PRIME POINTS

- In the past, only experienced nurses worked in critical care areas. Now, recent nursing graduates work in ICUs and must be trained to provide care for such patients.

- A revamped program for orienting new nurses in the ICU focused on helping them become technically proficient quickly and providing consistent instruction.

CEContinuing Education

This article has been designated for CE credit. A closed-book, multiple-choice examination follows this article, which tests your knowledge of the following objectives:

1. Identify problems with new graduate orientation
2. Discuss the 5-stage model of skill acquisition
3. Describe the challenges preceptors face with new graduate nurses

Graduate Nurses in the Intensive Care Unit: An Orientation Model

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Clinical nurse specialists and nurse educators in critical care search for more efficient and effective ways to orient recent nursing graduates to critical care. Graduate nurses are often overwhelmed with the multiple roles and tasks required in caring for critical care patients. The preceptors at Catholic Medical Center, Manchester, New Hampshire, identified a major concern with graduate nurses: too much time was required for the new nurses to become proficient at completing basic critical care tasks such as clearing volumetric pumps, performing sterile dressing changes, suctioning endotracheal tubes, and emptying collection containers. These frustrations in skill attainment led our preceptor committee and educator to seek a more efficient approach to skill development during orientation of new graduate nurses. After a review of existing literature, we implemented a plan to improve the orientation of new graduate nurses.

Review of Literature

Casey et al used a survey to evaluate the stresses and challenges experienced by new graduates in 6 acute care hospitals during a 1-year period. Several overall themes were apparent in the new graduates’ reports of what was most difficult in their transition from student to nurse:

- Lack of confidence in skill performance
- Deficits in critical thinking and clinical knowledge
- Relationships with peers and preceptors
- Struggle with being dependent on others yet wanting to be independent
- Frustration with the work environment
- Organization and priority-setting skills
- Communicating with physicians

For many graduates, having other new graduate peers available to talk to and share clinical experiences was helpful. Graduates with less than 6 months of experience indicated that lack of organizational skills was a barrier to optimal performance in
In another survey of newly graduated nurses, Thomka received feedback from several graduate nurses that expectations during this transitional period were unclear. In that study, responses from graduates included that they expected less “in-the-fire” experience and would have preferred several weeks of 1-on-1 mentoring. A nurse mentor working with these graduates voiced the need for new nurses to carry a smaller patient load so mentors can focus on meeting the learning needs of the nurses. One graduate nurse in a phenomenological study by Delaney voiced concern that having multiple preceptors (6) was frustrating and confusing, because the preceptors each had their own routine and way of doing things.

The 5-stage model of skill acquisition as described by Dreyfus and Dreyfus and the application of this model to nursing by Benner enhances the understanding of the learning process with graduates. Benner’s model explains how a nurse develops from a novice to an expert. In the novice stage, lacking experience or contextual meaning, graduates are given rules to guide performance. The nurses first gain situational experience by making objective measurements, such as obtaining a patient’s blood pressure, daily weight, or urinary output. The nurses start to apply these basic patient findings within the rules or guidelines they have been told are normal. This process becomes the foundation for contextual knowledge as the nurses progress to the expert level.

**Unit Preceptor Team**

Our unit’s preceptor team consists of a critical care educator, a chairperson, and several experienced preceptors from all 3 shifts. Our nurse preceptors are divided into 2 categories: primary and clinical resource. The primary preceptor group consists of nurses who work mostly full-time and are consistently coassigned to train nurses who are new to our unit. The preceptors are familiar with the orientation process and are competent to evaluate and document the progress of new nurses. Primary preceptors are also invited to participate in our unit-based annual preceptor appreciation day. This day is dedicated to recognizing the efforts of preceptors and to increasing the preceptors’ own knowledge. Activities in the past have included interactive group discussions and guest speakers on different learning styles and generational differences. Each year, 1 primary preceptor is selected as preceptor of the year in recognition of his or her work, and the winner is awarded a 1-year membership to the American Association of Critical-Care Nurses. The role of clinical resource preceptor is reserved for critical care nurses who are entry-level preceptors and are assigned occasionally to work with new employees in the absence of the primary preceptor.

