2013

The Effect of a Refresher Program upon the Professional Role Confidence Level of Transitioning Returnee Nurses

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THE EFFECT OF A REFRESHER PROGRAM UPON THE PROFESSIONAL ROLE

CONFIDENCE LEVEL OF TRANSITIONING RETURNEE NURSES

DISSERTATION

Presented in Partial Fulfillment of the

Requirements for the Degree of

Doctor of Philosophy in Nursing

Barry University

Virginia Hackett

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by

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Abstract

Background: The ever increasing nursing shortage could be alleviated by recruiting and preparing out of practice registered nurses (RNs) to care for the anticipated expanding aging population. Nurses who have taken a hiatus from the nursing workforce must again overcome the issue of confidence about their role as a practicing professional nurse in order to transition back as safe, competent health-care workers that instill public trust.

Purpose: To test the Transition Model among a group of RNs participating in a refresher program with the intent to re-enter nursing practice after a period of not working in the acute care environment. This study tested the hypothesis that returning registered nurses enrolled in a RN Refresher Program will develop improved self-confidence in their role as a professional nurse as they transition through the supportive refresher program.

Theoretical Framework: The chosen theoretical framework for this study was Transition Theory by Afaf Meleis.

Methods: A pre/post-test quantitative correlational design was used to examine the effects of a refresher course upon the confidence level of returnee RNs enrolled in a RN Refresher Program. Data derived from the Life Experience Survey was compared to an enrollee's margin in life score to detect any facilitators or inhibitors to the transition experience. Data was analyzed using bivariate correlation, multiple regression, and dependent *t*-tests statistics.

Results: Three hypotheses were tested for relationships among the variables. The instruments for confidence and life experience had usable data for this sample, however, the margin in life scale did not, which adversely affected hypothesis one and hypothesis two and therefore were not supported. Regression analysis found that 31.0% ($R^2 = .310$,

adj R^2 = .12) of the variance was explained by the model, but the model was not

significant, F (5,18) = 1.62, p = .21. Examination of the beta weights revealed that none

of the predictor variables contributed to the model. Hypothesis 3 was supported by this

study. The confidence level scores pre- and post-refresher program were significantly

increased. On average, participants experienced significantly greater professional role

confidence following the RN Refresher program (M = 18.90, SE = .47) than they did

prior to the program (M = 14.21, SE = .50), t (94) = -11.09, p = .000, and the effect size

was large, r = .75.

 Conclusion: It is hoped that the results from this study will be used by nurse recruiters

when evaluating a returnee nurse for future employment for their healthcare organization.

It is also hoped that information from this study is used by refresher program providers

for potential grant acquisitions for the underserved returnee nurse population.

DEDICATION

This research study is dedicated to the one I love, Jack Hackett, my husband and best friend. You were my rock and salvation on more than one occasion throughout this educational journey. I would like to thank you from the bottom of my heart for all those times I called upon your computer expertise and uncanny ability to find needed resources that helped me. Your loving support, unrelenting assistance, and encouragement were ever present, even into the wee hours of the night when we were both exhausted and I had a deadline to meet. I feel that, through this educational journey, together we have grown as a supportive loving team for each other. Although we always agree to disagree, we both have always said that together we can accomplish anything. Thank you for helping me with this wonderful achievement.

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CHAPTER ONE

The current national nursing shortage is predicted to escalate within the next 10 years unless the nursing profession can come up with successful strategies to significantly improve retention and recruitment within the nursing workforce. Out-of-practice registered nurses (RNs) who have been away from the acute care setting (hospitals) greater than two to five years are an under-utilized resource for recruitment efforts by the profession. The problem of low self-confidence combined with personal, situational, and organizational obstacles adversely affects the transitioning re-entry RNs return to active nursing practice. The nursing profession needs to determine if the current interventional method (a refresher course) supplies adequate support to assist these nurses to improve their professional role confidence level in order to return to active safe nursing practice.

The purpose of this study was to test Meleis' Transition Model among a group of RNs participating in a refresher program with the intent to re-enter nursing practice after a period of non-practicing. This pre-test/post-test quantitative, correlational study examined the impact of a preparatory refresher course upon the confidence level of re-entry nurses while transitioning back to contemporary practice. Another aim of this study was to examine other variables (loads/burdens in life and power/positive influence in life) that could inhibit or facilitate the confidence level of transitioning re-entry RNs preparing in their role readiness to return to the workforce. Meleis' (2010) theory of transition offered a framework to examine the impact of the personal and situational changes that occurred for the returnee nurses in this study as they attempted to transition and journey back into the role of an active, confident, and safe professional RN.

Background of the Study

Nursing shortages are cyclical, often spiraling up and down with periodic recessions. Since World War II, the United States (U.S.) has experienced 11 recessions. In the past decade, there have been frequent headlines in the news crying out for more nurses due to acute care shortages. However, with the recent severe economic recession of 2006-2008, with overall labor unemployment reaching over 9% (Bureau of Labor Statistics, 2010, nursing experienced an unexpected rise in numbers, ending a nursing shortage that began in 1998. During this period, Buerhaus and Auerbach (2011) reported that full-time equivalent (FTE) RNs increased in hospitals tremendously; over 407,000 nurses achieved employment, of which 50-year-olds accounted for 60% of this increase. These authors suggested that this resurgence into nursing during this recession period may be attributed to the fact that 7 out of 10 nurses are married; perhaps many nurses were strongly motivated to return to the workforce to subsidize the lost wages of an unemployed spouse in order to sustain their family's economic welfare.

Hospitals and nursing schools cannot be lulled into thinking that the shortage is over. These baby boomer nurses will likely retire within the next decade, and the predicted shortage of nurses is going to increase dramatically by 2020 due to the increased needs of an aging society combined with the potential retirement of an aging pool of current nurses. In addition, there is an insufficient supply of potential new graduates to fulfill the needs of our health care industry (Buckis, 2004; Gauci Border & Norman, 1997). The retention and recruitment of RNs has become an area of national concern. The literature suggests that safety and quality of care are linked to strong nurse-patient ratios and improved patient outcomes. The health, safety, and welfare of our

nation and the world will be at stake without a sufficient amount of nurses to care for those in need. The shortage of nurses could be alleviated by the recruitment of those nurses who have been out of the workforce greater than two to five years who may want to return.

Nursing Shortage

The future forecast of projected nurse shortages, as reported by the U.S. Health Resources and Services Administration (HRSA) (2006), paints a grim picture for healthcare in America. Buchan and Calman (2004) reported that the shortage of healthcare personnel in general and registered nurses in particular is the biggest obstacle in improving health and well-being worldwide. Negative patient outcomes related to short-staffing have been identified globally. In their study of 188,752 patients and 3,985 nurses in the United Kingdom, Rafferty et al. (2007) found that patients cared for in hospitals with lower nurse-to-patient ratios enjoyed consistently better outcomes. Moreover, patients cared for in hospitals with a higher nurse-to-patient ratio demonstrated a mortality rate 26% higher than those in the more favorably staffed institutions. Cho, Hwang, and Kim (2008) utilized data from over 27,000 patients receiving care in intensive care units in Korea. They discovered that for every additional patient allocated to a nurse, the odds of dying rose by 9%.

Every state in the U.S. is reporting a future situational crises of an insufficient number of RNs needed to care for the projected aging baby boomers on the horizon. Nursing schools cannot keep pace with the need to produce more RNs due to a lack of nurse educators (American Association of Colleges of Nursing [AACN], 2005). The faculty shortage is crippling nursing education's ability to produce more qualified nurses.

Currently, nursing schools are turning away thousands of students per year. In 2005-2006, the AACN (2006) reported over 40,000 qualified applicants were denied access to baccalaureate and graduate nursing programs in the U.S. (as cited in Falk, 2007). In the AACN publication: *Special Survey on Vacant Faculty Positions for Academic Year 2009 – 2010,* it was identified that 56% of nursing schools had nursing faculty vacancies and 22.9% of nursing schools needed additional faculty. The U.S. population is expected to grow, and the need for nurses is expected to increase by 23% by 2016 (Rich & Nugent, 2010). Now is the time to identify how to best utilize the resources the profession potentially has within the rank and file of already licensed nursing professionals.

The U.S. Health Resources and Services Administration (HRSA) (2006) reports that inactive nurses probably account for more than 18.3% of RNs documented in its database. This statistic only accounts for inactive licensed RNs (nurses who have chosen not to pay a licensing fee since they are not working). In many states, RNs exist who pay the licensing fee and maintain an active license on file yet are not always actively working. The Florida Center for Nursing (FCN) (2008) is working to clarify how many actively licensed nurses are actually working in acute care settings.

The FCN is also working with the Florida Board of Nursing (FBON) in obtaining improved data regarding active nurses' work behaviors and the phenomena of potential workforce. The FCN (2010) identified 187,000 RNs in Florida's potential nurse workforce, and the voluntary survey completed by those nurses revealed that an estimated 160,303 (85.5%) of the nurses are actually working in nursing in Florida in various settings. The FCN (2010) reported that the current shortage of RNs will probably

balloon to 260,000 RNs by the year 2025 due to the retirement of RNs who are presently

over 50 years old and comprise a large portion of the nursing employment.

Florida, along with the rest of the country, needs to train more nurses (which can

take from two to four years per nurse) and to retain more of those who are already

licensed. Non-practicing RNs are an underutilized pool of potential workforce

professionals that could be brought back into the acute care setting. Out-of-work nurses

who have left the profession for various reasons, such as childcare, eldercare, and

alternative job opportunities, are an excellent source for recruitment. These nurses are

already fully trained, hold educational degrees, and are licensed, mature, and have an

array of past experiences as an RN.

Issues Impacting the Decision to Leave Practice

Currently, nursing still remains a predominantly female profession. In 2008,

more than 90% of RNs were female (FCN, 2008). Women are more likely to experience

career interruptions since childbearing remains the responsibility of women, and

therefore pregnancy and family issues were often cited reasons for leaving nursing

(Durand & Randhawa, 2002). Buchanan (2002) reported that some nurses seek changes

away from the hospital setting to other career areas, such as school nursing, home health,

or employment in medical offices, since these alternate sites provide improved family-

friendly hours; alternative places of employment have also provided a work site outlet

when leaving acute care nursing for some type of negative reasons (Meredith, 2002).

Work-related issues have been cited in the literature as an impetus that influenced

the decision by these nurses to take a break from nursing. Negative reasons cited for

leaving the acute care setting included rotating shifts, unsupportive management, or

unrealistic expectations (Crouch, 2002); other factors that impact nurse burnout or turnover rates are heavy workloads and short staffing issues.

Reasons to Return to Practice

Returning RNs are those nurses who wish to return to active clinical practice after a period of absence from the nursing profession. Length of years out of active practice can vary significantly for each participant and must be an important educational consideration when these individuals attempt to transition back into the world of nursing. Nurses are not immune to the complexities of life and often desire to return to active nursing practice due to many types of changes in their lives.

Significant life changes or crises often compel an RN to return to the workforce. A common reason a nurse may seek re-employment in acute healthcare is often due to economic hardship. Financial changes can occur due to a poor economy or due to changes in one's personal life. There may be a change in marital status, such as separation, divorce, or widowhood, or a loss of a non-acute care job by an RN (such as home care or working in a doctor's office), and recent medical surgical experience is needed. The literature further suggested issues of a failed business venture or no longer having small children to attend to. Some nurses cite missing nursing and the collegial work environment (Curtis & Schneidenbach, 1991; Loquist, 1991). It is also not uncommon for nurses to feel a call to duty whenever there is a call for more RNs in the headlines due to a nursing shortage or due to a critical community catastrophe such as the attack on the World Trade Center in 2001.

Re-tooling the Re-entry Nurse

According to Quant (2001), inactive, educated nurses are an excellent source for

recruitment due to the cost efficiency of refreshing a re-entry RN compared to preparing

a brand new RN novice. Re-entry nurses can be prepared educationally, technologically,

and skill-wise in less than two to six months. Presently, hospitals are scrambling for

qualified staff yet view re-entry nurses as needing extensive re-training without

individually assessing their capabilities or knowledge base and will not hire them until

they take a refresher course. Recruiters prefer to hire RNs with current practice

experience or will hire a new graduate novice from a nursing school over a re-entry nurse

on the grounds that their education is more up to date. The National Council of State

Boards of Nursing (NCSBN) (2011) has expressed concerns with the issue of training

and retention of newly graduated nurses. *Transition to Practice* is a recent study

launched by NCSBN in July 2011 as an expansive initiative that provides a way to

empower and formalize the journey of newly licensed nurses from education to practice.

The NCSBN fully acknowledges that there are problems with transitioning to practice,

yet it does not include the re-entry nurses in its study. Returnee RNs are not immune to

the problems of transitioning; if anything, these nurses have more to cope with since they

are navigating many roles in their lives simultaneously (wife, mother, daughter,

caregiver, bread winner) and must supplement their past role concept as a professional

nurse.

Although these nurses are carrying varying degrees of personal burdens (such as

loss of a spouse or an empty nest) and situational loads (loss of a job or loss of financial

support) as they enter a refresher program, it is imperative that these programs nurture the

self-confidence level and promote a healthy role identity as a professional nurse. Nurses

who do desire to return to the workforce must be prepared to face the challenges of the

role as a professional nurse in today's constantly changing healthcare environment. A

negative recruiter response can scare away out-of-practice RNs since these returnees

suffer from lack of self-confidence, anxiety, and self-esteem issues (Hitchcock, 2003;

Quant, 2001; Wilcock, 2000). One out-of-work RN was quoted that she "felt as welcome

as used scrubs" after going to a nursing job fair (Domrose, 2001, p. 28). Returnees are

rarely hired unless they complete a refresher course; however, locating a program can be

a challenge. Domrose (2001) further reported that refresher courses are almost

impossible to find. Those who are lucky to find a course near to their home must wait

until there is an opening since seats are limited and many programs do not run

consistently due to prohibitive costs and lack of available funding by the government or

hospital administrators who are seeking nurses for their institutions.

Refresher Programs

Re-entering the workforce is noted in the nursing literature to be a stress-inducing

phenomenon and does require preparedness with a refresher program. Although the U.S.,

Great Britain, and Australia recognize the necessity for re-entry programs, Mark and

Gupta (2002) discovered in their research that there is a lack of a centralized directory of

nursing re-entry programs available. Their research further revealed that the AACN

surveyed its 554-member nursing schools in 2001 in an attempt to address this challenge.

Of the 294 responding schools (54%), only 68 schools (23%) indicated that they offer

refresher continuing education courses (AACN, RN Refresher Courses: Survey of

Member Schools, unpublished data, 2001). According to Mark and Gupta (2002), a

major limitation shared by several re-entry programs includes a lack of effective recruitment strategies that would include dissemination of program information and encouragement of more participants.

The various programs surveyed (either classroom or online) update a nurse's knowledge and reintroduce nurses back to active clinical practice. Many of the refresher programs are based at an institution of higher learning and offer traditional lecture/lab/clinical components or on-line didactics. The classroom programs also vary in length (6 to 14 weeks) and have a didactic and a clinical component that a participant must successfully complete. Program instructors ideally will subjectively assess the level of competence of each of the participants for future job recommendations at the end of each program.

In general, online programs can be difficult to master, especially for these nurses, since most require that the returning nurse have excellent computer skills, which many of them lack if they are over 40 years old and attended nursing school prior to the age of computers. Computer literacy is now a must have skill for all healthcare workers to master in order to document on the electronic healthcare record (EHR) that is utilized at most hospitals today. Additional online programs advertised by other educational agencies may offer online theory modules with a self-arranged preceptor clinical component, which many re-entering nurses find difficult since they have been disconnected from the profession and lack collegial contacts.

The preparatory re-education transition process may vary for each returnee nurse due to the resources available to them in the community they reside in (urban or rural) and their personal financial status since these programs can be costly. Refresher

programs are considered continuing education and therefore do not meet the criteria for

financial aid assistance at most educational institutions unless the site can provide college

credits for the courses. Unfortunately, an out-of-work nurse may not have a job or the

financial resources to pay for this mandatory continuing education. Nurses who have a

strong need to re-enter current practice often need to do so due to changes and losses in

their lives that have affected them socially and economically. When they turn to their

profession for assistance, sadly they are not always faced with a welcome mat.

Today's healthcare environment is in a constant state of change, hence the need

for updated knowledge for the practicing nurse. Thomas (2003) reported that "acute care

is more acute, home care is more essential, and rehabilitation care is in every care plan"

(p. 332). Returning RNs who possessed past self-assurance now encounter uncertainty

and anxiety as they transverse the re-educative landscape. According to Khan, Schmidt,

Schoville, and Williams (1993), nurses who made sound, quick decisions in the past are

challenged when they return to an unfamiliar working landscape and can no longer do

things as quickly and must ask many questions. Understandably, nurses will no longer be

able to function as experts when they move from a familiar to an unfamiliar environment

These re-entry nurses are in the vulnerable position of feeling deficient in their role as a

confident, knowledgeable nurse. These nurses need professional interventional support

in order to assist them to make a successful transition back into practice as a confident,

professional nurse who is ready to seek out an available job after a refresher course.

Transition is a central concept in nursing. All human beings experience multiple

changes during their lifetime, some positive and some negative. Nurses are known to be

instrumental in assisting their patients to therapeutically cope and transition with the

various changes and differences in their health during illness. Nurses are also human beings who are not immune to life-changing experiences. They too need to make transitions within their own lives that can impact their professional employment. The decision to return to practice after a hiatus is often due to newly developed additional changes in their personal/situational life that require some type of transitioning. Refresher courses promise to update their knowledge, skills, and confidence levels in order to prepare them for their updated role as a professional nurse.

Although these courses attempt to improve these nurses' self-confidence levels, the many articles addressing this population of nurses cite poor self-confidence as a major impediment/problem in future job acquisition post-refresher course. Confidence is often cited in the literature (Bandura, 1977; Grundy, 1993) as an important variable that should be assessed and promoted since confidence is an important educational learning and transition outcome. It is critical for current healthcare professionals to possess a certain amount of confidence to progress in competency development and skill mastery and professional role acquisition. Nursing educators may unknowingly inflict uncertainty on returnee students when experiencing new learning situations, thereby negatively impacting the returnee's self-esteem and self-confidence. It is very important that the personal subjective confidence level of a returnee is quantitatively measured pre-program and is compared to post-program levels to determine if the refresher program had a positive outcome and assisted the returning nurse acquire a higher level of self-confidence in their newly developed nurse-self.

Problem Statement

There is a projected nursing shortage that is forecasted to exponentially grow by 2025 with a need for an additional 260,000 RN healthcare positions (Buerhaus, Staiger, & Auerbach, 2009). A shortage of this magnitude will significantly affect patient safety and health outcomes. The literature suggests that there is a large pool of nurses who are underutilized (Quant, 2001). These out-of-work RNs lack confidence and worry about returning to the workplace without significant support and improved knowledge base to function in this current complex health environment. Recruiting these nurses back into the workforce without appropriate re-entry educational preparation may create more difficulties, additional stress, and challenges in the workplace. Nursing is a service profession, and those in its care must feel safe and reassured. Professional low self-confidence makes others uncomfortable and distrustful of an expected expert when receiving their service, especially in the context of healthcare (Kroner & Biermann, 2007). Returning to the workplace without having undergone such a preparatory program could be risky and unsafe and could potentially negatively affect patient outcomes. As advocates for the public, nurses are responsible to maintain their knowledge and skills to provide safe and efficient care to achieve quality outcomes for the clients we serve.

In light of the current and future nursing shortage, nursing cannot afford to let potential excellent nurses remain on the sidelines if they are available and willing to return to active practice. However, it is imperative that all methods of inquiry for improving the confidence and re-education for out of practice nurses be explored; it is crucial to the future safety and well-being of all patients entrusted to our nation's nurses.

Purpose of the Study

The nursing shortage only promises to get worse. We need to know now if RN refresher courses are providing the appropriate training needed to assist these nurses with their confidence levels to facilitate their transition and return as safe practitioners in the healthcare field. Therefore, the purpose of this study was to test the Transition Model among a group of RNs participating in a refresher program with the intent to re-enter nursing practice after a period of non-practice by examining the effect of a preparatory refresher course upon the professional role confidence level of re-entry nurses while preparing to transition back to contemporary practice. Another aim of this study was to examine other variables (loads/burdens in life and power/positive influences/conditions in life) that may inhibit or facilitate the confidence level of these transitioning re-entry RNs as they prepare to return to the workforce.

Research Questions and Hypotheses

1. Is there a relationship between the nature of transition variable (perceived total life experience score) and transitional conditions (margin in life composite score for health/body, self-concept, interdependence/ connectedness, parenting satisfaction, and religiosity/spirituality) among RNs enrolled in a Refresher Program?

> H1. There will be a correlation between the nature of transition predictor variable of perceived total life experiences and transitional condition's margin in life composite score for health/body, self-concept, interdependence/ connectedness, parenting satisfaction, and religiosity/spirituality, among RNs enrolled in a Refresher Program.

2. Is there a relationship between transition condition variables (health/body, self-concept, interdependence/ connectedness, parenting satisfaction, and religiosity/spirituality) and the pattern of response (professional role confidence) among RNs enrolled in a Refresher Program?

> H2. There will be a correlation between transition condition predictor variables of health/body, self-concept, interdependence/ connectedness, parenting satisfaction, and religiosity/spirituality, and the outcome criterion of pattern of response of professional role confidence, among RNs enrolled in a Refresher Program.

3. Is there a difference between the mean scores for pattern of response (professional role confidence, measured pre- and post-therapeutic intervention of a refresher program) among RNs enrolled in a refresher program?

> H3. There will be a significant difference between the mean scores for pattern of response of professional role confidence, measured pre- and post-therapeutic intervention of a refresher program, among RNs enrolled in a refresher program.

Theoretical Framework

In the 1960s, Meleis realized that nurses' major work involved preparing people for developmental, situational, and health-illness transitions and caring for them to ensure that they cope well and emerge from a transition with well-being. Meleis had the realization that potential problems individuals may suffer from when changes occur stem from not being properly prepared for a transitional experience (role insufficiency) and

that preparation was useful as a preventative as well as therapeutic intervention of role supplementation.

The foundational philosophical underpinnings for Meleis' mid-range nursing theory consisted of: (1) symbolic interactionism – a philosophical view of how people interact effectively and through which a dynamic self is formed as a result of a series of experiences and interactions; (2) role-theory – a theory that influenced Meleis' work on role insufficiency and role supplementation ; and (3) feminist post-colonialism – a theory that triggered the inclusion of society and community as important conditions in this mid-range theory; in addition, nursing is predominately a female profession and is subject to feminist issues happening in a society. Meleis (2010) was also influenced by (4) Florence Nightingale's focus on environment, health, and well-being.

