculturation is multidimensional and requires being able to maneuver through the process. How successful this process is depends on the support provided to the NLRN. While the NLRN is navigating the professional acculturation process, the expectation is that the NLRN will also develop professional responsibility. Professional responsibility is the other theme identified with the NLRN’s practice. Developing professional responsibilities can be seen through three themes associated with Benner’s

model of professional development. Adaptation of Benner's domains of practice is seen on a linear line as surviving as a novice nurse, being excited in becoming an advanced beginner, and, lastly, having a sense of perspective of the role of the nurse when the NLRN feels successful in achieving competent practice. How NLRNs adapt to the new culture is highly influenced by caring relationships with colleagues. These relationships also affect the length and quality of time spent in each phase as either a novice, advanced beginner, or competent nurse (Martin & Wilson, 2011).

Multiple studies have focused on job stress and job satisfaction. However, not many studies can be found on the relationship between personal attributes of NLRNs and how that affects the work environment (Unruh & Ning Jackie, 2014). As NLRNs transition to practice, the first year has been described as the most difficult time of their career and has been shown to influence the NLRN's intention to remain in the profession (Gardiner & Sheen, 2016). Silvestre et al. (2017) reports that 17.5% of NLRNs left their first job within a year and 33.5% left within two years. Specific to NLRNs adjusting to the hospital environment is reality shock with the difficulty of developing professional responsibilities and acculturation to the professional role (Gardiner & Sheen, 2016).

Newly licensed registered nurses upon leaving school have very high anticipations of the professional practice environments (Kramer et al., 2011). The future of the profession lies with NLRNs, who are integral to the delivery of health care. Yet they continue to feel isolated and stressed in their transition experience. The literature identifies that in order for NLRNs' transition experience to be considered successful, certain concerns need to be addressed. The concerns are as follows: constructive evaluation during the transition process; a supportive work environment; and, thirdly, a

less stressful environment (Gardiner & Sheen, 2016). It has been noted that work environment and workplace stress have been topics covered extensively in the literature; however, there is a lack of literature on the NLRN experience when it comes to receiving constructive evaluation. Also, with the emphasis placed on overcoming the challenges NLRNs face when transitioning to the professional role, more knowledge is needed about what NLRNs need to make a successful transition to the professional work environment.

Transition to Practice Programs

Nursing research on NLRN transitioning has resulted in the development of transition to practice programs designed to make it easier to adjust to the profession. Job dissatisfaction among NLRNs is a major concern for any organization since studies have shown that nurses who are dissatisfied have tendencies to not only leave the workplace but also the workforce. Therefore, it is important to provide an environment that will have a positive effect on NLRNs (Unruh & Ning Jackie, 2014). As newly licensed registered nurses enter the labor force, particularly in acute care hospital settings, they generally have large amounts of theoretical knowledge but need more clinical practice skills. Historically, bridging the gap between theory and practice has been proven successful when using residency programs as one approach to addressing the challenges for NLRNs (Crimlisk et al., 2017). According to Dyess and Parker (2012), transitioning NLRNs is costly and time intensive for organizations. Having transition programs that support NLRNs through this transition shock can positively impact not only the organization but also the NLRN. From an organizational perspective, Silvestre and colleagues (2017) indicate that the average turnover cost for a NLRN is \$70,500 while the cost associated with a NLRN in a residency program is \$13,460; therefore, it is

beneficial to have transition or residency programs since it is costly and time consuming to train NLRNs who may end up leaving a healthcare institution. With NLRNs, Crimlisk and colleagues (2017) point out that the impact includes the development of clinical practice and the integration into the work environment. There has been an increase in development of these programs with the goal of supporting NLRNs during this phase. The structure and content of these programs vary; however, there is some indication that a similar focus has been placed on those organizations that has positive outcomes (Dyess & Parker, 2012).

Frameworks for successful transition programs take into account situational as well as personal factors since they may have an impact on program outcomes. With NLRNs, their perceptions and responses to the daily experience during the transition period affect job satisfaction, turnover, and intention to leave. Situational factors refer to the dynamics of the workplace. Determinants such as leadership, support for professional practice, empowerment, and person-job fit can each affect the NLRN's perception of the work environment (Laschinger et al., 2016). According to Laschinger and colleagues (2016), NLRNs believe it is important to have congruence between their professional nursing practice and the work environment. Newly licensed registered nurses' congruency between work needs and the job fit is influenced by certain personal factors such as resilience which, in turn, affects work outcomes like job satisfaction. Additionally, attributes such as hope, optimism, resilience, and self-efficacy which describe a NLRN's psychological state may also have an impact on work life. For NLRNs, having high levels of these traits positively influences their responses to their surroundings which, in turn, affects satisfaction and retention (Laschinger et al., 2016).

These programs support transition to practice and facilitate adaptation to a fast paced environment. Hence having an aggressive strategy for workforce succession planning can be successful when it comes to quality patient care (Jones et al., 2017). Jones and colleagues (2017) also state that an advantage of hiring NLRNs is the ability to build and have an impact on values and professional practice. Benner, Sutphen, Leonard, and Day (2010) indicate that traditional classroom education does not work with transitioning NLRNs; instead interactive programs are more effective. According to Jones et al. (2017), in addition to 1:1 preceptorship, best practices for onboarding NLRNs include some traditional on-boarding procedures, cohort hiring, simulation, and competence progression monitoring. Rush and colleagues (2013) also present several features that are common to transition to practice programs. The most common feature shared by these programs is the availability of a defined person for the NLRN as a resource even though the resource person may at times be the preceptor, mentor, or a clinical coach. Another common feature among formal transition programs is mentorship. This is a one-to-one resource available to NLRNs. This role is also ambiguous since there is no defined way to train and select a mentor. Another common feature of transition to practice programs is providing opportunities for NLRNs to meet with their peers and discuss their transition experiences (Rush et al., 2013).

There may be direct or indirect outcomes of transition to practice programs; however, retention or turnover rates of NLRNs are what are most frequently used (Silvestre et al., 2017). Retention and turnover are important indicators of outcomes in transition to practice programs for NLRNs (Rush et al., 2013). It has been documented that with transition programs that support NLRNs, the turnover rates are lower. It has also

been noted that lower turnover leads to continuity of care which positively impacts patient safety outcomes. From a financial perspective, lower turnover rates also benefit the organization (Silvestre et al., 2017). The literature has identified that transitional programs are essential to support the development and integration of NLRNs into the work environment. As a whole, there is not enough information regarding what embodies best practices in a transition program. Therefore, additional studies are needed to see the outcomes of transition programs over time. Also additional studies are needed to compare transition programs with and without formal institutional support (Rush et al., 2013).

Nursing Practice Competence

As mentioned earlier, other avenues have been suggested to eliminate the theory-practice gap in NLRNs entering acute care practice settings. Another approach is addressing NLRNs' competency as they transition to the professional role (Dyess & Parker, 2012). With advances in technology and highly specialized clinical environments, the assumption is that NLRNs would be job ready. They are expected to be able to demonstrate clinical competence in providing evidence-based care and independently practice while remaining accountable and responsible. Even though healthcare settings have structured programs to assist NLRNs in the application of theory into clinical practice, the transition to the work environment continues to be a problematic and stressful period (Missen, McKenna, & Beauchamp, 2016). Missen and colleagues (2016) indicate that an area of concern for NLRNs is the development of nursing skill competence within the first year of practice to be able to deliver safe patient care.

Assessment of NLRNs' competency is essential to help them transition from student to practitioner (Missen et al., 2016).

There is confusion in the literature about what is clinical competence (Missen et al., 2016). Goudreau and colleagues (2015) defined competency as a "complex knowing of how to act based on the mobilization and combination of a variety of internal and external resources within a family of situations" (p. 573). Competence is often interchangeably used with competency and competencies. Competence develops over time and as an abstract concept it is difficult at times to define, assess, and measure. When it comes to professional standards, competence is seen as a core component; hence, assessing competency starts during nursing education and continues throughout the NLRN's profession. There are several generic instruments that measure competence, and they include the integration of attitudes, knowledge, skills, and values in specific situations and whether or not one is functional (Flinkman et al, 2017).

Depending on who is assessing nursing practice competence, manager or educator, there are often different reference points related to what is required competence; consequently, competency assessment relies on the assessor's judgment. A clinical practice educator may use minimum requirements based on what is needed for a NLRN during basic nursing education. On the other hand, the manager is looking at the NLRN's expected competence level in relation to the particular clinical setting. Most hospital settings have specialized nursing care that have certain expected competencies that a NLRN may need to succeed in that nursing specialty. Newly licensed registered nurses' competence is complex and relates to the definition of competency based on the assessor's background. However, it is agreed that competencies related to core tasks of

nursing like acting responsibly, ethically, professionally, and those related to patient care are essential to providing quality care. The competencies are needed from the beginning of professional practice and continue to further develop with time (Numminen et al., 2014).

O'Leary (2012) indicates that there are 23 generic indicators of nursing competency with different levels of competency being self-assessed. Benner (1984) describes how NLRNs in clinical settings build their competence along a continuum from novice to expert as they gain experiences that require them to apply their acquired knowledge and skills to real world work in the medical field. It is a necessity to have nurses in the medical profession who are competent since having a strong knowledge base and clinical competence result in better patient safety and outcomes (O'Leary, 2012). Apart from experience, there are multiple methods of developing competence. There are the traditional methods that include formal educational courses, inservice education, and conferences. Other methods that NLRNs may engage in to develop competency involve activities like pursuing certification, belonging to professional organizations, engaging in research, publishing in journals, and/or maintaining professional portfolios (Lima, Jordan, Kinney, Hamilton, & Newall, 2016). The practice environment contributes to the NLRN's competency development, particularly specific attributes like commitment, confidence, curiosity, insight, morale, and motivation. These attributes may not be something that can be taught; however, having an environment conducive to these aspects is essential in developing competence (Lima et al., 2016).

In the emotionally intelligent nurse, competence is more of a combination of attitudes, knowledge, and skills. Clinical competence is an ongoing process in which

one's professional capabilities grow and deepen with experience from the different practice environments. Caring is the core of nursing science, and clinical competence should start with caring in combination with the necessary knowledge and skills in nursing practice (Lejonqvist, Eriksson, & Meretoja, 2016). Nurse competence contributes to quality and safe patient care. This competence is a reflection of the nurse's professional strengths and weaknesses. It has been well recognized that for NLRNs a gap exists between nursing education and clinical practice. Competence is a concept often difficult to operationalize which makes it difficult to assess in a nurse. Particularly for NLRNs, competence may have been the minimum required level of competence achieved to successfully complete their educational program. A key problem is often that the expectation of the work environment when it comes to NLRNs' competence may differ from that of the nursing program they attended. Therefore, NLRNs are often anxious and uncertain about their competence in maintaining and succeeding in their professional role. More collaboration is needed between schools of nursing and practice environments to facilitate a more supportive intervention and assessment of NLRNs' competence as they transition (Numminen et al., 2014).

Current nursing education is not aligned with the practice environment.

Traditionally, education has been content laden and focused mainly on the hospitalized patient instead of understanding population health concepts (Simpson & Richards, 2015). Nurse educators need to develop teaching strategies to deliver the necessary skills, knowledge, and attitudes to effectively prepare students to practice as nurses in present and future healthcare environments (National Advisory Council on Nurse Education and Practice, 2010). The Institute of Medicine (2010) report on the future of nursing with a

focus on education indicates that revision of current educational systems is crucial to make a seamless transition from academia to practice. The current approach, a curriculum based on the nursing process, is not relevant in today's healthcare environment. Instead the focus is on improved healthcare outcomes through the provision of safe and quality care (American Association of Colleges of Nursing, 2008). The American Association of Colleges of Nursing (2008) recommends a certain core knowledge that is essential for baccalaureate nursing programs and suggests possible approaches; however, translating this knowledge into practice remains complex and often problematic.

Curriculum has many definitions and, depending on the philosophical approach, certain aspects are emphasized in education. Basically, curricula are written plans with common components: goals, delivery methods, resources, and evaluation methods. In nursing academia, curriculum includes matters that affect a student's learning and progression. Curriculum implementation intends that learning will occur; therefore, how teaching is organized is important. Instructional design and presentation of materials need to follow certain principles and processes for learning to occur (Billings & Halstead, 2012).

