ORIENTATION PRACTICES FOR NURSES
IN OPERATING ROOM SETTINGS IN IOWA HOSPITALS

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by
Carol Hepplewhite Hull
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ORIENTATION PRACTICES FOR NURSES
IN OPERATING ROOM SETTINGS IN IOWA HOSPITALS

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Carol Hepplewhite Hull

Approved by Committee:

Linda Brady, R.N., Ph.D., Chairperson
S. Kay Montgomery, R.N., M.A.
Susan Allyn, M.S., M.S.E.
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An Abstract of a Thesis by
Carol Hepplewhite Hull
February 1993
Advisor: Linda H. Brady, R.N., Ph.D.

The Problem
The purpose of this study was to describe
methods of orientation for nurses in operating room
settings in Iowa hospitals.

Procedure
This study obtained data from 89 hospitals with
operating room settings who were members of the Iowa
Hospital Association in 1992. A 50 item
questionnaire was mailed to 125 hospitals within 94
Iowa counties. The hospitals receiving
questionnaires were categorized as rural, rural
referral, and urban based on the Medicare
classification system.

Findings
Most nurse orientees had no operating room
experience. Length and cost of orientation varied.
Most hospitals reported the use of competency based
orientation. Preceptors were used in 55.1% of
orientation programs. Most hospitals did not provide
recognition for the preceptor role.

Recommendations
Research is needed to develop a cost-effective
method to prepare preceptors for the infrequent staff
turnover experienced in rural Iowa hospitals.
Replication of this study using a larger sample of
states would provide additional information
concerning the orientation needs of rural hospitals.
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CHAPTER I

INTRODUCTION

Background

Hospitals and medical centers face the continuing challenge of providing qualified nurses in patient care settings. One portion of this challenge is how to prepare the new nurse employees for independence as quickly as possible while ensuring mastery of the job and a positive experience that will help retain nurses (Sullins, 1989). Increasing economic constraints in the health care system have made it necessary to design orientation programs so that nurses can function effectively in their clinical areas. Conventional orientation programs are frequently lacking in the degree of clinical support and follow up required at the unit level (Mooney, Diver, & Schnackel, 1988).

Hospitals and medical centers provide facilities not only for the traditional operating room setting but also for ambulatory surgery. Patients are often admitted to a preoperative care unit the morning of surgery and then proceed to surgery, the recovery room, and then to the postoperative care unit. The patient may be discharged directly from a
postoperative care unit on the day of surgery or may be admitted as an inpatient for a day or more following the surgical procedure (Kee, 1989).

As the operating room environment and needs of the surgical patient become more complex, effective orientation programs for nurses become even more important for safe patient care (Faulhaber, Coleman, & Cardwell, 1987). The changing roles of the perioperative nurse demand more than apprenticeship or on-the-job training. Being highly skilled in the performance of tasks is no longer sufficient if high quality care is to be provided within increasingly limited time frames (Kee, 1989).

Although perioperative nursing is widely believed to be limited to the performance of skills within the operating room, current practices demonstrate otherwise. The term perioperative encompasses preoperative, intraoperative, and postoperative nursing care (Kee, 1989). The Association of Operating Room Nurses (AORN) describes perioperative nursing as follows:

Perioperative nursing practice is flexible and diverse and includes a variety of nursing roles that incorporate both behavioral and
technical components of professional nursing. The scope of practice for each perioperative nurse may include, but is not limited to, roles such as scrub person, circulator, manager, educator, and first assistant. The perioperative nurse delivers care through use of the nursing process as reflected in the Standards of Perioperative Nursing Practice in a manner that is cost-effective without compromising quality of care (AORN, 1992, p. 1).

Perioperative nurses are the major providers of nursing care throughout critical periods of psychological as well as physiological stress. The perioperative nurse, therefore, needs to be adept not only in technical functions associated with the surgical setting but also in allaying patient anxieties, in providing preoperative and postoperative patient education, ascertaining self-care abilities of the patient, and determining the general health status of the patient (Kee, 1989).

Supervisory personnel in operating room patient care areas continue to be confronted with the problem of declining numbers of registered nurses prepared
for the perioperative role. In addition, as mentioned earlier, there is an increasing demand for an educationally sound and cost-effective method of preparing beginning practitioners for the operating room setting (Fitzpatrick, DiMattia, & Fennessey, 1982).

Shoup (1988) reports that the number of nurses practicing in the operating room has been on the decline since the 1960s. She describes the shortage as partially attributed to the lack of exposure nursing students have to the operating room in their basic educational program. Kee (1989) further describes the change in emphasis on intraoperative nursing care within nursing education programs. Undergraduate curricula in nursing provide limited, if any, experience in perioperative nursing practice. Confronted with the need to include information from a large body of knowledge into a structured time frame, educators generally have chosen to incorporate perioperative nursing into medical-surgical courses or to offer an elective course in perioperative nursing. This significant change in curricula has resulted in difficulty with recruitment of nurses into the specialty of perioperative nursing.
Marta (1987) agrees that this change in emphasis has resulted in an overall reduction in the number of surgical nurses. Marta (1987) further describes the effects of a diminishing pool of surgical nurses on the quality of patient care: "With a decreasing pool of OR [operating room] nurses, more technical staff may be hired, which can lead to frustration, RN turnover, and ultimately poor staffing. With fewer professionals giving nursing care in the OR, the quality of patient care may diminish" (p. 669).

Nurses come into new positions from varied educational and clinical backgrounds as well as at different stages in their careers. Hospitals have attempted to implement several types of orientation programs in the past that were designed to address the varied needs associated with this pool of nurses. Most of these programs were characterized by an extensive time period for the orientation process during which the educational needs of new employees were addressed. Despite the increased expenditure of time and money for these extensive orientation programs, there is little evidence to document better preparation and increased retention of nurses (Shogan, Prior, & Kolski, 1985).
In response to the problems identified with traditional orientation approaches for new nurse employees, the AORN, through the National Committee on Education, recommends the use of preceptor programs with orientation for new nurse employees in the operating room setting (AORN, 1988). The primary role of the OR preceptor is that of a role model and resource person during the first critical weeks of the orientation process (Saad, 1987). A review of the literature reveals a lack of studies that address the use of recommendations from the Association of Operating Room Nurses in the orientation process for new nurse employees in the operating room patient care areas.

Purpose

The purpose of this study was to describe the methods of orientation for registered nurses employed in operating room settings in hospitals within the state of Iowa.
Definition of Terms

For purposes of this study, the following definitions were used.

**Hospitals**

An institution where sick or injured persons receive medical or surgical care (Webster, 1988). For purposes of this study, hospitals will be identified as members in the Iowa Hospital Association. Furthermore, hospitals will be categorized according to bed size and geographic location by the Medicare reimbursement classification system for Iowa, which is as follows:

- Rural: 0 to 50 beds
- Rural Referral: 51 to 150 beds
- Urban: 151 or more beds (G.Meyer, June 12, 1992)

**Learner**

The learner is an inexperienced new graduate, an experienced registered nurse new to the OR, or an experienced perioperative nurse who is new to the facility (AORN, 1988).

**Nursing Care Setting**

An organized component of the hospital in which patients regularly receive nursing care (JCAHO, 1991).
Operating Room

The environment in which the patient's surgical procedure is performed (AORN, 1992).

Operating Room Nurse

A registered nurse who assumes the perioperative role in providing care to patients experiencing surgical intervention (AORN, 1992). The term operating room nurse and perioperative nurse are used interchangeably throughout the paper.

Perioperative Nursing Practice

Those nursing activities performed by the professional nurse during the preoperative, intraoperative, and postoperative phases of the patient's surgical experience (AORN, 1992).

Preceptor

An experienced registered nurse who has specific responsibility to provide and direct learning experiences for the learner. The preceptor acts to facilitate learning within the goals and objectives of the program. The role of preceptor may include primary orientor, role model, advisor, resource person, counselor, and evaluator (AORN, 1988).
Standard

A criterion used by general agreement to determine whether something is as it should be. An agreed upon level of excellence. An established norm determined by opinion, authority, research, and/or theory (AORN, 1992).

Methods of Orientation

The means by which personnel are introduced to the physical surroundings, routines, policies and procedures, necessary technical skills, and organizational culture specific to the operating room setting. For purposes of this study, the methods of orientation will be measured by self-report of the person responsible for orientation of new nursing staff in the operating room patient care area of each institution selected.

Culture shock

That phenomenon that occurs in response to transition from one setting to another in which the individual is placed in an unfamiliar situation where former patterns of behavior are ineffective and in which basic cues for social intercourse are absent (Brink & Saunders, 1976).
Significance of the Study

This descriptive study will enhance the body of knowledge pertaining to the methods of orientation for new nursing staff in perioperative settings. The study will also demonstrate the incidence of the use of preceptors within the state of Iowa. The differences between rural and urban hospitals and medical centers with respect to orientation practices will be identified.

The study will establish baseline information regarding orientation practices in Iowa and may stimulate further study. For example, other states could be surveyed to establish how orientation of new nurse employees is being accomplished. In addition, the incidence of competency based orientation programs could be investigated. Further depth in the areas of preceptor preparation, educational requirements for the staff education position, plans and methods for establishing the educational needs of staff in the surgical setting could also be studied.

The results of the study may be used by personnel responsible for staff education within the surgical setting when reviewing or developing
orientation programs for their respective institution. The results may also be used by the Association of Operating room nurses when examining the issues related to orientation practices on a national level.
CHAPTER II
REVIEW OF THE LITERATURE

Overview

The review of the literature begins with a discussion of the history of perioperative nursing. An introduction to the concept of orientation within the context of new nursing staff in the surgical setting follows. A description of the use of preceptors in the orientation program for nurse employees is then presented. Examples of the use of preceptors are presented and the chapter concludes with a discussion of related research.

Historical Perspective on Perioperative Nursing

Operating room nursing was identified as an area of specialization in 1889 (Groah, 1983). The nursing literature describes the nurse in an assisting role to the surgeon as well as in a coordinating role for operating room activity (Lee, 1976).

From 1900 to 1920 the roles of the scrub nurse and circulating nurse began to develop. The scrub nurse dressed in sterile attire and assisted the
surgeon with instruments throughout the surgical procedure. Two examples of names ascribed to this role were "sterile gloved nurse" and "instrument nurse." The surgeon preferred that a senior member of the nursing team function in this role. The circulating nurse coordinated activities throughout the surgical procedure including preparation of the surgical suite and the acquisition of supplies. Nursing authorities preferred that an experienced member of the surgical team function in this role.

In 1919 a section on operating room technique first appeared in the standard curriculum developed by the National League for Nursing Education. This was intended to be a guide for schools of nursing regarding the use of the operating room experience (Groah, 1983).

The decade of the 1930s brought about an attempt to standardize the level of nursing care in the operating room. In 1933 the Subcommittee on Surgical Nursing of the Education Committee of the National League for Nursing Education outlined a master curriculum plan for an advanced course in operating room technique and standards. It was the first attempt to standardize the level of nursing care in
the operating room by a national organization. This curriculum was to serve as a model for training graduate nurses to work in the operating room during the next decade (Groah, 1983).

The Depression resulted in a decrease of the patient census in most hospitals; therefore, hospitals had to reduce the number of nurses they employed. In addition, many schools of nursing were forced to close because of a lack of necessary financial resources. Consequently, the number of graduate and student nurses was declining by 1940 (Groah, 1983).

An acute nursing shortage occurred when the United States entered World War II (WWII) because many nurses left positions in hospitals in order to join the armed forces. Hospitals responded by training ancillary personnel to take the place of graduate and student nurses. In addition, the armed forces developed programs to train nurses and corpsmen to function in mobile field hospitals near the actual battle sites. The term operating room technician was created to describe the personnel trained to assist in surgery (Shoup, 1988; Groah, 1983).
The use of nonprofessional to perform tasks formerly identified as nursing responsibilities continued after WWII. An increasing shortage of nurses prompted many hospitals to hire operating room technicians, trained while in the armed forces, to fill vacancies in operating rooms. Hospital administrators questioned the use of nurses in a technical area such as the operating room. As a result, operating room technicians, under the direct supervision of a registered nurse, performed routine duties thereby allowing the nurse to carry out more complex tasks. The technical roles, however, were not well defined and there was a lack of formal training outside the armed forces (Groah, 1983).

The formation of the first independent specialty nursing organization for operating room nurses was the result of a meeting of concerned operating room supervisors in New York in 1949 whose purpose was to pool knowledge and exchange ideas. This meeting resulted in the formation of a New York state organization for operating room nurses. The initial goals of the state organization were to stimulate the formation of similar groups in other parts of the country, be a specific group to pool and share
nursing knowledge and technology, provide optimum care to the surgical patient through a broad educational program, make a body of knowledge available to operating room nurses, motivate experienced operating room nurses to share their expertise with others, and to be an association for the benefit of all professional operating room nurses. Other state organizations for operating room nurses grew as a result of the enthusiasm and assistance of the New York state organization. In 1957 the Association of Operating Room Nurses (AORN), an independent national organization of operating room nurses was formed (Groah, 1983; Driscoll, 1976; Shoup, 1988).

The initial development of standards for nursing practice in the operating room began in 1965 with the publication of an article on standards for administrative and clinical practice in the operating room authored by the AORN Board of Directors. In 1969 the AORN published the first official statement defining nursing care in the operating room. This provided direction for the practitioners of operating room nursing as well as for nursing educators. In 1978 the AORN expanded the role of the operating room
nurse from intraoperative care to perioperative care. Perioperative care included the preoperative, intraoperative, and postoperative phases of the patient's surgical experience. A revision occurred in 1985 that further emphasized the scope of nursing practice (Groah, 1983; Shoup, 1988).

In 1988 the AORN, through the National Committee on Education, advocated the use of preceptor programs as the recommended method of orientation for new nurse employees in the operating room setting. AORN published the Preceptor Guide for Perioperative Nursing Practice in the same year. AORN (1988) described the purpose of this guide as "to provide the experienced clinician with a reference to assist in developing an orientation program for learning based on established recommended practices and competencies" (p. 1).

The Concept of Orientation

Nurses who present for orientation to a health care setting may be categorized according to their work experience. The three categories are graduate nurses who are making the transition from student to practitioner, nurses returning to
active practice after months to years of not practicing as a nurse, and experienced nurses who are new to an institution or transferring from one area of practice to another (Bastien, Glennon & Stein, 1986).

Orientation provides the employee with new facts and principles for application in the work environment. Orientation of new employees also satisfies requirements for staff orientation specified by the Joint Commission on Accreditation of HealthCare Organizations (Sullins, 1989).

Standards established by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) (1991) that relate to the orientation of new nursing staff in the operating room setting are as follows:

Nursing Care

N.C.2.3 Nursing staff members participate in orientation, regularly scheduled staff meetings, and ongoing education designed to improve their competence (p.133).

N.C.5.4 The nurse executive and other nursing leaders are responsible for developing, implementing, and evaluating programs to promote the recruitment, retention, development, and
Continuing education of nursing staff members (p.138).

**Surgical and Anesthesia Services**

S.A.1.6.1 A registered nurse, qualified by relevant education, training experience, and documented competence, is responsible for planning and directing nursing care of patients who undergo surgery and other invasive procedures when receiving anesthesia (p. 274).

The 1993 Standards for Orientation, Training, and Education of staff developed by the JCAHO (1992) are a much more specific guideline and state:

- New staff in the operating room, obstetrical, delivery room, other special invasive procedure rooms (for example endoscopy suite, cardiovascular laboratory), and other areas of the hospital where patients undergo procedures related to surgical, invasive, or anesthesia risks are provided with additional education regarding infection control issues. At a minimum, the following areas are addressed:
  - Principles of asepsis, sterilization and
disinfection, documented maintenance and surveillance of sterilization equipment used, the selection of draping and gowning materials wearing apparel for staff in surgery or anesthesia areas, and methods of controlling traffic in areas used for surgical or anesthesia services (p. 2).

The Standards for Orientation, Education, and training for staff (Joint Commission for Accreditation of Healthcare Organizations, 1993) include the following criteria which specifically address the use of competencies during orientation of staff:

SE. 4 Each individual in the organization is competent, as appropriate to his/her responsibilities in the knowledge and skills required to perform his/her responsibilities (p. 11).

The content to be presented in employee orientation process includes philosophy, goals, policies, procedures, role expectations, and physical facilities (Bachman, 1980). The AORN publishes standards that specify content to be included during employee orientation in the "Standards of
Administrative Nursing Practice: OR' section of the Standards and Recommended Practices for Perioperative Nursing (1992). The standard that addresses development of operating room personnel with an explanation of the statement is as follows:

Standard IX.
Staff development programs shall be provided for operating room personnel. Orientation programs assist employees to adjust to the organization, environment, and duties.

Criteria
1. Orientation programs are established and required for all personnel. Content included is not limited to:
   a. philosophy, mission, and role of the agency
   b. philosophy, purpose, and objectives of operating room services
   c. policies and procedures of agency and operating room
   d. job descriptions and performance standards
   e. skills assessment (p. 4-4).
Chrisman (1990) emphasizes the need to include content specific to the culture of the operating room environment with orientation content. A nurse new to the surgical setting commonly experiences weeks to months of initial feelings of distress before settling into an established routine. Chrisman (1990) and Davidhizer and Bowen (1991) describe this experience as culture shock. Brink and Saunders (1976) define culture shock as "that malady that occurs in response to transition from one setting to another; in which the individual is placed in an unfamiliar setting where former patterns of behavior are ineffective; and which basic cues for social intercourse are absent" (p. 126).

The Concept of Preceptors in Nursing

The concept of a preceptor has been described in a variety of ways. Bachman and Ridely (1984) describe the preceptor as a tutor, coach, goalsetter, trouble shooter and evaluator. DeBlois (1989) describes the preceptor as a combination of practitioner, teacher, consultant, and researcher. Saad (1987) presents the primary goal of
the OR preceptor as a role model and resource person during the first critical weeks of orientation. The AORN (1988) defines a preceptor as follows:

An experienced registered nurse who has specific responsibility to provide and direct learning experiences for the learner. The preceptor acts to facilitate learning within the goals and objectives of the program. The role of the preceptor may include primary orientor, role model, advisor, resource person, counselor, and evaluator (p. 2).

The purpose of preceptor programs are to assist newly hired professional nurses in adapting to their role responsibilities and environment during the orientation period. Each new nurse employee (orientee) is assigned to a specially prepared clinical nurse who acts as a resource and support person in the clinical setting to which the orientee is assigned.

The AORN (1988) expands on the purpose and goals of preceptor programs:

A preceptor program helps the learner become familiar with the policies and procedures in the perioperative nursing department. It encourages
staff participation in the orientation process, while stimulating professional growth and accountability that ultimately leads to increased job satisfaction for the preceptor (p. 2).

Additional purposes and goals of a preceptor program include the following:

1. Coordination of the learner's assignment on a daily basis, incorporating the necessary surgical experience for the learner to function independently at the conclusion of orientation.

2. Evaluation of the performance of the learner.

3. A sharing with appropriate personnel information regarding the learner's performance of an assignment and continuous learning needs.

4. Consistency and continuity in the learning process of the learner.
5. Facilitation of the social and professional transition of the learner into perioperative nursing practice (pp. 2-3).

The roles and responsibilities of the learner are described in the Preceptor Guide for Perioperative Nursing Practice (AORN, 1988).

1. Demonstrate knowledge of the policies, procedures and regulations of the preceptorship program.

2. Know the objectives of the program and work toward them.

3. Be accountable for actions, obligations, and learning material.

4. Communicate regularly with the preceptor to facilitate the orientation and evaluation process.

5. Communicate his/her learning needs to the preceptor.

6. Meet with the instructor and preceptor on a regular basis to discuss the progress of the orientation process.
7. Communicate any needs or problems with the instructor and preceptor as they arise (p. 8).

Alspach (1987) developed a "Bill of Rights" for the preceptor and stated the responsiveness of the employer to the rights of the preceptor has a positive influence on the development and satisfaction of clinical preceptors and will, in turn, assist in ensuring success of the orientation program. The Preceptor's Bill of Rights states that preceptors have a right to the following:

1. A clear definition of their role.
2. A clearly stated set of expectations for their performance.
3. A clear delineation of their responsibilities to the preceptee.
4. A clear distinction for their responsibilities in relation to who are involved in the orientation program.
5. A clear statement of all expected outcomes for the staff nurse orientation program.
6. Valid and reliable evaluation tools to appraise preceptee performance.
7. The resources necessary to fulfill their responsibilities.
8. Continuing and responsive support systems for fulfillment of their responsibilities.
10. Adequate training in the knowledge, skills and attitudes necessary to fulfill their responsibilities. (p. 1)

The AORN (1988) identified nine roles and responsibilities of the preceptor in The Preceptor Guide for Perioperative Nursing Practice.

1. Act as a resource person, role model and consultant to the learner.
2. Create and maintain an atmosphere that promotes learning and trust.
3. Demonstrate knowledge of the objectives and material to be taught. Teach on a level that the learner can understand.
4. Plan assignments with the learner to fulfill his/her objectives and the objectives of the program.
5. Keep an ongoing line of communication
with the learner and advisor/instructor
to facilitate the learning and evaluation
process.
6. Demonstrate a working knowledge of
the policies, procedures and
regulations of the institution.
7. Complete an orientation program for
preceptors.
8. Demonstrate communication skills
necessary to facilitate the
teaching/learning process.
9. Demonstrate clinical knowledge and
competency in the operating room (p. 7).