Mid-range theories are useful tools in helping to understand the scope of nursing practice in a range of contexts and situations. Meleis and her team of researchers defined transition as a passage from one fairly stable state to another fairly stable state, and it is a process triggered by a change. She also felt that transitions are processes that occur over time and have a sense of flow and movement; whereas change means substituting one thing for another and tends to be abrupt (Meleis, 2010). Transition is not just an event but rather the "inner re-orientation and self-redefinition" that people go through in order to incorporate change into their lives (Bridges, 2004, p. xii). The following is the applied Transition Model to the returnee nurse as developed by this researcher:
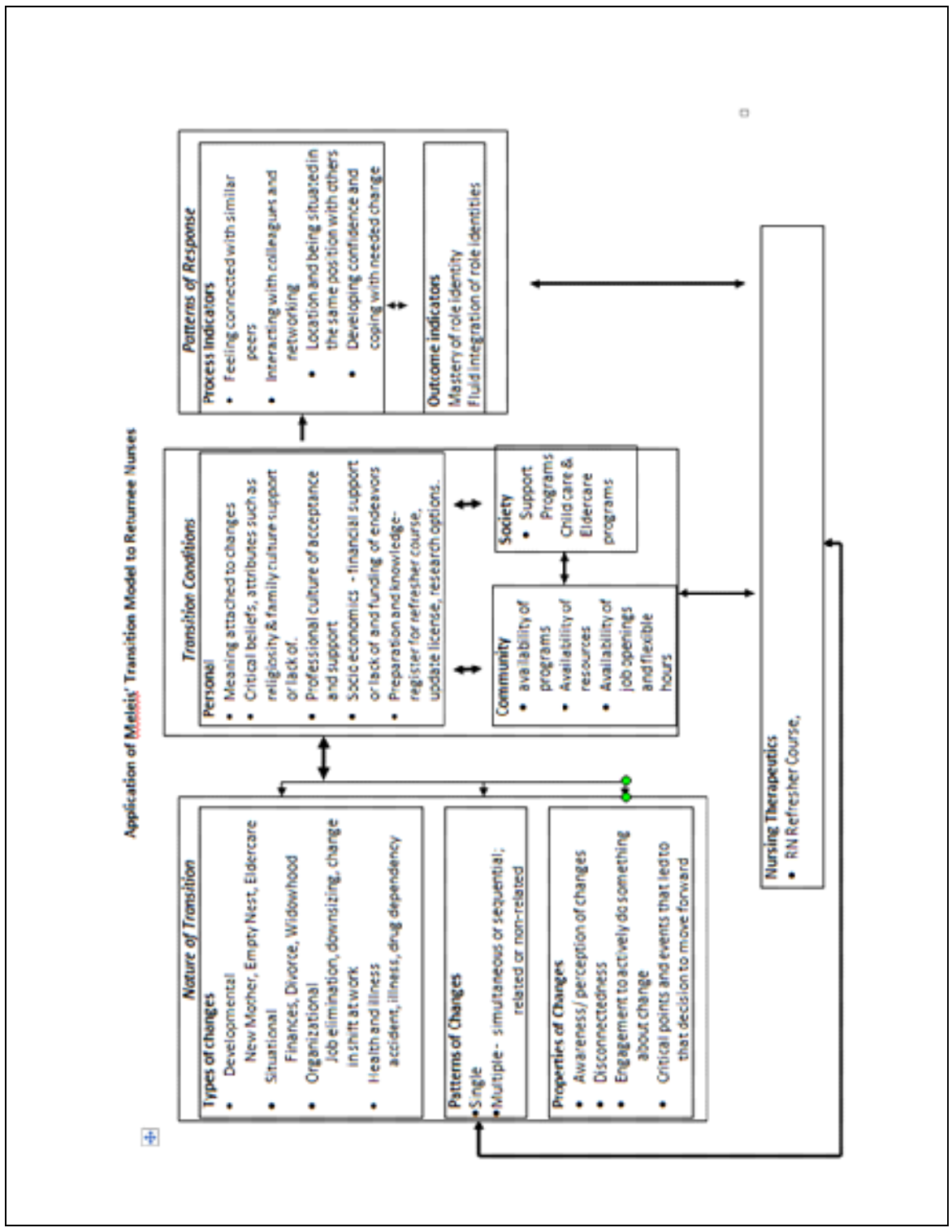
Figure 1. Hackett's (2012) adaptation of Meleis' (2010) Theory of Transition Model to Returnee Nurses.

Explanation of the Model

All human beings experience changes in their lives. Everyone needs time to adapt or transition when a change occurs. Transitions are both a result of and result in change in lives, health, relationships, and environments. These types of changes can be developmental, situational, health/illness, or organizational in origin. Interestingly, these changes can occur singularly, in multiple combinations, or various other patterns. Time is needed to adapt to the change, and often, feelings of disconnectedness occur. Usually some type of critical point or event occurs that can trigger the need for adaptation. It is important that the involved person perceives and is aware of the change and is engaged to do something about it. A returnee nurse who registers for a refresher course is aware that he or she needs to actively engage in some type of re-education process in order to properly prepare oneself to return to the nursing workplace.

Meleis (2010) strongly believed that transitions are affected by conditions that act as facilitators and inhibitors that are broken down to personal and environmental (community or societal). These conditions can either help or hinder progress toward achieving a healthy transition in one's life and are all applicable to the returning nurse. Personal facilitators or inhibitors such as faith, economic support, preparatory education, and community and social support can influence the outcome of the transition process. The sense of feeling connected (with peers in the profession) and self-confidence is an indication of mastery of an individual's newfound role to identify with as a professional nurse.

Nature of Transitions

There are many types of transitions according to Meleis (2010):

a) Developmental transitions are encountered in the normal course of growth and development. Roles change during one's lifetime (becoming a new mother, taking on a caretaker role for an elderly or disabled family member, or dealing with an empty nest), with complementary adjustments in one's counter role that eventually takes over.

b) Situational transitions involve the addition or the subtraction of individuals in the pre-existing "constellation of roles and complements" (p. 15). Each situation requires the definition and re-definition of the roles involved in the interactions. A job loss, a debilitating family member's illness, divorce, or widowhood are situations that affect family roles and dynamics.

c) Health/illness transition includes sudden role changes (an accident or a stroke) that result from a person moving from a well state to an illness state and vice versa, or a gradual change due to a chronic illness that can progress into debilitation.

d) Organizational transition includes changes arising in an organization that impact roles of individuals and involves downsizing or loss of positions.

The nature of any transition includes that the various types of changes can occur singularly or in multiple combinations that can impact a person's life. In order for the transition process to begin, the involved individual must have an awareness and clear perception of the identified change(s) and an engagement to act upon the change. The act of enrolling in a refresher course demonstrates that a returnee nurse is aware of the changes in their life and is already engaged to act upon it and start the transition process.

Facilitating and Inhibiting Transitional Conditions

Meleis (2010) strongly believed that transitions are also affected by conditions that act as facilitators and inhibitors to a healthy transition, which are broken down to personal and environmental (community or societal). These conditions either help and empower a healthy transition or hinder and burden the progress toward achieving a healthy transition in one's life:

a) Personal conditions entail the meanings attributed to the events that precipitated a transition and the process itself. Cultural beliefs, religion, and spiritual attitudes are important components that can facilitate or hinder a transition experience. Socioeconomic conditions and level of income can adversely affect one's admittance into an instructional program. Preparation and knowledge (registration for a re-entry program) indicates an awareness, engagement, and responsibility for one's own learning, which may facilitate the transition experience, whereas lack of preparation may act as an inhibitor. Personal feelings of connecting with others are important to the eventual pattern of response of confidence and reconnecting with professional role identity.

b) Community conditions include community resources that can also facilitate or inhibit healthy transitions. The location of where returnee nurses reside greatly impacts the availability of programs, job opportunities, and support programs. Support or lack of support from partners, families, and professional colleagues are important considerations.

c) Societal conditions include a stereotyped meaning that can stigmatize an individual, marginalization (gender, cultural, etc), and attitudes supporting or not supporting the endeavor. Nurses sometimes face the stigma of being the caregivers in a family and are relied upon by family members, especially if a family member becomes

debilitated, which can hinder a nurse's career path. Returnee nurses also must confront recruiters who can have a negative view of a nurse who has been home being a caregiver to dependents.

Meleis's transition theory also incorporates adult developmental and learning concepts since her research involved adult clients who needed therapeutic interventions. She developed process indicators that characterized a healthy transition based on the strong influences of Malcolm Knowles's adult learning theory of the self-directed learner and Patricia Benner's goal attainment theory.

Process Indicators that Characterize Healthy Transitions

a) Feeling connected by making new contacts and re-establishing old connections are often primary sources of information and support. Continuity in relationships between providers and clients supports transitions. Re-entry nurses who connect in a refresher course often develop a collegial bond.

b) Interacting helps to identify the meaning of the transition. The behaviors developed in response to the transition are often uncovered, clarified, and acknowledged (communicating stories in a refresher course).

c) Location and being situated can impact almost anything in a person's life (health, nutrition, family relationships, employment opportunities, etc.) and are characterized by the creation of new meanings and perceptions. Making comparisons (which can be multidirectional) is a way of "situating" oneself in terms of time, space, and relationships; it is a way to explain who, what, and where they are and where they have been or want to be. Relevant information or advice from respected sources such

educators and role models can help set goals for individuals and answer questions about what to expect in their future role as a nurse in the current healthcare environment.

d) Developing confidence and coping looks at the extent to which there is a pattern indicating that the individuals involved are experiencing an increase in their level of confidence (which is a progressive from one point to the next in the transition trajectory). Refresher courses should be vehicles to help their students develop improved confidence to cope with the demands of professional practice to re-establish themselves as safe practitioners. According to Meleis (2010), nursing therapeutics involve education, which is a primary modality for creating optimal conditions in preparation for transition.

Outcome Indicators that Characterize Healthy Transitions

a) Mastery emerges when successful completion of a transition is determined by the extent to which individuals demonstrate mastery of the skills and behaviors (role) needed to manage their new situations or environments and demonstrate a healthy, improved transition and readiness for employment. Refreshers should feel confident in their professional role to seek a position in the healthcare environment.

b) Fluid integrative identities emerge when transition experiences result in identity re-formulation. Refresher nurses should have a new, confident view of their role as a nurse who can practice safely.

Inherent in each of the types of transitions involves the fluid movement of role transitions, which "denotes change in role relationships, expectations, or abilities due to the shifting burdens or loads. Role transitions require a person to incorporate new

knowledge, alter his/her behavior, and thus change his/her definition of himself/herself in the social context" in order to cope with new responsibilities (Meleis, 2010, p. 15).

Relationship of this Study to Transition Theory

The downturn in the U.S. economy combined with a nursing shortage can act as a driving force for an out-of-work nurse to return to practice. Other important changes in a nurse's personal, social and community life (such as divorce, illness, death, or loss of a previous job) also impact the need to return to practice. Transition theory provided a framework to understand the impact of the types of changes affecting a returnee's life and the need to transition and move forward. The key concepts of this theory consider the challenge to self-identity that occurs during the transition process. Self-identity and transition are concepts that are closely linked (Meleis, 2010) and are applicable to the returning nurse who must learn an updated version of his or her role as a confident, professional nurse in today's fast-paced healthcare environment. Another key concept considers that healthy transitions are often linked to the development of relationships and connections with others. Again, returning RNs should experience improved self-confidence in their updated role identity when they interact with peers experiencing similar situations. Lastly, the process of transition can make a person more vulnerable to risks. These returning RNs may experience intimidation and vulnerability when seeking a position in healthcare if they do not take the re-educative steps to improve their confidence and reformulate their definition of themselves as a professional nurse who can deliver safe, competent nursing care to patients.

Definitions of Key Terms

Nature of Transition

Theoretical definition. Transitions are related to changes in life that can be developmental, situational, health/illness, or organizational in nature. Transition is conceptualized by Meleis (2010) "as passage from one life phase, condition, or status to another, is a multiple concept embracing the elements of process, time span, and perception" (p. 25).

Operational definition. The nature of transition was operationalized by the Life Experience Survey (LES) developed by Sarason, Johnson, and Siegel (1978). The instrument provides a composite score and/or subscale scores for three factors related to various life changes that can be perceived as positive or negative by a respondent. The LES provides a quantitative method for assessing the perceived impact of life changes by measuring: positive life change score (the higher the score, the more positive perception, and the lower the score, the less positive perception of the change event), negative life change score (the higher the score, the more negative perception, and the lower the score, the less negative perception of the change event), and total amount of rated change for those life-changing events (addition of positive and negative scores to indicate the degree of importance in their life of the change event) identified by the respondent.

Transition Conditions

Theoretical definition. Transition conditions are those factors that influence transitions. Transition conditions can act as facilitators or inhibitors to the transition process and involve personal and environmental factors (Meleis, 2010).

Operational definition. Transition conditions was operationalized by the Margin in Life Scale (MIL) developed by Stevenson (1982). The instrument is an objective way to evaluate the life-in-process (burdens/loads and powers) of adults because it focuses on the complexities of adult life.

The MIL takes into account internal and external conditional factors that are rated for importance by the participant. The most up-to-date MIL scale (Stevenson, 1982) contains 58 items that examine the sources of burdens and resources for an individual: Health/Body = 18 items, Religiosity/Spirituality = 12 items, Self-Concept = 13 items, Interdependence (connectedness) = 10 items, and Parenting Satisfaction = 5 items. Participants are asked to rate each conditional item on a 1-10 scale for the level of importance in their life and then evaluate each item on a 1-5 scale for the amount of burden and/or power that item exerts in their life. A mathematical equation is calculated (explained under instruments) to determine the level of margin an individual possesses to cope with the change they are faced with. A calculated margin score between 0.45 and 0.69 is considered a good margin to attempt a new experience or change in one's life. A margin score of below 0.30 indicates too much load and dangerous stress limits and poor outcomes. A margin score above 0.70 indicates too little load or challenge and, therefore, a person may not be operating to potential and achieve his or her goal.

Patterns of Response

Theoretical definition. A healthy pattern of response is characterized by both process and outcome indicators. It is important to identify process indicators of feeling connected, interacting, feeling situated, and developing confidence that will move a

subject in the direction of healthy role mastery and identity reformation rather than vulnerability (Meleis, 2010).

Operational definition. The patterns of response was operationalized by the Confidence Scale (C-Scale) The C-Scale contains five situation specific statements that are answered on a Likert-type scale of one to five. The largest number five indicates a higher score on the item pertaining to confidence. The score of each question is added together to obtain the confidence score. The total score can range from a low of five, indicating low self-confidence, to a high of 25, indicating high self-confidence. Professional role confidence was the specific situation measured in this study.

Nursing Therapeutics

Theoretical definition. Nursing therapeutics could be conceptually considered in relationship to transitions, antecedents, and consequences. Nursing therapeutics will enable nurses to select the most fruitful kinds of action and optimal intervention points for achieving a desirable healthy outcome. A therapeutic nursing intervention is conceptualized as occurring after the transition consequences have been experienced, whereas a preventive intervention occurs before the transition or before the consequences (Meleis, 2010, p. 29).

Operational definition. Nursing therapeutics was operationalized by the RN Refresher Program for returnee nurses. A refresher course is meant to offer out-of-practice RNs professional collegial and educational support when undergoing the return to practice situational type of transition. Support includes those aspects of the internal and/or external environment of an individual that provide the strength necessary to meet

the tasks at hand (Meleis, 2010). Professional role confidence was measured pre- and post-refresher program intervention.

Research Assumptions

There are three basic theoretical assumptions of transition theory: (1) there is a challenge to self-identity that occurs during the transition process. When self-identity is threatened during disruption, there is a need for reconstruction of identity based on the new required role and responsibility. (2) Healthy transitions are often linked to the development of relationships and connections with others, since there is a need to feel and stay connected. Personal contacts and connections with others aid as a primary source of information about resources. (3) Some type of change or changes (death, illness, loss of a job, or lack of financial support) to a person creates a process of transition that tends to make a person more vulnerable. As Meleis (2010) stated: "vulnerability is related to transition experiences, interactions, and environmental conditions that expose individuals to potential damage, problematic or delayed recovery, or delayed or unhealthy coping" (p. 52).

This study holds true several applicable assumptions: (1) that the literature supports the assumption that returnee nurses enter into a refresher program with many personal and situational changes in their life that will challenge their confidence in their role identity as a professional nurse; (2) if a refresher program is effective as a facilitator and new connections are made with other colleagues, then the nurse should experience an outcome of improved confidence and professional role adaptation, which is interpreted as a healthy outcome; and (3) the potential outcome of a post-course low self-confidence

score may adversely affect the returnee RN by making them more vulnerable to criticism and rejection when attempting to transition back into nursing workforce.

Significance of the Study

By identifying transitions as a central concern in a refresher course, it would allow for the development of a coherent curriculum framework that would emphasize therapeutic nursing re-educative methods that would facilitate the transition experience and encourage a healthy outcome. Returning nurses have so much to cope with when transitioning back to practice, which can really affect their mastery of their re-defined professional nurse role during a course, in post-course confidence, and for future job acquisition. Refresher courses need to be designed with support for these returning nurses to perhaps assist with the situational loads they are carrying and eventually empower them. While most of the past studies have acknowledged the lack of confidence of this distinct population, there is a paucity of quantitative data measuring individual assessments of the internal and external load (which aligns with Meleis' inhibiting conditions) these returning nurses are carrying when they enter into a refresher program. There is also little data measuring the power or energy (facilitating conditions) these nurses may have in their lives to promote a successful outcome of improved confidence in their role identity as a professional nurse.

The theory of transition has a broad holistic scope and is applicable to returning nurses who need to re-define themselves and their place back in the workforce. These nurses suffer from role insufficiency that might be replaced with role supplementation with the intervention of a supportive RN Refresher course. The key concepts of the theory are applicable to returning nurses who must (1) learn an updated version of their

role as a nurse and simultaneously adjust the many roles in their personal life; (2) potentially connect with peers experiencing the same situation and develop new relationships during a supportive refresher course; and (3) potentially experience some type of vulnerability/criticism from recruiters and colleagues in the profession if they are not prepared with the interventional re-educational support of a refresher course that should instill confidence in the returnee nurse.

Implications for Nursing Education

Theories provide frameworks for complex situations such as the plight of the returnee nurse. Understanding the transition process may better prepare professional educators to develop nursing therapeutics that are congruent to the unique experiences of re-entry RNs in order to promote a healthy response to the transition. Educators who develop these refresher curriculums should benefit by having sound empirical data from this study to determine if these refresher courses are therapeutically preparing these nurses to feel improved confidence in their role as a nurse again who can provide safe and effective nursing care. Furthermore, this study may address the need for nursing educators to pre-assess the applicants for potential impediments or lack of readiness that might be interfering with these nurses' lack of self-confidence and ability to acquire a future nursing job. This study may also encourage continuing education instructors to assess their personal teaching styles since a supportive, nurturing educator can cultivate a returnee nurse. This study may also elucidate common situational impediments experienced by these returnee nurses (such as financial needs) that could be supported by the profession, hospital organizations, and governmental agencies in the form of grants and scholarships to assist the re-education transition process. It is also hoped that this

study may encourage more nursing schools to develop refresher courses and invite any returnee nurse with instructional needs to utilize their facilities and labs during slow times since the master level students could practice teaching their professional peers.

Implications for Nursing Practice

Current quality nursing practice demands that practicing RNs critically think and are knowledgeable, confident, skilled practitioners. Due to the advances in medicine, nursing must continually explore all avenues to improve and apply evidence-based practice. Continuing education is a vital component of professional practice. The findings of this study may provide the impetus to expand these continuing education programs since they are difficult to locate for those in need and to perhaps uncover creative educational strategies that will encourage improved confidence and role identity for those nurses transitioning back to the workforce. Confidence is crucial to better patient outcomes since a healthcare worker who exhibits low self-confidence makes those receiving care very uncomfortable, according to Kroner and Biermann (2007). An unconfident professional can instill fear in a patient. Perhaps this study may encourage better collaboration between schools of nursing, financial institutions, and hospital organizations to create more funding for continuing education programs that can enhance confidence and competency in all healthcare personnel.

Implications for Nursing Research

There is a need after this study to conduct follow-up research with this distinct group of nurses post-refresher course to determine the percentage of nurses who are successful in their re-entry endeavor to return to practice and to determine additional issues that may assist others in the process of re-entry. By identifying transition as a

central concept and significance to nursing, researchers can continue to further develop additional knowledge related to transitions, keep searching for gaps in knowledge, and work collaboratively to build upon each other's work. Further research can be instrumental in identifying critical points during transition that could benefit from interventional nursing therapeutics that are designed to prevent unhealthy outcomes. Nurses who never acquire a position post-refresher course would make an interesting research study to investigate what might be the obstacles or loads these nurses encountered that affected their job acquisition post-course that perhaps the profession could have addressed or assisted with.

Implications for Health/Public Policy

It is imperative to the health of the world that we bring back as many nurses as possible since the nursing shortage is not going to disappear; if anything, it is predicted to escalate. This study may bring to light the dire need for funding the re-educative process for these nurses since economic hardship is an often cited impetus to return to practice; however, it can also be an impediment to start a program. A refresher program is costly and time consuming to engage in. Re-educational financial backing for these future employees could be provided by the government and by private institutions who would like to employ them. This study also hopes to provide significant empirical data to assist the AACN and the FCN to seek funding of future bills that may support the continual growth of the nursing profession and continuing education programs.

Limitations of the Study

This study was limited to a non-randomized purposeful sample of registered nurses who have been out of current practice greater than two years who wanted to return

to acute care practice and were enrolled in an RN refresher course. Since the two

programs sites that were surveyed vary in length (clinical hours) and the allocation of

college credits versus continuing education units (CEUs), these uncontrollable variables

may have impacted the results of this study and was considered between the groups.

The participants were available to the researcher after approval of the program

director was obtained since they were already registered to attend the designated refresher

program. The study results are limited since a purposeful sample was used and the

sample may not be representative of future returning nurses' population. Since the

researcher has previously taught this given population, all contact with the participants

was kept minimal since the researcher was cautious of experimenter bias effect. The

chosen instruments are valid and reliable except for the demographic survey, which was

checked by impartial persons for content validity. Other limitations included use of

instruments that force choices for each item, that the purposeful sampling may have

caused sampling bias, and that the sample was predominantly female, since the

profession is mainly female, and females have the highest statistic for professional career

breaks.

<div align="center">**Threats to External Validity**</div>

External validity is the degree to which results are generalizable or applicable to

groups and environments outside the experimental setting (Gay et al., 2009). The

returning RNs invited to participate in this study were a non-randomized purposeful

sample who were drawn from the current pool of returning nurses enrolled in a

continuing education college based RN Refresher Course Program. Their responses were

voluntary. This sampling procedure may be a threat to external validity since such a procedure limits the researcher to generalize the finding to any other population.

Threats to Internal Validity

Internal validity is the degree to which observed differences on the dependent variable are a direct result of manipulation of the independent variable, not some other variable (Gay et al., 2009). Differential selection was a threat to the internal validity of this study since the groups being studied have already been formed by the perspective programs that were accessed for this research endeavor. According to Gay et al. (2009), results are weakened when a study deals with intact groups and non-random assignment to treatments; however, analysis of covariance can be used in such cases to equate the groups. The organismic variables identified on the demographic survey (age, sex, marital status, etc.) were controlled with looking at subgroups and utilizing the statistical method of analysis of covariance. Mortality or attrition of the participants was always a concern since these programs can run from 6 to 14 weeks, and individuals may drop out of the program. A larger sample was desired since the larger the sample, the stronger the validity of the study. A primary concern was that multiple samplings may be required to be surveyed since most of these courses have seat limitations. Another concern was history since newsworthy items concerning nursing job availability and hospital closings could affect performance on the variable (confidence) and enrollments in programs. Also test, re-test use of one of the instruments is a threat to internal validity.

Chapter Summary

This chapter has discussed the need to enhance the transition and retention of RNs who return to practice. The study was guided by Meleis' Transition Theory. Several

research questions and hypotheses were developed to test the theory. Transition Theory has a broad holistic scope and is applicable to returning nurses who need to re-define themselves and their place back in the workforce. These nurses suffer from role insufficiency that might be replaced with role supplementation with the intervention of a supportive RN Refresher course.

CHAPTER TWO

REVIEW AND CRITIQUE OF THE LITERATURE

The purpose of this study was to test the Transition Model among a group of RNs participating in a refresher program with the intent to re-enter nursing practice after a period of non-practice. This study examined the effect of a preparatory refresher course upon the professional role confidence level of re-entry nurses while transitioning back to contemporary practice. Another aim of this study was to examine other variables (loads/burdens in life and power/positive influences/conditions in life) that may inhibit or facilitate the preparatory transition of a re-entry RN to return to the workforce. A thorough literature review produced an understanding of past and recent studies related to confidence and role transition for the returnee/re-entry nurse wishing to transition back into active safe nursing practice in light of the nursing shortage. An extensive literature search was performed utilizing major electronic databases in the fields of nursing, medicine, education, psychology, and sociology. The following databases were accessed: the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Educational Resource Information Center (ERIC), Ovid, and Medline to investigate the issues and concerns surrounding the returning nurse's re-entry into acute care. Keywords and phrases searched in the databases included: transition, support, re-entry nurse, refresher programs, continuing education, confidence, professional role insufficiency, and role supplementation. This search was performed in English and encompassed a period from the 1920s to the present day. To better understand and to provide context on this study, it is important to provide a brief historical review of nursing shortages, continuing education, and the evolution of refresher courses.

Historical Overview

A return-to-practice refresher nurse course was first offered in the 1930s in response to the severe nursing shortage in that period (Cooper & Hornback, 1973) in hopes of updating nurses' skills so that they would re-enter the work world and improve the nursing shortage at that time. Federal funding through Public Law 146 (77th Congress), passed in 1941, and the Bolton Nursing Training Act passed in 1943, which created funding for both basic nursing education and refresher courses. Thousands of inactive nurses had their nursing skills updated through courses offered as a result of this funding (Stein, 1998). The ANA and the NLN helped convince the federal government to fund the Cadet Nurse Corps to assure an adequate supply of nurses during World War II (Schultz, 1990). Nursing as a field of employment made tremendous strides in the post-WWII period under the expanding economy of the Eisenhower presidency; since not only was federal funding available for nursing training, but also, for many, short-term continuing education courses as well.