Integrating didactic and clinical teaching into nursing education requires that students learn through multiple ways of knowing. In nursing science, Carper's theory of knowledge development incorporates all the ways of knowing. This structure is essential in teaching learning strategies that foster active engagement of the learners. Hence, the application of various teaching strategies is needed to facilitate student learning (Callen et al., 2013). Learning opportunities are based on recognizing individual students' learning styles. A learner-centered approach in a curriculum guides the needs of each learner. Use

of the principles of adult learning as the conceptual framework is reflected in the curriculum development, design, implementation, and evaluation (Davis, 2011). Today's complex healthcare systems require nursing programs to develop curricula that decrease the separation of classroom and clinical teaching and move "from task-based proficiencies to higher level competencies" (Institute of Medicine, 2010, p. 2).

Student characteristics and their active program participation impact learning. The nursing program's standards used for admission are reflective of its outcomes, successful completion of program and passing the National Council Licensure Examination (NCLEX) (Davis, 2011). Current graduates entering practice today are very different from past stereotypes. Apart from the various modes of entry into practice, students are reflective of the population that requires the nursing service (Battie, 2013). Therefore, student characteristics impact decision making and quality improvement in curriculum planning when there is a more diverse racial and ethnic student body. This diversity will be reflected in the nursing workforce and the population served as more culturally relevant care can be provided. Nursing programs geographically and socioeconomically are more accessible to diverse individuals who are not the traditional nursing students (Battie, 2013).

As students strive for knowledge and lifelong learning, problem solving and critical thinking become the focus of the learning outcome. This type of education facilitates active learning in the students (Stanley & Dougherty, 2010). Students engage in their learning environment and gain the skills and clinical reasoning necessary to construct meaning and extrapolate salient information in nurse-patient interactions. The new curriculum helps students apply professional values and behaviors to the delivery of

compassionate care to diverse populations in the clinical setting (Allen, 2013). Student learning occurs through the display of professional behaviors and skills. This is also a measure of safety and quality in health care. Good clinical performance leads to good clinical practice, which leads to better outcomes in the patients, in turn (Davis, 2011).

Current rapid technological, social, and economic change has made it difficult to provide students with the professional education needed to develop skills necessary for practice and professional growth. Today's graduate must develop the skills necessary for practice and professional growth. Therefore, it is essential that the nursing curriculum adequately prepare students for the professional role. Whatever the approach, teaching and learning should effectively link knowledge and skills to clinical situations (Benner et al., 2010). Further nursing research may be needed to better understand new graduate nurses' competence in the professional work environment. For instance, in examining the various methods of measuring competence, factors that may have influenced a NLRN's perception of competence have not been clearly identified. This is problematic because the NLRN's perception of competence may impact the extent to which they are able to successfully transition into the workforce. Additionally, other factors such as the NLRN's background and the environment can affect their experiences and perceptions of their own clinical competence.

Emotional Intelligence

The concept of emotional intelligence originates from various sources, and the earliest concept of emotional intelligence is formulated in theories of social intelligence by Thorndike. Those theories were further developed by Wechsler and Gardner (Yekta, & Abdolrahimi, 2016). Yekta and Abdolrahimi (2016) indicate that the most common

definition of emotional intelligence that is important is depicted in the Mayer and Salovey Ability Model, Bar-on Personality Trait or Emotional Quotient, and the Goleman Mixed Model.

Depending on the time period, emotions are viewed as “disorganized interruptions of mental activity, so potentially disruptive that they must be controlled” (Salovey & Mayer, 1990, p. 185). Another view of emotions is that of “an organizing response because it adaptively focuses on cognitive activities and subsequent action” (Salovey & Mayer, 1990, p. 186). Salovey and Mayer (1990) define emotions as organized responses characteristically in reaction to an internal or external circumstance that may have either positive or negative meaning for a particular person. Emotions are distinguishable from the concept of mood in that an emotion is adaptive and has the potential to transform a personal or social interaction into an experience that is enriching (Salovey & Mayer, 1990).

Intelligence “is a broad set of abilities that serve to describe interrelations among or causes of mental abilities” (Salovey & Mayer, 1990, p. 187). With the different types of intelligence, emotional intelligence fits into this conceptual definition of intelligence, particularly social intelligence. Social intelligence includes the ability of an individual to understand and manage oneself (Salovey & Mayer, 1990). The term emotional intelligence can be attributed to Wayne Payne in 1985, with this cluster of abilities relating to the emotional side of life. Daniel Goleman further elaborates on this type of intelligence and termed it as emotional intelligence (Vishavdeep et al., 2016).

After decades of research on intelligence, the concept of emotional intelligence emerged as an important area of research (Codier, Freitas, & Muneno, 2013). According

to Mayer, Salovey and Caruso (2004), the context for emotional intelligence has been influenced by several cultures including Greek Stoicism, the European Sentimentalist and Romantic movements. The term *emotional intelligence* has been used since the 1960s to comment on the character in literary works. However, it is in the 1980s when growing psychology research begins to focus on the interaction of emotion and thought that emotional intelligence is defined, a theory is developed, and how it is demonstrated is measured (Mayer et al., 2004). The general notion of emotion and intelligence are interconnected (Mayer et al., 2004). Mayer and colleagues' (2004) definition of intelligence refers to abstract thoughts, how they are accomplished, and the potential to learn and adjust to the environment. The various types of intelligence are often recognized by the kinds of information they are utilizing. These multiple specific intelligences influence EI with EI being viewed as "emotions govern, and often signal, motivated responses to situation" (Mayer et al., 2004, p. 198).

Codier and colleagues (2013) state that "three major models of emotional intelligence have emerged: the ability model, the personality model, and the mix model" (p. 23). With these models there are differing definitions of emotional intelligence and the instruments used to measure them (Codier et al., 2013). For the purpose of this study, the emotional intelligence personality model, specifically, trait emotional intelligence, is used. Trait emotional intelligence refers to emotional self-perceptions of the affective aspects of personality. It involves perception of one's own emotional abilities that encompasses the affective aspects of personality. Trait EI is related to outcomes including burnout and job performance (Andrei, Seigling, Aloe, Baldaro, & Petrides, 2016).

Within human relationships, nurses are more educated about understanding what is caring and nursing care. Throughout the nursing discipline, the concept of emotion is a fundamental component of nursing care. Dealing with emotions is paramount for nurses, as their practice requires them to provide emotional support not only to patients but also their families. Having the emotional competence or emotional intelligence skills necessary can assist with patient outcomes since having an understanding of the concepts of emotional intelligence affects stress and clinical decision-making skills. For NLRNs, the transition into the workplace may require less effort if there is an understanding of emotional intelligence competencies and skills (Smith, Profetto-McGrath, & Cummings, 2009).

Marvos and Hale (2015) specify that understanding good indicators that positively influence NLRNs during their transition to practice is essential in their overall clinical performance. These good indicators have been positively correlated with retention of NLRNs. Identifying factors that positively influence clinical performance and address issues with NLRN retention is vital. Therefore, a good indicator such as measuring EI in NLRNs is warranted. Traditional methods of measuring intelligence have not correlated with professional nursing performance in the workplace. Hence this is an area of concern for prospective employers seeking to hire top performers (Marvos & Hale, 2015). Marvos and Hale (2015) indicate there is evidence that academic performance can be predicted by EI and that EI also contributes to cognitive performance in students by showing a positive correlation. However, further research is needed to explore EI and clinical performance overall. Currently, EI correlates with particular performance measures like critical thinking abilities and peer learning (Marvos & Hale, 2015). In Marvos and Hale's

(2015) study, they found significant correlation between EI sub-score managing emotions and clinical performance. This study indicates that the ability to manage emotions correlates with the ability to communicate clearly, to be responsive and caring, and to intervene appropriately in patient care situations (Marvos & Hale, 2015).

Marvos and Hale state that there are several models of emotional intelligence in use; however, there is not an operational definition of emotional intelligence within the nursing literature. The impact of emotional intelligence is studied in a variety of professional fields with EI emerging as a prevailing concept (Yekta & Abdolrahimi, 2016). Yekta and Abdolrahimi (2016) point out that EI has not been mentioned in any nursing field before the 2000s. Even though nurses have examined EI in fields such as education, management, and research, there is no mention of EI and professional nursing practice (Yekta & Abdolrahimi, 2016). Further research is needed to examine if there is a correlation with the emotional intelligence of nurses, particularly NLRNs, and its impact in their work settings. There is a knowledge gap between the different areas of nursing and emotional intelligence (Yekta & Abdolrahimi, 2016). One such gap is identifying and determining emotional intelligence in nursing either in individuals or in groups. Smith and colleagues (2009) suggest the interplay between emotions and critical thinking in the nursing profession is not fully known. Emotions are used to critically measure situations when making decisions. In nursing decisions, clinical decision making and critical thinking consider emotional information in reasoning; emotional intelligence is viewed as the system that monitors emotional information. How emotional intelligence in nursing practice relates to other constructs and whether or not it is possible to describe behavioral indicators of emotional intelligence still need to be explored (Smith et al., 2009).

Resilience

The concept of resilience in nursing is fairly new. Rooted in the discipline of psychology, work on resilience started in the 1970s. The original studies of resilience involved youths who were suffering from schizophrenia, and the findings from these studies indicated that some children are better able to handle their environments than others (Thomas & Revell, 2016). According to Thomas and Revell (2016), certain protective factors are identified in individuals who exhibit resilience. The elements include humor, critical thinking, self-esteem, positive outlook, and problem solving skills. In the 1980s, researchers examined external factors such as families and their social community characteristics that may influence resilience. Both positive and detrimental factors were noted; however, it was not until the early 2000s that there was a paradigm shift. This change by resilience researchers involved a move from character traits and risk factors examination to assessing factors that may prevent psychological issues (Thomas & Revell, 2016).

This change in thinking is a result of phenomenological inquiry that identifies characteristics associated with resiliency in youths who survived high-risk situations (Richardson, 2002). Richardson (2002) indicates that resiliency occurs in three movements. These movements or paradigm shifts involved phenomenological identification of characteristics as opposed to emerging from theory grounded in academics. This model, the basis of resiliency theory, defines how one copes with adversity or changes that result in identifying resilient qualities attained through a system of disruption and reintegration. The first movement describes qualities that help people cope with adversity. These qualities can be both internal and external such as self-esteem

and support systems. The second movement is the resiliency process in which the desired qualities identified in the first movement are acquired. This is an attempt to find out how resilient qualities are acquired. The third movement, resilience theory, involves the identification of individual motivational forces that foster self-actualization in persons. This force that drives the fulfillment of one's potential is resilience (Richardson, 2002). Following these movements of resiliency inquiry, studies regarding resiliency education and training efficacy are conducted. These studies indicate that through education; resilience can be modified based on the instruction, ideas, and support provided in attempts to maintain positive change (Waite & Richardson, 2004).

With nurses constantly being involved in suffering and tragedy in their daily interactions in the workplace, investigators continue to pursue ways to help increase nurses' resiliency to help them overcome the adversities they face on the job. In nursing, adversity may cause stress. The adversity that nurses need to overcome is from constant interaction on a daily basis with suffering and tragedy. Hence finding strategies to support the nurses' professional resilience in the workplace is paramount (Thomas & Revell, 2016). The literature supports that in order for resilience of NLRNs to be further developed, it is necessary to understand what affects a NLRN's level of resilience in order to be able to support the concept.

The concept of resilience is complex with most definitions revolving around two fundamental constructs: adversity that is significant and adapting positively. Resilience is a dynamic process; when one is stressed or exposed to trauma, the ability to adapt successfully, be moderate, or remain competent indicate good functioning resilience (Guo et al., 2017). Newly licensed registered nurses may work in high stress areas. This can

lead to emotional exhaustion and moral distress, which may be alleviated by an individual's high level of resilience. Resilience can help NLRNs cope with stress. In the face of adversity, nurses who are highly resilient may be better at turning to external factors, such as art, physical exercise, or problem-solving skills, and/or internal factors, such as finding ways to minimize the impact of traumatic events (Hylton Rushton, Batcheller, Schroeder, & Donohue, 2015). Hylton Rushton et al. (2015) state that developing resilience occurs through coping, hope, and self-efficacy.

