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The Lived Experience of Nurse Practitioner Role Transition: A Phenomenology Study

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UNIVERSITY OF NORTHERN COLORADO

Greeley, Colorado

The Graduate School

THE LIVED EXPERIENCE OF NURSE PRACTITIONER
ROLE TRANSITION: A PHENOMENOLOGY STUDY

A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy

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College of Natural and Health Sciences
School of Nursing
Nursing Education

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This Dissertation by: Anthony Michael Angelow

Entitled: *The Lived Experience of Nurse Practitioner Role Transition: A Phenomenology Study*

has been approved as meeting the requirement for the Degree of Doctor of Philosophy in College of Natural and Health Sciences in School of Nursing and Program of Nursing Education

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ABSTRACT

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This qualitative, descriptive phenomenology study sought to answer the following question: What experiences do nurse practitioners identify as being associated with their transition to the nurse practitioner (NP) role? Using purposive sampling and snowball techniques, eight nurse practitioners participated in this study. The study included participants from across the United States. Data from this study were developed from unstructured interviews with participants using audio-recorded open-ended questions, which were then transcribed by the principal investigator. The data were analyzed using Colaizzi's (cited in Creswell, 2013) method for qualitative data analysis to identify common themes. Four central themes were generated from these data: emotive responses during the transition, building blocks for advanced practice, establishing vital relationships, and the educational journey. These themes were validated with the participants using a member checking process. An audit enhanced dependability and confirmability. Based on the emergence of the themes, this study described the NP role transition process as a time of mixed emotions. Intense feelings of excitement, stress, and nervousness were commonplace occurrences during the transition process. Negative feelings of stress and nervousness inhibited the ability of NPs to engage in their role. Fortuitously, these negative feelings occurred more significantly at the beginning of the

role transition and diminished over time as NPs became more confident and competent in their role. Factors of NP role transition that provided the NP with building blocks for advanced practice included prior registered nurse experience, setting clear workplace expectations, and formal orientation programs. Without these factors, the transition to the NP role might have been challenging. Establishing relationships with experienced NPs and physician collaborators provided the NP with mentorship, support, and additional knowledge-building. The educational journey provided the basis for knowledge needed to function in the NP role. Curricular activities that provided meaningful interaction and knowledge applications were most beneficial to the NP's role transition. The findings of this study were explored and recommendations for nurse practitioner educators to improve nurse practitioner role transition were asserted. Additionally, future research needs were addressed.

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CHAPTER I

INTRODUCTION

Nurse educators hold the responsibility of ensuring the adequate preparation of the advanced practice registered nurse (APRN) to provide high quality, cost-effective care to patient populations in an evolving healthcare system. As the healthcare system in the United States is undergoing reform, APRNs, specifically nurse practitioners (NPs), are called upon to provide high quality, cost-effective care as independent providers. The need for an increased number of NPs has resulted in parallel changes to educational and clinical practice aspects of the NP role including eliminating experience requirements as admission criteria for NP programs and increasing NP autonomy in clinical practice. Previous researchers asserted the attainment of hallmark NP skills and the transition from the registered nurse (RN) to the NP is experiential in nature (Brown & Draye, 2003). However, the experiences needed to accomplish these goals are poorly understood. The elimination of two potential experiential components of NP preparation and clinical practice opens the door for new areas of inquiry into the education and preparation of NPs. Research is needed to discover the experiential components guiding the role transition of NPs who offer high quality, cost-effective care. Understanding these components is essential to ensure educational programs continue delivering curricula that prepare the NP adequately for a complex role.

Setting the Stage

Healthcare Reform

A failing U.S. healthcare system requires healthcare reform. The U.S. healthcare system is one of the most expensive healthcare systems in the world, thus becoming a driving force for healthcare reform. Currently, the United States spends 17% of its gross domestic product on health care annually. By the year 2020, the Institute for Health Care Improvement (IHI; 2016) predicts an increase in this expenditure to 20%. As part of this reform, on March 23, 2010, the Affordable Care Act (ACA) became law, increasing health care access to millions of Americans previously uninsured and decreasing healthcare-associated costs through insurance company legislative action (The White House, 2010). The IHI developed the Triple Aim initiative--a framework developed to optimize health system performance based on three main goals: (a) improvement of the quality and satisfaction of the patient experience of care, (b) improvement in the health of populations, and (c) a reduction in healthcare costs. According to the Institute of Medicine (IOM; 2010a) report, healthcare reform is inevitable but faces significant challenges that threaten its success including (a) a shortage of physician providers, (b) increased numbers of Americans seeking health care due to an increasing geriatric population, and (c) increased numbers of insured Americans seeking health care through the implementation of the ACA.

Physician shortage. The Association of American Medical Colleges (2017) asserted there would be a shortage of 130,000 physicians by the year 2025. Although, this shortage was not inclusive of only primary care settings, the Association projected that 37% of this physician shortage would directly affect primary care. The remaining

63% of the projected shortage would affect other areas of health care including specialty care, acute care, long-term care, and palliative care arenas, to name a few. The impact on primary care provided here delivers a solid foundation to gain insight behind the overall physician shortage. However, the physician shortage affects all areas of health care (Brown, 2013).

There are numerous reasons for the anticipated physician shortage, specifically in primary care. First is a reduction in the recruitment of newly trained primary care physicians. More than one-half of all medical students voice an interest in primary care in their first year of medical school. By the third year of medical school, only 20% of students continue to pursue training in primary care specialties. Coupled with an aging population of primary care physicians nearing retirement, this decrease in interest in primary care as a specialty does not adequately replace the aging physician population. Second, system-based issues and concerns are contributing to decreased interest in primary care and cause current primary care providers to seek employment in other specialties. This issue arises due to income differences in primary care and specialty practices. One of the main reasons for this financial influence is current insurance reimbursement systems. Current insurance reimbursement systems for primary care reward volume. Primary care physicians continue to increase their number of patient visits for their practices to remain profitable. The increase in number of patient visits causes a concern when providing a higher quantity of care while sacrificing care quality (Brown, 2013).

Current projections of enrollments in schools of medicine and graduate medical education programs indicate allopathic and osteopathic programs will produce 169,029

new primary care physicians between 2015 and 2035. Even with this projection, a deficit of at least 33,283 primary care physicians will remain due to increasing numbers of primary care physicians nearing retirement and the overall growth of the general population in the United States needing access to health care (Petterson, Liaw, Tran, & Bazemore, 2015). The shortage affects all areas of health care. There is a call to increase numbers of healthcare providers in primary care, acute care, and long-term care settings (Brown, 2013; Petterson et al., 2015).

Increasing geriatric population. The overall U.S. population is expected to increase from 314 million to 400 million individuals by the year 2050 (U.S. Census Bureau, 2016). In 2012, 62.8% of the U.S. population was under the age of 65 years while 37.2% of the population was 65 years or older. The U.S. Census Bureau predicts a drop in the population under the age of 65 to 57.3% with an increase in individuals 65 years or older to 42.7% by the year 2030 (Ortman, Velkoff, & Hogan, 2014). By the year 2050, the U.S. Census Bureau (2016) predicts a significant increase in the population over the age of 65 years from the current 48 million to 88 million individuals. Individuals representing the oldest of the population, aged 85 years and older, will increase from 5.9 million in 2012 to a predicted 18 million in 2050 or an estimated 20% of the geriatric population (Ortman et al., 2014). With an increase in the overall U.S. population and specifically the geriatric population, the U.S. Census Bureau also predicted an increased life expectancy from 68.6 years in 2015 to 76.2 years in 2050.

The American Geriatric Society (AGS; 2016) agreed that as the last of an aging Baby Boomer generation reaches age 65 in 2030, the geriatric population will exceed 70 million individuals in the United States as a result of longer life expectancies, thus

resulting in substantial growth in the demand for health care. The healthcare demand focuses on the need to treat chronic illness and its acute exacerbations (AGS, 2016). In 2014, the Centers for Disease Control and Prevention (CDC; 2016) identified an increase in average life expectancy of 19.3 years for both genders aged 65 years. More specifically, the CDC asserted an increased life expectancy for males aged 65 years or older of 18 years and females at 20.5 years. An estimated 21.7% of the geriatric population suffers from fair or poor health from chronic medical conditions.

Contributors to the poor health status of the geriatric population include smoking (8.4%), obesity (30.5-36.2%), and hypertension (63.4-79.9%). In addition, 92.9% of the geriatric population requires some form of long-term, chronic healthcare management including (a) hospice care, (b) adult day services, (c) home healthcare for acute and chronic illness, (d) nursing home-based care, and (e) residential community-based care (CDC, 2016).

As this population continues to age, chronic illness care remains an important focus in the primary care arena while management for exacerbations of these chronic illnesses remains an important focus for the acute care environment. The presence of one chronic illness increases the risk of a patient experiencing an exacerbation, while the presence of more than one chronic illness increases this risk 10-fold. These facts call for primary care providers to provide quality management of chronic disease and health promotion activities while acute care providers must meet the demands of chronic illness exacerbation. With an aging population, development of more chronic illnesses and increases in chronic illness exacerbation pose a dilemma to a healthcare system experiencing a shortage of providers. Currently, healthcare provider data exhibit a lack

in the ability of the current provider workforce to care for this population (Bodenheimer, Chen, & Bennet, 2009).

Increasing number of insured Americans. According to the IOM (2010a) report, the ACA will present many demands on the healthcare system. The ACA seeks to expand insurance coverage to 34 million Americans. The expansion of this coverage will increase the need for healthcare access. Before the implementation of the ACA, an estimated 46.3 million Americans were uninsured. With the implementation of the ACA, uninsured Americans are now gaining insurance coverage and seeking health care, leading to an increased demand for healthcare access and the number of qualified providers (Pettersen et al., 2012).

Individuals without healthcare insurance coverage are less likely to access preventative health care as the majority of these individuals represent a poverty-stricken population. In 2015, one of five uninsured Americans did not seek essential health care (The Henry J. Kaiser Family Foundation, 2016). More than 53% of uninsured Americans asserted the inability to afford healthcare-related costs without health insurance coverage. Due to cost, uninsured Americans do not seek required medical care for major health problems and chronic conditions. This lack of care results in increased rates of hospitalizations for acute and exacerbated illness likely preventable with access to primary and preventative healthcare services. Hospitalizations for acute illness and exacerbation of a chronic illness substantially increase healthcare-related costs and the rate of mortality. The goal of ACA is to decrease the number of uninsured Americans, allowing affordable and regular access to health care (The Henry J. Kaiser Family Foundation, 2016).

As of early 2016, the U.S. Department of Health and Human Services (HHS) estimated 20 million Americans gained health insurance coverage under the ACA, increasing the population of Americans seeking healthcare access. Specifically, young adults aged 19 to 25 years previously represented the largest uninsured population. Under the ACA, this population noted an increase of 6.1 million insured young adults. Nationally, the ACA increased health insurance coverage through the following provisions: (a) the Medicaid program expansion, (b) the Health Insurance Marketplace program, (c) allowing younger adults to stay on their parents' private health insurance plans, (d) the requirement to cover those with pre-existing health conditions, and (e) changes in employer-based health insurance requirements (HHS, 2016).

Autonomous Practice of the Nurse Practitioner

Over the last few years, NP autonomy has presented a complex debate among healthcare communities. The implementation of the ACA resulted in an increase in the accessibility of health care to approximately 32 million citizens in the United States. Currently, the number of primary care physician providers is inadequate to meet this demand for health care. Although NPs have a history of providing quality health care, solid opposition from physician-based organizations has not allowed the NP to practice in a fully autonomous role. Even in light of this opposition, the IOM urges NPs to practice to the fullest extent of their education and training as licensed independent practitioners (Weiland, 2015).

Autonomy is integral to the element of a profession, making autonomous practice the cornerstone of the NP (Ulrich, Soeken, & Miller, 2003; Weiland, 2015). However, physician groups argue that NP education is deficient in preparing NPs to practice

independently. When compared with the rigor of medical school, which includes a minimum of four years of basic medical didactic and clinical education and three years of residency, NP programs do not adhere to the same rigorous experiences. These physician groups assert the lack of rigor does not allow the NP to understand the complexity of medical issues. They argue the lack of a comprehensive medical education and no supervision by a physician could lead NPs to misdiagnose atypical cases. However, NPs continue to exhibit clinical efficacy through exceptional patient safety and clinical outcomes (Zand, 2011).

Historically, NP practice relied on physician support, mentoring, and supervision. However, the initial purpose of the NP role was full practice autonomy independent from medicine. Due to a lack of support for social, structural, and legislative changes from both nursing and medicine, the autonomous role of the NP did not initially come to fruition. Dependent on legislative state regulations (Weiland, 2015), the NP required a physician-provider to collaborate with and supervise the NP. Over the last few years due to changes in the healthcare system, autonomy remains a critical variable for NPs to explore. With a change in focus on developing a better healthcare system, evidence supports that NPs produce high-quality health care and patient outcomes while promoting cost-effectiveness (Ulrich et al., 2003). Cost effectiveness arises from the ability of the NP to streamline health care through a holistic model with an emphasis on disease prevention and the prevention of complications resulting from the presence of chronic illnesses. Even through a more cost-effective form of health care, there is evidence to support the NP is equal in clinical competence when compared to physician providers (Ulrich et al., 2003; Weiland, 2015; Zand, 2011).

Historical Perspectives on Nurse Practitioner Education

The National Council of State Boards of Nursing (NCSBN; n.d.) describes the NP as a nurse who builds on the competencies of a registered nurse by demonstrating a greater depth and breadth of knowledge than the baccalaureate-prepared RN. The NP must exhibit a greater analysis and synthesis of data with increased complexity of skills and interventions. Finally, the NP needs to embrace greater role autonomy in practice. The NP is a registered nurse, previously prepared at the baccalaureate level, and further educated at the graduate level in a specific role and patient population (NCSBN, n.d.).

To gain authority to practice, the NP must complete an advanced practice program at the graduate level and, in most states, successfully complete a certification examination. The certification examination provides a process for validation of an advanced practice nurse's qualifications and knowledge for practice. Certification examinations are reflective of entry-level practice. Regardless of the certification requirement of a particular state, all state boards in the US and certification examinations require a minimum of 500 supervised clinical hours through an educational program. Lastly, all states and certifying bodies require the graduate to complete a program accredited by either the American Association of Colleges of Nursing (AACN; 2013) or the National League for Nursing (NCSBN, n.d.).

The AACN (2013) evaluates graduate level NP programs based on one of the following guidelines: (a) the essentials of master's education in master's programs or (b) the essentials of doctoral education in doctoral programs. All NP programs are also evaluated on (a) criteria for evaluating nurse practitioner programs, (b) any other relevant professional standards focusing on NP education, and (c) the National Organization of

Nurse Practitioner Faculties' standards for NP education (AACN, 2013). Accreditation has proved to be beneficial; however, these standards evaluate the program's ability to produce qualified nurse practitioners based on an academic evaluation of designated competencies. The evaluation of role transition from an RN to the NP does not necessarily occur in the educational arena; rather this evaluation occurs during clinical employment through the evaluation of clinical outcomes (Boswell & Long, 2014).

Background

According to the IOM (2010b), advanced nursing education is vital to the profession of nursing. Advanced levels of education prepare nurses to assume the roles of the APRN, which are essential to the evolving health care system. The IOM's report called for APRNs to practice independently and to the full scope of their educational preparation while embracing the role of the autonomous provider. In these roles, the NP must deal with not only the increasing complexity of disease but also the complex nature of the care environment (American Association of Nurse Practitioners [AANP], 2010). As an autonomous provider, the NP must be able to transition from the role of the baccalaureate-prepared nurse to manage patients who present with undifferentiated signs and symptoms (Durham, Fowler, & Kennedy, 2014).

Role Transition

The transition to the NP remains challenging and coincides with a significant career adjustment. This role transition in some circumstances shifts the experienced expert RN to an inexperienced novice NP based on the presence of prior RN experience (Barnes, 2015b; MacLellan, Levett-Jones, & Higgins, 2015). Four defining attributes construct this transition: (a) absorption of the role, (b) shift from a provider of care to

prescriber of care, (c) straddling two identities, and (d) mixed emotions. The absorption of the role is part of the overall learning of the role during the time of transition from the RN to the NP. The shift from provider to prescriber includes a greater breadth of autonomy and responsibility in patient care and is both exciting and challenging; at the same time, it is intimidating for the new graduate NP. The straddling of two identities leaves the NP no longer performing the role of the RN and is not necessarily identified as a physician. The straddling of two identities requires the NP to move from the expert level to the novice level or possibly the novice level to the novice level if there is a lack of prior RN experience including periods of self-doubt. The final attribute, mixed emotions, represents 10 negative emotions and a single positive emotion occurring simultaneously. These emotions include frustration, stress, anxiety, and excitement, just to name a few (Barnes, 2015b; Durham et al., 2014).

Role transition includes both personal and environmental antecedents. The most notable of the personal antecedents is experience as there is a gap in the literature regarding this particular antecedent. Previous researchers failed to define experience as an antecedent to role transition. Much of the NP literature described experience as a necessary component in NP preparation and role transition; however, the types of experience remained unidentified. No formal studies identifying the relationship of prior RN experience to role transition were available. However, some scholars asserted prior experience as an RN provided a strong underpinning for the NP role transition. Nurse practitioners with less RN experience struggled through role transition and required additional time for role transition (Barnes, 2015b; MacLellan et al., 2015). Only one previous study reported no correlation between prior RN experience and transition to the

NP role (Barnes, 2015a). Coinciding with the personal antecedent of experience is the environmental antecedent of support. Previous researchers identified support as a significant experience in promoting role transition (Barnes, 2015b). Positive peer support is critical to a smooth transition to the NP role (MacLellan et al., 2015). Sources of support include experienced NPs, collaborating physicians, and other staff members of the health care system (Barnes, 2015b; MacLellan et al., 2015). Although previous research identified RN experience before entering an NP program and the experience of support upon entering the NP clinical practice role as necessary components of NP role transition, a gap in the literature left the experiences necessary for this transition undefined. In addition, previous researchers based their studies on the assumption that an RN entered NP education as an experienced expert RN and did not account for those individuals entering NP education without prior RN experience. Changes in educational and practice environments threaten to widen the knowledge gap regarding the experiences necessary to transition from the RN to the NP role.

Changes in Nurse Practitioner Educational Environment

In response to the need for an increased number of NPs nationally, educational institutions continue to recognize an increase in admission to NP programs. According to the AANP (2010), there are currently 600 million patient visits to NPs each year with increasing numbers of annual visits. As the demand for NP providers continues to rise, admissions to NP programs are also growing (AANP, 2010). In 2009, the AACN conducted a survey, which demonstrated an overall 50.5% increase in NP program enrollment at master's and doctoral levels with a 10.5% increase in graduation rates.

In light of this information, numerous educational institutions have eliminated or decreased the quantity of required prior RN experience as part of the standard admission requirement to allow for the growth of admissions to NP programs. More students in NP programs have limited or no previous clinical nursing experience. Historically, NP students entered advanced nursing education with prior RN experience. The lack of prior RN experience challenges the NP faculty member to examine teaching methods that support student growth and competency attainment (Durham et al., 2014). The transition from the RN to the NP proves to be challenging even for the experienced expert RN; based on previous research, there is no clear identification as to how prior RN experience affects the ability of the RN to transition to the NP role (Barnes, 2015b; MacLellan et al., 2015). Previous research deemed experience as an essential antecedent to NP role transition. However, a gap in the literature left the identification of the necessary experiences for this role transition poorly understood (Barnes, 2015b). Lack of prior nursing experience to foster enrollment growth might generate new challenges in the education of NPs and call for a change in NP curricula to address the elimination of this experiential component (Durham et al., 2014; IOM, 2010b).

Changes in the Nurse Practitioner Practice

The IOM (2010a) report called for a transformation in nursing practice. A key factor in this transformation is ensuring the ability of nurses to practice according to the full extent of their education, training, and licensure. The IOM provided a specific focus on APRNs as a notable factor in transforming the healthcare system as a whole. The AANP (2011) responded to this initiative by asserting the need to remove scope-of-practice barriers for the NP and asserted this was the only way to ensure NPs were

practicing to the full extent of their education and training. Current scope-of-practice barriers on NPs raise healthcare costs, decrease the quality of care, and limit access to health care for many Americans. Although the AANP was not asserting the need for expanded scope-of-practice or higher salaries, their recommendations included the removal of unwarranted restrictions placed on the current NP scope-of-practice. The IOM and the AANP both asserted the need to increase independent APRN practice due to a changing healthcare system. These organizations asserted eliminating practice restrictions in all 50 states of the United States would increase the availability of NP providers and meet the demands resulting from the United States' healthcare reform (AANP, 2011; IOM, 2010a).

Although an autonomous NP role is essential for NPs in an evolving healthcare system, researchers need to better understand the overall experiences during an NP's role transition (Barnes, 2015b; MacLellan et al., 2015). Previous evidence supported that physician oversight of the NP was unnecessary and there was no evidence to support a relationship between physician collaboration/supervision and quality of care (AANP, 2011). However, previous research on NP role transition assumed NPs entered clinical practice with physician collaboration agreements. Even though there was no evidence to support physician collaboration for providing high-quality care, a gap in the literature left the role of physician collaboration as a form of mentorship during role transition undefined. The nursing profession was left unsure as to how or if this factor would affect NP role transition (Barnes, 2015b; MacLellan et al., 2015).

Problem Statement and Research Purpose

An examination of the current literature uncovered gaps regarding experiences associated with NP role transition as well as physician collaboration as a form of mentorship (Barnes, 2015b; MacLellan et al., 2015). Educational institutions have increased enrollment while simultaneously eliminating/decreasing the quantity of prior RN experience required for admission into graduate-level programs (Durham et al., 2014). These gaps in the literature failed to establish or negate prior RN experience and physician collaboration as a form of mentorship as being associated with NP role transition. Elimination of prior RN experience and physician mentorship could have an unknown effect on the RN's ability to transition into the role of the NP.

In addition to prior RN experience and physician collaboration, other unidentified factors might be associated with NP role transition. It is imperative that future research studies focus on discovering experiences associated with the role transition of NPs. This research addressed current gaps in the literature to ensure educational programs and practice settings implemented strategies to maximize benefits and limit barriers to NP role transition. Discovery of these experiences could provide a focus for future inquiry regarding NP role transition, educational practices, and institutional support systems.

The purpose of this study was to explore the process of NP role transition and discover the lived experiences associated with this role transition.

Research Question

The following research question guided this study:

- Q1 What experiences do nurse practitioners identify as being associated with their transition to the NP role?

Theoretical Framework

The theoretical framework used to inform this study is fully described in Chapter II but is summarized here. This study was informed by transitions theory (Meleis, 2015), which has over the last few years developed into a mid-range theory. Although historically used in nursing practice, this theory has also found applicability in education and has been used to inform nursing curricula at numerous universities. This framework defines transitional circumstances that can either advance or hinder transition (Meleis, 2010). The transition is situational as the RN progresses to the NP through education and entry into clinical practice. Nurse practitioners can experience successful or unsuccessful transitions. One of the paradigms that contributed to the development of this theory is the lived experience. This specific paradigm within the theory allowed this researcher to focus questions related to the lived experience of role transition from the RN to the NP. This focus encompassed those experiences associated with role transition starting before the educational program, during the educational program, and upon entering clinical practice (Meleis, 2015).

Research Design

The methodology of this study is fully described in Chapter III but is summarized here. The principal investigator of this study chose a descriptive phenomenological approach to discover the experiences NPs cited as being associated with their transition to the NP role. The gap in the literature identified by this researcher was the overall experiences, whether they were beneficial or created barriers for role transition, were poorly understood. This principal investigator identified two potential changes to NP education and practice that might be eliminating experiences influencing NP role

transition. However, other unidentified factors might have influenced NP role transition including experiences before entering NP education, during NP education, and upon entering the first clinical role. Changes in both NP education and practice, elimination of experiences, and the non-identification of additional experiences influencing role transition could have had an unknown effect on the RN's ability to transition into the role of the NP.

Much remains unknown about the experiential components associated with NP role transition. Thus, phenomenology would be an appropriate qualitative methodology as it “describes the common meaning for several individuals of their lived experiences of a concept or phenomenon.... Phenomenologists focus on what all participants have in common as they experience a phenomenon” (Creswell, 2013, p. 76). In this dissertation, the phenomenon of interest was role transition. This approach was appropriate as the researcher sought to understand the experiences NPs cited as being associated with their transition to the NP role.

The participants of this study included nurse practitioners who (a) were currently certified in one of six recognized nurse practitioner certification categories, (b) were self-identified as currently practicing as a nurse practitioner on a full-time basis, (c) had practiced as a nurse practitioner for a minimum of one year to a maximum of three years, (d) had a minimum of one year of RN experience prior to entering the NP role, and (e) had a physician collaborator in their first NP role. The six recognized nurse practitioner categories included (a) family/individual across the lifespan, (b) adult-gerontology, (c) neonatal, (d) pediatrics, (e) women's health/gender-related, and (f) psychiatric-mental health. Both primary and acute care certifications within the population foci categories

were accepted for inclusion into the study. A purposeful sampling technique was utilized to recruit participants with the selected characteristics. Purposeful samplings “are those who know the information required, are willing to reflect on the phenomena of interest, have the time, and are willing to participate” (Richards & Morse, 2013, p. 221). A snowball sampling technique was used to gain additional participants.

Significance to Nurse Practitioner Education and Practice

This study explored the process of NP role transition and discovered the lived experiences of NPs associated with NP role transition. The researcher hoped the findings from this study would inform nurse educators and practice administrators of the experiences, which would assist NPs in successful role transition and limit experiences that emerged as barriers. In the educational and practice settings, this might help nurse educators refine current and develop new curricular methods and help institutional administrators offer support mechanisms to promote experiences beneficial to role transition and limit barriers. Findings from this study might lead to additional research on NP role transition.

Summary

Nurse practitioners are called to address the challenges of healthcare reform by providing high-quality patient care autonomously. This call necessitates an increase in the number of NPs, thus encouraging educational institutions to increase admissions to NP programs to meet the healthcare demand while maintaining high-quality healthcare providers. Due to changes in NP education and practice, understanding role transition becomes important for both the nurse educator and practice administrators. The purpose of this study was to explore the process of NP role transition and discover the lived

experiences associated with this role transition. Using a phenomenology method, the principal investigator of this dissertation sought to understand the process of NP role transition. This study utilized transitions theory, which assisted this researcher in understanding the overall process of role transition for the NP.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction and Overview

The purpose of this study was to explore the process of NP role transition by discovering the lived experiences associated with this transition. Literature findings related to NP role transition from the RN to the professional practice of the NP were explored to provide insight into this topic. The research was reviewed from both NP practice and educational perspectives. This review of literature continued as new findings helped inform the data collection, analysis, and synthesis chapters of this study.

For this study, this principal investigator conducted literature searches within a range of 1997-2017. The rationale for this period was Brown and Olshansky published their seminal work on NP role transition in 1997. The search utilized the CINAHL Plus and Academic Search Premier databases within the EBSCO database. Additional references were located through reference lists in scholarly work and the use of MEDLINE and PubMed databases. Major search terms included *role*, *nurse practitioner*, and *transition*. Combinations of those terms were used to enhance the discovery of scholarly material. The PubMed database identified pertinent literature under major MeSH search terms of *nurse practitioner* and *role development*. This literature search was limited to research that focused on NP role transition. Additional research that

focused on educational strategies and educational outcomes was not included as this was not the focus of this study.

This chapter includes four sections. The first section identifies the role of the NP and the importance of NP role transition through the development of hallmark skills. The second section identifies and summarizes current research on role transition antecedents. The third section summarizes gaps in the literature related to NP role transition and describes how this study identified the gaps. The final section describes the theoretical framework that influenced this study.

The Role of the Nurse Practitioner

The purpose of this section is to summarize the literature on the role of the NP as compared to the RN and the influence role transition has on the NP in providing quality care. As part of the role transition, the NP must be able to build on the knowledge and skill set of the RN to obtain the hallmark skills of the NP. The undergraduate RN utilizes an established medical diagnosis to guide performance assessments and interventions. The role of the RN is not medical diagnosing but establishing interventions based on nursing diagnoses identified in response to an established medical diagnosis. In contrast, the role of the NP is to assess undifferentiated signs and symptoms, take into account the complexity of issues surrounding these signs and symptoms, establish a medical diagnosis, implement a plan of care, and evaluate the outcome of the plan of care. This process does not allow the NP to rely on a pre-determined medical diagnosis; rather, the NP develops diagnoses based on the subjective and objective assessments of undifferentiated signs, symptoms, and other complex factors. This process is termed diagnostic reasoning (Durham et al., 2014).

Diagnostic reasoning is the hallmark skill required by the NP to produce high-quality patient care. The NP must be able to transcend the knowledge and the thought processes of the RN to analyze undifferentiated signs and symptoms and utilize this analysis to establish diagnoses while planning for appropriate care (AANP, 2010). This higher level of knowledge allows the NP to make valuable patient care decisions while applying practical judgment in ambiguous situations, resulting in high-quality patient care (Durham et al., 2014; Ritter, 2003). Without successful role transition, diagnostic reasoning will not be fostered and might negatively impact patient outcomes and other factors related to NP clinical and professional practice (Durham et al., 2014).