Preceptors, like others serving in a special
capacity, deserve recognition and appreciation for
their efforts (Greipp, 1989). Recognition serves as
an incentive to the preceptor and demonstrates
administrative support of the preceptor program.
Turnbull (1983) reports most institutions consider
the recognition of selection as a preceptor to be a
sufficient reward. Employees who receive no
additional reward for putting forth additional effort
into their work as a preceptor are at a greater risk
for burnout (Greipp, 1989).
AORN (1988) uses the term learner, in a preceptor program, for the new nurse employee presenting to the operating room setting for orientation. The learner is described as "an inexperienced new graduate, an experienced RN new to the OR, or an experienced perioperative nurse new to the facility" (p. 2). AORN (1988) further defines the learner within the preceptor program as an adult learner. Lunn (1984) emphasizes the focus of adult learning as the values, characteristics, and behaviors exhibited in a learning situation rather than the chronological age of the individual learner.

Preceptors and Adult Education

The field of adult education continues to grow as the need for lifelong learning is recognized in all aspects of an individual's life. Adult education, like nursing, is in the theory development stage of growth and has not embraced one theory to guide practice decisions (Gessner, 1989). Merriam (1987) notes:

A theory of adult learning would be a set of interrelated principles that enable us to understand how adults learn. Carried a step
Further, if we understand how adults learn we should be able to predict when and how learning will take place and, as practitioners, arrange for its occurrence (p. 189).

Several conceptual frameworks for adult learning have been proposed and the work of Malcolm Knowles is the best known. Knowles (1990), building on the work of Edward Lindeman (1926) and others, is credited with proposing the concept of andragogy in the United States (Cross, 1981). Andragogy was defined as the art and science of helping adults learn (Knowles, 1970). Knowles modified his original definition of andragogy in 1980 after receipt of feedback from a number of other educators.

Originally I defined andragogy as the art and science of helping adults learn, in contrast to pedagogy as the art and science of teaching children. Then an increasing number of teachers in elementary and secondary schools (and a few in colleges) began reporting to me that they were experimenting with applying the concepts of andragogy to the education of youth and finding that in certain situations they were producing superior learning. So I am at the point now of
seeing that andragogy is simply another model of assumptions about learners to be used alongside the pedagogical model of assumptions (Knowles, 1980, p. 222).

Since 1970 adult education scholars have debated whether or not andragogy is a theory of adult education. Many scholars find the underlying assumptions of the concept useful even though they do not believe the underlying assumptions constitute a theory (Davenport & Davenport, 1985; Pratt, 1988).

Knowles (1990) highlights the fundamental assumptions about adult learning originally proposed by Lindeman in 1926.

1. Adults are motivated to learn as they experience needs and interests that learning will satisfy; therefore, these are the appropriate starting points for organizing adult learning activities.

2. Adults' orientation to learning is life centered; therefore, the appropriate units for organizing adult learning are life situations, not subjects.

3. Experience is the richest resource for adults' learning; therefore, the core
methodology of adult education is the analysis of experience.

4. Adults have a deep need to be self directing; therefore, the role of the teacher is to engage in a process of mutual inquiry with them rather than to transmit his or her knowledge to them and then evaluate their conformity to it.

5. Individual differences among people increase with age; therefore, adult education must make optimal provision for differences in style, time, place, and pace of learning (p. 31).

Four basic assumptions concerning adult education as proposed by Knowles (1980):

1. As a person matures, his or her self concept moves from one of a dependent personality toward one of a self-directed human being (p. 43);

2. An adult accumulates a growing reservoir of experience, a resource for learning (p. 44);

3. The readiness of an adult to learn is closely related to the developmental
tasks of his or her social role (p. 1); and

4. There is a change in time perspective as individuals mature, from one future application of knowledge to immediacy of application; thus an adult is more problem-centered than subject-centered in learning (p. 53).

The Use of Preceptors in Nursing

Young, Theriault, and Collins (1989) describe the use of preceptors with the new graduate. The preceptor program, a formalized orientation process, is designed to assist the new nurse graduate in the transition from student to practitioner. The preceptor program includes orientation to the role of the professional nurse as well as the physical environment, routine, procedures, and protocols of the unit in which the nurse is employed (Harrison & Price, 1987).

Schempp and Rompre (1986) report preceptor programs provide a supportive environment for the new graduate in transition from the academic setting to the work setting by facilitating the development of
competence and confidence.

Young, Theriault, and Collins (1989) describe the way in which preceptors assist with the transition:

The assumption underlying the use of preceptors is that a consistent one-to-one relationship provides the most effective mechanism for learning. The preceptor can effectively provide one-to-one teaching, modifying the teaching process according to the learning needs of the neophyte, provide immediate responses to questions, and correct errors before they become habits. This anticipatory socialization allows the new graduate to learn role expectations for the staff nurse position before assuming the role independently, resulting in a smoother transition from student to effective and efficient staff nurse (p. 127).

Research

A review of 21 articles about preceptor programs in schools of nursing and service settings was conducted by Shamian and Inhaber (1985). They compared a variety of aspects of preceptor programs.
Responsibilities of preceptors with respect to preceptor programs included orientation of the learner (orientee) to the nursing unit, socialization of the learner within the nursing unit, teaching and evaluation of the learner, establishment of objectives during orientation, and communication with appropriate personnel regarding progress of the learner. Criteria for selection of preceptors included years of experience, leadership skills, communication skills, decision making ability, and interest in professional growth. The authors report a variety of ways preceptors are prepared for their role as well as a variety of content included within the specific method of preparation.

Shamian and Inhaber (1985) note the difficulty in drawing conclusions from the descriptive data. They note the preceptor model for education and orientation purposes is alive and well. The authors propose five recommendations to facilitate the preceptor process. They recommend that the preceptor and learner work the same shift, manuals be developed to describe the roles and functions of the preceptor within the nursing unit, workshops be conducted prior
to beginning as a preceptor, preceptors have a written description of their role responsibilities, and some form of reward be given to the preceptor.

Young, Theriault, and Collins (1989) conducted a survey of registered nurses serving as preceptors at Louise Obici Memorial Hospital (LOMH). The purpose of the survey was to determine conditions for a successful preceptor program and to identify factors that contribute to the success and satisfaction of the preceptor. The sample size of 30 was divided into two groups. The first group consisted of 21 registered nurses serving as preceptors. The second group contained 9 registered nurses who had resigned from the preceptor role. The questionnaire was developed by a task force of nurses, with representation from the staff development department, clinical assistant directors, head nurses, and preceptors. The questionnaire included components of the preceptor program practiced at LOMH as well as components documented in the nursing literature. Task force members approved the questionnaire as well as procedures for distribution of the questionnaire. A response rate of 63% (19 out of 30) was achieved.

Data were sorted and placed into two groups
identified as either positive or negative factors influencing preceptor satisfaction. Analysis of the data provided insight into the strengths and weaknesses of the LOMH preceptor program. All respondents felt the preceptor program benefitted the new nurse graduate and improved patient care. Involvement in the program was identified as a challenge as well as an opportunity to share knowledge, experience, and opinions about the nursing profession. Additional benefits, as identified by preceptors, included an increased awareness of hospital and nursing policies and procedures, increased clinical knowledge, and preparation for teaching and leadership roles. All respondents, including those who had resigned, identified the experience as satisfying and rewarding.

Problems consistently identified included lack of time for the preceptor and learner (orientee) to develop a mutual plan for orientation, lack of coworker support, lack of identical work schedules for the preceptor and learner, reassignment of a preceptor to another nursing unit leaving the learner alone, absence of personal recognition, minimal input by the preceptor on individualization of the
orientation plan to be consistent with the learning needs of the learner, and selection of some preceptors more frequently than others by head nurses.

Recommendations identified by Young, Theriault, and Collins (1989) were the need for presentation of the preceptor program's goals, objectives, and long term benefits for nursing staff to the head nurse group; the distribution of a preceptor program manual to each unit; incorporation of a planning day for preceptors and learners at the beginning of orientation; and ensuring identical work schedules for preceptors and orientees.

Giles and Moran (1989) describe a research study that was designed prior to implementing a preceptor program at the University of Wisconsin Hospital and Clinic and was intended to measure outcomes of the preceptor program. The study compared the "buddy" method of orientation, in use at the time of the study, with the newly developed preceptor program. The buddy method of unit orientation involved an experienced nurse assisting a newly employed nurse through the orientation period. The study provided summative evaluation data measuring the impact of the
program. The focus of the outcomes included the
effects of the program on the orientee, preceptor,
nursing unit, and organization. The study was
conducted over a two year period.

The following research questions were addressed
in the study:

1. Does the preceptor method provide increased
orientee satisfaction with his/her
orientation?
2. Will both staff nurses and nurse managers
perceive the preceptor method as a
satisfactory method for orienting nurses?
3. Does training and experience in precepting
increase a preceptor's comfort, skill in
this role, and perceived importance of the
preceptor role?
4. Are new nurses able to complete their
orientation more quickly when precepted?
5. Will the retention of nurses be improved by
the preceptor method of orientation? (p. 8).

A quasi-experimental design was used with
orientees and buddies from the previous year compared
to orientees and preceptors during the first year of
the program. Although the emphasis was collection of
quantitative data, qualitative data were also obtained.

Subjects included nursing administrators, nurse managers, preceptors, newly employed or transferring nurses, and other experienced staff nurses. The newly employed or transferring nurses included new graduates as well as nurses with previous working experience. The study included 5 critical care nursing units as well as 17 specialty nursing units that served a distinct patient population. The research instruments were researcher developed. Cronback's alpha was applied to measure the internal consistency of the tools. Alpha levels of .78 or greater were obtained for each instrument. Face validity was established by expert review and literature search. Incomplete questionnaires were excluded from the study.

Although the results of the study did not demonstrate statistical significance, the study did provide additional information about learning with the preceptor method of orientation. The results were presented in four sections. The first discussed satisfaction by the orientee. Testing of the hypothesis that precepted orientation would provide
increased orientee satisfaction was accomplished by comparison of nurses oriented by the buddy system during the year previous to implementation of the preceptor program, with those precepted the first year of the program. A 17 item questionnaire, based on desirable characteristics of orientation programs found in the literature, measured orientee satisfaction with the orientation process. Orientees were asked the degree to which orientation was stressful, whether orientation was individualized, and whether their learning needs were met. Each statement was rated on a 1 to 5 Likert type scale that provided a range of scores from 17 to 85 based on the orientees level of satisfaction. Although the findings were not statistically significant, nurses oriented by the preceptor method were more satisfied with their orientation than those participating in the buddy system of orientation.

The second section of results addressed satisfaction by others. It is important to note that the findings did not demonstrate statistical significance. Preceptors, responding to a narrative questionnaire, expressed greater satisfaction with the preceptor method of orientation as compared to
the buddy system of orientation. The preceptors cited improved continuity in the persons orienting new staff as well as what was included in the orientation plan. In addition many respondents commented that orientation was better organized, better monitored, and progressed in a more logical sequence than with the buddy system of orientation. Preceptor participation stimulated continued learning and self development.

Nurse managers responded to a 17 item Likert-type questionnaire. Although the results did not demonstrate statistical significance, in comparison with the buddy method of orientation, 86% of nurse managers indicated a greater satisfaction with the preceptor method of orientation. They believed orientees experienced less stress during the transitional period and received a more individualized orientation.

Staff nurses, who were neither orientees nor preceptors, were surveyed with the identical questionnaire as the nurse manager group. The results did not demonstrate statistical significance but did reveal the preceptor method of orientation was preferred by 84% of the respondents. The staff
nurse group expressed similar feelings to the nurse managers regarding the benefits of preceptors. They also identified a reduction in frustration levels when working with precepted orientees.

The results of the questionnaire used with the assistant director group did not demonstrate statistical significance, but cited improved standardization of the orientation process, improved definition of orientation roles and responsibilities, and more involvement of staff nurses in a structured and accountable manner.

Giles and Moran (1989) cited concerns identified by preceptors and head nurses. A problem identified by preceptors was the lack of adjustment of their patient assignment to allow adequate time for precepting activities. Head nurses reported difficulty in scheduling the orientee and preceptor together because of illness, annual leave, and education programs. A team approach to precepting was instituted to alleviate the scheduling problem. A primary and substitute preceptor are designated in the team approach.

The third section of results addressed the preceptor's comfort, skill, and perceived importance
of the role. Instruments were researcher developed and administered to the preceptors three different times: before the preceptor workshop, immediately after the preceptor workshop, and after the precepting experience.

In order to evaluate preceptors' feeling of comfort with their role, a Semantic Differential Rating Scale (Giles and Moran, 1989), composed of 13 pairs of opposing words, was administered to the preceptor group. An example of a pair of opposing words appearing on the instrument was "frustrated vs. satisfied." The feelings were rated on a 7 point scale. The results were not statistically significant, but revealed preceptors were more comfortable following training and experience in precepting. Preceptors in specialty units and critical care areas reported they were equally comfortable in their role.

A Self Diagnostic Preceptor Inventory (Giles and Moran, 1989) measured the preceptor's self assessed skill. A questionnaire evaluating 40 competencies, (i.e., assessing learning needs), was administered to the preceptor group. Preceptors rated each item on a scale of 1 to 5. A variation of 40 to 200 was
possible. Results did not demonstrate statistical significance.

Competencies identified on the Self Diagnostic Preceptor Inventory were used to evaluate how important preceptors felt about their role. Rating of competencies on a scale of 1 to 5 occurred before and after the preceptor workshop as well as after the precepting experience occurred. The results revealed there was no difference in the preceptor's view of their role.

The final section of results addressed length of orientation. Head nurses were surveyed regarding the length of orientation for 79 buddy system nurses as well as 127 nurses participating in the preceptor program. Of this group of 206 nurses, 60% were assigned to specialty units and 40% were assigned to critical care units. The orientation was considered complete when the orientee could practice independently and safely as determined by the head nurses. The orientees were counted as full staff members on the work schedule as an acknowledgement of the completion of orientation. Head nurses reported an increase in length of orientation by 6 days for the preceptor group. The authors contend the
increase in length was not surprising because of staff feedback regarding the inadequacy of the buddy method. The inadequacy of the buddy method was confirmed by the head nurse rating of whether each orientee was ready to complete the orientation process. Orientees in the preceptor program were judged by the head nurses to be more prepared to assume full responsibilities at the completion of the orientation period than their counterparts in the buddy system of orientation.

The effect of the preceptor method of orientation on retention of nurses during the first year of employment was also addressed. In the study the turnover rate of nurses during their first year of employment was reduced from 33% with the buddy system of orientation to 18% with the preceptor method of orientation. The turnover rate for all nurses at the hospital was reduced by 4%. The authors report the data suggest the preceptor method of orientation was the significant factor in the reduction of turnover among nurses during the first year of employment.

Shamian and Lemieux (1984) studied the effectiveness of the preceptor teaching model versus
the formal teaching model to determine which one was more effective in developing the knowledge base of participating nurses in regard to the use of restraints as well as the assessment of the confused patient. The preceptor teaching model, described as a method of decentralized instruction at the nursing unit level by a member of the nursing staff, was compared to the formal teaching model, described as centralized teaching carried out by the inservice education department and which may or may not contain members of the nursing management team.

The study identified 14 nursing units in a 600 bed teaching hospital in Montreal as needing instruction regarding the policies and procedures governing the application of restraining devices and the assessment of confused patients. Nursing units were excluded from the study if the use of restraints was minimal or absent or if the type and purpose of the restraints were different. The nursing units utilized were randomized into preceptor units and formal teaching units. The hypotheses of the study were:

1. Nurses in preceptor units will know the policies and procedures of restraints better
than the nurses in the formal teaching unit.

2. Nurses in preceptor units will be able to assess the confused patient better than nurses in the formal teaching units.

3. More nurses in the preceptor units will take part in the teaching program than will nurses in the formal teaching units (Shamian & Lemieux, 1984, p. 87).

Participants in the study responded to two questionnaires. The first questionnaire consisted of 31 items in three sections. The three sections were demographic data, knowledge of policies and procedures, and knowledge of assessment of the confused patient. The first questionnaire was administered by the preceptor to the participant immediately following the teaching session in the preceptor units. The participants in the formal teaching group were given the first questionnaire following the completion of the second teaching session. The second questionnaire consisted of 19 items in two sections. The sections were knowledge of policies and procedures and assessment of the confused patient. The second questionnaire was identical to the corresponding sections on the first
questionnaire. The second questionnaire was mailed to participants in both groups 3 months following the teaching session on assessment of the confused patient. The questions addressing knowledge of policies and procedures, as well as knowledge of assessment of the confused patient, were multiple choice. The answers were graded as correct or incorrect. Two members of the research team coded the responses. Descriptive statistics and chi-square analysis were used to analyze the data. Statistical significance was defined as $p < .05$.

The participants were randomly assigned to into two groups, and each group participated in two teaching sessions. The first session addressed new hospital policies and procedures regarding the use of restraints. The participants in the preceptor group experienced individual presentations by his or her assigned preceptor. The formal teaching group attended a group presentation on the topic. The second session was a group presentation on the assessment of the confused patient. The class was given to the preceptor group at a separate time than the formal teaching group. The same instructors presented identical presentations to the two groups.
There was no overlapping of the two groups at any time.

The first questionnaire was distributed and collected by individual preceptors immediately following the teaching session on assessment of the confused patient. The participants in the formal teaching group received the first questionnaire immediately following the second teaching session on physical assessment of the confused patient. A participant who did not attend both teaching sessions was excluded from completing the first questionnaire. The second questionnaire was mailed to all nurses who had participated in either one or two sessions in the formal teaching group and to all nurses in the preceptor units. In addition, a sample group of those who did not attend any segment of the educational program also received a questionnaire.

The sample size was 316 nurses, which included all nurses working in the original 14 nursing units identified as needing instruction. A total of 186 subjects were in the formal teaching group and 130 subjects in the preceptor group.

The results of the study by Shamian and Lemieux (1984) were analyzed as to demographic data, level of
knowledge of policies and procedures, level of knowledge of assessment of the confused patient, and attendance at educational sessions. In terms of demographic data, the authors report homogeneity between the preceptor and formal teaching groups. The majority (65%) of nurses were under 30 years of age, and 39% received their education outside Canada.

The response rate for completion of the first questionnaire was 26% (49 of 130) for nurses in the formal teaching group and 62% (81 of 130) in the preceptor group. The second questionnaire was completed by 46% (86 of 186) in the formal teaching group and 72% (94 of 130) in the preceptor group.

There were 8 multiple choice questions that identified the knowledge level of policies and procedures. The same questions were repeated at the 3-month interval. There was no significant difference in knowledge between the formal teaching group and the preceptor group on the first questionnaire.

There were 11 multiple choice questions that identified knowledge of assessment of the confused patient. There was no significant difference in knowledge level between the formal teaching group and the preceptor group as demonstrated by data from the
first questionnaire. The balance shifted greatly in the results of the second questionnaire: 50% (4 of 8) items showed a significant difference in favor of the preceptor group. The overall knowledge of assessment of the confused patient as demonstrated by the formal teaching group on the first questionnaire was 77.3%. The retention of information after 3 months as demonstrated on the second questionnaire was 74.0%. The overall knowledge demonstrated by the preceptor group on the first questionnaire was 78.2%. The retention of information as demonstrated on the second questionnaire was 85.2%. The difference in knowledge between the formal teaching group and the preceptor group on the first questionnaire was 0.9% and 11.2% on the second questionnaire. The preceptor group appeared to gain information during the 3-month period. Shamian and Lemieux (1984) suggest this was partially attributable to the ongoing reinforcement by the preceptor.

Data regarding attendance at the educational sessions revealed the preceptor group had a 90% (115 of 130) attendance rate at the individual session with the preceptor regarding policies and procedures, whereas the formal teaching group had a 50% (93 of
attendance rate at the group session on policies and procedures. The attendance rate for each group at the session on assessment of the confused patient was 80% for the preceptor group and 36% for the formal teaching group. There were 50% of the nurses who did not attend either teaching session from the formal teaching group and 10% of the nurses from the preceptor group.

The authors suggest the preceptor teaching model furnishes results superior to those of the formal teaching model in the areas of attainment of knowledge, acquisition of assessment skills, and attendance at educational programs. Visibility of preceptors on the nursing units acted as a constant reminder of subject matter, thus serving as a reinforcing agent.

The benefits of the preceptor teaching model emerged after the 3-month interval which indicates the preceptor teaching model may be more conducive to reinforcement and internalization of the material taught over the formal teaching model.

Shamian and Lemieux (1984) made three recommendations for further study. They were as follows:
1. A similar study could be carried out to replicate the present one and to strengthen its findings.

2. A similar study could be undertaken, containing an evaluation of changes in practice to indicate whether the use of the preceptor system makes itself felt on the practical side of the practice.

3. Variations in preceptor teaching models should be tested in order to determine precisely which model yields the best results (p. 89).

Alspach (1989b&c) reported the results of a readership survey on the use of preceptors in critical care orientation programs. The survey appeared in the October 1988 issue of Critical Care Nurse, a publication for nurses employed in critical care areas such as the coronary care unit and intensive care unit. The participants were asked to return the survey by mail. A total of 351 nurses participated in the survey. The results of the readership survey did not demonstrate statistical significance; however, the results did provide information about the use of preceptors in the
orientation process for critical care nurses throughout the United States. Results were reported in two issues of Critical Care Nurse in 1989. The majority of respondents, 88.3% (310 of 351), were between the ages of 20 and 40 years. Female respondents totaled 92.3% and the male respondents totaled 6.6%. Nearly 44% of the respondents had a baccalaureate degree. Diploma graduates comprised 29.9% and graduates from associate degree programs comprised 21.1%.

A total of 65.5% of the respondents worked at hospitals where filling the preceptor role was a voluntary function. Precepting was necessary for advancement in 26.5% of reporting institutions and in 20% of the institutions, precepting was mandatory for all staff nurses. Educational preparation prior to functioning in the role of preceptor was provided for 61% of the respondents. The content most often covered in programs where educational preparation for the preceptor role occurred was assessment of orientee learning needs, application of teaching and learning principles, performance evaluation, and planning for learning experiences. More than one-third of the training programs did not include
content on adult education, teaching of clinical skills, implementing learning plans, or reality shock.