There may be various definitions of resilience, but the commonalities are strength and an individual's ability to overcome challenges. As a result of a nursing shortage from an increased demand for nurses and a decrease in supply, recruiting and retaining NLRNs is a major issue affecting healthcare organizations (Hart, Brannan, & De Chesnay, 2014). Hart et al. (2014) suggest that vacancies created by the nursing shortage and costs associated with nursing turnover affect outcomes and quality of patient care. When it comes to health disparities, nurses are not usually considered a vulnerable population despite the high amount of job stress faced by experienced nurses and NLRNs in today's healthcare environment. There are a variety of hardships affecting nurses in the workplace, such as ethical dilemmas, high patient acuity, a lack of support from administrators, medical errors, and an increase in the use of new technology. Even though nurses continue to serve and provide remarkable care with few resources, retention remains problematic because of job stress. Coping with pressures in the current environment is difficult for nurses with experience, so for NLRNs it may be even more arduous (Hart et al., 2014).

The transition shock experienced by NLRNs as they adjust to their professional roles is a main reason why NLRNs leave the profession. Challenges found in this period include adapting to the new environment, lack of confidence, knowledge deficit, and time management, and these can lead to mental stress and physical exhaustion (Wahab et al., 2017). Wahab and colleagues (2017) state that a potential solution for the challenges faced during this transition period is to improve resilience. Resilience is developed as a result of interactions with one's environment and also with opportunities for self-growth. Therefore, depending on the social environment and available resources, resilience and how it is developed could differ. Newly licensed registered nurses who react resiliently when faced with stressors will come out of that stressful experience with a positive outcome (Wahab et al., 2017).

In the study by Wahab and colleagues (2017), it is noted that there are certain factors that either facilitate or impede the development of resilience. First, resilience is perceived as the NLRN's ability to persevere until a task is completed. The tenacity to overcome any obstacles that arise while performing a task facilitates resilience development. The need to persevere comes from an understanding that the NLRN has a professional responsibility to fulfill a role. Secondly, this professional responsibility to be upheld is a result of the profession chosen in which NLRNs have a moral responsibility to fulfill the role assigned to them. Having camaraderie in the work environment facilitates resilience as it aids the NLRN to assimilate into the work environment. The third factor that affects resilience is the capacity to integrate self in the work environment so that the NLRN can adapt to function in the new role as a professional nurse. During the transition period, additional knowledge and skills such as effective communication

and time management are taught to the NLRN so he or she can acculturate and be able to survive in the clinical area. The final factor that affects resilience is the importance of continuing to build resilience so NLRNs need to be empowered by taking ownership of their learning. There are times when the workload is overwhelming; therefore, in order to continue being resilient, the NLRN has to be self-motivated, resourceful, and knowledgeable about when to seek help. The NLRN can learn from those who have the expertise and knowledge (Wahab et al., 2017).

Factors that either facilitate or impede resilience fall into two categories: individual and external. Individual factors include personality traits such as humility, initiative, introspection, patience, and resourcefulness. External factors are the nurse managers and preceptors who help them adapt to their new role through constructive feedback, guidance, and supervision. There is a synergistic effect with the relationship of individual and external factors. If an individual has a low level of resilience to the initial stressors of a high demand work setting, having the support and assistance from others in the work setting can balance and strengthen the NLRN's motivation to be resilient and overcome stressors (Wahab et al., 2017).

The literature identified that developing or perceiving oneself as resilient is helpful in overcoming workplace adversity (McDonald, Jackson, Vickers, & Wilkes, 2016). There are inconsistencies regarding personal attributes of nurses (e.g., age, education, experience) contributing to their resiliency. However, there is evidence of a relationship between resilience and intrapersonal characteristics such as adaptability, competence, coping, flexibility, self-efficacy, skill recognition, and others (Hart et al., 2014). According to Hart et al. (2014), there exists a considerable amount of information

regarding the importance of resilience in the workplace. Nursing administration needs to be cognizant of a lack of resilience in nursing staff to be able to provide needed support to guide nurses in becoming or staying resilient in today's healthcare environment (Hart et al., 2014). Even though there is reported value of resilience, there is a lack of research on resilience in newly licensed registered nurses' transitioning to the clinical practice (Hudgins, 2016). A knowledge gap also exists with contextual factors specific to the NLRNs' resilience development particularly to the work environment and hospital culture (Waheb et al., 2017).

Chapter Summary

The purpose of this study is to assess the emotional intelligence and resilience among NLRNs as they transition to their professional role. Major themes are transition, nursing practice competence, emotional intelligence, and resilience. Transition is a journey that is often difficult, frustrating, and stressful for newly licensed registered nurses adapting to their professional roles. Having a transition-to-practice program in healthcare organizations supports the NLRN during the critical entry and progression into practice period and may mitigate some of the difficulties associated with the transition. Also, with advanced healthcare technologies, nursing practice competence contributes to the safety and quality of patient care. With NLRNs, competence is a complex issue, especially since it is often difficult to operationalize nurse competence assessments. Emotional intelligence demonstrates that there is a positive correlation with EI and the clinical performance of the NLRN. Given the challenges in today's healthcare environment, identifying factors that have significant correlations with NLRNs' clinical performance is important in aiding their transition into their roles as working

professionals. Resilience shows us that one's perceptions of resilience can assist with coping with the challenges of role transition. As they experience transition shock in the beginning of their transition journey, resilience is built as NLRNs come to understand their experiences.

It is evident from the literature that even with many studies about NLRNs' transitioning to the work environment, there remains room for additional research focused on the NLRN's person-level characteristics. During the transition period, NLRNs are not consistently supported. The theoretical framework of transition shock explains that the focus is on NLRNs as they are exposed to their professional practice roles for the first time. This discrepancy occurs as NLRNs are immersed into the healthcare environment where they often moved from idealistic view of the nursing profession to the reality of the practice environment, a move which often leads to role ambiguity and conflict. Since it is known that transitioning for NLRNs is a challenge, it is important to look at certain constructs that may affect this process. The relationship between emotional intelligence and resilience and how that relationship is demonstrated in nursing practice need to be further explored. There may be defining behavioral characteristics that can either be determined or identified in NLRNs that can affect practice either on an individual level or in groups. Therefore, this study sought to answer the following research questions: What is the relationship between emotional intelligence and resilience among newly licensed registered nurses transitioning to the professional role? What is the difference in emotional intelligence and resilience between NLRNs who transition in the critical care nursing specialty and those who do not?

Chapter Three

Methods

This chapter describes the methodology of the research study including research design, assumptions, setting, sampling plan, and data analysis. The most effective method in examining the phenomenon of interest is determined by giving a description of the specific steps to be followed.

The purpose of this study was to assess emotional intelligence (EI) and resilience among NLRNs as they transitioned to their professional role. This study explored if EI and resilience had any effects on how NLRNs transitioned into their professional roles. Information gathered from quantitative measurements was acquired from accounts provided by the research participants for the purpose of answering the following questions: RQ1: What is the relationship between emotional intelligence and resilience among newly licensed registered nurses transitioning to their professional role? RQ2: What is the difference in emotional intelligence and resilience between NLRNs who transition in critical care nursing specialty and those who do not? Using deductive reasoning as suggested by quantitative methods, the survey results were examined to assess NLRNs' EI and resilience while transitioning into practice.

Research Design

There are several approaches to data analytic research, including quantitative and qualitative data analysis methods. Each of these two approaches has strengths and limitations based on the philosophical assumptions and the types of research strategies

used. Both approaches have evolved over time with quantitative research dominating the social sciences from the 19th to the mid-20th centuries (O'Dwyer & Bernauer, 2014).

Interest in qualitative research increased over the second half of the 20th century.

Quantitative research examines variables and their relationships. These variables are quantified and measured using instruments that transform data generated into useable statistics that can be used to generalize the results to the larger population.

According to O'Dwyer and Bernauer (2014) when selecting a research design using the quantitative approach, the approach taken is based on the intended purpose. In this case, the purpose of the dissertation was to examine the relationship between two characteristics, EI and resilience. When measuring a naturally occurring phenomenon, non-experimental research design is adopted (O'Dwyer & Bernauer, 2014). This study was a descriptive, cross-sectional research design that was used to determine whether EI and resilience are correlated and whether there were differences between those who transitioned in a critical setting and those in other specialty areas. In this research design, there was no manipulation of variables (Polit & Beck, 2014). Descriptive and inferential quantitative data analyses were used to test the research questions.

Strengths of Non-Experimental Design

There are several strengths associated with a non-experimental design. First, this type of design not only has the ability to study several attributes at the same time but is also able to study attributes that cannot easily be explored in experimental research.

Second, non-experimental research designs are not too costly to conduct in comparison to experimental designs that may be time-consuming and costly. Finally, in using this research design, conducting the analysis is straightforward. It is not necessary to have

specialized software or skills to analyze the data (O'Dwyer & Bernauer, 2014). For this dissertation, the strength of the non-experimental design was that NLRNs are not subjected to an artificial laboratory so their answers have a higher degree of external validity.

Weakness of Non-Experimental Design

In non-experimental research design, the most significant weakness is that conclusions of causation cannot be drawn. This limits the capacity of the researcher to make causal inferences from the data. Nevertheless, the aim of this study was not to establish causation but rather to better understand individual differences in characteristics of NLRNs. Therefore, a survey study was preferred over an experimental design for the purposes of this research project. Qualitative research was not selected for this research design because EI and resilience are quantifiable variables that can be measured and have interpretable meaning. A qualitative approach gathers information on a phenomenon usually through interviews, open-ended questions, and focus groups. This form of inquiry, usually with only a few participants, has findings that cannot be generalized to the population as a whole. Instead it serves to inform about practice, theory, or a specific situation. Since this was an exploratory study examining the correlation between EI and resilience, a quantitative approach was appropriate to summarize the characteristics of this relationship (O'Dwyer & Bernauer, 2014).

Research Assumptions

Research assumptions are views accepted as truths even though they may not be validated (O'Dwyer & Bernauer, 2014). Assumptions in this study were that NLRNs were able to:

- Express their opinions openly; since the survey is anonymous there is no reason participants should not be truthful.
- Communicate in English; in order to take the NCLEX-RN there needs to be proof of English competency, particularly if a candidate attended school outside of the United States.
- Understand study instructions in order to complete the survey accurately.
- Complete questionnaires independently since this participant represents the population from which inferences will be made.

Setting

The setting for this study was large metropolitan hospital systems located in [REDACTED] where NLRNs were either already working or newly hired. The setting was chosen based on the number of healthcare systems in the area and the possibility of having a greater number of available NLRNs since NLRNs make up a large portion of today's workforce. These large healthcare systems included the following:

- [REDACTED] with six hospitals and numerous ancillary healthcare facilities including a nursing home;
- [REDACTED] which consists of six hospitals, two long term care facilities, and various other healthcare facilities including primary care, specialty care, and corrections health services clinics; and
- [REDACTED] has five hospitals and other ancillary healthcare system.

There are also private health systems in the area as follows:

- [REDACTED] has eight hospitals and various other healthcare systems;

- [REDACTED] has three university hospitals and over 30 outpatient facilities;
- [REDACTED] has two facilities; and
- [REDACTED] has 10 hospitals throughout the area.

Therefore there are approximately 40 hospitals and even more other healthcare settings which could employ approximately 1,000 NLRNs.

Sampling Plan

It is not practical to survey every member of the entire population that is being studied; therefore, having a representation or sample of that particular populace to make inferences about its characteristics was necessary (Ryan, 2013).

Sampling Strategy

A purposive sampling strategy was used to identify participants through their employers, especially for those who became a licensed registered nurse within the last 18 months. The convenience of having NLRNs in established settings allows for easy accessibility. Because of the availability of many NLRNs in the region, using agreeable facilities without additional institutional review board (IRB) approval processes was preferred. Once IRB approval was received from Nova Southeastern University (see Appendix A), the directors for research from all the facilities were approached; however, only [REDACTED] gave permission and [REDACTED] required additional IRB approval, which was granted, to collect data (see Appendix B).

Eligibility Criteria

The inclusion criteria to participate in the study were the following: (1) nurses working at current job who have been registered nurses less than 18 months or (2) nurses

hired that has been a registered nurse for less than 18 months. They read and comprehend English since in order to take the NCLEX there needed to be proof of English competency, particularly if a candidate attended school outside of the United States. This is important since the survey was in English and not translated into any other languages, so it was important that the NLRNs understood the questions being asked.