**Problems With Current New Graduate Orientation**

In years past, our new graduates began their clinical orientation with a 1-patient assignment for 2 weeks, before a second patient was added for the remaining 10 weeks. A new graduate nurse was coassigned with a preceptor to care for 1 patient, and the preceptor often had an additional patient of his or her own. This situation often became frustrating to the preceptor when time had to be split between the needs of an additional patient and the learning needs of a new graduate nurse. This approach was not designed to be goal-directed learning, other than to care for the assigned patient together. This orientation format was developed to accommodate our normal staffing pattern, a ratio of 2 patients to 1 nurse. The orientation schedule for a new nurse was not formally organized by an educator but was simply assigned by the clinical leader (shift leader). The preceptors were chosen at random from staff available on each shift, and the unit did not have a core group of nurses trained as preceptors. As a result, a single orientee could potentially be assigned to work with multiple preceptors during a 1-week period. In addition, new graduate nurses were being given different information about basic critical care concepts by each daily preceptor.
consistent with the beliefs of that preceptor. Assigning a different preceptor to a new graduate nurse also made it hard to track the progress or educational needs of the new nurse.

**Orientation Program Redesign Goals**

The goal of our redesign was to help graduate nurses first become fluent with hands-on technology and skills, so their thought process could be dedicated to higher level thinking when they were later assigned to work with the unit preceptors. The new program also had to provide structure to the learning process in a normally unstructured patient care environment. We also wanted a process in place to ensure that each graduate was given the same information about basic care concepts, so that the autonomy that critical care offers does not confuse the graduate nurses before they have developed their own critical-thinking skills. During the program redesign, we took steps to avoid repeating concepts that did not work in the past. One past mistake was assigning 2 patients to a new graduate nurse too early in the orientation process. Historically, this situation led to frustration for both the graduate nurse and the preceptor, because the graduate was not always ready to care safely for 2 acutely ill patients.

**Program Redesign**

After we had reviewed the stages of skill acquisition that a graduate nurse must move through before becoming competent, we wanted to develop an orientation program that could be designed to best meet the needs of the learners, with a primary goal of fostering critical thinking skills sooner. Understanding that graduate nurses need to develop technical proficiency early in their training, we redesigned the graduate nurse's learning process.
orientation program to include 3 phases (see Figure).

Phase 1 starts with the graduates’ first day on the unit. This phase was designed to outline a structured approach to patient care and to give standardized information on basic care to each graduate. These goals would be accomplished by having all the graduates initially assigned to work with the unit educator. The expected duties of the graduate relative to patient care would be outlined and discussed in advance, so the care delivered would be structured, and we could avoid having the graduate become overwhelmed with all the tasks at hand. In phase 2, the goal was to have provided enough hands-on experience and structure in phase 1 for the graduate nurse to now be able to care for 1 patient independently (under supervision). By phase 3, the graduate nurses should be ready to work the hired shifts they were hired for and to care for 2 patients under the supervision of their preceptors.

Day One
The first day in the intensive care unit, the graduate nurses are assigned to work with our critical care educator and do not have a patient assignment. This day is used to provide an orientation to the physical unit and to introduce each graduate nurse to staff members and unit policies and references. Equipment used is presented, with time for hands-on return demonstration. A digital photograph of each new employee with his or her primary preceptor is taken and is posted in the staff lounge to welcome the new employees and introduce them to current staff. An overview of the orientation template is explained to the graduates (see Figure and Table 1), including the timeline of all 3