The lack of a written job description for the preceptor role was cited by 57% of the respondents. Of the 43% of the responses indicating the use of a job description for the preceptor role, 89% of those respondents indicated the job description specified the responsibilities of the preceptor to the orientee, 71% of the respondents indicated performance expectations for the preceptor were specified, 55% of the respondents reported the job description distinguished the role of preceptors from other who assisted in the orientation process, and 38% of the respondents indicated the inclusion of a description of how the preceptor's performance would be evaluated.

In terms of incentives, rewards, or recognition for functioning in the preceptor role, 62% of the participants indicated they did not receive any incentives, rewards, or recognition. Of those receiving some type of incentives, 11% indicated the incentive was in the form of a certificate of appreciation, luncheons (dinners or teas), special
name tag, or better evaluation toward advancement on a clinical ladder and 6% indicated the incentive was in the form of a pay differential (Alspach, 1989b&c).

Alspach (1990b) reported the results of a second readership survey describing national trends in the provision of critical care orientation programs. The survey was published in Critical Care Nurse twice during 1989. The number of individuals returning the survey was 148. The survey included questions specific to the institution, instructors, general features of the program, the orientee, and the orientation program. The results of the survey did not demonstrate statistical significance; however, the results did provide a description of the orientation process for critical care nurses throughout the United States.

The number of hospital beds in the reporting institutions ranged from 39 to 1315 with an average of 386. Critical care units within each institution ranged from 1 to 11 with an average of 3. The number of critical care beds within each institution ranged from 4 to 175 with an average of 36. Nurses employed in the critical care units at each institution ranged from 5 to 500 with an average of 93.
The number of critical care instructors at the reporting hospitals ranged from 0 to 20 with an average of 2.3 per institution. Critical care instructors per critical care unit ranged from 0 to 4 with an average of 1 per unit.

When asked whether the critical care instructors had advanced preparation in the field of adult education, the responses were 51% yes and 49% no. The questionnaire also requested information about the amount of time a critical care instructor worked in the role of an educator. Respondents reported 41% of the instructors worked as educators all of their work time, whereas 59% did not function as an educator for all of their work time. A follow up question asked whether the critical care instructors also worked as staff nurses. A total of 56% answered yes and 44% answered no. Those who answered yes to this question were asked to indicate the percentage of time the critical care instructor spent in the educator role rather than the staff nurse role. The average percentage of time worked as a critical care instructor was 58% and the percentage of time worked as a staff nurse was 42%.

The final question in the section addressing the
orientation instructor of the survey asked whether any other health professionals taught in the orientation program. A total of 76% (113 of 148) of participants answered yes and 24% answered no. The health care professionals identified were respiratory therapists, physician, staff nurse, dietician, pharmacologist, clinical nurse specialist, and head nurse or social worker.

Following the section on the orientation instructor, the survey focused on the orientation program. The length of critical care orientation programs ranged from 3 days to 20 weeks with an average of 7.5 weeks. Orientation programs having a variable length totaled 86% and 14% of the programs had a fixed duration. The respondents reported the maximum amount of time allowed for orientation ranged from 1 to 36 weeks and averaged 10.67 weeks. The cost for the orientation of a single critical care nurse ranged from $600 to $40,000 with an average of $8877 per nurse.

In response to the question of whether the hospital used a preceptorship for the orientation of critical care nurses, a total of 95% (140 of 148) answered yes and 5% answered no. For those
respondents answering yes to the preceptorship question, there were additional questions about their preceptorship program. The first question asked whether the preceptor was responsible for one or more than one orientee at a time. A majority of respondents (81%) indicated the preceptor was responsible for only one orientee at a time whereas 19% reported the preceptor was responsible for more than one orientee at a time. When asked whether the preceptor was the same person for the entire orientation period, 80% indicated the preceptor changed during the orientation period and 20% indicated the preceptor remained the same throughout the orientation period. The next item asked whether the preceptor and orientee shared the same work schedules. A total of 66% reported the preceptor and orientee shared the same work schedules and 34% (47 of 140) reported the preceptor and orientee may have had different work schedules. In response to the question of whether preceptors had a written job description, the majority of respondents (63%) answered no. The final item in the series of questions asked whether preceptors had an ongoing peer support system to assist them in their work.
Responses indicated 44% had a peer support system and 56% did not have a peer support system.

Following the section on preceptors, the survey focused on information about the orientee. Respondents indicated the number of RNs oriented to critical care each year ranged from 1 to 250 with an average of 26. Next, respondents described the composition of orientee groups as 47% RNs with experience but new to critical care, 37% RNs with previous critical care experience, and 20% were new graduates. The age distribution of orientees, as indicated by survey participants, was between the ages of 20-29 years (64%), between the ages of 30-39 years (29%), and the remaining 7% were 40 years or older. The majority of respondents (64%) indicated a year of experience in nursing was not required prior to entering the critical care nursing. A number of subjects indicated the requirement had been dropped when problems arose with recruitment and shortages.

The next section of the survey addressed the orientation program, beginning with assessment of orientees' knowledge and skill in critical care nursing prior to or at the beginning of orientation. The majority of responses (79%) indicated hospitals
did assess the orientee for knowledge and skill in critical care nursing whereas 11% indicated no assessment was conducted. Types of assessment used were interviews with the orientee, written checklists of required knowledge and skills, direct observation of orientees' clinical performance, written tests developed by the hospital, and the Basic Knowledge Assessment Tool (a researcher developed tool specific for assessment of knowledge in critical care). When asked who participated in planning the orientation program, respondents indicated head nurses (79%), critical care instructors (74%), preceptors (66%), staff nurses (45%), and orientees (43%). In response to the question "Are all outcomes for the orientation program written in a clear and unambiguous form?" 53% answered yes, 41% answered no, and 6% did not respond.

The next question asked respondents to indicate whether their orientation program used the traditional educational approach or a competency-based approach. The use of the traditional educational approach, based on instructional objectives, was reported by 55% of the participants. The use of a competency-based approach, consisting of
competency statements and performance criteria, was reported by 59% of the respondents. In addition, 21% identified the use of both approaches.

Participants were asked to indicate what percentage of the orientation program occurred on the clinical unit, in the classroom, and in the simulated laboratory. Responses indicated an average of 70% of the orientation program occurred on the clinical unit, 25% in the classroom, and 5% in the simulated laboratory. The ranges for usage of the clinical unit, classroom, and simulated laboratory were 20%-100%, 0%-80%, and 0%-30% respectively. The teaching method used most often (45%) was demonstration on the clinical unit. Lecture was reported in use by 24% of the programs, group discussion in 14% of the programs; audiovisual programs in 6% of the programs; and skill workshops, as well as written self-instruction, in 5% of the programs. Role play and computer-assisted instruction were reported in use by less than 1% of the programs.

When asked which types of audiovisual equipment were used during the orientation program, 86% of participants indicated the use of a videocassette player. The easel/chalkboard, slide projector, and
overhead projector were identified by 70%, 68%, and 68% of the respondents respectively. Computers were used in 20% of the programs.

The next series of questions addressed evaluation of the orientation program. The first question asked which evaluation tools were used to determine successful completion of the orientation program. Program completion by the orientee was determined by more than one evaluation tool in 87% of the programs. A total of 8% of the programs used a single evaluation tool, and 5% indicated they did not use any specific evaluation tool. Respondents indicated the types of evaluation tools used with orientees to determine successful completion of the orientation program were clinical skills checklists (86%), interview of the orientee (51%), questionnaires completed by the orientee (50%), and questionnaires completed by the preceptor (38%). The next two questions referred to the use of written tests in the program. Respondents were asked if they used written tests to indicate the type of test item used with written testing of the orientee. A total of 111 surveys indicated the use of written testing. Data revealed multiple-choice test items
were in use by 96% of the programs. Fill-in-the-blank items were in use by 59% of the programs, while true/false items were in use in 51% of the programs. Matching items were reported by 47% of the programs and the least common type of test item in use was the essay question. The next question asked whether the validity and reliability of tests was determined. Of the respondents indicating the use of written tests, only 23% (25/111) answered yes.

Respondents were asked to describe how they determined when an orientee had completed the orientation program. This was an open-ended question and the responses were grouped according to literal similarity to other responses. The responses indicated a variety of mechanisms were used to determine completion of orientation by the orientee. A total of 51% of the participants indicated the orientee demonstrated the established performance criteria. Mutual decision asking, for example among the preceptor, orientee and head nurse, was the mechanism in 14% of the programs. The unilateral decision of the preceptor was cited by 8% of the programs while 7% of programs used the orientee's perception of comfort level as the indicator. Time
was used as the basis for determination of program completion in 6% of the programs. The ability of an orientee to function independently with a normal workload was the determining factor in 4% of the programs. Finally, 10% of the responses were grouped into an "other" category and indicated either no mechanism was in place, unit needs were the determining factor, or unilateral decision of the unit director after the orientee completed specific classes.

Future Trends in Healthcare

Harvey (1987) described the change in the cause of illnesses as well as the change in treatment of the surgical patient. At the beginning of the century, 70% of all illnesses were due to acute infectious diseases. Life expectancy was 47.5 years. Today the majority of illnesses confronting the population are of a chronic noninfectious nature. Life expectancy has risen to 74.5 years. Fries (1986) predicted that in the next 25 years illnesses related to aging will present the most serious problem.

By the year 2000 it is expected there will be a
decline in the number of hospitals. Those in existence will be part of large multihospital corporations. The majority of nurses and physicians will be salaried. Consumers of health care will get medical care from a prepaid medical plan. Hospitals will be major intensive care areas receiving only those patients with the most complicated problems (Harvey, 1987).

The shift in disease, as well as the scientific and technological advances, will result in a change in the methods utilized during surgery as well as the environment in which surgical procedures take place. The major surgical procedures performed will be surgical replacement of organs including kidneys, lungs, hearts, muscles, and nerves. Experts predict that 80% of all surgeries will be performed on an outpatient basis. Minor surgeries will be performed in ambulatory surgical facilities. Surgical lasers will be used for a variety of procedures. The trend toward less invasive and less radical surgery whenever possible will be a way of life in the 21st century (Harvey, 1987).

As perioperative nursing progresses, the traditional "scrub" and "circulating" roles may
become obsolete. The future may bring new names as well as new functions. Each of these new roles, whether staff nurse, clinician, manager, or researcher, will make use of the nursing process and will demonstrate humanized care for surgical clients and their families. Perioperative nursing roles in the future could include a practitioner role, encompassing greater assistive activities during surgery or broader consultative responsibilities with surgical clients and families. The teaching role could be expanded to include health promotion, disease prevention, and wellness regimens (Gruendeman & Meeker, 1987).

Conclusion

In the State of Iowa, the methods of orientation for new nurse employees in the surgical setting, have not been identified. In addition the use of preceptors in the orientation of new nurse employees has been advocated by the professional organization for perioperative nurses. It is unclear at this time how many hospitals/medical centers are using the preceptor method.

The literature describes the components of an
orientation program, the standards by which orientation programs are judged, the description of the concept of preceptors as well as their use with new graduates, and the roles and responsibilities of preceptors as well as orientees. The nursing research literature includes a comparison of traditional teaching methods with the preceptor method as well as descriptive investigations regarding orientation and the use of preceptors within the specialty of critical care nursing.

This study attempts to identify methods of orientation for new nurse employees in the operating room setting and the incidence of the use of the preceptor method of orientation.
CHAPTER III

METHODOLOGY

Design

A descriptive survey research design was used to examine the methods of orientation for registered nurses employed in operating room settings in hospitals within the state of Iowa.

Setting

This study was conducted on hospitals with operating room services in 94 counties across Iowa. The hospitals that did not offer operating room services, such as mental health facilities, were omitted. The hospitals varied in number of beds, group that controlled the institution (such as county, state, veterans affairs, for-profit, nonprofit, and church affiliated), and number of employees.

Sample

This survey was distributed to all hospitals with operating room settings that were members of the Iowa Hospital Association in 1992 and who consented to participate in the study.
The Dillman Method

This researcher chose the Total Design Method (TDM) by Dillman (1978) as the framework for creation of the survey. The primary goal in constructing mail questionnaires, according to Dillman (1978), is to create a document that is concise, clear, appears easy to answer, and is aesthetically pleasing in order to motivate the respondents to complete it. When developing a TDM survey, questions are distinguished from answers by the use of lower case and upper case letters. Lower case letters are always used for answers. Directions for answering questions are also written in lower case letters and enclosed in parentheses.

In addition to the use of upper case lettering, answer categories, according to Dillman (1978), are identified by a consistent numbering system instead of boxes and blanks. Numbers are placed one space to the left of the answer, which helps to ensure that respondents will identify the answer they want to indicate. Dillman (1978) stresses the importance of assigning the same number to the same answer category throughout the survey so as not to confuse the respondent.
In the case where multiple columns are used in the survey, Dillman (1978) recommends the use of numbers rather than the words next to the answer categories. These numbers are a logical extension of the answering procedure and reduce confusion for the respondent.

Dillman (1978) recommends arranging the response categories and their corresponding numbers in a vertical line on the page. This technique helps the respondent prevent missing a question (inadvertent omission), which occurs when respondents are asked to move back and forth across a page with their answers.

When providing directions for answering questions, Dillman (1978) recommends the same marking procedure be used throughout the survey and the directions be repeated frequently if the respondents are asked to identify more than one response for some questions and only one answer for other questions. Dillman (1978) recommends the encirclement process because it results in fewer ambiguous markings.

The final task when formulating the pages of use of well-constructed transitions to provide a
sense of flow and continuity to the questionnaire. These transitions serve to add a conversational tone and guide the respondent from one part of the questionnaire to another.

Dillman (1978) recommends the use of a cover letter and two follow-up correspondences with the Total Design Method (TDM) for mail questionnaires. The cover letter serves to introduce the survey and to motivate the respondent to immediately pick up the questionnaire, fill it out, and return it.

According to Dillman (1978) the first paragraph of the cover letter is intended to explain what the study is about and convince the respondent that the study will be useful. The second paragraph seeks to convince the respondent that his or her response is important and that no one else's can be substituted. The third paragraph promises confidentiality and describes the use of a numbering system for identification. The fourth paragraph offers the respondents the opportunity for a copy of the results of the study. In closing, Dillman (1978) suggests including a method for contacting the researcher with any questions about the study.

The first follow-up correspondence in the Total
Design Method (Dillman, 1978) is a postcard that provides a contrast to the envelopes containing the original mailing and the second follow-up mailing. The first paragraph of the postcard is designed to thank those respondents who have completed and returned their surveys and to remind those who have not responded to do so as soon as possible. This initial statement is followed by a sentence that amplifies the message contained in the original cover letter of how important each recipient is to the success of the study. A brief reminder of the study's purpose concludes the first paragraph, and the postcard closes with an invitation to call for a replacement questionnaire if one is needed.

The second follow-up correspondence in Dillman's (1978) Total Design Method (TDM) is a letter that contains a tone of insistence not found in the previous correspondences. The letter opens by telling the respondent his or her questionnaire has not yet been received. This serves to inform the respondent that he or she is receiving individual attention and to reinforce the message of earlier correspondences that the respondent is important to the success of the study. The second and third paragraphs of the letter speak to the social
usefulness of the study and to the importance of each response. The fourth paragraph informs the respondent that a replacement questionnaire is enclosed. Dillman (1978) believes that it is essential that a replacement questionnaire be included with the second follow-up mailing. Because this letter is sent 3 weeks following the original mailing (see Procedure section), it is probable that the original questionnaire, if not lost or thrown away, could be difficult for the respondent to find. The closing statement again offers a copy of the results of the study and thanks the respondent for his or her participation.

Instrument

The instrument was a 49-item questionnaire (see Appendix A) based on two instruments developed by Alspach (1988 & 1989a). This researcher used questions from both surveys. The questions chosen from the survey were modified to address orientation needs of nurses in the operating room setting. In addition, this researcher developed additional questions addressing areas of preceptor programs not identified in the original questionnaires.

In keeping with the purpose of this study, the
instrument was composed of questions relating to (a) content and mechanics of the orientation program; (b) instructors for the orientation program; (c) preceptors utilized during the orientation program; and (d) orientees participating in the program. In addition, the survey's initial questions were designed to establish characteristics of the responding institution.

Validity, the extent to which the survey measures what it is suppose to measure, was addressed through the use of face validity (Wilson, 1986). The survey was reviewed by 2 experts in the use of preceptors for orientation of nurses in the hospital setting and 3 experts in the specialty of operating room nursing.

Procedure

A pilot study was completed following the approval of the research proposal from the Human Subjects Research Review Committee at Drake University. The purpose of the pilot study was to validate the clarity of the cover letter and survey form. In addition, the pilot study attempted to validate the practicality, convenience, and the relevance (applicability and
appropriateness) of the survey to the purpose of the study itself. This researcher was also interested in the time required to complete the survey, whether the subjects found anything inappropriate about the survey, and whether there were any instructions that were not clear.

The package for the pilot study of the survey included a personally signed cover letter for pilot subjects (see Appendix B); the survey instrument (see Appendix A); a response form (see Appendix C); all copies of the proposed correspondence for the actual study (see Appendix D to F); and a self-addressed, return envelope. The package was compiled in a brown envelope and distributed to the pilot study participants personally. Revisions were done as deemed necessary following the return of the pilot surveys (Appendix G).

The initial mailing package for the actual study was sent to the director of nursing in the individual hospital within the sample. The package included a cover letter (see Appendix D) requesting the survey be forwarded to the person responsible for orientation of nurses to the operating room setting. The cover letter (see Appendix D) was personally
signed. The package also included a survey instrument (see Appendix G); and a self-addressed return envelope. The pilot participants were asked personally to participate in the actual study.

The first follow-up mailing to the director of nursing, a postcard (see Appendix E), was mailed to participants one week following the initial mailing (September 23, 1992). The postcard (see Appendix E) served as a thank-you to the participants who had returned the survey and a reminder to those participants who had not returned the survey. The postcard (see Appendix E) was personally signed and the address typed on the front.

The third and final mailing to the director of nursing included a second personally signed cover letter (see Appendix F); another copy of the survey (see Appendix G), and a stamped, self-addressed return envelope. This package was mailed 3 weeks following the initial mailing (October 9, 1992) using first-class postage. The mailing was sent to all participants who had not yet responded to the previous mailings.

For the purposes of this study, the Total Design Method (Dillman, 1978) was used with one exception. The use of certified mail with the third follow-up
was omitted. Huizinga and Murphy (1988) demonstrated a small (5.8%) response rate using certified mail, whereas Kern (1990) demonstrated a 16% response rate using first-class postage with the third follow-up mailing.

**Ethical Considerations**

The proposal was submitted to the Human Subjects Research Review Committee at Drake University before the study was instituted. In order to protect the rights of the subjects used in this study, informed consent was obtained. Subjects were informed in the cover letter that their responses would be kept confidential, their participation was voluntary, and they were free to withdraw from the study at any time by writing to the researcher and requesting to be withdrawn from the study.

Strict confidentiality was maintained by reporting the findings of this study in group form so that the individual identities of the hospitals were not disclosed.

The researcher requested the questionnaire be completed by the director of nursing or the
person responsible for instituting the orientation program for nurses working in the operating room setting. A returned, completed questionnaire implied consent for participation. The participants were also informed that the results of the study would be available to them by completing and returning the survey. The danger to individuals participating in the survey was minimal. The individual completing the survey would lose 60 to 90 minutes of time if they agree to participate in the study.

4 surveys (4.9%) not included in the data because the respondents failed to answer two or more pages of questions on the survey. A total of 89 questionnaires, therefore, constituted the sample. Responses were received from 70 out of 89 (79.8%) counties where hospitals were located. Seven of the 99 counties in Iowa do not have hospitals located within the county line.

There were 63 (70.2%) surveys received from hospitals in the rural category, 6 (6.7%) surveys in the rural referral category, and 20 (22.9%) surveys from hospitals in the urban category.
CHAPTER IV

ANALYSIS AND RESULTS

Description of the Sample

Of the 125 hospitals invited to be participants in this study, 95 (76%) returned completed questionnaires. One additional institution responded but was unable to complete the questionnaire explaining the recent change in OR management and the unavailability of the data. There were 6 surveys (4.8%) not included in the data because the respondents failed to answer two or more pages of questions on the survey. A total of 89 questionnaires, therefore, constituted the sample.

Responses were received from 70 out of 92 (76.08%) counties where hospitals were located. Seven of the 99 counties in Iowa do not have hospitals located within the county line.

There were 63 (70.8%) surveys received from hospitals in the rural category, 6 (6.7%) surveys in the rural referral category, and 20 (22.5%) surveys from hospitals in the urban category.
Characteristics of the Sample

Of the 89 hospitals in this study, there were a total of 63 rural hospitals, 6 rural referral hospitals, and 20 urban hospitals. In Table 1 the number of hospital beds, operating rooms, surgeries, outpatient surgeries, and inpatient surgeries in the sample as well as the ranges and means for the entire sample and for each hospital category.

Insert Table 1 about here

Table 2 identifies the distribution of responses based on the number of hospital beds.