Determination of Sample Size: Power Analysis

Sample size determination is an important step in planning any study. There are various methods for determining an appropriate and sufficient sample size for a given study. The following were used to determine the desirable sample: population size, margin of error, confidence level, and standard deviation. The population size is the total number of NLRNs transitioning to a professional work environment in an acute care setting with a margin of error +/-5%. The confidence interval is 95% with a standard deviation 0.5 (Ryan, 2013).

The sample size is significant in determining the power of the study. In using a sample of the population to approximate outcomes to represent an entire population, the larger the sample, there is an increase in the power of the study. For this study, a power analysis for sample size was done using G-power 3.1.9.2 software. Using correlation statistical method, a medium effect size of 0.3, exact two tailed test with alpha 0.05 and 80% power yielded a sample size of 84. However, for this study there were only 73 participants. The changes in recruitment affected the sample size; therefore, the total number of study participants was less than anticipated.

Protection of Human Subjects

After the research study was reviewed and approved by the university's institutional review board (IRB) the local nursing organization which had not required an additional formal IRB approval process was notified. For those organizations that did require IRB approval, permission was sought. In conducting the research, all basic principles regarding the involvement of human subjects were adhered to. Ethical principles were applied and upheld. For example, informed consent was a prerequisite for this study. Each participant was provided with a participant letter (see Appendix C) that provided information about the study. By choosing to complete the survey, the participant gave permission. Participants were also treated with dignity and respect since the gathered data were anonymous and remained confidential.

Risks and benefits of participation

There were no more than minimal risks in participating in this research study. The researcher was aware that there may have been a risk in loss of confidentiality by self-disclosure or participation. However, not collecting any personal health identifiers and the use of gatekeepers to recruit and collect information minimized this problem. By participating, there were no ill-gotten gains, only an understanding that they were contributing to the knowledge base bridging how NLRNs transition to their professional role.

Data storage

Survey participants were able to access the REDCap survey from any device that connected to the Internet. REDCap is a secure web-based site where data were entered and saved at a data center hosted by the University of San Francisco, even though the survey may be displayed on a local monitor (Harris et al., 2009). The survey does not run

on devices being used; instead it runs at the data center, which is locked and guarded at all hours (twenty four hours a day/seven days of the week). Entrance to the data center requires multiple card key entries in addition to an operations desk staffed twenty four hours, seven days of the week by a security camera system. REDCap servers are guarded by multiple firewalls and intrusion detection systems. All electronic connections to the REDCap environment are encrypted (Harris et al., 2009).

Recruitment

Recruitment for the study was done through hospitals in the designated region. Once the researcher was given permission, a designated person or gatekeeper was identified and contacted at each facility and local nursing organizations to identify NLRNs currently employed and provide these potential participants with information. Using a prepared electronic mail (e-mail), potential participants were notified of the study and given information on study purpose, methodology, data collection, and data analysis procedure. Information was also given on how to contact the researcher for questions, concerns, or additional information. The gatekeeper also provided the potential participants with a flyer with the facts about the study, the link to the survey, and instructions on how to contact the researcher for those who needed further information. The researcher made it known to the gatekeepers that, if needed, the researcher would attend any gathering of NLRNs such as new employee orientations, meetings, or educational offerings.

In trying to recruit at the various healthcare systems in [REDACTED], there were several obstacles encountered. Except for [REDACTED] and [REDACTED], the other healthcare systems either had policies in place that excluded

conducting research in their facilities if you were not an employee or they did not have a process in place for nursing research. The only local organization that allowed researcher to disseminate information to its members in [REDACTED] was the [REDACTED] [REDACTED] who shared the research information with the [REDACTED] [REDACTED] of its organization.

Instrumentation

A review of the literature found various instruments that measured emotional intelligence and resilience. For this study, Petrides (2009) Trait Emotional Intelligence Questionnaire Short Form (TEIQue-SF) and Connor-Davidson Resilience Scale (CD-RISC) were used. Use of the TEIQue-SF is available free of charge for academic research while permission to use the CD-RISC was obtained from the copyright holder (see Appendix D). In order not to overwhelm the participants, one questionnaire (see Appendix E) was prepared by the researcher that included demographic items, the TEIQue-SF, and the 10-item Connor-Davidson Resilience Scale (CD-RISC) for administration to participants. Data for this study were collected and managed using REDCap electronic data capture tool hosted at Nova Southeastern University. Research Electronic Data Capture (REDCap) is a secure, web-based application designed to support data capture for research studies providing an intuitive interface for validated data entry; audit trails for tracking data manipulation and export procedures; automated export procedures for seamless data downloads to common statistical packages; and procedures for importing data from external sources (Harris et al., 2009). There were 49 items in the survey; 30 items for EI, 10 items for resilience, and 9 background information items. A field test of the survey performed by five people with two to three

years of nursing experience indicated that it took less than 15 minutes to complete all items.

Trait Emotional Intelligence Questionnaire Short Form

Andrei and associates (2016) indicated that for the trait EI to achieve an accurate representation of the personality dimensions, content analysis was undertaken of the prominent EI models and related personality constructs such as those by researchers Bar-On, Goleman, and Salovey and Mayer. Only core elements common to more than a single model of EI were retained. Trait EI redefined EI models as they were operationalized by self-report and linked them to psychology theories (Andrei et al., 2016). Petrides (2009) indicated that the Trait Emotional Intelligence Questionnaire (TEIQue) has a strong psychometric and theoretical basis. It was created to represent 15 facets of trait EI. With 10 items for each facet, the full form yields 153 items. Of the 15 facets, 13 refer to factors of emotionality, self-control, sociability, and well-being. The other two answer items about auxiliary facets, adaptability, and self-motivation. The answers for items in the TEIQue are provided on a 7-point scale ranging from 1 (strongly disagree) to 7 (strongly agree). The TEIQue instrument psychometric basis is reflected in its cross-cultural stability since it has been replicated in several languages. The full TEIQue provides scores on global trait EI, the four factors, and the 15 facets (Petrides, 2009).

The Trait Emotional Intelligence Questionnaire Short Form (TEIQue-SF) is a measure of emotional intelligence that provides a quick view of emotional functioning, the ability to manage relationships, emotional control, and response to pressure (Petrides, 2009). The Trait Emotional Intelligence Questionnaire – Short Form (TEIQue-SF) was

taken from the full form and consists of 30 items. There are two items per facet, and responses are given on the same 7-point Likert scale. The primary intention of the TEIQue-SF is to measure global trait EI; it does not compute facet scores. At the global composite level, the TEIQue-SF has identical scores as the full form. The TEIQue-SF psychometric properties have been validated through item response theory analysis. Concurrent validity of the TEIQue-SF has been established through correlations between the TEIQue-SF and the TEIQue full form. Internal reliability for global trait EI using the short form has a Cronbach's alpha of 0.87; however, for the four trait EI factors, the TEIQue-SF internal reliability is 0.69 (Petrides, 2009).

Connor-Davidson Resilience Scale

Resilience is a multidimensional characteristic that is represented by one's personal qualities that allowed him or her to flourish when facing adversity. How one responds to factors that disrupt well-being can be viewed as a measure of one's stress-coping abilities, in this case resilience. To quantify resilience, the Connor-Davidson Resilience Scale (CD-RISC) was developed. It is a brief self-rated assessment that is also used as a clinical measure to evaluate treatment response. The scale includes content from various sources including Kobasa's construct of hardiness, Lyon's work on assessing patience, Rutter's work on stress and coping, and Shackleton's understandings on faith (Connor & Davidson, 2003).

The CD-RISC has 25 items with a five-point response range as follows: "not true at all (0), rarely true (1), sometimes true (2), often true (3), and true nearly all the time (4)" (Conner & Davidson, 2003, p. 78). The rating is based on the subjects' feelings over the previous month. The scores range from 0-100 and resilience is reflected with higher

scores. The reliability of the CD-RISC was assessed using the test retest with a correlation coefficient of 0.87. Cronbach's alpha, 0.89, was used to evaluate internal consistency. Correlations between the CD-RISC scores with various other measures including hardiness and perceived stress were conducted to determine convergent and divergent validity (Connor & Davidson, 2003).

Having a comprehensive understanding of how individuals respond to stressors is important in studying resilience (Campbell-Sills & Stein, 2007). In doing a more thorough analysis of the CD-RISC, Campbell-Sills and Stein (2007) modified the original scale and recommended a 10-item version which is comprised of items from the original scale: 1, 4, 6, 7, 8, 11, 14, 16, 17, and 19. The scoring ranges from 0-40, with resilience reflected in higher scores. Cronbach's alpha was used to assess the internal consistency of the 10 items that comprised the CD-RISC. The Cronbach's alpha was equal to 0.85, which indicated strong agreement among the items of this scale. In addition, construct validity of the 10-item measure was conducted with a validity coefficient of 0.94. The 10-item CD-RISC scores correlated highly with the 25-item scale with a coefficient of 0.92. The 10-item CD-RISC demonstrated that using a subset of the original CD-RISC items can reliably assess resilience (Campbell-Sills & Stein, 2007).

General Statistical Strategy

Data analyses were performed using the Statistical Package for Social Sciences (SPSS) version 23 (IBM, 2015). Descriptive statistics were obtained in order to summarize the characteristics of the sample. Correlational analysis was used in an attempt to measure any association between the variables of interest. The descriptive statistics information includes means, modes, ranges, and standard deviations on

demographic information like age, gender, and race of the new graduate nurses; these were collected only to describe the sample. Pearson correlation coefficient was used to determine relationship between emotional intelligence and resilience. Normality testing was done to check normal distribution, and independent sample T-test was used to compare the mean of two different samples. Additionally, regression was also used to predict if certain variables affect emotional intelligence and resilience (O'Dwyer & Bernauer, 2014).

Data Cleaning

Data entry accuracy was crucial in preventing threats to validity of the study. Data cleaning procedures were performed to ensure accuracy of data entry. The researcher inspected data entry to verify veracity whether it was missing information or other invalid data. Ten of the surveys were not used because the first two questions, which were used to identify potential participants, indicated that the participant did not meet the inclusion criteria and the survey was stopped. Since these surveys were not completed, they were not included in the study. If a participant met the inclusion criteria, all subsequent questions were mandatory, so if one was not answered, the survey could not be submitted. This ensured there were no missed or invalid items. Hence these valid surveys were reflected in the data analysis. Based on the study design and the survey used, careful monitoring and data cleaning during data collection identified problems that could easily be handled (Salkind, 2010).

Descriptive Statistics

Descriptive analyses were used to interpret and summarize data in order to explain patterns that were not immediately apparent in the raw data. Analysis of the

dependent and independent variables included frequency distributions, measures of central tendency, and variability. Frequency distributions provided a tabulated summary of categorical and continuous data frequency in which scores occur in a distribution. In a distribution of raw scores, measures of central tendency describe the typical score as single values commonly reported as mean, median, and mode. The arithmetic average of all scores is the mean, the middle score is the median, and the most common occurring score in the distribution is the mode. Measures of variability also known as measures of dispersion are generally range, variance, and standard deviation. The Levene's test was used to test for equality of variances. These values were important in that they illustrated variability of scores in the distribution. Pearson correlation was used to examine if there was an association between EI and resilience. If the correlation coefficient showed that there was a positive linear relationship between EI and resilience, the significance of these results were determined using the correlation coefficient, the degrees of freedom, and critical values of the correlation coefficient table. Since there was a comparison between two correlation coefficients, critical care specialty and other specialty areas, the Fisher r-to-z transformation was done (O'Dwyer & Bernauer, 2014).

Reliability Testing

Reliability testing refers to the consistency of a measure of an attribute and nothing else. The most widely used nursing reliability approach is internal consistency, which was evaluated by calculating coefficient or Cronbach's alpha. Normal range is -1.0 to 1.0 with a higher value indicating stronger agreement among the items within a scale (Polit & Beck, 2014). The instruments utilized in this study demonstrate sufficient

internal consistency for elements being measured. Reliability scores are reported for the use of these tools.