The American Nurses Association (ANA) describes continuing education (CE) as those professional learning experiences designed to enrich the nurse's contributions to quality healthcare and his or her pursuit of professional career goals; those learning experiences are achieved through programs, offerings, and independent studies that meet specified criteria for contact hours (ANA, 1994, p. 5). Many nurses, including the ones not in current professional practice, accept this concept of lifelong learning since the healthcare knowledge base is always growing at such a rapid rate, and it has become a professional necessity to maintain currency in practice in order to provide clients with safe, competent nursing care.

Re-entry nurses often possess a wealth of background abilities and nursing knowledge. However, these nurses must acquire new technical skills and updated knowledge in order to competently re-enter the healthcare world of today. Benner's (1984) theory of skill attainment discusses the issues of self-assurance and esteem regarding acquiring certain levels of skill achievement in order to be considered expert. Skill attainment principles are still applicable today and easy to relate to since it is uncomfortable for someone who once considered themselves to be an expert to be cast into the novice role again as they acquire new knowledge and skills. The return to a novice role is applicable to a returning nurse after a hiatus from nursing while engaged in a continuing education refresher program. The change in role from expert to novice requires a change in a person's self-definition in their social context. The concepts of role theory are integrated in Meleis' transition theory, which makes it an applicable lens when viewing the issues and challenges surrounding re-entry RNs as they attempt to reformulate their definition of the professional nurse role as they transition back into the current healthcare environment after a situational change in their life. Keywords and phrases identified to be addressed in this literature review surrounding this topic of interest included transition, support, confidence, and professional role.

Transition

Transitioning and re-entering the workforce is not a new phenomenon, especially for women who experience the new situation of divorce or death of a spouse, loss of financial means, or poor health issues. Bonnel (2009) examined the obstacles and issues faced by middle-aged female nurses who are traumatically forced back into the workforce after a divorce. After exhaustive research, Bonnel determined that few re-entry programs

exist in the United States, and those that do exist are significantly underfunded. Bonnel used quantitative and qualitative methods utilizing a variety of approaches, including interviewing resource center directors, reviewing existing center curricula quantitative data, and gathering various demographic data from the centers. Content data from each of the curricula were quantitatively and qualitatively analyzed employing various coding methods, ensuring that the content includes pertinent topics necessary to aid in the re-entry of the displaced homemaker. Nine of the 10 directors agreed to be interviewed and provided the curricula that would be evaluated quantitatively using a five-level Likert scale that included the following components: challenges faced by displaced homemakers, financial resources, values identification, goal setting, job readiness, time management, communication skills, problem solving, work-life balance, self-esteem development, and social support skills. Due to time constraints, only seven of the directors were actually interviewed. All of the directors were interviewed using the same questions, which were provided in advance and were recorded with their permission. The seven centers were located in a variety of cities throughout the United States (three of which were located in Florida).

All of the programs ($n = 7$) in Bonnel's study ranged from six weeks to nine weeks, all held classes full-time during the workday, and only two of the centers provided evening classes. Each of the centers had an annual participant enrollment of 100-200 per year, which was 99% female. The participants were from a broad socioeconomic spectrum, and each participant received initial pre-program assessments utilizing various tools (Myers-Briggs Type Indicator [MBTI], Learning Styles, Strong Interest Inventory [SII], etc.) and received between 24-100 ($m = 50$ hours) hours of instruction and training

(90-99% of the participants completed their training). Each curriculum included career counseling concepts and theories of self-esteem, andragogy, social support skills, and the utilization of subject matter experts. The following themes were identified regarding the adequacy of the programs: *Funding* was primarily from state revenue; *Curriculum* was meeting the needs of the participants; and *Career Counseling* was felt to be strong. The identified themes touched on many of the situational changes and conditional inhibitors impacting the returnee nurse: lack of social and financial support, loss of connections, the need for self-esteem (confidence) development, and the need for adult learning principles in the curriculum. Historically, these issues have plagued this population of nurses as they attempt to transition back to practice, according to much of the literature. This study hoped to quantify these issues.

In another study, Hammer and Craig (2008) used face-to-face interviews in their qualitative phenomenological study to examine the experiences of nine nurses ($n = 9$) who returned to nursing after completing a refresher course at a Midwestern university from 2000 to 2005. Criteria for participation included completion of the refresher course, employment in nursing within six months, location within driving distance of the researcher, willingness to participate in face-to-face interviews, and willingness to allow the researcher and a peer debrief colleague to review the transcribed interviews for themes. Possible participants were contacted by the university to obtain permission to release their names to the researcher to participate in this study. The participants were all women, and most were married (one person was divorced). All had previous experience in nursing (2-12 years, m = 6.2 years) and had become inactive from nursing for 5-27 years ($m = 15$ years) due to the demands of having multiple children (2-8 children, $m =$

3.5 children). All were actively seeking to return to nursing due to financial benefits, children growing older, and purpose in life issues. The investigators wanted to learn "What were the experiences and the meanings of those experiences for nurses who took a nurse refresher course to return to nursing practice after being inactive?" Several themes emerged: locating a refresher course/clinical site to practice; support during the transition process involved family, friends, and mentors; lack of good orientation in new job; peer support; and issues of self-efficacy. Some participants experienced feelings of inadequacy while others experienced improved self-esteem depending on their mentoring experiences.

The investigators concluded that nurses who seek a refresher course are often at transition points in their lives and that the course process and transitioning back into the workforce created more stressors for a period of time for these nurses. One of the investigators did reveal that she also was a returnee nurse (however, not a participant in this study), and she mentioned a possible perspective bias and an attempt to bracket her experiences to present the participants' experiences. There was no mention of data protection by the investigator. The investigator also never provided empirical data regarding the size of the particular program (number of participants in the program from 2000-2005). This study clearly brings up the topic of multiple simultaneous situation transitions with which these nurses encounter and cope. The study further elucidates the need for the profession to support these nurses who provide excellent resources to alleviate the nursing shortage and provide mature, competent care. This study hoped to quantify some of this data.

Asselin, Osterman, and Cullen (2006) felt that although there is significant

literature on the development of refresher programs, there was a paucity of literature

regarding the experience of returning to practice from a professional practice perspective.

Using a descriptive, exploratory qualitative design , this study examined the experience

of RNs who return to acute care. The purpose of this study was to describe the

experience of nurses returning to acute care practice with an additional aim to identify

factors in the practice environment that hinder transition and/or facilitate retention of

nurses who return to practice. A purposive sample of five RNs voluntarily participated in

this study. The participants were all female, ages 40-50 years, and had different

educational backgrounds (BS, AAS, and Diploma). The career breaks varied from 2 to

25 years, and each had a minimum of 10 years of nursing practice experience. All

completed the same refresher program (72 hours didactic and 32 hours clinical time), and

all had returned to acute care in the Northeast within one year of taking the course. After

the researchers obtained institutional review board approval, each nurse who participated

shared her story with the same two researchers who used an audio tape to record the

interaction. The researchers guided the questions and had the tapes transcribed by a

professional. Saturation of the data was achieved with repeated themes after only five

interviews.

Several themes emerged from this phenomenological study: 1) motivation prior to

entry (the need for challenges and a need to make a difference in nursing); 2) coping

during the process of returning to practice (concerns about patient safety and fears of

making mistakes and peer teaching and support); 3) role of environment (stress due to

vertical hindrance related to organizational inflexibility in scheduling versus horizontal

hindrances related to floating to other units and lack of welcoming behaviors by existing staff); 4) role of guilt on several levels (personal – related to missing family time; patient – related to tasks versus quality patient care; team – related to being asked to work extra hours for short staffing; and organizational – related to completing occurrence reports on colleagues).

This study also revealed factors that facilitate the retention of nurses who return to practice, including classroom education and the importance of the instructor to be nurturing, friendly, and understanding of the nurses' learning needs. Support was a key theme on the nursing units that facilitated retention, especially the appropriate preceptor match for the re-entry nurse. This study emphasized the need for support from the profession from the time the participant enters into a refresher program, throughout the program, and post-program by their peers, supervisors, and the organization in which they eventually practice. This study's themes correlate with many of the facilitating conditions and process indicators mentioned in Meleis' model that contribute to a positive situational transition experience. Appropriate preparation and support ensures a return-to-practice nurse who is confident and a valued mature member of the healthcare team who provides safe, competent care to the patients. This study hoped to quantify these facilitating themes identified in this study.

The nature of any transition can be due to various life-changing occurrences. Regardless whether the change is developmental, situational, health related, or due to organizational upheavals, most changes produce stress for an individual. Returning back to school can be stressful too. Life stress has been shown in the literature to interfere with learning. Chacko and Huba (1991) wanted to quantitatively test the relationships

among variables depicted in the causal learning model that relate to academic

achievement among undergraduate 134 nursing students. These researchers administered

the Learning and Study Skills Inventory (LASSI) (an affective instrument that assesses

motivation), the Life Experience Survey (LES) (an affective instrument that assesses life

changes and stressors), and the ASSET test (a cognitive instrument that assesses reading

ability, language ability, and math ability) to nursing students during their first semester

in a two-year community college program. All the instruments were noted in the

literature to be reliable and valid. Academic achievement, the dependent variable, was

measured by the final grade obtained by subjects in their first nursing theory course.

Ninety-five (n = 95) out of 134 subjects fully completed the 3 instruments.

The subjects were mostly adult learners over the age of 24 ($m = 29$). Forty-four

percent were married, 35% were single, and 21% were separated or divorced. More than

one-third of the subjects worked more than 20 hours per week, and many of the subjects

had children. It was hypothesized that life stress was indirectly related to academic

achievement. Path testing was used for testing the causal learning model. Multiple

regressions were computed using as criterion variables each of the four endogenous

variables in the model: academic achievement, self-efficacy, concentration/preparation

for class, and self-monitoring/use of study strategies. The significance criterion for

retaining a path coefficient was set at $p < .05$. The path analysis supported many of the

effect (e) pathways tested in the model. Language ability ($e = .29^{**}$), reading ability ($e =$

$.28^{**}$), and self-efficacy ($e = .33^{**}$) were found to be direct effects on academic

achievement. This result supports the hypothesis that self-efficacy is directly related to

academic achievement. The researchers also determined that student's life stress

($e = -.19*$), motivation ($e = .26**$), and self-monitoring/use of study strategies ($e = .45**$) were direct effects on students' concentration and preparation for class. This finding supports the view that life stress has a negative relationship with academic achievement via its direct relationship with one's concentration and preparation for class.

The study by Chacko and Huba (1991) is applicable to the returnee nurse since their life changes are stressful and may negatively impact their concentration and success in a refresher program. This study also elucidated the positive relationship of self-efficacy (confidence) and academic achievement. However, these researchers pointed out a gap in their study – that a more appropriate variable for the adult learner should have been the ability to react to and cope with life stress rather than concentration and preparation for class. The researchers felt that individuals' degree of life stress does not necessarily correspond with their ability to cope with this stress. This study hoped to fill that gap and utilize the margin in life scale (MIL) to determine the ability to react and cope with the assessed life stressors (determined by the LES) impacting the transitioning returnee nurse.

All four studies related to transition and the special needs of this population that highlight the applicability of Meleis' transition theory. Bonnel's (2009) qualitative study emphasized the common themes of loss of connections, poor financial resources, the need for role readiness (insufficient), and, lastly, poor self-confidence. The lack of refresher courses in the community and funding issues can be major hindrances to this population. Hammer and Craig (2008) also cited the transition issue of lack of programs in the community environment and the need for financial and emotional support and the effect on self-efficacy. Asselin et al. (2006) discussed the role of environment, personal

attitudes of coping, and feelings of guilt that can hinder the transition experience. Lastly, Chacko and Huba (1991) emphasized the need to assess the impact of the transition on academic achievement and self-efficacy but pointed out the need to assess the subjects' coping ability to react to the change. This study hoped to quantitatively corroborate the nature of the transitions and the conditional hindrances and facilitators experienced by these returnee nurses that would affect their coping and achievement. Future grant acquisitions often require quantitative facts to support grant proposal applications. Hopefully, this research provides needed statistical data for education and healthcare institutions for government funding incentives.

Support

The issue of support is a vital aspect of conditional facilitators or hindrances since returnee RNs feel inadequate in their role as a nurse and therefore seek the guidance and support of a strong program and the support of their family, friends, and colleagues in the field. Barriball, Coopamah, Roberts, and Watts (2007) were interested in learning about the returnee nurse's evaluation of return-to- practice programs in England. This was a multi-method study with data collected in two concurrent phases: from the current return to practice (RTP) students ($n = 17$; questionnaire and focus groups) to gain insight into the "returning to practice" experience; and secondly, all students who had completed a RTP course in the same school during the previous 2 years (telephone interviews: $n = 78$) to gain insight into the "returned to practice" experience. A questionnaire was distributed to the census sample ($n = 17$) of returnees upon enrollment into the RTP program. All of the participants were female, and approximately one-half the sample were 40 years of age or younger with dependent children. The questionnaire requested demographic

information as well as data regarding participants' expectations and anxieties about returning to practice. The participants were also invited to participate in one of three focus group discussions, which were audio-recorded and transcribed and held at the end of the program. Field notes monitoring the mood and levels of engagement of participants were also taken. Content analysis was used to identify themes emerging from the data. Appropriate approval from the ethics committee was obtained. The course was 8 weeks with a minimum of 75 hours in practice.

Three key issues emerged from the data from the first group ($n = 17$): 1) the varied personal circumstances (economic necessity due to domestic changes related to separation or divorce and reduced childcare responsibilities) and professional histories of the returnees; 2) the challenge of providing adequate support in practice (a lack of understanding among colleagues and loss of status from previously held positions and a critical deficiency of mentorship opportunities) that reflected returnees' individual needs and aspirations; and 3) the importance of flexible employment opportunities to meet returnees' expectations of an appropriate work life balance. The findings of the study suggested that the decision to return to practice was not impulsive but was not a long-thought-out plan. The enrollment occurred due to critical changes in the person's life and that these changes increased their home life demands.

A key issue identified by the researchers was that managers, practitioners, and educators need to work closely together to ensure that there is sound understanding and support of the needs of returnees. The researchers stated that RTP initiatives are dependent upon the implementation of policies aimed at improving the working lives of healthcare staff. This study confirms that the issues and challenges facing a returnee

nurse are similar on a global scale and involve situational transitions that require

supportive programs and work environments to support the returnee and assist with

coping with multiple roles and confidence building. This study further suggests that the

nursing shortage is a global phenomenon that will potentially worsen in time due to the

insufficient supply of nurses, which cannot keep pace with the ever-expanding worldwide

population growth. This research study should provide some important quantitative data

that adds to the body of nursing knowledge about this phenomenon.

Hawley and Foley (2004) were interested in learning the effectiveness of

preparing nurses to return to practice. In this quantitative research of one refresher

program at University of North Carolina (UNC) Chapel Hill School of Nursing in North

Carolina, the researchers sent out 125 surveys to all of the 1990-2000 graduates (100%)

who had participated in the Nursing Update registered nurse refresher program offered

through the Continuing Education Department of UNC. The data collected included

demographics, a nursing employment post-program, effectiveness of the program in

preparing the graduates, and positive factors of the programs.

The researchers received back 30% of the surveys ($n = 37$). The participants were

41 to 60 years of age when they completed the course, and all resided in North Carolina.

Most had BS or Diploma degrees (n = 28), and a few had an Associate in Applied

Sciences (AAS) ($n=8$) or a master's degree ($n = 1$). Time away from nursing practice

ranged from 1 to 36 years (most respondents had been away 5 to 15 years). The reason to

take the course was a desire to return to nursing, change in marital status/income, and

children who were now older. The survey revealed that 78% of the respondents ($n = 29$)

were employed and 65 to 70% felt prepared for professional issues, clinical knowledge,

and nursing theory. The results of their program effectiveness revealed that of the participants (only 37 out of 125 surveys), 84% felt prepared with clinical skills, and 87% felt prepared with their self-confidence and role competence.

This research study elucidated that the most positive factor of their refresher course was the strong support of the program coordinator and clinical instructor (100%), as well as the strong support of their fellow students (86%). The combination of strong support and small student-to-faculty ratio (8:1) in the clinical setting were felt to be key elements that may be missing in other refresher programs, especially self-study formats with unstructured clinical experience with an assigned preceptor. The researchers never cited which statistical tests were performed to achieve the results of their study. The researchers did cite that a limitation of the study was the low response rate; this researcher wonders if it may have occurred due to some nurses being reluctant to admit that they were not employed post-program. This reluctance is a concern since the whole purpose of these programs is to support a returnee nurse's transition back into the workforce. This research study hoped to quantify the facilitating or inhibiting conditions that impact transition.

Walker and Merriam (1997) wanted to investigate the value of the Theory of Margin developed by McClusky (1963) as a predictor of adults' persistence in higher education. In this correlational study, the Margin in Life (MIL) scale, developed by Stevenson (1982), and a demographic survey developed by the researcher, were administered to 513 students in both a 4 year academic institution and a 2 year technical school. Of this sample, 215 students were over 25 years of age and comprised the nontraditional student sample. The main hypothesis tested whether or not the MIL scale

predicted persistence for the nontraditional student (over 25 years of age) through 3

consecutive quarters. Additional hypotheses tested for differences among demographic

factors, full-time versus part-time status, prior education, institution attended, and

between traditional and nontraditional students. The researchers utilized analysis of

variance and set the parameter for the study at $p < .05$. While the MIL scale failed to

predict persistence in higher education for nontraditional students ($p = .2853$), other

factors from the demographic survey, correlated using one way ANOVA and refined with

Tukey-HSD, revealed significant differences between specific groups of students. The

subscale items that demonstrated that the significant differences were health, religiosity,

interdependence, and self-confidence. Those who were younger, had strong faith, were

connected (interdependent), and possessed a higher self-confidence had higher MIL

scores than the older, non-traditional student, which suggested more power to achieve

goals. These outcomes suggest that the MIL scale used in this research endeavor may

have some usefulness in assisting students to assess their current situation and use this

knowledge in making a decision to start a demanding educational venture (such as a

refresher course). The returnee nurse would be considered a non-traditional student and

therefore may lack the needed power to achieve goals, hence the need for support.

Beckert and Day (2001) sought to explore the factors contributing to and benefits

received from participation in structured learning programs by select older adults. The

researchers wanted to test the assumption that individuals with a low margin would not

likely participate in structure learning activities. The MIL scale was administered to 163

older adults participating in a structured learning program. Approximately 35% of the

participants had a low margin according to the scale. The researchers followed up this

initial study with select older adults ($n = 9$) with low margin to explore the factors

contributing to and the benefits received from participation in a structured learning

program. In-depth, semi-structured interviews were conducted to explore the impact of

the factors of the Margin in Life scale:1) health, 2) religiosity/spirituality, 3) self-concept,

4) interdependence, and 5) parenting had on participation in structured learning activities

for these older adults. Grounded theory methodology was followed to analyze the data.

Health, religious beliefs, self-concept, social interaction, affordability and availability of

courses, and personal interest were among the factors contributing to participation in

structured learning activities by those studied. Benefits reported include improvement of

health, increased knowledge and understanding, improved self-concept, increased social

interaction, and improved quality of life.

Although this study did not inform the reader how the researchers chose the nine

participants (inclusive criteria) or mention protection of their rights, these results

supported McClusky's suggestion that participation in structured learning programs may

increase the "power" of older adults and help them better deal with life's challenges.

This research endeavor measured that power and determine the effect it has on

professional role confidence. Hence, the need exists for available and affordable

structured refresher programs that offer support and guidance for returnee nurses to help

"power" them to manage critical changing events in their lives to help them transition

back to safe, competent nursing.

The literature has shown that financial assistance, emotional support, and a sound

educational program facilitate the transition process. Support from family, friends,

instructors, employers, and financial institutions is beneficial to the adult learner whose

life is multifaceted and change is ongoing and transition is ever present. Barriball et al. (2007) affirmed in their multi-method study that support of family and especially colleagues in the field were vital as conditional facilitators to the returnee nurse. A key issue identified by the researchers was that a supportive educational and work environment was needed to support and encourage returnee nurses back to practice. Hawley and Foley (2004) reiterated the necessity of a supportive return to practice program with nurturing instructors and acceptance by colleagues in the field. Walker and Merriam (1997) further confirmed in their correlational research that adults need enough support and power prior to starting a new endeavor in order to be successful. Lastly, Beckert and Day (2001) emphasized the importance of structured learning activities for promoting improved power that can help adults to better deal with life's challenges.

The support cited in these studies resulted in positive outcomes of self-confidence and feelings of competence in the professional role. In these studies, the MIL scores have correlated and supported many of the natural and conditional constructs (situational changes, health, self-confidence, religiosity, and interdependence) identified in Meleis' Transition Theory and therefore can be an adjunctive instrument in supporting demographic data. This study had wanted to quantitatively corroborate the nature of the transitions (measured with the Life Experience Survey) and the conditional hindrances and facilitators (measured with the Margin in Life scale) experienced by these returnee nurses and show their strong relationship. Further, this study had hoped to demonstrate that an appropriate refresher program can make the difference and have a strong, positive impact upon the confidence level (measured with the confidence scale) of a returnee who may enter the program with negative life experiences and a low margin in life score.

Confidence

A common theme of concern that arose in the literature regarding the returnee nurse is the subject of self-confidence. As noted from the previous studies outlined, the theme of supportive educators, preceptors, and work colleagues was stressed by several authors (Barriball et al., 2007; Hawley & Foley, 2004; Becket & Day, 2001) since anxiety and lack of self-confidence among this group has been well documented (qualitatively) and the need for instructor approval. Confidence in one's professional role self is mandatory for today's practicing professional nurse.

Quant (2001) is often quoted in many of the articles already mentioned in the literature for his insightful discussion of the adult educational needs of a nurse transitioning back to active nursing practice. Although Quant gleaned his descriptive analysis from secondary data, he noted that one of the causes of anxiety for these RNs is an under-estimation of their ability to learn new things and doubtfulness of their ability to cope with new information and practice since they feel out of date and out of practice, which causes feelings of uncertainty.

Elwin (2007) felt that a key focus for reducing anxiety and increasing confidence in nurses returning to practice would be through reflective journaling by students of their application of acquired knowledge that would demonstrate synthesis of theoretical principles. The aim of her study was to carry out a thematic analysis of reflective journals written by participants ($n = 50$) in a return to practice program in order elicit common experiences and shared meanings of these nurses' learning journeys. Data was drawn from participants' journals across four consecutive programs in 18 months. All of the participants were requested to keep reflective journals during their 60 hours of

supported clinical practice. The participants provided informed consent, and codes were used to link journals to each cohort of students so there could be no direct identification.

The journals were analyzed using interpretive phenomenology based on Heidegger's ontological philosophy. The three common themes were anxiety, modes of learning, and the role of support. Journal entries describing feelings about participants' lack of competence and confidence added to their anxiety. It was crucial that experiential learning modalities were utilized in promoting the self-confidence of the participants who entered the program with a wealth of past clinical practice and situated knowledge that could be built upon. It was also extremely helpful that the program attempted to match clinical placements with the physical and social contexts in which the participants' previous practice was developed. The participant's past confidence in that environment was built upon, and the participant did not have to reinterpret or re-situate their learning to a different type of unit of practice.

The last theme identified by Elwin (2007), role of support, is also linked to confidence. Support can be viewed as an intervention or facilitator in decreasing anxiety and enhancing self-esteem and confidence. Whether support is perceived or received, both are "essential for successful integrations in the work-place as well as promoting feeling of self-worth and self-efficacy, both of which are important factors in the retention of nurses" (Elwin, 2007, p. 209). The researcher notes that the returnee transition from the nurse-self of old to the confident anticipated nurse-self of the future was facilitated by a supported learning environment and the importance of person-environment fit. This article elucidates the need for a well-structured program that supports returnee nurses and takes into account their past experience and knowledge in

order to foster improved competence and confidence. This study hoped to measure the growth in confidence by a post-interventional refresher course.

Nurses gain self-confidence through practice since judgments about care delivery and intervention strategies provide a nurse with a sense of security in their ability to function as a valued member of the nursing staff. Grundy (1993) felt that confidence is considered a very important aspect of rendering nursing care to patients, yet educators did not have a valid and reliable instrument to measure confidence for tracking the development of this phenomenon or studying the factors that influence the level of confidence. The purpose of her study was to determine the internal consistency, test-retest reliability, and the construct validity of the C-Scale in the measurement of confidence associated with performance of physical assessment. Thirty-nine student nurses in their first year of a baccalaureate nursing program completed the instruments; however, data from five of these students were not included due to attrition from the study or the program.