Insert Table 2 about here

The job title of the person completing the questionnaire varied from a staff/clinical-level nursing position in the OR to the director of nursing for the entire hospital. The most frequent response (n=26) for the rural hospitals was a job title at the director level. Rural referral hospitals reported the job title of the person completing the survey was
<table>
<thead>
<tr>
<th>Sample</th>
<th># Beds</th>
<th># ORs</th>
<th># Surgeries</th>
<th># Inpatient Surgeries</th>
<th># Outpatient Surgeries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
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<td>1-4</td>
<td>13-2984</td>
<td>15-4000</td>
<td>30-2154</td>
</tr>
<tr>
<td>Mean</td>
<td>42.33</td>
<td>1.93</td>
<td>693.35</td>
<td>323.51</td>
<td>459.88</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>110-279</td>
<td>5-10</td>
<td>3953-8250</td>
<td>439-4685</td>
<td>1974-4324</td>
</tr>
<tr>
<td>Mean</td>
<td>199.5</td>
<td>7.60</td>
<td>5607.80</td>
<td>2408.60</td>
<td>3199.20</td>
</tr>
<tr>
<td>Urban</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>45-879</td>
<td>2-26</td>
<td>1389-15,906</td>
<td>612-6942</td>
<td>545-7450</td>
</tr>
<tr>
<td>Mean</td>
<td>312.29</td>
<td>9.90</td>
<td>7509.94</td>
<td>2834.83</td>
<td>4102.23</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>19-879</td>
<td>1-26</td>
<td>13-15,906</td>
<td>15-6942</td>
<td>30-7450</td>
</tr>
<tr>
<td>Mean</td>
<td>107.42</td>
<td>4.09</td>
<td>2631.13</td>
<td>1065.24</td>
<td>1481.72</td>
</tr>
</tbody>
</table>

Note. N=89
### Table 2

**Number of Hospital Beds in the Institution**

<table>
<thead>
<tr>
<th>Number of Beds</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 100</td>
<td>64</td>
<td>71.30</td>
</tr>
<tr>
<td>101-200</td>
<td>5</td>
<td>5.5</td>
</tr>
<tr>
<td>201-300</td>
<td>8</td>
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<tr>
<td>301-400</td>
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<td>5.5</td>
</tr>
<tr>
<td>401-500</td>
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<td>0.00</td>
</tr>
<tr>
<td>501-600</td>
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<td>1.1</td>
</tr>
<tr>
<td>601-700</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>701-800</td>
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<td>0.00</td>
</tr>
<tr>
<td>801-900</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>*</td>
<td>4</td>
<td>4.5</td>
</tr>
<tr>
<td>Total</td>
<td>89</td>
<td>100.00</td>
</tr>
</tbody>
</table>

* = missing responses

Note. N = 89
at director or supervisor level. The results from urban hospitals revealed the most frequent responses were from the director, supervisor, and manager levels.

Respondents were asked to identify the number of registered nurses (RNs), graduate nurses (GNs) and licensed practical nurses (LPNs) employed in a full-time capacity (working 36 or more scheduled hours in a work week) as well as a part-time capacity (working less than 36 scheduled hours in a work week). Table 3 presents the number of nurses employed full time and part time in hospital operating room settings in Iowa and identifies the mean and range of the entire sample as well as by hospital category.

Insert Table 3 about here

The highest level of education preparation of the nurses employed in all hospitals in the sample varied widely from a practical nurse diploma (Certificate) to a master's degree in nursing or a masters degree in a field other than nursing. Table 4 presents these data, identifying the range and mean for the entire sample as well as by hospital category.
<table>
<thead>
<tr>
<th>Sample</th>
<th>FT RN</th>
<th>PT RN</th>
<th>FT GN</th>
<th>PT GN</th>
<th>FT LPN</th>
<th>PT LPN</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
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<td>0-3</td>
<td>0-2</td>
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<tr>
<td>Mean</td>
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<td>2.54</td>
<td>0</td>
<td>0</td>
<td>0.77</td>
<td>0.64</td>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>9-20</td>
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<td>0</td>
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<tr>
<td>Mean</td>
<td>13.6</td>
<td>4.0</td>
<td>1.75</td>
<td>0</td>
<td>1.66</td>
<td>0</td>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
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<td>0</td>
<td>0</td>
<td>0-4</td>
<td>0-3</td>
</tr>
<tr>
<td>Mean</td>
<td>25.55</td>
<td>6.50</td>
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<td>0</td>
<td>0.69</td>
<td>0.58</td>
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<tr>
<td><strong>Total</strong></td>
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<td></td>
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<tr>
<td>Range</td>
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<td>1-3</td>
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<td>0-4</td>
<td>0-3</td>
</tr>
<tr>
<td>Mean</td>
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<td>3.60</td>
<td>0.09</td>
<td>0</td>
<td>0.87</td>
<td>0.59</td>
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</table>

Note. N=89
<table>
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<tr>
<th>Sample</th>
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<th>PN PT</th>
<th>ADN FT</th>
<th>ADN PT</th>
<th>DIP FT</th>
<th>DIP PT</th>
<th>BSN FT</th>
<th>BSN PT</th>
<th>BA/BS FT</th>
<th>BA/BS PT</th>
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<th>OTH PT</th>
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<tbody>
<tr>
<td>Rural Range</td>
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<td>0-3</td>
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<td>0-9</td>
<td>0-2</td>
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<td>0-1</td>
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<td>Mean</td>
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<td>1.34</td>
<td>1.65</td>
<td>2.06</td>
<td>0.76</td>
<td>0.64</td>
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<td>3-5</td>
<td>0-8</td>
<td>0-3</td>
<td>1-4</td>
<td>0-1</td>
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<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>Mean</td>
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<td>7.0</td>
<td>3.66</td>
<td>4.60</td>
<td>1.50</td>
<td>1.50</td>
<td>0.33</td>
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<td>0</td>
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<td>1-30</td>
<td>0-17</td>
<td>1-50</td>
<td>0-7</td>
<td>0-38</td>
<td>0-7</td>
<td>0-3</td>
<td>0-1</td>
<td>0-2</td>
<td>0</td>
</tr>
<tr>
<td>Mean</td>
<td>0.66</td>
<td>0.55</td>
<td>8.35</td>
<td>3.53</td>
<td>12.88</td>
<td>3.00</td>
<td>6.78</td>
<td>1.33</td>
<td>1.20</td>
<td>0.16</td>
<td>0.60</td>
<td>0</td>
</tr>
<tr>
<td>Total Range</td>
<td>0-4</td>
<td>0-3</td>
<td>0-30</td>
<td>0-17</td>
<td>0-50</td>
<td>0-9</td>
<td>0-38</td>
<td>0-7</td>
<td>0-3</td>
<td>0-1</td>
<td>0-2</td>
<td>0</td>
</tr>
<tr>
<td>Mean</td>
<td>1.03</td>
<td>0.68</td>
<td>4.24</td>
<td>2.13</td>
<td>5.10</td>
<td>2.23</td>
<td>3.16</td>
<td>0.88</td>
<td>0.64</td>
<td>0.13</td>
<td>0.36</td>
<td>0</td>
</tr>
</tbody>
</table>
Major Findings of the Study

Table 5 presents the data regarding the number of nurses undergoing orientation and includes the ranges and means for the entire sample as well as by hospital category.

Table 5

<table>
<thead>
<tr>
<th></th>
<th># Nurse Orientees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample</td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>0-4</td>
</tr>
<tr>
<td>Mean</td>
<td>1.06</td>
</tr>
<tr>
<td>Rural referral</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>0-7</td>
</tr>
<tr>
<td>Mean</td>
<td>2.83</td>
</tr>
<tr>
<td>Urban</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>0-23</td>
</tr>
<tr>
<td>Mean</td>
<td>5.92</td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>0-23</td>
</tr>
<tr>
<td>Mean</td>
<td>2.27</td>
</tr>
</tbody>
</table>

Note. N=89
The data regarding the categorization of nurse orientees is presented in Table 6.

Table 6

**Number of Nurse Orientees by Hospital Classification**

<table>
<thead>
<tr>
<th>Nurse orientee</th>
<th>R</th>
<th>RR</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>LPN-no OR experience</td>
<td>9</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>LPN-with OR experience</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>GN</td>
<td>5</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>RN-no OR experience</td>
<td>25</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>RN-with OR experience</td>
<td>16</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Note.** R = Rural (n=40)  RR = Rural referral (n=5)  U = Urban (n=16)

Table 7 presents data regarding the length and cost of orientation, identifying the ranges and means for the entire sample as well as by hospital category.

____________________________________________________

Insert Table 7 about here

____________________________________________________

In response to the request to identify the criteria used to determine the cost of orientation,
<table>
<thead>
<tr>
<th>Sample</th>
<th>Average Length (weeks)</th>
<th>Maximum Length (weeks)</th>
<th>Cost (dollars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>2-36</td>
<td>2-52</td>
<td>200 - 30,000</td>
</tr>
<tr>
<td>Mean</td>
<td>14.20</td>
<td>23.89</td>
<td>4,280.40</td>
</tr>
<tr>
<td>Rural referral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>18-24</td>
<td>24-52</td>
<td>5,000 - 25,000</td>
</tr>
<tr>
<td>Mean</td>
<td>22.00</td>
<td>34.40</td>
<td>13,000.00</td>
</tr>
<tr>
<td>Urban</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>12-36</td>
<td>20-52</td>
<td>5,500 - 63,000</td>
</tr>
<tr>
<td>Mean</td>
<td>21.88</td>
<td>34.00</td>
<td>9,887.23</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>2-36</td>
<td>2.52</td>
<td>200 - 63,000</td>
</tr>
<tr>
<td>Mean</td>
<td>16.54</td>
<td>27.52</td>
<td>6,159.22</td>
</tr>
</tbody>
</table>

Note. N=89
the majority of respondents indicated salary of the new employee. Table 8 summarizes the criteria used by hospitals to determine the cost of orientation for nurses in the OR setting. Respondents identified all criteria that applied to their setting.

Insert Table 8 about here

These data can be broken down further according to hospital classification. Table 9 summarizes these data.

Insert Table 9 about here

Table 10 presents data regarding the number of orientation instructors and includes the range and means for the entire sample as well as hospital categories.

Insert Table 10 about here

The highest level of educational preparation of the orientation instructors in all hospitals in the
Table 8

Criteria Used to Determine the Cost of Orientation for Nurses in the OR Setting

<table>
<thead>
<tr>
<th>Criteria</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instructor salary</td>
<td>21</td>
<td>23.6</td>
</tr>
<tr>
<td>Preceptor time</td>
<td>23</td>
<td>25.8</td>
</tr>
<tr>
<td>Salary of the new employee</td>
<td>70</td>
<td>78.7</td>
</tr>
<tr>
<td>Preparation time for the instructor</td>
<td>12</td>
<td>13.5</td>
</tr>
<tr>
<td>Preparation time for the preceptor</td>
<td>15</td>
<td>16.9</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>10.1</td>
</tr>
</tbody>
</table>

Note. N=89
### Table 9

**Criteria Used to Determine the Cost of Orientation According to Hospital Classification**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>R</th>
<th>RR</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instructor salary</td>
<td>13</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Preceptor time</td>
<td>15</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Salary of the new employee</td>
<td>50</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Preparation time for the instructor</td>
<td>5</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Preparation time for the preceptor</td>
<td>7</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

Note.  
R = Rural (n=63)  
RR = Rural referral (n=6)  
U = Urban (n=20)
Table 10

Number of Orientation Instructors per Hospital

<table>
<thead>
<tr>
<th>Sample</th>
<th>Orientation Instructors</th>
</tr>
</thead>
</table>
| Rural
| Range          | 0-13                    |
| Mean            | 1.41                    |
| Rural referral  |                         |
| Range          | 0-3                     |
| Mean            | 1.66                    |
| Urban
| Range          | 0-17                    |
| Mean            | 4.61                    |
| Total
| Range          | 0-17                    |
| Mean            | 2.13                    |
the orientation instructors in all hospitals in the sample varied widely from an associate degree in nursing to a masters degree in nursing or a masters degree in a field other than nursing.

Table 11 describes the breakdown of responses by hospital classification when one, two, or three instructors were indicated.

Insert Table 11 about here

Respondents were asked whether the orientation instructors had attained certification in operating room nursing (CNOR) and whether the orientation instructor had advanced educational preparation in the field of adult education. Table 12 identifies the number of orientation instructors who had attained CNOR certification. Table 13 identifies the number of orientation instructors who had advanced educational preparation in the field of adult education and Table 14 identifies the type of preparation in the field of adult education for the orientation instructors.

Insert Tables 12 to 14 about here
### Table 11

**Educational Levels of Orientation Instructors**

When one instructor indicated

<table>
<thead>
<tr>
<th>Ed Prep</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADN</td>
<td>12</td>
<td>13.48</td>
</tr>
<tr>
<td>Diploma</td>
<td>25</td>
<td>28.08</td>
</tr>
<tr>
<td>BSN</td>
<td>10</td>
<td>11.23</td>
</tr>
<tr>
<td>BA/BS</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MSN</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MA/MS</td>
<td>2</td>
<td>2.24</td>
</tr>
</tbody>
</table>

When two instructors indicated

<table>
<thead>
<tr>
<th>Ed Prep</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADN</td>
<td>6</td>
<td>6.74</td>
<td>1</td>
<td>1.12</td>
</tr>
<tr>
<td>Diploma</td>
<td>10</td>
<td>11.23</td>
<td>14</td>
<td>15.73</td>
</tr>
<tr>
<td>BSN</td>
<td>3</td>
<td>3.37</td>
<td>3</td>
<td>3.37</td>
</tr>
<tr>
<td>BA/BS</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1.12</td>
</tr>
<tr>
<td>MSN</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MA/MS</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

When three instructors indicated

<table>
<thead>
<tr>
<th>Ed Prep</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADN</td>
<td>1</td>
<td>1.12</td>
<td>1</td>
<td>1.12</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Diploma</td>
<td>4</td>
<td>4.49</td>
<td>3</td>
<td>3.37</td>
<td>5</td>
<td>5.61</td>
</tr>
<tr>
<td>BSN</td>
<td>1</td>
<td>1.12</td>
<td>2</td>
<td>2.24</td>
<td>1</td>
<td>1.12</td>
</tr>
<tr>
<td>BA/BS</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MSN</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MA/MS</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 12

<table>
<thead>
<tr>
<th>Orientation Instructors Having CNOR Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>When one instructor identified</td>
</tr>
<tr>
<td>n</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>When two instructors identified</td>
</tr>
<tr>
<td>n</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>When three instructors identified</td>
</tr>
<tr>
<td>n</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>
Table 13

Orientation Instructors Having Advanced Educational Preparation in the Field of Adult Education

When one instructor identified

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>20</td>
<td>22.47</td>
</tr>
<tr>
<td>No</td>
<td>28</td>
<td>31.46</td>
</tr>
</tbody>
</table>

When two instructors identified

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6</td>
<td>6.74</td>
<td>9</td>
<td>10.11</td>
</tr>
<tr>
<td>No</td>
<td>14</td>
<td>15.73</td>
<td>11</td>
<td>12.35</td>
</tr>
</tbody>
</table>

When three instructors identified

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>4</td>
<td>4.49</td>
<td>2</td>
<td>2.24</td>
<td>2</td>
<td>2.24</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>3.37</td>
<td>4</td>
<td>4.49</td>
<td>4</td>
<td>4.49</td>
</tr>
</tbody>
</table>
Table 14

Nature of Instructor Preparation in the Field of Adult Education

When one instructor identified

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.E.</td>
<td>24</td>
<td>26.96</td>
</tr>
<tr>
<td>Coursework</td>
<td>1</td>
<td>1.12</td>
</tr>
<tr>
<td>Both</td>
<td>6</td>
<td>6.74</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

When two instructors identified

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.E.</td>
<td>8</td>
<td>8.99</td>
<td>8</td>
<td>8.99</td>
</tr>
<tr>
<td>Coursework</td>
<td>1</td>
<td>1.12</td>
<td>1</td>
<td>1.12</td>
</tr>
<tr>
<td>Both</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1.12</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2.24</td>
<td>2</td>
<td>2.24</td>
</tr>
</tbody>
</table>

When three instructors identified

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.E.</td>
<td>3</td>
<td>3.37</td>
<td>3</td>
<td>3.37</td>
<td>3</td>
<td>3.37</td>
</tr>
<tr>
<td>Coursework</td>
<td>1</td>
<td>1.12</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1.12</td>
</tr>
<tr>
<td>Both</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Note. N=89
The majority of respondents in the sample (55.1%, n=49) indicated their hospitals used a preceptorship for orientation of nurses to the operating room setting (Figure 1).

Insert Figure 1 about here

Table 15 summarizes these data according to hospital classification.

Insert Table 15 about here

Those responding yes to the preceptor question were asked additional questions about their preceptorship program. The 49 respondents indicated the preceptor was not the same person for the entire orientation period in 31.5% (n=28) of the cases whereas 23.6% (n=21) of the respondents indicated the preceptor was the same person. Those 28 respondents indicating the preceptor was not the same person for the entire orientation program were asked how often the change in preceptors occurred. The change occurred three or more times in 15.7% of the responses in an orientation period (Figure 2).
Figure 1. Use of Preceptorship for Orientation

- No Response (2.2%)
- No (42.7%)
- Yes (55.1%)
Table 15

Use of Preceptorship for Orientation According to Hospital Classification

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Yes</th>
<th>%</th>
<th>No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>24</td>
<td>(26.96%)</td>
<td>37</td>
<td>(41.57%)</td>
</tr>
<tr>
<td>Rural referral</td>
<td>6</td>
<td>(6.74%)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>19</td>
<td>(21.34%)</td>
<td>1</td>
<td>(1.12%)</td>
</tr>
</tbody>
</table>

Note. N=89
Figure 2. Frequency of Preceptorship Change Throughout the Orientation Period

- Once (12.2%)
- Twice (18.4%)
- Three or more (28.6%)
- No Response (40.8%)
When asked how many orientees the preceptor was responsible for at one time, the highest percentage of respondents (48.9 %, n=49) indicated the preceptor was responsible for one orientee at a time (Figure 3).

Insert Figure 3 about here

Respondents were then asked whether the preceptor and orientee shared the same work schedule. Table 16 presents data regarding the preceptors and orientees who share the same work schedule for the entire sample as well as by hospital categories.

Insert Table 16 about here

The next item asked whether preceptors have a written job description. The majority of respondents indicated 38.2% (n=34) of hospitals do not have a written job description for preceptors (Figure 4).

Insert Figure 4 about here
Figure 3. Number of Orientees Each Preceptor is Responsible for at One Time

Three or more
Two (6.1%) (4.1%)

One (89.8%)
Table 16

Number of Preceptors and Orientees Who Share the Same Work Schedules

<table>
<thead>
<tr>
<th>Hospital Type</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>(%)</td>
</tr>
<tr>
<td>Rural</td>
<td>22</td>
<td>(45.83)</td>
</tr>
<tr>
<td>Rural referral</td>
<td>6</td>
<td>(12.24)</td>
</tr>
<tr>
<td>Urban</td>
<td>16</td>
<td>(32.65)</td>
</tr>
<tr>
<td>Total</td>
<td>44</td>
<td>(89.8)</td>
</tr>
</tbody>
</table>

Note. n=49
Figure 4. Written Job Description for Preceptors

Yes (16.9%)

No Response (44.9%)

No (38.2%)

These responses are presented according to hospital categories in Table 18.

When asked whether preceptors have an ongoing peer support system to assist them in their preceptor role, the majority of the 49 respondents (71.4%, 35) indicated they have an ongoing peer support system and 28.6% (14) indicated they do not have an ongoing peer support system. These data are presented according to hospital type in Table 19.
Among those 15 respondents who indicated their hospital has a written job description for preceptors, the majority indicated all elements are included in the job description (Table 17). Each respondent could identify more than one response for this question.

Insert Table 17 about here

These responses are presented according to hospital categories in Table 18.

Insert Table 18 about here

When asked whether preceptors have an ongoing peer support system to assist them in their preceptor role, the majority of the 49 respondents (71.2%, n=35) indicated they have an ongoing peer support system and 28.57% (n=14) indicated they do not have an ongoing peer support system. These data are presented according to hospital type in Table 19.

Insert Table 19 about here
Table 17

Elements Included in the Preceptor Job Description

<table>
<thead>
<tr>
<th>Element</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of preceptor in the orientation process</td>
<td>14</td>
<td>93.33</td>
</tr>
<tr>
<td>Evaluation of the preceptor</td>
<td>12</td>
<td>80.00</td>
</tr>
<tr>
<td>Performance criteria</td>
<td>14</td>
<td>93.33</td>
</tr>
<tr>
<td>Preceptor responsibilities to the orientee</td>
<td>14</td>
<td>93.33</td>
</tr>
</tbody>
</table>

Note. n=15
Table 18

Elements Included in the Preceptor Job Description According to Hospital Classification

<table>
<thead>
<tr>
<th>Element</th>
<th>R</th>
<th>RR</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of preceptor in the orientation process</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Evaluation of the preceptor</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Performance criteria</td>
<td>6</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Preceptor responsibilities to the orientee</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
</tbody>
</table>

Note.  R = Rural (n=7)  RR = Rural referral (n=4)  U = Urban (n=7)
Table 19
Ongoing Peer Support System for Preceptors
According to Hospital Classification

<table>
<thead>
<tr>
<th>Hospital Type</th>
<th>Yes</th>
<th>%</th>
<th>No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>16</td>
<td>32.65</td>
<td>8</td>
<td>16.33</td>
</tr>
<tr>
<td>Rural referral</td>
<td>6</td>
<td>12.24</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Urban</td>
<td>13</td>
<td>26.53</td>
<td>6</td>
<td>12.24</td>
</tr>
</tbody>
</table>

Note. Rural (n=24) Rural referral (n=6) Urban (n=19)
The next item asked how preceptors were selected. The majority of the 49 respondents indicated preceptors are chosen by supervisors/managers (Table 20).

Table 20

Selection of Preceptors

<table>
<thead>
<tr>
<th>Person selecting</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee volunteers</td>
<td>6</td>
<td>12.24</td>
</tr>
<tr>
<td>Chosen by supervisor/manager</td>
<td>24</td>
<td>48.98</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>36.73</td>
</tr>
</tbody>
</table>

Note. n=49

As Table 21 illustrates, preceptor selection was consistent across the hospital categories.