Limitations

There were several limitations that existed with this study. The first limitation was the potential of a low response rate, which was 73, with only 63 respondents meeting the criteria to participate. This led to a limitation due to small sample size; however, this could have been overcome by following up with gatekeepers to encourage study participation. Other limitations included not being able to generalize the results, a lack of having a control group, a lack of randomization, and the inability to manipulate variables. This could have been overcome by the potential volume of NLRNs available in the region. Finally, the use of a correlational study does not provide a reason why a relationship exists.

Threats to Internal Validity

Internal validity refers to whether or not the findings from the instrument used truly represent the construct it is claiming to measure (Polit & Beck, 2014). Several threats could have compromised whether or not a relationship exists between EI and resilience. They were the individual characteristics of the participants, whether respondents were inattentive when answering the instrument, and whether their responses to the first section of the instrument may have influenced their responses to the second part (Polit & Beck, 2014).

Threats to External Validity

Threats to external validity were affected by the sampling. Newly licensed registered nurses in south Florida may not have been a true representation of all NLRNs

in the country or even in the state since there were not enough participants in the study to determine how similar the characteristics, such as age and gender, of the sample participants were to the population. The specificity of using only NLRNs in two healthcare systems and one local professional organization in [REDACTED] may have created an issue with generalizability (Polit & Beck, 2014).

Chapter Summary

The purpose of this non-experimental research study was to assess EI and resilience among NLRNs transitioning to the professional role and to answer the following research questions: RQ1: What is the relationship between emotional intelligence and resilience among newly licensed registered nurses transitioning to their professional role? RQ2: What is the difference in emotional intelligence and resilience between those who work in critical care nursing specialty and those who do not? A quantitative research design was used. For this study, the instruments that measured emotional intelligence and resilience were the Trait Emotional Intelligence Questionnaire Short Form (TEIQue-SF) and the Connor-Davidson Resilience Scale (CD-RISC), which are considered to be reliable and valid. Approval from NSU IRB was obtained prior to implementation. The study incorporated NLRNs currently working in the professional role and NLRNs transitioning into the work environment for the first time. The recommended sample size was 84; however, it was not achieved. Quantitative descriptive statistics were utilized to perform statistical analysis to understand if emotional intelligence and resilience have any effect on NLRNs in the initial stage of their role transition into the professional work environment. Data analyses included results of statistical tests: Descriptive statistics, independent samples test, Pearson's correlation,

and Fisher's R to Z transformation. Chapters 4 and 5 will share the findings and interpretation of the results.

Chapter Four

Results

The primary aim of this non-experimental research study was to assess emotional intelligence (EI) and resilience among newly licensed registered nurses (NLRNs) as they transitioned to their roles as professional nurses. This study addressed the following research questions: RQ1: What is the relationship between emotional intelligence and resilience among newly licensed registered nurses? RQ2: What is the difference in emotional intelligence and resilience between NLRNs who transition in critical care nursing specialty and those who do not? This chapter presents the results of the study. All participants completed the Connor-Davidson Resilience Scale (CD-RISC) to measure resilience and the Trait Emotional Intelligence Questionnaire Short Form (TEIQue-SF) to measure EI. Statistical analyses were performed using SPSS, version 23.

Data Cleaning

There were 73 participants who attempted the survey; however, only 63 respondents met the inclusion criteria of being a registered nurse for less than 18 months. Of the completed surveys, none were missing any data. Prior to any data analyses, data cleaning approaches were taken to ensure that each variable met assumptions of normality. Data were tested for normality using the Shapiro Wilkes test, and boxplots was used to check for outliers.

Description of the Sample

Following Institutional Review Board (IRB) approval from Nova Southeastern University, the study was planned for a convenience sample of 84 participants from several local hospital systems in [REDACTED]; however, only [REDACTED], and a local nursing organization gave approval for recruiting participants. As a result, 73 NLRNs participated in this study, with only 63 meeting the study criteria. Participants were either from a private hospital health system, a public tertiary hospital health system, or a local professional organization.

Responses to the Measurements

Sample Characteristics

Demographic variables included the following: age, gender, nursing program completed, the population each participant works with, and each participant's nursing specialty (see Table 1). Of the nurses in this sample, 3.2% were aged 21 years and under ($n = 2$); 74.6% were aged 22 to 34 ($n = 47$); 15.87% were aged 35 to 44 ($n = 10$); and 6.35% were aged 45 and older ($n = 4$). Furthermore, a majority of the sample (79.37%) were women ($n = 50$); 20.63% were men ($n = 13$). Overall, the nurses listed their entry educational level into nursing as a bachelor's degree ($n = 39$, 61.9%); an associate degree ($n = 19$, 30.16%); LPN to RN ($n = 2$, 3.17%); and a second bachelor's degree ($n = 3$, 4.77%). In addition, a majority of the participants ($n = 49$, 77.8%) worked with adult patients; 13 (20.6%) worked with pediatric patients; and one nurse worked with both adult and pediatric patients (1.6%). As for nursing specialty, the majority ($n = 28$, 44.83%) of the NLRNs transitioned in critical care areas; two (3.17%) in emergency; seven (11.11%) in medical surgical; nine (14.28%) in neuroscience; one (1.6%) in

oncology; one (1.6%) in rehabilitative; seven (11.11%) in telemetry; 1(1.6%) in trauma; 2 (3.17%) in women's health; and 5 (7.93%) in other areas.

Table 1

Participant Demographics Descriptive Statistics

Age	Frequency	Percentage (%)
21 and under	2	3.2
22 - 34	47	74.6
35 - 44	10	15.9
45 – and over	4	6.3
Gender	Frequency	Percentage (%)
Male	13	20.6
Female	50	79.4
Nursing Program Completed	Frequency	Percentage (%)
Associate	19	30.2
Bachelor's	39	62
LPN to RN	2	3.1
Second bachelor's degree	3	4.7

Population Worked With	Frequency	Percentage (%)
Adult	49	77.8
Pediatrics	13	20.6
Both	1	1.6

Nursing Specialty	Frequency	Percentage (%)
Critical care	28	44.43

Other Specialty Areas

Emergency	2	3.17
Medical Surgical	7	11.11
Neuroscience	9	14.28
Oncology	1	1.6
Rehabilitative	1	1.6
Telemetry	7	11.11
Trauma	1	1.6
Women's Health	2	3.17
Other	5	7.93

Resilience and Emotional Intelligence Scores

The descriptive statistics for resilience (see Table 2), global trait EI and trait EI factors – well-being, self-control, emotionality, and sociability (see Table 3) in newly licensed registered nurses are presented here. For resilience ($N = 63$), the minimum response score was 17, and the maximum response score was 40 ($M = 32.32$, $SD = 5.193$, range = 23, variance = 26.962). For global trait EI ($N = 63$), the minimum response score was 2.8, and the maximum response score was 7.0 ($M = 6.056$, $SD = 1.009$, range = 4.3, variance = 1.019). For the EI factor of well-being ($N = 63$), the minimum response score was 1.7, and the maximum response score was 7.0 ($M = 6.003$, $SD = 0.965$, range = 5.3, variance = 0.932). For the EI factor of self-control ($N = 63$), the minimum response score was 3.7, and the maximum response score was 7.0 ($M = 5.466$, $SD = 0.907$, range = 3.3, variance = 0.823). For the EI factor of emotionality ($N = 63$), the minimum response score was 3.5, and the maximum response score was 7.0 ($M = 5.79$, $SD = 0.845$, range = 3.5, variance = 0.715). For the EI factor of sociability ($N = 63$), the minimum response score was 3.2, and the maximum response score was 7.0 ($M = 5.214$, $SD = 0.938$, range = 3.8, variance = 0.88). The sample was also broken down into two groups and analyzed (see Table 4).

Table 2

Resilience Scores

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
Total Group	63	23	17	40	32.32	5.193	26.962
Critical Care	28	23	17	40	33.21	5.69	---

Other	35	18	22	40	31.60	4.72	---
Specialty							
Areas							

Table 3

Global Trait EI and EI Factors Scores

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
Global Trait EI	63	4.3	2.8	7.0	6.06	1.01	1.02
Well-Being	63	5.3	1.7	7.0	6.00	.97	.93
Self-Control	63	3.3	3.7	7.0	5.47	.91	.82
Emotionality	63	3.5	3.5	7.0	5.79	.85	.72
Sociability	63	3.8	3.2	7.0	5.21	.94	.88

Table 4

Critical Care Scores

	N	Range	Minimum	Maximum	Mean	Std. Deviation
Global Trait EI	28	4.3	2.8	7.0	5.99	1.23
Well-Being	28	5.3	1.7	7.0	5.96	1.19
Self-Control	28	3.2	3.8	7.0	5.59	.89

Emotionality	28	3.5	3.5	7.0	5.78	1.01
Sociability	28	3.5	3.2	6.7	5.20	1.11

Non Critical Care Areas Scores

	N	Range	Minimum	Maximum	Mean	Std. Deviation
Global Trait EI	35	2.8	4.3	7.0	6.11	.81
Well-Being	35	3.2	3.8	7.0	6.04	.76
Self-Control	35	3.3	3.7	7.0	5.37	.92
Emotionality	35	2.9	3.9	6.8	5.80	.70
Sociability	35	3.2	3.8	7.0	5.22	.80

Reliability Testing

Connor-Davidson Resilience Scale (CD-RISC)

The reliability testing for resilience using the Connor-Davidson Resilience Scale (CD-RISC) produced a Cronbach's alpha of 0.878, which indicated a high level of internal consistency for the scale with this specific sample group. This finding was similar to established measurements of Cronbach's alpha of 0.89 (Connor & Davidson, 2003).

Trait Emotional Intelligence Questionnaire Short Form

The reliability testing for emotional intelligence using the Trait Emotional Intelligence Questionnaire Short Form (TEIQue-SF) was generalizable and will produce similar results with similar populations (Cooper & Petrides, 2010). The reliability

analysis for the TEIQue-SF produced a total Cronbach's alpha equal to 0.89. Even though the measure was comprised of 30 items, 26 of them are assigned to one of the following constructs: well-being (six items); self-control (six items); emotionality (eight items); sociability (six items). The remaining four items contribute only to the cumulative TEIQue score. According to Petrides (2009), the Cronbach's alpha for the four trait EI factors using the TEIQue-SF was 0.69; hence, the results of this study correlated with recognized internal validity.

Hypothesis Testing

Research Question 1

Research question 1: What is the relationship between emotional intelligence and resilience among newly licensed registered nurses transitioning to their professional role? Among the whole sample tested, there was a significant positive correlation between resilience with global trait EI ($r = 0.471, p = 0.000$) and EI factors, well-being ($r = 0.478, p = 0.000$), self-control ($r = 0.473, p = 0.000$), and sociability ($r = 0.368, p = 0.003$). Resilience had a positive correlation with emotionality ($r = 0.227, p = 0.74$); however, this relationship was not statistically significant. As such, the results demonstrated a statistically significant correlation between many constructs of EI and resilience. (Table 5 presents the results of the correlation analyses.) Therefore, these results failed to reject the null hypothesis that there is no relationship between emotional intelligence and resilience among NLRNs transitioning to the professional role.

Table 5

Group Correlation Analysis Between Resilience and EI

Resilience

	All Participants (n = 63)	Critical Care Nursing Specialty (n = 28)	Other Specialty Areas (n = 35)
Global Trait EI	0.471**	0.410**	0.607**
Well-Being	0.478**	0.495**	0.493**
Self-Control	0.473**	.0382**	0.543**
Emotionality	0.227	0.101	0.415**
Sociability	0.368**	0.213	0.592**

** Correlation is significant at the 0.01 level (2-tailed)

Among newly licensed registered nurses transitioning to their professional role in critical care, resilience positively correlated with global trait EI ($r = .471, p = .030$), and the EI factor well-being ($r = .495, p = .007$). These correlations were statistically significant. Weak correlations were seen between resilience and the EI factor emotionality ($r = .101, p = .609$) and resilience and sociability ($r = .213, p = .277$). However these correlations were not statistically significant (See Table 5).

Among newly licensed registered nurses transitioning to their professional role in other specialty care areas, resilience positively correlated with global trait EI ($r = .607, p = .000$), EI factors well-being ($r = .493, p = .003$), self-control ($r = .543, p = .001$), emotionality ($r = .415, p = .013$), and sociability ($r = .592, p = .000$). These correlations were statistically significant (See Table 5).