The researcher compared the mean confidence scores of the student ($n = 34$) performing physical assessments at the beginning and end of semester. To test statistical significance, the student's t-test for paired data was used to compare mean scores of the nursing students. The mean score of the C-Scale for the nursing students significantly increased ($p < 0.001$) from 13.6 measured at the 6th week of the semester to 18.5 at the end of the semester. The researcher also utilized concurrent validity by administering two other instruments along with the C-Scale (the C-VAS, which is a 100 mm confidence visual analogue scale and the C-VDS, which is a confidence verbal descriptor scale), which showed moderate to high correlations. The researcher felt that the two other tools

had some problems since the C-VDS has too few categories to capture the phenomenon and the C-VAS is uni-dimensional and may not capture the complexity of the phenomenon. The C-Scale is therefore a better measure of factors that influence the degree of confidence and evaluating the effectiveness of specific strategies aimed at increasing the level of confidence, especially during skill performance. This study is applicable to the returnee nurse since an important outcome measure (that has not been empirically measured in the literature regarding returnee nurses) is the development of confidence in re-assuming the role identity of the professional nurse in order to provide safe and effective care to patients. Each returnee must feel confident and supplement any feelings of role insufficiency in order to be an effective practitioner in today's health environment. This study hoped to measure the confidence growth phenomenon.

Petersen (2000) wanted to determine the effects a clinical preceptorship experience had on baccalaureate nursing students regarding critical thinking and self-confidence. Forty-eight senior-level baccalaureate nursing school student participants were drawn from three nursing programs in Iowa and Nebraska. The control group school in Iowa ($n = 10$) did not have a mandatory clinical preceptorship experience school program; whereas the other two programs did require a clinical preceptorship experience during the final semester for the experimental group ($n = 38$). The Watson-Glaser Critical Thinking Appraisal was used to measure critical thinking ability, and the Confidence Scale was used to determine self-confidence levels. An analysis of covariance (ANCOVA) was used to determine the effect of the clinical preceptorship experience on critical thinking ability and self-confidence levels. A Pearson product-moment correlation was used to determine the relationship between critical thinking and

self-confidence levels. The 0.05 level of significance was used for all statistical tests. The finding indicated that there is no significant difference in critical thinking ability or self-confidence levels of these students whether or not they completed a clinical preceptorship or not. The Pearson *r* results suggest that there is a weak negative correlation between critical thinking ability and self-confidence levels.

Most refresher courses have some type of clinical experiences for the returnee nurse; however, not all programs utilize the preceptorship model for this experience. Petersen's (2000) study may suggest that self-confidence is not adversely affected by those programs that do not offer such preceptor experiences for the returnee nurse. However, the negative correlation of the critical thinking ability to the self-confidence level of an adult may factor into the past experiences of a returnee. Perhaps those nurses who were required to utilize a high level of critical thinking in their past job performance may have more difficulty transitioning back to the workplace since their self-confidence may suffer from their high expectations. It is extremely difficult to have been an expert and now to be cast in a novice role again.

The development of self-confidence is a crucial element of nursing education. Nursing is a service profession, and those in its care must feel safe and reassured. The literature supports the issue of confidence for the professional nurse. Grundy (1993) felt that since confidence is such an important outcome of nursing education that the profession should have some empirical method of measuring this phenomenon. Petersen (2000) sought to discover if a preceptorship clinical experience would provide increased confidence and critical thinking. Even though there were no significant correlations with those with and without a preceptor, it was interesting to note that the level of confidence

was negatively correlated to levels of critical thinking. This is applicable to returnee nurses who may have functioned in their previous work life as critically thinking experts who now view themselves as deficient compared to their past self. These beliefs can adversely impact their confidence level. Elwin (2007) also identifies confidence, educational support, and roles that facilitate the nurse-self of the future.

This research study's main focus was confidence since it is a major theme identified in most of the literature relevant to returnee nurses transitioning back to active current practice. However, there is a paucity of quantitative data concerning this phenomenon in this population of nurses in all of the literature. This study hoped to provide the empirical statistical data concerning confidence growth in one's professional role for returnee nurses since this is a very important learning outcome by post-refresher program and a mastery outcome in transition theory.

Professional Role

The current role of the professional nurse is challenging due to the increasing complexity of today's healthcare. Returning nurses must move forward from the nurse of old to the nurse of new, according to Elwin (2007). Re-entry nurses are very aware that they need updates and mentoring. The proactive engagement to participate in a refresher course reveals that these returnee nurses no longer feel sufficient in their role, and they need to supplement and build upon their past knowledge base in order to rejoin the workforce. Role supplementation is defined as any deliberative process or intervention to decrease, ameliorate, or prevent role insufficiency. Role supplementation is further defined as the "conveying of information or experience necessary to bring the role incumbent and significant others to full awareness of the anticipated behavior patterns,

units, sentiments, sensations, and goals involved in each role and its complement"

(Meleis, 1975, p. 267, as reported in Meleis, 2010, p. 540).

Manning and Neville (2009) examined this issue of work-role transition and supplementing one role, as a staff nurse, for another, as a clinical nurse educator. In a qualitative study utilizing transition theory as a conceptual framework, a sample of eight clinical nurse educators (CNEs) were interviewed about their transition from an experienced staff nurse to an inexperienced educator. The aim of the study was to describe nurses' experiences as they transition from staff nurse to the role of CNE. The eight CNEs were a purposive sample, and all provided written consent to participate after the study was described. They were assured of anonymity and were allocated pseudonyms. All semi-structured interviews were tape recorded and the data transcribed by the researcher. The participants were not permitted to read the transcripts for accuracy checks. Thomas's general inductive approach was utilized to sort and organize the data into significant themes. The themes are reported in three phases: endings, neutral zone, and beginnings.

Phase 1-Endings represented a time of letting go of old ways of being that revealed the following themes: 1) thinking back when the CNE position was applied for; 2) went in blind into the position since participant was unaware of the CNE role and what it entailed; 3) orientation or disorientation since none of the participants received an appropriate orientation and they were unsure of their roles; and 4) more than expected as the role contained numerous extra responsibilities. Phase 2, or the Neutral Zone, represented a time that had positive and negative aspects, and the CNE felt unsure and vulnerable. Identified themes revealed: 1) chaos and turmoil - loss of confidence and

self-esteem and confusion over past collegial relationships and the need to develop and form new relationships; 2) finding support - in the novice role again and the need to find a mentor and networks for support; overwhelmed- intra-role conflict and trying to establish role clarity and assuming too much work load and wanting to please; 3) stress levels - commitment to the role and the organization and feeling like an impostor since they did not feel they had the skill for the job. Phase 3, or Beginnings, included: a time of new understanding and values, attitudes, and new identities. The theme of opening doors revealed relinquishing their old identity and embracing the new role as CNE.

This study's findings are applicable to the returnee nurse transitioning from the nurse of old to the nurse of new. Any type of work-role transition should have the formation of wider support relationships to support the process, as well as communicating with more experienced mentor or colleagues. Leaders should be acknowledging the work role transition and be aware of the various phases in order to help reduce potential or actual stressors that could adversely hinder the mastery of the role transition. The article further elucidates that developing role identity is integral to any orientation program and needs to be an ongoing process. As returnee nurses transition through a refresher course, it is crucial that the program provides excellent mentors to act as role models to help these nurses embrace their updated identity as a professional nurse. These programs must provide a clear picture of what is expected of a competent nurse in today's environment to reduce stress and feelings of insufficiency. Hopefully, this research demonstrated growth in the professional role confidence scores, which indirectly reflects excellent teaching and role modeling.

In another study, Duke (2010) explored the lived experience of nurse practitioner (NP) graduates' transition to hospital-based practice. The purpose of this hermeneutic phenomenological study was to gain insight into the meaning and lived experience of NPs with at least one year of work experience regarding their initial transition from new graduate to hospital-based practitioner. The researcher used a purposive sample of NPs who had one to three years of NP practice experience in a hospital setting and met the inclusion criteria. Twelve female participants were interviewed after giving informed consent and were voice-recorded via open-ended telephone interview. The age range of the 12 NPs was 29 to 51 years ($m = 38.9$), with an average number of years of RN experience being 10 years. Each participant's anonymity was assured by requesting that he or she choose a pseudonym. The final number of participants was determined at a point when data saturation had been reached. The research question was, "What is the lived experience and meaning of transitioning into hospital-based practice from the perspective of NPs with at least one year of work experience?" (p. 4). Meleis' Transition Theory was utilized as a framework for this study along with van Manen's (1990) research approach to determine applicable themes. Six themes emerged from this research: Going from expert RN to novice NP; System integration; "Don't Give Up;" Learning "On the Fly;" They Don't Understand my NP Role; and Succeeding Through Collaboration.

Despite having had a good foundational nursing experience as an RN, study participants expressed a great deal of role uncertainty about themselves and their new NP role. The NPs' situational transition experience (Meleis, 2010) was supported by changes they expressed in their professional roles and was associated with their need to acquire

additional skills and knowledge, while coping with emotions such as low self-esteem, stress, and uncertainty. Mentors provided support and feedback, which was a positive influence on the NPs' self-confidence. Duke (2010) suggested that the role transition of an NP would be negatively impacted if the NP's self-confidence was poor or stunted. The role transition process from RN to NP was consistent with several of the transitional conditions as described by Meleis (2010). Returnee nurses may also experience this uncertainty phenomenon related to their identity as an RN after a hiatus. Many of the returnee nurses in a refresher program can be out of practice from 2 to 25 years due to various changes in their lives. The role they remember as a nurse has changed, and they too face uncertainty as they try and master the RN role in today's healthcare environment. This research study hoped to quantify the transitional conditions that impact role confidence.

Harrison (2004) wanted to examine these non-traditional education adult students transitioning back to higher education while fulfilling multiple roles in life. The purpose of her study was to explore the lived experience and Margin in Life of re-entry women. The researcher utilized McClusky's Power Load Margin Theory (1970) for her study that consisted of 10 re-entry nursing students who volunteered for participation. McClusky was interested in the adult learner and developed his Theory of Margin to predict adults' persistence in higher education. Simultaneous triangulation was employed applying quantitative (only one instrument (MIL scale)) and qualitative method (phenomenology) at the same time in order to enhance the understanding of the lived experience of the participants. Participants ($n = 10$) completed Stevenson's Margin in Life (MIL) scale (1982) and demonstrated an average margin of 0.60492, which is a strong predictor of a

healthy margin to be successful in an endeavor. Systematic phenomenological analysis revealed five main themes: success (persistence to finish), support (from family, friends, and self), transitions (academic and financial), challenges (balancing responsibilities and relationships with faculty and hospital staff), and relationships (with fellow students). The Margin in Life score documented for the 10 participants in this study was all above 0.50, indicating a margin well within the limits identified as normal by McClusky in order to be able to handle new challenges or deal with emergencies in life. All of the participants progressed successfully through the course of study and managed multiple roles, which is congruent with the strong margin demonstrated by the Margin in Life Scale (Stevenson, 1982).

The population for this study was small and lacked persons of color or males and should therefore be replicated with such in order to determine the reality of the lived experience of these returnee nurses. However, Harrison felt that it was important for nurse educators to have an understanding of the complexity of the lives of these students. The Margin in Life instrument proved to be an excellent tool to assist a researcher to elucidate the facilitators and inhibitors experienced by adults as they juggle their many roles and responsibilities during a transition period of their life. It was hoped that this MIL instrument would quantify these transition conditions for the re-entry nurse in this research study.

Professional role acquisition requires time and development with clear role modeling and opportunities for role taking as cited in the previous two articles. The qualitative research by Manning and Neville (2009) suggested that supportive relationships helps reduce stress and improves self-confidence. Mentors are positive role

models and help with professional role identity as a CNE. Duke (2010) also addressed

the issue of role uncertainty for new NPs. The strong supportive role of the mentor was

an important aspect of successful transition into the NP role. Uncertain returnee nurses

would also benefit with strong mentors to help with role modeling. Lastly, Harrison

(2004) combined quantitative and qualitative methods to help elucidate the confounding

roles that can make the transition situation a complex endeavor unless there is adequate

support to facilitate the change. This study hoped to demonstrate that a therapeutic

refresher program may provide effective professional role preparation for returnee nurses.

It is hoped that this research study demonstrates the significant difference between the

pre- and post-refresher program professional role confidence levels of these returnee RN

participants, which would indicate that a therapeutic nursing outcome has occurred.

Chapter Summary

This chapter has demonstrated that historically, continuous learning has been

paramount to competent, confident nursing care and better patient outcomes. The

profession needs to foster and support more returnee refresher programs to reduce the

nursing shortage. Several articles cite the importance of support (educational, emotional,

and financial) for these returnees in order to promote self-confidence. The literature has

also shown that self-esteem/self-confidence is linked to successful professional role

identity and is an attribute that is crucial to the development of a safe, competent nurse

who instills trust and fosters better patient outcomes. Professional role confidence is an

important trait that should be promoted and measured pre- and post-refresher course to

determine the effectiveness of a continuing education program. Strong quantitative

analytical data concerning the professional re-development of this distinct group of

nurses was lacking in the literature and needed to be promoted and recorded. It is hoped that this correlation study adds to the body of nursing knowledge about the phenomenon of confidence and transitioning back to practice. It is hoped that this study provides important quantitative data for the acquisition of financial grants for the expansion and improvement of future re-entry programs. It is also hoped that data derived from this study provides healthcare organization's human resource recruiters vital information that should be taken into consideration when a returnee nurse applies for a position.

CHAPTER THREE

METHODS

The purpose of this study was to test the Meleis' Transition Model among a group of RNs participating in a refresher program with the intent to re-enter nursing practice after a period of non-practice. This study examined the effect of a preparatory refresher course upon the professional role confidence level of re-entry nurses while transitioning back to contemporary practice. Another aim of this study was to examine other variables (loads/burdens in life and power/positive influences/conditions in life) that may inhibit or facilitate the transition of a re-entry RN to return to the work force.

Meleis' Transition Theory (2010) provided the framework for this study. There were three independent variables: the nature of the transition, the transition condition, and the interventional nursing refresher program that is advertised to improve an individual's professional self-confidence (the dependent variable). Select demographic variables (gender, age, marital status, ethnicity, socioeconomic level, years of past nursing experience, academic degrees, years away from nursing, and primary reasons for leaving and returning to nursing) may act as mediating variables that may affect the transition conditions and confidence level. This study utilized the Life Experience Scale (LES) to operationalize nature of transition, the Margin in Life scale (MIL) to operationalize transition conditions, and the Confidence Scale (C-Scale) to operationalize professional role confidence. The demographic survey was used to describe the sample population and demonstrate homogenicity of the participants.

In this chapter, the following are presented: overview of the design; hypotheses reviewed; setting and sample; ethical considerations for this study; recruitment and

proposed data collection procedure; instrumentation; data analysis plan; and chapter

summary.

Overview of the Design

A correlation design utilizing a pre- and-post-test format was used to ascertain the

relationships between the predictor (independent) variables: the RN refresher program,

the nature of transition measured by the LES score, transition conditions measured by the

MIL score and the criterion (dependent) variable, and professional role confidence level

of returnee nurses measured by the C-Scale. A correlation design helped to determine

whether a relationship existed among the variables and to what degree a relationship

existed in order to make predictions without identifying cause and effect (Gay et al.,

2009).

Hypotheses Reviewed

The following hypotheses were tested to examine the relationship among the

study variables:

H1. There will be a correlation between the nature of transition predictor variable

of perceived total life experiences and transitional condition's Margin in Life composite

score for health/body, self-concept, interdependence/ connectedness, parenting

satisfaction, and religiosity/spirituality, among RNs enrolled in a Refresher Program.

H2. There will be a correlation between transition condition variables of health/

body, interdependence/ connectedness, self-concept, parenting satisfaction, and

religiosity/ spirituality, and the outcome criterion of pattern of response of professional

role confidence among RNs enrolled in a Refresher Program.

H3. There will be a significant difference between the mean scores for pattern of response of professional role confidence and measured pre- and post-therapeutic intervention of a refresher program, among RNs enrolled in a Refresher Program.

Setting

Assessed subjects were returnee nurses who were registered for a refresher course from advertised programs in two cities in the U.S., one in the Northeast and one in the Southeast. The two programs selected to participate in this study were chosen since they are similar in format (classroom didactics and one clinical instructor for the group), run consistently two to four times per year, and have been rarely cancelled, according to the program directors.

The context for this study took place at two locations: a mid-sized college in the suburbs of New York (NY) and a large college in southeast Florida (FL). Both institutions are four-year colleges that offer degrees in Associate in Arts, Associate in Science, Baccalaureate Degrees, Master Degrees, and Continuing Education courses. The refresher programs are offered through the continuing education division of each college. Each program combines didactic instruction and hospital clinical hours of practice in order to complete the program. The northeast program (NY) is 6 weeks in duration, and the participant is awarded an educational certificate with assigned continuing education units (CEUs) for the 160 contact hours (80 hours of didactic and 80 hours of clinical). The southeast program (FL) is 12 weeks in duration, and the participant earns 10 college credits upon completion (which includes 80 hours of didactic and 160 hours of clinical). Permission from program directors was obtained (Appendix

B) to survey the students after Institutional Review Board (IRB) exempt status was granted from the researcher's university.

General Sampling Strategy

Returnee nurses entering a refresher program are a distinct population of nursing students engaged in a unique program; therefore, a purposive sampling of participants was necessary. The sample could not be randomized or stratified since it consisted of a purposive sample. Purposive sampling is the process of selecting a sample that is believed to be representative of a given population (Gay et al., 2009, p. 134). These subjects are believed to be representative of this population of nurses.

Projected Sample Size

An adequate sample size ensures reliability of a study by minimizing the chance for interpretative error. Kerlinger and Lee (2000) informed researchers that the smaller the sample, the larger the chance that a standard error can occur, and the larger the sample, the smaller the chance for a standard error to occur. Correlation studies should have at least 30 participants in order to establish the existence or nonexistence of a relationship (Gay et al., 2009). A study should aim for a sample size of 15 participants per independent variable, or a total number of 50 more than the number of independent variables.

Sample Size by Power Analysis

A priori analyses was conducted using G*Power 3 (Faul, Erdfelder, Lang, & Buchner, 2007) in order to compute sample sizes for specific statistical tests given effect sizes, alpha levels, and power analyses. This analysis was performed to balance between committing a Type I and Type II error (Kerlinger & Lee, 2000). The alpha level (α) was

set at .05 and beta (β) at .20. The preferred power calculated was $1 - \beta = .80$. A medium effect size was chosen, which is acceptable in behavioral research (Kerlinger & Lee, 2000).

All variables were measured as continuous data. Hypothesis 1 was tested for correlational relationship between two variables by means of a two-tailed Pearson's Product moment correlation. Hypothesis 2 tested the relationship between five predictors to one outcome criterion. The statistical test was standard linear multiple regression. Based on this parameter, the minimum sample for hypothesis 1 was 84 participants and for hypothesis 2, the minimal sample was 92 participants. Hypothesis 3 used a dependent *t* test to compare the pre- and post-intervention mean scores to determine if the intervention of engaging in a refresher program improved professional confidence among the participants. The minimum sample size was 34. It was anticipated that some questionnaires may be returned incomplete (when greater than 30% of the data is absent) and may be unusable; therefore, at least 108 individuals were recruited to participate.

Inclusion Criteria

The sample included RNs in the state of Florida and New York. The inclusion criteria for participant selection included the following: each participant must be (a) a RN, (b) licensed by the State of Florida or New York and have been out of the nursing workforce for two years or more, (c) currently enrolled in a RN Refresher Program with a theory and clinical component, (d) able to read and speak English, and (e) able to provide informed consent to take part in this study, which involved human subjects. It was anticipated that all participants who registered for a refresher course would meet this criteria.

Exclusion Criteria

The exclusion criteria for participation in this study included the following: (a) an invalid or expired RN license, (b) not currently enrolled in a refresher program that has a theory and clinical component, (c) cannot read or speak English, or (d) cannot or would not provide consent to participate in completing the surveys for the researcher.

Ethical Considerations

Respect and protection of the participants was observed by the researcher by first obtaining Institutional Review Board (IRB) approval from Barry University (Appendix A) for this study. Since this study intended to have the participants remain anonymous, IRB exempt status was sought and approved. Letters of affirmation of participation from the program directors was received from the intended study sites in order to execute this study (Appendix B).

A researcher has an obligation to conduct his or her study in an ethical manner and convey the purpose of the study to the participants in a clear, honest manner so that they may choose to partake in the study and that deception does not occur by the researcher (Creswell, 2008). This researcher provided a clear explanation of the study to each class of refresher returnee nurses. Each potential participant was handed a cover letter describing this study followed by a verbal description in class about the proposed study so that any questions were addressed.

Participants were informed that it was their right and their choice whether or not to take part in this study. The study had the participants remain anonymous since no one, including the researcher, would be able to link the individual surveys to anyone who voluntarily participated in this study. The surveys did not have any identifiers and were

only available to the researcher and her advisor to review. The cover letter (Appendix D) provided detailed information about the study that included aims, benefits, data collection procedures, data security, and the lack of benefits or potential risks for the participants. Although there were no associated risks or direct benefits of this study to the participants, the future returnee nurses may benefit from the findings of this study.

The volunteers for this study were also informed verbally and in the cover letter that by completing the surveys, they were consenting to participate in this study and that they may choose to decline to participate at any time during the study without penalty (Gay et al., 2009). Contact information for the researcher, her advisor, and the contact person for Barry University's Institutional Review Board were also provided in the cover letter if any questions should arise at a later date.

Participants were asked to place the completed survey packets (each enclosed in a sealed envelope) in a sealed box with a lid located on a table in the front of the classroom. Refreshments were provided by the researcher for all those in the class to enjoy while completing their surveys or enjoy at their convenience. In addition, a small gift (in the form of a pen with a light) was provided for each participant to enjoy; one was enclosed in each packet envelope as a thank you for their participation at each survey session. All data was entered into SPSS for analysis and was stored in three locations to minimize the threat of lost data: on a computer hard drive, on a secondary removable hard drive, and on a small flash drive. All paper data was stored in a locked cabinet only accessible to the researcher and will be destroyed after five years. Participants were informed that aggregate findings from this study will be submitted for journal publication and podium/poster presentations in the future.

This study accepted the following principles as being true without proof or validation: (a) that the participants answered the questionnaires honestly and thoughtfully, (b) that the participants devoted adequate time and effort to their responses, and (c) that the researcher was independent of those being researched and the findings were not influenced by the researcher.

Access and Recruitment

Since the researcher had approval to recruit volunteers for this study by the refresher course educational director of each institution (Appendix B), the researcher posted flyers in each continuing education office site (Appendix C), which described the proposed study. The researcher also had additional copies available for distribution to each registered student scheduled to take the upcoming refresher course. In the beginning of the program, the researcher was introduced by the class instructor on a prearranged date and time. All potential study participants were provided with an informational cover letter (Appendix D), and a 10 minute verbal informational session outlined the aim of this study, the researcher's interest in returnees as a past educator in continuing education, and the lack of quantitative data in the literature about returnee nurses that may be useful for future programs and funding procurement. The researcher described the two-phase pre/post-test study: Phase 1, which took place at the beginning of the program and included a 120-question survey, and Phase 2, which took place at the end of program with a short 5-question follow-up questionnaire.

It was explained that the researcher needed to have each of the participants choose a personal four-digit number that they could easily recall. The chosen number was inscribed on both surveys so that the researcher had no difficulty correlating the results of

the two surveys and the participants remained anonymous. The enrollees of this study voluntarily agreed to be surveyed by the principal investigator, but only after all questions had been satisfactorily answered. Their consent for involvement was their participation and completion of the questionnaires. The choice to partake in this two-phase study (beginning and end of program) was voluntary and did not affect their progression in the program. Participants were assured that they could withdraw from the study at any time without consequence. Those who chose not to take part in this study went to an available lounge with their refreshments during the period of time it took to survey the participants.

Procedure

Once the participants read the cover letter, had their questions answered, and agreed to participate, those who consented to partake in the study were given in Phase 1 a manila envelope containing a survey questionnaire, a small appreciative gift (pen with a light), and the researcher's business card for recording a personal four digit number for later recall in Phase 2 of this study. The Phase 1 questionnaire (120 questions that included a Confidence survey [C-Scale], the Life Experience Survey [LES], the Margin in Life survey [MIL], and a demographic survey) took approximately 35-45 minutes to complete. Since refresher program classes are typically small (less than 15 students per class), there were multiple cohorts of students surveyed. To ensure an adequate sample size of 108 participants or more, each packet had a **N** (for northeast site) or a **S** (for southeast site) on the left-hand corner to differentiate for the researcher the location source of the data since the programs do vary slightly in allocation of CEUs/college credits and clinical hours. There were corresponding numerical listings (1, 2, 3, 4 ...)

next to each location letter to keep record of each class survey. For example, N-1 would be the first class in the Northeast site, whereas S-2 would be the second class surveyed in the Southeast site.