Insert Table 21 about here

When asked whether participation as a preceptor required for advancement in a clinical nursing position, the majority of respondents indicated participation as a preceptor was not required for
Table 21

Selection of Preceptors According to Hospital Classification

<table>
<thead>
<tr>
<th>Selection of Preceptors</th>
<th>R</th>
<th>RR</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee volunteers</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Chosen by supervisor/manager</td>
<td>15</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>2</td>
<td>10</td>
</tr>
</tbody>
</table>

Note.  R = Rural (n=25)  RR = Rural referral (n=6)  U = Urban (n=19)
advancement in a clinical nursing position (Figure 5).

Table 22 presents these data according to hospital classification and illustrates consistency across the hospital categories.

When asked whether a training program/session was provided for nurse preceptors as a part of their role preparation, 29 of the 49 (59.18%) respondents indicated the hospital does not provide a training program/session for preceptors, whereas 20 (40.82%) of the respondents indicated the hospital does provide a training program/session for preceptors. Table 23 identifies these data according to hospital type.
Figure 5. Precepting as a Requirement for Job Advancement

<table>
<thead>
<tr>
<th>Hospital Type</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>19</td>
<td>(38.77)</td>
</tr>
<tr>
<td>Rural referral</td>
<td>1</td>
<td>(2.12)</td>
</tr>
<tr>
<td>Urban</td>
<td>24</td>
<td>(48.87)</td>
</tr>
</tbody>
</table>

Note: [Table 27 provided here]

- No Response: (4.1%)
- Yes: (73.5%)
Table 22

Precepting as a Requirement for Job Advancement
According to Hospital Classification

<table>
<thead>
<tr>
<th>Hospital Type</th>
<th>Yes</th>
<th>%</th>
<th>No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>3</td>
<td>(6.12)</td>
<td>19</td>
<td>(38.77)</td>
</tr>
<tr>
<td>Rural referral</td>
<td>3</td>
<td>(6.12)</td>
<td>3</td>
<td>(6.12)</td>
</tr>
<tr>
<td>Urban</td>
<td>5</td>
<td>(10.20)</td>
<td>14</td>
<td>(28.57)</td>
</tr>
</tbody>
</table>

Note. n=49
Table 23

**Training Program/Session Provided for Preceptors According to Hospital Classification**

<table>
<thead>
<tr>
<th>Hospital Type</th>
<th>Yes (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>4 (8.16)</td>
<td>23 (40.82)</td>
</tr>
<tr>
<td>Rural referral</td>
<td>4 (8.16)</td>
<td>2 (4.08)</td>
</tr>
<tr>
<td>Urban</td>
<td>12 (24.49)</td>
<td>7 (15.29)</td>
</tr>
</tbody>
</table>

Note. n=49
Among those 20 hospitals providing a training program/session for preceptors, the content areas covered in the program/session that were cited most frequently by respondents were communication techniques and roles and responsibilities of the preceptor (Table 24).

Table 24

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Frequency of inclusion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment of learning needs</td>
<td>80</td>
</tr>
<tr>
<td>Communication techniques</td>
<td>100</td>
</tr>
<tr>
<td>Learning styles</td>
<td>80</td>
</tr>
<tr>
<td>Methods of Instruction</td>
<td>75</td>
</tr>
<tr>
<td>Documentation of orientees' progress</td>
<td>90</td>
</tr>
<tr>
<td>Roles and responsibilities of the preceptor</td>
<td>100</td>
</tr>
<tr>
<td>Principles of adult education</td>
<td>50</td>
</tr>
<tr>
<td>Reality shock/culture shock</td>
<td>55</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
</tr>
</tbody>
</table>

Note. n=20
Table 25 identifies these responses by hospital categories and reveals the topics are presented in a greater number of rural referral and urban hospitals.

Table 25

<table>
<thead>
<tr>
<th>Content Area</th>
<th>R</th>
<th>RR</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment of learning needs</td>
<td>2</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Communication techniques</td>
<td>4</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Learning styles</td>
<td>1</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Methods of Instruction</td>
<td>1</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Documentation of orientees progress</td>
<td>4</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Roles and responsibilities of the preceptor</td>
<td>3</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Principles of adult education</td>
<td>0</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Reality shock/culture shock</td>
<td>2</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Note. R = Rural (n=24) RR = Rural referral (n=6) U = Urban (n=19)

Those hospitals providing a training program/session for preceptors were also asked to identify how long the training program/session lasts. The
most common response was one day in length (Table 26).

Table 26

Length of Preceptor Training Program

<table>
<thead>
<tr>
<th>Days</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1</td>
<td>6</td>
<td>12.24</td>
</tr>
<tr>
<td>1</td>
<td>9</td>
<td>18.36</td>
</tr>
<tr>
<td>2</td>
<td>7</td>
<td>14.28</td>
</tr>
<tr>
<td>3 or more</td>
<td>3</td>
<td>6.12</td>
</tr>
</tbody>
</table>

Note. n = 49

These responses are presented according to hospital categorization in Table 27.

Table 27

Length of Preceptor Training Program/Session by Hospital Classification

<table>
<thead>
<tr>
<th>Hospital Type</th>
<th>Length (days)</th>
<th>&lt;1</th>
<th>1</th>
<th>2</th>
<th>&gt;3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td></td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rural referral</td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Urban</td>
<td></td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>

Note. n = 49
When asked whether incentives, rewards, or recognition were provided for preceptors, 25 of the 49 respondents (30.4%) said they do not provide incentives, rewards, or recognition. Of those 13 indicating they provide incentives, rewards, or recognition, the highest number of respondents (n=6) indicated preceptors receive this in the form of a certificate or plaque. Table 28 summarizes these data.

Table 28
Preceptor Incentives, Rewards, or Recognition

<table>
<thead>
<tr>
<th>Incentive/reward/recognition</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better work schedule</td>
<td>4</td>
<td>8.16</td>
</tr>
<tr>
<td>Certificate/plaque</td>
<td>6</td>
<td>12.24</td>
</tr>
<tr>
<td>Listing in hospital publication</td>
<td>3</td>
<td>6.12</td>
</tr>
<tr>
<td>Compensatory time off</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Increase in base salary</td>
<td>3</td>
<td>6.12</td>
</tr>
<tr>
<td>Increase in educational benefits</td>
<td>4</td>
<td>8.16</td>
</tr>
<tr>
<td>Luncheon for all preceptors</td>
<td>4</td>
<td>8.16</td>
</tr>
<tr>
<td>Pay differential for preceptors</td>
<td>2</td>
<td>4.08</td>
</tr>
<tr>
<td>Reduction in workload</td>
<td>4</td>
<td>8.16</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>10.20</td>
</tr>
</tbody>
</table>

Note. n=25
The next series of questions referred to the implementation of the orientation program and were addressed to the entire sample of 89. The majority of responses indicated assessment of knowledge and skills in perioperative nursing is done prior to or at the beginning of the orientation program (Figure 6).

Figure 6

Assessment of Knowledge and Skills in Perioperative Nursing

No (25.8%)

Yes (74.2%)
Among those 66 hospitals that assess knowledge and skills in perioperative nursing prior to or at the beginning of orientation, the most common methods of assessment cited were observation of employee performance and interview with the orientee (Table 29). Respondents identified all methods of assessment that applied to their institution.

Table 29

Methods of Assessment of Knowledge and Skill in Perioperative Nursing

<table>
<thead>
<tr>
<th>Method</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct observation of orientee's performance</td>
<td>57</td>
<td>86.36</td>
</tr>
<tr>
<td>Interview with orientee</td>
<td>55</td>
<td>83.33</td>
</tr>
<tr>
<td>Written checklists</td>
<td>49</td>
<td>72.24</td>
</tr>
<tr>
<td>Written pretests</td>
<td>6</td>
<td>9.08</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1.51</td>
</tr>
</tbody>
</table>

Note. n=66

Table 30 presents these data according to hospital categories.

Insert Table 30 about here
Table 30

Methods of Assessment in Perioperative Nursing Knowledge and Skill According to Hospital Classification

<table>
<thead>
<tr>
<th>Method</th>
<th>R</th>
<th>RR</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct observation of orientee's performance</td>
<td>37</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Interview with orientee</td>
<td>32</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>Written checklists</td>
<td>29</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Written pretests</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Note. R = Rural (n=41) RR = Rural referral (n=6)
U = Urban (n=19)

The next item asked whether there were written outcome behaviors for nurses participating in the orientation program. The respondents indicated 44.9% (n=40) had written outcome behaviors for the nurse orientees while 49.43% (n=44) did not have written outcome behaviors.

When asked to identify all of the individuals who participated in planning the orientation program, the majority of respondents (88.8%, n=79) indicated the head nurse/nurse manager was involved
(Table 31). Respondents were able to indicate more than one response.

Table 31

Participants in the Planning of Orientation Programs

<table>
<thead>
<tr>
<th>Participants</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head nurse/nurse manager</td>
<td>79</td>
<td>88.8</td>
</tr>
<tr>
<td>Orientation instructor</td>
<td>24</td>
<td>27.0</td>
</tr>
<tr>
<td>Preceptor</td>
<td>29</td>
<td>32.6</td>
</tr>
<tr>
<td>Orientee</td>
<td>22</td>
<td>24.7</td>
</tr>
<tr>
<td>Staff nurse/clinical nurse</td>
<td>36</td>
<td>40.4</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>13.5</td>
</tr>
</tbody>
</table>

Note. N=89

Table 32 summarizes these data according to hospital categories.

Table 32 about here

The next item asked respondents to indicate the approach used by the orientation program (competency based, traditional, or other). The majority of hospitals (55.1%, n=49) use a
<table>
<thead>
<tr>
<th>Participants</th>
<th>R</th>
<th>RR</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head nurse/nurse manager</td>
<td>56</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>Orientation instructor</td>
<td>11</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Preceptor</td>
<td>9</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Orientee</td>
<td>9</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Staff nurse/clinical nurse</td>
<td>25</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>-</td>
<td>2</td>
</tr>
</tbody>
</table>

Note.  
R = Rural (n=63)  
RR = Rural referral (n=6)  
U = Urban (n=20)
competency based approach in the orientation program (Figure 7).

Table 33:

Figure 7

Approach Used in Structuring Orientation Programs

- No Response (4.4%)
- Other (10.1%)
- Traditional (30.4%)
- Competency based (55.1%)

Note: A common approach is that the survey questions are used when implementing the original program. The majority of the respondents (94.8%) indicated that they used survey questions during actual training sessions (response 34). Respondents indicated all what was applied to their institutions.
A summary of these data according to hospital categories is presented in Table 33.

Table 33

Approach Used in Structuring Orientation Programs According to Hospital Classification

<table>
<thead>
<tr>
<th>Approach</th>
<th>R</th>
<th>RR</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competency-based</td>
<td>30</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Traditional</td>
<td>25</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

Note. R = Rural (n=63) RR = Rural Referral (n=6) U = Urban (n=20)

When asked to identify the settings used to implement the orientation program, the majority of respondents (94.6%) indicated the operating room suite was used during actual patient care (Table 34). Respondents indicated all settings that applied to their institutions.

____________________________________

Insert Table 34 about here

____________________________________
Table 34

**Settings Used to Implement Orientation Programs**

<table>
<thead>
<tr>
<th>Setting</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classroom</td>
<td>25</td>
<td>28.1</td>
</tr>
<tr>
<td>Simulation laboratory</td>
<td>26</td>
<td>29.2</td>
</tr>
<tr>
<td>OR suite during actual patient care</td>
<td>87</td>
<td>97.8</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>10.1</td>
</tr>
</tbody>
</table>

Note. N=89
These data are summarized according to hospital classification in Table 35.

Table 35

Settings Used to Implement Orientation Programs According to Hospital Classification

<table>
<thead>
<tr>
<th>Setting</th>
<th>R</th>
<th>RR</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classroom</td>
<td>8</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Simulation Laboratory</td>
<td>12</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>OR suite during actual patient care</td>
<td>61</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

Note. R = Rural (n=63) RR = Rural Referral (n=6) U = Urban (n=20)

When asked to identify the topics presented to nurses during the orientation program, respondents reported content areas most often covered in the program included principles of sterile technique, documentation of patient care, methods of sterilization and disinfection, and patient positioning. Table 36 lists the frequency with which content areas are included in the orientation program.
### Table 36

**Content Areas Presented during Orientation Programs**

<table>
<thead>
<tr>
<th>Content area</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia</td>
<td>70</td>
<td>78.7</td>
</tr>
<tr>
<td>Clinical nursing research</td>
<td>10</td>
<td>11.2</td>
</tr>
<tr>
<td>Documentation of patient care</td>
<td>87</td>
<td>97.8</td>
</tr>
<tr>
<td>Emergencies in the OR</td>
<td>80</td>
<td>89.9</td>
</tr>
<tr>
<td>Ethical issues</td>
<td>41</td>
<td>46.1</td>
</tr>
<tr>
<td>Instrumentation</td>
<td>86</td>
<td>96.6</td>
</tr>
<tr>
<td>Legal issues</td>
<td>57</td>
<td>64</td>
</tr>
<tr>
<td>Methods of sterilization and disinfection</td>
<td>87</td>
<td>97.8</td>
</tr>
<tr>
<td>Nursing process applied in the OR setting</td>
<td>69</td>
<td>77.5</td>
</tr>
<tr>
<td>Patient positioning</td>
<td>87</td>
<td>97.8</td>
</tr>
<tr>
<td>Principles of sterile technique</td>
<td>88</td>
<td>98.9</td>
</tr>
<tr>
<td>Quality assurance</td>
<td>64</td>
<td>71.9</td>
</tr>
<tr>
<td>Reality shock/culture shock</td>
<td>19</td>
<td>21.3</td>
</tr>
<tr>
<td>Safety for patients and personnel</td>
<td>85</td>
<td>95.5</td>
</tr>
<tr>
<td>Standards of perioperative nursing practice</td>
<td>78</td>
<td>87.6</td>
</tr>
<tr>
<td>Wound healing</td>
<td>33</td>
<td>37.1</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>10.1</td>
</tr>
</tbody>
</table>

Note. N=89
Table 37 summarizes topic areas according to hospital categories.

The next item asked that respondents identify the teaching methods utilized during the orientation program. The frequency for each teaching method is identified in Table 38.

Table 39 presents teaching methods used in orientation programs according to hospital categories.

A total of 57 (64%) respondents reported other health care professionals teach in the orientation program. When asked to identify which health care professionals participated in the orientation program. The most frequent responses
<table>
<thead>
<tr>
<th>Content area</th>
<th>R</th>
<th>RR</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia</td>
<td>49</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>Clinical nursing research</td>
<td>6</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Documentation of patient care</td>
<td>62</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Emergencies in the OR</td>
<td>55</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>Ethical issues</td>
<td>26</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Instrumentation</td>
<td>61</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>Legal issues</td>
<td>38</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Methods of sterilization and disinfection</td>
<td>61</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Nursing process applied in the OR setting</td>
<td>45</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>Patient positioning</td>
<td>61</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Principles of sterile technique</td>
<td>62</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Quality assurance</td>
<td>47</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Reality shock/culture shock</td>
<td>9</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Safety for patients and personnel</td>
<td>59</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Standards of perioperative nursing practice</td>
<td>53</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>Wound healing</td>
<td>22</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

**Note.**  
R = Rural (n=63)  
RR = Rural referral (n=6)  
U = Urban (n=20)
Table 38

Teaching Methods Used in Orientation Programs According to Hospital Classification

<table>
<thead>
<tr>
<th>Teaching method</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiovisual programs</td>
<td>45</td>
<td>50.6</td>
</tr>
<tr>
<td>Computer-assisted instruction</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>Demonstration in the OR suite</td>
<td>89</td>
<td>100</td>
</tr>
<tr>
<td>Group discussion</td>
<td>58</td>
<td>65.2</td>
</tr>
<tr>
<td>Lecture</td>
<td>25</td>
<td>28.1</td>
</tr>
<tr>
<td>Role play</td>
<td>48</td>
<td>53.9</td>
</tr>
<tr>
<td>Written self-instruction</td>
<td>20</td>
<td>22.5</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2.2</td>
</tr>
</tbody>
</table>

Note. N=89
Table 39

Teaching Methods Used in Orientation Programs According to Hospital Classification

<table>
<thead>
<tr>
<th>Teaching method</th>
<th>R</th>
<th>RR</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiovisual programs</td>
<td>25</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Computer-assisted instruction</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Demonstration in the OR suite</td>
<td>63</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Group discussion</td>
<td>37</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>Lecture</td>
<td>11</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Role play</td>
<td>31</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Written self-instruction</td>
<td>7</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Note.  R = Rural (n=63) RR = Rural referral (n=6) U = Urban (n=20)
were physicians ($n=22$), surgical technologists ($n=15$), and nurses ($n=11$).

When asked whether any books were used as a resource for the orientation program, 66.3% ($n=59$) of the respondents said yes and 25.8% ($n=23$) of the respondents said no. The two most frequently cited books cited by respondents were *Alexander's Care of the Patient in Surgery* and *Berry and Kohn's Operating Room Technique*, two well known perioperative nursing care textbooks. The third most commonly identified book was the AORN Standards and Recommended Practices, which contains the standards of patient care for the intraoperative phase of the surgical experience for the patient.

When asked whether any journals used as a resource for the orientation program, 59.6% ($n=53$) of the respondents said yes and 31.5% ($n=28$) of the respondents said no. The most frequently cited journal was the AORN Journal.

The next item asked whether audiovisual equipment was used during the orientation program. The majority of respondents (59.6%, $n=53$) indicated yes. Of those responding yes, the most commonly cited audiovisual equipment in OR orientation
yes. Of those responding yes, the most commonly cited audiovisual equipment in OR orientation programs was the video cassette player. Table 40 identifies the frequency of selected audiovisual equipment used in OR orientation programs.

Insert Table 40 about here

Table 41 summarizes these data according to hospital classification.

Insert Table 41 about here

When asked to identify any teaching/learning aids used in conjunction with the orientation program, the modal response indicated that none were used (Table 42).

Insert Table 42 about here

The final set of data referred to the evaluation of the orientation program. Respondents were asked whether written tests were used in the evaluation process of the nurse orientee. The majority of
Table 40  
Audiovisual Equipment Used in Orientation Programs

<table>
<thead>
<tr>
<th>Equipment</th>
<th>n</th>
<th>% hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audio tapes</td>
<td>23</td>
<td>43.40</td>
</tr>
<tr>
<td>Computers</td>
<td>3</td>
<td>5.66</td>
</tr>
<tr>
<td>Closed-circuit tv</td>
<td>4</td>
<td>7.55</td>
</tr>
<tr>
<td>Easel/chalkboard</td>
<td>6</td>
<td>11.32</td>
</tr>
<tr>
<td>Overhead projector</td>
<td>8</td>
<td>15.09</td>
</tr>
<tr>
<td>Slide projector</td>
<td>9</td>
<td>16.98</td>
</tr>
<tr>
<td>Video cassette player</td>
<td>45</td>
<td>84.91</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>5.66</td>
</tr>
</tbody>
</table>

Note. n=53
Table 41

Audiovisual Equipment Used in Orientation Programs According to Hospital Classification

<table>
<thead>
<tr>
<th>Equipment</th>
<th>R</th>
<th>RR</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audio tapes</td>
<td>13</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Computers</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Closed circuit tv</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Easel/chalkboard</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Overhead projector</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Slide projector</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Video cassette player</td>
<td>28</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Note. R = Rural (n=63)  RR = Rural referral (n=6)  U = Urban (n=20)
### Table 42

**Teaching/Learning Aids Used in Orientation Programs**

<table>
<thead>
<tr>
<th>Aids</th>
<th>N</th>
<th>% hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bulletin board</td>
<td>14</td>
<td>15.73</td>
</tr>
<tr>
<td>Flip charts</td>
<td>8</td>
<td>8.99</td>
</tr>
<tr>
<td>Three dimensional models</td>
<td>9</td>
<td>10.11</td>
</tr>
<tr>
<td>Posters</td>
<td>16</td>
<td>17.89</td>
</tr>
<tr>
<td>None</td>
<td>43</td>
<td>48.31</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>8.99</td>
</tr>
</tbody>
</table>

**Note.** N=89
respondents (83.1%, n=74) indicated written tests were not used in the evaluation process, whereas 15.7% (n=14) indicated written tests were used. Of those 14 using written tests, the respondents were asked to identify the type of test question used in the written tests. The most common test questions were true-false, multiple choice, and fill-in-the-blank (Table 43).

Insert Table 43 about here

Table 44 summarizes these data according to hospital categories.

Insert Table 44 about here

The final question asked participants to identify the information used to determine when a nurse has successfully completed the orientation to the OR setting. The responses are identified in Table 45.