Research Question 2

Research Question 2: What is the difference in emotional intelligence and resilience between NLRNs who transition in critical care nursing specialty and those who do not? To answer the question if there is a difference between emotional intelligence and resilience in NLRNs who transitioned in critical care nursing specialty and other specialty

areas, independent samples *t*-tests were conducted to test for these potential differences. An individual samples T-test failed to reveal a statistically significant difference between the mean scores of resilience, global trait EI, and EI factor scores (see Table 6).

Table 6

Comparison of Resilience and Emotional Intelligence Scores Between Critical Care Nursing Specialty and Other Specialty Areas

	Nursing Specialty						Mean Difference	95% Confidence Interval of the Difference (lower, higher)	t (df)	Sig (2-tailed)
	Critical Care			Other						
	N	Mean	SD	N	Mean	SD				
Resilience	28	33.21	5.69	35	31.60	4.72	1.61	(-1.01, 4.24)	1.23 (61)	.22
Global Trait EI	28	5.99	1.23	35	6.11	.81	-.116	(-.659, .427)	-.43 (44.63)	.67
Well-Being	28	5.96	1.19	35	6.04	.76	-.08	(-.57, .41)	-.32 (61)	.75
Self-Control	28	5.59	.893	35	5.37	.919	.22	(-.24, .68)	.97 (61)	.34
Emotionality	28	5.78	1.01	35	5.80	.70	-.02	(-.46, .41)	-.11 (61)	.92
Sociability	28	5.20	1.11	35	5.22	.80	-.02	(-.52, .48)	-.09 (47.54)	.93

Additionally, in trying to answer the research question What is the difference in emotional intelligence and resilience between NLRNs who transition in critical care nursing specialty and those who do not, using the Fisher *r*-to-*z* transformation, *z* was calculated to assess the significance of the difference in strength between two correlation

coefficient of critical care nursing specialty and other specialty areas. Results showed no statistical difference in the strength of correlation between resilience and global trait EI, $z = 1.01$ ($p = 0.312$); resilience and well-being, $z = -0.01$ ($p = 0.992$); resilience and self-control, $z = 0.77$ ($p = 0.441$); resilience and emotionality $z = 1.27$ ($p = 0.204$); resilience and sociability $z = 1.74$ ($p = 0.081$).

The NLRNs in the study were mostly females, ages 34 years and younger who completed BSN nursing programs and worked mostly with adult patient populations. This study explored the psychometric characteristics of the 10-item Connor-Davidson Resilience Scale (CD-RISC) to measure resilience and the 30-item Trait Emotional Intelligence Questionnaire Short Form (TEIQue-SF) to measure emotional intelligence among 63 newly licensed registered nurses in south Florida. It was demonstrated that both scales possessed satisfactory reliability. The internal consistency (Cronbach's alpha) of the items in the CD-RISC was 0.878 and for the TEIQue-SF was 0.708. These values were comparable to what authors of original studies reported for resilience: Cronbach's alpha of 0.89 (Connor & Davidson, 2003) and emotional intelligence Cronbach's alpha 0.69 (Petrides, 2009). There was no statistically significant relationship found between emotional intelligence and resilience in NLRNs. As for looking at the difference in emotional intelligence and resilience between NLRNs who transition in critical care nursing specialty and those who do not, if they remain in the area, then that is a marker for successful transition.

Chapter Summary

This research study focused on NLRNs emotional intelligence and resilience. A variety of statistical tests were used to analyze the data in this study. Pearson correlation

coefficients were computed to answer the following research questions: RQ1: What is the relationship between emotional intelligence and resilience among newly licensed registered nurses transitioning to their professional role? RQ2: What is the difference in emotional intelligence and resilience between NLRNs who transition in critical care nursing specialty and those who do not? The results from the correlation tests showed that there was not a statistically significant relationship between global trait EI and resilience among NLRNS as a whole. However, when looking at NLRNs who transitioned in a critical care setting and those who transitioned in other specialty areas, there was significance in the emotionality trait. Chapter five summarizes findings of this study and discusses implications for future research.

Chapter Five

Discussion and Summary

The current research was conducted to assess if certain levels of emotional intelligence (EI) are associated with similar levels of resilience among a sample of NLRNs. Furthermore, the study explored whether EI and resilience play a role in NLRNs' transitioning in different specialty care areas.

This study was built upon the theoretical framework of Duchscher transition shock theory. Duchscher described NLRNs experiencing reality shock as the transition shock experienced when they start to practice professionally. The stress and strain of what they were taught as students and what they are coming to know in the work world are inconsistent (Duchscher, 2009). This discrepancy has been shown to result in stress and reality shock for NLRNs (Gardiner & Sheen, 2016). Duchscher (2008) identified three stages of transition experienced by NLRNs as they go from a graduate to staff nurse. The stages, "doing," "being," and "knowing" are on a continuum as new nurses adjust to their own practice (Duchscher, 2008). According to Duchscher (2009), transition shock is inherent in the first stage which is influenced by certain factors such as history and situational context which give rise to certain expectations about the professional role and responsibilities of the work culture. Initially, role transition experience varies for the professional and is impacted by individual essential physical, intellectual, and emotional issues that affect their well-being. Transition shock develops as the experience of an individual moves from the known role to a somewhat less familiar role, in this case student to professional practicing nurse (Duchscher, 2009).

Duchscher transition shock theory may explain why newly licensed nurses in general experience transition shock as they move from one role to the next. The theory does not explain why two nurses go through the same transition process, both experiencing transition shock; however, one is able to adapt and integrate and chooses to stay in the work area and the other one is not. There may be a profile of person-level characteristics of the nurses themselves that explains whether they successfully transition into the professional nursing role. The theory does not take into account individual differences in personality traits which may explain what causes stress in the transition process. Does each individual have the resilience and emotional intelligence which may play a role in transition shock? This research looks at the individual differences of newly licensed nurses in the transition process to determine if one possesses certain person-level characteristics that may require specific interventions when considering the individual.

For decades we have believed in transition theory being Kramer's reality shock or Duchscher transition shock theory. With these theories, transition is the experience of moving from one state to the next. Even though transition may take into consideration conditions that affect the life of a person in this process, it does not take into account person-level traits that may impact an individual's behavior and personality. There are too many individual personality traits and too much variability such as age, culture, education, and language with NLRNs. Additionally, generalizations cannot be made especially when the majority of the incoming workforce is millennials. Millennials have certain expectations about the workplace such as work life balance or use of cutting edge technology, and this may not be congruent with what other generations think of the

nursing role. Although the data analysis did not statistically support the transition shock theory, there is still a need for further studies to validate transition shock theory.

Summary of the Findings

The analysis of the study results provides information regarding the relationship of NLRNs' EI and resilience and its relation to their transition into the professional role in different specialty care areas. These results can assist hospital administrators and nurse leaders in providing an understanding of how to effectively have a program or intervention that will make a difference to successfully transition NLRNs into their professional roles. What the study has shown is that regardless of specialty area, the NLRNs exhibited high levels of resilience and emotional intelligence with the exception of resilience and the EI subscale of emotionality. These results may suggest that NLRNs are learning how to react to stressors in the environment so their emotional responses may not be perceived as positive. However in looking at those who transitioned in critical care specialty and those who transitioned in other specialty care areas the differences were a weak relationship between the EI trait factor emotionality and resilience and emotionality and sociability. Newly licensed registered nurses transitioning in other specialty care areas have higher emotional intelligence for the factor emotionality than those in the critical care specialty.

Emotional intelligence is one's ability to assess how well one understands and manages emotions and guides thinking and behavior management (Heydari, Kareshki, & Armat, 2016). In looking at the demographics, the assumption can be made that since the majority of the respondents are age 34 and under, this may be the first time the NLRNs are entering the workforce. If so, they may not have enough experience to be able to

identify certain emotional qualities that affect their thoughts and decision making which in turn affects how they behave in certain situations.

Also, the study results showed that NLRNs transitioning in the critical care specialty have a lower EI factor for emotionality and sociability than those in other specialty care areas. In caring for critical care patients, there are often multiple roles and tasks required. Nursing is different from other professions in that there are several educational entry levels for NLRNs. Even though a State Board of Nursing approves minimal requirements for nursing educational programs, having a national accreditation is voluntary, and this requires a higher level of quality. Passing a national licensure exam is used to assess minimal competency for entry into practice. Programs may require students to have learning in acute and chronic settings; however, there is no guarantee that NLRNs will have some exposure to newer technologies and treating complex clinical conditions as is seen in critical care areas. Critical care settings require learning traditional nursing skills as well as additional skills and specialized knowledge to deal with complex health issues and often life-threatening situations. With NLRNs being the majority of the workforce entering critical care areas, they may not be adept in dealing with patients who are critically ill. These results may suggest that in dealing with a high acuity patient population, death and dying, advanced technology, and use of multiple diagnostic devices is overwhelming and affect the emotional responses of NLRNs in critical care settings and how they interact with others when dealing with these stressors. Therefore, the ability to manage their emotions and interact with others socially in a highly stressful environment may take a while to develop since they are learning to build trusting relationships in stressful situations.

Nursing is a challenging profession in which transitioning from the role of a student to the workforce can be difficult. Newly licensed registered nurses have claimed that there are striking discrepancies between what they were taught in school and the realities of the nursing profession (Feng & Tsai, 2012). With standards of care continually evolving, there is often a disconnect between what is learned in nursing school as best practice and actual clinical practice. Being a NLRN with limited experience, it is a struggle to fill the theory practice gap. Having resources to support NLRNs so that they deliver safe care and not struggle in an ever-changing environment may serve to explain why some nurses successfully transition into the workforce and others do not (Yarbrough, Martin & Alfred, McNeill, 2017). A recommendation to overcome the disconnect between what is taught in schools and the reality of the practice setting is having clinical faculty actively working in the hospital settings so they can better understand how to bridge the theory and practice gap.

Further investigation is needed to address whether there is a relationship between NLRNs' emotional intelligence and resilience. However, the responses in the study found that NLRNs' emotional intelligence and resilience are person-level attributes that may have an influence on NLRNs and their practice. By identifying certain aspects in NLRNs, assistance can be provided to implement best practice programs to successfully transition NLRNs to professional practice. For newly licensed registered nurses, transition support may improve their competence and confidence. The study findings may be integrated into the literature through clinical inquiry exploration.

Integration of the Findings with Previous Literature

The study results produced similarities as evidenced from the literature review regarding nurses, emotional intelligence, and resilience. The integration of these study findings within the literature is explored for further discussion.

Emotional Intelligence

According to Li and associates (Li, Cao, Cao, & Liu, 2015), previous research has shown that emotional intelligence has assisted with the formation of successful human relationships in the workplace. If EI interventions are introduced during the NLRNs' transition period into the professional role, they may increase emotional coping mechanisms and enhance social skills that may benefit NLRNs in the long run. This may develop and enhance their personal and professional selves (Li et al., 2015). Yekta and Abdolrahimi (2016) described emotional intelligence as one of the most important skills a healthcare professional can possess. Specifically with nursing, there are practical applications of emotional intelligence such as how a NLRN reduces stress, having an empathetic relationship with the patient, and improving clinical practice. As a result, evidence-based interventions may be created to enhance this personal attribute (Beydler, 2017; Yekta & Abdolrahimi, 2016). Wang, Toa, Bowers, Brown, and Zhang (2018) reiterate emotional intelligence training in clinical practice as it may increase a nurse's intent to stay. As a whole, this study showed high levels of emotional intelligence in NLRNs. Brennan (2017) indicates that those with higher levels of emotional scores likely are satisfied with their jobs.

Resilience

Delgado, Upton, Ranse, Furness, and Foster (2017) state that inclusive of organizational support, having strategies to build resilience could mediate stress. With

NLRNs having interventions to build resilience, in addition to other characteristics like emotional intelligence, NLRNs have the potential to prevent negative impact and promote the positive aspects to deal with and adapt to the emotional conflict in nursing work. Waheb and associates (2017) describe improved resilience as a potential solution to transition shock as NLRNs comprehend and manage their situations resulting in their becoming more resilient. In this study, the NLRNs had a high level of resilience, and according to Guo and associates (2017), having resilience can help nurses with tough situations and result in greater levels of job satisfaction which correlates significantly with retention.