### Table 1 Template of duties for orientation of new nursing graduates

<table>
<thead>
<tr>
<th>Primary nurse</th>
<th>Secondary nurse</th>
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<tbody>
<tr>
<td>Give report (shift and charge nurse)</td>
<td>Monitor hourly intake and output</td>
</tr>
<tr>
<td>Assess patient every 4 hours (including patency of feeding tube)</td>
<td>Check vital signs hourly</td>
</tr>
<tr>
<td>Document assessment every 4 hours</td>
<td>Empty any drains and bladder catheter at end of shift</td>
</tr>
<tr>
<td>Administer scheduled, stat, and as-needed medications</td>
<td>Check concentrations of intravenous infusions</td>
</tr>
<tr>
<td>Double sign medication orders</td>
<td>Check calculation of dosages for intravenous infusions (Imed)</td>
</tr>
<tr>
<td>Check physicians’ orders and note new orders</td>
<td>Check dates on intravenous tubing, change as needed</td>
</tr>
<tr>
<td>Call physician as needed</td>
<td>Check tube feeding dates, refill and change as needed</td>
</tr>
<tr>
<td>Participate in collaborative rounds</td>
<td>Obtain blood glucose levels as ordered</td>
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<tr>
<td>Check laboratory reports, cultures, arterial blood gas analyses</td>
<td>Adjust insulin infusion as ordered</td>
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<tr>
<td>Lighten up (sedation)</td>
<td>Titrare all intravenous infusions, mix new bags as needed</td>
</tr>
<tr>
<td>Check ventilator settings with assessment</td>
<td>Collect all specimens from arterial catheter for laboratory tests</td>
</tr>
<tr>
<td>Document weanings from ventilator</td>
<td>Provide mouth care every 2 hours</td>
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<tr>
<td>Provide mouth and skin care/bath</td>
<td>Check, clear, and document patient-controlled analgesia pump</td>
</tr>
<tr>
<td>Reposition patient every 2 hours (chart)</td>
<td>Check AV-Impulse system (Orthofix Inc, McKinney, Texas), sequential compression boots, thromboembolic deterrent stockings</td>
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<tr>
<td>Review morning chest radiograph</td>
<td>Listen to report</td>
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<tr>
<td>Talk with family members (in person and by phone)</td>
<td>Review past 24 hours of progress notes, physicians’ orders, medical history, and findings on physical examination</td>
</tr>
<tr>
<td>Provide problem-oriented documentation</td>
<td>Assist patient out of bed to chair by using appropriate mechanical lifts</td>
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<tr>
<td></td>
<td>Perform inline suctioning as needed</td>
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<tr>
<td></td>
<td>Keep head of bed elevated 30º (intubated or tube feeding)</td>
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</tbody>
</table>

Questions to ponder
1. Is my patient a full code; if no, why?
2. Does my patient have any allergies?
3. Why is my patient in intensive care?
4. Why is the patient still receiving mechanical ventilation?
5. How has my patient done at weaning from the ventilator in the past?
6. When were the last specimens sent for culture? What was cultured? What were the results?
7. Who are the patient’s family members?
8. What do I need to ask the physician, if anything?
9. Who is available for consultation (physician groups) and why?
If the graduate nurse has a question, the preceptor encourages the new nurse to verbally explore all options and rationale before making a final decision, instead of the preceptor just giving the graduate nurse an immediate answer.
Table 2  Individualized orientation schedule

<table>
<thead>
<tr>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
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<td>June</td>
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<tr>
<td>18</td>
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<td>21</td>
<td>22</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Hospital orientation</td>
<td>Hospital orientation</td>
<td>Hospital orientation</td>
<td>Hospital orientation</td>
<td>Hospital orientation</td>
<td>July 1</td>
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<td>July</td>
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<td></td>
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<tr>
<td>2</td>
<td>Day 1</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>ICU educator</td>
<td>8 AM-4:30 PM</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>8 AM-4:30 PM with ICU educator</td>
</tr>
<tr>
<td>9</td>
<td>Class</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>8 AM-4:30 PM Basic concepts</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>8 AM-4:30 PM Vascular disease</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>7 AM-3:30 PM with ICU educator</td>
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<tr>
<td>16</td>
<td>Class</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>8 AM-4:30 PM Basic dysrhythmias, part 1</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>8 AM-4:30 PM Ventilator modes</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>7 AM-3:30 PM with ICU educator</td>
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<tr>
<td>23</td>
<td>Class</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td>8 AM-4:30 PM Basic dysrhythmias, part 2</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>8 AM-4:30 PM Basic dysrhythmias, part 2</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td></td>
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<tr>
<td>30</td>
<td>Class</td>
<td>31</td>
<td>Aug</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8 AM-4:30 PM Basic dysrhythmias, part 3</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>8 AM-4:30 PM Renal</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td></td>
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<tr>
<td>Aug</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>Class</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>8 AM-4:30 PM Cardiac A &amp; P</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>8 AM-4:30 PM Cardiac dysfunction I</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>7 AM-3:30 PM with ICU educator</td>
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<td>13</td>
<td>Class</td>
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<td>15</td>
<td>16</td>
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<td>18</td>
</tr>
<tr>
<td>8 AM-4:30 PM Cardiac dysfunction II</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>8 AM-4:30 PM Pacemakers</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>7 AM-3:30 PM with ICU educator</td>
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<tr>
<td>20</td>
<td>Class</td>
<td>21</td>
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<td>23</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>8 AM-4:30 PM Hepatic/renal</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>8 AM-4:30 PM Critical-thinking scenarios</td>
<td>7 AM-3:30 PM with ICU educator</td>
<td>7 AM-3:30 PM with ICU educator</td>
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<td></td>
<td>27</td>
<td>28</td>
<td>29</td>
<td>30</td>
<td>31</td>
<td>Sept</td>
</tr>
<tr>
<td>7 AM-3:30 PM with ICU preceptor</td>
<td>7 AM-3:30 PM with ICU preceptor</td>
<td>7 AM-3:30 PM with ICU preceptor</td>
<td>7 AM-3:30 PM with ICU preceptor</td>
<td>7 AM-3:30 PM with ICU preceptor</td>
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<tr>
<td>7 AM-3:30 PM with ICU preceptor</td>
<td>7 AM-3:30 PM with ICU preceptor</td>
<td>7 AM-3:30 PM with ICU preceptor</td>
<td>7 AM-3:30 PM with ICU preceptor</td>
<td>7 AM-3:30 PM with ICU preceptor</td>
<td>7 AM-3:30 PM with ICU preceptor</td>
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</tr>
</tbody>
</table>