Nurse Practitioner Clinical Practice

The ability to gather data through subjective and objective assessment with an underlying knowledge of disease pathophysiology and etiology assists the NP in effectively identifying a medical diagnosis in an undifferentiated situation. Identification of a medical diagnosis requires the NP to develop a list of differential diagnoses, correctly rule out unlikely diagnoses, and narrow the list to the correct medical diagnosis. Precise recognition of a diagnosis is imperative in developing and implementing a plan of care to treat a patient's disease process and evaluate patient outcomes. This ability allows the NP to ensure the patient is receiving the highest level of quality care (Harjai & Tiwari, 2009; Pirret, 2016; Pirret, Neville, & LaGrow, 2015; Rajkomar & Dhaliwal, 2011). The NP uses this increased level of knowledge and skill to identify the risks for disease development and provide health promotion/disease prevention education to patients to prevent disease development while also promoting high-quality and cost-effective care (Pirret, 2016). The effectiveness of this process has a potential to directly

affect three additional major factors in patient care and professional NP practice: (a) patient safety and outcomes, (b) healthcare finance, and (c) medical malpractice. Nurse practitioners are at the forefront of clinical care and called to provide high-quality care, which is equitable to traditional physician provider colleagues (Markewitz, 2013; Pirret, 2016; Pirret et al., 2015).

Patient Safety and Outcomes

The first elementary step in providing safe patient care is accurately assessing and diagnosing a patient's medical condition. This process assists the provider with correctly identifying the disease process, which then leads to an effective and successful treatment plan. Clinicians need to utilize these strategies to ensure patient safety and produce optimal outcomes. Although an essential step to ensure patient safety and produce optimal outcomes, this process is complex and error prone (Rajkomar & Dhaliwal, 2011).

An erroneous diagnosis might lead to the treatment of a non-existent disease. Every treatment modality including therapeutic, diagnostic, and pharmacologic interventions presents with both risks and benefits when using these modalities appropriately. Providing the wrong treatment to a patient due to a diagnostic error increases the patient's risk of adverse outcomes and places the patient at risk for safety concerns related to non-essential treatment. Diagnostic error also leads to a delay in treatment for the actual diagnosis and increases a patient's morbidity and mortality associated with the actual diagnosis, producing suboptimal outcomes (Rajkomar & Dhaliwal, 2011).

Shojania, Burton, McDonald, and Goldman (2003) conducted a systematic review of post-mortem autopsy results and recognized that at least 5% of autopsy reports

demonstrated diagnostic error as the cause of death. Death in the cases reviewed revealed a two-fold cause. First, inappropriate treatment interventions based on an erroneous diagnosis increased the patient's risk for unintended and unnecessary injury because of the side effects of the interventions. Side effects attributed to inappropriate treatment might lead to patient death. Second, an erroneous diagnosis causes a deficiency in treating the true underlying disease process. Untreated disease might lead to long-term chronic disease, deterioration of the patient's medical condition, and, ultimately, death resulting from an untreated disease process (Rajkomar & Dhaliwal, 2011; Shojania et al., 2003). In addition to patient safety and outcomes, effective diagnosing affects financial reimbursement of practices and institutions.

Healthcare Finance

Astronomical costs from preventable medical errors are a major source of increased healthcare dollars in the United States. Over the last few years, the healthcare industry recognized an eight-fold increase in healthcare costs due to medical error. According to the Institute of Medicine, in 1999, an estimated 44,000-98,000 deaths were directly attributable to diagnostic/medical error (Cassatly & Mitsch, 2011). These deaths were a direct result of diagnostic/medical error and resulted in approximately two billion dollars of additional healthcare-related costs. In 2008, a study by the Health Section of the Society of Actuaries (cited in Cassatly & Mitsch, 2011) reported an increase in healthcare costs from diagnostic/medical error—a total of \$19.5 billion. A governmental analysis of Medicare recipients projected an estimated 15,000 deaths per month secondary to diagnostic/medical errors (Cassatly & Mitsch, 2011).

In light of these stifling outcomes, Congress passed the Tax Relief and Health Care Act of 2006, which prevented the payment of healthcare services in the presence of a preventable diagnostic/medical error. The Center for Medicaid and Medicare Services (Cassatly & Mitsch, 2011) developed a system to identify preventable adverse patient outcomes and now denies or significantly reduces healthcare reimbursement in the presence of these adverse outcomes. Preventable errors causing injury or death to a patient cause the medical institution to bear sole financial responsibility (Cassatly & Mitsch, 2011). Numerous diagnostic/medical errors are preventable through diagnostic accuracy (Harjai & Tiwari, 2009; Rajkomar & Dhaliwal, 2011; Shojania et al., 2003)

Preventable diagnostic/medical errors, also termed never events, most commonly happen as a direct result of improper care and prolonged hospitalization. As a response to this problem, healthcare systems implemented screenings for all identified preventable diagnostic/medical errors on admission to decrease the incidence of negative financial impact. However, costs associated with these screenings continue to increase healthcare dollars. Routine screenings for all possible preventable diagnostic/medical errors might disregard the importance of an effective diagnostic ability and the important role of a thorough assessment in preventing diagnostic/medical errors. Even with the use of routine screening when appropriate, the NP must be able to utilize a deeper breadth of knowledge and skill to apply the results of these screenings to overall, complex patient cases (Weingarten, 2013).

Diagnostic/medical errors are preventable adverse outcomes as a direct result of improper health care or other system related factors. Inappropriate diagnosing is a cause of medical mismanagement and an improper diagnosis can lead to adverse outcomes

from the progression of the undiagnosed illness. More than 50% of medical costs from medical injury are a direct result of a diagnostic/medical error. Diagnostic and medical errors include a missed diagnosis, inappropriate care for a diagnosis, or a preventable consequence of a medical condition the provider failed to prevent or recognize. More than 400,000 are preventable diagnostic/medical errors, thus increasing healthcare cost by \$3.7 billion per year. Diagnostic/medical errors reflect approximately 72% of total health care costs (VanDenBos et al., 2011). The financial impact of diagnostic/medical errors does not account for costs related to lawsuits produced by medical errors (Cassatly & Mitsch, 2011; VanDenBos et al., 2011).

Medical Malpractice

Legally defined, medical malpractice contains the following essential elements: (a) a duty to the patient, (b) the clinician failing to meet a recognized standard of care, and (c) the patient suffering injury as a direct result of the failure to meet a recognized standard of care. Medical malpractice might result from the inability to identify a diagnosis correctly, inappropriate treatment for a diagnosis, lack of treatment for an unrecognized diagnosis, or failure to follow policies and procedures in place to safeguard the patient (Zientek, 2010). An increase in medical malpractice suits has been observed in the physician practice realm, which historically does not extrapolate to NPs. Although still less than physician colleagues, over the last few years the National Nurse Practitioner Data Bank (Carson-Smith & Klein, 2003) reported an increase in NP malpractice lawsuits including scope of practice issues, inappropriate anesthesia, and incorrect diagnosis.

The average award for a malpractice claim is about \$799,000. Although physician-based lawsuits have historically yielded a higher award, NPs have now recognized a significant increase in malpractice award payments (Canady, 2016). In addition to malpractice awards, defense costs are also on the rise. An analysis of 26,853 malpractice claims yielded a mean malpractice defense cost ranging from \$22,959 to \$64,646. A noted difference in malpractice defense costs was based on specialty service. For instance, malpractice defense costs for cardiology and oncology yielded a mean range of \$78,890 to \$83,056 while nephrology, ophthalmology, and dermatology yielded a mean range of \$7,283 to \$24,007 (Seabury, Chandra, Lakdawalla, & Jena, 2012). Although not all malpractice claims related directly to an error in diagnosis, a fair number of claims arose from failure to appropriately diagnose and treat patients. A retrospective review analyzed 156 post-mortem malpractice cases and determined 56% of those cases directly related to an erroneous diagnosis (Harris & Peeples, 2015).

The NP must be able to assess undifferentiated signs and symptoms, develop a medical diagnosis, and develop plans of care to ensure safe patient outcomes. The NP must be able to identify risk factors for disease development and provide necessary interventions to promote wellness and disease prevention. As part of role transition, NPs must develop these skills as a necessary component to ensure they are functioning with the hallmark skills needed to produce high-quality and cost-effective care. Effective role transition ensures a reduction in unnecessary healthcare spending and a decrease in the incidence of adverse events leading to litigation (Carson-Smith & Klein, 2003; Cassatly & Mitsch, 2011; Harjai & Tiwari, 2009; Markewitz, 2013; Pirret, 2016; Pirret et al., 2015; VanDenBos et al., 2011).

Nurse Practitioner Role Transition

The purpose of this section is to present and review current literature with regard to NP role transition. This section is followed by a synthesis to identify and summarize gaps in the literature and their relationship to the research methodology. Numerous researchers asserted NP role transition is challenging, stressful, and complex. Previous research identified the challenges, stressors, and rewards experienced during role transition (Barnes, 2015b; Kelly & Matthews, 2001; Steiner, McLaughlin, Hyde, Brown, & Burman, 2008). Prior research focused on the NP in primary care with one study focusing on the NP in acute care, one study focusing on the NP in emergency care, and two studies focusing on the NP in neonatal care. It is important to note that at this time of this literature review, the NP in emergency care was not an official NP population focus identified by the consensus model (American Nurses Association [ANA], 2007). A review of two concept analyses on NP role transition revealed experiences influencing role transition (Barnes, 2015b; Kelly & Matthews, 2001; MacLellan et al., 2015; Steiner et al., 2008). This section contains a presentation of the relevant literature regarding experiences that influence NP role transition.

Identifiable experiences related to role transition were formulated based on Brown and Olshansky's seminal work in 1997 (Barnes, 2015b; MacLellan et al., 2015). In this seminal work, a theoretical model of the role transition for NPs in primary care was developed through the use of grounded theory methodology and describes the experiences of NPs during their first year of practice (Brown & Olshansky, 1997). Identified experiences influencing NP role transition included (a) graduate-level education, (b) prior RN and work life experience, (c) engagement in the NP role, (d)

mentorship from experienced NP colleagues, and (e) physician collaboration (Barnes, 2015b; Brown & Olshansky, 1997; MacLellan et al., 2015).

Graduate Level Education

Nurse practitioners must complete a minimum of a master's level graduate education to achieve certification and licensure in the United States. Regardless of state-based certification requirements, all 50 states have a graduate-level education requirement to earn licensure as an NP (NCSBN, n.d.). Standards of accreditation from the AACN (2013) and the National League for Nursing (n.d.) are the basis of NP educational requirements. The National Organization of Nurse Practitioner Faculties (NONPF; 2017) sets standards for NP education nationally. Professional organizations that provide scopes and standards of NP practice within particular population foci lend additional requirements for NP education. Each educational institution has academic freedom to execute NP education through methods that adhere to their instructional mission, vision, and education philosophy but the basis of education must adhere to the aforementioned standards (AACN, 2013; AANP, 2010; ANA, 2007; NCSBN, n.d.).

Three previous research studies were identified that focused on the influence of graduate-level education regarding NP role transition. Joyce, DiGiulio, Jadotte, and Dreker (2014) completed a systematic review on faculty strategies that influenced student transition from the RN to the NP. The focus on their study included NPs working in adult, family, and pediatric primary care settings during their first year of practice. Heitz, Steiner, and Burman (2004) examined the role transition that occurred in family NP students with a focus on educational aspects that contributed to role transition. Brown and Olshansky (1998) conducted an earlier study on the challenges of becoming a nurse

practitioner during the first year of practice. Authors of these studies all agreed that graduate level education was necessary for NP role transition since it is a requirement for NPs to gain certification and licensure as an NP. Actual factors of graduate level education that influence NP role transition remain poorly understood. Likely NP role transition factors in graduate level education remain unidentified (Brown & Olshansky, 1998; Heitz et al., 2004; Joyce et al., 2014).

Graduate level education is integral to the role transition of NPs. Nurse practitioners are required to embark on graduate level education as a requirement for certification and licensure (Brown & Olshansky, 1998). Previous researchers asserted that NP role transition begins but does not occur solely in the educational setting (Joyce et al., 2014). Nurse practitioner students begin NP role socialization during graduate level education (Heitz et al., 2004). This role socialization is influenced by faculty guidance, mentorship, and educational methods/activities provided during the educational journey (Joyce et al., 2014). Although this socialization is important for role transition, guidance, mentorship, and curricular strategies provided by NP faculty are not sufficient to produce full transition into the NP role. Nurse practitioners reported the educational process did not sufficiently prepare them for the feeling of discomfort that occurred during the transition from the expert RN to the novice NP (Brown & Olshansky, 1998). Nurse practitioners reported difficulty in relinquishing their status as an expert RN and taking on the status of a novice NP. Nurse practitioners indicated they had unrealistic expectations when taking on the NP role (Brown & Olshansky, 1998; Heitz et al., 2004; Joyce et al., 2014).

Previous researchers asserted full role transition does not occur until the completion of the first year of NP practice. During this transition, there are likely experiences the NP reflected on as he/she entered his/her first clinical role that influenced his/her role transition (Joyce et al., 2014). One of those experiences is the interaction with a clinical preceptor during practicum experiences; however, this was not clearly identified or delineated in the research as a benefit or barrier to NP role transition (Joyce et al., 2014). Curricular methods might prove to be a benefit or barrier to NP role transition; however, specific curricular methods benefitting or inhibiting role transition have not been identified clearly (Brown & Olshansky, 1998). Other unidentified experiences likely occurred throughout graduate level education that influenced NP role transition. Additional research is needed to discover experiences within graduate level education that influenced NP role transition (Brown & Olshansky, 1998; Heitz et al., 2004; Joyce et al., 2014).

Prior Registered Nurse and Work Life Experience

Experience is important for both skill acquisition and developing competency. Experiences can be useful during a role transition to build on prior knowledge, skill, and competency (Benner, 2001). Four previous research studies were identified that focused on the influence prior experience had on NP role transition. Barnes (2015a) conducted a study examining the relationship among role transition, prior RN experience, and a formal orientation in the first NP position. Heitz et al. (2004) examined the role transition that occurred in family nurse practitioner students and the influence prior RN experience had on this transition. Kelly and Matthews (2001) conducted a qualitative study on the effect prior RN experience had on role transition. Steiner et al. (2008)

conducted a quantitative study on the effect prior RN experience had on role transition. The authors of these studies concluded that prior RN experience was not defined nor confirmed as a promoter or an inhibitor of role transition. Future research would be beneficial in determining the influence of prior RN experience on role transition (Barnes, 2015a; Steiner et al., 2008).

Historically, prior RN experience was revered as a necessary component of the RN becoming an NP (Durham et al., 2014; Kelly & Matthews, 2001). However, available research provided conflicting conclusions with regard to prior RN experience and the influence this experience had on NP role transition. In one previous research study, prior RN experience had a weak, but positive, correlation on NP role transition after the application of a Bonferroni correction to the data. Before this correction, there was a negative correlation between prior RN experience and NP role transition (Steiner et al., 2008). In another research study, prior RN experience was not a promoter or inhibitor of NP role transition (Barnes, 2015a). Both of these researchers asserted their conclusions left the actual influence of prior RN experience on NP role transition as unknown (Barnes, 2015a; Steiner et al., 2008).

Prior RN experience might provide a foundation of confidence and an ability to build on prior knowledge to make good clinical decisions (Kelly & Matthews, 2001). While providing a foundation for NP knowledge and practice, the NP with prior RN experience must be able to recognize the importance of incorporating and building upon their RN role to attain the advanced knowledge and skill of an NP (Heitz et al., 2004). During NP role transition, NPs with longer periods of RN experience reported the same challenges as NPs with less RN experience (Kelly & Matthews, 2001). Prior RN

experience might prove to be a benefit or inhibitor of NP role transition. Nurse practitioners with less RN experience might or might not have the appropriate knowledge to build upon while engaging in the NP role while NPs with longer periods of RN experience might face more difficulty in fully engaging with the NP role (Heitz et al. 2004; Kelly & Matthews, 2001). Lastly, there might be a difference in the influence of prior RN experience based on quality vs. quantity of experience. The number of years and type of prior RN experience might be influential to NP role transition. The influence of prior RN experience has not been clearly defined (Heitz et al. 2004; Kelly & Matthews, 2001). Nurse practitioners with prior experience as an expert RN might have feelings of discomfort, uncertainty, and insecurity when returning to the novice role (Kelly & Matthews, 2001).

Prior experience in general also remains poorly defined. Available research on NP role transition was dated. With the changes in and complexity of NP education and practice today, new research is imperative in understanding NP role transition within this new, complex context. It is unknown whether prior experiences are limited to RN experience or overall work life experience. Prior experiences outside of working in the RN role might have an influence on the RN's ability to transition to the role of the NP (Barnes, 2015a). Future research is needed to discover if prior RN experience is an influential factor on NP role transition. Future research should focus on identifying all experiences that influence NP role transition (Barnes, 2015a; Heitz et al., 2004; Kelly & Matthew, 2001; Steiner et al., 2008).

Engagement in the Nurse Practitioner Role

Three previous research studies were identified that focused on the influence of prior experience regarding NP role transition. Fleming and Carberry (2011) conducted a grounded-theory study to discover experiences of expert critical care nurses in their transition to the role of an NP within the critical care setting. Chang, Mu, and Tsay (2006) explored novice NP feelings of role confidence. Kelly and Matthews (2001) conducted a qualitative study that attempted to understand the engagement of the new NP in the clinical role. Authors of these studies concluded that NPs transitioning from the role of an expert RN felt insecure in their role and ability during the transition period (Chang et al., 2006; Fleming & Carberry, 2011; Kelly & Matthews, 2001).

The RN who is engaging in the role of the NP progresses through three phases in the role transition process (Chang et al., 2006). The first phase of engagement requires the new NP to understand the reality of the new role versus the idealized role. This phase requires the NP to relearn the role of the NP and return to the novice level. In phase two, the NP must clarify the understanding of the new role while building on the previous focus of the RN role. In phase three, the NP must embrace the NP role completely and implement his/her abilities within the newfound role (Chang et al., 2006). To some extent, the new NP must disengage with the previous expectations of an RN and engage into the role of the NP with newfound expectations and knowledge building (Kelly & Matthews, 2001). The NP's feelings of insecurity and uncertainty impact these phases (Fleming & Carberry, 2011; Kelly & Matthews, 2001).

The ambiguity of the NP's actual role and function further impacts the feelings of insecurity and uncertainty. This ambiguity results from unclear or not well understood

role delineations (Kelly & Matthews, 2001). Previously, NPs reported that when working within interdisciplinary teams, there was a lack of clarity regarding their actual role within the team. These NPs also felt the interdisciplinary team was unclear regarding the NP's role within the team dynamic (Fleming & Carberry, 2011). These unclear role delineations might lead to the NP functioning as an RN within the team and not allow the NP to engage in the NP role. More research is needed to understand factors that assist the NP in moving past the RN role and fully engaging in the role of the NP (Chang et al., 2006; Fleming & Carberry, 2011; Kelly & Matthews, 2001).

Mentorship from Experienced Nurse Practitioner Colleagues

Five previous research studies were identified that focused on the influence of mentorship relating to NP role transition. Hayes (1998) wrote a seminal study focusing on the role of the clinical preceptor mentor relationship. Cusson and Viggiano (2002) expanded Hayes' seminal work on mentor-mentee relationships and explored the relationship of mentoring for NPs in neonatal care. Barker (2006) further investigated the role of mentorship for NP transition. Harrington (2011) also explored the role of mentorship in NP transition to develop a model of NP mentorship. Leggat, Balding, and Schiftan (2015) referenced Hayes' seminal work and expanded it to explore the relationship between formal mentoring programs and a novice NP's ability to develop the clinical leadership competency required for the advanced practice role within an Australian healthcare system. Authors of these studies concluded the role of the clinical preceptor mentor relationship is important in NP role transition (Hayes, 1998; Cusson & Viggiano, 2002). Adding depth to the meaning of the NP student/clinical preceptor relationship and evaluating the impact mentoring experiences has on the student's ability

to transition to the NP role are necessary (Hayes, 1998). Mentorship must begin with a short-term clinical preceptor and move into a long-term senior NP mentorship role with clear goals and objectives (Barker, 2006; Harrington, 2011; Leggat et al., 2015).

The mentoring process is designed to bridge the gap between the educational process and clinical practice as an NP (Barker, 2006). The mentor can assist the new NP in role clarification and the development of key NP competencies required for a specific specialty/focus. A model for mentoring new NPs could accelerate their role transition and fill the gap of provider shortages. The function of mentoring should focus on both career and psychosocial aspects of role transition. The career aspect of mentorship assists the NP in transitioning into the clinical and non-clinical functions of the role. The psychosocial aspect of mentorship assists the NP in developing confidence and a better self-image (Harrington, 2011).

The mentor-mentee relationship includes a short-term preceptor mentor and a long-term institutional mentor (Barker, 2006). Hayes (1998) conducted seminal work on short-term mentorship in the form of the clinical preceptor. The relationship between students and the NP preceptor during graduate level education might influence the student's confidence in taking on the NP role and transitioning from the role of the RN. A positive correlation was identified between mentoring of a clinical preceptor and an NP student's self-efficacy. However, students reported lower self-efficacy scores on items not related directly to the NP clinical focus such as (a) career planning, (b) professional activities, (c) research, and (d) consultation (Hayes, 1998). This form of short-term mentoring is beneficial for successful role transition in the clinical aspect of the role (Leggat et al., 2015).

Although Hayes' (1998) research was beneficial in identifying mentorship roles in the form of a preceptor, other mentorship opportunities are available as students graduate and enter NP clinical practice. Mentorship is also defined as a long-term relationship after the experience of a preceptor to promote role transition with an end goal of achieving expertise in the aspects of the NP role (Cusson & Viggiano, 2002). Preparation for role transition should begin with a short-term preceptor mentorship during graduate level education and continue with institutional supports, promoting long-term mentorship as the student enters NP clinical practice (Barker, 2006; Cusson & Viggiano, 2002). These supports will assist in strengthening their functions in the NP role and enhance role transition to the NP (Barker, 2006; Cusson & Viggiano, 2002; Leggat et al., 2015).

Regardless of the types of mentorship, clear goals must be set to ensure a successful mentorship and transition (Harrington, 2011). The effective mentor recognizes the potential in the mentee and mobilizes internal resources of that mentee to promote transition into the role. For mentorship to be successful, mentors and mentees must engage in a conversation to set expectations and objectives for the mentoring relationship and determine an end to the mentoring relationship. Mentoring is not meant to be infinite and promote dependence; rather, it is a finite relationship allowing the mentee to become independent and recognize other sources of support beyond the mentoring relationship. A mentoring relationship begins in the educational setting and continues into the first clinical position (Barker, 2006).

In addition to long-term and short-term mentorship relationships, mentoring is also described as formal and informal. Formal mentorship is organizational in nature and delivered by the institution whereas an informal mentorship develops as the mentor and

the mentee grow their relationship (Harrington, 2011). Growth in the mentor-mentee relationship supports the NP's ability to build skills within the workplace interdisciplinary relationship, focuses novice NPs on future trends that influence the work environment, and promotes advocacy for changes that constructively influence the future of the NP role (Leggat et al., 2015). Implementation of a mentorship program also influences an NP's ability to take on clinical leadership. Clinical leadership influences clinical care, policy, and engagement in all aspects of health care, both professionally and clinically. Mentorship programs enhance the NP's clinical leadership ability, thus improving the NP's ability to lead clinical collaboration initiatives and improve systems of care (Leggat et al., 2015).

Evidence supported mentorship programs as a benefit to NP role transition. Utilization of both short-term and long-term mentorships is beneficial in assisting the NP to progress with more independence (Barker, 2006). The majority of previous literature focused on developing effective NP mentorship programs (Barker, 2006; Harrington, 2011). Further research on the NP's experience with mentorship would be valuable in identifying factors that make mentorship beneficial to role transition and those that might present a barrier. This research would assist institutions with developing strong mentorship programs (Leggat et al., 2015).

Physician Collaboration

Three previous research studies were identified that focused on the influence of physician collaboration relating to NP role transition. Barton (2006) conducted an ethnography-focused study exploring physician collaborators and their influence on new-to-practice NP transition. This particular study included only physicians as participants

and focused on physician collaborators' experiences with mentoring NPs. Bailey, Jones, and Way (2006) conducted a narrative analysis of physician and nurse practitioner collaboration from the perspectives of both NPs and physicians. O'Brien, Martin, Heyworth, and Meyer (2009) conducted a phenomenology study on the experiences of collaboration between NPs and physicians within the context of long-term care facilities. Authors of these studies concluded the role of the physician collaborator and the impact of this collaborative relationship had an unknown influence on NP role transition (Bailey et al., 2006; Barton, 2006; O'Brien et al., 2009).

Physician collaboration is part of the legalities of NP clinical practice in many states across the United States. However, physician collaboration is also a mechanism of support for the new-to-practice NP undergoing transition. Physician collaboration might serve as a mentoring relationship that influences NP role transition (Bailey et al., 2006; Barton, 2006; O'Brien et al., 2009). Previous research identified inconsistencies in the interpretation of the collaborative relationship between the physician and the NP. These inconsistencies contributed to confusion in understanding if this collaborative relationship was beneficial or inhibitory in NP role transition (Bailey et al., 2006; Barton, 2006).

Overall, physician collaborators lacked clarity with regard to the role and scope of practice for the NP upon taking on a collaboration/mentorship agreement. Nurse practitioners also agreed their role was not truly understood by physician collaborators (Bailey et al., 2006, Barton, 2006). Physician collaborators stated they maintained clinical authority over the NP as they were unsure of the regulatory clinical authority an NP was able to possess (Barton, 2006). Both physicians and NPs acknowledged

philosophical differences in patient care focused on disease prevention and health promotion (Bailey et al., 2006). Physician collaborators recognized the uniqueness of the NP population in their clinical knowledge base and philosophical focus of care.

Applying physician-based clinical knowledge benchmarks to the NP population was not beneficial to the development, competence, and transition of the NP (Barton, 2006).

Physician collaborators reported a greater sense of collegiality between the NP and the physician, which they believed promoted quality health care (Barton, 2006). Nurse practitioners also reported a greater sense of collegiality through the collaborative relationship (O'Brien et al., 2009). However, physician collaborators also acknowledged that if NPs were successful in role transition, knowledge development, and competency attainment, this would challenge the professional boundaries between nursing and medicine. As NP mentees became more competent and independent in their role, the physician collaborators described mixed feelings of support and hesitation for their success (Barton, 2006). This likely could present a barrier to the NP's role transition when under the mentorship of a physician collaborator. However, there is no clear evidence to support this assertion.

While negotiating a collaborative relationship, NPs and physicians expressed certain valued behaviors within this relationship (O'Brien et al., 2009). Four behavioral themes emerged as valued in a collaborative relationship: (a) approachability, (b) interpersonal skills, (c) listening, and (d) verbal message skills. However, their understanding and expectation of these behaviors varied (O'Brien et al., 2009). There were differences in the understanding of a collaborative relationship between the physician and the NP (Bailey et al., 2006).

With regard to approachability, both agreed this was a valued behavior. However, physician collaborators valued NP partners who were well controlled under stress and could convey even-tempered exchanges while NPs wished physicians would control their tempers under stress and limit pressured, negative judgments while promoting equity in patient assignments for the jobs “no one wanted to do” (O’Brien et al., 2009). With regard to interpersonal skills, both agreed this was a valued behavior. Interpersonal skills included the acceptance of each other’s limitations and work styles while maintaining open communications. Physicians felt as though the quantity and quality of interpersonal interactions were sufficient to produce an effective working and mentoring relationship. However, NPs felt as though they had to accommodate the physician's work style while physicians were less likely to accommodate to the NPs’ work style. Nurse practitioners felt as though they wanted more face-to-face time and open communication with the physician collaborator (O’Brien et al., 2009). With regard to listening, both agreed this was a valued behavior and both agreed the listening behaviors of their counterparts could be improved. Physicians sought more active listening from the NP when receiving responses to questions. Nurse practitioners desired active listening from physicians and valuing of knowledge and education when setting mutual goals of quality patient care (O’Brien et al., 2009). Lastly, both agreed verbal message skills were a valued behavior. However, physicians would have liked their NP counterparts to assume a complementary role and preplan their verbal messages to relay complete and accurate information that is timely and brief. In contrast, NPs wanted their physician collaborators to be more comprehensive with their rationale for decision-

making while articulating any problems that might arise in a sensitive, respectful manner (O'Brien et al., 2009).

As the previous research suggested, there was no clear indication as to whether or not physician collaboration was beneficial or inhibited NP role transition. A gap in the literature failed to identify the influence physician collaboration had on mentoring the new-to-practice NP. An agreement by both NPs and physicians indicated physician collaborators lacked clarity of the NP role (Bailey et al., 2006; Barton, 2006). Physician collaborators and NPs reported a greater sense of collegiality being formed between the NP and the physician, which they believed promoted quality health care (Barton, 2006; O'Brien et al., 2009). However, differences existed in the perception of valued behaviors within this relationship and philosophical differences in patient care practices (Bailey et al., 2006; O'Brien et al., 2009). Previous researchers indicated a formal orientation to the collaborative relationship would benefit both physicians and NPs (Bailey et al., 2006). Since the role of physician collaboration is not clear with regard to role transition, further research is needed to identify experiences that influence NP role transition. This research might help determine if physician collaboration has any influence on the transition process (Bailey et al., 2006; Barton, 2006; O'Brien et al., 2009).

Summary of Identified Gaps and Research Methodology

The purpose of this section is to synthesize the findings of available research to identify and summarize gaps in the literature and address how this study's research methodology could address the identified gaps. Although numerous research studies exist on the transition from the student to the new-to-practice RN, a review of the literature presented the principal investigator with limited research available on NP role

transition. Brown and Olshansky (1998) provided seminal research on NP role transition, which identified experiences influencing NP role transition. This research was focused on the NP in primary care, as other specialties were not prevalent at the time, and provided a framework for future research in the field. This literature review was limited to original research, systematic reviews, and meta-analyses. The majority of the available research on role transition focused on the NP in primary care, specifically the family nurse practitioner. Minimal research studies were available on other NP specialties. Previous research focused on the following experiences: (a) graduate level education, (b) prior RN and work life experience, (c) engagement in the NP role, (d) mentorship from experienced NP colleagues, and (e) physician collaboration.