Implications of the Findings

Implications for Nursing Education

With the continued nursing shortage and academic institutions' attempts to meet the increased demands, NLRNs need to feel that they are prepared to undertake their new role in the workplace. Therefore, education is an important aspect of preparing the NLRN for the professional role (Bennett, Grimsley, Grimsley, & Rodd, 2017). The transition period is identified as a vulnerable period for NLRNs in which they may decide to leave the profession. Nurse educators need to prepare NLRNs to cope with the realities of the practice environment and anticipate and address the needs that may arise during this stage (Keil & Van Der Wege, 2018). They identified the concepts of emotional intelligence and resilience as personal characteristics that can be modified by implementing changes in the nursing program that will have a positive impact on factors that contribute to stress. The use of simulation is a practice that addresses many of the areas that have known to cause stress in NLRNs. With simulation, nurse educators provide opportunities to empower

nursing students and make them more comfortable with dealing with difficult tasks they may encounter in the practice environment such as physician conflict. Simulation also allows the students to make mistakes and learn from the experience, which is something they would never be allowed to do in an actual patient situation (Keil & Van Der Wege, 2018).

Keil and Van Der Wege (2018) indicate that stress is a constant in the nursing profession, especially with the introduction of new expectations and technology. Knowing that NLRNs will experience high levels of stress during the transition phase, nurse educators can play an important role in preparing them for the change from school to the workforce. Nurse educators can foster the development of personal characteristics such as emotional intelligence and resilience to help them positively adapt to stress.

Implications for Nursing Practice

Newly licensed registered nurses today are practicing in many different areas. Reports have indicated that there is a significant nursing shortage with hospitals' experiencing an estimated turnover rate of 16.5%, which is an increase from previous estimates (Yarbrough, Martin, Alfred, & McNeill, 2017). Yarbrough and colleagues (2017) point out that NLRNs' estimated turnover rate in the first year is 17.5%, and the estimated cost of replacing a nurse is between \$82,000 - \$88,000. The shortage is significant with not enough nurses to fill this need in the next 10-15 years (Yarbrough et al., 2017). Therefore, it is essential to focus on factors that can influence retention in organizations.

The orientation phase in which NLRNs are transitioning to their professional roles is an influential and extremely important stage when it comes to the impact on their

practice (Yarbrough et al., 2017). NLRNs face many challenges and pressures to meet the work place expectations (Bennett et al., 2017). Nursing education does not always prepare NLRNs for working in different areas and what students learn in school may not be congruent with what is practiced in the workplace. Bennett and colleagues (2017) also suggest that stress is one of the main factors that influenced a NLRN's competence

Even though stress on the job is inherent to nursing, it is recognized as a challenge in the profession. In order to be successful with the transition process, NLRNs may have resources that at times may be intangible, such as emotional intelligence and resilience (Keil & Van Der Wege, 2018). Nursing practice leaders can implement structured transition to practice or residency programs in their facilities to decrease NLRN turnover (Silvestre et al., 2017). Evidence supports that these programs promote a culture of learning, support, and mentoring which allows NLRNs to develop in their practice (Jones et al., 2017).

Implications for Nursing Research

By trying to identify if there is a relationship between emotional intelligence and resilience among newly licensed registered nurses transitioning to their professional role and if there is a difference in emotional intelligence and resilience between those who transitioned in critical care specialty and those in other specialty areas, it is evident that more research is needed on this topic. Given the sample size of this study, replication of the study using a larger sampling size would be beneficial as would extending the period in which to recruit participants although hospitals are not amenable to NLRNs for several reasons. NLRNs may be in an institution that does not have a formal residency program or they could be somewhere where NLRNs are over studied. Additionally, replicating the

study may be difficult since not many healthcare institutions in the area have a process in place for nursing research. This is a limiting factor when it comes to nursing research.

The ones that do have a process require the researcher to go through a separate institutional review board (IRB).

Another implication for nursing research is the use of the REDCap software for data collection. REDCap provided a secure web-based site where the survey could be accessed by any device connected to the Internet. It was an intuitive interface that had the capability to create mandatory fields so that the survey had to be completed in its entirety by those who attempted for the data to be saved. It also allowed the researcher to ask questions that met the inclusion criteria and end the survey for those who did not meet the criteria. That feature helped with data cleaning.

Implications for Public Policy

Not having a seamless transition to the work environment has serious consequences such as disillusionment with the profession, emotional exhaustion, and high levels of stress. This can lead to burnout, patient safety issues, and increased turnover (Gardiner & Sheen, 2016). There is a need for best practices such as transition to practice and residency programs to train NLRNs to ensure retention and consistent quality of care for patients. National nursing organizations such as the American Association of Colleges of Nursing (AACN), the National Council of State Boards of Nursing (NCSBN), the American Nurses Association (ANA), and the American Nurses Credentialing Center (ANCC) have principles regarding transition to practice programs. It is imperative that standardized initiatives be in place to ensure success for NLRNs in an increasingly complex work environment. With these national organizations having

published reports, both educators and hospital administrators should at least try to use the evidence to implement strategies to ensure job success for NLRNs.

Institutions and hospital systems have a variety of policies related specifically to nursing and nursing practice. This study and its implications are significant when creating or reviewing policies that include orientation processes for successful transitioning of NLRNs. Policies may be revised or written to address specific interventions or programs that NLRNs can participate in that would increase or sustain certain personal characteristics such as emotional intelligence and resilience that would allow NLRNs to positively engage in their work environment. Examples of programs include peer support groups or programs that offer resources for work-life balance.

Limitations

There are certain limitations in this study that require attention. First, the recruitment process posed some challenges as it related to the investigator's having access to the participants. Gatekeepers were used since the investigator did not have direct contact, so the investigator did not have the ability to actively try recruiting and reminding potential participants of the dissertation study. Second, the goal was to recruit as many NLRNs who wanted to participate in the study with the investigator anticipating a minimum of 84 participants. However it took longer than expected to get potential participants to complete the survey. Even though IRB approval was obtained quickly from the educational institution, approval from the different sites was required and took longer than anticipated. Having to get multiple IRB approvals for the same study is burdensome for the researcher. By the time site approval was obtained, it lessened the amount of time spent to recruit NLRNs. Thus only 73 individuals participated, with only

63 meeting the study criteria. The small number of participants limited the power to detect significance effects in relation to the traits. Caution is warranted in generalizing the findings to the entire population of NLRNs even though the sample was diverse in terms of age, gender, specialty area, and nursing program. Nevertheless, the results may provide some insights on NLRN attributes that can assist with preparing NLRNs to transition into hospital settings in the [REDACTED] area. Also, not having optimal sample size may have limited the power to detect statistically significant effects when such effects exist. There may also be the threat of social bias because the NLRNs may feel an internal pressure to show their best face, so that may influence how they answered the survey questions.

Future Research

A recommendation for the future is to continue the exploration of emotional intelligence and resilience in newly licensed registered nurse. Replicating the study with a larger sample may provide more information and support in increasing generalizability and statistical power. There is limited research available that explores person-level characteristics, including emotional intelligence and resilience, in newly licensed registered nurses. Furthermore, this dissertation study is the first known to explore and interpret whether there is a relationship between these two characteristics. Findings from this study made it evident that more research in this area is needed to further the understanding of the individual traits that may impact the transition of nurses from school to the workforce. This study did not show a cause; therefore, more predictive studies may be needed to have a better understanding of these person-level characteristics.

Additionally, a future research proposal for emotional intelligence and resilience would be a longitudinal study. This prospective study would involve performing an assessment of these characteristics in certain cohorts of NLRNs at the beginning of the transition process and then perform ongoing training for a certain period to determine if NLRNs are provided with the appropriate resources and whether they build their EI and resilience levels. If so, over time what is the effect on remaining in their current position? Those NLRNs who were provided an intervention can be compared to other cohorts of NLRNs who were not provided with any additional training resources yet assessed for emotional intelligence and resilience at the same times during their transition process. By providing this training resource as an intervention, the study may be conducted to investigate whether emotional intelligence and resilience can be improved if certain programs are implemented. It may be valuable to seek the perspective of the hiring facilities to see if they have processes in place to support these types of needs. These research topics will help provide insight about future strategies in developing programs to transition NLRNS in the workplace.

Another recommendation for further research is to identify if there is a correlation with EI and resilience in NLRNs who graduated from specific educational programs such as an associate, bachelor's, second degree bachelor's, or LPN to RN. Assessing emotional intelligence and resilience at the beginning of the NLRNs' transition period can provide information for future academic program development to incorporate training on how or when to enhance these characteristics. These types of inquiry may add knowledge to NLRNs' approach to the work environment and provide the support to overcome any challenges encountered such as getting NLRNs to answer surveys.

As with any Likert-type survey, responders are not able to disclose their reasons for choosing a certain answer to a statement. Another proposed study is to perform a phenomenological study with NLRNs' transitioning to the professional role in which they are interviewed to see if they can identify characteristics they possess or specific interventions offered by hospital administration and nursing management that best supports them. An additional recommendation is to involve hospital administrators and nurse managers into the study. They should be interviewed and/or surveyed to determine how their perception of their leadership styles influence the transition process. Information from hospital administrators and nurse managers about their operational measures could be compared and contrasted with the NLRNs' emotional intelligence and resilience. Other research about NLRNs' perseverance, self-determination, or other person-level traits, in addition to emotional intelligence and resilience, is necessary to assist in building the body of knowledge in nursing practice. Self-report bias may have been a problem, so future research may involve an observational study to get a more accurate picture.

Conclusion

The study examined the relationship between emotional intelligence and resilience in NLRNs and found no significant correlation. Hence, there is a need for further exploration of this relationship in the future, with an emphasis on person-level characteristics exhibited in NLRNs who are successful in transitioning to their professional role. Having an understanding of factors that facilitate and impede emotional intelligence and resilience may be useful for nursing management and hospital administrators in deciding what interventions best support newly licensed registered

nurses in their transition. It is a stressful time for new nurses, and Duchscher's (2009) reality shock theory can be used as a theoretical framework for formulating future studies that are focused on understanding what qualities in nurses determine successful versus unsuccessful transitions to the workforce. This work can ultimately contribute to a better understanding of how person-level characteristics such as emotional intelligence and resilience play a role in the transition process and help to determine what resources are needed in nursing programs and the workforce to facilitate nurses' successful integration into their nursing careers. Future considerations would be adding in more personality traits, such as perseverance and self-determination, to see what specific characteristics nurses have that would build a personality profile. More research will build a robust body of knowledge and highlight on a national level the need to focus on identifying and incorporating interventions to build and strengthen these attributes in the professional setting.

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Appendix A

IRB Approval

MEMORANDUM

To: **Lee Fonghong**

From: [REDACTED]
Center Representative, Institutional Review Board

Date: **February 26, 2018**

Re: **IRB #: 2018-97; Title, "The relationship of emotional intelligence and resilience of newly licensed registered nurses transitioning to the professional role"**

I have reviewed the above-referenced research protocol at the center level. Based on the information provided, I have determined that this study is exempt from further IRB review under **45 CFR 46.101(b) (Exempt Category 2)**. You may proceed with your study as described to the IRB. As principal investigator, you must adhere to the following requirements:

- 1) **CONSENT:** If recruitment procedures include consent forms, they must be obtained in such a manner that they are clearly understood by the subjects and the process affords subjects the opportunity to ask questions, obtain detailed answers from those directly involved in the research, and have sufficient time to consider their participation after they have been provided this information. The subjects must be given a copy of the signed consent document, and a copy must be placed in a secure file separate from de-identified participant information. Record of informed consent must be retained for a minimum of three years from the conclusion of the study.
- 2) **ADVERSE EVENTS/UNANTICIPATED PROBLEMS:** The principal investigator is required to notify the IRB chair and me ([REDACTED] respectively) of any adverse reactions or unanticipated events that may develop as a result of this study. Reactions or events may include, but are not limited to, injury, depression as a result of participation in the study, life-threatening situation, death, or loss of confidentiality/anonymity of subject. Approval may be withdrawn if the problem is serious.
- 3) **AMENDMENTS:** Any changes in the study (e.g., procedures, number or types of subjects, consent forms, investigators, etc.) must be approved by the IRB prior to implementation. Please be advised that changes in a study may require further review depending on the nature of the change. Please contact me with any questions regarding amendments or changes to your study.