The students were reassured that their responses were anonymous and that they did not have to answer any questions on the surveys that they feel are intrusive or personal. The returnee students were asked not to place any personal identifying information (such as a name or address) on any of the forms. However, the students were asked to choose a four-digit number that is significant to them that they easily recalled for use in Phase 2 of the study. They were instructed to place this number in the right upper corner of their survey and on the researcher's business card to place in their wallet for use in Phase 2.

Once the Phase 1 surveys (120 questions) were completed (approximately 35-45 minutes), the participants were asked to place the completed survey packet envelope into a sealed box with a lid at the front of the classroom and encouraged to take a short break (refreshments provided by researcher) and enjoy their gift. The researcher secured all surveys and returned to her office as soon as possible. All surveys completed by the participants were inspected for completeness since when greater than 30% of the data is absent, the survey is considered unusable and excluded from analysis (Creswell, 2008) and therefore destroyed (shredded).

The students had the researcher re-visit them at the end of their program for the second phase of the research study. The researcher reminded them of the purpose of the study and asked that they complete the second questionnaire if they voluntarily chose to. The researcher reminded them that there were no consequences to them if they chose not

to participate in this phase of the study. The researcher distributed the second survey (that was printed on pastel colored paper for easy identification of the post-survey) that consisted of 5 questions with a multiple-choice answer format, which took no longer than 10 minutes to complete. Each participant was again asked to record their four digit number on the right-hand corner of the questionnaire for collation of the data with the first survey. If participants had trouble recalling their personal number, they referred to the researcher's business card in their wallet upon which they had previously recorded their meaningful number. The researcher also had a list of the numbers used by that cohort that could be easily checked by a participant. After completing the survey, the participants deposited their surveys into a sealed box. The researcher again secured the second surveys and examined them for completeness in her office prior to entering the data into SPSS and storing the surveys with Phase 1 questionnaires in the designated locked cabinet in her home office.

Data Management and Storage

All paper surveys were protected in a locked file cabinet accessible only to the researcher, and the computer data was stored in the following three locations to minimize the threat of lost data: on a computer hard drive, on a secondary removable hard drive, and on a small flash drive. Data from these surveys were also entered into SPSS V21.0 (2012) for analysis. The post-course surveys were joined with the pre-course surveys and placed in the same locked file cabinet. Standard linear multiple regression correlation and dependent two-tailed t-test were used to analyze the computer data. All data will be held for a period of five years and then destroyed (shredded).

Instruments/Measures

The researcher used the following instruments to collect data for this study, which were placed in each research packet (Appendix E): (a) a researcher-developed demographic instrument to determine homogenicity of the population and the discovery of potential mediating variables; (b) the Life Experience Survey (LES) (Sarason et al., 1978) to measure the nature of the transition experience of the participant; (c) the Margin in Life (MIL) (Stevenson, 1982), to measure the transition conditions present in the participants life as being burdensome or powerful; and (d) the confidence scale (C-Scale) (Grundy,1993) to measure the professional role confidence level of the participant before the refresher program (Phase 1) and after the interventional refresher program (Phase 2).

The chosen standardized questionnaire tools are noted in the literature to be reliable and valid instruments. A standardized test allows comparisons among test takers from anywhere since the test is administered, scored, and interpreted in the same way no matter where or when it is used (Gay et al., 2009). However, self-report instruments have a common problem of a tendency of an individual to respond in a particular way (response set) that cannot be controlled by the researcher. The researcher received permission to utilize all standardized instruments (Appendix F) from the publishers.

Demographic Questionnaire

A 10-item demographic questionnaire (Appendix E) developed by the researcher was used to describe the participants and possibly identify any mediating variables that might impact this study. Item 1, gender, is a nominal level item and serves to describe the participants since nursing is predominately female, and most of the literature cites child-bearing/care and family issues as reasons for women taking a hiatus from their

career. Item 2, age, is an open-ended item that again helps to describe the participants since the literature identified women primarily in their forties as registering for refresher courses after raising their family. Item 3, ethnicity, is an open-ended item that helps to describe the participants in the sample. Item 4, marital status, is a nominal item that may correlate to emotional support conditions during transition. Item 5, socioeconomic status, is an ordinal item that may correlate to a negative situational change or a burdensome condition. Item 6, years in nursing experience, is an open-ended item that may help to describe the participants and may positively or negatively impact MIL score and confidence level in the beginning of the program. Item 7, highest academic degree, is an ordinal item that may correlate to the MIL score since education has been noted in the literature to act as a form of empowerment. Item 8, years out of active practice, is an open-ended item and helps to describe the sample of participants and the amount of hiatus years that may impact the beginning MIL score and confidence levels. Item 9, reasons for leaving nursing, is a nominal item that seeks to learn about the transitional situational variables that impacted the participant's hiatus from nursing. Item 10, reason for enrolling in course, is a nominal item that again seeks to learn what situational transitions may be impacting the participant's return to the profession.

Content validity was affirmed by submitting the instrument to the RN refresher course instructors at each research site to verify if the information requested is understandable and relevant to the selected population planned. Since there were two different sites for sampling, the researcher was able to determine the reliability of this instrument and demonstrate homogenicity of these two groups with this demographic instrument, which was evaluated for internal consistency by means of Cronbach's alpha.

The widely accepted value of .70 was used. The criterion used to identify poorly

functioning items had a correlation of <.15 between an item and the subscale score.

Life Experience Survey

Life-changing events can be stressful and can adversely affect one's health and

psychological well-being and have instigated numerous past research experiments.

Scientists have been trying to quantify life stress that results from the impact of life

changes. Holmes and Rahe (1967) developed a widely used instrument to quantify the

impact of life change and the stress it creates through the Social Readjustment Rating

Scale (SRRS). The SRRS is a self-administered questionnaire that contains 43 events

that the subjects respond to by checking those events that pertain to their recent

experiences during the past year. Events may vary in terms of their desirability

depending on the circumstances and perceptions of the respondent. However, the SRRS

instrument fails to capture the desirability of an event; desirable and undesirable life

events are combined in determining the life stress score.

Noting the shortcomings of the SRRS instrument, Sarason et al. (1978) developed

the Life Experience Survey (LES) to assess the impact of life changes that allow for a

separate assessment of positive and negative life experiences as well as individualized

ratings of the impact of events. They utilized 34 of the items on the SRRS instrument

and further refined their instrument by gender-specific other items from the SRRS. For

example, the pregnancy item has a female or a male response. Since males cannot carry a

fetus, their response differs from a female since males can be involved with a woman

who is carrying their child, which can dramatically change their lives too. This

instrument not only acknowledges the total change score but also considers the positive or negative effect of the change and also the degree of that effect (-3 to +3).

Reliability. The researchers conducted two test-retest reliability studies on two groups of undergraduate psychology students ($n = 34$ and $n = 58$, respectively). Pearson product-moment correlations were computed to determine the relationships between scores obtained at the two testings. Test-re-test correlations for the positive change scores were .19 and .53 ($p < .001$), for the negative change scores were .56 and .88 ($p < .001$), and for the total change scores were .63 and .64 ($p < .001$). The researchers noted that the finding may have varied because of the small sample size; however, they suggest that LES is a moderately reliable instrument, especially when the negative and total change scores are considered. Also the five- to six-week test-re-test interval may underestimate reliability because subjects may have experienced new events during the intervening period.

Validity. The researchers in this study wanted to compare the SSRS and the LES. They performed a comparative study of 69 female subjects from an undergraduate human sexuality course. The subjects were given the SSRS, LES, the Beck Depression Inventory, and the State-Trait Anxiety Inventory. A surprising finding was that no significant correlations were found between anxiety and the four life change measures (SSRS score, positive score, negative score, and the total life score). However, significant findings were obtained for correlations with the Beck Depression Inventory. Correlations between positive, negative, and total LES scores and depression were .02, .37 ($p < .01$), and .24 ($p < .05$), respectively. The correlation between the life change unit score from SSRS and depression was .17 (*ns*). The difference between the

correlations obtained with the LES negative change score and the SSRS life change unit score was significant, t (66) = 2.31, $p <$ .05. The results of this study suggested that the LES possesses certain advantages over the SSRS as an instrument for assessing life changing stressful events. This instrument was found to be valid since the negative life change score significantly correlated with stress-related and self-rated depression measures.

A major consideration in the assessment of life stress concerns the nature of the relationships obtained between life change scores and stress-related dependent variables. Scores on the LES, the Beck Depression Inventory (Beck, 1967), and the Internal-External (I-E) Locus of Control Scale (Rotter, 1966) were obtained for a sample of 64 (34 males, 30 females) college students drawn from undergraduate psychology courses. Results revealed a significant relationship between negative change and scores on the Beck Depression Inventory (.24*, $p <$ .05). An additional finding was that individuals who report having experienced high levels of negative change appear to be more externally oriented (locus of control = .32**, $p <$ .02), perceiving themselves as being less capable of exerting control over reinforcement contingencies in their environment. The result suggests that life stress may affect individuals differently depending on the degree of their perceived control over events. Therefore, this instrument was an excellent choice in assessing the positive or negative impact of life-changing events that have occurred to a returnee nurse in the past year. In addition, this instrument is an appropriate measure to compare to conditions affecting the control of those life situations that were measured by the Margin in Life scale.

Scoring. The LES instrument (Appendix E) includes 60 items divided into two sections. Section 1 contains 47 life changes that are common to individuals in a wide variety of situations and an additional three blank lines for items not mentioned for a respondent to add. Section 2 contains 10 items that are for traditional students only and pertain to academic life and were not used for this study.

As the subjects read each of the 47 items, they were asked to rate separately the desirability and impact of events that they have experienced in the past year (0-6 months or 7 months-1 year) that they perceived as a positive or negative impact on their life at the time of occurrence. Ratings are on a 7-point scale ranging from extremely negative (-3) to extremely positive (+3). If an event did not occur, the item is coded as 0. Every event that occurred is coded as one "life change unit." In order to sum up the impact ratings: A positive change score was derived by summing the impact ratings of those events experienced by the subject as positive; a negative change score was derived by summing the impact ratings of those events experienced by the subject as negative. By adding these two values, a total change score can be obtained representing the total amount of rated change (desirable and undesirable). This instrument may provide an educator some insight into an applicant beginning a refresher program to determine individual variations of how each respondent perceives the transition of which they are the center.

Margin in Life Scale

McClusky, a psychologist, was concerned with finding ways to help adults maintain a positive approach to life and examined adult learning. He developed the "margin theory" in 1963 as a means for studying the complexities of the adult years.

McClusky felt that adults face continuous growth, change, and integration and constant effort must be made to use available energy to meet living responsibilities and any unpredictable crises or problems.

According to McClusky (1963), the key factors of adult life are the load the adult carries in living, which is the self and the social demands required by a person to maintain autonomy, and the power, which is the resources, abilities, possessions, positions, and allies a person can command when coping with load. Loads that dissipate energy can be external (things in the environment such as family, career, socio-economic status, or community) or loads can also be internal (physiological function, intellect, spiritual/religious concerns, self-concept, goals, and self-expectations). Power is any source of energy that can be used to accomplish the load. External powers include physical or social skills, economic status, and family, work, or community. Internal powers include physiological function, intellect, education, self-concept, spiritual/religious strength, and goals.

McClusky's formula for margin (M) was designed that the load (L) was the designated numerator, and the power (P) was the designated denominator ($M = L/P$). This formula for his theory suggests that the greater the power in relationship to the load, the more margin will be available to cushion or handle load requirements (McClusky, 1970). Theoretically, one could increase the margin available by either decreasing the load or increasing the available power. However, McClusky never developed a research instrument so that MIL could be measured in adult subjects. Stevenson (1982) first developed an instrument to measure load, power, and MIL scale that gives a quantitative and objective way to study the life in process of adults. This instrument focuses attention

on the complexities of adult life (health, religion, connecting with others, parenting, and confidence) and therefore aligns well as a quantitative tool to measure many of the transition conditional concepts discussed in transition theory.

The instrument designer, Stevenson, remarked that the scale was mostly used as an assessment tool to gather and organize data about several dimensions of adult life. The value of the load to power ratio is its usefulness in describing the amount of margin involved in adult growth and adjustments (or transitions) to life. The valid and reliable measurement of load, power, and margin should aid in measuring the whole human being as an interactant in his or her life space, which aligns with Meleis' Transition Theory.

Reliability. Instruments are noted to be reliable when the measurement results of the same items produce similar outcomes. Kerlinger and Lee (2000) reported that reliability is the lack of distortion or consistent precision of a measurement by an instrument and use such synonyms as dependability, stability, and predictability. Through methodological studies, Stevenson (1982) was able to develop and refine the MIL instrument with excellent results for validity and reliability. Stability was tested through test-retest reliability, and Cronbach's alpha reliability coefficients were obtained to test for internal consistency. This instrument has evolved: Form 1 (211 items) tested 146 men and women subjects; Form 2 (203 items) was given to 103 volunteers, of which 66 subjects were repeaters from Form 1. Item analyses and deletion were performed using Pearson product moment correlation coefficients, which helped reduce the 203 items to 94 on Form 3. Further testing and refinement has produced Form 4, which has 58 items across five subscales that measures discrete dimensions of adult life: health, self,

family, religiosity/spirituality, and connectedness. Each of the subscales produced r >

.80.

   Validity. Validity measures whether the instrument is serving its purpose and

measuring what it is supposed to measure (Gay et al., 2009). A factor analysis was

performed and showed encouraging compatibility with the dimensions of life upon which

the subscales were originally developed. Therefore, validity was established for this

instrument through factor analysis and the known-groups approach to construct validity.

Although there are no published studies utilizing the MIL scale to measure the load and

power levels of returnee nurses enrolled in continuing education re-entry refresher

program and attempting to transition back to professional nursing practice, there are

many studies that have used the MIL scale instrument to measure different aspects of

adult life, especially the adult learner returning to school to further his or her

undergraduate education.

   Harrison (2004) in her dissertation study used the MIL scale among re-entry

women who would be returning to school for a traditional baccalaureate nursing

education. The purpose of the study was to explore the lived experience and margin in

life of re-entry women (n=10) enrolled in two traditional baccalaureate nursing programs

in the Midwest. These non-traditional students (several years post-high school age)

frequently fill multiple roles in addition to their student role. Demographic data was

collected (designed by the researcher), and semi-structured interviews were performed.

The average MIL score was 0.60. Simultaneous triangulation was employed applying

quantitative and qualitative methods. Five themes were identified and were congruent

with success and support. All the participants progressed successfully through the course

of study and managed multiple roles, which is congruent with the strong margin demonstrated by the MIL score. The instrument was found to be a reliable predictor of success for this population of non-traditional nursing students.

Kalnych and Lamkin (2010) wanted to examine the application of MIL regarding attrition and remediation among emergency medicine residents since burnout rates among residents are high (25-75%). The study sought to determine if there was a difference between emergency medicine (EM) residents' MIL scores and remediation, at risk for remediation, and those considering leaving their residency training. Volunteer EM residents ($n = 279$) completed the MIL for Emergency Medicine questionnaire, which measured six life areas: health/body, religion/spirituality, self-confidence, interdependence, parenting, and EM work. Residents self-reported if they were considering leaving EM training, and program directors provided data regarding remediation, at risk for remediation, and attrition rates. MIL scale scores ($M = .63$) had no statistically significant differences between those on remediation versus those not. Women scored lower on the MIL and the life areas of health, self-confidence, interdependence, and parenting satisfaction ($p = <.01$). The results of this study suggest that EM residents in general appear to have a sufficient margin overall but that investigation is needed to determine if there are characteristics in the work environment that affect women differently than men. This is applicable to the returnee nurses since the majority of those returning are women, and there may be extra loads in their lives that would affect their MIL scores and transition outcomes.

Lagana (2005) performed a correlational study ($n = 64$, 31 females and 33 males) utilizing the MIL scale to investigate if relationships exist between involvement in career-

related professional development outlets and activities and MIL scores for full-time

student affairs professionals. The subjects ages ranged from 22 to 67 years ($M = 41.5$

years). The mean MIL score for subjects was .60, which indicated that the subjects had

sufficient amount of power. Correlation coefficients (Pearson r) were calculated to

determine if relationships existed between MIL scores and the number of career-related

professional development outlets and activities. Partial correlation coefficients were

calculated to determine if relationships existed between subjects' ages and the

relationship between MIL scores and the number of career-related professional

development outlets and activities. Results suggested the possibility that a negative

correlation may exist between MIL scores and the number of career-related professional

development outlets. The researcher mentioned that the correlations were weak, possibly

due to the small number of subjects, and a larger population was suggested. Age of the

subjects did not influence the results.

Scoring. Each question on the instrument asks the participant to rank each item.

Across from each item addressed is four columns titled: 1) Importance of Item, 2) Load,

3) Power, and 4) Not Applicable. Participants are asked to rate each item for importance

on a scale of 1-10 or if the item is non-applicable (NA). Once participants have selected

how important an item is, they are then asked to rate the amount of load (burden) and

power (amount of resources) that item is currently representing in their lives on a scale of

1 -5. In scoring the instrument, the load serves as the numerator and power serves as the

denominator, resulting in a ratio that is subtracted from 1 to determine the level of

margin. Margin is calculated by the load/power ratio: Margin = 1- Load/ Power. A

calculated margin score of 0.45- 0.69 indicates a strong margin to accomplish a goal.

However, a margin score below 0.30 indicates dangerous stress limits and potential for failure. Interestingly, a margin score above 0.70 indicates too little load or challenge to an individual and, therefore, a person may not be operating to potential and achieve their goal either. According to Stevenson, it is important that individuals possess a moderate to high MIL score (between 0.50 to 0.70) so that they have enough margin to master their load (in the case of the returning nurse, to complete the refresher course with high levels of self-confidence and eventual job attainment).

The valid and reliable measurement of load, power, and margin (Appendix E) should aid in measuring the whole human being as an interactant in his or her life space. The Margin in Life (MIL) scale instrument appeared to be a good fit to measure many of the life area constructs encompassed in Meleis' Transition Theory, which was the theory tested.

Confidence Scale (C-Scale)

Confidence is viewed as a situational specific trait rather than a general trait (Bandura, 1977). Self-confidence is a person's belief that he or she can succeed and is context-specific. According to Perry (2011), self-confidence can be related to self-efficacy theory, and it is affected by one's perspective, role, self-esteem, sense of self, and experiences related to the context or setting. Bandura (1977) postulates that "efficacy beliefs influence goals and aspirations; the stronger the perceived self-efficacy, the higher the goals people set for themselves and the firmer the commitment to them" (p. 145). Confidence is an important attribute for a returning nurse to possess or develop during a refresher course in order to achieve the goal of a competent professional nurse who is ready to assume that role and instill trust in the clients that they care for.

Developing confidence is an important component of clinical nursing practice. Nursing is a service profession, and those patients in the care of a nurse must feel safe and comfortable. Low self-confidence exhibited by a nurse can make patients feel uncomfortable since they need to trust that their nurse can deliver competent care. Susan Grundy, a nursing professor, felt that nurse educators needed a valid and reliable tool to track this phenomenon. An instrument that can measure the psychometric properties of confidence would assist with studying the factors that influence the degree of confidence. Grundy (1993) developed the confidence scale (C-Scale) (Appendix E) in order to provide nurse educators with such a tool. This psychometric instrument is adaptable to measure any number of situations or skills where confidence is a questionable outcome that is desired to be measured.

Reliability and validity. The first instrument to measure the concept of confidence in nursing students was first developed by Morgan and Thorne (1985), who developed a four-item questionnaire to measure confidence in nursing students related to their performance of injections skills. The test-retest reliabilities ($n = 46$) were satisfactory at two days ($r = .96$) and one week ($r = .78$) re-testing. Even though the researchers wanted to quantify confidence, three out of the four questions focused more on actual correctness of performing the skill of injection. The correct method of performance was determined by an interaction between the student and instructor and did not adequately separate the degree of confidence the student personally experienced during the performance. Three of the four questions were phrased specifically for injection skills. Also, there was inadequate testing of the psychometric properties of the instrument, such as internal consistency.

O'Neill (1985) wanted to correct this deficiency in instrumentation by changing the phrasing. She constructed a five-item C-Scale that was used to measure levels of confidence in baccalaureate nursing students who performed dressing changes. This new confidence scale is phrased for use in the measurement of any psychomotor skill. The Cronbach's alpha ranged from .93 ($n = 27$) to .94 ($n = 18$), indicating a high internal consistency. This confidence instrument continued to be tested with students' performance of physical assessment skill and the internal consistency ($n = 44$) remaining high at .91.

Grundy (1993) wanted to determine the internal consistency, test-retest reliability, and the construct validity of the C-Scale in the measurement of confidence associated with the performance of physical assessment. Thirty-nine volunteer first-semester nursing students reviewed the ethical proposal and signed consents to participate. Data was collected four times during the semester. The scores on the C-Scale were correlated with a 100-mm Confidence Visual Analogue Scale (C-VAS) and a Confidence Verbal Descriptor scale (C-VDS). The mean C-Scale for the participating nursing students ($n = 34$, since five participants were lost to attrition) significantly increased ($p < .001$) from 13.6 to 18.5. The C-Scale was correlated with two other measures of confidence: the correlation coefficients for the C-Scale with the C-VAS, which ranged from .58-.80, and with the C-VDS, which ranged from .73 -.76. The internal consistency of the C-Scale was evaluated, and the Cronbach's alpha ranged from .84-.93. The C-Scale consistently demonstrated high internal consistency reliability throughout all periods of administration to both students and nurses. Concurrent validity was supported by both the C-VAS' and the C-VDS' high to moderate correlation to the C-Scale.

Scoring. This instrument is one page in length and contains five situation-specific statements that are answered on a Likert-type scale of one to five. The largest number, five, indicates a higher score on the item pertaining to confidence. The score of each question is added together to obtain the Confidence Score. The total score can range from a low of 5, indicating low self-confidence, to a high of 25, indicating high self-confidence.

<center>**Data Analysis Plan**</center>

Once the data for this study were collected, all survey questionnaires were first visually examined for accuracy and reviewed for missing data. Only surveys containing complete scales were used in the analysis. Therefore, the number of participants used in each analysis was dependent on the number of completed items on the scales used in the analysis. All data were entered into Statistical Package for the Social Sciences (SPSS) version 21.0 for interpretation and analysis (SPSS, 2012). The entered data were checked for flaws and for outliers.

Each instrument was hand summed and the sums entered into the computer data file. Data entered into the computer file were visually rechecked for accuracy and checked by means of frequency distribution to reveal the entry of any impossible scores. Instruments were then computer summed and compared to the hand-summed values to assure consistency of results. All paper surveys were locked in a file cabinet by the researcher. All computer data from the surveys were stored in three locations (hard drive on the computer, external hard drive, and small flash drive) to ensure safety and prevent the loss of important data results.

Descriptive statistics were used to delineate the sample through the use of frequencies, percentages, measures of central tendency (mean, median, and mode), and measures of variation (standard deviation and ranges). Frequency distributions helped to detect any flawed data values.

Reliability Testing

Since each sample is unique, the researcher subjected each of the scales to tests of reliability for internal consistency using Cronbach's alpha. In this study, a number of scores for a number of variables had to be correlated. The result of this data analysis is a number of correlation coefficients, ranging from -1.00 to +1.00. Since some of the variables chosen are ratio and interval in nature, a Pearson *r* measure of correlation was appropriate. In order for a correlation coefficient to be statistically significant, it must reflect a true statistical relation, not a chance one (Gay et al., 2009). As recommended by the literature, the planned level of significance was set at the appropriate level of .05; a correlation of this size, for this population, would occur by chance no more than 5 out of 100 times. Even if a coefficient is statistically significant, a low coefficient represents a low degree of association between two variables. Significance does not mean strength; it only indicates that the probability that a given relation is not due to chance (Gay et al., 2009).

Hypothesis Testing

Prior to hypothesis testing, all data used as dependent variables were evaluated to determine if the data was appropriate for parametric testing. To determine if the data was normally distributed, histograms were constructed and examined, and the KS score was calculated. A significant KS is accepted as evidence of non-normal distribution. H1.

There will be a positive correlation between the nature of transition predictor variable of

perceived total life experiences and transitional condition's Margin in Life composite

score for health/ body, self-concept, interdependence/ connectedness, parenting

satisfaction, and religiosity/ spirituality, among RNs enrolled in a Refresher Program.