With regard to graduate level education, previous educators agreed this factor influenced NP role transition. Previous researchers identified the need to further explore factors influencing the role transition of the NP within and outside of the educational environment. Additional unidentified experiences, both inside and outside of graduate level education, likely influenced NP role transition (Brown & Olshansky, 1997; Heitz et al., 2004; Joyce et al., 2014). Results conflicted on a correlation between role transition and prior RN experience. In addition, previous researchers suggested overall work life experience outside of RN experience might influence NP role transition. Also, unknown experiences likely influenced NP role transition relating to these factors. It would be beneficial to explore whether or not NPs found prior RN experience beneficial in their role transition (Barnes, 2015a; Chang et al., 2006; Fleming & Carberry, 2011; Heitz et al., 2004; Kelly & Matthews, 2001; Steiner et al., 2008). In the context of mentorship, previous research identified no clear recognition of experiences that made mentorship

beneficial for the RN transitioning to the NP role (Barker, 2006; Cusson & Viggiano, 2002; Hayes, 1998; Leggat et al., 2015). Lastly, although physician collaboration was a factor of support for the new-to-practice NP, no clear understanding was found regarding the influence of physician collaboration in NP role transition (Bailey et al., 2006; Barton, 2006; O'Brien et al., 2009). Numerous researchers asserted a need for further research. This research might help to confirm the influence of the above identified experiences related to NP role transition and identify additional experiences influencing role transition that have not yet been discovered (Barnes, 2015a; Brown & Olshansky, 1997; Chang et al., 2006; Fleming & Carberry, 2011; Heitz et al., 2004; Joyce et al., 2014; Kelly & Matthews, 2001; Steiner et al., 2008).

This review of literature provided insight into how certain experiences before NP education, during NP education, and post-NP education might influence NP role transition for a new-to-practice NP. However, previous researchers agreed a gap existed in the literature and knowledge regarding which factors influenced role transition and if these factors were a benefit or barrier to NP role transition. Most previous researchers asserted still unidentified experiences influenced NP role transition. In addition to published research studies, this principal investigator reviewed previous dissertations addressing factors related to NP role transition and concluded further research would be beneficial to either confirm current factors or identify other factors that might influence NP role transition (Barnes, 2013; Davis-Kennedy, 2014; Duke, 2010; Wallace, 2010; Wending, 2016; Withlow, 2015).

Theoretical Framework

The theoretical framework that informed this study was transitions theory (Meleis, 2015). According to Meleis (2010), transitions are prompted when there is a change in an individual or environment occurring from a critical event. The transition begins as soon as the individual foresees the event. For the purpose of this study, the event triggering the transition is the RN who decides to pursue graduate level education to change from the role of RN to the role as NP. As soon as this decision is made, the RN begins the process of transition (Meleis, 2010). This section gives an overview of transitions theory, identifies prior relevant research using transitions theory as a framework, and relates transitions theory to this particular study.

Overview of Transitions Theory

Transitions are a common nursing phenomenon as they occur in many different aspects of the profession. Some examples of transitions include (a) patients receiving care in the hospital who are preparing for discharge, (b) patients newly diagnosed with a life-altering disease, (c) a spouse of a patient receiving information of the development of a long-term illness, and (d) a student beginning his/her first position in nursing. The transition begins before the actual event takes place. For instance, a hospitalized patient begins transition to discharge as soon as the hospitalization occurs. More relevant to this study is a nurse who begins the transition to an NP upon making the decision to embark on graduate level education (Meleis, 2015).

Three paradigms have guided the development of transitions theory: (a) role theory, (b) the lived experience, and (c) feminist postcolonialism. These paradigms were instrumental in shaping and continuing the development of transitions theory over the last

40 years of its existence. These paradigms aided the evolution of this theory into a middle-range theory (Meleis, 2015). A brief explanation of each of these paradigms provides additional insight into the theory and its relevance to this current study.

Role theory. Role theory is an interactionist paradigm developed by Turner (2001) in 1978. Role theory assists in framing the type and nature of questions regarding the movement from one role to another. This assists the nurse in identifying the transition when taking on a new role or changing behaviors within a current role. From this theory, Meleis (2015) developed the role supplementation framework, which requires the nurse to identify factors necessary for the development of a new role. This theory and framework apply to both clinical and non-clinical circumstances (Meleis, 2015).

Lived experience. This paradigm transcends the historical empirical knowledge as a way of knowing. The subjective nature of experiential knowing, the lived experience, is more holistic in nature (Meleis, 2015). This subjective way of knowing can complement empirical ways of knowing. The perceived view developed out of this paradigm and led to the development of the transitions concept (Chick & Meleis, 1986). This paradigm assists researchers in focusing on the experience of the response to change and being in transition. These experiences can lead to new ways of knowing (Meleis, 2015).

Feminist postcolonialism. This paradigm focuses on a system that questions power relationships in societies and institutions. These power relationships can lead to society and political oppression that can influence the way change takes place and an individual's responses to change. This paradigm provides a framework for understanding the experience of transition. This understanding encompasses a multiple lens approach

and takes into consideration race, ethnicity, nationality, and gender as possible oppressive factors. To understand how individuals cope with transitions fully, these oppressive factors need to be taken into consideration (Meleis, 2015).

Paradigm relationship to this study. The three aforementioned paradigms have continued to shape transitions theory and assisted in making this theory applicable to this study. Role theory focuses on the movement from one role to another. In relation to this study, the role movement occurred from the role of the student to the role of the NP. The lived experience focuses on a subjective way of knowing using individual's experiences to generate knowledge about the experience of a transition. In relation to this study, the principal investigator used a phenomenology approach to study the experience of transition to the role of the NP, which was consistent with this theoretical framework in explaining the experience of transition. Feminist postcolonialism focuses on a power system that causes oppression and influences the experience of transition (Meleis, 2015). During the transition to the role of the NP, factors might cause oppression and a lack of successful transition. Identifying these factors from the experiences of those who undergo this transition would be beneficial to inform future research and interventions in relation to role transition.

Assumptions of the Theory

Assumptions within a theory are what is assumed to be true by the theorist prior to developing the theory based on personal values and biases. These assumptions assist the theorist and those using the theory to explain, predict, and understand phenomena (Chinn & Kramer, 2011). Meleis (2015) identified 11 assumptions related to transitions theory. The following four assumptions of the theory are summarized as they were

relevant to this study. First, a human being's responses are shaped by interactions with significant others and reference groups. For the purposes of this study, other NPs, physicians, health care providers, educators, preceptors, and institutional support systems might influence NP role transition. Second, situational change triggers a process of transition. The situational change in this study was the decision to embark on the journey to becoming an NP. Third, individuals experience a process in relation to change and have varied responses and outcomes. For the purpose of this study, factors that occurred prior to the decision to make a change, during the educational journey, and as the NP entered clinical practice might have influenced the NP's responses and outcomes to role transitions. Lastly, the environment influences an individual's ability to learn and enact new roles. For the purpose of this study, environmental factors might have influenced the ability to transition to the NP and enact a new role.

Components of Transition Theory

Transition theory is a conceptual framework to describe the experiences of individuals undergoing a change or growth in skills, goals, behaviors, and functions (Meleis, 2015). Transition is defined as "a passage from one life phase, condition, or status to another (Chick & Meleis, 1986, p. 237). Transitions theory includes four main components: (a) transition triggers, (b) properties of transition, (c) conditions of change, (d) patterns of responses and (e) intervention (Meleis, 2015). Each of these components is explored here as well as their relevance to this study.

Transition triggers. Transitions theory identifies four factors, known as change triggers, that prompt a transition experience: developmental, situational, health-illness, and organizational (Meleis, 2015). The transitional trigger relevant to this study was the

situational change trigger. Changes in a situation cause a transitional experience as the individual moves from one role to another. Examples of situational changes include (a) the nurse becoming a manager, (b) the nurse moving from novice to expert, or (c) the student nurse entering a new clinical site (Meleis, 2015). According to Schumacher and Meleis (1994), a situational change might include a change in a job role or scope of practice. For this study, the situational trigger was the decision to embark on the journey to becoming an NP. This decision led to an anticipated change in role and scope of practice and initiated the experience of transition.

Properties of transition. In addition to triggering a change event, transitions contain specific properties (Meleis, 2015: (a) time span, (b) process, (c) disconnectedness, (d) awareness, and (e) critical points (Chick & Meleis, 1986). The time span is the moment when the situational change comes to one's awareness (Meleis, 2015). For this study, situational change awareness occurred at the time when the individual decided to become an NP. The end of a transition is fluid and does not end until there is a mastery of the new role or the developing of certain competencies (Meleis, 2015). The end of the transition for this study would be when the NP became fully immersed in the role and developed necessary competencies to function in the role of the NP. The process property describes the experience of transition--a dynamic and fluid process (Meleis, 2015). The transition process of disconnectedness occurs through the process of transition when individuals identify with a break in their feelings of security with what is familiar to them as they work through the process of identifying with a new role (Meleis, 2015). For this study, the individual transitioning to the role of the NP would experience a period of disconnectedness as he/she went through the process of

relinquishing familiar roles to the unfamiliar NP role. Through this process, the individual would also develop awareness of the event and define/redefine the meaning of the change for him/her. Throughout this process, the individual would meet critical points or milestones, i.e., turning points in his/her transition to the NP role (Meleis, 2015).

Conditions of change. Once a change trigger initiates, both observable and unobservable behaviors are responses to the transition and influence the individual's experience of transition. These behaviors begin at the time of awareness of an anticipated change. The following conditions influence the experience of transition: (a) personal, (b) community, (c) societal, or (d) global. Self-expectations, the expectations of others, and the personal perception of other's expectations influence the experience of transition (Meleis, 2015). For this study, the principal investigator sought to understand the experience of NP role transition. The principal investigator was aware both observable and unobservable factors influenced the role transition and sought to discover those factors.

Patterns of response. Patterns of response occur through process and outcome indicators. These patterns of response portray a solid transition (Meleis, 2010). Patterns of response identify how an individual responds to a change event. From a nursing perspective, there are two sets of responses: process patterns and outcome patterns (Meleis, 2015). Process patterns are measured by the level of engagement in the transition along with actions and interventions. The process pattern measurements include (a) engaging, (b) location and being situated, (c) seeking and receiving supports, and (d) acquiring confidence (Meleis, 2015). First, responses can be measured by the

level of engagement the individual has in the transition. Second, the response can be measured by the individual's position within a system and his/her ability to interact with the system. This position and interaction allow for insight into how a person recognizes his/her position in the healthcare system. Lastly, the response can be measured by the individual's ability to handle new and conflicting demands in his/her new role (Meleis, 2015; Meleis, Sawyer, Im, Schumacher, & Messias, 2000; Schumacher, Jones, & Meleis, 1999).

The assessment of outcome patterns occurs throughout the transition. There are five outcomes: (a) mastery, (b) fluid and integrative identity, (c) resourcefulness, (d) healthy interaction, and (e) perceived well-being. The mastery outcome is identified by mastery of the role through the integration of goals into one's identity and a mastery of his/her environment. Fluid and integrative identity are the ability of the individual to go back and forth during a period of transition from the old role to the new anticipated role. Healthy interactions and connections are measured through the formation of new relationships and the maintenance of current relationships that offer support to the completion of the transition process (Meleis, 2015).

Interventions. Interventions are useful in role transition to ensure individuals meet the outcomes of the role transition. Interventions for a transition include (a) clarifying roles, competencies, and meanings; (b) identifying milestones; (c) mobilizing support; and (d) debriefing. While clarifying roles, competencies, and meanings, the individual determines the meaning attributed to the change in role (Meleis, 2015). In this study, the NP during the transition reflected on the meanings he/she applied to the role change. Identifying milestones is integral in managing the process of transition. This

milestone identification assists the individual and available supports to identify a need for specific intervention if the transition is not progressing (Meleis, 2015). In this study, NPs reflected on those milestones that influenced their role transition. Mobilizing support and resources set the stage for the person going through a transition to practice what he/she encounters (Meleis, 2015).

Transitions Theory in Research

The transition focus of this study informed nurse educators of the experiences during NP transition. This form of transition is defined as a situational transition. A review of literature identified transitions theory within nursing educational research. Some qualitative studies were identified (Meleis, 2010). Brennan and McSherry (2007) conducted a study exploring the transition and professional socialisation from healthcare assistant to a student nurse. Main themes that emerged identified positive and negative perceptions during this role transition along with the introduction of a new concept in this transition process known as “the comfort zone,” which provided an exploration of the reversal back to the healthcare assistant role from the role of the student nurse. Delaney and Piscopo (2007) conducted a study on nurses' experiences with transitioning from RNs to BSNs. The authors of this study found the transition from RN to BSN was congruent with an increase in the quality of patient care through an enhancement of nursing knowledge and practice. Sharoff (2006) conducted a study exploring how experienced, certified holistic nurses learned to become competent practitioners. The author of this study found a disconnect between the structure of traditional nursing and the need of nurses for continued personal and professional growth and development. Although focusing on RN role transition, these studies provided insight into the process

of role transition, the factors influencing role transition, and the outcomes of role transition. These findings were similar to the focus of this dissertation on NP role transition. A search of the ProQuest database uncovered qualitative dissertations using transitions theory as a framework to study specific factors in role transition. All of these dissertations concluded that further research would be beneficial to either confirm current factors or identify other factors that might influence NP role transition (Davis-Kennedy, 2014; Duke, 2010; Wallace, 2010; Wending, 2016; Withlow, 2015).

Summary

The transition to an NP is a stressful and challenging time consisting of a complex process that remained poorly understood in the literature (Barnes, 2015a). Entering the role of the NP requires more depth and breadth of knowledge with a different scope of practice from the role of the RN (AANP, 2011; NCSBN, n.d.). As part of the role transition, NPs must develop hallmark skills beyond the role of the RN to provide safe, quality patient care (Durham et al., 2014; Harjai & Tiwari, 2009; Pirret, 2016; Pirret et al., 2015; Ritter, 2003). Previous research on experiences influencing role transition concluded there were conflicting findings on how those experiences influenced NP role transition. Further research is need to discover the influence of these experiences and identify additional experiences related to NP role transition through a description of the process (Barnes, 2015a; Brown & Olshansky, 1997; Chang et al., 2006; Fleming & Carberry, 2011; Heitz et al., 2004; Joyce et al., 2014; Kelly & Matthews, 2001; Steiner et al., 2008).

Transitions theory was utilized as the theoretical framework to inform this study. Transitions theory infomed numerous qualitative studies and dissertations on role

transition as previously summarized. Although previous research focused on RN role transition, findings of these studies were similar to the focus of this dissertation. The studies provided an overall description of role transition, identified factors related to role transition, and specified outcomes recognized by role transition. The purpose of this study was to explore the process of role transition from the RN to the NP and discover the lived experiences associated with this role transition. Through this exploration, a description of the process was developed with an identification of the factors influencing role transition, making transitions theory suitable for informing this study (Meleis, 2015).

CHAPTER III

METHODOLOGY

Introduction and Overview

The purpose of this study was to explore the process of NP role transition and discover the lived experiences associated with this role transition. This chapter discusses the study approach and the method of inquiry used to answer the following research question:

- Q1 What experiences do nurse practitioners identify as being associated with their transition to the NP role?

This chapter includes a discussion of the research design, methods, and the standards of trustworthiness used to complete the research study. The design is described in detail in an effort to demonstrate agreement with the research question. Two major methods of research are identified: quantitative and qualitative.

Research Design

Quantitative Versus Qualitative Research

Quantitative research is a well-established method of inquiry while qualitative research is still in a stage of growth and development (Barnham, 2015; Yilmaz, 2013). Quantitative research methods investigate a known phenomenon according to numerical data and analyzed through mathematical methods known as statistics (Yilmaz, 2013). Data associated with quantitative research include the expression of number or

percentages (Barnham, 2015). As a form of empirical research, numerical data obtained are useful in testing a theory or hypothesis consisting of variables. These variables are in numerical form and analyzed with statistical methods. The purpose of quantitative analysis is to establish whether the selected theory or hypothesis explains the measurable phenomenon of interest (Yilmaz, 2013).

Qualitative research is more complex to define due to its multifaceted nature (Yilmaz, 2013). Qualitative research gives an in-depth understanding of attitudes and behaviors regarding the phenomenon of interest (Barnham, 2015). This form of research deals with findings that are not linked to statistical analysis. The phenomenon associated with qualitative research cannot be limited to isolated, predefined variables. A naturalistic approach is used to gather data to reveal in descriptive terms the meaning(s) individuals associate with their environment (Yilmaz, 2013). Qualitative research is associated with a deeper understanding of meanings derived from interrogative strategies instead of statistical analysis. Qualitative research produces an in-depth description of the phenomenon from the perspective of the research subject and uses the researcher as the primary instrument of data collection and analysis (Barnham, 2015). Qualitative research is useful in exploring a poorly understood phenomenon (Streubert & Carpenter, 2011).

Qualitative Method of Inquiry

Since qualitative research is used to explore a phenomenon that remains poorly understood, it proved to be a useful form of inquiry in this study. Limited research was available on the role transition of NPs and the overall experience of role transition remains poorly understood. Available literature focused on specific factors identified as

being associated with NP role transition. However, the conclusions of these studies had conflicting findings or identified the need for future research on NP role transition from a broader context. Available research indicated unidentified factors remain that are associated with NP role transition (Barnes, 2013; Brown & Olshansky, 1998; Fleming & Carberry, 2011; Heitz et al., 2004; Joyce et al., 2014; Leggat et al., 2015; O'Brien et al., 2009).

The research question was best answered using a descriptive phenomenology design. From a general perspective, phenomenology seeks to describe the common meaning of several individuals based on their lived experience of a phenomenon (Creswell, 2013; Streubert & Carpenter, 2011). Descriptive phenomenology is based on the philosophy of Husserl (1962) and aims at describing the essential and meaningful essence of experiences with a phenomenon (Willis, Sullivan-Bolyai, Knafel, & Cohen, 2016). The use of descriptive phenomenology offers the nurse scientist the ability to describe the lived experience and aspects of that experience. Furthermore, descriptive phenomenology involves the “direct exploration, analysis, and description of a phenomenon” (Streubert & Carpenter, 2011, p. 81). This form of phenomenology “stimulates our perception of lived experiences while emphasizing the richness, breadth, and depth of those experiences” (Streubert & Carpenter, 2011, p. 81).

According to VanManen (2014), “phenomenology does not just pose a problem to be solved or a question to be answered” (p. 37). Phenomenology seeks to describe meanings that arise from experiences. A phenomenologist is concerned with *wondering* and asking what a certain experience is like (VanManen, 2014). Based on the research question, a descriptive phenomenology method was used based on the *wonder* of the

experience of NP role transition. This design produced the ability to explore, analyze, and describe in a meaningful way the experiences associated with NP role transition from the lived experience of the NP. Knowledge discovered in this study contributed to the current body of literature regarding NP role transition and provided useful insight into practice and educational changes that might positively influence future NPs in their role transition.

Three steps are required for descriptive phenomenology: intuiting, analyzing, and describing. The first step—intuiting—required the principal investigator become immersed in the phenomenon of interest. The principal investigator became the tool for data collection by listening to descriptions of the phenomenon as described by the participants of the study (Streubert & Carpenter, 2011). The principal investigator was cognizant of avoiding “all criticism, evaluation, or opinion, and pay strict attention to the phenomenon under investigation as it is being described” (Streubert & Carpenter, 2011, p. 81). In this study, interviews allowed participants to describe experiences associated with their NP role transition in their own words. The participants fully described their experiences throughout the interviews without added criticism, evaluation, or opinion. This process is described in the data collection section of this chapter.

The second step of the process—analyzing—was to identify the concepts that gave common understanding to the phenomenon. As the descriptions of the phenomenon were collected from the participants’ perspectives, common themes began to emerge from the data (Streubert & Carpenter, 2011). Verbatim interview transcripts were analyzed to identify themes that emerged from the data. Hence, these themes represented

the commonalities of the NP role transition experience from the perspectives of the participants. This process is described in the data analysis section of this chapter.

The third step of the process—describing--was to communicate and provide a written description of the phenomenon through the perspectives of the participants. This description included critical elements of the phenomenon identified in the data (Streubert & Carpenter, 2011). The data contained critical elements and essences common to the lived experiences of NP role transition and described those essences in detail. This process is described in the data analysis section of this chapter.

Phenomenology seeks to describe the common meaning of several individuals based on their lived experience of a phenomenon (Creswell, 2013; Streubert & Carpenter, 2011). More specifically, descriptive phenomenology offers the nurse scientist the ability to describe the lived experience and the aspects of that experience related to a phenomenon (Willis et al., 2016). The purpose of this research was to explore the process of NP role transition and discover the lived experiences associated with this role transition. Descriptive phenomenology answered the research question using participants' lived experiences to develop an exhaustive description of the experiences nurse practitioners identified as being associated with their transition to the NP role. The use of direct quotations from the participants allowed new knowledge of the NP role transition process to emerge in the findings of the study through the description of the NP role transition process.

Role of the Principal Investigator

The role of the researcher in a qualitative study is to access the thoughts and feelings of participants included in the study (Sutton & Austin, 2015). According to Fink

(2000), a qualitative researcher utilizes a phenomenology method to acquire data based on participant experiences, which serves as an imprint of reality and the basis for empirically grounded conclusions. Creswell (2013) described the practicality of the researcher bracketing him or herself out of the study. The role of this principal investigator was multifaceted.

The primary responsibility of the principal investigator in this study was as a facilitator of knowledge development. Phenomenological researchers are interested in the subjective account of others and often use an interview technique to gather data. The description that develops through the accounts of those who have experienced the phenomenon serves as the knowledge base (Englander, 2012). To develop knowledge of NP role transition, the principal investigator served as the instrument of data collection. In other words, data collected in the study occurred using a human subject (the principal investigator) rather than using inventories, tools, or questionnaires (Denzin & Lincoln, 2003). Knowledge developed in this study included an exhaustive description of experiences nurse practitioners identified as being associated with their transition to the NP role. Data were derived from interviews using open-ended questions to extract participants' lived experiences with NP role transition. These interviews served as the primary data source for the research.

There needs to be an acknowledgment of the principal investigator's own bias to function as a facilitator of truth exploration. Bias occurs through previous knowledge, personal beliefs, opinions, literature reviews, and previous experience(s) with the phenomenon of interest (Barnham, 2015; Creswell, 2013; Yilmaz, 2013). Additional biases might arise during participant interviews and should be documented in a journal

(Creswell, 2013). Bias is not inherently negative in qualitative research. In fact, bias is unavoidable when conducting qualitative research. Ignoring or avoiding biases is not beneficial. Hence the researcher must exhibit reflexivity to reflect upon his/her own biases and articulate his/her positions and subjectivities so the reader understands the filters through which questions were asked, data were gathered and analyzed, and findings were reported (Sutton & Austin, 2015). Previous knowledge and experience with the phenomenon should not be cumulated with the participants' descriptions of their lived-experiences but might be useful in framing questions for the interview and setting a context to understand the descriptions provided by the participants (Streubert & Carpenter, 2011).

Prior knowledge and experience with NP role transition were acknowledged from the beginning of the study and the principal investigator was cognizant of identifying biases that might have developed through participant interviews. These items were noted in a journal to minimize the possibility that they would influence the data generated from the participants (Creswell, 2013). A conscious effort was made to ensure previous knowledge and experience did not influence the content of the interview as to allow the results to reflect participants' lived experiences. As a nurse practitioner himself, the principal investigator brought certain assumptions and biases to the study that could have potentially interfered with data collection and analysis. Before engaging in data collection, the use of a journal documented prior knowledge, experience, and notions about NP role transition. This prior knowledge and experience were revisited before each interview. In addition, after each interview, the principal investigator returned to that journal to re-clarify his pre-conceived notions and to record any new biases that might

have emerged or general thoughts so as not to introduce bias or influence the interview direction. The following are selected experts from the journal:

Prior to becoming a nurse practitioner, I had three years of bedside registered nurse experience and then transitioned into the nurse practitioner role. The principal investigator recalls the transition from the RN to the NP role was at times stressful, and he felt uncertain of his abilities to function in the provider role. He remembers having a good support system from mainly his physician collaborators. There were other NPs on the unit, but we were all new to the unit and were unable to offer each other support. One of the biggest aspects related to my role transition was the fact that I had to separate myself from the RN role and engage in the provider role. This was a different focus and was uncomfortable at first, but became better with time. My time as an RN in the emergency department really helped to make me independent as a provider and really helped to enhance my diagnostic reasoning ability. I also think that my health assessment course was one of the biggest contributors to my NP role transition. In the class, I truly learned how to think of the provider. I need to remember not to let these experiences intertwine with the experiences reported by my participants.

During the literature review, I gained some additional knowledge from other researchers on role transition. This knowledge includes that prior RN experience is undefined as a facilitator or negative aspect of NP role transition. Physician collaboration as a form of support is also undefined as a facilitator or negative aspect of NP role transition. These are the gaps in the literature that I identified, but I need to make sure not to influence the participants to answer these questions directly, but to allow them to express their experiences fully. I also learned about the feelings that previous studies reported from the perspective of the NP during role transition. I need to make sure I allow my participants to fully express their own feelings and not influence their discussion of these feelings during interviews or data analysis.

After my second interview, I am noticing that the first two participants have said some things that are very similar. As I was interviewing the second participant, I had to be cognizant of the fact that I don't react or add commentary when the participants are providing their experiences. Unlike the first participant, I noticed the second participant was seeking my approval of what was being said. I tried to keep consistent in my response to their seeking for approval. I kept saying "that is very interesting" or "could you expand on that more."

Today was my sixth interview; I noticed that I need to keep my reactions and additions to their descriptions in check. It is difficult to determine if I am asking for clarification on something we have discussed or if I recall information from an interview with another participant. I have found that the field notes are invaluable to me at this point. As a question for clarification arises, I note it on a

piece of paper in front of me, which helps to keep me focused on what clarification I need from this particular participant and not including information from prior participants. I am having to stick to my interview guide more strictly than I did with the first few interviews to ensure I am asking the same questions and reworking questions based on the other interviews. This helps to keep me focused and make sure I am not forcing themes to emerge that do not exist.

Other methods besides journaling were used to reduce bias during the interviews and data analysis. Using a standard interview guide and opening question for each participant ensured that the questions did not change based on what a prior participant reported. The use of field notes helped during data analysis as they provided a basis for and a confirmation of what was being described by the participant. Field notes were taken during the interview to point out important comments, statements, and thoughts from the research participant. Later the field notes were used during transcript review to confirm an understanding of the contents of the transcript and validate the description.

Philosophical Assumptions

This research included four philosophical assumptions of qualitative research that related to the interpretive framework of social constructivism: ontological, epistemological, axiological beliefs, and methodological. These four philosophical assumptions influenced the problem, the question, and how the principal investigator answered the research question. The philosophical assumptions assisted the principal investigator in ensuring the findings contributed to the body of knowledge (Creswell, 2013).

The first assumption was ontological--the nature of reality. Numerous realities are related to a phenomenon (Creswell, 2013). Understanding there were multiple views regarding this phenomenon, the results of this research described the differing views of multiple participants. These differing viewpoints were clustered into common themes

that emerged from the data. Identifying the commonalities among the differing viewpoints allowed for the development of a description of the experiences nurse practitioners identified as being associated with their transition to the NP role.

The second assumption was epistemological, which focuses on what counts as knowledge, how knowledge claims are justified, and the relationship of the principal investigator to the phenomenon. Knowledge is known through the subjective experiences of the participants. These subjective views serve as the evidence (Creswell, 2013). In this study, data were derived from participant interviews and results were reported using direct quotes from the participants. From these direct quotes, an exhaustive description was developed of the experiences nurse practitioners identified as being associated with their transition to the NP role. To lessen the distance between the principal investigator and the participants, open-ended questioning and direct quotes from the study participants were used, which allowed common themes to emerge from the data.

The third assumption was axiological, focusing on the role of values. There must be an acknowledgment that research is value-laden with biases present (Creswell, 2013). As described earlier, bias was acknowledged and attempts were made to ensure this bias did not influence the interview process. To understand the data provided by the participants, the principal investigator used his own experience in conjunction with the description of the participants' experience to develop an exhaustive description of the phenomenon. Although utilizing this knowledge to help understand the data provided by participants, the research findings did not include the acknowledged biases within the exhaustive description.

The final assumption was methodological--the process and language of the research. Inductive logic was used to study the phenomenon within the context and allowed an emerging design (Creswell, 2013). This study utilized a descriptive phenomenology method to explore the process of NP role transition through the discovery of the lived experiences of NPs. A detailed interview guide was open to revision to reflect better questioning, which led to understanding the research problem. The interview guide was not revised during the data collection process. The guide was finalized prior to beginning data collection. These revisions were based on the principal investigator's experiences during participant interviews. Data analysis utilized an inductive logic pathway. Transcripts were developed from the interviews and those transcripts were read to identify themes among the transcripts. The themes were validated through data analysis procedures (Creswell, 2013).

Interpretive Framework

The interpretative framework for this study was social constructivism. Social constructivism seeks to understand the world in which the participants of a study live and work. Subjective meanings are developed from the experiences of individuals that seek to describe a phenomenon. The goal of research conducted using the social constructivism framework is to focus on participants' views of a particular phenomenon. Research using social constructivism as an interpretive framework relies on participants being able to describe their views of the phenomenon as they experienced it. Using open-ended questioning is a skillful tact in eliciting descriptions from participants based on their experiences with the phenomenon (Creswell, 2013).