The NSU IRB is in compliance with the requirements for the protection of human subjects prescribed in Part 46 of Title 45 of the Code of Federal Regulations (45 CFR 46) revised June 18, 1991.

Appendix B

Permission Approval to Collect Data

[REDACTED]

Education & Development

[REDACTED]

February 9, 2018

Lec Fong Hong

[REDACTED]

Dear Ms. Fong Hong,

In response to your e-mail dated, February 8, 2018, this is to confirm that I have reviewed your request to recruit perspective participants from [REDACTED] for your study titled, Newly Licensed Registered Nurses Resilience and Emotional Intelligence.

[REDACTED] supports our staff who seek to advance their personal and professional growth as we believe this will be beneficial to our patients, staff and organization in the long run.

This letter serves as our intent to support you in your research endeavors, pending approval from your School's Institutional Review Board (IRB). As soon as you are granted IRB approval from them, please let me know.

I wish you success with the IRB. We are excited to support you in this scholarly work. If there is anything more that I can do, please feel free to contact me.

Sincerely,

[REDACTED]

Director, Clinical Education
Chair, Nursing Research Council

[REDACTED]

An Equal Opportunity Employer

[REDACTED]

DATE: June 18, 2018

TO: [REDACTED]

FROM: [REDACTED] IRB

STUDY TITLE: [1240325-1] THE RELATIONSHIP OF EMOTIONAL INTELLIGENCE AND RESILIENCE OF NEWLY LICENSED REGISTERED NURSES TRANSITIONING TO THE PROFESSIONAL ROLE

REFERENCE #:

SUBMISSION TYPE: New Project

Dear [REDACTED]

This letter serves to confirm that [REDACTED] has executed an Institutional Authorization Agreement (IAA) with the Nova Southeastern University (NSU) IRB to rely on their approval of this study.

The NSU IRB is the IRB of record and has continuing oversight of this study.

As Principal Investigator for this study at BHSF, it is your responsibility to submit the following to the [REDACTED] Institutional Review Board Office:

1. A copy of the NSU IRB initial approval letter and approved consent form(s) for this site.
2. Copies of approved advertisements, flyers, and recruitment materials to be used at this site.
3. Copies of NSU IRB approval letters and consent form(s) when the study is renewed.
4. Copies of revised approved consent form(s).
5. Copy of the final report when the study is completed.
6. Notification of any actions by the NSU IRB affecting their approval to conduct the study, including suspension or termination of approval.
7. Notification if changes to study personnel are to be made. The [REDACTED] IRB Office must approve new study personnel before they can be added to the study.
8. Report of all unanticipated problems.

It is your responsibility to maintain compliance with all NSU IRB and [REDACTED] institutional requirements.

[REDACTED]

Sincerely,

[REDACTED]

HRPP Director

Institutional Review Board

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within [REDACTED] records.

Appendix C

Participant Letter for Anonymous Surveys Nova Southeastern University Consent to be in a Research Study Entitled

The relationship of emotional intelligence and resilience of newly licensed registered nurses transitioning to the professional role

Who is doing this research study?

This person doing this study is Lee FongHong with Ron and Kathy Assaf College of Nursing. She will be helped by Dr. Julia Aucoin.

Why are you asking me to be in this research study?

You are being asked to take part in this research study because (1) you are working as a nurse and have been a registered nurse less than 18 months or, (2) you were just hired as a nurse and you have been a registered nurse for less than 18 months. You must also be able to read and comprehend English.

Why is this research being done?

The purpose of this study is to assess the emotional intelligence and resilience among NLRNs as they transition to their professional role

What will I be doing if I agree to be in this research study?

You will be taking a one-time, anonymous survey. The survey will take approximately 15 minutes to complete.

Are there possible risks and discomforts to me?

This research study involves minimal risk to you. To the best of our knowledge, the things you will be doing have no more risk of harm than you would have in everyday life.

What happens if I do not want to be in this research study?

You can decide not to participate in this research and it will not be held against you. You can exit the survey at any time.

Will it cost me anything? Will I get paid for being in the study?

There is no cost for participation in this study. Participation is voluntary and no payment will be provided.

How will you keep my information private?

Your responses are anonymous. Information we learn about you in this research study will be handled in a confidential manner, within the limits of the law. Survey participants are able to access REDCap surveys from any device that connects to the Internet. Data is entered into a secure web-based site and saved at a data center hosted by the University of San Francisco Street even though it may be displayed on a local monitor. It does not run on computer being used, instead it is at the data center which is locked and guarded at all hours twenty four hours, seven days of the week. This data will be available to the researcher, the Institutional Review Board and other representatives of this institution, and any granting agencies (if applicable). All confidential data will be kept securely REDCap servers that are guarded by multiple firewalls and intrusion detection systems. All electronic connections to REDCap environment are encrypted. All data will be kept for 36 months and destroyed after that time by erasing all electronic files.

Who can I talk to about the study?

If you have questions, you can contact the researcher or her dissertation chair.

If you have questions about the study but want to talk to someone else who is not a part of the study, you can call the Nova Southeastern University Institutional Review Board (IRB).

Do you understand and do you want to be in the study?

If you have read the above information and voluntarily wish to participate in this research study, please click on the link below

<https://redcap.nova.edu/redcap/surveys/?s=HTDWND9KRL>

Appendix D

Permission to Use Scale

Dear Lee:

Thank you for your interest in the Connor Davidson Resilience Scale (CD-RISC). We are pleased to grant permission for use of the CD-RISC in the project you have described under the following terms of agreement.

1. You agree (i) not to use the CD-RISC for any commercial purpose unless permission has been granted, or (ii) in research or other work performed for a third party, or (iii) provide the scale to a third party without permission. If other colleagues or off-site collaborators are involved with your project, their use of the scale is restricted to the project described, and the signatory of this agreement is responsible for ensuring that all other parties adhere to the terms of this agreement.
2. You may use the CD-RISC in written form, by telephone, or in secure electronic format whereby the scale is protected from unauthorized distribution or the possibility of modification. In all presentations of the CD-RISC, including electronic versions, the full copyright and terms of use statement must appear with the scale. The scale should not appear in any form where it is accessible to the public, and should be removed from electronic and other sites once the project has been completed.
3. Further information on the CD-RISC can be found at the www.cd-risc.com website. The scale's content may not be modified, although in some circumstances the formatting may be adapted with permission of either Dr. Connor or Dr. Davidson. If you wish to create a non-English language translation or culturally modified version of the CD-RISC, please let us know and we will provide details of the standard procedures.
4. Three forms of the scale exist: the original 25 item version and two shorter versions of 10 and 2 items respectively. When using the CD-RISC 25, CD-RISC 10 or CD-RISC 2, whether in English or other language, please include the full copyright statement and use restrictions as it appears on the scale.
5. [REDACTED]
6. Complete and return this form via email to [REDACTED]
7. In any publication or report resulting from use of the CD-RISC, you do not publish or partially reproduce items from the CD-RISC without first securing permission from the authors.

If you agree to the terms of this agreement, please email a signed copy to the above email address. Upon receipt of the signed agreement and of payment, we will email a copy of the scale.

Sincerely yours,

Jonathan R. T. Davidson, M.D.
Kathryn M. Connor, M.D.

Agreed to by:

Andrew Lee Ferrelberg
Signature (print)

8/27/2017

Date

RAI PhD candidate
Title

Nova Southeastern University
Organization

Appendix E

Questionnaire - Newly Licensed Registered Nurses Resilience and Emotional Intelligence

Thank you for taking the time to complete the following survey. This survey has been developed to gather information on emotional intelligence and resilience in newly licensed registered nurses. The questionnaire should take less than 15 minutes to complete. Your responses are completely anonymous.

- 1) I am currently working as a Registered Nurse.
 - Yes
 - No

- 2) I have been a Registered Nurse for less than 18 months?
 - Yes
 - No

- 3) When I read information in English, I understand it.
 - Yes
 - No

- 4) What is your age? 21 and under
 - 22 - 34
 - 35 - 44
 - 45 - 54
 - 55 and over

- 5) What is your gender?
 - Male
 - Female

- 6) Nursing program completed ADN
 - BSN
 - LPN to RN
 - Second degree BSN

- 7) Patient population primarily work with
 - Adult
 - Pediatrics
 - Both

8) Nursing specialty area that best describes where most of your career has been spent so far

- Ambulatory
- Corrections
- Critical care
- Emergency
- Labor & Delivery
- Medical Surgical
- Neuroscience
- Oncology
- Operating Room
- Orthopedics
- Palliative
- Perianesthesia
- Psychiatry
- Radiology
- Rehabilitative
- Telemetry
- Transplant
- Trauma
- Women's Health
- Other

9) Are you still employed in your original unit of hire?

- Yes
- No

Please indicate how much you agree with the following statements as they apply to you over the last month. If a particular situation has not occurred recently, answer according to how you think you would have felt.

	Not True At All	Rarely True	Sometimes True	Often True	True Nearly All The Time
10. I am able to adapt when changes occur					
11. I can deal with whatever comes my way					
12. I try to see the humorous side of things when I am faced with problems					
13. Having to cope with stress can make me stronger					
14. I tend to bounce back after an illness, injury or other hardships					
15. I believe I can achieve my goals, even if there are obstacles					
16. Under pressure, I stay focused and think clearly					
17. I am not easily discouraged by failure					
18. I think of myself as a strong person when dealing with life's challenges and difficulties					
19. I am able to handle unpleasant or painful feelings like sadness, fear and anger					

Please answer each statement below by choosing the number that best reflects your degree of agreement or disagreement with the statement. Do not think too long about the exact meaning of the statements. Work quickly and try to answer as accurately as possible. There is no right or wrong answer. There are seven possible responses to each statement ranging from 'Completely Disagree' (number 1) to 'Completely Agree' (number 7)

20. Expressing my emotions with words is not a problem for me	1	2	3	4	5	6	7
21. I often find it difficult to see things from another person's viewpoint	1	2	3	4	5	6	7
22. On the whole, I'm a highly motivated person	1	2	3	4	5	6	7
23. I usually find it difficult to regulate my emotions	1	2	3	4	5	6	7
24. I generally don't find life enjoyable	1	2	3	4	5	6	7
25. I can deal effectively with people	1	2	3	4	5	6	7
26. I tend to change my mind frequently	1	2	3	4	5	6	7
27. Many times, I can't figure out what emotion I'm feeling	1	2	3	4	5	6	7
28. I feel that I have a number of good qualities	1	2	3	4	5	6	7
29. I often find it difficult to stand up for my rights	1	2	3	4	5	6	7
30. I'm usually able to influence the way other people feel	1	2	3	4	5	6	7
31. On the whole, I have a gloomy perspective on most things	1	2	3	4	5	6	7
32. Those close to me often complain that I don't treat them right	1	2	3	4	5	6	7
33. I often find it difficult to show my affection to those close to me	1	2	3	4	5	6	7
34. On the whole, I am able to deal with stress	1	2	3	4	5	6	7
35. I often find it difficult to show my affection to those close to me	1	2	3	4	5	6	7
36. I'm normally able to "get into someone's shoes" and experience their emotions	1	2	3	4	5	6	7
37. I normally find it difficult to keep myself motivated	1	2	3	4	5	6	7
38. I'm usually able to find ways to control my emotions when I want to	1	2	3	4	5	6	7
39. On the whole, I'm pleased with my life	1	2	3	4	5	6	7
40. I would describe myself as a good negotiator	1	2	3	4	5	6	7
41. I tend to get involved in things I later wish I could get out of	1	2	3	4	5	6	7
42. I often pause and think about my feelings	1	2	3	4	5	6	7
43. I believe I'm full of personal strengths	1	2	3	4	5	6	7
44. I tend to "back down" even if I know I'm right	1	2	3	4	5	6	7
45. I don't seem to have any power at all over other people's feelings	1	2	3	4	5	6	7
46. I generally believe that things will work out fine in my	1	2	3	4	5	6	7

life							
47. I find it difficult to bond well even with those close to me	1	2	3	4	5	6	7
48. Generally, I'm able to adapt to new environments	1	2	3	4	5	6	7
49. Others admire me for being relaxed	1	2	3	4	5	6	7