Insert Table 45 about here
<table>
<thead>
<tr>
<th>Question type</th>
<th>n</th>
<th>% hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essay</td>
<td>2</td>
<td>14.28</td>
</tr>
<tr>
<td>Fill-in-the-blank</td>
<td>9</td>
<td>64.28</td>
</tr>
<tr>
<td>Matching</td>
<td>6</td>
<td>42.85</td>
</tr>
<tr>
<td>Multiple choice</td>
<td>10</td>
<td>71.42</td>
</tr>
<tr>
<td>True/false</td>
<td>11</td>
<td>78.57</td>
</tr>
<tr>
<td>Short answer</td>
<td>5</td>
<td>35.71</td>
</tr>
</tbody>
</table>

Note. n=14
Table 44

Types of Test Questions Used on Written Tests According to Hospital Classification

<table>
<thead>
<tr>
<th>Question type</th>
<th>R</th>
<th>RR</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essay</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Fill-in-the-blank</td>
<td>2</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Matching</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Multiple choice</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>True/false</td>
<td>3</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Short answer</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Note. R = Rural (n=63) RR = Rural referral (n=6) U = Urban (n=20)
Table 45

Information Used to Determine Completion of Orientation Programs

<table>
<thead>
<tr>
<th>Information source</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation of outcome behaviors</td>
<td>54</td>
<td>60.7</td>
</tr>
<tr>
<td>Feedback from the orientee</td>
<td>79</td>
<td>88.8</td>
</tr>
<tr>
<td>Feedback from the preceptor</td>
<td>49</td>
<td>55.1</td>
</tr>
<tr>
<td>Feedback from other members of the health team</td>
<td>68</td>
<td>76.4</td>
</tr>
<tr>
<td>Clinical skills performance testing</td>
<td>47</td>
<td>52.8</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>6.7</td>
</tr>
</tbody>
</table>

Note. N=89
Table 46 summarizes these data according to hospital categories.

The other members of the health team cited by respondents more than once in the final question were physicians (n=18), operating room technicians (n=13), other nurses (n=13), and nurse anesthetists (n=4).
Table 46

Information Used to Determine Completion of Orientation Program According to Hospital Classification

<table>
<thead>
<tr>
<th>Criteria</th>
<th>R</th>
<th>RR</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation of outcome behaviors</td>
<td>35</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Feedback from the orientee</td>
<td>54</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>Feedback from the preceptor</td>
<td>25</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>Feedback from other members of the health team</td>
<td>45</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>Clinical skills performance testing</td>
<td>28</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Note.  R = Rural (n=63)  RR = Rural referral (n=6)  U = Urban (n=20)
CHAPTER V
DISCUSSION

Introduction

The purpose of this study was to describe the methods of orientation for registered nurses employed in operating room settings in hospitals within the state of Iowa. Using the Total Design Method (Dillman, 1978) 125 surveys were mailed to directors of nursing (DON) in 125 hospitals in Iowa. The hospitals receiving the surveys were categorized as rural, rural referral, and urban based on the Medicare classification system using bed size and geographic location. The DON in each of the receiving hospitals was asked to pass the survey to the individual responsible for the orientation of nurses to the operating room setting. A total of 89 usable responses were returned after mailing the original survey, a follow-up reminder, and a second survey to those not responding to both the survey and follow-up reminder. The 89 hospitals responding were further categorized as 63 rural, 6 rural referral, and 20 urban hospitals.

The results of this study suggest that
orientation practices for nurses in operating room settings is indeed a concern for nurses in Iowa hospitals. Based on the response rate, it would appear that the 89 hospitals represent a population willing to provide information on a topic they believe is very important.

This researcher believes that the use of the Total Design Method (Dillman, 1978) made a significant contribution to the high response rate. In addition, mailing the survey to directors of nursing, who potentially share an interest in the orientation of nurses and who may supervise the individual or individuals responsible for orientation practices in the OR, may have also contributed to the high response rate. This researcher also believes that sending the survey in September and avoiding the holidays of Thanksgiving, Hannukah, Christmas, and New Year's Eve contributed to the high response rate.

The Sample

The data revealed Iowa is a state with diversity in terms of hospital size, number of operating rooms in each hospital, as well as the educational
background of the nurses who work in the operating room settings. The majority of nurses employed in Iowa hospitals (as represented by all three hospital categories) were RNs (registered nurses) working in a full- or part-time capacity. Rural and urban hospitals employ RNs with an associate degree or a diploma as their highest level of educational preparation, while the majority of nurses from rural referral hospitals had a diploma or baccalaureate degree. It was interesting to note that the data regarding the highest educational preparation of nurses from urban hospitals did not reveal a larger number of baccalaureate- or master's-prepared nurses considering the access to colleges and universities in close geographic proximity to this population. This study, however, did not ask respondents to identify the number of nurses currently enrolled in a formal education program leading to an advanced degree.

The respondents identified that Iowa hospitals are performing a larger number of outpatient surgeries as compared to inpatient surgeries. This was clearly demonstrated in the data from rural hospitals where the number of outpatient surgeries
consistently exceeds the number of inpatient surgeries. The rural referral and urban hospital data demonstrated a more balanced mix of outpatient and inpatient surgeries although the number of outpatient surgeries generally exceeded the number of inpatient surgeries. One possible explanation for this is the fact that rural referral and urban hospitals offered a wider variety of types of surgeries as compared to the rural hospitals. Because a hospital stay is required for some patients prior to major surgery, this may have increased the number of inpatient surgeries reported by the rural referral and urban hospitals.

The Orientation

In terms of the number of nurses undergoing orientation in Iowa hospitals, the rural hospitals reported the smallest number of orientees whereas the urban hospitals reported the largest number of orientees. In other words, the number of nurses being oriented correlated well with the number of hospital beds in the institution. It was interesting to note that, although a small turnover rate of
nurses in OR settings occurred in rural hospitals, rural referral, and urban hospitals employed the highest number of GNs. In all three categories of hospitals, the majority of orientees who were RNs did not have any previous OR experience.

The literature regarding nurse orientation focuses primarily on program structure, the use of preceptors, and the importance of orientation to nurse recruitment and retention. Three articles were found that addressed the cost of orientation for nurses. Flewellyn and Gosnell (1987), in a study comparing the costs of traditional and competency-based programs, found the orientation of GNs (graduate nurses) was more costly than orienting the experienced RN. Trimiglozzi and Cooke (1985) reported an estimated cost for orientation of nurses to the OR setting was $8,000 to $10,000. Of the participants in this study who identified an estimated cost for orientation, approximately two-thirds fall within this range. The remaining one-third of these respondents indicated a cost for orientation that exceeded the $10,000 figure cited by Trimiglozzi and Cooke (1985). A limitation associated with the analysis of the cost for
orientation data is that hospitals reported a cost figure based on their own individual method for calculating cost rather than a standard method of orientation cost calculation. In addition, the majority of the respondents indicated the cost for orientation was based on the salary of the new employee.

This researcher is concerned that in a time of cost containment due to limited health care reimbursement dollars, approximately 20% of the responding hospitals indicated they did not know the cost associated with nurse orientation in the OR setting. The majority of these hospitals were rural hospitals. This places approximately 20% of operating room orientation programs hospitals in a vulnerable position when discussion of cost-containment measures occurs.

There was a wide range of responses for the average and maximum lengths of orientation. Generally, the rural referral and urban hospitals reported a longer orientation time period as compared to the rural hospitals.

The rural hospitals noted all staff were responsible to assist with orientation of new
employees. The rural referral and urban hospitals identified specific staff positions responsible for the orientation of registered nurses in the operating room setting.

The questions requesting respondents to identify the formal educational preparation, CNOR certification, and advanced educational preparation in the field of adult education of the orientation instructor may serve to describe the current qualification of those serving in this capacity. The CNOR certification is a voluntary certification in perioperative nursing (Fairchild, 1993). Eligibility for the examination includes a minimum of two years of employment in a perioperative setting. These two years of employment may be in a general staff position, a teaching or administrative position, or a research position in the operating room (National Certification Board: Perioperative Nursing, 1992).

The composite of an orientation instructor in Iowa hospitals was that of a nurse with a diploma who may have had continuing education (CE) programs on the topic of adult education and without CNOR certification. This researcher is concerned that those functioning in the role of orientation
instructor may need additional formal education to provide optimum conditions for learning, to provide structure for the orientation program in accordance with adult educational principles, and to meet the needs of the individual learner.

The majority of hospitals implement assessment of knowledge and skills in perioperative nursing prior to, or at the beginning of, orientation by direct observation, interviews with the orientee, and/or written checklists. The information obtained from the orientee regarding assessment of perioperative knowledge and skills coupled with the knowledge, skills, education, and training that is required for each position, as specified in the 1993 Joint Commission for Accreditation of Healthcare Organizations Standards for Orientation, Training, and Education (JCAHO, 1993), provide the framework for developing individualized orientation programs for nurse orientees.

The majority of respondents indicated that the head nurse/nurse manager plans the orientation program. Respondents from rural hospitals also indicated staff nurses provided input into the orientation program whereas rural referral and urban
hospitals indicated orientees and preceptors provide input into planning the orientation program. This researcher is concerned that neither the orientee nor the preceptor is consistently identified by all hospitals as having input into planning an individualized orientation program. The data provided information that is consistent with problems identified in orientation programs by Young, Theriault, and Collins (1989) and Shamian and Inhaber (1985).

The majority of respondents reported the use of a competency-based approach in the orientation program that is consistent with the AORN Competency Model (AORN, 1988), a guideline describing the fundamental knowledge and skills necessary to fulfill the functions and activities of a perioperative nurse. It is interesting to note that the competency-based approach is not as popular with the rural hospitals as with the rural referral and urban hospitals.

The respondents reported the operating room suite, during actual patient care, is the setting most frequently used to implement the orientation program. The next two most common settings were the
simulation laboratory and the classroom. This researcher is concerned that the majority of Iowa hospitals may be using actual patient care situations for new employees to practice skills before demonstrating competency in that skill.

The respondents revealed the topics presented to nurses during the orientation program by 50% or more of the hospitals adhere to the minimum standards established by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO, 1992). This researcher anticipated a higher percentage of hospitals would present information on legal issues, quality assurance, and the nursing process, all of which are topics that appear regularly in nursing literature as well as in curriculums for baccalaureate and master's degree programs in nursing. It was interesting to note that those topics not covered by 50% of respondents included ethical issues, reality/ culture shock, and nursing research.

The respondents identified a limited number of books and journals used in the orientation program. It was not surprising that the hospitals with a greater amount of money (rural referral and urban
hospitals) generally identified the higher number of resources. However, this researcher is concerned that Iowa hospitals are identifying the use of a limited number of books and journals used for the orientation program. For example, approximately one-fourth of the respondents identified the *Standards and Recommended of Practices for Perioperative Nursing* (1992) as a publication used in the orientation program. That leaves three-fourths of Iowa hospitals not identifying standards of practice for perioperative nursing as a resource for the orientation program. With the consistent expansion in technology used in the care of the surgical patient, books and journals are vehicles for the dissemination of such information. The AORN Journal and listings of AORN publications are benefits of membership in the Association of Operating Room Nurses. It is unfortunate that this study did not ask about individual or agency membership in the Association of Operating Room Nursing on the survey, for it may have been helpful in exploring the reasons for the limited amount of resources identified by the respondents.
The Preceptor Program

Approximately 55% of the sample responded affirmatively to the question regarding the use of preceptors in the OR setting. This researcher believes it is important to note that approximately 40% of Iowa hospitals do not currently use preceptors even though the Association of Operating Room Nurses (AORN) recommends the use of preceptors for orientation of nurses to the OR. The majority of hospitals not currently using preceptorships in orientation are classified as rural hospitals.

Of those respondents indicating the use of preceptors, data revealed a change in preceptors at least once and as many as three or more times during the orientation program. This practice is inconsistent with the provision of a consistent one-to-one relationship in the learning process for a new employee as described by Young, Theriault, and Collins (1989). Most respondents indicated the preceptor and orientee share the same work schedule, which is consistent with recommendations by Shamian and Inhaber (1985) as well as Young, Theriault, and Collins (1989). In addition, the data revealed most
of the preceptors are responsible for only one orientee at a time.

In contrast to the literature that recommends that preceptors have a written job description, nearly 40% of the preceptors in Iowa do not have a written job description for their preceptor activities. It is a concern of this researcher that nearly 40% of Iowa hospitals do not provide a written job description for preceptors because such job descriptions provide direction as well as clarification of the preceptor activities for the preceptor, the orientee, OR staff, and the supervisor.

The majority of survey respondents reported that preceptors in Iowa hospitals are provided with an ongoing peer support system. A description of the exact nature of the peer support was not included in this study.

Respondents report most preceptors in Iowa hospitals are chosen by their supervisor/manager. This is consistent with the description of the administrator's roles and responsibilities in preceptor programs (AORN, 1988), which says the administrator is responsible for choosing the persons
best qualified to serve as preceptors.

Data revealed that preceptors in most rural hospitals are not provided with a training session or program. The rural referral and urban hospitals appear to present the most comprehensive preceptor training programs in terms of topics identified on the survey. Even in those hospitals providing a training program/session, it is interesting to note that a limited number of programs cover principles of adult education. The preceptor is responsible for directing the learning experiences of orientees who are adults and the literature recognizes there are unique characteristics of adult learner (AORN, 1988; Knowles, 1980; Lindeman, 1926; Merriam, 1987). If the preceptor is unfamiliar with the principles of adult learning, then this researcher wonders how a preceptor can effectively provide direction and organization to the learning experiences of the orientee.

The literature also describes the phenomenon of culture shock that is experienced by orientees during the orientation time period. Data revealed most preceptor training sessions/programs do not include information on the concept of culture shock. This
This researcher is concerned that preceptor training programs/sessions in Iowa hospitals may not include the concept of culture shock and, therefore, may not prepare the preceptor to assist the orientee when he/she experiences symptoms of culture shock throughout the orientation period.

Most preceptors in Iowa hospitals are not provided with incentives or rewards for their efforts. This is not consistent with the recommendation by Shamian and Inhaber (1985) and Greipp (1989). Recognition serves as a reward to those nurses participating in the development of new staff and is one way to demonstrate administrative support. There is a greater risk for burnout when incentives and rewards are not provided to preceptors (Greipp, 1989). This researcher is concerned that in a time of reduced reimbursement dollars leading to downsizing of hospital nursing staff and increased workload and performance expectations, preceptors in Iowa hospitals are at an even greater risk for burnout because some form of incentives, rewards, or recognition is not provided. Combined with the information on cost of orientation, this researcher questions whether it is really cost
effective not to budget money for incentives when omitting the incentives may lead to preceptor burnout and additional staff turnover.

Several statistics found in this study were comparable to results found in the Alspach (1990b) study. These included the average and maximum lengths of orientation, high cost of orientation, high percentage of respondents indicating the most common setting used in the orientation program was during actual patient care on the clinical unit, the use of the VCR for the orientation program, the limited number of books and journals used for implementation of the orientation program, and demonstration on the clinical unit as the most frequently cited teaching method.

There were three areas where the results of the Alspach (1989b, 1989c) study and this study were not comparable. The provision for a preceptor training program was more common in the Alspach study (1989b) as compared to this study. A higher percentage of the preceptor training programs in the Alspach (1989b) study included a component on the principles of adult education.
Limitations of the Study

1. The use of the Medicare system for classification of hospitals produced three hospital groups of unequal size.

2. Determination of reliability of the survey instrument was not addressed.

3. Respondents identified the estimated cost for orientation without a standardized method for calculation of this cost.

Recommendations for Further Research

Should this study be repeated using the same survey, this researcher recommends the following:

1. Modification of the survey instrument
   a. Include same-day admissions under the question addressing the number of surgeries performed.
   b. Clarify the instructions for questions 4 and 5 by adding a request to fill in all blanks.
   c. Modify the format of questions 14-16 to include a range for time and cost
for the respondent to circle.

2. Continue the use of the Total Design Method (Dillman, 1978).

3. Revise the hospital classification system to provide a more even distribution of hospitals within the three groups.

4. Provide a standardized method for respondents to calculate cost for orientation.

Recommendations for further research on orientation practices for nurses in the operating room setting are as follows:

1. Investigate a cost effective method to prepare preceptors for the infrequent staff turnover in the rural setting.

2. Repeat the study using a sample of 5-10 states located throughout the United States and review the findings in terms of the orientation needs of the rural hospital.
Summary

This study achieved its purpose of examining the methods of orientation for registered nurses employed in operating room settings in hospitals within the state of Iowa. This exploratory process has uncovered much valuable information where very little existed before. The process has also left this researcher believing that much more needs to be done in the identification of the needs for those providing orientation for nurses in hospital OR settings. This study may be viewed as laying the groundwork for further research in the area of operating room orientation for nurses.
REFERENCES


APPENDIX A
PILOT SURVEY FORM
FOR THE STUDY OF ORIENTATION PRACTICES FOR NURSES
IN OPERATING ROOMS IN IOWA HOSPITALS

THE OPERATING ROOM DEPARTMENT

Please answer the following questions about the operating room department. Use the back of this page if you need additional space.

1. Job title of the person completing the survey

2. Number of operating rooms in the institution

3. Number of surgeries performed in the past 12 months
   Of those surgeries indicate the following:
   Outpatient surgeries
   Inpatient surgeries

4. Indicate the number of nurses employed in the operating room in a staff/clinical position according to full time or part time status. (Fill in the blanks)

   Full time: working 36 or more scheduled hours in a work week.
   Part time: working less than 36 scheduled hours in a work week.

<table>
<thead>
<tr>
<th>FULL TIME</th>
<th>PART TIME</th>
</tr>
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<tbody>
<tr>
<td>RNs</td>
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<tr>
<td>GNs</td>
<td></td>
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<tr>
<td>LPNs</td>
<td></td>
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</table>

5. Indicate the number of nurses employed in the operating room in a staff/clinical position according to educational preparation: (Fill in the blanks)
FULL TIME          PART TIME

LPN
Associate degree
Diploma
Baccalaureate degree-Nursing
Baccalaureate degree-other than Nursing
Other

If you answered OTHER to question 5, describe the educational preparation of those nurses employed in the operating room setting.

_________________________________________________________________

THE ORIENTEE'S

Please answer the following questions about nurses hired to work in the operating room setting. Use the back of this page if you need additional space.

6. Number of nurses undergoing orientation to the operating room setting in the past 12 months

7. Indicate the number of nurses undergoing orientation to the operating room setting in the past 12 months according to the following categories:

LICENSED PRACTICAL NURSES WITH EXPERIENCE BUT NEW TO THE OPERATING ROOM

LICENSED PRACTICAL NURSES WITH EXPERIENCE IN THE OPERATING ROOM SETTING

NEW GRADUATE NURSES

REGISTERED NURSES WITH EXPERIENCE BUT NEW TO THE OPERATING ROOM SETTING

REGISTERED NURSES WITH EXPERIENCE IN THE OPERATING ROOM SETTING
The Instructors

Please answer the following questions for each orientation instructor in the operating room department. Use the back of this page if you need additional space.

8. Job title of the person(s) responsible for the implementation of the orientation of new nurses in the operating room setting

9. Number of orientation instructors for the operating room department

10. Educational preparation of the orientation instructor(s):
(Circle the highest level of education completed)

<table>
<thead>
<tr>
<th>INSTRUCTOR(S)</th>
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<tbody>
<tr>
<td>01 ASSOCIATE DEGREE IN NURSING</td>
<td>01</td>
<td>01</td>
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<tr>
<td>02 DIPLOMA IN NURSING</td>
<td>02</td>
<td>02</td>
</tr>
<tr>
<td>03 BACCALAUREATE DEGREE IN NURSING</td>
<td>03</td>
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<tr>
<td>04 BACCALAUREATE DEGREE IN A FIELD OTHER THAN NURSING</td>
<td>04</td>
<td>04</td>
</tr>
<tr>
<td>05 MASTERS DEGREE IN NURSING</td>
<td>05</td>
<td>05</td>
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<tr>
<td>06 MASTERS DEGREE IN A FIELD OTHER THAN NURSING</td>
<td>06</td>
<td>06</td>
</tr>
<tr>
<td>07 OTHER</td>
<td>07</td>
<td>07</td>
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</table>

If you answered OTHER, describe the educational preparation of the orientation instructor.
11. The instructor has attained CNOR certification. (Circle number)  

INSTRUCTORS(S)  

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<tr>
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<th>#1</th>
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<tbody>
<tr>
<td>01 YES</td>
<td>01</td>
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<tr>
<td>02 NO</td>
<td>02</td>
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</table>

12. The instructor has advanced educational preparation (course work, continuing education offering) in the field of adult education. (Circle number)  

INSTRUCTORS(S)  

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<tr>
<td>01 YES</td>
<td>01</td>
<td>01</td>
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<tr>
<td>02 NO</td>
<td>02</td>
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</table>

13. What is the nature of the advanced educational preparation of the orientation instructor in the field of adult education? (Circle number)  

INSTRUCTORS(S)  

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<tbody>
<tr>
<td>01 COURSEWORK IN A COLLEGE OR UNIVERSITY SETTING</td>
<td>01</td>
<td>01</td>
</tr>
<tr>
<td>02 CONTINUING EDUCATION SESSION/WORKSHOP</td>
<td>02</td>
<td>02</td>
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<tr>
<td>03 BOTH</td>
<td>03</td>
<td>03</td>
</tr>
<tr>
<td>04 OTHER</td>
<td>04</td>
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</table>

If you answered OTHER, describe the advanced educational preparation of the orientation instructor in the field of adult education.
THE ORIENTATION PROGRAM

Please answer the following questions about the orientation program in the operating room department. Use the back of this page if you need additional space.

14. What is the average length of time for orientation of nurses employed in the operating room (weeks, months, year)?

15. What is the maximum amount of time allowed for orientation of a nurse to the operating room (weeks, months, year)?

16. What is the estimated cost for orientation of a nurse to the operating room setting?

For questions 17 through 33, a PRECEPTOR refers to an experienced registered nurse who has specific responsibility to provide and direct learning experiences, within the goals and objectives of the orientation program, for the newly hired nurse for the operating room setting.

17. What criteria is used to determine the cost of orientation? (Circle all that apply)
   01 INSTRUCTOR SALARY
   02 PRECEPTOR TIME
   03 SALARY OF THE NEW EMPLOYEE
   04 PREPARATION TIME FOR THE INSTRUCTOR
   05 PREPARATION TIME FOR THE PRECEPTOR
   06 OTHER

If you answered OTHER to question 17, describe the criteria used to determine the cost of orientation for a nurse to the operating room setting.
18. Is a preceptorship used for orientation of the nurse to the operating room setting? (Circle number)
   01 YES
   02 NO

   If YES, answer questions 18 through 32. If NO, move to question 33.