Researchers conducting a study using social constructivism frameworks must recognize their background with the phenomenon should be used to understand the meaning of participants' experiences with the phenomenon. In other words, the principal investigator must not amalgamate his own experiences of the phenomenon into the findings of this study but instead use his experiences to make sense of what the participant was describing. Being able to use one's own experience with a phenomenon to assist in understanding another individual's experience with the phenomenon helps the principal investigator make sense of the meaning others have shared about the phenomenon (Creswell, 2013).

The ontology of social constructivism focuses on realities constructed through experience (Crotty, 1998). In this study, the participants responded to open-ended interview type questions that described their reality of the phenomenon and how their experiences influenced their reality. The epistemology of social constructivism focuses on the development of knowledge based on lived experiences by both the participants and the researcher (Crotty, 1998). Data of the study were comprised of experiences described by participants that were associated with their role transition. Data were obtained using open-ended questions in an interview format. Knowledge discovery emerged during data analysis using participant data to formulate an exhaustive description of the experiences nurse practitioners identified as being associated with their transition to the NP role. Through the participants' descriptions of their own experiences, common themes emerged that were the source of knowledge discovery.

The axiology of social constructivism focuses on honoring individual values (Crotty, 1998) including recognizing biases on the part of the principal investigator and

not interjecting biases into the study. Prior knowledge and experience with NP role transition were acknowledged from the beginning of the study and steps were taken to identify additional biases that might have developed through participant interviews. These items were noted in a journal to minimize the possibility they would influence data generated from the participants. While not fusing this previous knowledge with the participants' descriptions of their own experiences, this previous knowledge of NP role transition was used to make sense of the participants' descriptions of their own experiences. Finally, social constructivism focuses on the use of inductive reasoning to discover ideas and obtain a consensus on the interview results (Crotty, 1998). This part of the framework is achieved through the data analysis process by following a structured approach. This structured approach led to an overall exhaustive description.

The social constructivism framework often works well with a phenomenology method. Phenomenology focuses on the lived-experiences of individuals who are exposed to a phenomenon (Creswell, 2013; Streubert & Carpenter, 2011). In this study, the phenomenon under investigation was NP role transition. Participants of the study had experience with NP role transition and hence could describe their lived experiences with NP role transition. The description of these experiences was the source of data collection. In the social constructivism framework, the participants' views on and experiences with a phenomenon become the goal of the research (Creswell, 2013; Crotty, 1998). Hence, by interviewing participants, gaining a description of their experiences and using direct quotes to substantiate the overall exhaustive description in the findings of the study, this research was best conducted using a descriptive phenomenology method with social constructivism as a framework. The constructivist worldview is demonstrated

in phenomenological studies by participants' describing their own experiences (Creswell, 2013; Crotty, 1998). The discovery of knowledge in this research emerged from participants' descriptions of the experiences they identified as being associated with their transition to the NP role.

Research Participants, Sampling, and Recruitment

Research Participants

The target population for this study was nurse practitioners who had experience with transitioning to the NP role. The inclusion criteria included nurse practitioners who (a) were currently certified in one of the six recognized nurse practitioner certification categories, (b) self-identified as currently practicing as a nurse practitioner on a full-time basis, (c) had practiced as a nurse practitioner for a minimum of one year to a maximum of three years, (d) had a minimum of one year of RN experience prior to entering the NP role, and (e) had a physician collaborator in their first NP role. Six recognized nurse practitioner certification categories included (a) family/individual across the lifespan, (b) adult-gerontology, (c) neonatal, (d) pediatrics, (e) women's health/gender-related, and (f) psychiatric-mental health (ANA, 2007). Both primary and acute care certifications within the certification categories were accepted for inclusion.

Rationale for inclusion criteria. The rationale for these inclusion criteria was to limit variability among participants. Attaining nurse practitioner certification ensured the study participants had the education and training necessary for the NP. Nurse practitioner certification examinations are competency-based, entry-level examinations that provide a valid and reliable assessment of the clinical knowledge and skills of the nurse practitioner (American Nurses Credentialing Center, 2017). These inclusion criteria ensured all

participants had successfully attained certification, which meant upon entry into practice and during role transition the participants had the clinical knowledge and skills necessary for the entry-level nurse practitioner. Hence, this inclusion criterion limited variability among the participants.

Participants who self-identified as currently practicing as a nurse practitioner on a full-time basis was chosen as an inclusion criterion to limit variability in the data by ensuring similar employment status. In other words, all participants in the study self-identified as having full-time NP clinical employment. Those NPs who worked part-time or in per-diem positions might have had different experiences with NP role transition than those who worked full-time in the NP clinical role. By selecting only participants who self-identified as being full-time in clinical practice, this limited possible variability among the participants.

Participants were required to have practiced as a nurse practitioner for a minimum of one year to a maximum of three years to satisfy the inclusion criterion. The rationale for this inclusion criterion was based on the results of seminal research that concluded the NP role transition process could take up to one year. The maximum of three years of clinical NP experience was selected to limit the possibility that participants were too far away from experiencing the phenomenon to accurately recall their lived experiences. Hence, this criterion offered consistency in the longevity of NP role transition experience.

The final two inclusion criteria chosen based on the identified gaps in the literature included the participant (a) had a minimum of one year of RN experience prior to entering the NP role and (b) had a physician collaborator in his/her first NP role. Based on a review of the literature, conflicting results on a correlation between role

transition and prior RN experience created a gap in the literature. Participants were required to have RN experience prior to entering the NP role to increase the ability of the research findings to address this gap. In addition, a review of the literature concluded no clear understanding existed regarding the influence of physician collaboration in NP role transition. Participants were required to have had a physician collaborator in their first NP role to increase the ability of the research findings to address this gap.

Sample size. According to Richards (2011), qualitative research typically requires lower numbers of data/participants. The number of participants in a qualitative research method is not a logical factor to consider. A phenomenology study might have as few as three participants with a general range of 5 to 10 participants. Some studies reported numbers of participants as 20-25. However, this was not a commonality (Creswell, 2013; Englander, 2012; Richards, 2011). The qualitative researcher is not interested in the number of participants to ensure adequate statistical outcomes. Instead, the researcher is interested in being able to gain a rich description of the phenomenon. Hence, the number of participants included in a qualitative research study is based not on a number but on data saturation (Englander, 2012).

Data collection utilizing a qualitative method should continue until the researcher believes saturation has been reached. Data saturation is achieved when no new themes emerge from participants and data are repeating. Hence, it is likely impossible to pre-determine the number of participants needed for a qualitative research study (Englander, 2012; Streubert & Carpenter, 2011).

Sampling

Sampling is the process of selecting participants for a study that represents the population under investigation (Streubert & Carpenter, 2011). The population under investigation in this research was nurse practitioners. To ensure the target population was investigated and the data obtained could answer the research question, inclusion criteria were formulated as previously described. A purposive sampling technique was used to ensure selected participants met required inclusion criteria for this research. The goal of purposive or purposeful sampling is to select participants who would most likely benefit the study. Purposive sampling allows for the selection of participants based on characteristics relevant to the study. In a descriptive phenomenology study, the participants must all have experienced the phenomenon under investigation, be able to reflect on the phenomenon of interest, and are willing to participate in the study (Richards & Morse, 2013; Polit & Beck, 2012; Streubert & Carpenter, 2011). In addition to purposive sampling, a snowball sampling technique was utilized to gain additional participants through current study participants who would likely meet inclusion criteria (Creswell, 2013). A snowball sampling technique uses already identified participants who meet inclusion criteria to assist in the recruitment of future participants. This assistance is offered based on current participants' knowledge of inclusion criteria for the study and their knowledge of colleagues who potentially meet inclusion criteria (Creswell, 2013; Polit & Beck, 2012; Streubert & Carpenter, 2011).

Recruitment

Participant recruitment took place after approval was received from the Institutional Review Board (IRB) at the University of Northern Colorado (see Appendix

A). Recruitment of participants was completed using the following social media groups for nurse practitioners and nurse practitioner networking groups: (a) Acute Care Nurse Practitioners Facebook page, (b) Nurse Practitioners in Acute Care Facebook page, (c) Drexel Nurse Practitioners Facebook page, and (d) the Nurse Practitioner Faith Community Facebook page. Verbal consent to advertise this research was obtained from the page administrators of each individual page. In addition, the Nurse Practitioner Networking Listserv of Fitzgerald Health Education Associates was used for the recruitment of participants. Verbal consent to advertise this research on the Listserv was obtained from both the President and the Chief Executive Officer of Fitzgerald Health Education Associates, LLC. Another venue for participant recruitment took place through the Drexel University NP Graduate Listserv. Verbal consent to advertise this research on the Listserv was obtained from the Chair of the Department of Advanced Practice Nursing at Drexel University, College of Nursing and Health Professions. Lastly, an e-mail was sent out to the Nurse Practitioner Listserv at Cooper University Healthcare. Verbal consent to advertise this research on the Listserv was obtained from the Vice President of Advanced Practice Providers at Cooper University Healthcare. In addition to these methods of purposive sampling, participants were gained through a snowball sampling approach. Information about the study was disseminated in the form of a recruitment letter through the above-mentioned services and included (a) general information about the study, (b) the research purpose, (c) inclusion criteria, and (d) the principal investigator's contact information (see Appendix B).

Recruitment was an ongoing cyclical process and continued until data saturation was achieved. Eight participants met inclusion criteria for this research study. Seven

participants were gained from the purposive sampling technique and one participant from the snowball technique. Each participant was interviewed and the interview was audio recorded. At the completion of each interview, the audio recording was transcribed and reviewed for data analysis. This process is further described in the data collection and analysis sections of this chapter. Data saturation was achieved once the data were repetitious and no new themes emerged. Repetition in the data was noted starting with the sixth participant. When compared to the descriptions provided by the other participants, no new descriptions emerged. Discovery of repetitious data without the emergence of new descriptions continued in the seventh and eighth participant interviews. Hence, data saturation was achieved with eight participants.

Data Collection

Prior to beginning data collection, a pilot study was completed with three experienced nursing researchers. The purpose of this pilot was to test the interview prompts identified in the interview guide. Based on feedback received from the doctoral dissertation committee during the proposal defense and feedback received from experienced nursing researchers, the interview prompts were updated and are reflected in the interview guide (see Appendix C). These interview prompts were finalized in the research proposal approved by the doctoral committee and submitted to the Graduate School at the University of Northern Colorado. In addition, the interview guide was subsequently included in the IRB proposal.

After IRB approval was attained from the University of Northern Colorado, participant recruitment began. Interested participants contacted the principal investigator through the University of Northern Colorado e-mail system. Upon receiving an e-mail

from a potential participant, the participant was sent a short survey to complete to ensure the participant met inclusion criteria of the study. Once the survey was completed by the potential participant, the principal investigator confirmed via email the participant's qualification for inclusion in the study. Those who did not qualify for inclusion in the research were thanked for their interest. Once it was determined a participant met the inclusion criteria, an e-mail was sent to set up a date and time to complete the interview. The time selected for the interview was based on the availability of each participant to ensure the interview process did not interfere with work schedules or other personal commitments. Once an appointment time was chosen by the participant, a confirmation e-mail was sent to that participant with the appointment date and time. This e-mail also included the informed consent document for the participant's review (see Appendix D). Prior to attending the interview, the participant was asked to take time to reflect on his/her overall experience with the transition to the role of the NP and the factors he/she found helpful during role transition and those factors he/she did not find helpful during role transition. Each participant was sent an e-mail reminder of his/her appointment time at least 24 hours prior to the scheduled interview. Each interview was scheduled for a two-hour time block.

The principal investigator is the primary instrument for data collection in a descriptive phenomenology study (Streubert & Carpenter, 2011). As such, data were collected through unstructured participant interviews. Interviews were conducted in a virtual format using the Zoom® Video Conferencing web-based software. In the appointment confirmation e-mail, the participant was sent a link to access the Zoom® software. At the date and time of the appointment, the principal investigator and the

participant logged into the appointment using the provided Zoom® link. At the start of the appointment time, the purpose of and rationale for the study were reviewed with each participant along with the informed consent document. The participant was then able to ask additional questions regarding the study. The participant was made aware his/her participation was voluntary and he/she could withdraw participation in the study at any time. Once all questions were answered, the consent form was signed by the participant and e-mailed to the principal investigator. The participant retained the signed document as his/her copy of the consent form. The participant was reassured his/her data would remain confidential and secure.

After informed consent was obtained, the participant was assigned a unique identifier number and basic demographic data were collected (see Appendix E). The unique identifier served to ensure participant anonymity and increase data security. The purpose of collecting the demographical information was to provide a generalized description of the participant population. Data collected included (a) the participant's age, (b) the participant's self-identified gender, (c) the participant's self-identified ethnicity, (d) level of initial NP education (master's or doctoral education), (e) the type of educational program (on-site, online, or hybrid program), (f) any NP certification achieved by the participant, (g) the number of years in clinical practice as an NP, (h) state(s) of licensure, (i) state(s) of NP practice, (j) practice specialty, (k) if this was his/her first NP position, (l) if there was an orientation included for this or other positions, (m) approximate number of hours per work week, (n) number of years of RN experience, (o) primary specialty as an RN, and (p) if he/she achieved any RN specialty certifications. In addition to these questions, the participants were asked if there were

any cultural, gender, or other issues they would like the principal investigator to consider during the interview.

Eight participants were included in this research study. The age of the participants ranged from 27-53 years of age. Of the eight participants in the study, seven identified as female and one identified as male. No participants identified as any other gender. All eight participants identified Caucasian as their ethnicity.

Seven of the participants reported being master's degree prepared and one participant reported being doctorally prepared. Three participants attended an onsite program, two participants attended an online program, and three attended a hybrid program. An onsite program was defined as a program where the students were required to meet physically, face-to-face weekly on a campus. An online program was defined as a program conducted completely asynchronous online without any face-to-face or synchronous component. A hybrid program was defined as a program that was partially asynchronous online but had a synchronous component such as an on-campus requirement or synchronous class sessions held virtually or face-to-face.

Four participants self-identified as being certified as Family Nurse Practitioners, two participants self-identified as being certified as Adult-Gerontology Primary Care Nurse Practitioners, one participant self-identified as being certified as an Adult-Gerontology Acute Care Nurse Practitioner, and one participant self-identified as being certified as a Pediatric Primary Care Nurse Practitioner. No participants self-identified as being a Neonatal, Women's Health, or Psychiatric-Mental Health Nurse Practitioner. None of the participants were dual certified in another NP certification. Participants' experience ranged from one to three years of clinical practice as a Nurse Practitioner.

Participants were licensed and practicing from seven different states including Arizona, California, Colorado, Michigan, New Jersey, Pennsylvania, and Texas. The participants also came from a variety of specialty practice settings within their certification focus. Four of the participants reported this was their first position. Three of the participants reported having an orientation in this or another position as an NP. All the participants self-identified as full-time NPs in clinical practice with a range of 36 to 42 hours worked per week.

Years of experience as an RN prior to becoming an NP ranged from 6 to 30 years. A variety of RN specialties were identified prior to becoming an NP. Five of the participants reported holding a specialty RN certification. None of the participants identified cultural, gender, or other issues they wanted the principal investigator to consider during the interview.

Once the demographic information was collected, data collection began using unstructured participant interviews. The interviews occurred with non-leading, open-ended questions to discover experiences participants identified as being associated with their transition to the NP role (see Appendix C). Once the dialogue began, the principal investigator allowed the participant to explain his/her role transition experience. The goal of the unstructured interview was to understand the experience of the NP's role transition (Creswell, 2013). The interviews lasted approximately one hour; however, the principal investigator allocated two hours to each interview to allow free discussion. The interview was conducted with video and audio capability; however, only the audio portion of the meeting was recorded for analysis. Just recording the audio portion was an additional step to ensure participant anonymity and increase the level of data security.

While participating in the interview, field notes were used to develop a richness of description by making comments that could later be used to verify the findings of the study (Englander, 2012).

After the interview was completed, the participants were asked if there was anyone else they knew who would be willing to complete an interview and were given permission to share the principal investigator's contact information with their NP colleagues. In addition, participants were asked if they are willing to meet with the principal investigator again. The purpose of the second meeting was to review with the participants the findings generated from the data and to verify the themes and descriptions generated from the data aligned with their experiences. Two of the participants agreed to participate in a follow-up meeting. This process of member checking is described in the data analysis section. Lastly, all participants were provided with a thank-you letter via e-mail. In addition, as a recognition of their time and participation in this research study, each participant was provided with a virtual \$10 Amazon gift card via e-mail.

Data Security and Handling

Throughout the research, steps were taken to ensure the data were secure. Each participant was assigned a unique identification number (UIN). This UIN was used to respect the participant's privacy and confidentiality. All files for each individual participant were labeled with this number. Lastly, the UIN could not be traced back to individual participants.

Only secured equipment was utilized during the research process to ensure the protection and security of the data. A laptop stored information and data throughout the

study; it was secured by the following methods: (a) it was only used for this research purpose, (b) it was locked with a complex password, and (c) all files were stored on the laptop within a complex, password secured folder. When not in use, the laptop was kept in a locked filing cabinet. Only the principal investigator had access to the laptop, the passwords, and the filing cabinet key.

In addition to the secured laptop, the virtual interviews took place over a secured internet connection and did not utilize public Wi-Fi or public Internet connections. The laptop contained encryption software and all files were secured with encryption capabilities. The audio recordings were downloaded directly to the secured laptop in the password protected folder. All files including audio recordings, consent forms, and transcripts will be kept for a minimum five years. After that time, all files except for the consent forms will be destroyed. The researcher advisor, Faye Hummel, will retain the informed consents for a minimum of five years.

Data Analysis

Colaizzi's (cited in Creswell, 2013; Shosha, 2012) method of qualitative data analysis was utilized as it was found to be appropriate for a descriptive phenomenological approach. This method of data analysis developed an exhaustive description of the participants' experiences with the phenomenon under investigation. Data collection and data analysis in a descriptive phenomenological study occur simultaneously in an ongoing, cyclical process. The purpose of this process is to assist with identifying data saturation. As described previously, data saturation was achieved when common themes emerged from the data and no new themes were identified. This research achieved data

saturation after eight participants. Table 1 provides an overview of the procedural steps in completing this descriptive phenomenology study.

Table 1

Colaizzi's Procedural Steps in Phenomenology

Step	Colaizzi's procedural steps in phenomenology
1	Describe the phenomenon of interest
2	Collect participant's description of the phenomenon
3	Read and re-read all the participant's descriptions of the phenomenon
4	Return to the original transcripts and extract significant statements
5	Try to spell out the meaning of each significant statement
6	Organize the aggregate formalized meanings into clusters of themes
7	Write an exhaustive description
8	Return to the participants for validation of the description
9	If new data are revealed during validation, incorporate them into an exhaustive description

Source. Streubert & Carpenter, 2011, p. 79.

Step one of this process was describing the phenomenon of interest. Chapters I and II of this dissertation described what is known and unknown about NP role transition. Step two was to collect participants' descriptions of the phenomenon. Data collection occurred through recorded interviews. At the completion of each interview, the audio recording was reviewed and typed into a verbatim transcript by the principal investigator.

After the transcript was completed, the audio recording was compared to the transcript to ensure the accuracy of the transcript.

In the third step of data analysis, the transcripts were obtained, read, and re-read to understand all of the participants' descriptions of the phenomenon (Shosha, 2012; Streubert & Carpenter, 2011). During these readings, personal thoughts, feelings, and ideas were recorded in the journal. These readings occurred initially and then were ongoing to compare the data collected among the participants to identify themes and the emergence of any new descriptions or themes. This process helped ensure that prior knowledge of NP role transition was used to understand the participants' descriptions. However, prior knowledge, thoughts, feelings, or ideas were not included in the final exhaustive description of the phenomenon; only the participants' described experiences were reflected. The purpose of this transcript reading was to acquire an understanding of the participants' experiences with their NP role transitions.

The next step of the analysis method was to return to the original transcripts and extract significant statements (Shosha, 2012; Streubert & Carpenter, 2011). During this part of the process, the transcripts were searched for significant statements that pertained to the phenomenon of NP role transition and revealed the description of the experiences they identified as being associated with their transition to the NP role. When a significant statement was identified, a notation was made on the transcript. In addition, the significant statement was written on a separate piece of paper noting the page and line number of where the significant statement could be found in the transcript. These statements were manually coded using a color-coding system.

The next step of the analysis method was to try to spell out the meaning of each significant statement (Shosha, 2012; Streubert & Carpenter, 2011). Each significant statement (a direct quote) from the transcript was read and meaning was devised from the significant statement. Prior knowledge of NP role transition was used to understand the significant statements but was not included in the meaning described by the participants. The meaning was a description formulated from the direct quote of the participant.

The next step of the analysis method was to organize the aggregate formalized meanings into clusters of themes (Shosha, 2012; Streubert & Carpenter, 2011). Themes that emerged from the data were developed from the meanings associated with each significant statement. Initially during this part of the analysis process, 13 common themes emerged from the data. As the common themes were reviewed over a period of a few months, these themes were narrowed to four final themes and nine sub-themes that encompassed the participants' descriptions of the experiences they identified as being associated with their transition to the NP role. The principal investigator reflected upon the data and grouped descriptions into similar headings. Reflection occurred throughout the study in a cyclical nature, both initially and after each interview. During this process of reflection, the principal investigator searched the data for new descriptions or themes to determine if data saturation was achieved. The final common themes are discussed in Chapter IV of this dissertation.

The next step of the analysis method was to write an exhaustive description (Shosha, 2012; Streubert & Carpenter, 2011). Based on the final four common themes that emerged from the data, a description of each theme was developed. The description of each theme led to an overall, exhaustive description of the participants' descriptions of

the experiences associated with their transition to the NP role. This exhaustive description was cumulative of all four themes and nine sub-themes.

The next step of the analysis method was to return to the participants for validation of the description. This process is also known as member-checking (Shosha, 2012; Streubert & Carpenter, 2011). Two of the enrolled participants agreed to participate in member-checking. Each was sent the final exhaustive description of the experiences nurse practitioners identified as being associated with their transition to the NP role. Each participant had one week to review the exhaustive description after which a follow-up phone call was scheduled. During the phone call, each participant validated the description and agreed with the description presented to them. The final step of the process was to incorporate any new data revealed during this member-checking process into the exhaustive description (Shosha, 2012; Streubert & Carpenter, 2011). During the process of member checking, the two participants validated the exhaustive description and did not have any additional information to include into the description. Member checking offered this study a higher level of credibility, which is described later in this chapter.

Ethical Considerations, Issues, and Benefits

General Ethical Considerations

The following ethical considerations were related to this study: (a) obtaining university IRB approval, (b) examining professional association standards, and (c) gaining permission from participants (Creswell, 2013). Before beginning participant recruitment, approval was obtained from the IRB at the University of Northern Colorado (see Appendix A). Professional standards of nursing research were reviewed and a

course on ethical research was completed. Lastly, a participant consent form was developed, reviewed with all participants prior to beginning the interview, and signed by all participants prior to beginning the interview (see Appendix D).

As the study began, potential ethical considerations included (a) disclosure of the purpose of the study, (b) not pressuring participants into signing the consent form, and (c) respecting the norms of indigenous societies (Creswell, 2013). All potential participants were informed of the purpose of the study upon initial contact. Before the start of the interviews, the purpose of the study was reviewed with the participants. After presenting and reviewing the consent form with the participants, they were made aware they were under no obligation to participate and could withdraw participation at any time. Lastly, each participant was asked if there were any cultural, gender, or other issues to be considered during the interview process.

During data collection, potential ethical considerations included (a) showing respect and as little disruption as possible, (b) avoiding deceiving participants, and (c) not using participants without giving back (Creswell, 2013). Trust was built with the participants through discussions and reviewing the purpose of the study before the interview. Participants picked a time and date convenient for them that caused the least amount of disruption in their daily activities and work schedules. The use of leading questions was avoided. Personal impressions of the participants' responses were not shared with the participants. All information was secured as described earlier in this chapter. Lastly, each participant was verbally thanked, sent a thank-you note via e-mail, and provided with a \$10 digital Amazon gift card via e-mail as a recognition of the participants' time and willingness to participate.

During data analysis, potential ethical considerations related to this study included (a) avoiding siding with participants, (b) avoiding only disclosing positive results, and (c) respecting the privacy of participants (Creswell, 2013). Avoiding “going native” was important to ensure the data discovered were useful, trustworthy, and relevant. Bracketing was used as a method to ensure preconceived notions and knowledge were not included in the study findings and did not influence questioning. A pre-developed research guide was used with every participant in the study (see Appendix C). Each participant was listened to and allowed to discuss his/her experiences without interruption or interjection. Each participant was assigned a UIN to ensure confidentiality and respect for privacy.

During data reporting, potential ethical considerations related to this study included (a) not falsifying evidence, data, or findings; (b) non-plagiarism; and (c) avoiding disclosing information that might harm participants (Creswell, 2013). All evidence, data, and findings were recorded accurately based on the data collected in this study. The principal investigator reviewed this material and used the material frequently to ensure there was no academic dishonesty or plagiarism. Finally, the findings of the study included only composite descriptions and aggregate data to ensure participants were not identifiable.

Anticipated Ethical Issues

Risk to participants was minimal in this study. There was a potential for physical discomfort while the participant was sitting during the interview. If the participant appeared uncomfortable or upon request, a brief break was offered or provided.

Although unlikely, recalling the events of role transition might have presented the

participant with reliving unpleasant experiences. The planned intervention for psychological discomfort was to assist the participant in identifying the need for counseling services and the use of therapeutic communication. This did not occur throughout data collection with any of the participants and was not necessary.

Benefits for Participation in the Study

The largest benefit for participating in the study was its contribution to the development of new nursing knowledge and nursing science. Results of this study have the potential to ensure NP practice remains strong. Furthering the knowledge of role transition for the NP could also contribute to ensuring quality patient outcomes. The benefits of participation in this study outweighed any potential risks. The anticipated ethical issues were reviewed prior to conducting the study to ensure no harm would come to the participants, thereby upholding the ethical principle of beneficence. To ensure the ethical principle of autonomy, each participant voluntarily signed an informed consent document prior to participation in the study. Through the measures used to secure the data and by reporting in the aggregate, the ethical principles of both beneficence and justice were upheld, thereby ensuring the participants' confidentiality and anonymity were maintained (Streubert & Carpenter, 2011).

Trustworthiness

The bracketing method was used to establish trustworthiness to ensure bias was minimized in the findings of this study from the previous knowledge, experience, and opinions this principal investigator had about transitioning to the role of the NP. However, it was recognized that this previous knowledge and experience would be useful when reading and understanding the experiences described by participants and

developing an exhaustive description. The model developed by Lincoln and Guba (1985) was used to establish trustworthiness. Use of this model assisted in ensuring trustworthiness within the study or, in other words, ensured the research was representative of participants' experiences (Lincoln & Guba, 1985). Four identified techniques supported trustworthiness within this study: (a) credibility, (b) dependability, (c) conformability, and (d) transferability (Lincoln & Guba, 1985).

Credibility

Credibility increases the probability that the findings of the study are reliable. Credibility in this study occurred through member checking, which consisted of returning to the participants and providing them with the exhaustive description. Two of the participants agreed to participate in this process. The purpose of member checking in this study was to ensure the written data coincided accurately with the participants' intended meaning. The participants' experiences with role transition must be reflected in the research findings from their point of view and experiences. Two participants who underwent member checking validated the exhaustive description, thus increasing credibility in this study.

Dependability and Conformability

Following the analysis of credibility, scrutinizing the study for dependability was essential. Dependability ensured the results of the study were consistent. In addition to establishing dependability, conformability occurred concurrently. Conformability allowed the principal investigator to provide evidence and the process that led to the conclusions of the study. In this study, the process of ensuring dependability and conformability occurred via the use of an audit trail (Lincoln & Guba, 1985; Mateo &

Forman, 2014; Streubert & Carpenter, 2011; Tappen, 2011). The purpose of the audit trail was to allow an outside viewer to explore the research process, evaluate decisions that were made, and understand the basis for the decisions made in the research process. The audit trail was kept in the form of a journal that depicted a log of decisions made throughout the data collection process and during data analysis. The audit trail was used as a part of the peer debriefing process.

Transferability

Transferability ensured the study findings had meaning to others studying the same phenomenon (Lincoln & Guba, 1985). Transferability is determined through the judgment of those who would potentially utilize the research (Lincoln & Guba, 1985; Streubert & Carpenter, 2011; Tappen, 2011). This research utilized purposeful sampling and provided a detailed description of the sample and the context in which the research was conducted. This description could allow outside experts and consumers of the knowledge generated from the research to judge the transferability of the findings to other populations.

Limitations and Delimitations

Limitations

The limitations of a study influence the findings of a study and depict the deficiencies in a sample, problems with the design, and weakness in data collection. It is imperative to identify and discuss any identified limitations. Readers of the research must be aware of limitations, the principal investigator's attempt to be aware of these limitations, and that the limitations were taken into consideration during the interpretation of data and dissemination of findings (Polit & Beck, 2012).

One limitation of this study was the selection of participants. The study did not take into account the following NP populations: (a) those with less than one year of clinical practice, (b) those with greater than three years of clinical practice, (c) those who might hold an older certification outside of those identified by the consensus model, and (d) those who worked less than full time. The inclusion criteria were developed to increase the ability of the research findings to answer the research question and address identified gaps in the literature. Although the above-mentioned NPs might have had a unique perspective to contribute to the research, these specific populations did not meet the focus of this research. These populations might be useful in future research studies if this research was extrapolated to other populations. For instance, perhaps a future research study could focus on those NPs who did not enter full-time practice and their experiences with role transition. Another example of a future study might include, looking at NP role transition in new-graduate NPs.