Hypothesis 1 identified two continuous variables. A two-tailed Pearson's product

moment correlation was used to test for relationship. A Pearson r is a measure of

correlation appropriate when both variables are expressed as continuous (ratio or interval)

data; it takes into account every score and produces a coefficient between -1.00 and

+1.00. The score closest to 1.00 has the strongest correlation whether it is negative or

positive. H2. There will be a correlation between transition condition variables of

health/ body, interdependence/ connectedness, self -concept, parenting satisfaction, and

religiosity/ spirituality and the outcome criterion of pattern of response of professional

role confidence among RNs enrolled in a Refresher Program. Hypothesis 2 identified six

variables: five predictor variables and one criterion variable; therefore, standard linear

multiple regression was used to examine the relationships.

Regression analysis is a method of explaining the "nature and closeness of the

relationship" between two or more variables. This analysis informs the researcher the

extent to which one may predict some variables by knowing others. Multiple regression

analysis determines not only whether variables are related but also the degree to which

they are related. The more independent (predictor) variables added, the greater the

chance to explain the outcomes of the dependent (criterion) variables (Gay et al., 2009).

The multiple regression summary produces an R value that is quite helpful because when

it is squared, it provides the percentage of variance in the criterion variable explained by

the predictor variables. Therefore, if a significant $R2$ value is obtained, the beta (β)

weights associated with each variable are examined for their comparative contribution to

the prediction equation.H3. There will be a significant difference between the mean

scores for the pattern of response of professional role confidence and measured pre- and

post-therapeutic intervention of a refresher program, among RNs enrolled in a Refresher

Program. Hypothesis 3 sought to compare two dependent means (same variable) but at

two different points in time. Therefore, a dependent t test was used since it is a

parametric test of significance that is used to determine whether, at a selected probability

level, the means of two matched, or non-independent samples, are significantly different

or whether the means for one sample at two different times are significantly different

(Gay et al., 2009). A two tailed test of significance with α = .05 was performed so as to

allow the researcher to examine both directions for the outcomes of their tests and either

reject or not reject the null hypothesis. A researcher must make the decision that the

difference between the means is, or is not, likely due to chance in order to avoid a Type I

or Type II error.

Threats to External Validity

The returning RNs invited to participate in this study were a non-randomized

group who were drawn from the current pool of returning nurses enrolled in a Continuing

Education college based RN Refresher Course Program. Their participatory responses

were voluntary. This sampling procedure may be a threat to external validity since such a

procedure limits the researcher to generalize the finding to any other population, although

this sample of participants is believed by this researcher to be a good representative of

this distinct population of nurses. The researcher left the room while the participants

completed the surveys to minimize any feeling of pressure.

Threats to Internal Validity

Differential selection was a threat to the internal validity of this study since the

groups being studied had already been formed by the perspective programs that were

accessed for this research endeavor. The organismic variables identified on the

demographic survey (age, sex, marital status, etc.) and the intervening variables such as

length of time out of nursing and reasons for leaving and returning were controlled with

looking at subgroups and utilizing the statistical method of analysis of covariance.

According to Gay et al. (2009), results are weakened when a study deals with intact

groups and non-random assignments (Northeast program versus the Southeast program);

however, analysis of covariance can be used in such cases to equate the groups.

Mortality or attrition of the participants was always a concern since these courses run for

6 to 12 weeks, and individuals may drop out of the program. A larger sample was

achieved since the larger the sample, the stronger the validity of the study. In order to

achieve the sample size, multiple classes were accessed (n = 15 classes) since most of

these courses have seat limitations of less than 15 students. Another concern was history

since newsworthy items concerning nursing job availability and hospital closings could

affect performance on the variable (confidence). In addition, test, re-test use of the

instruments and participant response set can impact the validity of this study.

Chapter Summary

This chapter has described the research design (correlation) and the methodology

(four quantitative instruments) that were used to describe the sample and explore the

relationships between various demographic variables, the Life Experience Survey (LES)

scores, the Margin in Life (MIL) scores, and the Confidence Scale (C-Scale) instrument

scores pre-refresher program and post-refresher program. Through purposive sampling,

data collection took place at two colleges that had continuing education programs that

offered Nurse Refresher Programs geared for the RN out of current practice for more than

then two years. The voluntary participants, after meeting inclusion criteria, completed

the demographic survey, the LES, the MIL scale instrument, and the C-Scale instrument.

At the end of the program, the participants were retested on the C-Scale. Data was

analyzed using bivariate correlation, multiple regression, and dependent *t* test techniques.

CHAPTER FOUR

FINDINGS OF THE STUDY

The current national nursing shortage is predicted to escalate within the next 10 years unless the nursing profession can come up with successful strategies to significantly improve retention and recruitment within the nursing workforce. Out-of-practice registered nurses (RNs) who have been away from the acute care setting (hospitals) greater than two to five years are an under-utilized resource for recruitment efforts by the profession. The problem of low self-confidence combined with personal, situational, and organizational obstacles adversely affect the transitioning re-entry RNs' return to active nursing practice. The nursing profession needs to determine if the current interventional method (a refresher course) supplies adequate support to assist these nurses to improve their professional role confidence level in order to return to active safe nursing practice.

The purpose of this study was to test Meleis' Transition Model among a group of RNs participating in a refresher program with the intent to re-enter nursing practice after a period of non-practicing. This pre-test/post-test quantitative, correlational study examined the impact of a preparatory refresher course upon the confidence level of re-entry nurses while transitioning back to contemporary practice. Another aim of this study was to examine other variables (loads/burdens in life and power/positive influence in life) that could inhibit or facilitate the confidence level of transitioning re-entry RNs preparing in their role readiness to return to the workforce.

Meleis' (2010) Theory of Transition offered a framework to examine the impact of the personal and situational changes that occurred for the returnee nurses in this study as they attempt to transition and journey back into the role of an active, confident, and

safe professional RN. There were three independent variables: the nature of the transition, the transition condition, and the interventional nursing refresher program that is advertised to improve an individual's professional self-confidence (the dependent variable). Select demographic variables (gender, age, marital status, ethnicity, socioeconomic level, years of past nursing experience, academic degrees, years away from nursing, and primary reasons for leaving and returning to nursing) may act as mediating variables that may affect the transition conditions and confidence level. This study utilized the Life Experience Scale (LES) to operationalize nature of transition, the Margin in Life scale (MIL) to operationalize transition conditions, and the Confidence Scale (C-Scale) to operationalize professional role confidence. The demographic survey was used to describe the sample population and demonstrate homogenicity of the participants. A total of 121 surveys were distributed to volunteers enrolled in a Refresher Program; 95 participants submitted all initial instruments and the post-test for confidence; 26 submitted only the initial instruments, and no post-test data is available.

Description of the Sample

The sample consisted of 121 participants, mostly females ($n = 117$, 96.7%), ranging in age from 26 to 73 years ($M = 45.83$, $SD = 10.72$). Prior to taking the RN Refresher program, they had engaged in nursing between 0 and 47 years ($M = 10.19$, $SD = 9.42$) and had been away from nursing between 2 and 30 years ($M = 9.09$, $SD = 6.98$). Additional demographic information for the sample is presented in Table 1. Participants were asked specific reasons for having not been engaged in nursing practice and reasons prompting them to enroll in the RN Refresher program. This information is summarized in Table 2.

Table 1

Demographic Characteristics of the Sample (N = 121)

Characteristic	*n*	%
Ethnicity		
Black	24	19.8
White	56	46.3
Hispanic	13	10.7
Jewish	2	1.7
Asian	12	9.9
Middle Eastern	1	.8
Indian	3	2.5
No response	10	8.3
Marital status		
Single	17	14.0
Married	75	62.0
Divorced	13	10.7
Widowed	6	5.0
Separated	7	5.8
Other	3	2.5

(Table 1 continued)

Characteristic	*n*	%
Socioeconomic status		
<$30,000/year	25	20.7
$31,000 to $50,000/year	17	14.0
$51,000 to $70,000/year	14	11.6
>$70,000/year	46	38.0
Chose not to answer	19	15.7
Highest degree achieved		
Diploma	5	4.1
Associate's degree	27	22.3
Bachelor's degree	66	54.5
Master's degree	23	19.0

Table 2

Reasons for Leaving Nursing and Enrolling in the RN Refresher Program (N = 121)

Reasons	*n*	%
Reasons for leaving nursing		
Pregnancy/childbearing	41	33.9
Inflexible work schedule	11	9.1
Negative working environment	9	7.4
Family obligations	42	34.7
Health	12	9.9
Other	42	34.7
Reasons for enrolling in RN Refresher course		
Financial	56	46.3
Loss of previous job	16	13.2
Loss of spouse or significant other	1	.8
Missing professional nursing	67	55.4
Empty nest	15	12.4
Other	22	18.2

Note. Percentages exceed 100% due to participants providing multiple reasons.

Estimation of Reliability as Internal Consistency Among the Research Instruments

Cronbach's alpha (α) was calculated for all instruments and presented in Table 3. All values exceeded the .70 benchmark considered adequate for reliability as internal consistency.

Table 3

Cronbach's Alpha for the Research Instruments

Instrument	n	Number of items	α
Pre-test confidence	95	5	.97
Post-test confidence	95	5	.97
Life Experience Scale	115	50	.80
Margin in Life total scale	31	58	.96
Margin in Life subscales			
Parenting satisfaction	74	5	.77
Self-concept	80	13	.87
Religiosity/spirituality	74	12	.95
Interdependence/connectedness	66	10	.88
Health/body	111	18	.95

Response to Measurement Instruments

Scores for all research instruments were calculated and are summarized in Table

4.

Table 4

Summary of the Scores for the Research Instruments

Instrument	*n*	range	*M*	*SE*	*SD*
Pre-test confidence	121	5 to 25	14.32	.44	4.82
Post-test confidence	95	5 to 25	18.90	.47	3.57
Life Experience Scale	116	-45 to 56	-3.10	1.32	14.21
Margin in Life total scale	31	-.10 to .78	.41	.05	.30
Margin in Life subscales					
Parenting satisfaction	74	-.64 to .80	.30	.04	.35
Self-concept	80	-.30 to .80	.30	.04	.34
Religiosity/spirituality	74	-.61 to .80	.34	.04	.34
Interdependence/ connectedness	66	-1.53 to .80	.34	.05	.40
Health/body	111	-.94 to .80	.41	.03	.33

Based on these scores, it is evident that prior to engaging in the RN Refresher

program, the participants' confidence level was higher than midlevel and improved at

post-test evaluation. Their life experiences were more negative than positive, and their

MIL scores, in total and in the subscales, fell within the .30 to .70 range, indicating they had an adequate margin to meet new challenges, changes, or emergencies in life.

Evaluation of Distribution and Detection of Outliers

The scores on the MIL total scale and the pre- and post-test scores for confidence were used to operationalize dependent variables. These scores were evaluated for shape of distribution by histograms and calculation of the Kolmogorov-Smirnov (*K-S*) value, values for skewness, and kurtosis and homogeneity of variance through *Q-Q* plots. Outlying cases were detected by stem-and-leaf plots and identified by boxplots. Outlying scores were retained in the statistical analyses.

All three measures had significant *K-S* values, indicating that the distribution of the scores deviated from normality. This test is affected by large samples in which small deviations from normality yield significant results (Field, 2009). While the number of participants providing complete responses for the pre-test measure of confidence exceeded 100 ($n = 121$), only 31 participants provided responses to all 58 of the items on the MIL total scale. The scores for all three measures fell short of meeting the assumptions for parametric testing. While the parametric tests used are considered robust when used with large sample sizes, hypothesis testing wherein the scores for the MIL total scale are used must be viewed with caution.

Margin in Life – Total Scale

The histogram of the scores for the MIL measure did not appear normally distributed (see Figure 2). This finding was supported by the significant *K-S* statistic = .20, $p = .002$. The negative value for skewness, -.46, indicates that the frequent scores are clustered at the higher end of the distribution and the tail points toward the lower,

more negative scores. The negative value for kurtosis, -1.41, indicates that there are too

few scores in the tails, and the distribution is quite flat. There were no extreme scores.

The *Q-Q* plot did not assume a linear pattern, indicating that the scores contained a large

amount of variance.
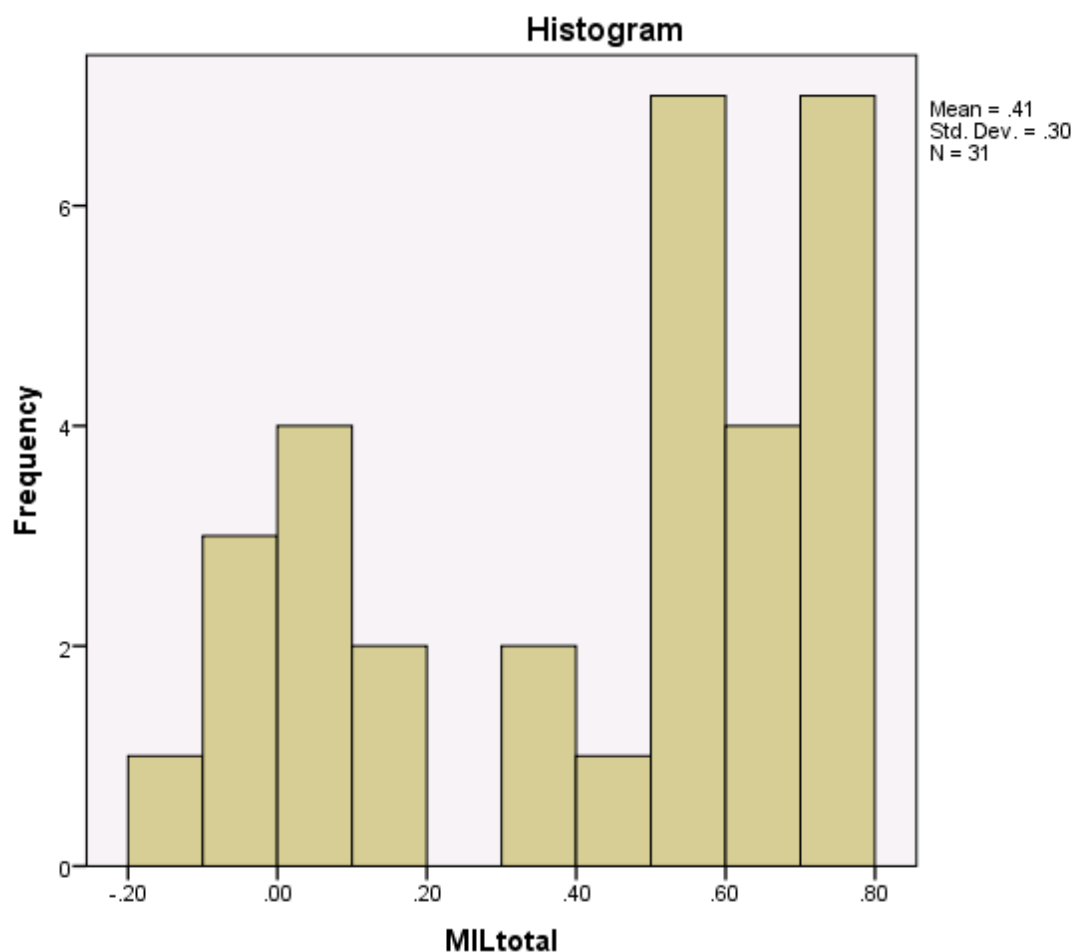
Figure 2. Histogram of the composite scores for Margin of Life.

Pre-Test Confidence

   The histogram of the scores for the pre-test Confidence measure did not appear

normally distributed (see Figure 3). This finding was supported by the significant *K-S*

statistic $= .16$, $p = .00$. The positive value for skewness, .33, indicates the frequent scores

are clustered at the lower end of the distribution and the tail points toward the higher or

more positive scores. The negative value for kurtosis, -.25, indicates there are too few

scores in the tails. There were no extreme scores. The *Q-Q* plot demonstrated a

clustering of scores along the regression line indicating acceptable variance.
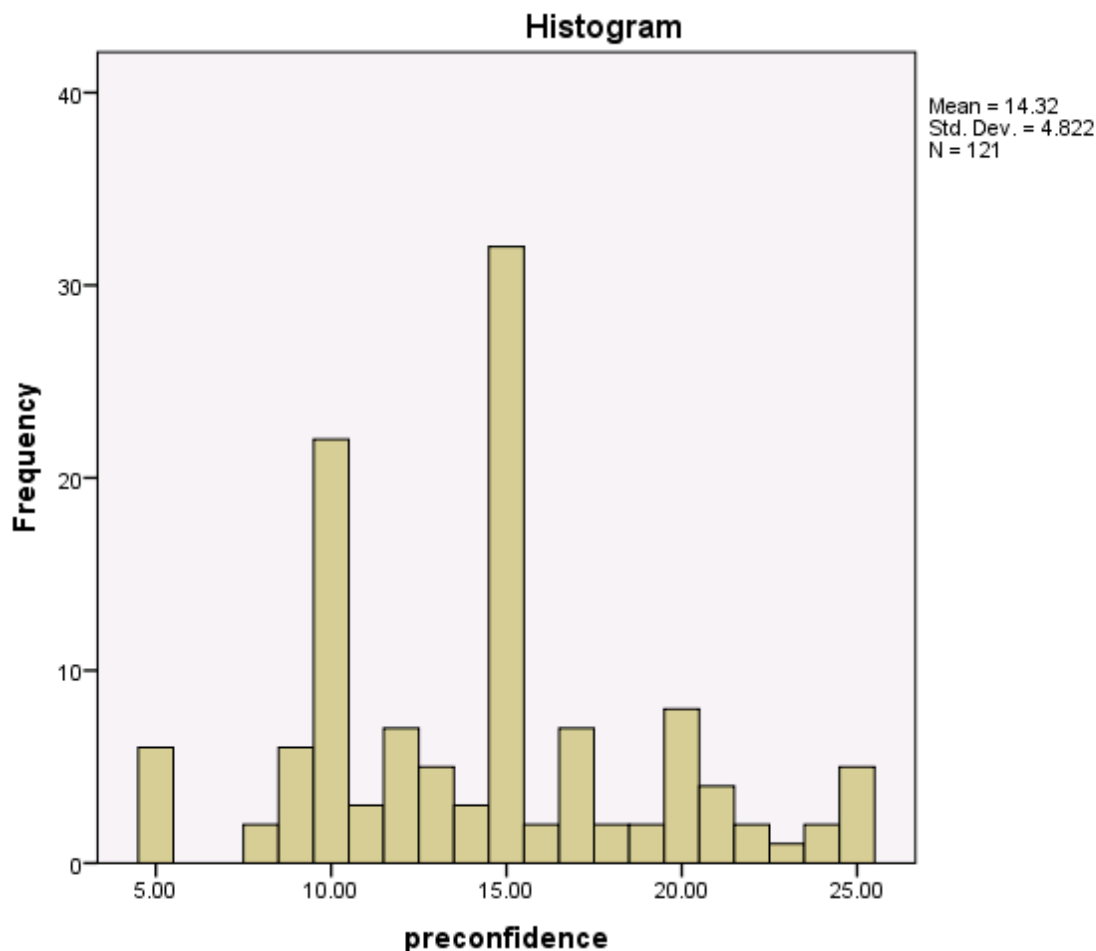
Figure 3. Histogram for pre-test scores for Confidence.

Post-Test Confidence

The histogram of the scores for the post-test confidence measure did not appear

normally distributed (see Figure 4). This finding was supported by the significant *K-S*

statistic = .16, *p* = .00. The negative value for skewness, -.75, indicates that the scores

tend to cluster at the higher end of the distribution. The positive value for kurtosis, .10,

indicates that there are too few scores in the tails. There was one extreme score, < 5.0.

The *Q-Q* plot demonstrated a clustering of scores along the regression line, with the

exception of the one outlying score, indicating acceptable variance.
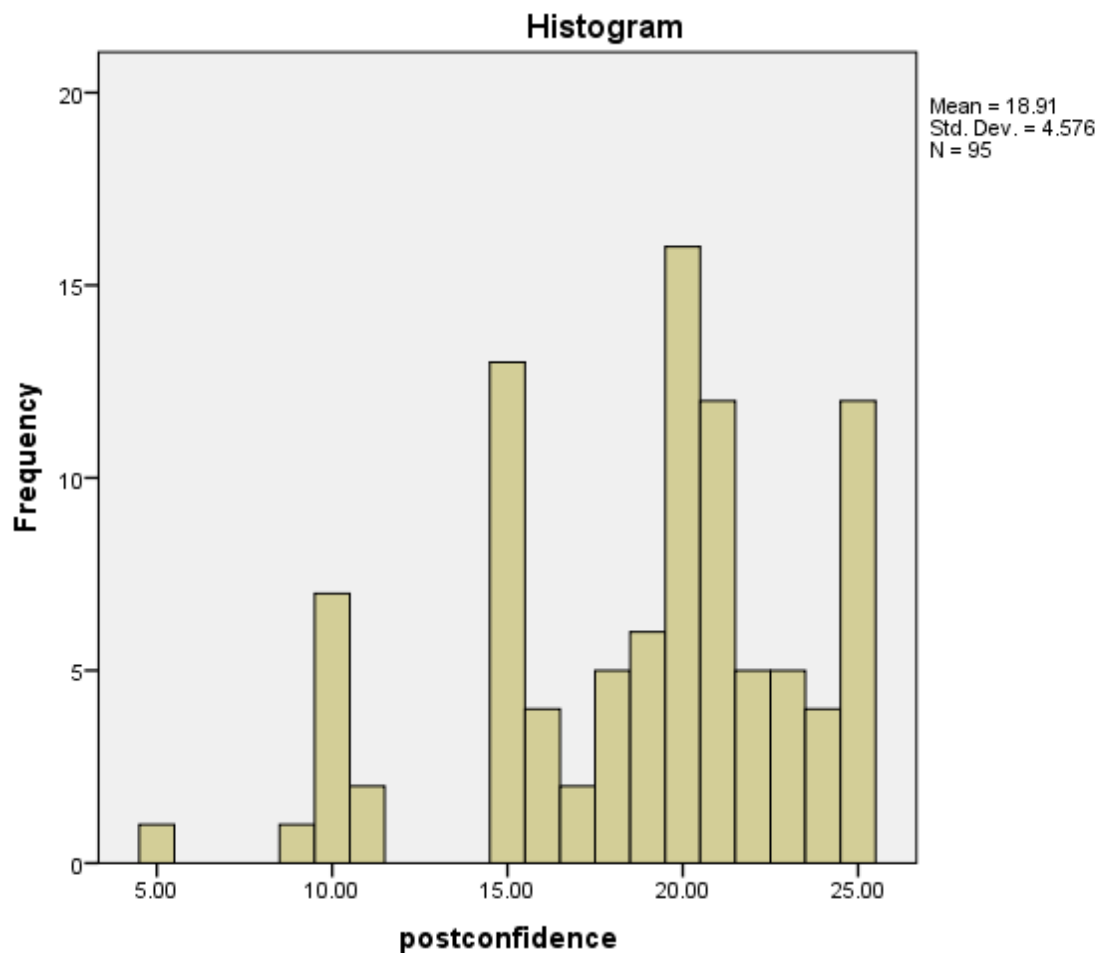
Figure 4. Histogram for post-test scores for Confidence.

Hypothesis Testing

Three hypotheses were tested to determine the relations among the chosen

variables. Several statistical testing techniques were employed and are discussed

individually with each hypothesis.

The following research questions and hypotheses were tested:

1. Is there a relationship between the nature of transition variables (perceived total life experience score) and transitional conditions (Margin in Life composite score for health/body, self-concept, interdependence/connectedness, parenting satisfaction, and religiosity/spirituality) among RNs enrolled in a Refresher Program?

> **H1**. There will be a correlation between the nature of transition predictor variable of perceived total life experiences and transitional condition's Margin in Life composite score for health/body, self-concept, interdependence/ connectedness, parenting satisfaction, and religiosity/spirituality, among RNs enrolled in a Refresher Program.

Hypothesis 1 considered the bivariate correlation between the nature of transition variables as measured by the Life Experience scores and the transitional condition variable as measured by the Margin in Life, total scale which is a composite score of the subscales for parenting satisfaction, self-concept, religiosity/spirituality, interdependence/connectedness, and health/body. This hypothesis was tested by means of a two-tailed Pearson product moment correlation. The research hypothesis was not supported. The correlation coefficient was not significant, $r = .24$, $p > .05$, indicating there was no correlation between the two variables.

2. Is there a relationship between transition condition variables (health/body, self-concept, interdependence/connectedness, parenting satisfaction, and

religiosity/spirituality) and the pattern of response (professional role confidence) among RNs enrolled in a Refresher Program?

> **H2**. There will be a correlation between transition condition variables of health/body, interdependence/connectedness, self-concept, parenting satisfaction, and religiosity/spirituality and the outcome criterion of pattern of response of professional role confidence among RNs enrolled in a Refresher Program.