Abbreviations: A & P, anatomy and physiology; ICU, intensive care unit.
assigned preceptor. The idea is to select patients whose clinical status is stable who do not have orders for procedures. Admissions, bedside procedures, and transfers are introduced later into assignments when the graduates have gained confidence with a regular routine.

The goal of this stage is to provide supervised independence for the graduate nurses. They start to make individual decisions about patient care, while still being supervised closely by their preceptors. This phase provides an opportunity for the graduate nurses to perform procedures they have previously practiced with a preceptor, for example, preparing and administering an intravenous medication without the step-by-step direction of the preceptor. Although the preceptor monitors the preparation and delivery, the graduate nurse is allowed to approach the process independently. If the graduate nurse has a question, the preceptor encourages the new nurse to verbally explore all options and rationale before making a final decision, instead of the preceptor just giving the graduate nurse an immediate answer. An effort is also made to assign the preceptors and graduates patients who are close to each other, so that the 2 teams can assist each other with unscheduled procedures, patient care, or lunch coverage. The graduates also learn to be comfortable with communication skills such as hand-off report, communication, and delegation.

One struggle for the preceptors during this phase is the conscious effort to stay focused on the graduate nurses and not become distracted by other acute issues taking place with other patients. This focus also becomes difficult at times for noninvolved staff members, who may view the preceptor as doing nothing, but in actuality the preceptor is listening to report with the graduate nurse.

Phase 2

In phase 2, each new graduate is coassigned with either a unit preceptor or the educator to care for 1 patient. The preceptors are added at this point to assist the educator, so the supervision responsibility does not exceed more than 2 patients per nurse. With this approach, the preceptors are used in a more efficient manner; 1 preceptor is assigned to 2 patients (similar to our normal staffing pattern). Patients the graduate nurses are qualified to care for are chosen each evening before the scheduled day by the educator or assigned preceptor. The concept was developed to provide structure to the learning environment and to allow graduate nurses time for attention to detail. We hoped that fostering this attention to detail in new nurses would promote a more prudent practice later when the nurses were challenged with multiple tasks at hand.

Phase 3

In phase 3 of the orientation, each new graduate nurse is assigned to care for 2 patients under the supervision of 1 preceptor. By week 9, the new nurses begin working their assigned evening or night shift (with a preceptor). The graduates are not scheduled to work the night before a class day. Matching patients’ acuity to the skill level of graduate nurses became a challenge. Most days, all 4 graduates were assigned to the unit on the same day because they attended classroom lectures twice a week. This arrangement required preceptors and charge nurses to find 8 patients on a single shift.

Once orientation is completed, a graduate nurse is expected to be able to care for 2 critical care patients receiving mechanical ventilation.
that would match the skill level of new graduate nurses. Typically, the preceptor or educator would request an assignment the day before, and the charge nurse would adjust the assignment if the assigned patient’s condition changed.

Between weeks 9 and 10, each new graduate is assigned a time to complete the basic dysrhythmia examination. This time frame allows the graduate nurses the opportunity to gain clinical experience with rhythm identification and treatment while caring for patients with the preceptors. If a passing score of 85% is not obtained on the examination, the unit educator provides individual remediation in identified areas of weakness.