Another limitation was the recognized previous knowledge of the principal investigator who currently teaches nurse practitioner students, has experience with his own role transition, and currently practices as an NP. A pre-conceived understanding of NP role transition might have contributed bias to the research findings. It was imperative to recognize this bias and use bracketing to minimize any possible bias. As this writer is a novice researcher, the interview questions might have unintentionally introduced bias or limited responses. However, these questions were trialed on experienced researchers to gain feedback on interviewing techniques and on the appropriateness and usefulness of interview prompts being used in this study.

Delimitations

Delimitations of a research study set the conceptual boundaries of the study. Delimitations are not weakness or flaws of the study; rather, they set the boundaries of the study and the ways in which the study lacks generalizability. Under delimitations, one must consider the size and nature of the sample, the uniqueness of the setting, the period during which the study was conducted, and the limitations of methods (Glatthorn & Joyner, 2005).

One delimitation was this study was generalized to the NP population and did not consider populations such as primary care, acute care, or pediatrics. Role transition might be different among other NP populations. However, due to the research question and the purpose of this study, it was necessary to focus on a broader perspective. Previous research has focused on NPs in primary care and one study focused on NPs in acute care. Once a broad description of the experiences nurse practitioners identified as being associated with their transition to the NP role is disseminated, population-focused NP specialties would be a valuable area of research regarding role transition.

Summary

In this chapter, the methodology of the study was presented. A descriptive phenomenological approach was used to answer the research question of this study. The purpose of the study was to explore the process of NP role transition and discover the lived experiences of NPs associated with this role transition. A purposive sampling technique was used and supplemented with a snowball sampling technique to gain study participants who met the following inclusion criteria: (a) currently certified in one of the six recognized nurse practitioner certification categories, (b) self-identified as currently

practicing as a nurse practitioner on a full-time basis, (c) had practiced as a nurse practitioner for a minimum of one year to a maximum of three years, (d) had a minimum of one year of RN experience prior to entering the NP role, and (e) had a physician collaborator in their first NP role. Unstructured interviews using open-ended questions were conducted with the participants using the principal investigator as the instrument. Data were analyzed and saturation was identified utilizing Colaizzi's (cited in Creswell, 2013; Shosha, 2012) method. Saturation was identified once common themes emerged from the data due to repetition in the experiences described and no new themes developed. Ethical considerations, limitations, and delimitations of this study were also presented.

CHAPTER IV

ANALYSIS

Introduction and Overview

The purpose of this chapter is to report the results and findings of the study. This study was conducted using a descriptive phenomenology approach. Data collection occurred through unstructured participant interviews. Colaizzi's (cited in Creswell, 2013; Shosha, 2012) method of qualitative data analysis provided a framework for the analysis procedures. Transitions theory was used to inform this study and provided a framework for the knowledge generated in this study. The central research question of this study was as follows:

- Q1 What experiences do nurse practitioners identify as being associated with their transition to the NP role?

Eight nurse practitioners were interviewed and asked to describe their experiences during NP role transition. During data analysis, four central themes and nine sub-themes emerged from the data. The themes represented a description of the experiences NPs associated with their transition to the NP role. Evidentiary support in the form of direct quotations from the participants supported the identified themes. Finally, an exhaustive description emerged reflective of the experiences nurse practitioners identified as being associated with their transition to the NP role.

Study Data

Unstructured interviews of eight voluntary NP participants generated the data for this descriptive, phenomenological study. Data contained within this study emerged from unstructured interviews, which generated audio recordings and verbatim transcripts. Chapter III described the data collection and analysis procedures. This section summarizes data collection and analysis procedures along with a description of the participants included in the study.

Interview Process

Each interview was conducted using Zoom™ video conferencing software. The software was able to provide both video and audio conferencing options during the interview; however, only the audio portion of the interview was recorded for transcription. The video portion of the meeting was not recorded in an attempt to increase participant confidentiality. Each interview was scheduled for a two-hour time block. Actual interview times ranged from 45 minutes to 75 minutes in duration. During interviews, the use of field notes assisted in the development of rich descriptions of the participants' experiences. The principal investigator used the field notes during transcript review to confirm an understanding of the contents of the transcript and validate the descriptions. During data analysis, a comparison occurred among the field notes, the transcript, and any notes made on the transcript to seek clarification in participant statements. For example, Participant #3 stated, "I lacked clarity in my expectations." A comparison between this participant statement and a field note from the interview that stated "the participant was not provided a clear list of expectations from their direct

supervisor” assisted the principal investigator in clarifying the participant was discussing a lack of clear expectations from their supervisor.

Each interview started with reviewing the purpose of the study and obtaining informed consent as described in Chapter III. Once consent was obtained, the participant was assigned a random, unique identifier number (UIN). This UIN was generated using the month and day the interview was confirmed and a code to determine the participant’s sequence in the interview process. For example, a participant confirmed the interview date on July 11, 2017. This participant was third in the interview sequence. Thus, the generated UIN was 0711-003, which reflected the confirmation date and the participant’s sequence in the scheduled interviews. The UIN permitted the principal investigator to recognize the sequence of participants during data analysis procedures, which ensured the data analysis commenced with the first participant interviewed and concluded with the last participant interviewed. To further increase anonymity of the participants during data analysis and result reporting, a participant number replaced the UIN. For example, participant “0711-003” is reported in the results and findings section as Participant #3. Finally, demographic data collected on each participant are described later in this chapter.

An interview guide provided consistency for each interview (see Appendix C). Each interview started with the following broad opening question: “Would you tell me about your experience transitioning to the role of the NP?” While describing their experiences, field notes were taken to note items that needed further clarification or to make note of experiences/statements repeatedly mentioned by the participant. For example, Participant #1 stated, “There was really no clear understanding of what my role was to be.” A field note was made regarding this statement. Later in the interview, the

participant was asked to expand on the statement. Probing techniques allowed for an increase in the breadth, depth, and richness of the data collected by allowing the participant to further expand on their comments.

After giving an overall description of their experiences and clarifying information, participants were asked to describe their experiences before entering their NP educational program, during their educational program, and upon entering their first NP role. These data were elicited through the following probing questions: “Tell me about any experiences prior to entering graduate-level education that influenced your role transition either positively or negatively,” “Tell me about the experiences during graduate-level education that influenced your role transition either positively or negatively,” “Tell me about the experiences as you entered your first clinical role that influenced your role transition either positively or negatively,” and “Tell me how you felt as you entered your first clinical practice role.” At the conclusion, participants were asked one final probing question: “Reflecting back on your experience with role transition what could have made this a more positive experience?”

Data collection occurred simultaneously with data analysis. First, an interview was completed. Next, the audio recording was transcribed by the principal investigator. The principal investigator concurrently listened to the audio recording and read the transcript to verify accuracy. The principal investigator then analyzed each transcript before the next interview and before the development of another transcript. When a subsequent interview took place, the same process was followed and then compared to previous transcripts. A comparison then occurred between the analysis of the first and second participant data

Colaizzi's (cited in Creswell, 2013; Shosha, 2012) method provided the framework for data analysis. Step one of this method is describing the phenomenon of interest. The phenomenon of interest in this study was NP role transition. Step two of Colaizzi's procedural steps for phenomenology was to collect participants' descriptions of the phenomenon; this step provided the data for the study. Data collection occurred through recorded unstructured interviews as described above. At the completion of each interview, the audio recording was reviewed and typed into a verbatim transcript by the principal investigator. The transcript was read and re-read multiple times to gain a global understanding of participants' descriptions of the phenomenon (Shosha, 2012; Streubert & Carpenter, 2011). The principal investigator read the transcript line by line numerous times and during this reading, personal thoughts, feelings, and ideas were recorded in a journal. This use of a journal helped provide the basis for the exhaustive description that emerged from the data. The journal also assisted the principal investigator to ensure his prior knowledge of NP role transition was used to understand the participants' descriptions but not included in the final exhaustive description of the phenomenon. The final exhaustive description reflected only the lived-experiences described by the participants. Furthermore, the journal provided a step by step examination of the data analysis process.

The purpose of this transcript reading was to acquire an understanding of the participants' experiences with NP role transition. As described earlier, the reading of a transcript occurred initially after each interview and was ongoing in a cyclical nature. This cyclical process allowed the principal investigator to compare the data collected from new participants to the data of prior participants. The sequential analysis process,

starting with the first participant and ending with the last participant, assisted in the identification of common themes among participants and the recognition of any new descriptions or themes that emerged.

The next step of the analysis method was to return to the original transcripts and extract significant statements (Shosha, 2012; Streubert & Carpenter, 2011). During this part of the process, the principal investigator went back to each transcript and searched for significant statements that pertained to the phenomenon of NP role transition and revealed the description of the experiences participants identified as being associated with their transition to the NP role. When a significant statement was identified, the statement was manually coded using a color-coding system and highlighted with a unique colored highlighter. Each color corresponded with a significant statement and the same color was used to highlight similar statements of the same nature throughout the additional transcripts. The significant statement was also written on a separate piece of paper noting the page and line number of where the significant statement appeared in the transcript; the color associated with that statement was noted. Extraction of significant statements occurred in a cyclical, sequential manner.

The next step of the analysis method was to try to spell out the meaning of each significant statement (Shosha, 2012; Streubert & Carpenter, 2011). Each significant statement consisted of a direct quote from the transcript. The significant statements were read and a meaning formulated. Prior knowledge of NP role transition was used to understand the significant statements but was not included in the meaning derived from the participants. The meaning was a description formulated from the direct quote of the participant. For example, each significant statement was read in the context of the

transcript, the research journal, and the field notes to determine the meaning/description of the statement. The meaning was notated next to the significant statement located in the research journal. In other words, the principal investigator sought to understand what the participant was describing. Thus far, each step of this process was completed in a cyclical, sequential nature as described previously. As more transcripts were reviewed, significant statements with the same color code and their meanings were grouped together.

The next step of the analysis method was to organize the aggregate formalized meanings into clusters of themes (Shosha, 2012; Streubert & Carpenter, 2011). The principal investigator searched each meaning for keywords that underscored the description provided by the participant. Each keyword was highlighted using a color-coding system and placed into groups. These groups signified common themes that emerged from the data. Initially, 13 common themes emerged from the data. A recurrent review of the common themes occurred over a period of a few months. The themes were merged with other similar themes, which narrowed the total list to eight common themes. Each of these eight common themes was given a new color-coding identifier. The principal investigator further reflected on each theme and grouped similar themes under a global heading in a flowchart format. The flow chart included four central themes as the top headings: experience of role transition, mentorship and support, life and professional experiences, and educational preparation. All themes that described these headings were placed in the flowchart under the top headings and determined to be sub-themes. For example, under the heading “experience of role transition,” three sub-themes were included: feelings during the transition, the experience of transition, and feelings during

the first role as an NP. Each sub-theme was tallied starting with the first interview and ending with the last interview to determine how many times that sub-theme occurred during the interviews. If at least 50% of the participants mentioned the sub-theme, then it was confirmed as a significant sub-theme and subsequently used in the results of the study. If less than 50% of the participants mentioned the sub-theme, then it was eliminated. This sequential process also assisted in ensuring no new themes had emerged at the end of the interviews, thus increasing the likelihood of achieving data saturation. Achieving data saturation was fully described in Chapter III. For example, under the theme heading “experience of role transition,” two final sub-themes were included: feelings during the transition and feelings during the first role as an NP.

Once the sub-themes were identified, each sub-theme was then further analyzed to determine the essence of the description and was re-titled to reflect the essence of the sub-theme description. For example, the sub-themes “feelings during the transition” and “feelings during the first role as an NP” were reviewed and re-titled/re-organized to reflect their meaning. Hence, the final sub-themes were titled “an exciting experience” and “a time of negative emotion.” The final research findings included four final themes and nine sub-themes that emerged from the data. The four central common themes were re-titled to reflect an overall global description of the sub-themes included within them. For example, the main theme “experience of role transition” was retitled Emotive Responses During the Transition to accurately describe the combined essence of the two sub-themes--“an exciting experience” and “a time of negative emotion.”

The next step of the analysis method was to write an exhaustive description (Shosha, 2012; Streubert & Carpenter, 2011). Based on the final four common themes

that emerged from the data, a description of each theme developed. The individual descriptions of each theme led to an overall exhaustive description of the participants' experiences associated with their transition to the NP role. This exhaustive description was cumulative of all four themes and nine sub-themes. Hence, there was an overall exhaustive description of NP role transition as experienced by the NPs enrolled in this research study.

The next step of the analysis method was to return to the participants for validation of the description—a process known as member-checking (Shosha, 2012; Streubert & Carpenter, 2011). Two of the enrolled participants agreed to participate in member-checking. Each of these participants was sent the final exhaustive description of the experiences nurse practitioners identified as being associated with their transition to the NP role. Each participant had one week to review the exhaustive description and then a follow-up phone call was scheduled. During the phone call, each participant validated the description and agreed with the description presented to them; neither participant had anything to add. This research achieved data saturation after eight participants.

Participants

A total of 12 individuals responded to the research participation request. Two potential participants did not qualify for inclusion in the study based on the pre-screening survey process described in Chapter III. The inclusion criteria of the study required participants have no less than one year of NP practice and no more than three years of NP practice. One of the initial potential participants did not qualify for inclusion since he/she had been a nurse practitioner for eight years. A second participant did not qualify for inclusion in the study since he/she had been a nurse practitioner for 13 years. Seven

participants completed the interview process. Three of the initial qualified potential participants expressed interest in participating in the study and met inclusion criteria but failed to respond in setting up an interview date and time after multiple requests. The study gained one additional qualified participant using the snowball method.

Participant demographic data were fully described in chapter III and are summarized here. The age of the participants ranged from 27 to 53 years. Seven participants identified as female and one identified as male. Eight of the participants identified Caucasian as their ethnicity. Seven of the participants reported being master's degree prepared and one participant reported doctoral preparation. Three participants attended an onsite program, two participants attended an online program, and three attended a hybrid program. Four participants self-identified as being certified as family nurse practitioners, two participants self-identified as being certified as adult-gerontology primary care nurse practitioners, one participant self-identified as being certified as an adult-gerontology acute care nurse practitioner, and one participant self-identified as being certified as a pediatric primary care nurse practitioner. Participants were licensed in seven different states and practiced in five different states across the United States. The participants came from a variety of specialty practice settings, within their certification focus. Years of experience as an RN before becoming an NP ranged from 6 to 30 years. Table 2 provides a summary of selected demographic data of the participants.

Table 2

Participant Demographic Information

#	Age	Gender	Ethnicity	Education	Program Type	Certification	NP Exp. (years)	State(s) Practicing	Specialty	RN Exp. (years)
1	51	Female	Caucasian	Masters	Hybrid	FNP	2	CA	Family Practice	26
2	27	Female	Caucasian	Masters	On-Site	AGACNP	1	NJ	Trauma Surgery	3.5
3	46	Female	Caucasian	Masters	Online	FNP	2	AZ	Family Practice	6
4	51	Female	Caucasian	Masters	Online	FNP	2.5	NJ	Pulmonary	18
5	31	Female	Caucasian	Masters	Hybrid	PCPNP	3	NJ	Pediatrics	8
6	35	Female	Caucasian	Masters	On-Site	AGAPNP	1.5	NJ	Vascular Surgery	6
7	53	Female	Caucasian	Masters	Hybrid	FNP	3	NJ	Urology	30
8	39	Male	Caucasian	Doctorate	On-Site	AGAPNP	3	MI	Palliative Care	12

Note. FNP = family nurse practitioner, AGACNP = adult-gerontology acute care nurse practitioner, PCPNP = primary care pediatric nurse practitioner, AGPCNP = adult-gerontology primary care nurse practitioner.

Results and Findings

The central research question that guided this study was as follows:

Q1 What experiences do nurse practitioners identify as being associated with their transition to the NP role?

In this descriptive phenomenological study, eight participants were interviewed and shared their experiences associated with their transition to the NP role. Participants were carefully selected based on their characteristic properties regarding entering the role of the NP through a purposive sampling technique. Through the data analysis of participant interviews, common themes emerged from the data to generate new knowledge regarding the experiences nurse practitioners identified as being associated with their transition to the NP role. The data generated four final central themes and nine sub-themes representing a description of the lived experiences of NP role transition. The generated themes are presented in Table 3 and addressed in the subsequent sections of this chapter.

Table 3

Themes and Sub-Themes

Theme	Sub-Theme
Emotive responses during the transition	An exciting experience A time of negative emotion
Building blocks for advanced practice	The foundation of patient care Navigating without a roadmap Gathering the tools for NP practice
Establishing vital relationships	Experienced NP relationships Physician collaborator relationships
The educational journey	Knowledge building through application Interactive learning environments

Emotive Responses During the Transition

The first theme that emerged from the analysis of individual interviews described the feelings and emotions the participants experienced during their transition to the NP role. Initially, through a manual coding process, this theme was labeled as “feelings during the role transition.” This theme transformed to Emotive Responses During the Transition. The rationale for the final naming of this theme was to encompass a greater essence of the intense feelings participants described experiencing during their NP role transition. The participants described feeling “excited” for their new role along with the negative emotions of “stress” and “nervousness.” According to the theoretical framework used to inform this study (transitions theory), disconnectedness occurs throughout a transition. During disconnectedness, individuals identify with a break in their feelings of security as they relinquish their familiar role and identify with a new role. Through this process, the individual also develops awareness of the event and defines/redefines the meaning of the change for him/her (Meleis, 2015). For this study, the participants experienced a period of disconnectedness, leading to intense feelings of “excitement,” “stress,” and “nervousness” as they relinquished their familiar role of the RN and embraced the unfamiliar role of the NP. The essence of this theme described the intense feelings of the participants undergoing NP role transition.

There were two associated sub-themes: “an exciting experience” and “a time of negative emotion.” These two sub-themes cumulated in providing an exhaustive description of the emotive responses during the transition experienced by the participants. All eight participants described their feelings and emotions during role transition. Six of the eight participants described negative feelings associated with their transition. Four of

the eight participants described their “excitement” to enter the NP role. In reference to the emotive responses during the transition, the participants used phrases such as “nervous to take on an entirely different role,” “it was stressful to take full responsibility of patient care,” “I was really excited...I finally attained my goal,” and “I became more excited as I became comfortable with my role.”

An exciting experience. The participants of this study described their feelings of excitement for the NP role. Four of the participants described being “excited” during their transition. The source of excitement differed among individuals. The overall feeling of excitement was an emotive response experienced during the transition regardless of the source. The feelings of excitement stemmed from multiple factors including goal attainment, becoming more educated in their specialty, providing care for patients at a higher level, and providing opportunities for other healthcare professionals, specifically RNs. Factors that produced a feeling of excitement afforded the transitioning NP with a newfound sense of security and an increasing level of comfort in his/her new role. The feelings of excitement flourished as the NP became more comfortable and confident in his/her practice. Participants used various terms in describing their excitement as they entered the NP role: “excited,” “exciting,” “encouraging,” “thrilled,” and “great.” Each of the four participants who described excitement personalized this feeling based on his/her own experiences.

The first participant who described a feeling of excitement was Participant #2. This participant described being excited as she entered her first NP role. She felt as though she had attained her goal and was also able to work in a specialty that was interesting to her. Participant #2 stated, “I was really excited because it’s kind of

something I always wanted to do. So, I felt like I finally attained my goal. I've always wanted to work in trauma, so it's like oh, this is great. I'm really doing what I wanted to do.”

Participant #3 described her concurrent feelings of being excited and nervous about her new role. This participant's statements linked to those of Participant #2 and provided some more depth into the feeling of excitement mixed with feeling nervous. Participant #3 stated,

I was just excited to be in the role, but also a little nervous because you don't want to do harm to anybody. You are now the provider making the decisions . . . and you want to make sure you are making the right ones. It was thrilling to be able to do that but made me nervous at times as well.

Participant #5 described her feelings of excitement in the new role similar to the previous participants but was able to expand on her excitement and personalized this feeling to becoming more educated in her specialty and gaining more knowledge in this area. Participant #5 stated,

It was very exciting for me, and I am excited to continue my learning during this time of transition. In fact, I'm planning on getting certified later this year. I think you can never stop educating yourself...continuing education is one thing, but more practice-based things are helpful as well. For me, it is just so exciting to be able to push myself to learn more and more about my role.

Participant #8 described a feeling of excitement in being able to provide the nursing staff with opportunities he wanted as a nurse. The previous experience of being a nurse gave him an understanding of what nurses wanted and how to respond to their needs. This participant agreed with prior participants who described their feelings of excitement but personalized this feeling based on the ability to provide for the nursing staff. Participant #8 stated, “Although I was afraid of the role initially, I become more

excited as I become more comfortable in my practice and recognizing the significance of my impact on patients and the nursing staff.” Participant #8 further stated,

It was really exciting and...I have such a good relationship with the nursing staff. I respect them...I listen to them...and I empower them. I give them everything that I wanted as a nurse. I am excited that I am able to do that for them in this role.

A time of negative emotion. The participants of this study had the opportunity to openly discuss the lived experiences associated with their transition to the NP role. The rationale for describing these feelings as negative was related to the descriptions provided by the participants. There are both positive and negative forms of stress. However, based on the participants’ descriptions, stress resulted from not feeling comfortable in their new role and prohibited full engagement. Hence, the feelings of stress and nervousness were described by the participants as being negative in nature.

During analysis of the interviews, six participants described negative feelings associated with the transition to the NP role. Nurse practitioners who are transitioning to their new role experience stress and nervousness. These feelings cumulated from the process of disconnectedness as described in transitions theory. Moving from the RN to the NP role coincides with a loss of security as the transitioning NP takes on a new scope of practice in which they are now the primary, independent decision maker for patient care. The fear of making an error, which could negatively affect a patient, contributes to these feelings. The transitioning NP needs to become comfortable with stepping out of the RN role and fully embracing the power and impact of the NP role. In general, these negative feelings last for approximately one year after starting in the role but NPs experience the highest levels of stress during the first few months within this new role; in critical situations, these feelings often return. Participants used various terms in

describing these negative emotions as they transitioned to the NP role: “nervous,” “stressful,” “challenging,” “anxiety,” “uneasy,” and “overwhelmed.”

Participant #2 was the first participant to describe negative emotions associated with role transition. She described being nervous because it was an entirely different role from that of the RN:

You are no longer just required to pass medications, assess, and maintain a patient for a 12-hour shift; instead, you are now required to make decisions independently and completely lead the care of the patient. That alone made me nervous, and it was very stressful knowing that if there was an error or a problem with the patient I am now solely responsible. It gets better over time, but the first few months was the worst.

Participant #3 agreed with Participant #2 and described the transition to the role of the NP as stressful and challenging, most notably during the first few months of the transition. Participant #3 stated, “The most stressful and challenging part of the process was the first few months. I needed to get out of the RN thought process and take full responsibility as the NP.” The movement from the role of the RN to the independent decision-making capacity of the NP presented her with feelings of stress as she became more familiar with the role, specifically in critical situations where she remembered having the “RN staff look to me for critical/life-saving decisions to be made quickly.”

Participant #4 described being extremely nervous as she entered the role of the NP and became acquainted with the responsibilities and expectations of the role. Her statements coincided with those of previous participants: “I was constantly wondering if my education prepared me enough make critical decisions independently. I was very nervous because of this and was uneasy when taking care of a critical patient.” The anxiety and feelings of nervousness lasted for quite a while but described it as “being most intense within the first few months of practice as an NP.” It was challenging for

this participant as she tried to “move beyond the role of the RN and fully embrace the role of the NP.”

Participant #6 described feeling very overwhelmed when entering the NP role: “Being the NP and having to make independent decisions is very different from the comfort of the RN role. Every day it seemed to become easier, but overall I felt as though I was in survivorship mode.” In correlation with previous interviews, Participant #6 described the movement from the RN role to the NP role as being stressful: “Having to make independent decisions was stressful especially in the beginning, but has become easier over time... However, there are times where, in critical situations, the feelings of stress returns... The first year was the most challenging.”

Participant #7 described the stressful experience and related this feeling to a sense of “imposter syndrome.” Consistent with other participants, she described these feelings as derived from relinquishing the RN role and taking on the NP role:

I had been a nurse for so long, which helped. However, having your former colleagues look to you to make decisions and them questioning your position definitely led me to suffer from imposter syndrome. I had to become comfortable in my new role, but until then it was quite a challenge and stressful, to say the least. It does get better over time.

Participant #8 described his feelings of role transition as being stressful as he came to understand the impact his role had in the care of patients and their final outcomes. This coincides with feelings experienced by other participants. Participant #8 stated,

I was definitely afraid of being who I really was, the NP. Because I was a nurse for so long, I was comfortable caring for people but had to step out of that role and into my new role. I suddenly recognized the significance of my power as the provider. I was the one making the decisions, and that was stressful.

Summary. The first theme described the emotive responses during the transition. Transitions theory explains a process known as disconnectedness in which the individual develops a sense of insecurity as he/she relinquishes a familiar role and transitions into a new, unfamiliar role (Meleis, 2015). The transitioning NP must relinquish his/her role of the RN and become immersed in the role of the NP. The movement from the RN to the NP role includes emotive responses associated with this transition. Negative feelings of “nervousness,” “stress,” “challenge,” “anxiety,” “uneasiness,” and “being overwhelmed” accompany the transition process. These negative feelings are a result of taking on a higher level of responsibility and navigating the unfamiliar waters of a new scope of practice. These negative feelings last for approximately one year after starting in the role but NPs experience the highest level of these negative feelings during the first few months. In light of these negative feelings, the transition to the NP role also includes a feeling of excitement as individuals meet their professional goals, increase their level of education, provide higher levels of patient care, and give back to other healthcare professionals. The feelings of excitement flourish as the NP becomes more comfortable and confident in his/her practice. The associated emotive responses of excitement and negative feelings are a mixed-bag of emotions and feelings that correspond with a loss of security as one enters the NP role followed by an increasing sense of security as one becomes more confident and comfortable in the NP role.

Building Blocks for Advanced Practice

The second theme that emerged from the analysis of individual interviews described the experiences participants felt were necessary as a basis for their transition to their new role. These experiences, or building blocks, assisted the participants in

transitioning to their new role. If these experiences were not present, the participants indicated these experiences might have proven to be beneficial during the transition to their new role. Initially, through a manual coding process, this theme was labeled as “professional experiences.” This theme transformed to Building Blocks for Advanced Practice. The rationale for the final naming of this theme was to encompass a larger essence of professional experiences the participants described as being integral to or necessary for their transition to the role of the NP. The participants described experiences they felt assisted them during their role transition along with experiences they desired to have but were not present during their role transition. For instance, participants described their prior RN experience as “essential” in providing them a “good background” for starting off their career as an NP. Participants also described prior RN experience gave them the ability to “understand patient care,” “take care of multiple diagnoses,” “treat the whole patient,” and gave them “self-confidence.” Participants further described factors that made their transition more difficult. For instance, participants stated they were “not clear on expectations” and they felt as though they “assumed” what their expectations should have been. Overall, participants reported being “on their own” during the transition. Having clear role expectations set by direct supervisors would have been a “benefit” and caused a “less stressful” transition. Lastly, participants reported a lack of sufficient orientation to their position. Statements such as “wish there was something that was more formal,” “lack of initial orientation really hindered me,” and “structured orientation would have made me feel much more supported” spoke to the lack of an ability to engage in their actual position as an NP at a particular institution or practice.

According to the theoretical framework used to inform this study (transitions theory), interventions are useful in role transition to ensure individuals meet the outcomes of the role transition. Interventions for a transition include (a) clarifying roles, competencies, and meanings, (b) identifying milestones, (c) mobilizing support, and (d) debriefing (Meleis, 2015). Identifying milestones is integral in managing the process of transition. This milestone identification assists the individual and available supports to identify a need for specific intervention if the transition is not progressing (Meleis, 2015). In this study, NPs reflected on those milestones that influenced their role transition and identified needed experiences to be able to identify transitional milestones efficiently. Clarification of the NP role and a structured orientation program coincided with interventions described in this theory. Having role clarification and a structured orientation could assist NPs in transition by (a) clarifying their direct supervisor's expectations of the NP role, (b) determining the competencies needed for success, (c) identifying milestones associated with being successful, (d) mobilizing support systems as needed to champion success, and (e) determining opportunities for growth through debriefing.

Three associated sub-themes encompassed the building blocks for advanced practice: “the foundation of patient care,” “navigating without a roadmap,” and “gathering the tools for NP practice.” These three sub-themes cumulated in providing an exhaustive description of the building blocks for advanced practice. All eight participants described their prior RN experience as providing them with a foundation for patient care. Six participants described not having clear expectations set forth by direct supervisors when starting their first NP role. Seven participants described a lack of

formal orientation, which left them without the tools necessary for their NP practice. In reference to the building blocks for advanced practice, the participants used phrases such as “providing a background for patient care,” “understanding what is expected of me,” and “having the tools necessary to do my job.”

The foundation of patient care. A common sub-theme that emerged from the data was prior RN experience. A variety of life and professional experiences are associated with transitioning to the NP role. However, prior RN experience is a significant building block for advanced practice, which assists the NP in constructing the foundation of patient care practices. Prior RN experience provides the NP with a plethora of “core skills” and abilities that assist them in their transition to the NP role. Through the experiences gathered as an RN, the new-to-practice NP learns how to be “flexible” and “evaluate situations.” Prior RN experience provides a “background” for providing patient care and a framework to make valuable patient care decisions. This experience provides the NP with the ability to interact with, advocate for, and understand the needs of a particular patient population. Participants in this study used various phrases in describing the utility of their prior RN experience as they entered the NP role such as “overall aspects of patient care and how to treat patients came from my experience as an RN,” “it really helped me to have a basis for the care,” and “my RN experience was invaluable.” All eight participants described their prior RN experience as providing a foundation of patient care they delivered as an NP.