Hypothesis 2 considered the predictive relationship between the scores on the five subscales of the margin in life - parenting satisfaction, self-concept, religiosity/spirituality, interdependence/connectedness, and health/body - and the outcome criterion of post-test confidence. Standard linear multiple regression analysis was used to test this hypothesis; however, only 24 out of 95 participants provided complete responses to all six measures.

To determine that the predictor variables were independent and no two or more variables were measuring the same attribute, collinearity statistics of tolerance and variance inflation factor (VIF) were calculated. Tolerance values may range from zero to one. A tolerance value close to zero indicates multicollinearity; values above .6 are recommended. Tolerance values ranged from .07 to .22; all tolerance values fell below the .6 value, indicating that the predictor variables were likely measuring the same attribute and multicollinearity was a problem within this data set. VIF is the reciprocal of tolerance; a value of 10 is typically recommended as the maximum level of VIF (Chan, 2004; Field, 2009) with values above 10, indicating multicollinearity. VIF values for the five predictors ranged from 4.51 to 13.55, which again indicate that multicollinearity is a

problem within the data set.   The independent variables were not independent of each other.

Regression analysis found that 31.0% ($R^2 = .310$, adj $R^2 = .12$) of the variance was explained by the model but the model was not significant, $F (5,18) = 1.62$, $p = .21$. Examination of the beta weights reveals that none of the predictor variables contributed to the model. Tables 5 and 6 provide a summary of this analysis.

Table 5

Means, Standard Deviations, and Inter-correlations for Post-test Confidence and Predictor Variables (n = 24)

Variable	M	SD	1	2	3	4	5
Post-test Confidence	20.21	4.36	.36	.27	.34	.18	.21
Predictor variable							
1. Parenting satisfaction	.38	.35	--	.87	.83	.84	.84
2. Self-concept	.39	.31		--	.89	.94	.94
3. Religiosity/spirituality	.45	.30			--	.87	.92
4. Interdependence/connectedness	.38	.33				--	.92
5. Health/body	.47	.30					--

Table 6

Regression Analysis Summary for Variables Predicting Post-test Confidence (n =24)

Variable	*B*	*SE B*	β	*t*	*p*
Constant	18.53	1.71		10.83	.00
Parenting satisfaction	5.79	5.25	.46	1.10	.28
Self-concept	8.05	10.10	.57	.80	.44
Religiosity/spirituality	11.75	7.59	.81	1.55	.14
Interdependence/ connectedness	-9.50	7.87	-.72	-1.21	.24
Health/body	-11.47	9.91	-.80	-1.16	.26

The data for hypothesis 2 was provided by a sample that fell below that considered the minimum for multiple regression analysis with five predictors. Additionally, the data violates the assumptions for parametric testing in the areas of normal distribution of scores, independence of variables, and equal variance. Analysis of the data was carried out, and the research hypothesis was not supported, but results cannot be considered accurate.

3. Is there a difference between the mean scores for pattern of response (professional role confidence, measured pre- and post-therapeutic intervention of a refresher program) among RNs enrolled in a refresher program?

> **H3**. There will be a significant difference between the mean scores for pattern of response of professional role confidence, measured pre- and post-therapeutic intervention of a refresher program, among RNs enrolled in a refresher program.

Hypothesis 3 tested for differences in the mean scores for the pattern of response of professional role confidence, measured pre- and post-therapeutic intervention of a RN Refresher program. As the same participants provided responses at two points in time, a dependent t test was used. On average, participants experienced significantly greater professional role confidence following the RN Refresher program ($M = 18.90$, $SE = .47$) than they did prior to the program ($M = 14.21$, $SE = .50$), $t (94) = -11.09$, $p = .000$, and the effect size was large, $r = .75$. The research hypothesis was supported.

Chapter Summary

This study approached 121 participants enrolled in a RN Refresher program. Descriptive information collected supported that the sample was representative of the typical population of RNs that engage in such programs. Data used to measure the variables of C-Scale, LES, and MIL were collected through previously developed instruments with evidence of appropriate psychometric estimates.

While the instruments for confidence and life experience performed well with this sample, the measure of MIL did not. Only 31 participants responded to all 58 items on the instrument, and analysis of distribution of scores and homogeneity of variance found

that the scores did not meet the assumptions of parametric testing. Further, prior to regression analysis, the test of collinearity demonstrated that the measures for the sub-scales of margin in life were highly correlated and likely not independent. The data for MIL was included in testing of hypotheses 1 and 2, but the results cannot be generalized and must be viewed with caution. Hypotheses 1 and 2 were not supported.

Hypothesis 3 compared the results of pre- and post-test measure of confidence at the start and following completion of a RN Refresher program. An adequate number of participants completed this instrument and the data did not substantially violate the assumptions of parametric test. A dependent *t* test found that the scores significantly increased between the two testing and the effect size was large; therefore, the hypothesis was supported.

CHAPTER FIVE

SUMMARY AND DISCUSSION

The purpose of this study was to test Meleis' Transition Model among a group of RNs participating in a refresher program with the intent to re-enter nursing practice after a period of non-practicing. This pre-test/post-test quantitative, correlational study examined the impact of a preparatory refresher course upon the confidence level of re-entry nurses while transitioning back to contemporary practice. Another aim of this study was to examine other variables (loads/burdens in life and power/positive influence in life) that could inhibit or facilitate the confidence level of transitioning re-entry RNs preparing in their role readiness to return to the workforce. This chapter summarizes the study results and discusses the researcher's findings as they relate to the research hypotheses. The findings of this study should add to the body of nursing knowledge since it has significant implications for nursing education, practice, public policy, and research. The researcher also discusses strengths and limitations of the study, along with the significance to nursing and recommendations for future study. It concludes with a chapter summary.

Summary of the Study

The projected nursing shortage that is forecasted to exponentially grow by 2020 (Buckis, 2004; Gauci Border, 1997) emphasizes more than ever the need to bring back into nursing any nurses who have taken a hiatus and feel unconfident in their role as a professional nurse to return to active practice. It is well documented in the literature (Buchan & Calman, 2004) that nursing shortages significantly adversely affect patient

safety and health outcomes. Nursing is a service profession, and those in its care must feel safe and reassured that the nurses caring for them are safe, competent professionals.

Professional low self-confidence levels make others uncomfortable and distrustful of an expected expert when receiving their service, especially in the context of healthcare (Kroner & Biermann, 2007). Nurses need to provide a safe and trusting environment for their patients. Patients have the right to have a confident nurse who they can trust. Transitioning back to the workplace without having undergone a Refresher preparatory program and improving their confidence could be risky and unsafe and could negatively affect patient trust and other health outcomes.

This study had two phases: Phase 1 at the beginning of the Refresher program and Phase 2 at the end of the program. The surveys were explained and distributed in each class by the researcher to all volunteers. In total there were 121 participants, and n = 95 participants submitted all initial instruments and the post-test for C-Scale; the remaining (n = 26) participants submitted only the initial instruments so no post-test data is available. The study measured the confidence levels of these returnee nurses pre- and post-refresher program and tried to determine if recent life experiences and conditional variables had any correlation and ascertain the impact of the interventional refresher program. This study adds to the quantitative nursing literature that these returnee nurses' professional confidence levels are positively impacted by an interventional refresher course and feel sufficient in their professional role to deliver safe, competent patient care. The theoretical framework chosen to guide this study was based on Meleis' (2010) Transition Theory. The following research hypotheses were tested:

H1. There will be a correlation between the nature of transition predictor variable of perceived total life experiences and transitional condition's Margin in Life composite score for health/body, self-concept, interdependence/connectedness, parenting satisfaction, and religiosity/spirituality among RNs enrolled in a Refresher Program.

H2. There will be a correlation between transition condition variables of health/body, interdependence/connectedness, self-concept, parenting satisfaction, and religiosity/spirituality and the outcome criterion of pattern of response of professional role confidence among RNs enrolled in a Refresher Program.

H3. There will be a significant difference between the mean scores for pattern of response of professional role confidence, measured pre- and post-therapeutic intervention of a refresher program, among RNs enrolled in a Refresher Program.

A correlation design utilizing a pre- and post-test interventional format was used to ascertain the relationships between the predictor (independent) variables: the RN refresher program, the nature of transition, transition conditions, and the criterion (dependent) variable, professional role confidence level of returnee nurses. Data was collected using four instruments with 120 items, which was comprised of a demographic instrument (developed by the researcher) with 10 items to describe the sample population and determine homogenicity of the participants (gender, age, ethnicity, marital status, socioeconomic status, years of nursing experience, highest academic degree, years out of active practice, reason for leaving active nursing, and reason for enrolling in the course), as well as three standardized instruments that were used to study major study variables.

This study utilized the Life Experience Scale (LES) (Sarason et al., 1978) to operationalize nature of transition for Hypothesis 1, the Margin in Life scale (MIL) (Stevenson, 1982) to operationalize transition conditions for Hypothesis 1 and Hypothesis 2, and the Confidence Scale (C-Scale) (Grundy, 1993) to operationalize professional role confidence for Hypothesis 2 and Hypothesis 3. Data were analyzed using PASW Statistics 21.0 (SPSS, 2012), and the hypotheses were tested using bivariate correlation, standard linear multiple regression, and dependent t-test.

The study utilized a purposive sampling strategy from refresher programs in two locations in different geographical areas (Northeast and Southeast). Since many of the classes were small, data was collected over a 15 month period from the RN volunteers (n = 121) who were enrolled in one of these continuing education refresher programs. The participants were mainly women (n = 117, 96.7%) and had few men (n = 4, 3.3%), ranging in age from 26 to 73 years (M = 45.83, SD = 10.72), who were out of nursing practice between 2 and 30 years (M = 9.09 years, SD = 9.72). The participants were ethnically diverse (46% White, 19.8% Black, 10.7% Hispanic, 9.9% Asian, 3.3% Indian/Middle Eastern, and 8.3% no response). The participants were well educated: Master's degree (19%), Bachelor's degree (54.5%), Associate's degree (33. 3%), and Diploma certificate (4.1%). The data further revealed that 62% of the sample participants were married and all others were single (14%), divorced (10.7%), widowed (5%), separated (5.8%), or other (2.5%). These nurses took a hiatus from active nursing practice for multiple reasons, including: pregnancy/childbearing (33.9%), family obligations (34.7%), inflexible work schedule (9.1%), negative work environment (7.4%), health (9.9%), and other (34.7%), which included due to lack of hospital job

availability after graduation, alternate employment opportunities, moving to and from the U.S., disabled children, and elder parents. The percentages for reasons to take a hiatus exceed 100% due to participants providing multiple answers. The reason that the nurses wanted to return to practice was also due to multiple reasons: miss the profession (55.4%), financial (46.3%), loss of a previous job (13.2%), loss of a spouse or significant other (0.8%), empty nest (12.4%), and other (18.2%), such as new BS degree, new opening of jobs in hospitals, and successful obtainment of work visas and green cards. The percentages for reasons to return to practice exceed 100% due to participants providing multiple reasons.

Statistical analysis revealed that Hypothesis 1 and Hypothesis 2 were not supported. Hypothesis 1 considered the bivariate correlation between the nature of transition variables as measured by the LES score and the transitional condition variable as measured by the MIL composite score. The results did not support a significant relationship between these two independent variables. Hypothesis 2 considered the predictive relationship between the scores on the five subscales of the MIL instrument and the outcome criterion of post-course confidence. The results did not support a significant relationship between the scores; in addition, the data violated the assumptions for parametric testing in the areas of normal distribution of scores, independence of variables, and equal variance. Hypothesis 3 tested for differences in the mean scores for the pattern of response of professional role confidence, measured pre- and post-therapeutic intervention of a RN Refresher program. Hypothesis 3 was supported, indicating that the scores significantly increased between the two testing and the effect size was large ($r = .75$).

Discussion of Findings

The study findings are discussed as they pertain to the participants' demographic

and background characteristics, as well as in the context of the hypotheses and the

correlations found between the major study's variables. References to supportive and

differing literature are made from previous studies where applicable.

Demographic and Background Characteristics

A purposive sampling strategy was utilized in gathering data from RNs enrolled

in a Refresher program with the intent to return back to active nursing practice. The

demographic and background findings discussed will be compared with previous studies

concerning this unique population of nurses to ascertain the degree of generalizability of

the findings.

Statistically, nursing still remains a predominantly female profession ($> 92\%$).

Descriptive information collected from the participants in this study supported that the

sample was closely representative of the typical population of RNs that engage in RN

Refresher programs across the country. Much of the demographic data of the participants

related well with the literature that described this population of nurses (Buchanan, 2002;

Buerhaus et al., 2009; Hall and Andre, 1999; Quant, 2001). This study's participants

consisted of mostly females (n = 117, 96.7%) and few men (n = 4, 3.3%). Compared to

the three million RNs in this country, the percentage of men enrolled in the programs

surveyed were representative of their percentage presence in the profession. Some states,

like Florida, have a higher male nurse workforce presence than other states. According to

the Florida Center for Nursing (FCN) (2008), males comprise 9.56% of RNs in the

workforce. When the researcher separated the Florida cohort participants from the

general sample, it was determined that 8% of the participants from Florida were in fact
male.

The participants of the study were well educated according to the findings of this
study: 4% Diploma certificates, 22% Associate degrees, 55% had Bachelor's degrees,
and 19% Master's degrees. This finding deviates from previously published research
where most of the returnees were predominately Associate degree nurses with some with
Bachelor degrees (Hitchcock 2003; Quant 2001; Wilcock 2000). Some of these
participants with previous Associate degrees could not find employment in the hospital
setting initially. Now that they have a BS degree, they are seeking a hospital position and
need the refresher course to provide the up to date hospital clinical experience they need
to apply for these jobs. These well educated nurses deserve a place back in our
workforce since studies have shown that nurses with higher levels of education derive
better patient outcomes (Cho et al., 2008).

The data from this study further revealed that the participants ranged in age from
26 to 73 years (M = 45.83, SD = 10.72). Many studies cite the average age of returnee
nurses to be in the mid 40s with an age spread between 30 to 60 years old (Buchanan,
2002; Buerhaus et al., 2009; Hall & Andre, 1999; Quant, 2001). Although the mean age
of the participants aligns with the literature it must be noted that this study possessed two
age related outliers; there were several participants in their late 20s (*n* = 7) and several
participants in the 60-73 year age range (*n* = 14). In reviewing their surveys, the younger
participants were more likely to lack hospital work experience due to the inability to get a
job post-graduation due to a poor job market at the time they completed their education.
Nursing graduates have a limited time (usually less than two years) to secure a job in the

acute care environment before a recruiter recommends a refresher program. The older nurses cited the need for this course so that they could come out of retirement since many lost retirement investments with the poor economy. These potential trends were touched upon in the literature by Buerhaus et al. (2011) when the economy was so poor and high unemployment rates were in the news. These programs may see an increase in enrollments of past nursing graduates who have never experienced the acute care environment post-graduation and need the refresher program for job acquisition, or older enrollees needing to boost up their resume so that they may find employment to supplement their social security.

Nurses in the U.S. are predominately white and yet the U.S. population is becoming increasingly diverse. According to the U.S. HRSA (2006), the national average for ethnicities for RNs is 83% White, 5.4% Black, 3.6% Hispanic, 5.8% Asian, 0.3% Indian, and 1.7% other. This sample of nurses who participated in this study was ethnically more diverse than the national average for nurses: 46% White, 19.8% Black, 10.7% Hispanic, 9.9% Asian, 3.3% Indian /Middle East, and 8.3% no response. The diversity of this sample aligns to the location of the programs since they were located in ethnically diverse areas in New York and Florida. For example, 52% of the nurses working in New York City are member of minority groups (NYSED, 2002). The source for most of the sample (n = 96) was from a program in the NYC vicinity. As the U.S. population becomes increasingly diverse, the nursing workforce should reflect that diversity in race, ethnicity, and gender. Greater efforts need to be made by the profession to encourage nurses from different ethnicities to return to practice.

The data further revealed that 62% of the sample participants were married and all others were single (14%), divorced (10.7%), widowed (5%), separated (5.8%), or other (2.5%). This sample data agrees with the literature (Blankenship, Winslow, & Underwood, 2003; Buerhaus et al., 2009, Curtis & Schneidenbach, 1991; Loquist, 1991). Along with this breakdown of participants' marital status, this study revealed that many of the feminine issues related to why one leaves the profession still exists and aligns with a large volume of literature (Buchanan, 2002; Durand & Randhawa, 2002); Hall & Andre, 1999; Quant, 2001). Family obligations (35%), pregnancy/ childbearing (34%), and other (35%), which included alternative work areas, relocation, visa problems, etc., and health (10%), were strong reasons the nurses took a leave from active practice.

A negative work environment (7.4%) or inflexible work schedule (9.1%) were not strong reasons for leaving active practice according to the participants of this study, and the results therefore do not support this reason for leaving nursing as cited by other articles (Crouch, 2002; Meredith, 2002). Considering that nursing is a largely female profession, it is not surprising that family and childbearing remain consistently high reasons to take a hiatus from practice along with alternative work areas (most probably to accommodate the family needs). This study quantitatively reinforces these feminine issues that appear to be prominent in this female dominated profession. This study supports the recommendations by Asselin et al. (2006) that there is a desperate need for improved organizational support (vertical and horizontal) for their female employees and the need for more refresher programs to help transition any nurse back to current practice when they are ready.

The length of time away from acute care varied; some participants were away only two years while others up to 30 years (M = 9.09 years, SD = 6.98), which agrees with past studies (Hammer &Craig, 2008; Quant, 2001). Most breaks in employment were due to family and children obligations, involvement with alternate professions, or lack of job availability due to the economic recession. As mentioned previously, some of the younger participants had zero acute care work experience since they were never able to secure jobs in a hospital environment post-graduation from nursing school. The presence of younger nurses is a new phenomenon for returnee nurses involved in a refresher program compared to the past literature (Asselin et al., 2006; Hall & Andre, 1999) and reflects the downward trend in employment that occurred for nurses during the U.S. economic recession that began in 2006 (Buerhaus et al., 2009). It is possible that as the economy rallies and jobs start to open up for more RNs, more refresher courses may experience more returnee nurses in their enrollments who lack previous acute care experience entirely.

Relationships between Major Study Variables

Hypothesis 1. The first hypothesis proposed a correlation between the nature of transition predictor variable of perceived total life experiences and transitional condition's Margin in Life composite score for health/body, self-concept, interdependence/connectedness, parenting satisfaction, and religiosity/ spirituality among RNs enrolled in a Refresher Program. The results of statistical analysis did not support this hypothesis and indicated that no significant relationship existed between the LES and the MIL composite scores. The correlation coefficient was not significant (r = .24, p > .05), indicating there was not a correlation between the two variables.

The data demonstrated that while the LES scores, reflecting their life changes, were more negative than positive for most of the participants in this sample, these negatively perceived changes could actually act as a stimulus to move the returnee forward. The returnees had significant improvement in their professional role confidence scores by the end of the program despite all the negative life experiences recorded in the surveys. Chacko and Huba (1991) did a study that hypothesized that life stress has a negative relationship with academic achievement. However the researchers reported a gap in their study: individuals' degree of life stress does not necessarily correspond with their ability to cope with stress. Results of this study may support that gap since these participants were coping with their stress in a therapeutic manner.

It must be noted that even though the results of the two instruments (LES and MIL) did not correlate, the composite MIL scores (M= .41), which was a measure for transition conditions, fell within the .30 to the .70 range (Stevenson, 1982), indicating that the participants had adequate margin to meet new challenges, changes, or emergencies in life. However, this score is questionable since it is a composite score for all 58 items on the instrument, which lacked completed responses to all items on the instrument by many of the participants in the study. The tool had completion responses by only 31 of the 121 participants, and therefore the MIL composite score should be viewed with caution.

It must be noted that data derived from the demographic survey and the LES from this study gave the researcher rich quantitative insight into the many natures of transitions that the participants were experiencing in multiplicity the past year prior to the program. The need to transition back to professional practice was triggered by various life

stressors, which were reflected in the responses on the LES, some negative and some positive, that were developmental, situational, environmental/ organizational, and health in nature (Meleis, 2010) and aligned to the responses on the demographic survey. Due to the poor economy, many of the participants related financial issues (debts, loss of property, etc.); many were experiencing negative situational changes that were adversely affecting their life activities (stressed family relations and decreased social gatherings) and change in residences (foreclosures) and relationships (separation and divorce). Negative organizational changes occurred for many with job eliminations or job downsizing. For those experiencing developmental changes such as age (time for me), empty nest, or marriage, the life experience was more positive. The issues cited most frequently for enrolling in a refresher course on the demographic survey also agreed with the literature (Quant, 2001; Durand & Randhawa, 2002): missing the profession (55.4%), financial (46.3%), loss of previous job (13.2%), and empty nest (12.4%). Findings from this study match previously published research indicating that nurses who seek a refresher course are often at transition point in their lives (Hammer & Craig, 2008). Positive and negative life experiences often act as a stimulus to start a new endeavor or program (refresher in this case) to improve one's circumstances.

Hypothesis 2. The second hypothesis proposed a correlation between transition condition variables of health/body, interdependence/connectedness, self-concept, parenting satisfaction, and religiosity/ spirituality, and the outcome criteria of pattern of response of professional role confidence among RNs enrolled in a Refresher program. The research hypothesis was not supported.

Although the MIL scale was operationalized to measure the five transition conditions, disappointingly, the instrument lacked completed responses to all 58 items on the instrument by many of the participants in the study. The tool had completion responses by only 31 of the 121 participants for all five subscales. The low sample size fell below that considered the minimum for multiple regression analysis with five predictors. Further, prior to regression analysis, test of collinearity demonstrated that the measures for the sub-scales of the MIL were highly correlated and likely not independent of each other. The data results violated the assumptions for parametric testing in the areas of normal distribution of scores, independence of variables, and equal variance.

The difficulty with this instrument is not sufficiently elucidated in the literature. The following studies utilized this instrument and it failed to produce the correlations that were sought: Lagana (2005) also utilized the MIL instrument for their correlation study (n = 64). Although their participants had a mean MIL score of .60 indicating a strong margin, the subset correlations were weak and possibly linked to a small number of subjects. Kalnych and Lamkin (2010) also used the MIL instrument in their correlation study. The MIL mean score was .63, indicating sufficient margin; however, the MIL scale scores had no statistically significant differences between those on remediation versus those not. Walker and Merriam (1997) used the MIL scale to predict persistence for non-traditional students. The MIL scale failed to predict persistence ($p = .2853$). The problems encountered with this instrument for this study will be explored under limitations of the study.

Hypothesis 3. The third hypothesis proposed a significant difference between the mean scores for pattern of response of professional role confidence, measured pre- and

post-therapeutic intervention of a refresher program, among RNs enrolled in a Refresher program. There were adequate number of participants that completed the pre- (n = 121) and post-test (n = 95) measure of professional role confidence at the start and following completion of a therapeutic intervention RN Refresher program, and the data did not substantially violate the assumptions of parametric test. As the same participants provided responses at two points in time, a dependent t test found the scores significantly increased between the two testing and the effect size was large, $r = .75$. An effect size this large indicates the strength of the relationship between the refresher program and professional role confidence. The findings from this study supports that a Refresher program is a very effective intervention strategy for returnee nurses who are unsure of themselves and may be experiencing role insufficiency in a very demanding profession and quantifies the confidence change that is experienced by them.

Findings from this study support previously published qualitative research regarding the confidence levels of returnee nurses (Barribell et al., 2007; Elwin, 2007; Hawley & Foley, 2004.). Although confidence building is a major goal in nursing, there is mostly qualitative data documented in the nursing literature that describes this phenomenon, especially its impact on nurses as they make the transition journey back to active practice as safe, competent care givers. The findings of this study illustrate that the nurses who were enrolled in this study did achieve improved confidence and role mastery as a professional nurse again.

Significance of the Study to Nursing

The completion of this study was very significant since it quantitatively adds to the body of knowledge concerning the returnee nurse experience in regaining their

professional role confidence. This quantitative study has demonstrated that this sample of returnee nurses are a good representative of the typical population of RNs that engage in such refresher programs. The instruments for life experience (LES) and professional role confidence performed well with this sample. The demographic data combined with the LES offered rich data about the nature of transition that was experienced by these returnee nurses; often in multiplicity.

The Margin in Life scale instrument to measure transition conditions was not as effective as a measurement tool due to the difficulty encountered by the participants. The repetitious response set by many of the participants indicated to the researcher that either the participant was very fatigued and wanted to complete the survey quickly, or did not truly understand the directions of how to complete each line item with three separate responses or that the participant found the instrument ambiguous and burdensome. An improved tool to measure transition conditions needs to be sought or created that is not quite so laborious. It must be noted that the act of preparing for and registering for a refresher program, that is in close proximity to one's home and provided within one's community, can be viewed as positive facilitating factors that are encompassed in transition conditions. It should be also noted that information from the demographic and LES also indicated facilitating support for these participants such as a strong sense of missing the profession (55%) and having marital support (62%). Transition conditions that involve personal support, community support, and preparation and knowledge are necessary conditions to move one forward from the old self to the new self, which is a successful outcome of improved confidence in their role identity, a goal of transition theory.