The target date for a graduate nurse to be ready to complete orientation is about week 12. For each graduate nurse, the specific date of completion is discussed with the unit director, educator, primary preceptor, and the graduate nurse at a final summation meeting. This meeting is scheduled by the unit educator and is used to summarize the progress and experiences of the graduate nurse. The graduate nurses are asked to self-evaluate their progress and address their comfort level with completing orientation. If it is decided that orientation will extend beyond the 12-week mark, specific goals are identified and agreed upon by the group. Once orientation is completed, a graduate nurse is expected to be able to care for 2 critical care patients receiving mechanical ventilation.

**Results**

The first year this template was used, the plan met the original goals of the redesign and had some unexpected benefits. The information provided was standardized, because all of the graduates initially worked with our critical care educator. Also learners’ attention to detail improved. One graduate nurse noticed that an intravenous tubing sticker listed an incorrectly calculated date of expiration. Another graduate noted that the respiratory therapist had recessed the inline suction catheter too far back after suctioning, so the closed-sheath system was leaking oxygen.

At the end of orientation, we met informally with the new graduates and requested feedback on the program. Feedback on the changed approach was positive. The graduates stated that they felt secure in having sufficient time to master the technical skills required (hands-on equipment) in the first phase of the program. One new graduate stated that this system of being coassigned with another new graduate to care for the same patient helped the first nurse foster a peer relationship with a new coworker. Another graduate suggested that we specifically add that the primary and secondary nurses share information gathered during patient care before giving intershift report. Although doing so seemed common sense, it had not been included in the written plan and therefore was not consistently done by each graduate nurse. This additional instruction would potentially prevent a fragmented report to the oncoming nurse. One graduate stated that although she had a high anxiety level initially when starting each phase, after a few days she was able to calm her fears because she knew that she was able to meet the expectations of more responsibility.

The preceptors found the new design surprisingly rewarding. Overseeing 2 graduate nurses with 1 patient each was less stressful than being assigned 1 graduate nurse and a patient of the preceptor’s own (as in the past). The preceptors recognized the strength that the new graduates had gained in the first 2 phases, as compared with new graduates in previous years. The graduates were no longer hesitant to do suctioning or turn patients. We think that this difference is directly linked with the specific time allotted to learn technical skills in phase 1. This comfort with hands-on tasks allowed the graduate nurses to focus on time-management skills, which is often difficult when advancing to a 2-patient assignment. The nurses also seemed to improve in prioritizing tasks, for example, when one patient needs a dressing change and another patient needs to have a blood sample obtained for laboratory tests at the same time. One preceptor also noted healthy competition; one of the new graduate nurses would say, “I got to start an IV,” and the other graduate nurse would then seek that opportunity.

Time-management and critical-thinking skills also seemed to improve with this model. One graduate commented that he had just changed a patient’s dressing 2 hours before, then wondered why it was resaturating so quickly. He reassessed the drainage and reviewed the patient’s laboratory values, activity, and fluid/volume status to determine an appropriate course of action. Instead of focusing on the dressing change technique or how late the hour was getting, he was wondering, Why did this soak through so
quickly? This example reflects just the desired level of critical thinking that we were hoping the graduates would achieve.

Our time frame for having a graduate nurse complete orientation to critical care has not changed; it remains at 12 weeks. These changes to our orientation format are not only cost-effective but also have improved our utilization of resources. The previous method of assigning 4 graduate nurses to 4 preceptors with each pair caring for 1 patient reduced our staffing capacity by half, because each preceptor was assigned 1 patient instead of 2. In phase 1, using the educator (who is normally out of staffing) to care for patients makes the preceptors available for a full assignment. This step also saves about $10 000 in nursing salary over this 2-week period (320 preceptor hours were not needed: 2 weeks with 4 preceptors). In phase 2, an additional $7500 was saved in nursing salaries, because the educator was again used in addition to a preceptor to work with the graduates. (A total of 240 preceptor hours were not needed: 3 weeks with 2 preceptors.) Our unit director commented that she was able to approve more summer vacation requests by staff because this template allowed preceptors to be used more efficiently.

Remaining Challenges

One challenge that remains is how to obtain the same benefits of this model when an odd number of graduates are hired. If a graduate nurse did not successfully pass the licensing examination and had to forfeit his or her hired position, a graduate nurse would not be paired. This model might not be a success if the educator and preceptors do not work as a team, communicate, and plan ahead of time. Also, we must trust that the clinical leaders and relief charge nurses will strive to keep the predetermined assignments and nurse-to-patient ratios and not alter the model to fit the immediate needs of the unit.