Participant #1 described how her prior RN experience prepared her well for patient care. Being able to see other NPs practice also gave her a better understanding of how the NP should function in the role:

All of my RN experience was beneficial. It taught me how to be flexible and how to evaluate situations presenting to me. The experiences I had as an RN provided me a good basis for NP practice. ...During my years as an RN, I was able to interact with and observe how NPs in the facility practice. This gave me a better understanding of the NP role and how I wanted to shape my own practice. ...Not only did I learn how to be flexible and evaluate the situation in front of me, I learned what my scope of practice as an NP should be.

Similar to Participant #1, Participant #2 described her prior role as an RN as being beneficial in her ability to interact with patients and understand how to care for patients appropriately:

I had a few years of experience as an RN prior to becoming an NP, and that was really helpful. I did not have experience in the specialty I took on as an NP, but the overall aspects of patient care and how to treat patients came from my experience as an RN. I really understood patients.

Participant #3 described her prior RN experience as playing a part in being able to begin in the NP role:

It really helped me to have a basis for the care I provide as an NP. ...My LPN and RN experience set a good basis for my practice as an NP. I already knew how patients wanted to be treated and I was able to make sure I was treating them the way they wanted to be treated.

Participant #4 provided additional evidence to support prior RN experience as being beneficial in providing care for patients as an NP:

I think that me being an RN was very helpful because I kind of already knew what to expect, what the doctors wanted, and how to care for patients. I had the experience of seeing different patients with different diagnoses and that helped me to understand what treatment plans would be necessary. My RN experience was invaluable because I basically learned...how to take care of patients.

Participant #5 added to the evidence the usefulness of prior RN experience in establishing a basis of self-confidence and of taking experiences as an RN and being able to implement them into her independent practice as an NP:

My RN experience gave me the ability to be in charge of myself...have more self-confidence that is important in being an independent practitioner. As an RN, I

really learned how to understand patient care. In general, looking at the health care system from the perspective of an RN gave me an idea of how I should care for patients and what I could do to improve the health care system as an NP.

Participant #6 described her RN experience as giving her the ability to provide patients with a better holistic aspect of care and to understand patient needs:

My nursing experience really helped me with the medical knowledge I needed to be an NP. Most importantly, as a nurse, I learned how to be a patient's advocate. Now as an NP, I am their advocate to make sure they are getting the best care possible. As a nurse, I learned how to look at the whole patient and all of the different aspects of their social and physical wellbeing. As an NP, I integrate that into my daily practice to make sure my patients are well cared for.

I have always enjoyed having a close bond with my patients. I learned to bond with patients from my nursing experience, and now as an NP, I feel like I can really connect with my patients on a level that other providers don't always do.

Participant #7 described her RN experience as being able to prepare her to take care of multiple patient diagnoses and situations.

All of my experiences as an RN, I think, prepared me well. I'm not saying I've seen everything, but I saw enough to give me a good background to start off my NP practice. I saw many different patients, diagnoses, and situations. Being an RN provided me the ability to respond to those things.

Participant #8 described his RN experience as providing him with a set of core skills that were important to his practice as an NP:

My RN experience helped me to be more confident as an NP. As a nurse, I really learned prioritization and organization. That helps to make me a good NP. Walking into any situation with multiple patients you need to be able to look at the whole picture and decide which patient needs your attention first. I learned how to do that from my years as a nurse. ...As a nurse, I had a strong experience of assessing patients and walking into a room and recognizing what was wrong and what to do right away. That was so helpful as I entered a specialty I was not familiar with.

Navigating without a roadmap. Upon further reflection, participants described feeling as if their first NP position lacked workplace expectations from direct supervisors,

which contributed to negative emotive feelings experienced during role transition. Expectations from direct supervisors were not always clear or furnished in advance. Hence, NPs lacked an understanding of their workplace expectations and could not set appropriate goals for themselves. While some of the more generalized aspects of the role might have been specified up front, the more complicated aspects of workplace expectations were left undefined. The lack of workplace expectations contributed to a challenging transition to the NP role. The lack of clarity was present in workplaces that might not have used NPs previously but was also present where NPs were already part of the team. This lack of clear workplace expectations coincided with a stressful experience. New NPs were left to assume the expectations of the workplace without any direction from their direct supervisors. Hence, there was no basis for setting milestones or determining if they were successful in their role. Direct supervisors setting clear workplace expectations would assist transitioning NPs in setting and evaluating milestones for their success while determining how they should function in a particular workplace. Participants used various phrases in describing the lack of role clarity as they entered the NP role: “on my own,” “no direction,” and “uncertainty.”

Participant #1 described her first role as lacking clarity of expectations beyond the general day to day logistics:

I needed to have more clarity in my role and what my scope of practice was. I didn't really have anyone overseeing me to set up expectations. It was expected that for the first three months I would take a patient load of eight patients per day. Other than that, I was not clear on how I would be setting up my own NP role within the practice. It was not clear on how I would move from the student to the NP and establish my own practice. The office manager was unable to provide me with clear expectations for my role. I wasn't clear on what types of patients I should handle independently, when I should include the attending physician, and when I should be consulting out to another service. All of this together really added a lot of undue stress to my first role.

Participant #2 agreed there was a lack of clarity in her scope of practice expectations and there was a difference between what was expected of other new nurse practitioners in their institution and what her role was:

I know with my friend we had gaps in what we did in our practice. ... When I met with other new NPs in this place, it was clear that all of us had a different understanding of what our roles were. I was not clear on my expectations from the beginning, and it would have been helpful to know, this is what I want you to do, this is what you are able to do, and this is what I need from you. Would have been a lot less stressful that way.

Participant #3 described the lack of clarity was from not having a support person to discuss their expectations. Although this triggered confusion, she was able to find what she needed in outside resources:

I figured out how to look up things and find answers to things because I didn't have anybody to speak with about these things. I just assumed they expected me to be fully independent in my role, so I adapted and overcame the situation. But, I was never sure if I was actually meeting the requirements they expected of me.

Participant #4 described not having an understanding of her true role within the service; although she was working alongside an experienced NP, the clarity of expectations was not made clear as this service was utilizing NPs for the first time: "The NP that had experience... was not clear on her role expectations in this service. I felt alone, and I guess I'll be figuring things out on my own. I don't think any of us really understood what they expected of us."

Participant #5 described dealing with a lack of role clarity from the aspect of a service that had not utilized NPs previously and only worked with physician assistants. This lack of understanding of the NP role led to a lack of clarity as to what her expectations were as part of the service:

When setting role expectations, issues were dealt with by saying, this is how we used to do things. They only worked with physician assistants previously, and

never an NP. So, they were not aware of the differences of our scope of practice and unable to set expectations for me within the practice. So, my actual role in the service was never clear.

Participant #7 described entering her role as an NP and the administrators of the practice not knowing how to set expectations. Hence, she described having to independently figure out what the expectations were:

I was largely on my own for my first NP role and did not feel that was appropriate. I was comfortable from the aspect of a nurse to initiate standing orders, but now I was making the decisions. The administrators had no idea what I could or could not do, so they could not set expectations for me. I had to figure it out myself. I was always feeling uneasy because I wasn't sure if what I was doing is what they wanted me to do.

Gathering the tools for nurse practitioner practice. Participants described their experiences with their transition to the NP role and the lack of a formal orientation, which left them without a clear understanding of the workplace environment and unequipped with the tools necessary to function in the workplace. These tools include understanding institutional policies and learning and performing required procedures. Unclear or lack of workplace expectations leaves NPs without an understanding of what their direct supervisors require of them. A lack of formal NP orientation presents a barrier for new-to-practice NPs during role transition. Therefore, formal orientation programs like those offered to new-to-practice RNs would be a beneficial support to the new-to-practice NP when transitioning to the role and would limit barriers to the transition experience.

Formal orientation programs should focus on learning about the facilities policies, procedures, and the resources available to the NP. An opportunity to network with other new-to-practice NPs in the same workplace through a formal orientation program would also be beneficial during the transition to the NP role. Participants used various phrases

in describing the lack of formal orientation as they entered the NP role: “it would have been really nice if we had a generic new to practice nurse practitioner orientation,” “having a time that would orient me to the policies of the facility would have been very beneficial in my day to day work as an NP,” and “having a structured orientation would have made my life and job so much easier.”

Participant #1 described the orientation process occurring during her clinical preceptorship and not in her first position as an NP. She worked for the same facility where she had completed her last clinical practicum rotation:

I precepted my first semester and last semester in the same clinic I was hired in. I was basically oriented through my preceptorship. The con of this was that as I entered the role of the NP in this clinic, it was assumed I had the tools necessary to complete my tasks. However, there was much I needed to learn that was not provided to me due to the lack of orientation.

Participant #2 indicated she had entered a position where they had no formal training from prior experiences or from their clinical practicum:

It would have been really nice if we had a generic new to practice nurse practitioner orientation. As a new graduate RN, you had that before you even started working, but this was not the same as an NP. The orientation would have been nice because it would have given us the opportunity to meet with other new NPs, at least once a month, and discuss new things we were going through or to even practice skills.

Having a time that would orient me to the policies of the facility would have been very beneficial in my day to day work as an NP. I really wish there was something that was more formal to help me with these things. I learned from my preceptors, but they had to keep giving me more time. I could have been on my own a lot quicker if there was a standardized way to gain the information all new NPs needed as they entered the facility.

Participant #3 described the lack of orientation to the work environment and the NP role made her feel very alone in the process. She also discussed that the lack of orientation time made her first role very stressful during her role transition:

I was expected to just start off on my own; I had no support or orientation when I first started. This was not ideal, initially, but when you are in the thick of a situation like this, you reflect on the bad things. Later, I found that this probably made me a stronger, independent clinician, but the lack of initial orientation really hindered me and took me longer to feel comfortable in my role as an NP.

Participant #4 discussed that a form of orientation could have made her role transition experience more positive:

I've heard in some hospitals they have an NP residency program or something like that. Basically, having a structured orientation would have made my life and job so much easier. Some form of structured orientation would have made me feel much more supported in my first role. There were many NPs that were new to practice and started around the same time as me. Having an orientation where we were all together, learning and building our skills would have been excellent. We could have discussed challenges we were facing and learned from one another. I really wish we had this.

Participant #5 described that having an orientation would have been beneficial to the transition process. The lack of orientation left her without the skills necessary to complete her job:

In my first role, I worked for three different hospitals within the health care system. I had no orientation to these facilities and did not even possess the basics of using the computer systems or knowing where my resources were. I just had to learn on the go. A little bit more of an orientation would have been very helpful to me.

Participant #6 described the lack of orientation in a facility where she had already worked as an RN. She felt comfortable with the healthcare system but felt the need for an orientation component:

I worked for this health care system, so I knew the people, and I knew the facility. I never had an orientation when I went from being the RN to the NP. Although I was comfortable with the facility and the people, a formal orientation would have been helpful because this was completely new for me.

Participant #7 described the need for a standardized orientation program similar to one provided to new graduate nurses:

You know, you have just enough knowledge to hurt somebody, but in the beginning, not enough to make sure you are making the best decisions. I think one of the keys here is to have an NP orientation like we do for new nurses. This gives you time to learn the role and make sure you are performing to a high level. An orientation program would give new NPs the time to consult with other new NPs and learn from each other while building more knowledge, skills, and learning the system.

Summary. The second theme described the building blocks for advanced practice. Transitions theory described interventions were useful in role transition to ensure individuals met the outcomes of the role transition. Interventions for a transition included clarifying roles, competencies, and meanings; identifying milestones; mobilizing support; and debriefing (Meleis, 2015). Transitioning NPs must acquire building blocks necessary for advanced practice in their first role as an NP. Prior RN experience provides the foundation for patient care utilized in NP practice. Through prior RN experience, the NP gains an understanding of patient needs, patient advocacy, dealing with complex patient situations, and establishing a framework for providing patient care. Furthermore, prior RN experience assists the NP in gaining self-confidence. Through prior RN experience, NPs can give meaning to their patient care activities.

Providing the NP with a clear set of workplaces expectations upon hire is essential to allow NPs to clarify their role within the workplace and set milestones to ensure a successful transition occurs. Identification of milestones leads to the ability of NPs to evaluate their transition and their success in NP practice. If the NP does not achieve these milestones, opportunities for growth should be identified through a debriefing with his/her direct supervisors. Resources can be mobilized to assist the NP in being successful in the workplace once the opportunities for growth are identified.

Without setting clear workplace expectations, NPs are left to navigate their role without a

roadmap and are unaware of what their direct supervisors require of them, leading to an increase in their emotive feelings during the transition.

Lastly, a formal orientation program provides NPs with the ability to gain competencies necessary for their role. The need for a formal orientation program differs from setting clear workplace expectations. For instance, setting clear workplace expectations allows NPs to understand the expectations of the NP role from their direct supervisors. A formal orientation program provides the NP with the tools necessary to meet those expectations. These tools include the identification of institutional policies and procedures, learning to perform the procedures necessary for patient care, and networking with other new-to-practice NPs in the workplace.

Establishing Vital Relationships

The third theme that emerged from the analysis of individual interviews described experiences with establishing vital relationships with other providers during the role transition process and how these relationships assisted in the transition to the NP role. Participants identified two sources of relationships with other providers: experienced NPs and collaborating physicians. Initially, through a manual coding process, this theme was labeled as “mentorship and support.” This theme transformed to Establishing Vital Relationships. The rationale for the final naming of this theme was to encompass a more expansive essence of the necessary peer relationships described by the participants and how these relationship experiences provided support during the role transition.

According to the theoretical framework used to inform this study (transitions theory), patterns of response that occurred through the transition process helped to determine if the transition was going well (Meleis, 2010). The patterns of response

identified how individuals responded to the change event. From a nursing perspective, there are two sets of responses: process patterns and outcome patterns (Meleis, 2015). For this analysis, the assessment of outcome patterns correlated with the relationships developed and their effect on the transition process. Five outcome patterns occur throughout the transition: mastery, fluid and integrative identity, resourcefulness, healthy interaction, and perceived well-being. With regard to establishing vital relationships, the outcome pattern of interest was “healthy interaction.” Healthy interactions and connections are measured through the formation of new relationships and the maintenance of current relationships, which offer support to the completion of the transition process (Meleis, 2015). Establishing vital relationships during role transition offers the NP varying forms of support through interactions with experienced NPs and collaborating physicians.

Two associated sub-themes encompassed establishing vital relationships: “experienced NP relationships” and “physician collaborator relationships.” These two sub-themes cumulated in providing an exhaustive description of establishing vital relationships as experienced by the participants. Seven participants described their establishment of a relationship with an experienced NP. Six participants described their establishment of a relationship with a physician collaborator. In reference to establishing healthy relationships, the participants used phrases such as “An NP mentor, someone who understands the role, would really have been helpful to me,” “it would be nice to be able to go to that support system to help you take care of things when you feel like you can’t,” and “I have learned so much.”

Experienced nurse practitioner relationships. Participants described their experiences with their transition to the NP role and the importance of having a relationship, or lack thereof, with an experienced NP. While some participants had a mentorship or preceptorship experience with an NP in their first role, some did not have this experience. The relationship with an experienced NP during a role transition is integral to the transition process. The mentorship fostered through a relationship with an experienced NP is beneficial when transitioning to the role of the NP by offering the new-to-practice NP multiple avenues of support. Having someone who understands the role of the NP is beneficial to address the lack of workplace clarity and the lack of a formal orientation program. Relationships with experienced NP mentors could assist in closing the gap when direct supervisors fail to set clear workplaces expectations.

Furthermore, having someone to understand the feelings of the new-to-practice NP during the transition offers an additional level of support and decreases the impact of negative emotive feelings. Having another new-to-practice NP relationship might prove to be beneficial but experiences gained from a relationship with an experienced NP are imperative. An experienced NP could offer advice and mentorship to the NP transitioning to the role another new NP could not provide. Those who have had a relationship with an experienced NP found this to be beneficial to their role transition. Those who have not had the experience of a relationship with an experienced NP mentor describe the desire to have this affiliation. Participants used various phrases in describing relationships with experienced NP mentors: “I have felt very supported by the NPs that I work with,” “I wish I had another NP, at the time, to support me and offer guidance,” and

“Having a formal mentorship program or mentor relationship is so important in the beginning.”

Participant #1 described not having a relationship with an experienced NP mentor during her role transition experience but described the desire to have this relationship:

I was working with a physician assistant who had been at the facility for 25 years. A very strong PA who did not understand the role or abilities of the NP. ...I recognize gaps in my practice, but I am not sure how to overcome them. More NPs in the practice would be helpful and would be able to help me overcome these gaps. An NP mentor, someone who understands the role, would really have been helpful to me.

Participant #2 described having a relationship with an NP mentor during her role transition experience. She described this experience as a positive aspect of her role transition and in becoming an independent NP:

The NPs I work with are just amazing. I am able to bounce ideas off of them without feeling judged. I am able to just talk out loud and ask if I am doing the right thing and what I can do better. ...I have felt very supported by the NPs that I work with, and they have taught me aspects of the role that I never learned in school. Having NPs to help me along the way has been a great experience. They have really helped me to learn the specifics of my role and make me a better NP all around.

Participant #3 described not having a relationship with an NP mentor during her role transition experience but described the desire to have this relationship:

I wish I had another NP standing next to me saying, oh, you could do it this way. There was no other NPs in my practice. I was a brand-new NP, so I have never worked as one. Everyone said, oh you will be fine. I wish I had another NP, at the time, to support me and offer guidance.

I wanted someone to understand if I was frustrated, upset, or happy. This is all part of the “growing up phase” when you enter a new role, but having another NP to even just discuss these things with would have been so helpful and comforting to me. It would be nice to be able to go to that support system to help you take care of things when you feel like you can’t.

Participant #4 described not having a relationship with an NP mentor during her role transition experience but described the desire to have this relationship:

I had another new NP with me, so we were able to talk about some things. We were able to discuss our concerns about the position. I wish we had another NP who had worked with this group before. I think that would have helped to develop the role of the NP better and help to set some standards on what we should be expected to do. Someone with experience.

Having another new NP with me gave me the ability to bounce ideas off of them and figure out what was working and what was not. But, having an NP with experience would have been great. A person who knew how we felt and could give us advice.

Participant #5 described not having a relationship with an NP mentor during her role transition experience in her first NP position but she did have a relationship with an experienced NP mentor in another position. This was found to be a positive experience.

Participant #5 stated,

In my very first role, I had no other NP to help me. In fact, I don't think they had any other nurse practitioners on that service. Then when I changed jobs a short time later, I had an experienced NP mentor me in that role. I thought to myself, if I had an NP in my first job, it would have been a much better experience, and I would have done so much better in that role.

Participant #7 described not having a relationship with an NP mentor during her role transition experience but described the desire to have this relationship:

I think having a formal mentorship program or mentor relationship is so important in the beginning. The only thing I wish is that I had taken a job with one of my old preceptors, so I could gain more experience with them and have more support. I did not have any NPs in my first role to bounce ideas off of or talk to and basically had no clinical supervision.

Participant #8 described not having a relationship with an NP mentor during his role transition experience but had a support person outside of the workplace to assist him:

Thank God I had another NP friend to help me, even just with preparing for the boards. A friend of mine was an NP for a very long time and was my salvation.

She was very good at what she did and really helped me, in the beginning, getting through my first NP role. I am so thankful I had another NP to support me.

Physician collaborator relationships. Participants described their experiences with their transition to the NP role and having a relationship with a physician collaborator. A relationship with a physician collaborator is a form of mentorship and support that provides NPs with the ability to increase the breadth and depth of clinical knowledge during their transition. The building of new knowledge is beneficial to the transition and the clinical practice of the NP. Although physician collaboration is beneficial in building knowledge, not all physicians understand the role of the NP. Working with a physician who does not understand the role of the NP can be challenging during the role transition process. However, a relationship with a physician collaborator is beneficial to the transition of the NP from a knowledge building perspective. Participants used various phrases in describing their relationship with a physician collaborator mentor: “They really don’t seem to understand the scope of practice or how to teach a nurse practitioner,” “helped me to build the knowledge I was lacking, and that made me more confident in my role,” and “they all had a different understanding of what the NP role was.”

Participant #1 described her collaborating physician as being helpful in building more medical knowledge about diagnoses but did not have a good understanding of the role of the NP in health care:

The role of the NP is still new to them and they really don’t seem to understand the scope of practice or how to teach a nurse practitioner. ... We work together, but they don’t always understand what I can actually do, and sometimes I feel like that leads to animosity. ... I really had a great relationship with my collaborating doctor. I was able to ask questions and get advice about the care of patients. He really helped me to build the knowledge I was lacking, and that made me more confident in my role.

Participant #2 described her interactions with collaborating physicians from a group setting:

I work with some great physicians, and most of them are used to the NP role and accept the NP role. However, there are a few that do not understand how an NP fits into their practice. For the most part, the attendings who understand the NP role seem comfortable to let us do what we do. The ones who do not understand our role, have no idea what to do with us. ...In my last clinical rotation, I was with a physician, and I truly don't believe he knew what to do with me. In fact, he admitted that a couple of times. ...For the most part, the physicians I work with are really comfortable teaching us, and I have learned so much from that aspect.

Participant #3 described her collaborating physician as being integral to her learning: "I found my attending physician to be very important to my growth. I became very comfortable with this physician, was able to ask questions, and was always learning something new."

Participant #4 described her experience with collaborating physicians as being beneficial to knowledge building. However, the physicians she worked with did not seem to understand the role of the NP:

There was a group of attending physicians that I worked with that taught me a lot. I always felt comfortable asking questions and learning from them. Though, I basically felt like I was below them, not equal to them. ...They really were not sure what we could do and just seemed to use me any way they thought they could. They really did not understand my actual role.

Participant #5 described attaining more medical-based knowledge from her collaborating physician but the physician did not truly understand the NP role:

My attending physician really taught me a lot. He was always willing to teach me. In fact, we always had a daily huddle on all the patients, and I learned so much from this. ...I really don't think he understood what we do. It's not as though he wasn't willing to learn, but it was challenging, for me, when he did not truly understand my role.

Participant #6 described challenges with the collaborating physicians she worked with as far as truly understanding the NP role but described the physicians as excellent educators:

The doctors were really good, like great educators. They used to give me homework to do, which was overwhelming, but I appreciate it now. They were training me exactly like a resident, and I learned a lot in that time. I think the physicians understood the role, but they all had a different understanding of what the NP role was. With each physician, I was utilized differently, and this led me to never feeling as a true independent provider. They all thought the NP role was different.

Summary. The third theme described establishing vital relationships.

Transitions theory describes the assessment of outcome patterns related to the relationships developed and their effect on the transition process. With regard to establishing vital relationships, the outcome pattern of interest was “healthy interaction.” Healthy interactions and connections are measured through the formation of new relationships and the maintenance of current relationships, which offer support to the completion of the transition process (Meleis, 2015). Establishing a relationship with an experienced NP offers the transitioning NP additional support throughout the transition process. The experienced NP mentor has an understanding of what it is like to be a new NP and can offer insight into role expectations and how to “survive” the first role as an NP. This relationship is essential, especially when workplace expectations are not made clear from direct supervisors. The relationship with an experienced NP is also beneficial in reducing the effects of negative emotive feelings experienced during the transition.

Establishing a relationship with a physician collaborator also proves beneficial to the transition of the NP. Although the physician collaborator might not fully understand the role and scope of practice of the NP, this relationship is beneficial in increasing the

breadth and depth of the NP's clinical knowledge base. This relationship is essential, especially when there is a lack of a formal orientation program. The physician collaborator relationship might assist in providing the tools necessary through additional knowledge building to be successful in the NP role. Overall, establishing vital relationships with experienced NPs and physician collaborators assisted in closing the gap when clear workplace expectations and formal orientation programs were not provided to the new NP.

The Educational Journey

The fourth theme that emerged from the analysis of individual interviews described experiences with learning during the educational journey and how this associated with the transition to the NP role. Initially, through a manual coding process, this theme was labeled as “educational preparation.” This theme transformed to The Educational Journey. The rationale for the final naming of this theme was to encompass a greater essence of the educational journey participants embarked on and how the aspects of their education associated with their transition into the NP role. The participants' educational programs varied from onsite, online, and hybrid style programs. Regardless of the type of program, the participants commonly described the same educational journey experiences associated with their NP role transition: clinical practicum and learning environments.

According to the theoretical framework used to inform this study (transitions theory), a transition is defined as “a passage from one life phase, condition, or status to another (Chick & Meleis, 1986, p. 237). Four factors, also known as change triggers, prompted a transition experience: developmental, situational, health-illness, and

organizational (Meleis, 2015). The transitional trigger relevant to this study was the situational change trigger. Changes in a situation cause a transitional experience as the individual moves from one role to another (Meleis, 2015). For this study, the situational trigger was the decision to embark on the journey of becoming an NP--starting with the educational journey. The environment influences the individual's ability to learn and enact his/her new roles. Environmental factors such as the educational journey influence the ability to transition to the NP role.

Two associated sub-themes encompassed the educational journey: (a) "knowledge building through application" and (b) "interactive learning environments." These two sub-themes cumulated in providing an exhaustive description of the educational journey as experienced by the participants. Seven participants described their experiences with the application of knowledge in clinical practicum. Five participants described their experiences with interaction in their learning environment. In reference to the educational journey, the participants used phrases such as "I took the knowledge I learned and was able to put it to use," "I got to apply what content I did learn in the classroom," and "responsible for our own learning and then had to apply our learning during our interactions with students and faculty."

Knowledge building through application. Participants described the experience of clinical practicum as part of their educational journey. Regardless of the type of program participants attended, the clinical practicum aspect of the educational journey provided an opportunity to build knowledge through the application of content learned in the classroom setting. Hence, clinical practicum better prepares NPs for their role transition by enhancing the knowledge necessary to function in the role. Classroom

learning is integral in attaining a knowledge base for NP clinical practice. In the classroom, learning is reflective of evidence-based practice but learning in the classroom environment is limited. It is not possible to learn every patient presentation or diagnosis the new-to-practice NP will encounter. In the clinical practicum environment, students encounter patient presentations and diagnoses not covered in classroom-based content. These additional experiences enable students to increase their breadth and depth of knowledge. Furthermore, aspects of the NP role are not addressed consistently in the classroom setting. Learning additional NP role aspects such as billing, job readiness, and interaction within the healthcare system might occur through experiences attained in the clinical practicum setting. Overall, clinical practicum augments the knowledge learned in the classroom and is a particularly beneficial part of the educational journey. The clinical practicum experience nurtures the application of classroom knowledge to actual clinical situations and builds additional clinical and professional NP knowledge. Participants used various phrases in describing their clinical practicum: “I was able to learn how to utilize resources to provide patient care,” “Helped me to understand the content I was learning and how to use what I learned in a real scenario,” and “I was able to understand and apply what I was reading in the book.”

Participant #1 discussed the benefits of being able to apply the knowledge learned in the classroom to clinical situations:

My education, classroom wise, helped me to learn evidence-based practice. During my clinical practicum, I was able to learn how to utilize resources to provide patient care. ...Clinical practicum is really where you do your best learning. ...I was able to take that knowledge I learned and actually put it to use and practice it.

Participant #2 described specific aspects of clinical practicum she found most beneficial to her transition:

My classroom education was excellent, but it was missing some of the additional aspects of the NP role that my clinical practicum was able to provide me. ...In clinical practicum, I took the knowledge I learned and was able to put it to use and really become comfortable using it in a real-life situation. ...The NPs I was with in clinical gave me the opportunity to really become comfortable with functioning as an NP, such as talking to physicians and residents as a provider instead of a nurse. ...I was able to see more of the business aspect and the management aspect of being a nurse practitioner. Something that was not focused on in the classroom. It really helped to round out my education.

Participant #3 described being in a self-learning classroom environment and using the clinical practicum aspect of her education to truly develop the knowledge needed to function as an NP:

I did not have a great experience with my online program. Basically, we were on our own learning what we needed to know. ...The NPs I worked with in clinical really helped me to understand what I was self-teaching in the classroom. ...In clinical, my preceptors took me under their wing and helped me to understand the content I was learning and how to use what I learned in a real scenario.

Participant #4 discussed the overall benefits of the clinical practicum experience during her NP education and how this experience augmented her classroom learning:

In the classroom, you learn the basics, like here is the common presentation, the risk factors, the diagnosis, and this is what you do with it. ...When I would go to clinical my preceptors really helped me focus that information down to how would I handle this patient in a real-life scenario. ...I had both physicians and NPs as preceptors, and each offered a different perspective, but with both, I always felt as though I was deepening my knowledge base of what I learned from the textbook. The NPs specifically discussed with me aspects of the role that was not taught in the classroom...like what type of position to look for, hour expectations, compensation, you know what I should be looking for in my first job.

Participant #6 described that during her clinical practicum experience, she was learning outside of the content taught in the classroom. In addition, she described clinical practicum as being the best learning method:

I really learned a lot in my NP program, like in the classroom, but they couldn't teach it all. ...Clinical is where I really learned...you never knew what was coming in, so I always had to be prepared to learn something new. ...I got to apply what content I did learn in the classroom and also got to see many different diseases that were not presented in the classroom or hadn't been presented yet. Clinical always gave me something to look up when I went home. A disease I didn't learn about or a presentation I never saw before. I think this really helped me to develop a strong knowledge base.

Participant #7 described her clinical as the most beneficial part of her learning experience because of the constructive feedback provided by her preceptors:

I learned the most from my preceptors in clinical. ...Learning the material in the classroom is important, don't get me wrong, but really working with the patients in clinical is where I was able to use that knowledge and learn more. I...was given constructive feedback by my preceptor, this is really what helped me to learn.