19. Is the preceptor the same person for the entire orientation period? (Circle number)
   01 YES
   02 NO

   If YES, answer question 20. If NO, move to question 21.

20. How often does the preceptor change during the orientation period? (Circle number)
   01 ONCE
   02 TWICE
   03 THREE OR MORE TIMES

21. How many orientees is the preceptor responsible for at one time? (Circle number)
   01 ONE
   02 TWO
   03 THREE OR MORE

22. Do the preceptor and orientee have the same work schedule? (Circle number)
   01 YES
   02 NO

23. Do the preceptors have a written job description for their role? (Circle number)
   01 YES
   02 NO

   If YES is circled answer question 24. If NO is circled, move to question 25.
24. What elements are included in the job description for preceptors? (Circle all that apply)
   01 ROLE OF PRECEPTOR IN THE ORIENTATION PROCESS
   02 EVALUATION OF THE PRECEPTOR
   03 PERFORMANCE CRITERIA FOR THE PRECEPTOR
   04 PRECEPTOR RESPONSIBILITIES TO THE ORIENTEE

25. Do preceptors have an ongoing peer support system to assist them in their role as a preceptor? (Circle number)
   01 YES
   02 NO

26. How are your preceptors selected? (Circle number)
   01 EMPLOYEE VOLUNTEERS
   02 CHOSEN BY SUPERVISOR/MANAGER
   03 OTHER

   If you answered OTHER, describe the way in which preceptors are selected.

27. Is participation as a preceptor by nurses required for advancement in a clinical nursing position? (Circle number)
   01 YES
   02 NO

28. Is a training program/session provided for nurse preceptors as a part of their role preparation? (Circle number)
   01 YES
   02 NO

   If YES, answer questions 29 through 31. If NO, move to question 32.
29. What topics are included as a part of the training program/session for preceptors? (Circle all that apply)
   01 HOW TO ASSESS LEARNING NEEDS
   02 COMMUNICATION TECHNIQUES
   03 LEARNING STYLES
   04 METHODS OF INSTRUCTION
   05 DOCUMENTATION OF ORIENTEES PROGRESS
   06 ROLES AND RESPONSIBILITIES OF THE PRECEPTOR
   07 PRINCIPLES OF ADULT EDUCATION
   08 REALITY SHOCK/CULTURE SHOCK
   09 OTHER

   If you answered OTHER, describe the topics included as a part of the training program/session for preceptors.

30. How long does the training program/session for preceptors last? (Circle number)
   01 LESS THAN 1 DAY
   02 1 DAY
   03 2 DAYS
   03 3 OR MORE DAYS

31. Are incentives, rewards, or recognition provided for those who function in the role as preceptors? (Circle number)
   01 YES
   02 NO

   If YES, answer questions 32. If NO, move to question 33.

32. What type of incentive, reward, or recognition is provided by your institution for nurse preceptors? (Circle all that apply)
   01 BETTER WORK SCHEDULE (HOURS, SHIFTS)
   02 CERTIFICATE / PLAQUE
   03 CITATION (LISTING) IN THE INSTITUTIONAL EMPLOYEE PUBLICATION
   04 COMPENSATORY TIME OFF
   05 INCREASE IN BASE SALARY
   06 INCREASE IN EDUCATIONAL BENEFITS
   07 LUNCHEON FOR ALL PRECEPTORS
   08 PAY DIFFERENTIAL FOR ALL PRECEPTORS
   09 REDUCTION IN WORKLOAD
   10 OTHER
If you marked OTHER for question 32, describe the incentive, reward, or recognition provided by your institution for preceptors in the operating room setting.

The next 00 questions refer to the implementation of the orientation program.

33. Does the orientation program include the assessment of knowledge and skills in perioperative nursing prior to or at the beginning of the orientation program? (Circle number)
   01 YES
   02 NO

If YES, answer questions 34. If NO, move to question 35.

34. Indicate the method of assessment you are currently using. (Circle all that apply)
   01 DIRECT OBSERVATION OF THE ORIENTEE'S PERFORMANCE
   02 INTERVIEW WITH THE ORIENTEE
   03 WRITTEN CHECKLISTS OF REQUIRED KNOWLEDGE AND SKILLS
   04 WRITTEN PRETESTS DEVELOPED BY YOUR INSTITUTION
   05 OTHER

If you answered OTHER, identify the method of assessment of knowledge and skills in perioperative nursing used by your institution.

35. Are there written outcome behaviors for nurses participating in the orientation program? (Circle number)
   01 YES
   02 NO
36. Who participates in planning the orientation program? (Circle all that apply)
01 HEAD NURSES / NURSE MANAGERS
02 ORIENTATION INSTRUCTORS
03 PRECEPTORS
04 ORIENTEE'S
05 STAFF NURSES / CLINICAL NURSES
06 OTHER

If you answered OTHER, identify who participates in planning of the orientation program.

37. Which approach does the orientation program use? (Circle number)
01 COMPETENCY BASED (COMPETENCIES, PERFORMANCE CRITERIA)
02 TRADITIONAL (INSTRUCTIONAL OBJECTIVES)
03 OTHER

If you answered OTHER, explain the approach used with the orientation program.

38. What settings are used to implement the orientation program? (Circle all that apply)
01 CLASSROOM
02 SIMULATION LABORATORY
03 OPERATING ROOM SUITE DURING ACTUAL PATIENT CARE
04 OTHER

If you answered OTHER, explain the setting used for the implementation of the orientation program.
39. What topics are presented to nurses during the orientation program?
(Circle all that apply)
01 ANESTHESIA
02 CLINICAL NURSING RESEARCH
03 DOCUMENTATION OF PATIENT CARE
04 EMERGENCIES IN THE OPERATING ROOM SETTING
05 ETHICAL ISSUES
06 INSTRUMENTATION
07 LEGAL ISSUES
08 METHODS OF STERILIZATION AND DISINFECTION
09 NURSING PROCESS APPLIED IN THE OPERATING ROOM SETTING
10 PATIENT POSITIONING
11 PRINCIPLES OF STERILE TECHNIQUE
12 QUALITY ASSURANCE
13 REALITY SHOCK/CULTURE SHOCK
14 SAFETY FOR PATIENTS AND PERSONNEL
15 STANDARDS OF PERIOPERATIVE NURSING PRACTICE
16 WOUND HEALING
17 OTHER

If you answered OTHER, identify the topics presented during the orientation program.

40. What teaching methods are used during the implementation of the orientation program?
(Circle all that apply)
01 AUDIOVISUAL PROGRAMS
02 COMPUTER ASSISTED INSTRUCTION
03 DEMONSTRATION IN THE OPERATING ROOM SUITE
04 GROUP DISCUSSION
05 LECTURE
06 ROLE PLAY
07 WRITTEN SELF-INSTRUCTION
08 OTHER

If you answered OTHER, explain the teaching method used for implementation of the orientation program.
41. Do other health care professionals participate as instructors in the orientation program? (Circle number)
   01 YES
   02 NO

If you marked YES for question 41, indicate the role of each person participating as an instructor in the orientation program (e.g. physician, surgical technologist).

42. Are any books used as a resource for the orientation program? (Circle number)
   01 YES
   02 NO

If you answered YES, indicate the perioperative books are used as resources for the orientation program. (Fill in the information requested. Continue on the back if you need additional space)

<table>
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<tr>
<th>AUTHOR</th>
<th>TITLE</th>
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43. Are any journals are used as resources for the orientation program? (Circle number)
   01 YES
   02 NO

If you answered YES, indicate the journals used as resources for the orientation program (Fill in the information requested. Continue on the back if you need additional space)

<table>
<thead>
<tr>
<th>NAME OF JOURNAL</th>
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<td>2.</td>
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<td>3.</td>
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</table>
44. Are any types of audiovisual equipment are used during the orientation program? 
(Circle number) 
01 YES 
02 NO 

If YES, answer question 45. 
If NO, move to question 46.

45. What types of audiovisual equipment are used during the orientation program? (Circle all that apply) 
01 AUDIO TAPES 
02 COMPUTERS 
03 CLOSED CIRCUIT TV 
04 EASEL / CHALKBOARD 
05 OVERHEAD PROJECTOR 
06 SLIDE PROJECTOR 
07 VIDEO CASSETTE PLAYER 
08 OTHER 

If you OTHER, identify the audiovisual equipment used in the orientation program.

46. Identify any teaching/learning aids used in conjunction with the orientation program. 
(Circle all that apply) 
01 BULLETIN BOARDS 
02 FLIP CHARTS 
03 THREE DIMENSIONAL MODELS 
04 POSTERS 
05 NONE 
06 OTHER 

If you answered OTHER, identify the teaching learning aid used in the orientation program.

The final 3 questions refer to the evaluation of the nurse orientee in the orientation program.
47. Are written tests used in the evaluation process of the nurse orientee during the orientation program? (Circle number)
   01 YES
   02 NO

   If YES, answer questions 48.
   If NO, move to question 49.

48. What type of questions are used in the written tests? (Circle all that apply)
   01 ESSAY
   02 FILL-IN-THE-BLANK
   03 MATCHING
   04 MULTIPLE CHOICE
   05 TRUE / FALSE
   06 SHORT ANSWER

49. How do you determine when a nurse orientee has successfully completed his/her orientation to the operating room setting? (Circle all that apply)
   01 EVALUATION OF OUTCOME BEHAVIORS FOR ORIENTATION
   02 FEEDBACK FROM THE ORIENTEE
   03 FEEDBACK FROM THE PRECEPTOR
   04 FEEDBACK FROM OTHER MEMBERS OF THE HEALTH TEAM
   05 CLINICAL SKILLS PERFORMANCE TESTING
   06 OTHER

   If you answered FEEDBACK FROM OTHER MEMBERS OF THE HEALTH TEAM, indicate the role of each person giving feedback (e.g. physician, surgical technologist).

   If you answered OTHER, identify how you determine the nurse orientee has successfully completed the orientation program.

   THANK YOU FOR YOUR ASSISTANCE IN THIS STUDY. PLEASE RETURN THIS SURVEY IN THE ENVELOPE PROVIDED.
APPENDIX B
PILOT PARTICIPANT LETTER

Date
Name of Hospital/Medical Center
(address)
(city), (state) (zip code)

Dear , (Pilot participant)

I am a graduate nursing student at Drake University preparing to conduct a study of orientation programs for nurses working in operating room settings in hospitals and medical centers in Iowa. As an orientation instructor in the operating room setting, I am concerned about how the orientation needs of the nurse employees are being met. The study I am planning to undertake will describe the methods of orientation for nurses in operating room settings in hospitals in Iowa.

In preparing to conduct this study I am requesting your assistance. Before sending the materials for the major study, I could benefit from your honest feedback. You are familiar with the operating room setting as well as the use of preceptors in a nursing situation and are in the best position to critique these materials. I am interested in whether the instructions for completion of the survey are clear, the amount of time required to complete the survey, whether you feel any of the questions are inappropriate, and whether you are able to access information requested in the questions. I am enclosing a response form for you to complete, but feel free to make any comments directly on the form as well.

You may be assured of absolute confidentiality in completing the survey and response form as your name will never be associated with either document. Identification numbers are included in the survey form for mailing purposes only.

Completion of the questionnaire and response form and its return will be an indication of informed consent and your willingness to be a part of the study. Your prompt return of the survey and response form in the enclosed envelope will be appreciated. Your response is very important to the success of the planned study. Please understand your institution will be included in the actual study.
Thank you for considering participating in this study. If you have any questions about this pilot study, please feel free to contact me at (515) 224-0958 or Dr. Linda H. Brady, Director of the Division of Nursing at Drake University, at (515) 271-2830.

Sincerely,

Carol H. Hull R. N., B. S. N.
2001 Elm Circle
West Des Moines, IA 50265
APPENDIX C

RESPONSE FORM
FOR THE PILOT STUDY OF
ORIENTATION PRACTICES FOR NURSES
IN OPERATING ROOMS IN IOWA HOSPITALS

Please feel free to make any comments directly on the survey.

1. What was the approximate time spent completing the survey form? __________

2. In order to achieve the purpose of the planned study, do you feel the amount of time spent completing this survey was reasonable? (Circle number)
   01 YES
   02 NO

If NO, what amount of time would be reasonable? __________

3. Were the instructions clear (this includes the cover letter, survey, and follow-up correspondence)? (Circle number)
   01 YES
   02 NO

If NO, please specify which areas you found confusing. What suggestions do you have for making the instructions clearer?

4. Did you find any of the questions unclear? (Circle one)
   01 YES
   02 NO

If YES, please specify which questions you found unclear. What suggestions do you have for making the questions clearer?
5. Please include any additional comments regarding the survey form, the cover letter, the follow-up correspondences, or the study itself.

Dear

I am a graduate student at the University of Iowa, conducting research on the topic of work stress and support for nurses working in the operating room setting. As part of this research, I am currently conducting a survey to assess the experiences of nurses employed at various hospitals within Iowa.

IN ORDER TO OBTAIN A COMPLETE PICTURE of your working environment, I am asking you to complete this survey. The survey is confidential and the information you provide will be used to improve the working conditions of nurses in the operating room setting. The survey will take approximately 10 minutes to complete.

The survey is designed to assess your experiences over the past year. You may be contacted by email or phone to discuss your responses. The survey responses will be compiled into a report, which will be shared with the nursing administration at your hospital. The survey responses will be used to identify areas for improvement and to plan interventions to support nurses in the operating room setting.

Completion of this survey is voluntary, and your participation will not affect your job performance. Your responses will be kept confidential, and your name will not be associated with your responses. No identifying information will be included in the survey results. The survey results will be used to improve the working conditions of nurses in the operating room setting.

Should you have any questions about the survey or the research, please contact me by email at [email address] or by phone at [phone number]. The results of the study will be published in a journal and made available to the public.

Thank you for your time and effort in completing this survey. Your participation is greatly appreciated.

Sincerely,

[Your Name]
APPENDIX D

LETTER #1 to DIRECTORS OF NURSING

Date
Name of Hospital/Medical Center
(address)
(city), (state) (zip code)

Dear , (Director of Nursing)

I am a graduate nursing student at Drake University conducting a study of orientation programs for nurses working in operating room settings in hospitals and medical centers in Iowa. As an orientation instructor in the operating room setting, I am concerned about how the orientation needs of the nurse employees are being met. The study I am undertaking will describe the methods of orientation for nurses in operating room settings in hospitals within Iowa.

IN ORDER TO CONDUCT THIS STUDY I AM REQUESTING YOUR HELP. Your institution is one of 125 hospitals within Iowa who provide surgical services. While you are under no obligation to participate in this study, I am asking you, or the person in your institution responsible for orientation of nurses to the operating room setting, to complete the enclosed survey by September 25, 1992 and return it in the enclosed envelope.

You may be assured of absolute confidentiality in completing the survey as your name will never be associated with it. Identification numbers are included in the survey form for mailing purposes only. These numbers will be used to check your institutions name off as the survey and response forms are returned.

Completion of the survey and its return will be an indication of informed consent and your willingness to be a part of the study. Your prompt return of the survey and response form in the enclosed envelope will be appreciated. Your response is very important to the success of this study. Should you wish to withdraw from the study at any time, please write to me and enclose the number of your survey and it will be withdrawn. The results of the study will be mailed to all who complete the survey response form.
Thank you for considering participating this study. If you have any questions about the study, please feel free to contact myself at (515) 224-0958 or Dr. Linda H. Brady, Director of the Division of Nursing at Drake University, at (515) 271-2830. 

Sincerely,

Carol H. Hull R. N., B. S. N.
2001 Elm Circle
West Des Moines, IA 50265

If you need a replacement questionnaire, please call me, 515-224-0958, and I will mail you another questionnaire today.

Sincerely,

Carol Hull, R. N., B. S. N.
APPENDIX E
POST CARD TO DIRECTORS OF NURSING

Date

Dear , (Director of Nursing)

Last week a questionnaire seeking your input about the methods of orientation for nurses practicing in operating room settings within hospitals in Iowa.

If you or the person to whom you delegated the completion of the questionnaire have completed and returned the questionnaire, please accept my sincere thanks. If you have not completed the questionnaire, and are willing to participate in the study, please complete the form in the next 48 hours. Your input is very important to the success of the study.

If you need a replacement questionnaire, please call me, 515-224-0958, and I will mail you another questionnaire today.

Sincerely,

Carol Hull, R.N., B.S.N.
APPENDIX F
LETTER #2 TO DIRECTORS OF NURSING

Date
Name of Hospital/Medical Center
(address)
(city), (state) (zip code)

Dear , (Director of Nursing)

Several weeks ago you were invited to participate in a study about the orientation practices for nurses within the operating room setting in Iowa hospitals. Because your participation is valued, I am sending you a questionnaire with the hope that you will find time in the next two days to complete it.

The study I am undertaking, as a graduate nursing student at Drake University, will describe the methods of orientation for nurses in operating room settings in hospitals within Iowa. As an orientation instructor in the operating room setting, I am concerned about how the orientation needs of the nurse employees are being.

Your institution is one of 122 hospitals within Iowa who provide surgical services. While you are under no obligation to participate in this study, I am asking you, or the person in your institution who is responsible for orientation of nurses to the operating room setting, to complete the enclosed survey by October 15, 1992 and return it in the envelope provided.

You may be assured of absolute confidentiality in completing the survey as your name will never be associated with it. Identification numbers are included in the survey form for mailing purposes only. These numbers will be used to check your institutions name off as the survey and response forms are returned.

Completion of the survey will be an indication of informed consent and your willingness to be a part of the study. Your prompt return of the survey and response form in the enclosed envelope will be appreciated. Your response is very important to the success of this study. Should you wish to withdraw from the study at any time, please write to me and
enclose the number of your survey and it will be withdrawn. The results of the study will be mailed to all who complete the survey response form.

Thank you for considering participating in this study. If you have any questions about the study, please feel free to contact myself at (515) 224 - 0958 or Dr. Linda H. Brady, Director of the Division of Nursing at Drake University, at (515) 271 - 2830.

Sincerely,

Carol H. Hull R. N., B. S. N.
2001 Elm Circle
West Des Moines, IA  50265
APPENDIX G
SURVEY FORM
FOR THE STUDY OF ORIENTATION PRACTICES FOR NURSES
IN OPERATING ROOMS IN IOWA HOSPITALS

THE OPERATING ROOM DEPARTMENT

Please answer the following questions about the operating room department. Use the back of this page if you need additional space.

1. Job title of the person completing the survey _______________________

2. Number of operating rooms in the institution _______________________

3. Number of surgeries performed in the past 12 months ___________
   Of those surgeries indicate the following:
   Outpatient surgeries ________
   Inpatient surgeries ________

4. Indicate the number of nurses employed in the operating room in a staff/clinical position according to full time or part time status. (Fill in the blanks)
   Full time: working 36 or more scheduled hours in a work week.
   Part time: working less than 36 scheduled hours in a work week.
   FULL TIME PART TIME
   RNs ________ ________
   GNs ________ ________
   LPNs ________ ________

5. Indicate the number of nurses employed in the operating room in a staff/clinical position according to educational preparation: (Fill in the blanks)
<table>
<thead>
<tr>
<th>FULL TIME</th>
<th>PART TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>LPN</td>
<td></td>
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<tr>
<td>Associate degree</td>
<td></td>
</tr>
<tr>
<td>Diploma</td>
<td></td>
</tr>
<tr>
<td>Baccalaureate degree-Nursing</td>
<td></td>
</tr>
<tr>
<td>Baccalaureate degree-other than Nursing</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

If you answered OTHER to question 5, describe the educational preparation of those nurses employed in the operating room setting.

THE ORIENTEE'S

Please answer the following questions about nurses hired to work in the operating room setting. Use the back of this page if you need additional space.

6. Number of nurses undergoing orientation to the operating room setting in the past 12 months

7. Indicate the number of nurses undergoing orientation to the operating room setting in the past 12 months according to the following categories:

LICENSED PRACTICAL NURSES WITH EXPERIENCE BUT NEW TO THE OPERATING ROOM

LICENSED PRACTICAL NURSES WITH EXPERIENCE IN THE OPERATING ROOM SETTING

NEW GRADUATE NURSES

REGISTERED NURSES WITH EXPERIENCE BUT NEW TO THE OPERATING ROOM SETTING

REGISTERED NURSES WITH EXPERIENCE IN THE OPERATING ROOM SETTING
THE INSTRUCTORS

Please answer the following questions for each orientation instructor in the operating room department. Use the back of this page if you need additional space.

8. Job title of the person(s) responsible for the implementation of the orientation of new nurses in the operating room setting

9. Number of orientation instructors for the operating room department

10. Educational preparation of the orientation instructor(s):
(Circle the highest level of education completed for each instructor)

<table>
<thead>
<tr>
<th>INSTRUCTOR(S)</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 ASSOCIATE DEGREE IN NURSING</td>
<td>01</td>
<td>01</td>
<td>01</td>
</tr>
<tr>
<td>02 DIPLOMA IN NURSING</td>
<td>02</td>
<td>02</td>
<td>02</td>
</tr>
<tr>
<td>03 BACCALAUREATE DEGREE IN NURSING</td>
<td>03</td>
<td>03</td>
<td>03</td>
</tr>
<tr>
<td>04 BACCALAUREATE DEGREE IN A FIELD OTHER THAN NURSING</td>
<td>04</td>
<td>04</td>
<td>04</td>
</tr>
<tr>
<td>05 MASTERS DEGREE IN NURSING</td>
<td>05</td>
<td>05</td>
<td>05</td>
</tr>
<tr>
<td>06 MASTERS DEGREE IN A FIELD OTHER THAN NURSING</td>
<td>06</td>
<td>06</td>
<td>06</td>
</tr>
<tr>
<td>07 OTHER</td>
<td>07</td>
<td>07</td>
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</table>

If you answered OTHER, describe the educational preparation of the orientation instructor.