Conclusion

The working environment in which a nurse acquires skills has changed drastically. In years past, a nurse was not considered for a position in critical care unless he or she had prior experience. This requirement provided a clinical work environment heavily populated with experienced personnel. Today, not only are graduate nurses accepted directly into critical care but their working environment is weighted with less-experienced nurses. The impact of this lesser experienced working environment on nurses moving from novice to expert has yet to be determined.

References


Financial Disclosures

None reported.
1. Which of the following are 2 of the themes identified in the transition from student to nurse?
   a. Deficits in critical thinking and clinical knowledge, and organization and priority setting skills
   b. Communication with physicians and crucial conversations with colleagues
   c. Being dependent and autonomous, and time management skills
   d. Frustrations with work environment and skill attainment

2. What is the theory used for the 5-stage model of skill acquisition?
   a. Neuman’s theory on systems
   b. King’s modeling and role-modeling theory
   c. Benner’s theory on novice to expert
   d. Bates’ humanistic nursing communication theory

3. The main role of the clinical resource preceptor includes which of the following?
   a. Primary clinical educator for all new graduate nurses
   b. Primary clinical preceptor for new hired staff nurses
   c. Reserved for critical care nurses who occasionally work with new employees
   d. Reserved for clinical nurse specialists who work primarily with clinical employees

4. Preceptors often became frustrated when which of the following occurred?
   a. Learning needs of the new graduate nurse were extensive and time to precept was lacking
   b. Time was split between the needs of an additional patient and the learning needs of a new graduate nurse
   c. Orientation was extended and schedules were formally arranged
   d. Time was split between preceptors to accommodate additional hours needed by certain new graduate nurses

5. Which of the following is identified as the major goal of the orientation program?
   a. Developing and implementing a focused orientation by using Benner’s theory
   b. Developing and implementing a complete wireless and integrated computer-based orientation program
   c. Helping graduate nurses identify their strengths and weaknesses
   d. Helping graduate nurses become fluent with hands-on technology and skills

6. Which of the following identifies one of the 3 phases of the program redesign?
   a. Outlining a structured hands-on approach experience to standardized basic care
   b. Outlining a structured approach to patient care and giving standardized information on basic care
   c. Providing a structure of independence and autonomy within the first month
   d. Outlining limited hands-on experience during the first month of orientation

7. New graduate nurses began providing care for 1 critically ill patient after how many weeks?
   a. 3 weeks
   b. 2 weeks
   c. 4 weeks
   d. 6 weeks

8. The primary goal of phase 2 is to do which of the following?
   a. Provide supervised independence for the graduate nurses
   b. Provide independent assignments of 2 patients for the graduate nurses
   c. Provide dependent assignments of 1 to 2 patients for the graduate nurses
   d. Provide coassigned independence for the graduate nurses

9. Preceptors struggled with which of the following during phase 2?
   a. Determining appropriate assignments for graduate nurses
   b. Regular changes to preceptor assignments
   c. Matching the skill levels of the graduate nurses to one another
   d. The conscious effort to stay focused on the graduate nurses and not become distracted

10. Which of the following was identified by the new graduates at the end of orientation?
    a. They felt confident in caring for 2 patients as required in the second phase
    b. They felt secure in having had sufficient time to master the technical skills required in the first phase
    c. They felt stressed for not having had sufficient time to master the technical skills required in the first phase
    d. They felt confident in caring for 2 critically ill patients during the third phase

11. Which of the following 2 areas were identified as having improved with the new redesigned model of orientation?
    a. Critical thinking and communication skills
    b. Communication and time-management skills
    c. Technical and critical thinking skills
    d. Time-management and critical thinking skills

12. Use of the nurse educator resulted in which of the following during phase 1 of the program?
    a. $15,000 savings in nursing salaries and 500 hours of preceptor time saved
    b. $10,000 savings in nursing salaries and 240 hours of preceptor time saved
    c. $15,000 savings in nursing salaries and 820 hours of preceptor time saved
    d. $15,000 savings in nursing salaries and 820 hours of preceptor time saved

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**AMERICAN ASSOCIATION of CRITICAL-CARE NURSES**

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Graduate Nurses in the Intensive Care Unit: An Orientation Model
Donna M. Proulx and Bethany J. Bourcier

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