Participant #8 described the process of learning in the classroom and the differences of learning in the clinical environment:

My program overall was not very supportive, and in the classroom, I really had to teach myself. It seemed very basic. ...What I learned from the books was very important. ...I didn't have any clinical experiences until the very end of the program, and that is where I really learned the most. Application for me is really where it is at. ...In clinical I was able to understand and apply what I was reading in the book. So, I think both the classroom and clinical are important but clinical for me was where I really learned.

Interactive learning environments. Participants described their experiences with their transition to the NP role and the experience of interaction in their learning environment. The learning environment must be well structured and contain interaction with faculty members and classmates. A structured educational environment might encompass different factors such as high academic standards for success, setting clear learning goals, and setting a meaningful learning experience. Interaction with faculty members and classmates is an essential factor in a structured learning environment. The need for interaction is critical in onsite, online, and hybrid educational programs.

Interaction with both faculty members and classmates is a decisive factor for meaningful learning and associated with better knowledge development for transitioning to the NP role. A lack of educational environment structure and interaction negatively impacts the transition to the NP role by leaving the NP feeling unprepared to engage in clinical practice. Participants used various phrases in describing interactive learning environments: “It could have been better if we actually met the faculty or the other students,” “the best aspect of the program was the interaction with the other students and the faculty,” and “I need a structured environment to learn in, and my classroom stuff didn’t offer me that.”

Participant #1 identified her program as a hybrid program. She described a highly structured program that held students to a high standard:

My education was held to a very high standard of expectations, academically. I knew I was being well prepared. The structure of the program made it easy to interact with the course faculty...and my fellow classmates. ...Being so well structured, I knew I that I was getting well-equipped. ...Having online and on-campus components really was helpful to make sure I was learning everything I needed to. I set my own schedule for learning but had to make sure I was ready to go by the time the on-campus events occurred. If I wasn’t prepared, I wouldn’t be successful. The best part was that how it was structured we had to constantly interact with our classmates and our teachers and both held us accountable for our learning.

I got my BSN in a typical program, where I attended on-campus classes. My NP program being a hybrid environment was much more structured, and I had a much better experience. I felt as though learning in this manner was much more intentional and beneficial to me. I learned a lot in my BSN program, but even though it was on-campus, it lacked structure. I felt like I was just going to class every week and learning was not as focused. With this hybrid program, I really was held to higher expectations and had clear goals for my learning.

I felt as if there was better structure because it was not a show up to a class, seat in a seat, and participate if you like situation. I had goals that I had to meet before going to class and participation was mandatory to make sure we were doing our work.

Participant #3 identified her program as an online program. She described a poorly structured program that made it difficult to learn:

My program had absolutely no structure at all, we were left on our own. It was just...here is the coursework, this is what you have to do, and we will see you at the end of the semester. ...At one point I did ask for more guidance, and I was told, this is a master's program you need to be able to figure it out. ...I really wish I went to a program that had a stronger focus. In this program, I was basically left on my own and didn't find out what I didn't know until I got my first job. ...I had no interaction with my classmates and very little interaction with the faculty. Having more interaction would have been good.

Participant #4 identified her program as an online program. She described the program as lacking focus: "The classroom portion was okay, I mean we were left to learn on our own, but I got through it. It could have been better if we actually met the faculty or the other students, but it was okay." She further stated, "I felt like when I took my first job that I was starting over instead of coming in and being comfortable with what I learned."

Participant #5 identified her program as an online program and described being in a structured environment that was beneficial to her learning and transition to the NP role:

I went to a very good online program. It was well organized, and I learned a great deal both in and out of the classroom. The best aspect of the program was the interaction with the other students and the faculty. There was a lot of interaction. You connected with the other students and learned in a very organized fashion. The faculty organized their courses well, and their expectations were clear. In the online environment, I learned so much better because it was more organized. It is easy to get distracted in the classroom, but in this online program, I found that the structure was so that we were responsible for our own learning and then had to apply our learning during our interactions with students and faculty. This made my learning experience so much better.

Participant #8 identified his program as an online program. He described that he learned better in the clinical practicum versus the classroom environment because it had better structure:

I wish I had more clinicals in my program and less classroom stuff. My preceptors in my clinical rotations set clear goals for my learning, so it was very structured. I need a structured environment to learn in, and my classroom stuff didn't offer me that.

He further stated:

The program did not have any planned interactions between students, so we had to do that ourselves and become super organized. I really like online learning because of its flexibility and affordability, but I think it needs much more structure, at least my program did. The lack of structure in my classroom setting really made it hard to feel comfortable with my knowledge when I first started as an NP. I didn't feel like I learned what I needed to be a successful NP.

Summary. The fourth theme described the educational journey. Transitions theory describes four factors, also known as change triggers, that prompt a transition experience (Meleis, 2015). The transitional trigger relevant to this study was the situational change trigger--the decision to embark on the journey of becoming an NP--which begins with the educational journey. The educational journey is an environmental factor that influences the ability to transition to the NP role. Learning environments include both classroom-based and clinical-based learning. The educational journey must include knowledge application, learning environment structure, and interaction with faculty members and classmates.

The clinical-based learning environment provides students with opportunities to apply knowledge learned in the classroom as well as expand the breadth and depth of their knowledge by expanding learning to other topics not covered in a classroom-based learning environment. The classroom-based learning environment must be structured to ensure the presentation of clear learning goals while fostering the achievement of these goals. There is a need to expand educational activities to include interaction with faculty and classmates throughout the educational journey. Students left "on their own" to learn

content with minimal or no faculty and classmate interaction feel unprepared for the NP role. A structured, interactive educational journey with opportunities for knowledge application fosters an increased preparation to enter the NP role by providing a basis for role transition. Even if students feels prepared to enter the NP role after their educational journey, setting clear workplace expectations in their first position and providing them with the tools necessary to function in this role is imperative.

Summary

The purpose of this chapter was to report the results and findings of this study. The chapter began by describing the research methods used to conduct the study. These methods were described in detail in Chapter III of this dissertation. This chapter presented the central research question and the correlation of answering that question with the chosen research methods. Using Colaizzi's (cited in Creswell, 2013; Shosha, 2012) method for qualitative analysis and transitions theory as a theoretical framework, four central themes emerged from the data with a total of nine sub-themes. The four central themes included (a) emotive responses during the transition, (b) building blocks for advanced practice, (c) establishing vital relationships, and (d) the educational journey. Each of the sub-themes contributed to an exhaustive description of each central theme presented in this chapter. Direct quotations from the participants provided support for the exhaustive description.

The first theme, Emotive Responses During the Transition, described the intense feelings individuals experienced during the transition to the NP role. The feelings were a mixed bag of emotions of positive and negative emotions. There is excitement to enter

the NP role along with feelings of stress and nervousness. The cumulation of this description illustrates the feelings an NP experiences during their role transition.

The second theme, Building Blocks for Advanced Practices, described factors that influenced the ability of the NP to transition into the role. Prior RN experience provided the NP with a foundation on which to provide patient care. Clear workplace expectations from direct supervisors were lacking in the NP's first job and should be integrated to ensure the NP can set clear goals, milestones, and mobilize supports as needed to meet expectations. A formal orientation program would be useful in ensuring the NP acquires the tools necessary to function within the NP role such as institutional policies and procedures, learning to perform the procedures necessary for patient care, and networking with other new-to-practice NPs in the workplace. A lack of clear workplace expectations and formal orientation programs leaves the NP feeling "on their own" and contributes to negative emotions experienced during the transition process.

The third theme, Establishing Vital Relationships, described relationships with experienced NPs and physician collaborators. Establishing a relationship with an experienced NP offers the transitioning NP additional support throughout the transition process through an understanding of what it is like to be a new NP and offers insight into role expectations. This relationship is essential, especially when workplace expectations are not made clear from direct supervisors, and reduces the effects of negative emotive responses experienced during the transition.

Establishing a relationship with a physician collaborator also proved beneficial to the transition of the NP. Although the physician collaborator might not fully understand the role and scope of practice of the NP, this relationship was beneficial in increasing the

breadth and depth of the NP's clinical knowledge base. This relationship is essential, especially when there is a lack of a formal orientation program, by providing the tools necessary to be successful in the NP role.

The fourth theme, The Educational Journey, described the benefits of knowledge building through application as well as structured, interactive learning environments. The educational journey is an environmental factor, which influences the ability to transition to the NP role. The clinical-based learning environment provides students with opportunities to apply the knowledge learned in the classroom as well as expanding the breadth and depth of their knowledge to other topics not covered in the classroom-based learning environment. The classroom-based learning environment must be structured to ensure the presentation of clear learning goals while fostering the achievement of these goals. There is a need to expand educational activities to include interaction with faculty and classmates throughout the educational journey. Students left "on their own" to learn content with minimal or no faculty and classmate interaction feel unprepared for the NP role. A structured, interactive educational journey with opportunities for knowledge application fosters an increased preparation to enter the NP role.

This study used a descriptive phenomenology method to generate an exhaustive description of the experiences nurse practitioners identified as being associated with their transition to the NP role. The results and findings of this study added to the current knowledge base related to understanding the process of NP role transition. As described previously in this dissertation, there were two gaps in the literature. The results and findings of this study addressed the identified gaps in the literature and contributed to new knowledge discovery, which are examined in Chapter V.

CHAPTER V

DISCUSSION AND RECOMMENDATIONS

Introduction and Overview

The purpose of this chapter is to discuss the findings of the study within the context of the theoretical framework, previous research, and to offer insight into the contributions of this study to nursing science. This study began with the identification of a problem. As described in Chapter I, an examination of the current literature uncovered a gap regarding experiences during NP role transition. The purpose of this study was to explore the process of NP role transition and discover the lived experiences during role transition. The following research question guided this study in addressing the identified problem and meeting the overall purpose:

- Q1 What experiences do nurse practitioners identify as being associated with their transition to the NP role?

A descriptive phenomenology method was the qualitative inquiry used to explore, understand, and produce an exhaustive description of the experiences NPs identified with their transition to the NP role. Transitions theory was the theoretical framework used to inform this study. This chapter examines the findings of the study within the context of the theoretical framework and compares prior research on NP role transition.

Furthermore, this chapter provides an overview of the contributions of this study to

nursing science, presents the limitations of the study, and makes recommendations for future research activities.

Discussion of the Findings

This section discusses the findings of the study organized by the four central themes presented in Chapter IV. The four central themes encompass nine sub-themes. A comparison of the findings to prior research and the theoretical framework occurred. Transitions theory is a framework developed for conceptualizing the process of a transition (Meleis, 2015). According to Meleis (2015), transitions are universal nursing phenomena that occur in many different aspects of the profession. Transitions are triggered when an event causes a change in an individual or the environment. The event related to this study, which triggered a transition, was the movement to the role of the NP. Eleven assumptions were included in this theory, which assist researchers in explaining, predicting, and understanding a phenomenon (Meleis, 2015).

The following four assumptions of the theory were relevant to this study. First, interactions with significant others and reference groups shape a human being's responses to a transition (Meleis, 2015). For this study, participants identified relationships with other NPs, physicians, educators, fellow students, and institutional support systems as experiences during their role transition. Second, situational change triggers a process of transition (Meleis, 2015). The situational change in this study was the decision to embark on the journey to becoming an NP. Third, individuals experience a process as a consequence of the change and have varied responses and outcomes to this process (Meleis, 2015). For this study, participants described their varied responses in the form of emotions occurring during their role transition. Lastly, the environment

influences the individual's ability to learn and enact his/her new roles (Meleis, 2015).

For this study, participants identified prior-RN experience, lack of clear job expectations, educational system factors, the establishment of vital relationships, and a lack of orientation programs as factors that influenced their responses to the role transition.

Throughout this discussion, an integration of these assumptions into each theme occurs.

Emotive Responses During the Transition

The first theme depicted the powerful emotions/feelings experienced during NP role transition. The predominant emotions described included excitement, stress, and nervousness. The negative emotions of stress and nervousness were highly predominant during the discussion and seemed to overshadow the positive emotion of excitement. The concurrent experiences of emotions were defined in prior research as excitement, stress, anxiety, and frustration (Barnes, 2015b; Durham et al., 2014). New NPs come to the role with a feeling of confidence in their RN role but lack the experience necessary to feel confident in their newfound role. This lack of confidence leads to a time of uncertainty and insecurity. Positive feelings such as excitement are often blunted by overwhelming negative feelings that occur during the transition (Chang et al., 2006; Fleming & Carberry, 2011; Kelly & Matthews, 2001). Transition theory offers insight into the basis for these feelings.

Transitions theory asserts that a situational change triggers a process of transition. The process includes varied responses by the individual undergoing a transition (Meleis, 2015). Throughout the transition process, individuals experience a period of disconnectedness. Disconnectedness occurs in response to extinguishing a familiar role and engaging in a new, unfamiliar role. Mixed emotions are often a consequence of this

period of disconnectedness (Meleis, 2015). As the participants of this study moved into the NP role, they described relinquishing their familiar role as the RN and engaging in the unfamiliar role of the NP. This unfamiliar role also included increased levels of responsibility for patient care that contributed to the participants feeling nervous and stressed. Hence, participants described mixed emotions during their NP transition.

Feelings of excitement ensued as individuals entered their new role and met their own personal and professional goals of becoming an NP. Furthermore, being able to provide quality, patient care and providing bedside nurses with opportunities to learn and grow were sources of excitement described during the transition process. The feelings of excitement flourished as the NP became more comfortable and confident in his/her practice. Prior research supported the findings of this study by asserting NPs felt excitement during role transition. Excitement is a positive experience for the transitioning NP, which aids in fostering the transition process and promoting engagement into the newfound role of the NP (Barnes, 2015a; Chang et al., 2006; Durham et al., 2014). Furthermore, prior research concluded as the NP becomes more confident in his/her new role, the feeling of excitement becomes more apparent and detrimental feelings diminish (Barnes, 2015b; Chang et al., 2006; Durham et al., 2014; Fleming & Carberry, 2011; Kelly & Matthews, 2001). This study also provided new insight into sources of excitement during NP role transition, which did not appear in previous research conclusions.

The negative feelings of nervousness and stress come from different avenues. These feelings cumulate from the process of disconnectedness as described in transitions theory (Meleis, 2015). Increased autonomy of decision making, fear of making an error,

and uncertainty in the ability to perform in the NP role contribute to negative feelings. Prior research supported the findings of this study by asserting negative emotions are a common occurrence during NP role transition. Negative emotions previously reported included stress, frustration, and anxiety (Barnes, 2015b; Durham et al., 2014). Moving to the NP role coincided with a loss of security as the transitioning NP took on a new scope of practice in which he/she was now the primary, independent decision maker for patient care. This loss of security increased negative feelings experienced during role transition and negatively impacted the process of NP role transition (Fleming & Carberry, 2011; Kelly & Matthews, 2001).

These negative feelings lasted for approximately one year after starting in the role. However, NPs experienced the highest levels of negative feelings during the first few months within this new role and in critical situations, these feelings often returned. Prior research supported the findings of this study by asserting the highest intensity of these negative feelings occurred at the beginning of the role transition. Increased confidence diminished the impact of adverse feelings and promoted role engagement (Barnes, 2015b; Chang et al., 2006; Durham et al., 2014; Fleming & Carberry, 2011; Kelly & Matthews, 2001).

As NP educators, we must recognize that these mixed feelings are inevitable as the NP transitions to his/her new role. We need to foster in our students the understanding that both negative and positive emotions are typical during the transition process. Nothing but time, knowledge, experience, and confidence help to alleviate the negative feelings experienced during the transition. As NP educators, we must remain

cognizant of assisting students in recognizing that becoming an NP is not synonymous with a complete relinquishment of the RN role.

Although the role of the NP comes with new challenges, skills, and increased autonomy, we need to continually remind students that as NPs, we are still nurses; we need to build on our current role as an RN to improve patient care experiences and outcomes. To accomplish this, we need to use our RN foundation to build a broader breadth and depth of knowledge. Instilling the appreciation of ascribing to lifelong learning in our students becomes imperative. Continually building more knowledge increases confidence in the NP role, which promotes engagement in the role during the transition (Fleming & Carberry, 2011; Kelly & Matthews, 2001). By fostering the awareness of lifelong learning in our students, we are promoting the need to continually build knowledge that would assist them in becoming more confident in their new role, limit the negative feelings experienced during NP role transition, and promote positive feelings during the transition.

Building Blocks for Advanced Practice

The second theme depicted the building blocks for advanced practice. The predominant building blocks described included prior RN experience, the need for clear workplace expectations, and the need for a formal orientation to the role of the NP. Prior RN experience is the foundation of patient care. A lack of clear workplace expectations left participants feeling as if they were navigating their new role without a roadmap. The lack of a formal orientation program left NPs unable to gather the tools needed for their practice. Transition theory offers insight into the basis for these building blocks.

Transition theory asserts that the environment influences the individual's ability to learn and enact his/her new roles (Meleis, 2015). Environmental factors found in this study influenced the ability of the individuals to learn and enact their NP role. "The foundation of patient care" environmental factor described prior RN experience as a necessary component of developing a foundation for providing patient care. This environmental influence allowed the NP to have a basis on which he/she provided patient care. "Navigating without a roadmap" discussed entering a new job setting and not having clear workplace expectations from supervisors. This environmental influence made it more difficult for the NP to transition into the role. "Gathering the tools for NP practice" discussed the need for a formal orientation program to allow NPs to gain to tools to perform their daily activities such as understanding institutional policies and procedures, performing necessary clinical procedures, gaining more education, and interacting with fellow new-to-practice NPs. Lack of this environmental influence interfered with the NP role transition. Therefore, as NP educators, we need to discover and implement ways to augment these environmental influences during the educational journey.

Prior registered nurse experience. The foundation of patient care an NP provides begins during the experience as an RN. Experiences gained as an RN furnish NPs with a basis for providing patient care, afford them experiences they can build upon in NP practice, and offer an understanding of patient needs. These experiences support the NP in his/her role transition and assist in the provision of quality patient care. The findings of this study contributed new knowledge to nursing science. Prior research conducted investigations on the effect of prior RN experience to an NP's role transition

but failed to substantiate any formal conclusions on the association of prior RN experience and NP role transition. Scholars respected that prior RN experience might be a necessary component of the RN becoming an NP (Durham et al., 2014; Kelly & Matthews, 2001). However, research findings to support this assumption were conflicting in nature and did not provide a precise conclusion of the effect of prior RN experience (Barnes, 2015a; Steiner et al., 2008). This study added to the nursing science by confirming prior RN experience was important to NP role transition. Prior RN experience provided the foundation of patient care the new NP could use to develop his/her patient care practices. The NP role was not separate from but instead built upon the knowledge and experience of RN education and practice.

Furthermore, prior research asserted prior RN experience might provide a foundation of confidence for the individual entering the NP role but other considerations regarding this experience were necessary to investigate (Kelly & Matthews, 2001). For instance, the amount of time and the type of specialty practice in the RN role might produce varying effects on NP role transition (Heitz et al., 2004; Kelly & Matthews, 2001). The findings of this study asserted prior RN experience as a fundamental experience provided the NP with a foundation to provide patient care. Having this foundation upon entering NP clinical practice helped build confidence in the new role, which led to enhanced role engagement. Confidence also helped to lessen the negative feelings one might experience during the transition process (Kelly & Matthews, 2001). Prior RN experience allowed the NP to engage in patient care activities more efficiently by recalling previous experiences provided to him/her as an RN. Hence, prior RN

experience provided the NP with a foundation upon which to build a new role and informed responsibilities within that new role.

The participants of this study reported varying ranges of time in the RN role and a wide array of RN practice specialties. However, this study did not identify the length of RN experience or type of RN experience as influencing NP role transition. While we understand prior RN experience is integral, the length of time in the RN role, the type of RN experience, and the influence of these experiences on NP role transition remain unclear. Future research initiatives should focus on length of RN experience, type of RN experience, and the influence these factors have on NP role transition.

As NP educators, we must be cognizant that prior RN experience provides the NP with a foundation for patient care. In addition, prior RN experience provides an avenue for building confidence in the NP role, thus limiting negative feelings experienced during role transition. When evaluating admission criteria, NP educators must be conscious to ensure admission criteria include prior RN experience as an admission requirement. Findings from this research supported previous RN experience as required admission criteria to NP programs.

On average, the RN undergoes most of his/her role transition, knowledge development, and gaining of significant experiences during the first year of RN practice (Duchscher, 2008; Dyess & Sherman, 2009; Kaihlanen, Lakanmaa, & Salminen, 2013). Based on this knowledge of RN role transition, we can formulate recommendations for NP program admission requirements that positively influence NP role transition. Since it takes approximately one year for the new RN to transition into his/her role, a minimum requirement of one to two years of RN experience would be a fair recommendation. One

to two years of RN experience would allow the RN time to establish a foundation for patient care to utilize in practice as the novice NP.

Clear workplace expectations and tools for practice. When there is a lack of clear workplace expectations, the NP is left on his/her own and without a roadmap to determine the requirements of the job. Without a clear delineation of workplace expectations, NPs are unable to set and evaluate milestones to measure his/her success in the new role. Hence, it is essential to ensure clear workplace expectations are set at the time of hire into a new position. In addition, we need to ensure NPs have the tools necessary to practice in their new role.

The lack of a formal orientation program leaves the NP unequipped with the tools necessary to function in the workplace. These tools include understanding institutional policies and learning/performing required procedures. A lack of formal NP orientation presents a barrier for the new-to-practice NP during role transition. The new NP must understand the reality of his/her new role and gather the tools necessary to engage in this role (Chang et al., 2006; Fleming & Carberry, 2011; Kelly & Matthews, 2001).

The findings of this study supported the need to ensure new-to-practice NPs have clear workplace expectations, the ability to build knowledge, and the ability to build the skills necessary to engage in the NP role. When engaging in a new role where expectations are unclear and the necessary skills are undeveloped, the novice NP lacks an understanding of his/her role and expectations within the interdisciplinary team (Fleming & Carberry, 2011; Kelly & Matthews, 2001). The ambiguity of the NP's expectations within the workplace has a negative impact on the feelings experienced during NP role transition. Feelings of insecurity and uncertainty lead to an adverse effect on the NP role

transition by impacting the NP's ability to engage with the NP role and disengage from the RN role (Chang et al., 2006; Fleming & Carberry, 2011; Kelly & Matthews, 2001).

A new job signals a new transition; hence, with each new job, clear workplace expectations must be established and communicated. As administrators in clinical practices, we need to ensure NPs have a clear understanding of how they fit into the practice setting. Nurse practitioner educators could address this need by partnering with local healthcare institutions and national NP organizations to establish clear workplace expectations. Although as NP educators we can advocate for and offer suggestions for establishing clear workplace expectations, it is unrealistic to assume we can prescribe the business operations of the practice setting. Hence, it is our responsibility to narrow the education-to-practice gap. We need to prepare our students by providing them with anticipatory knowledge and tools to manage and cope with the lack of clear workplace expectations.

With the limited resources we see in the healthcare system, NP educators must be prepared to anticipate deficits in the work environment and prepare NP students for role transition. The NONPF (2017) core competencies described the need to integrate both medical and professional role knowledge in NP education. The NONPF core competencies highly regard the need to include education on the professional aspects of the NP role, which incorporate role expectations. Education on the professional role of the NP must not be segregated to a single professional role course but should be integrated throughout the NP curriculum to ensure continual reinforcement of this knowledge. Continually reinforcing the professional aspects of the role, which incorporate role expectations, could augment a lack of clear workplace expectations and

provide new NPs with the ability to advocate for the development of these expectations within their workplace.

Specialty-focused professional nursing organizations expanded on the NONPF competencies by outlining the skills and knowledge necessary for NP educational programs. For example, the American Association of Critical-Care Nurses (AACN; 2012, 2018) expanded on the NONPF core competencies by describing the scope, standards, skills, and procedures necessary for the education of NPs in adult-gerontology acute care programs. Educators should be conscious of including within the curriculum the opportunity for students to gain education on the skills and procedures common to their NP specialty. Skills workshops or on-campus intensive sessions where students can practice skills would be a viable option for this recommendation. For example, educators in adult-gerontology acute care nurse practitioner programs should consider reviewing the AACN documents and provide skills workshops or on-campus intensive sessions that include education on interpreting 12-lead electrocardiograms, inserting arterial pressure catheters, interpreting chest radiographs, and inserting chest tubes--just to name a few (AACN, 2018). This education could prepare the new NP for role transition by providing tools for clinical practice common to his/her specialty-focus.

Nurse practitioner educators could also advocate for and participate in the development of a standardized NP orientation program through a professional organization such as the AANP. Currently, the AACN (n.d.) and the Emergency Nurses Association (2018) provide standardized online orientation programs for purchase by individuals or institutions. These online orientation programs provide RNs new to critical care and emergency nursing an avenue for a formal orientation to the specialty

while building the knowledge necessary to transition and function in those specialties. This type of program would be worthwhile to investigate as a possibility for the NP population. Future research to investigate institutions that offer NP orientations and the impact these orientation programs have on NP role transition would be beneficial to guide the development of a standardized NP orientation.

Lastly, NP residency programs are a relatively new phenomenon across the United States and might serve as a type of formal orientation program for new NPs. Nurse practitioner postgraduate residencies might be beneficial in filling the gap between education and practice (Nelson, 2017). There is a continued need for the development and standardization of NP residency programs that include interprofessional training, leadership/policy education, quality improvement and scholarship, diagnostic skill education, and dedicated mentorship and role development. University affiliation with NP educators could be one of many aspects that would enhance the development of residency programs (Brown, Poppe, Kaminetzky, Wipf, & Woods, 2015). Nurse practitioner educators play a pivotal role in the development of NP residencies and should partner with healthcare institutions and professional organizations to further the adoption of NP residencies. Nurse practitioner residency programs have the potential to influence NP role transition when there is a lack of clear workplace expectations and a lack of formal orientation. However, since no research is available on NP residencies and NP role transition specifically, it would be worthwhile to investigate through future research initiatives the influence of NP residencies on NP role transition.

Establishing Vital Relationships

The third theme depicted the establishment of vital relationships that would positively influence NP role transition. The predominant vital relationships included relationships with experienced NPs and collaborating physicians. These vital relationships could serve as a form of mentorship and support to the transitioning NP and assist in bridging the gaps when clear workplace expectations and orientation programs are not available. Transition theory offers insight into the basis of these relationships.

Transitions theory asserts that interactions with significant others and reference groups shape a human being's responses to the transition (Meleis, 2015). Furthermore, patterns of response occur through the transition process that help determine if the transition is going well by identifying how an individual is responding to the change event (Meleis, 2010). Regarding establishing vital relationships, the outcome pattern of interest was healthy interaction. Healthy interactions and connections are measured through the formation of new relationships and the maintenance of current relationships. These relationships offer support to the completion of the transition process (Meleis, 2015). Establishing vital relationships during role transition offers the NP varying forms of support and mentorship through interactions with experienced NPs and collaborating physicians.

Experienced nurse practitioner relationships. The mentorship fostered through a relationship with an experienced NP is beneficial when transitioning to the NP role by offering the new-to-practice NP another avenue of support. Having someone who understands the role of the NP addresses the lack of workplace expectation clarity and the lack of formal orientation programs. Prior research findings indicated the mentoring

process is designed to bridge the gap between the educational journey and clinical practice as an NP (Barker, 2006). A relationship with an experienced NP mentor could clarify the role, scope, and expectations for the new NP as well as the development of competencies required for the NP role. Furthermore, a relationship with an experienced NP offers positive psychosocial aspects to the role transition process. Having a relationship with an experienced NP mentor assists the NP in developing confidence and a better self-image (Harrington, 2011). Prior research supported the findings of this study (Barker, 2006; Harrington, 2011). This study concluded that an experienced NP could assist with NP role engagement.

A relationship with an experienced NP also benefits the NP's role transition by assisting the NP in achieving the confidence necessary to increase his/her independence in clinical practice. While increasing confidence, this form of relationship could assist in blunting the negative feelings experienced during NP role transition. Prior research supported the findings of this study (Chang et al., 2006; Kelly & Matthews, 2001; Leggat et al., 2015). Relationships with experienced NPs not only assisted the new NP in the ability to build skills within his/her current workplace but also encouraged active participation in the development of future work environments (Leggat et al., 2015). Building knowledge increased confidence. The development of confidence in the role fostered role engagement and decreased the negative feelings of role transition (Chang et al., 2006; Kelly & Matthews, 2001).

As NP educators, we must recognize the benefits offered through the development of relationships with experienced NPs. However, experienced NPs are not available in every practice setting. Professional NP organizations offer opportunities for novice NPs

to network with experienced NPs. The AANP (2012) offers a webpage for students and novice NPs to network with experienced NPs via social media channels as well as a tool to identify local and regional NP organizations. Nurse practitioner educators must ensure students are aware of these opportunities as an avenue to address the lack of experienced NP relationships.

Educators are experienced NPs who develop relationships with our students and serve as mentors as they progress through the educational journey. Perhaps we need to recognize our faculty-student relationship does not end upon graduation. The short-term goal of our relationship with our students is graduation from the NP program. We need to consider that a potential long-term goal would be to assist students who graduated in their role transition. Hence, the endpoint of this mentoring relationship would be the new NP embracing the support systems in his/her healthcare institutions and the broader professional NP community. One recommendation to achieve this would be for educators to consider offering a support group for new NPs who have graduated from their programs. These support groups would allow for continued interaction with their faculty members, hence providing a relationship with an experienced NP during his/her transition process. As part of this support group, we need to help the student recognize this is not an infinite relationship and there are professional and institutional supports the new NP should embrace. This support group could be structured to assist the new NP in identifying and embracing those supports.