11. The instructor has attained CNOR certification.
(Circle number)

<table>
<thead>
<tr>
<th>INSTRUCTOR(S)</th>
<th>A</th>
<th>B</th>
<th>C</th>
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<tbody>
<tr>
<td>01 YES</td>
<td>01</td>
<td>01</td>
<td>01</td>
</tr>
<tr>
<td>02 NO</td>
<td>02</td>
<td>02</td>
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</tbody>
</table>
12. The instructor has advanced educational preparation course work, continuing education offering) in the field of adult education.

(Circle number)  

<table>
<thead>
<tr>
<th>Instructor(s)</th>
<th>A</th>
<th>B</th>
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<tbody>
<tr>
<td>01 YES</td>
<td>01</td>
<td>01</td>
<td>01</td>
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<tr>
<td>02 NO</td>
<td>02</td>
<td>02</td>
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13. What is the nature of the advanced educational preparation of the instructor in the field of adult education?

(Circle number)  

<table>
<thead>
<tr>
<th>Instructor(s)</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 COURSEWORK IN A COLLEGE OR UNIVERSITY SETTING</td>
<td>01</td>
<td>01</td>
<td>01</td>
</tr>
<tr>
<td>02 CONTINUING EDUCATION SESSION/WORKSHOP</td>
<td>02</td>
<td>02</td>
<td>02</td>
</tr>
<tr>
<td>03 BOTH</td>
<td>03</td>
<td>03</td>
<td>03</td>
</tr>
<tr>
<td>04 OTHER</td>
<td>04</td>
<td>04</td>
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</table>

If you answered OTHER, describe the advanced educational preparation of the instructor in the field of adult education.

THE ORIENTATION PROGRAM

Please answer the following questions about the orientation program in the operating room department. Use the back of this page if you need additional space.

14. What is the average length of time for orientation of nurses employed in the operating room (weeks, months, year)?

15. What is the maximum amount of time allowed for orientation of a nurse to the operating room (weeks, months, year)?
16. What is the estimated cost for orientation of a nurse to the operating room setting? ________________

For questions 17 through 33, a PRECEPTOR refers to an experienced registered nurse who has specific responsibility to provide and direct learning experiences, within the goals and objectives of the orientation program, for the newly hired nurse for the operating room setting.

17. What criteria is used to determine the cost of orientation? (Circle all that apply)
   01 INSTRUCTOR SALARY
   02 PRECEPTOR TIME
   03 SALARY OF THE NEW EMPLOYEE
   04 PREPARATION TIME FOR THE INSTRUCTOR
   05 PREPARATION TIME FOR THE PRECEPTOR
   06 OTHER

If you answered OTHER to question 17, describe the criteria used to determine the cost of orientation for a nurse to the operating room setting.

________________________________________________________________________

18. Is a preceptorship used for orientation of the nurse to the operating room setting? (Circle number)
   01 YES
   02 NO

If YES, answer questions 18 through 32. If No, move to question 33.

19. Is the preceptor the same person for the entire orientation period? (Circle number)
   01 YES
   02 NO

If YES, answer question 20. If NO, move to question 21.
20. How often does the preceptor change during the orientation period? (Circle number)
   01 ONCE
   02 TWICE
   03 THREE OR MORE TIMES

21. How many orientees is the preceptor responsible for at one time? (Circle number)
   01 ONE
   02 TWO
   03 THREE OR MORE

22. Do the preceptor and orientee have the same work schedule? (Circle number)
   01 YES
   02 NO

   If YES is circled answer question 24.
   If NO is circled, move to question 25.

23. Do the preceptors have a written job description for their role? (Circle number)
   01 YES
   02 NO

24. What elements are included in the job description for preceptors? (Circle all that apply)
   01 ROLE OF PRECEPTOR IN THE ORIENTATION PROCESS
   02 EVALUATION OF THE PRECEPTOR
   03 PERFORMANCE CRITERIA FOR THE PRECEPTOR
   04 PRECEPTOR RESPONSIBILITIES TO THE ORIENTEE

25. Do preceptors have an ongoing peer support system to assist them in their role as a preceptor? (Circle number)
   01 YES
   02 NO

26. How are your preceptors selected? (Circle number)
   01 EMPLOYEE VOLUNTEERS
   02 CHOSEN BY SUPERVISOR/MANAGER
   03 OTHER
If you answered OTHER, describe the way in which preceptors are selected.

27. Is participation as a preceptor by nurses required for advancement in a clinical nursing position? (Circle number)
   01 YES
   02 NO

28. Is a training program/session provided for nurse preceptors as a part of their role preparation? (Circle number)
   01 YES
   02 NO

   If YES, answer questions 29 through 31. If NO, move to question 32.

29. What topics are included as a part of the training program/session for preceptors? (Circle all that apply)
   01 HOW TO ASSESS LEARNING NEEDS
   02 COMMUNICATION TECHNIQUES
   03 LEARNING STYLES
   04 METHODS OF INSTRUCTION
   05 DOCUMENTATION OF ORIENTEES PROGRESS
   06 ROLES AND RESPONSIBILITIES OF THE PRECEPTOR
   07 PRINCIPLES OF ADULT EDUCATION
   08 REALITY SHOCK/CULTURE SHOCK
   09 OTHER

   If you answered OTHER, describe the topics included as a part of the training program/session for preceptors.

30. How long does the training program/session for preceptors last? (Circle number)
   01 LESS THAN 1 DAY
   02 1 DAY
   03 2 DAYS
   03 3 OR MORE DAYS
31. Are incentives, rewards, or recognition provided for those who function in the role as preceptors? (Circle number)
   01 YES
   02 NO

   If YES, answer questions 32. If NO, move to question 33.

32. What type of incentive, reward, or recognition is provided by your institution for nurse preceptors?
   (Circle all that apply)
   01 BETTER WORK SCHEDULE (HOURS, SHIFTS)
   02 CERTIFICATE / PLAQUE
   03 CITATION (LISTING) IN THE INSTITUTIONAL EMPLOYEE PUBLICATION
   04 COMPENSATORY TIME OFF
   05 INCREASE IN BASE SALARY
   06 INCREASE IN EDUCATIONAL BENEFITS
   07 LUNCHEON FOR ALL PRECEPTORS
   08 PAY DIFFERENTIAL FOR ALL PRECEPTORS
   09 REDUCTION IN WORKLOAD
   10 OTHER

   If you marked OTHER for question 32, describe the incentive, reward, or recognition provided by your institution for preceptors in the operating room setting.

________________________________________________________________________

The next 00 questions refer to the implementation of the orientation program.

33. Does the orientation program include the assessment of knowledge and skills in perioperative nursing prior to or at the beginning of the orientation program? (Circle number)
   01 YES
   02 NO

   If YES, answer questions 34. If NO, move to question 35.
34. Indicate the method of assessment you are currently using. (Circle all that apply)
   01 DIRECT OBSERVATION OF THE ORIENTEE'S PERFORMANCE
   02 INTERVIEW WITH THE ORIENTEE
   03 WRITTEN CHECKLISTS OF REQUIRED KNOWLEDGE AND SKILLS
   04 WRITTEN PRETESTS DEVELOPED BY YOUR INSTITUTION
   05 OTHER

   If you answered OTHER, identify the method of assessment of knowledge and skills in perioperative nursing used by your institution.

35. Are there written outcome behaviors for nurses participating in the orientation program? (Circle number)
   01 YES
   02 NO

36. Who participates in planning the orientation program? (Circle all that apply)
   01 HEAD NURSES / NURSE MANAGERS
   02 ORIENTATION INSTRUCTORS
   03 PRECEPTORS
   04 ORIENTEE'S
   05 STAFF NURSES / CLINICAL NURSES
   06 OTHER

   If you answered OTHER, identify who participates in planning of the orientation program.

37. Which approach does the orientation program use? (Circle number)
   01 COMPETENCY BASED (COMPETENCIES, PERFORMANCE CRITERIA)
   02 TRADITIONAL (INSTRUCTIONAL OBJECTIVES)
   03 OTHER

   If you answered OTHER, explain the approach used with the orientation program.
38. What settings are used to implement the orientation program?
(Circle all that apply)
01 CLASSROOM
02 SIMULATION LABORATORY
03 OPERATING ROOM SUITE DURING ACTUAL PATIENT CARE
04 OTHER

If you answered OTHER, explain the setting used for the implementation of the orientation program.

39. What topics are presented to nurses during the orientation program?
(Circle all that apply)
01 ANESTHESIA
02 CLINICAL NURSING RESEARCH
03 DOCUMENTATION OF PATIENT CARE
04 EMERGENCIES IN THE OPERATING ROOM SETTING
05 ETHICAL ISSUES
06 INSTRUMENTATION
07 LEGAL ISSUES
08 METHODS OF STERILIZATION AND DISINFECTION
09 NURSING PROCESS APPLIED IN THE OPERATING ROOM SETTING
10 PATIENT POSITIONING
11 PRINCIPLES OF STERILE TECHNIQUE
12 QUALITY ASSURANCE
13 REALITY SHOCK/CULTURE SHOCK
14 SAFETY FOR PATIENTS AND PERSONNEL
15 STANDARDS OF PERIOPERATIVE NURSING PRACTICE
16 WOUND HEALING
17 OTHER

If you answered OTHER, identify the topics presented during the orientation program.
40. What teaching methods are used during the implementation of the orientation program? (Circle all that apply)
   01 AUDIOVISUAL PROGRAMS
   02 COMPUTER ASSISTED INSTRUCTION
   03 DEMONSTRATION IN THE OPERATING ROOM SUITE
   04 GROUP DISCUSSION
   05 LECTURE
   06 ROLE PLAY
   07 WRITTEN SELF-INSTRUCTION
   08 OTHER

   If you answered OTHER, explain the teaching method used for implementation of the orientation program.

41. Do other health care professionals participate as instructors in the orientation program? (Circle number)
   01 YES
   02 NO

   If you marked YES for question 41, indicate the role of each person participating as an instructor in the orientation program (e.g. physician, surgical technologist).

42. Are any books used as a resource for the orientation program? (Circle number)
   01 YES
   02 NO

   If you answered YES, indicate the perioperative books are used as resources for the orientation program. (Fill in the information requested. Continue on the back if you need additional space)

<table>
<thead>
<tr>
<th>AUTHOR</th>
<th>TITLE</th>
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<tbody>
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<td>3.</td>
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</tr>
</tbody>
</table>
43. Are any journals are used as resources for the orientation program? (Circle number)
   01 YES
   02 NO

   If you answered YES, indicate the journals used as resources for the orientation program
   (Fill in the information requested. Continue on the back if you need additional space)

   NAME OF JOURNAL
   1._________________________________________
   2._________________________________________
   3._________________________________________

44. Are any types of audiovisual equipment are used during the orientation program? (Circle number)
   01 YES
   02 NO

   If YES, answer question 45.
   If NO, move to question 46.

45. What types of audiovisual equipment are used during the orientation program? (Circle all that apply)
   01 AUDIO TAPES
   02 COMPUTERS
   03 CLOSED CIRCUIT TV
   04 EASEL / CHALKBOARD
   05 OVERHEAD PROJECTOR
   06 SLIDE PROJECTOR
   07 VIDEO CASSETTE PLAYER
   08 OTHER

   If you OTHER, identify the audiovisual equipment used in the orientation program.

46. Identify any teaching/learning aids used in conjunction with the orientation program.
   (Circle all that apply)
   01 BULLETIN BOARDS
   02 FLIP CHARTS
   03 THREE DIMENSIONAL MODELS
   04 POSTERS
   05 NONE
   06 OTHER
If you answered OTHER, identify the teaching learning aid used in the orientation program.

Questions 47 to 49 refer to the evaluation of the nurse orientee in the orientation program.

47. Are written tests used in the evaluation process of the nurse orientee during the orientation program? (Circle number)
   01 YES
   02 NO

If YES, answer questions 48.
If NO, move to question 49.

48. What type of questions are used in the written tests? (Circle all that apply)
   01 ESSAY
   02 FILL-IN-THE-BLANK
   03 MATCHING
   04 MULTIPLE CHOICE
   05 TRUE / FALSE
   06 SHORT ANSWER

49. How do you determine when a nurse orientee has successfully completed his/her orientation to the operating room setting? (Circle all that apply)
   01 EVALUATION OF OUTCOME BEHAVIORS FOR ORIENTATION
   02 FEEDBACK FROM THE ORIENTEE
   03 FEEDBACK FROM THE PRECEPTOR
   04 FEEDBACK FROM OTHER MEMBERS OF THE HEALTH TEAM
   05 CLINICAL SKILLS PERFORMANCE TESTING
   06 OTHER

If you answered FEEDBACK FROM OTHER MEMBERS OF THE HEALTH TEAM, indicate the role of each person giving feedback (e.g. physician, surgical technologist).
If you answered OTHER, identify how you determine the nurse orientee has successfully completed the orientation program.

50. Please add any additional comments regarding orientation of nurses to the operating room setting. If you need additional space use the back of this page.

THANK YOU FOR YOUR ASSISTANCE IN THIS STUDY. PLEASE RETURN THIS SURVEY IN THE ENVELOPE PROVIDED.
APPENDIX H

Extraneous Data from Surveys

Q-17. Criteria to determine the cost of orientation:

Cost of equipment and supplies: cost of educational materials.

Experience of the orientee - obviously the cost will be lower for a 4 month orientation than a twelve month orientation.

Have never calculated the cost.

New OR staff trained by charge nurse and fellow staff.

Benefits; staff nurse salary.

The staff nurse's salary while she is orienting the new OR nurse.

Q-18. Use of preceptorship for orientation

Loosely - mainly OR nurse manager responsibility but other RNS pitch in when she is tied up.

Q-20. Frequency of preceptor change during orientation:

1 preceptor for each specialty.

Changes for different specialties.

One RN preceptor is consistent for oversight purposes but each specialty utilizes a specific staff member.

Q-25. Ongoing peer support system for preceptors:

A yearly review (for preceptors) is offered.
Q-26. Selection of preceptors:

Combination of employee volunteers and chosen by supervisor.

Written application - approval by OR management council.

Q-28. Training program provided for preceptors

Has been in the past.

Q-29. Topics included in preceptor training program

Overview of preceptor program, building a professional relationship.

Methods of evaluation, problem solving, delegation.

Q-32. Type of incentive, reward, or recognition

We have a small unit - this is an expectation
Given recognition in performance appraisal
No other recognition.

Can apply to clinical ladder.

Factored into evaluation and therefore indirectly - increase in base salary.

They receive compensation as part of annual evaluation.

CEUs for training day; ongoing meetings with other preceptors; recognition on the clinical ladder; recognition pins.

Included in proficiency which goes before the governing body in this hospital system which approves promotions or special advancements.

Points on clinical ladder - pay bonus.
Q-36. Participants who plan the orientation program
Nurse clinicians in each specialty.
Hospital nursing educator.
Director of Nursing
CST, CRNA

Q-38. Settings used to implement the orientation program
Use empty OR room for role playing.
Crossover to PACU, central service and same day surgery as observation.
Office
Video tape viewing.
I usually work with the employee on days when there is no surgery. We do all sterilizing and wrapping too.

Q-39. Topics presented during orientation program
How to do patient teaching (preop teaching program).
Preoperative skin preparation, monitoring the patient during local anesthesia or IV sedation, traffic patterns, suture and wound closure devices, electrosurgical and other equipment information, malignant hyperthermia, specimen handling, blood administration.
Laser safety and radiation safety.
Accountability and liability.
Scrub duties, procedures, sutures.

Q-45. Types of audiovisual equipment used in the orientation program
The OR manual.
Q-46. Teaching/learning aids used in the orientation program

Specific articles in the literature and specific instructional books made by the orientation instructor.

Manuals

Q-50. Additional comments

Rural hospitals

We have a very small department and have had one orientee (an experienced nurse with many years of OR and managerial experience) in the past 5 years.

Our orientation is informal but we do cover all the basics and orientee has back-up with her for as long as needed. We do not "throw her to sink or swim".

We have a small staff without much turnover. We do interact with the orientee several times a day. We do have a good preceptor for them to work with.

Biggest obstacle in orientation has been lack of repetitiveness. Sent LPN to a large facility to learn to scrub. Made outcome goals and set schedule with supervisors at other facility. LPN was able to scrub for several of like cases with specialists which serve our facility. Use Davis and Geck - AORN series. Use films for our hip systems equipment, etc. and return demonstrations a lot. Moving into a new OR Nov. 10. Will be admitting and dismissing patient from area, so will be training staff for expanded role, new staff, new positions, new equipment, and new C.S.

We do not have an extensive training program. I demonstrate the prepping and positioning and explanations and then let new trainee do it while I "talk her through it." Then we discuss any omissions or other possible technique problems after and the reasons for doing it.
As we are just re-opening our 2 suite OR, we have not established a formal orientation program. We are anxious to hear any feedback you may have from this survey.

We have only 4 of us in our department - so orientation is "hands on" most of the time after some lecture. I usually have the new gal work with me until I feel she is comfortable and I'm comfortable with her work, then put her on rotating call.

We are very small and our OR supervisor spends a lot of 1:1 time with the new employees in her department.

I could use a good "sample" orientation packet - I feel our program is too much "hit or miss."

We implement on the job training almost exclusively with the other staff nurses teaching and orienting the new OR RN until she is ready to assume responsibilities on her own.

I feel OR orientation is a lengthy process. An RN may have been oriented and feel comfortable doing her job and then something else comes in she hasn't seen before. Positive attitude on the part of the RN and spirit of cooperation from medical staff is a must!

The RN's and ORT's do a lot of the orientation as a back-up in actual cases.

Since we are a small department everyone assists with orientation and have a checklist as things are covered and a checklist as they are performed. When I feel they have a good enough understanding and skill performance, they are assigned to call. Their orientation may continue on for several months until all skills are performed.

The nurses are generally the ones that are familiar with the hospital and its policies because they are med-surg nurses in our facility—may already have had OR experience.
Since we are a small hospital all orientation is on a 1:1 basis with checklist to cover all areas.

I feel it is important for a new employee to have adequate orientation to meet the needs of new employee and employer by proper availability of orientation.

The reason we allow 3 months orientation is because of our volume. We usually do surgery 2 times per week, and exposure is limited to kinds of cases you can observe during that time. With having only one OR suite, and my working in the OR with the new orientee, it is not difficult to decide when they have met the goals.

When look at new people for the OR we like them to have had some medical-surgical experience or OB experience for they are comfortable with regular nursing problems. Our nurses are ACLS and neonate certified.

The whole orientation process is a more job oriented or on the job training type of orientation. Through observation and listening we can get a feel for their readiness to function as a member of the OR team.

Turnover in our surgery is minimal. Candidates are closely screened before hiring. As we are a part of a larger hospital network, the one new hire we have had in the last 5 years did spend several days at [hospital name] for updating new techniques.

In a small hospital we do not have volume so it may take a new employee longer to learn in a specialty department. I use the buddy system and have the orientee demonstrate all procedures back after initial demonstration. Then they are monitored carefully until they feel comfortable with their role. It takes some nurses longer than others.

We are a small hospital - no one works OR full time. OR nurses are on call 24 hours a day - there may be weeks when they are not needed.
Orientation is an ongoing concern, especially for nurses new to the OR setting. I would appreciate any information back on that.

As we are a small hospital, there are usually only 2 professionals (RNs) involved in orientation so it is very much like a preceptorship.

We have a very small hospital. Our orientation program is basically all done by staff members.

We have a very small department. It is easy to give close and complete orientation by the staff. We had our most recent orientee 18 months ago, an LPN. She is well adjusted and functions completely independently.

Rural Referral hospitals

Our orientation program is in the process of being re-developed and updated. Many ideas to develop competencies are in the process of being put into practice.

Orientation is dependant on frequency and types of cases being done and the exposure of the new employee. Some orient faster than others. We also utilize a back-up call person after the 6 month orientation. A nurse remains available to assist on call for an individualized amount of time.

One preceptor used usually - occasionally 2 for the same person to provide a variety of ideas. Begins with an easy area and advances to difficult areas. If not ready in 5-6 months - can extend time period. Begins to take call at 6 months. We are currently utilizing a new manual to assist with orientation (AORN Blueprint for Orientation).
Urban hospitals

Orientation has been the weakest link in our OR setting. We re-evaluate the existing methodology which was loosely structured and the responsibility of one individual. In the last year we totally re-designed our orientation program to have a more consistent methodology. We re-structured our education committee which is inclusive of 13 staff nurses. This committee is responsible for orientation, preceptors, inservices, competency and skill labs, recommendations for policies and procedures, and quality issues and research. It is still in its infancy stage of development, but has proven to be much more effective and efficient in orientation of new nurses as well as continuing education for all OR personnel.

All RN's working in OR will attend a perioperative nursing course provided by the hospital (45 hours) during or after orientation.

I think we have a dynamic orientation program here!!

Our nurses also work in PACU when necessary. Our PACU nurses take call and help in the OR as well. The total number of RN's includes 2 from PACU.

Our orientation program is set up as follows: 2-3 weeks general OR information based on the skills of the individual. We have 5 specialty teams at the conclusion of those first 2-3 weeks so the RN will be functional on off shifts and may cross over into other teams. They have an average of 3 days to 2 weeks of orientation before being assigned to the nurse clinician on the team for which they were hired. The team orientation time schedule is based entirely on the skills and level of competency of each individual.
We are in the process of updating our program. The instructor/preceptor are one in the same who stays with the nurse until she is able to solo with occasional guidance. On occasion, another preceptor is assigned when the orientee rotates to certain specialties.