Prior research suggested a lack of understanding of what makes a relationship with an experienced NP beneficial (Barker, 2006; Harrington, 2011; Leggat et al., 2015). The findings of this study asserted developing a relationship with an experienced NP had

a meaningful influence on NP role transition but did not specifically identify which aspects of this relationship benefitted role transition. It is essential to understand in more depth the aspects of these relationships that benefit NP role transition. Future research exploring the new-to-practice NP and experienced NP relationships in more depth would be beneficial.

Physician relationships. Not all physicians understand the scope and role of the NP. Working with a physician who does not understand the role of the NP can be challenging during the role transition process. Specifically, it becomes difficult for the NP to integrate into the healthcare team when his/her scope and role is poorly understood. Prior research supported this finding. Overall, prior research concluded a relationship between a physician and NP colleagues might influence NP role transition (Bailey et al., 2006; Barton, 2006; O'Brien et al., 2009). Physicians reported they lacked a realistic understanding of the regulatory, clinical authority an NP possesses. Hence, they did not fully understand the scope and role of an NP when integrating him/her into an interprofessional team. Nurse practitioners also reported they felt their physician collaborators did not always understand their role (Bailey et al., 2006; Barton, 2006). These conclusions were consistent with the findings of this study.

As NP professionals, we hold the responsibility to educate other providers on our scope and role. The ability to educate other providers might prove difficult as the novice NP reports a lack of understanding of his/her scope and role. As NP educators, we must ensure we prepare our students in a way that assists them in better understanding the full scope and role of the NP. As described previously, one recommendation to achieve this is to ensure education on the professional role of the NP is integrated and reinforced

throughout the curriculum. As the NP community is striving for fully autonomous practice, we need to ensure our new-to-practice NPs are prepared to fully engage in the role without a physician collaborative/supervisory agreement. We can also address the lack of physician collaboration/supervision through the formation of support groups for new-to-practice NPs. As described earlier, these support groups could foster relationships with experienced NPs who could then assist the new NP in understanding his/her independent role and encourage him/her to educate other providers on his/her role.

This study concluded that although participants felt the physician collaborator did not understand the scope and role of the NP, the physician collaborator was useful in helping the NP build a more expansive breadth and depth of clinical knowledge. This knowledge-building assisted in the NP's role transition. This additional knowledge building assisted the new NP in developing more confidence in his/her role. As NP educators, we need to ensure students are ready to graduate and enter NP practice with the confidence and knowledge to engage in the role autonomously.

Many of the recommendations provided throughout this chapter could assist the educator in preparing NPs for their role transition. For instance, relationships with experienced NPs could support the new NP in skill building, knowledge development, and confidence (Chang et al., 2006; Kelly & Matthews, 2001; Leggat et al., 2015). The development of relationships with experienced NPs could augment the knowledge building provided currently by physician collaborators. Most importantly, we need to instill in our students the importance of interprofessional relationships. As we strive for independent practice, we are not seeking to sever ties entirely with our physician

colleagues but are seeking to work with them interprofessionally as independent, autonomous providers in patient care. New NPs must embrace all opportunities for learning from different avenues such as experienced NPs, physician colleagues, and interprofessional healthcare providers.

The Educational Journey

The fourth theme depicted the educational journey. The predominant aspects of the educational journey included interactive learning environments in the classroom and knowledge application in the clinical practicum setting. Transition theory offers insight into the basis of these aspects of the educational journey. Transition theory asserts the environment influences the individual's ability to learn and enact his/her new roles. For this study, the educational journey or educational setting was one of the environmental factors that influenced the transition to a new role (Meleis, 2015). Furthermore, the theory asserted that interactions with significant others and reference groups shaped a human being's responses to the transition. For this study, components of the educational journey such as interactions with faculty members and fellow students as well as curricular methods supporting knowledge development and application influenced the role transition (Meleis, 2015).

It is well known that graduate level education is a necessary component of the transition process as it provides the avenue necessary to gain certification and licensure as an NP. Nurse practitioner role transition begins in the educational journey and is influenced by faculty guidance, mentorship, and educational methods/activities (Brown & Olshansky, 1998; Heitz et al., 2004; Joyce et al., 2014). Prior research called for a further investigation into the aspects of graduate level education that influence NP role

transition (Brown & Olshansky, 1998; Heitz et al., 2004; Joyce et al., 2014). The findings of this study contributed new knowledge to nursing science by identifying the importance of NP education and preparation to NP role transition. Furthermore, this study discovered aspects of graduate level education that influenced NP role transition including knowledge application and interactive learning environments.

The clinical practicum learning environment provides the student with opportunities for more profound knowledge development and knowledge application. A clinical practicum augments the knowledge attained in the classroom by allowing the student to apply the knowledge learned in the classroom to clinical scenarios. Furthermore, the clinical practicum allows for the generation of new clinical and professional knowledge amiss in classroom content, permitting the student to generate a greater breadth and depth of knowledge. Students experience the opportunity to learn new diagnoses, evaluate new patient presentations, and learn additional professional aspects of the role. Lastly, we can assert role socialization is fostered in the clinical practicum setting as students begin to apply their knowledge to the patient care setting and interact with other healthcare providers.

Beyond the realm of the clinical practicum, it is imperative to examine the overall learning environment. An examination of prior research asserted specific curricular methods might influence NP role transition. Overall, we understand NP role transition begins in the educational process but the factors of graduate level education that influence NP role transition remain unknown (Brown & Olshanky, 1998; Heitz et al., 2004; Joyce et al., 2014). The findings of this study expanded on prior research and contributed new knowledge to nursing science by identifying the types of curricular

methods meaningful to NP role transition. Learning environments must contain interaction with faculty members and fellow students. Interactions with both faculty members and fellow students is a decisive factor for meaningful learning experiences and fosters better knowledge development for transitioning to the NP role. Students are eager to engage in activities that include interaction and knowledge application.

As NP educators, it is our responsibility to prepare students with the knowledge and skills necessary to foster NP role transition. The most prominent and immediate impact we can have on the role transition process is by reflecting on and implementing curricular strategies that promote NP role transition. By ensuring we have reliable curricular methods, we can positively influence the transition of the NP through knowledge development. Increasing breadth and depth of knowledge will build confidence in our students and encourage them to engage in their new role. The educational journey can augment the missing factors such as a lack of workplace expectations, a lack of orientation, and a lack of vital relationships. It is our responsibility as educators to narrow the gap between education and practice while increasing our students' engagement in their newfound NP role.

Classroom-based methods should be interactive and include collaboration between faculty members and fellow students to solve real-life patient cases. This form of structured environment is desired by NP students and viewed as meaningful learning experiences that better prepare the NP for his/her transition into the role. Even fully online programs must ensure meaningful interaction to enhance learning and foster NP role transition.

Furthermore, we must recognize the benefits of providing an ability for students to engage in knowledge application. Through the findings of this study, we recognized one place knowledge application occurred was in the clinical practicum learning environment. However, we would be remiss not to consider offering additional opportunities for knowledge application such as in the classroom environment. The classroom might be defined differently based on the type of program, e.g., on-site, online, and hybrid style programs. In each of these environments, we should investigate opportunities for additional knowledge application. Knowledge application fosters more in-depth knowledge development, hence increasing the NP's confidence, which in turn promotes engagement and transition in the NP role.

Educators must be innovative in their instructional methods. With some initiative and commitment, nurse educators could develop and implement a variety of synchronous and asynchronous tools to increase knowledge development and interaction (Petty, 2013). Two examples of possible instructional methods to enhance student engagement, content application, and synthesis are the flipped classroom and discussion boards.

There is a need to develop nursing professionals who can build their knowledge in complex, ever-changing environments. A flipped classroom engages students, creates interaction, and allows for knowledge application. Flipped classroom strategies might include peer instruction, small group work, short class discussion, and small group presentations. These methods incorporate active and collaborative learning while promoting students as active agents in the learning process rather than passive recipients (Schlairet, Green, & Benton, 2014). A flipped classroom offers students a structured avenue to present new knowledge, apply knowledge to patient care situations, provide a

deeper understanding of clinical reasoning, and enrich learning and the value of collaborative teamwork (Geist, Larimore, Rawiszer, & Sager, 2015; Ratta, 2015).

Another common instructional method used in NP education, specifically in online and hybrid-style programs, is discussion board assignments. Nurse practitioner educators need to proceed cautiously when implementing discussion boards (Adelman & Noguera, 2013). Discussion board assignments need to encourage sharing of knowledge, promote reflection, improve critical thinking, and cause meaningful interactions with others (Buckley, Beyna, & Dudley-Brown, 2005). Traditional discussion board assignments pose a question, invite the student to formulate an answer, and require peer replies. This method becomes redundant and does not embrace meaningful interaction, lacks true collaboration, lacks participation, and does not enhance critical thinking. The use of wikis, blogs, role-playing, and voice interactions within these assignments are methods to promote the constructivist view of learning in the online classroom while increasing engagement and interaction. Increased engagement and interaction lead to meaningful learning (Adelman & Noguera, 2013). Regardless of the method chosen by educators, there must be an assurance of meaningful, interactive collaboration.

The above discussion on flipped classrooms and discussion board assignments provided two options for interactive methods that foster interaction and knowledge application. The literature offered additional options for interactive methods. The use of student response systems, video conferencing, simulation, game-based learning strategies, and standardized patient encounters are tools educators could use to enhance knowledge application, promote in-depth discussions, nurture meaningful interactions,

and foster a deeper understanding of complex concepts (Carley, 2015; Sternberger, 2012). Podcasts are a method used to increase knowledge retention and application (Abate, 2013). Problem-based and team-based learning curricula are innovative, interactive, learning-centered teaching strategies that promote knowledge application in NP students (Corbridge, Corbridge, Tiffen, & Carlucci, 2013; Kilroy, 2004; Whitcombe, 2013).

While numerous techniques are available, not all might align with pedagogical practices of individual educators and institutions. Curricular methods might vary widely between faculty members and institutions based on pedagogical beliefs. Regardless of the curricular design and techniques chosen for graduate level NP programs, it is essential to engage in curricular methods that foster knowledge development, role socialization, and transition to NP practice. Curricular methods that include interaction, collaboration, and knowledge application assist in meeting these goals. These curricular methods are of the constructivist view, which aligned with the interpretive framework of this study (Adelman & Noguera, 2013; Sternberger, 2012).

Recommendations for Nurse Educators

The discussion of findings from this study includes recommendations for NP educators. The section includes the following summary of those recommendations and ideas for NP faculty members to implement them:

1. Nurse practitioner educators need to foster in students an understanding that both negative and positive emotions are normal during the transition process. Time, experience, and confidence will help alleviate negative feelings experienced during the transition. When teaching the role of the

NP, it is imperative to remind students they are still nurses and need to use their foundational nursing knowledge to build a broader breadth and depth of knowledge. Allowing students to understand they already have a foundation on which to build their NP role might instill confidence and limit negative feelings experienced during NP role transition.

2. Instilling the appreciation of ascribing to lifelong learning in our students becomes imperative. As nurse educators, we lead by example. The curricular methods we choose are important. Curricular methods that promote engagement and meaningful learning instill in students the importance of lifelong learning. As educators are teaching about the professional role of the NP, it is imperative to include a discussion on the significance of continuing education to promote quality patient care. Educators should share examples of active learning engagement utilized in their own practice and suggest resources for professional development after graduation. Abundant professional organization conferences, online resources, and educational platforms exist for NP continuing education.
3. Nurse practitioner educators must be conscious of including prior RN experience in their program's admission criteria. If an educational program decides not to include prior RN experience in their admission criteria, steps must be taken to ensure the program prepares the student for NP role transition despite this deficit. For example, perhaps faculty members of the program should consider developing a bridge program for students without prior RN experience. This bridge program should include education, skills,

and training that foster a foundation on which to build NP practice.

Educators will need to reflect on their curriculum to ensure the learning provides a strong foundation for patient care when prior RN experience requirements are not included or eliminated. Programs could also consider admitting students to core courses of the program without RN experience under the stipulation of completing a certain amount of time as a RN before starting clinical practicum courses.

4. Nurse practitioner educators must be prepared to anticipate deficits in the work environment. Although we can partner with local clinical agencies and professional organizations to advocate for clear role expectations, we cannot prescribe the function of the workplace. The most significant impact we can make as NP educators is to ensure our education contains the knowledge and skills necessary to prepare the NP for role transition in an environment lacking clear expectations and tools to perform in the role. Specialty-focused organizations, NONPF, and the Quality and Safety Education for Nurses Institute (2018) provide faculty members with the scope, standards of practice, skills, and attributes imperative to function in the NP role and improve quality and safety in patient care. Nurse practitioner educators should reflect on their curriculum to ensure the recommendations of these organization are implanted throughout their curriculum. These competencies are necessary to ensure education is continually provided to NP students and assists with successful program accreditation.

5. Within the curriculum, educators should include instruction on the skills and procedures common to the specialty-focused program in the form of workshops, simulation, or on-campus intensive sessions in their clinical specialty courses. Educators should consider partnering with local clinical facilities to combine forces and provide education for NP students as well as other healthcare professionals in these clinical facilities. Working with a partnering clinical facility might provide these skills, foster interdisciplinary practice, and decrease the financial burden to the educational institution. For programs that do not require an on-campus residency/visit, other options are available. The New England Journal of Medicine (2018) provides free procedural videos for use by healthcare professionals and students. YouTube has a plethora of videos available for skills and procedures. However, this calls for the educator to evaluate these videos and determine their relevance and accuracy. Educators can also consider video recording procedures and skills in the institution's facilities and include these videos in their courses. Since the students would not have the opportunity to gain hands-on practice in this environment, educators should consider instituting an assessment such as objective testing to measure the students' mastery of the content.
6. Nurse practitioner educators could advocate for and participate in the development of a standardized NP orientation program through a professional organization such as the AANP.

7. Nurse practitioner educators play a pivotal role in the development of NP residencies and should consider partnering with local healthcare institutions to participate in the development of NP residencies. Educators, clinicians, and administrators from the clinical facility and the educational institution could work collaboratively to seek funding opportunities for this initiative. Research grants might be available to develop NP residency programs and provide a mechanism to enrich the research base regarding NP residency programs and role transition. Partnering with local healthcare institutions would be valuable to instill interdisciplinary education and role socialization by exposing the new NP to collaboration with other providers and healthcare professionals. Educators could focus on the curriculum aspects of these programs while collaborating with local healthcare institution to obtain a location to implement residencies.
8. Educators should consider offering a support group for new NPs who have graduated from their programs. These support groups would allow for continued interaction with their faculty members, thus providing them a relationship with an experienced NP during their transition process. As students might not be local to the educational institution, these support groups could be offered virtually through video-conferencing software. It would not be feasible to mandate participation after the student has graduated. Hence, participation would be optional. The support group could meet virtually at regular intervals and these meetings could be recorded for individuals who are unable to attend at the scheduled date and

time. Individuals should be given the opportunity to share their experiences, ask questions, and seek advice on how to function in their role. If selected as an option, educators should discuss with their administrators a credit allocation for running the support group. If a support group is not a feasible option, there are alternatives. Educators could provide graduating students with the AANP website information for networking and connecting with other NPs.

9. As NP educators, we must recognize classroom-based methods should be interactive and include opportunities for deepening knowledge building and knowledge application. Just as we instill in our students the importance of lifelong learning, we as educators need to commit to lifelong learning in educational pedagogy. We need to critically reflect on our current curricular practices to identify the level of knowledge application and interaction. As we pledge our own lifelong learning, we need to seek sources to help us implement innovative curricular techniques. The literature was abundant with research on innovative curricular designs, suggestions for implementation, and considerations for their usefulness. We need to partner with our fellow educators to discover curricular designs that are innovative and enhance learning. These partnerships could occur in our own educational institutions as well as through networking through professional NP organizations such as AANP and NONPF. In addition, attending conferences focused on nursing education provides another avenue to discover best practices for NP education and gives educators the opportunity

to network with and learn from each other. Quality Matters (2016) is an organization that provides tools and peer reviews to evaluate the design of online and hybrid courses. Through these tools and peer reviews, we can reflect and receive feedback on current educational practices while discovering opportunities for growth.

Study Limitations

Several limitations are acknowledged. First, the principal investigator interviewed some candidates with whom he had professional associations through the workplace, academic institutions, or professional organizations. Knowing the principal investigator on a professional level might have influenced the voluntary participation of these participants.

Second, although confidentiality of the participants occurred in this study, the principal investigator had professional associations with some of the participants in the workplace, academic institutions, or professional organizations. Even with a guarantee of confidentiality, some of the research participants might have felt they could not engage in full honesty when discussing certain aspects of their experiences. They might have felt uncomfortable discussing aspects they perceived would make them look unfavorable as a professional.

Third, the sample of the study consisted solely of participants who identified as Caucasian. Even though race and ethnicity were not inclusion or exclusion criteria for participation in this study, there was no diversity of race, ethnicity, or culture among the participants. Racial, ethnic, or cultural components impacting NP role transition might have been left unaddressed by this study.

Lastly, some of the participants discussed previously transitioning from other healthcare-related roles including transitioning from the licensed practical nurse to RN and transitioning from ancillary staff to a nursing professional. It was not possible to completely disconnect those prior transition experiences with their NP role transition. Furthermore, participants who had a previous nursing-related role transition might have felt more comfortable with their transition process and presented a skewed view of their specific NP role transition experiences.

Recommendations for Future Research

The findings of this study raised awareness of numerous opportunities for future research on NP role transition. First, future research initiatives should focus on length of RN experience, type of RN experience, and the influence these factors had on NP role transition. It is important to discover this information to ensure our curriculum can adequately prepare NPs for role transition regardless of the length and specialty-focus as an RN. This research would also help us discover the optimal time frame for a prior RN experience admission requirement; this knowledge remains unclear.

Second, future research to investigate institutions that offer NP orientations and the impact these orientation programs have on NP role transition would be beneficial. Knowledge from this research could guide the development of NP orientation programs in the future. Findings from this research could help identify best practices for NP orientation program development.

Third, the impact of NP residencies on role transition is unclear. Therefore, future research to determine the impact on or association between residency programs and NP role transition would be beneficial and might support the development of more NP

residency programs. If NP residency programs are found to be beneficial to NP role transition, this would be an avenue to follow in narrowing the education-to-practice gap and better prepare NPs for role transition.

Lastly, it is essential to understand in more depth the experienced NP/new NP relationship to ensure we develop opportunities to foster future relationships that benefit NP role transition. Future research on the association between experienced NP relationships and role transition would be beneficial to discover factors that make a relationship with an experienced NP most beneficial to novice NPs.

Summary

This descriptive phenomenology study began with the identification of a problem. An examination of the current literature uncovered a gap regarding experiences associated with NP role transition. The literature implied factors associated with NP role transition remain poorly understood. The purpose of this study was to explore the process of NP role transition and discover the lived experiences associated with this role transition. The following research question guided this study to address the identified problem and meet the overall purpose:

Q1 What experiences do nurse practitioners identify as being associated with their transition to the NP role?

Findings of this study provided an exhaustive description of NP role transition including the experiences of this transition from the perspectives of NPs who lived this experience. The findings of this study were correlated with prior research findings and constructed through the lens of the theoretical framework--transitions theory.

During unstructured interviews, eight participants described their experiences with NP role transition. Four central themes emerged from the data: (a) Emotive Responses During the Transition, (b) Building Blocks for Advanced Practice, (c) Establishing Vital Relationships, and (d) The Educational Journey. Within these central themes were nine sub-themes. These sub-themes provided exhaustive descriptions of each central theme.

Under the first central theme--Emotive Responses During the Transition emerged the following sub-themes: (a) “an exciting experience” and (b) “a time of negative emotion.” These sub-themes described the emotive responses of participants during their role transition. Under the second central theme--Building Blocks for Advanced Practice emerged the following sub-themes: (a) “the foundation of patient care,” (b) “navigating without a roadmap,” and (c) “gathering the tools for NP practice.” These sub-themes described the building blocks participants identified with their role transition. Under the third central theme--Establishing Vital Relationships emerged the following sub-themes: (a) “experienced NP relationships” and (b) “physician collaborator relationships.” These sub-themes described the relationships participants found meaningful during their role transition. Finally, the following sub-themes emerged under the fourth central theme--The Educational Journey: (a) “knowledge building through application” and (b) “interactive learning environments.” These sub-themes described the components of NPs’ educational journey and role transition.

Therefore, this study described the NP role transition process as a time of mixed emotions. Intense feelings of excitement, stress, and nervousness were commonplace occurrences during the transition process. The negative feelings of stress and

nervousness could inhibit the ability of the NP to engage in his/her role. Fortuitously, these negative feelings occurred more significantly at the beginning of the role transition and diminished over time as the NP became more confident and competent in his/her role. Several factors of NP role transition provided the building blocks for advanced practice: prior RN experience, setting clear workplace expectations, and formal orientation programs. Without these factors, the transition to the NP role might prove challenging. Establishing relationships with experienced NPs and physician collaborators provided the NP with mentorship, support, and additional knowledge-building. The educational journey provided the basis of knowledge needed to function in this role. Curricular activities that provided meaningful interaction and knowledge application were most beneficial to the NP's role transition.

In conclusion, this study was able to address the problem identified at the beginning of this journey. While addressing the problem, the findings of this study offered insight into current recommendations for NP educators to promote a favorable NP role transition for the next generations of NPs. This study suggested areas we could examine more critically to promote NP role transition. This study supported findings from prior research on NP role transition and contributed new knowledge to nursing science. We must remain mindful of the opportunities this study provided for future research activities. As NP educators, it is our responsibility to nurture, guide, and support the next generation of NP professionals.

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APPENDIX A
INSTITUTIONAL REVIEW BOARD APPROVAL



Institutional Review Board

DATE: April 14, 2017

TO: Anthony Angelow, MSN, APN, AGACNP-BC, AGACNP-BC, ACNPC, CEN
FROM: University of Northern Colorado (UNCO) IRB

PROJECT TITLE: [1050087-1] The Lived Experience of Nurse Practitioner Role Transition: A Phenomenology Study

SUBMISSION TYPE: New Project

ACTION: APPROVED

APPROVAL DATE: April 14, 2017

EXPIRATION DATE: April 14, 2018

REVIEW TYPE: Expedited Review

Thank you for your submission of New Project materials for this project. The University of Northern Colorado (UNCO) IRB has APPROVED your submission. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on applicable federal regulations.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of April 14, 2018.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Sherry May at 970-351-1910 or Sherry.May@unco.edu. Please include your project title and reference number in all correspondence with this committee.

Thank you for a clear and thorough IRB application. Your materials and protocols are approved and you may begin participant recruitment and data collection.

Best wishes with your research.

Sincerely,

Dr. Megan Stellino, UNC IRB Co-Chair

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Northern Colorado (UNCO) IRB's records.

APPENDIX B
PARTICIPANT RECRUITMENT

This would be the message sent via listservs and other recruitment venues

Dear XXXX,

I am currently a student in the PhD in Nursing Education program at the University of Northern Colorado (UNC). As part of my doctoral studies I am currently working on completing my dissertation project.

I am exploring the process of nurse practitioner role transition to discover the lived experiences, which influenced this role transition.

Criteria for my study are nurse practitioners who: 1) are currently certified in one of the six recognized nurse practitioner certification categories, 2) are self-identified as currently practicing as a nurse practitioner on a full-time basis, 3) have practiced as a nurse practitioner for a minimum of one year to a maximum of three years, 4) had a minimum of one year of RN experience prior to entering the NP role, and 5) had a physician collaborator in their first NP role. The five recognized nurse practitioner categories, according to the consensus model, include: 1) family/individual across the lifespan, 2) adult-gerontology, 3) neonatal, 4) pediatrics, 5) women's health/gender-related, and 6) psychiatric-mental health. Both primary and acute care certifications within the population foci categories are acceptable.

If you meet these criteria, I am hopeful that you would consider being a participant in my study. Participation would include the completion of an interview lasting approximately 60 minutes. The interview will be conducted via video conferencing software and the audio portion of the interview will be recorded for transcribing. Your identity will not be revealed and your comments will remain confidential. All information obtained through the interview will be summarized in an aggregate nature to ensure your confidentiality. Any use of direct quotations will not include your name or any identifying information. I will share my findings with you to ensure they accurately describe your experience with role transition.

If you are interested in participating in the study or have any questions, please do not hesitate to contact me via phone or email. In addition, if you know of anyone else who may be interested in participating in this study, please feel free to provide them my contact information. Thank you for your time and consideration.

Best Regards,

Anthony M. Angelow, MSN, CRNP, ACNP-BC, AGACNP-BC, ACNPC

APPENDIX C
INTERVIEW GUIDE

Reflection Prior to Interview:

1. Before attending the interview, please take time to reflect on your overall experience with transition to the role of the NP and the factors, which you found helpful during role transition and those factors, which you found not helpful during role transition.

Broad Opening Question:

1. Would you tell me about your experience transitioning to the role of the NP?

Central Question:

1. How do nurse practitioners explain their experience with transition to the role of the NP?

Probing Questions:

1. Tell me about any experiences prior to entering graduate-level education that influenced your role transition either positively or negatively.
2. Tell me about the experiences during graduate-level education that influenced your role transition either positively or negatively.
3. Tell me about the experiences as you entered your first clinical role that influenced your role transition either positively or negatively.
4. Tell me how you felt as you entered your first clinical practice role.
5. Reflecting back on your experience with role transition what could have made this a more positive experience?

Probing Techniques:

1. Can you tell me more about that?
2. How/When did that happen?
3. What does that mean?
4. Why did you (insert facial expression/body language) when you shared that information with me?
5. Let's walk through that experience
6. Can you give more detail

APPENDIX D
INFORMED CONSENT

UNIVERSITY of
NORTHERN COLORADO



CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH
UNIVERSITY OF NORTHERN COLORADO

Project Title: The Lived Experience of Nurse Practitioner Role Transition: A Phenomenology Study

Researcher: Anthony M. Angelow, PhD(c), MSN, APN, ACNP-BC, AGACNP-BC, CEN

Research Advisor: Faye Hummel, PhD, RN, CTN-A

Phone: 970-351-1697

Purpose and Description: You are invited to participate in a research study. The primary purpose of this study is to explore nurse practitioner role transition. I am hoping to describe the overall process of nurse practitioner role transition and identify the factors which nurse practitioner's report were helpful and not-helpful during their own role transition.

If you agree to participate, you will also be asked to participate in an interview that will last between 60 to 90 minutes via secured web conferencing software. I will audio record the interview for transcription and analysis. At the beginning of the interview, I will collect basic demographic information such as your age, gender, ethnicity, education level, experience as an NP, and experience as an RN. This demographic information will also include your current certification information and information regarding your NP position. In the interview, you will be asked open-ended questions such as "Would you tell me about your experience transitioning to the role of the NP?"

We may further explore factors which you believe assisted in your role transition and situations which made role transition difficult. At the conclusion of the interview, I will request for you to allow me to contact you after the initial interview to follow up on any additional thoughts and to clarify my interpretations.

What will happen to the data? I will take every precaution to ensure the confidentiality of your data. You will be assigned a random unique identifier number to your data. By doing so, only I, as the researcher, will have access to your identity. Identifying information will not be disclosed in written reports of this study. All information within this study will be reported in the aggregate. All of the data collected in this study will be

stored on an encrypted laptop, which is password protected. When not in use, the laptop will be stored and locked in a filing cabinet to ensure an extra level of security. In addition, all data, including recorded audio files, will be stored in a password protected folder in the secured laptop. Only the researcher will have access to the data/passwords. The researcher will delete digital recordings and transcripts after five years.

What are the risks and benefits to participating in the study? All studies carry some minimal risk and discomfort to the participants. The researcher of this study believes the potential risks for this study are no greater than those you would normally encounter during participant in the interview. There is potential discomfort in sitting during the interview session. I will provide breaks for you when requested. The questions during the interview may cause some participants to encounter some emotional distress if you had a negative role transition experience. Upon completion of the interview, I will give you a thank you card and a \$10 gift card in appreciation for participating in this research study.

Participation is voluntary. You may decide not to participate in this study and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. Having read the above and having had an opportunity to ask any questions, please sign below if you would like to participate in this research. A copy of this form will be given to you to retain for future reference. If you have any concerns about your selection or treatment as a research participant, please contact the Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-2161.

Participant's Signature

Date

Researcher's Signature

Date

APPENDIX E
PARTICIPANT DEMOGRAPHIC FORM

Participant UIN: _____

Basic Participant Information

Age: _____

Gender: Male Female Other: _____

Ethnicity: _____

Nurse Practitioner Certification, Licensure, & Practice Information

What degree did you earn during your initial nurse practitioner education?

Master's Degree Doctor of Nurse Practice

What type of program did you attend for your initial nurse practitioner education?

On-Site Online Hybrid

Which of the following best describes your current NP certification?

Family Nurse Practitioner

Adult-Gerontology Nurse Practitioner

Acute Care Primary Care

Neonatal Nurse Practitioner

Pediatric Nurse Practitioner

Acute Care Primary Care

Women's Health Nurse Practitioner

Psychiatric-Mental Health Nurse Practitioner

How many years have been in clinical practice as a nurse practitioner?

1 year 2 years 3 years

What state(s) are you currently licensed in as a nurse practitioner?

In which state(s) are you currently practicing as a nurse practitioner?

What specialty are you currently practicing in?

Is this your first position as a nurse practitioner?

Yes No

Did you attend an orientation with this position or other positions?

Yes No

What is the number of hours you currently work per week?

Prior Nursing Experience Information

How many years of experience did you have? _____

What was your primary specialty as a registered nurse? _____

Have you held any specialty registered nurse certification? Yes No

If so, what certifications?

Other Information

Are there any cultural, gender, or other issues you would like me to consider during the interview?