Education

This study has shown that continuing education programs for nurses can provide a much needed workforce pipeline for the profession. Buerhaus et al. (2011) cited a low number of 30 to 40 year olds currently present in the nursing workforce. Interestingly, more than 50% of the survey participants were in this age range and could fit this need.

The Institute of Medicine (2010) nursing report recommends higher level of education in the nursing field so that nurses are better prepared to perform more complex care to sicker patients utilizing sophisticated new technologies available for providing care (Kenner & Pressler, 2011). The goal is to increase the proportion of nurses with a bachelor's degree from 50% to 80% by 2020. Many of the nurse participants in this study possessed either a bachelor's or a master's degree (n = 89, 73%). Since these courses can prepare a returnee nurse in 6-12 weeks, it makes sense to invest in this educative effort to put mature experienced nurses with advanced degrees back to work in such a short expanse of time.

This study also examined the pre- and post-program confidence scores of the 6 week refresher program in the Northeast to the 12 week program in the Southeast during a 9 month period. The 12 week program provided 10 college credits (which qualifies for financial aid), 80 hours of didactics, and l60 hours of clinical practicum. Comparatively, the 6 week program provided CEUs (continuing education units), 80 hours of didactics, and 80 hours of clinical practicum. The professional role confidence scores rose from 15.9 pre-program to 19.3 post-program for the 12 week cohort class (17.8% increase), whereas the same pre- and post-professional role confidence scores rose from 14.4 to

19.3 for the 6 week cohort class (25.5% increase). These findings suggest that both groups reached the same level of confidence as a group.

It should also be noted that during this 9-month period there were only two cohort 12 week programs that took place (n = 19 participants); whereas there were 7 cohort 6 week programs (n = 55 participants) during this same period. The shorter programs ran more programs in that time span since it also took advantage of simultaneously running a day and evening program for didactics at their college with clinical practice on weekends at multiple hospitals with adjunct clinical instructors. The result outcome, of improved professional role confidence, is evidence that these programs are therapeutic for these nurses. The results indicate that the instructors must be providing supportive and cultivating instruction to these returnee nurses.

Practice

Evidence from this study of improved professional role confidence demonstrates that continuing education for nurses is a vital component of professional practice. These programs can provide more nurses quickly for staffing units and improve the patient to RN ratio. Low nurse to patient ratios have been supported in the literature (Cho et al., 2008) as a method to reduce mortality rates and improve patient outcomes in healthcare institutions. Healthcare organizations need to partner with colleges that provide these programs for potential future staff personnel. Perhaps these healthcare organizations could sponsor a returnee and provide financial support for their educational pursuits since financial issues are an inhibitor for many desiring to return to practice since these programs are costly.

Standards of excellence need to be continually evaluated and upgraded in order to provide quality safe care to clients in the care of professionals. Healthcare organizations should not be burdened with the task of educating their staff when there are academic institutions with seasoned educators to perform that task. Academic partnering would be instrumental in assisting staff development personnel or nurse managers in methods of coaching and mentoring their newly hired nurses. Residency programs are extremely beneficial to the new graduates and to the returnee nurse who should be included in these retention improving strategies. Returnee nurses have the same initial fears as a new graduate nurse: fear of harming a patient and skill building, along with gaining additional professional role confidence. These mature women and men returnee nurses should be hired since they are usually stakeholders in a community and are often dedicated and conscientious workers.

Research

One of the goals for Magnet accredited healthcare institutions is to promote research. The collaboration between higher academic institutions and healthcare organizations cannot be overemphasized since trained educators who teach research could be instrumental to nursing staff wishing to start a research endeavor on a unit. Currently, tracking the progress and retention of new graduates occurs at most institutions in order to evaluate the success of these residency programs. These returnee nurses should be included in the residency programs that involve transition to practice studies since they too are experiencing change. Furthermore, research needs to be instituted and documented regarding the progress of returnee nurses post-refresher program. Tracking of hired returnee nurses would be most beneficial in collecting post-

program statistical data related to work environment adjustments and future educational

avenues to pursue with this population of nurses.

Health/Public Policy

Nurses need to get in contact with their legislators and senators to push for more

funding for re-educating the out of practice nurses who are in our rank and file. The

enactment of the Affordable Care Act will soon put a strain on our nurse supply since

more Americans than ever will be accessing our healthcare system. Currently more than

one third of the nurse workforce is over 50 years old and will be retiring by 2020. Not

only do we need more nurses to be re-educated and trained with continuing education

courses, but we also will need more advanced practice nurses to act as primary care

givers. Healthcare organizations need to develop creative strategies to find part time

employment for those RNs over 50 years old who would like to slow down but not stop

since these RNs have such strong experiential knowledge and leadership skills.

Healthcare organizations should also consider setting up day care centers on site as a

social support for the young new nurses who are mainly female. Children and family

obligations were obvious reasons in this study as to why females had taken a hiatus from

nursing. Females are the only gender that can bear children, and therefore this female

dominated profession and the healthcare organizations where they work should support

them.

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Strengths and Limitations of the Study

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One of the strengths of this study was the professional cooperation of the program

directors in providing permission for the researcher to seek volunteers from their

continuing education programs. The participants who volunteered for this study were

already registered in the program and met the criteria for the study. This study also had

strong program instructor support from both sites, which helped the researcher with

scheduling visits to the classrooms.

Another strength of this study was the exempt status of the participants who volunteered

after learning about this research endeavor. Nurses are always helpful and gladly

participated in this study. Very few nurses involved with the refresher program refused

to participate in this study. Since the refresher programs involved adult volunteers in

continuing education, there was no need to obtain IRB approval at the cooperating

colleges since exempt status was approved by the researcher's institution.

The Confidence Scale (C-Scale) proved to be a strong affective self report instrument for

this study in determining the professional role growth of the participants both pre- and

post-program. The internal consistency for this instrument was demonstrated by the

results of the Chronbach alpha (α), which exceeded the .70 benchmark. The participants

(n = 95) found the instrument easy to use and answered all questions. Dependent *t* test

found that the scores significantly increased between the two testing and the effect size

was large and the hypothesis was supported. Hopefully, future participants will benefit

from the results of this study. The researcher would like to have this study published so

that information about this unique group of under-served nurses will be disseminated and

recognized. Funding and more programs are very much needed in order to expand the

number of nurses who could be brought back into the profession.

This study surveyed two geographic areas that had diverse ethnicities. The

program participant sample for each site had excellent ethnic representation of the area's

population and nursing workforce and therefore improves the transferability of the

findings. In addition, the end of program gathering of the cohort refresher class provided the researcher with rich transition condition data (since the researcher was in attendance to do the Phase 2 post-course survey). Many of the program participants convened this last day to do course evaluations and receive their certificates of completion. Many had praises about the program and the feelings of connectedness and instructor support.

Limitations

The two sites chosen for this study had a strong reputation for consistently running their programs with strong enrollment numbers. This study had to be extended beyond the one year approval period provided by the Institutional Review Board (IRB) due to a natural disaster, Hurricane Sandy, on October 29, 2012. Extended IRB approval was received in the summer 2013 after enrollments in the Northeast site were gravely impacted by the devastation of this super storm. Many families experienced extensive home damage and loss of power for an extended period of time that altered any plans for educational pursuits. Enrollments dropped in half, and multiple cohorts of classes were surveyed. It was very time consuming and very expensive for the researcher to travel to the Northeast location more often than originally planned due to the low enrollments.

In searching for other sites for this study it became apparent that not only is there a lack of programs for returnee nurses to access in order to prepare to return to practice (Bonnel, 2009), but also that many courses do not run consistently. The profession also lacks a central depository of listings of all the available programs (Mark & Gupta, 2002). Each state has an individual website, and it was very time consuming to search for programs. The sites are often meshed, and the label of returnee nurse was often confused

with returnee nurses going back to school for advanced degrees not return to practice after a hiatus. There needs to be improved clarity on these websites.

Another limitation to this study was the Margin in Life (MIL) scale . This instrument had many of the necessary transitions conditions of facilitators and inhibitors that were measurable for the Transition Model. Prior to use, internal consistency was demonstrated by the results of the Chronbach alpha (α) of all subscales for this instrument. All values exceeded the .70 benchmark. However, in working with the instrument, the participants found it to be difficult and too long since each statement (58 items) had to have three ratings: one for importance, one for load, and one for power. Clustered responses by the participants indicated that they often chose the same power and load ratio for each statement regardless of the life area examined. Test of collinearity demonstrated that the measures for the sub-scales of MIL were highly correlated and likely not independent. Of the 121 MIL instruments collected, only 31 were filled out properly and usable. Therefore, due to the low number of respondents and the analysis of distribution of scores and homogeneity of variance, the researcher found that the scores did not meet the assumptions of parametric testing. The data for margin in life was included in testing of Hypotheses 1 and 2, but the results cannot be generalized and must be viewed with caution. Therefore, the hypotheses were not supported.

Another limitation was lack of researcher control concerning the time of day when the participants could be surveyed. The researcher was allowed time at the end of class time to approach the perspective participants. Fatigue of the participants may have impacted their responses on the survey tools.

Recommendations for Future Study

The researcher would like to find or create a superior quantitative psychometric tool for measuring the life world subsets that encompass transitional conditions of Transition Theory. Once a better tool is located or created, the researcher believes that this study should be replicated and/or triangulated with anecdotes of the participant's life world.

One of the benefits of doing a post-program evaluation was to attend the last day of class with the participants, which I would highly recommend for this type of study again. At this small celebration of course evaluations and certificate awards, the instructors would invite the participants to provide any program comments. The overwhelming verbal responses from the attendees were the definite need for the group classes and clinical encounters. Many commented that they needed to connect with peers in a similar situation while pursuing this transition together. This informal focus group accentuated that their new collegial bonds that were formed would be most helpful for future contacts for support and possible future job acquisitions. Even though the MIL scale did not provide the link of interdependence/connectedness, this informal end of program gathering substantiated that the interventional refresher program did provide the avenue for that needed support and pattern of response to help them master their confidence in their professional role again.

Additionally, the researcher would like to do a one year follow up to track past study participants to ascertain if jobs were obtained. If not, why? Additionally, the researcher would also like to survey human resource administrators regarding hiring new

graduates versus returnee nurses for their staffing workforce to determine if any bias exists.

Conclusion

The findings of this study support the important intervention that refresher programs provide to the out of practice nurses. The returnee nurse who is attempting to transition back into contemporary acute care practice is an excellent study choice that aligns well with Transition Theory. These under-served RNs have lost important connections in their professional life and are in need of support from their professional organizations. Many of these nurses suffer from role insufficiency, which was evident on many of the pre-program confidence scores. Many of their life events, which were captured on the demographic and Life Experience Scale, can be identified as one of the nature of transitions in Transition Theory.

The nursing profession needs to give more attention to these under-served professionals that can be re-oriented and streamlined back into the profession in a short period of time. Current trends of enrollees in these programs demonstrate that there could be a large pool of RNs who have excellent education credentials and were trained but never got jobs because of the economic recession. There is not enough recognition and financial support provided to this population of nurses. Healthcare organizations need to be made aware about this potential workforce pool of nursing professionals. Healthcare human resource recruiters, who often are not RNs, also need to be made cognizant about the value these nurses could provide to an organization's workforce.

A nursing shortage is on the horizon, and these nurses can be instrumental in providing safe, competent patient care. The findings of this study demonstrated that the

returnee nurses are confident in their professional role after a refresher program and feel

prepared to re-enter the labor force as competent nurses. Perhaps what these nurses are

lacking is confidence in their profession and the recruiters to see their potential and give

them a chance to provide safe competent nursing care to their patients in a confident

manner once again.

REFERENCES

Aiken, L. (2007). U.S. labor market dynamics are key to global nurse sufficiency. *Health Services Research, 42*(3), 1299-1320.

American Association of Colleges of Nursing (AACN). (2005). New data confirm shortage of nursing school faculty hinders efforts to address the nation's nursing shortage. Retrieved from http://www.aacn.nche.edu/media-relations/news-releases/archives

American Association of Colleges of Nursing (AACN). (2009). Nursing faculty shortage fact sheet. Retrieved April 2010 from http://www.aacn.nche.edu/Media/factsheets/FacultyShortage.htm

American Nurses Association (ANA)(1994). What is the A.N.A. doing for nurses? Here's what. *Journal of Nurse Empowerment*, *4*(4), 3.

Asselin, M., Osterman, P., & Cullen, H. A. (2006). In their own words: The experience of returning to acute care practice. *Journal for Nurses in Staff Development*, *22*(3), 104-111.

Bandura, A. (1977) Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, *84*(2), 191-215.

Barriball, K. L., Coopamah, V., Roberts, J., & Watts, S. (2007). Evaluation of return to practice: The views of nurse returnees from three NHS Hospital Trusts. *Journal of Nursing Management, 15*, 433-441.

Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects*. New York: Harper & Row.

Beckert, D., & Day, M. (2001). *Learning as a source of power: Participation and benefit factors of relatively educated older adults with low margin in structured learning activities.* (Unpublished doctoral dissertation). University of Wyoming, Laramie, WY.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice.* Menlo Park, CA: Addison-Wesley.

Blankenship, J., Winslow, S., & Underwood Smith, A. (2003). Refresher course for inactive RNs facilitates workforce re-entry. *Journal for Nurses in Staff Development, 19*(6), 288-291.

Bonnel, D. H. (2009). *Analysis of re-entry programs: An examination of national re-entry programs for women.* (Unpublished doctoral dissertation). California State University, Sacramento, CA.

Bridges, W. (2004). *Transitions: Making sense of life's changes*. Cambridge, MA: Da Capo Press.

Buchanan, M. J. (2002). Getting back. *Advance, 2*(1), 12-14.

Buchan, J., & Calman, L. (2004). The global shortage of registered nurses: An overview of issues and action. Retrieved from http://www.icn.ch/images/stories/documents/publications/GNRI/Global_shortage_Overview.pdf

Buckis, C. (2004). A long memory for nursing shortages. *The Lamp*, *61*(6), 20-21.

Buerhaus, P. I., & Auerbach, D. I. (2011). The recession's effect on hospital registered nurse employment growth. *Nursing Economics*, *29*(4), 163-167.

Buerhaus, P. I., Staiger, D. O., & Auerbach, D. I. (2009). *The future of the nursing workforce in the United States. Data, trends, and implications.* Boston, MA: Jones and Bartlett.

Chacko, S. B., & Huba, M. E. (1991). Academic achievement among undergraduate nursing students: The development and test of a causal model. *Journal of Nursing Education*, *30*(6), 267-273.

Chan, Y. H. (2004). Biostatistics 201: Linear regression analysis. *Singapore Medical Journal*, 45(2), 55-61.

Cho, S., Hwang, J., & Kim, J. (2008). Nurse staffing and patient mortality in intensive care units. *Nursing Research*, *57*(5), 322-330.

Cooper, S. S., & Hornback, M.S. (1973). *Continuing nursing education*. New York: McGraw-Hill.

Creswell, J.W. (2008). *Research design: Qualitative, quantitative, and mixed method approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Crouch, D. (2002). Should I stay or should I go? *Nursing Times*, *98*(4), 24.

Curtis, P., & Schneidenbach, L. (1991). Brief: Successful strategies for re-entry program one example. *Journal of Continuing Education in Nursing*, *22*(1), 36-38.

Domrose, C. (2001). You can go home again. *Nurse Week*, *33*(4), 28-32.

Duke, C. (2010). *The lived experience of nurse practitioner graduates' transition to hospital-based practice.* (Unpublished doctoral dissertation). East Carolina University, Greenville, NC

Durand, M., & Randhawa, G. (2002). RNs' views about returning to practice after a career break. *British Journal of Nursing*, *11*(7), 477-485.

Elwin, C. (2007). Returning to nursing practice: A learning journey. *Contemporary Nurse*, *24*(2), 203-211.

Falk, N. L. (2007). Strategies to enhance retention and effective utilization of aging nurse faculty. *Journal of Nursing Education*, *46*(4), 165-169.

Faul, F., Erdfelder, E., Lang, A., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavior, and biomedical sciences. *Behavior Research Methods*, *39*(2), 175-191.

Field, A. (2009). Discovering statistics using SPSS (3rd ed.). Thousand Oaks, CA: Sage.

Florida Center for Nursing. (2008). Licensed nurses in Florida: 2007-2008 trends and longitudinal analysis. Retrieved from

http.//www.flcenterfornursing.org/files/vacancies_Job_Growth.pdf

Florida Center for Nursing. (2010). The Florida nursing shortage: A summary of recent FCN research. Retrieved from

http.//www.flcenterfornursing.org/files/Nursing_Shortage_2010.pdf

Gauci Border, R., & Norman, I. (1997). Factors influencing turnover and absence of RN: A research review. *International Journal of Nursing Studies*, *34*(6), 385-394.

Gay, L. R., Mills, G. E., & Airasian, P. (2009). *Educational research:Competencies for analysis and applications* (9th ed.). Upper Saddle River, NJ: Pearson.

Grundy, S. E. (1993). The confidence scale: Development and psychometric characteristics. *Nurse Educator*, *17*(5), 30-33.

Hall, C., & Andre, C. (1999). RNs re-entering the workforce: A special needs group. *Contemporary Nurse*, *8*(1), 238-244.

Hammer, V. R., & Craig, G.P. (2008). The experiences of inactive nurses returned to
nursing after completing a refresher course. *The Journal of Continuing Education
in Nursing*, *39*(8), 358-367.

Harrison, P. G. (2004). *The lived experience of re-entry women in traditional
baccalaureate nursing education*. (Unpublished doctoral dissertation). Ball State
University, Muncie, IN.

Hawley, J. M., & Foley, B. J. (2004). Being refreshed: Evaluation of a nurse refresher
course. *The Journal of Continuing Education in Nursing*, *35*(2), 84-88.

Hitchcock, R. (2003). Many happy returners. *Nursing Standard*, *17*(34), 18.

Holmes, T. H., & Rahe, R. H. (1967). The social readjustment rating scale. *Journal of
Psychosomatic Research*, *11*, 213-218.

Institute of Medicine. (2010). *The Future of Nursing: Leading Change, Advancing
Health*. Washington, DC: National Academies of Science.

Jamieson, I., & Chris, T. (2009). Leaving from and returning to nursing practice:
Contributing factors. *Nursing Praxis in New Zealand*, *25*(2), 15-27.

Kalynych, C., & Lamkin, M. (2010). *The application of margin in life theory in regard to
attrition and remediation among emergency medicine residents*. (Unpublished
doctoral dissertation). University of North Florida, Jacksonville, FL.

Kerlinger, F.N. & Lee, H.B. (2000). *Foundations of behavioral research* (4th ed.).
Belmont, CA: Cengage Learning.

Khan, K., Schmidt, P.L., Schoville, R., & Williams, M. (1993). From expert to novice.
The American Journal of Nursing, *93*(9), 53-56.

Knowles, M. (1990). *The adult learner: A neglected species* (4th ed.). Houston, TX: Gulf
Publishing Company.

Krenner, C. A. & Pressler, J. L. (2011). Trends in nursing education. *Nurse Educator*,
36(5), 179-180.

Kroner, S., & Biermann, A. (2007). The relationship between confidence and self-
concept: Towards a model of response confidence. *Intelligence*, *35*, 580-590.

Lagana, B. (2005). *Power, load, and margin: Relationships between professional
development and margin in life among student affairs professionals at Ball State
University*. (Unpublished doctoral dissertation). Ball State University, Muncie,
IN.

Loquist, R. S. (1991). South Carolina studies inactive nurses. *Issues, 12*(2), 4-5.

Manning, L., & Neville, S. (2009). Work-role transition: From staff nurse to clinical
nurse educator. *Nursing Praxis in New Zealand*, *25*(2), 41-49.

Mark, S., & Gupta, J. (2002). Re-entry into clinical practice: Challenges and strategies.
JAMA, 288(9), 1091-1096.

McClusky, H. Y. (1963). The course of the adult life span. In W. C. Hallenbeck (Ed.),
Psychology of Adults (pp. 10-19). Washington, D.C: Adult Education of the
U.S.A.

Meleis, A. (1975). Role insufficiency and role supplementation: A conceptual
framework. *Nursing Research*, *24*, 264-271.

Meleis, A. I. (2010). *Transitions theory; Middle-range and situation-specific theories in
nursing research.* New York: Springer.

Meleis, A., Sawyer, L., Im, E., Hilfinger, M., DeAnne, K., & Schumacher, K. (2000). Experiencing transitions: An emerging middle range theory. *Advances in Nursing Science*, *23*(1), 12-28.

Meredith, R. (2002). I quit because it's an impossible task. *Nursing Times*, *989*(4), 25-26.

Morgan, J.S. & Thorne, S. (1985). Injection giving: The effect of time lapse between learning and actual practice on student confidence. *Nursing Papers*, 17: 49-58.

National Council of State Boards of Nursing (NCSBN). (2011). Transition to practice. Retrieved from https://www.ncsbn.org/363.htm

NY State Education Department (NYSED). (2002). Research report: Registered nurses in New York State, 2002. Vol. 1: Demographic, Educational, and Workforce Characteristics. Retrieved https://www.nysed.org/283.htm

Nottingham, E., & Foreman, K. (2000). Creating the right environment for return-to-practice candidates. *Nursing Standard*, *14*(32), 44-45.

O'Neill, S. (1985). The effects of using guided imagery cassettes on the dressing change proficiency scores of first semester baccalaureate nursing students. Unpublished report.

Perry, P. (2011). Concept analysis: Confidence/self-confidence. *Nursing Forum*, *46*(4), 218-230.

Petersen, R. A. (2000). *The effect of clinical preceptorships on critical thinking ability and self-confidence levels in baccalaureate nursing students*. (Unpublished doctoral dissertation). University of South Dakota, Vermillion, SD.

Quant, T. (2001). Education for RNs returning to practice. *Nursing Standard*, *15*(17), 39-41.

Rafferty, A., Clarke, S., Coles, J., Ball, J., James, P., McKee, M., & Aiken, L. (2007). Outcomes of variation in hospital nurse staffing in English hospitals: Cross-sectional analysis of survey data and discharge records. *International Journal of Nursing Studies, 44*, 175-182.

Rich, K. L., & Nugent, K. E. (2010). A United States perspective on the challenges in nursing education. *Nursing Education Today*, *30*, 228- 232. doi: 10.1016/j.nedt.2009.10.015

Rogers, A. (1996). *Teaching adults* (2nd ed.). Buckingham: Open University Press.

Sarason, I., Johnson, J., & Siegel, J. (1978). Assessing the impact of life changes: Development of the life experiences survey. *Journal of Consulting and Clinical Psychology, 46*(5), 933-946.

Schultz, P. R. (1990). Milestones in the success of nursing as an emerging discipline. *American Journal of Pharmaceutical Education*, *54*(Winter), 370-374.

Spielberger, C. D., Gorsuch, R. L., & Lushene, R. E. (1970). *Manual for the state-trait anxiety inventory*. Palo Alto, CA.: Consulting Psychologists Press.

Statistical Package for the Social Sciences (SPSS). (2012). Predictive Analytic Software (PASW) Statistics GradPack 21.0. Chicago, IL: Author.

Stein, A. M. (1998). History of continuing nursing education in the United States. *The Journal of Continuing Education in Nursing*, *29*(6), 245-252.

Stevenson, J. S. (1982). Construction of a scale to measure load, power, and margin in life. *Nursing Research*, *31*(4), 222-225.

Thomas, J. (2003). Changing career paths: From expert to novice. *Orthopaedic Nursing*, *22*(5), 332-334.

U.S. Bureau of Labor Statistics. (2010). Occupational outlook handbook: 2010-2011. Registered nurses. Washington, DC: U.S. Department of Labor. Retrieved from http://www.bls.gov/oco/ocos083.htm

U.S. Health Resources and Services Administration. (2006). Home page. Retrieved from http://www.hrsa.gov/

Walker, B., & Merriam, S.B. (1997). *Margin-in-life scale: A predictor of persistence for nontraditional students in higher education.* (Unpublished doctoral dissertation). University of Georgia, Athens, GA.

Webster's New Universal Unabridged Dictionary. (2nd ed.) (1983). New York: Simon & Shuster.

White, A., Roberts, V., & Brannan, J. (2003). Returning RNs to the workforce: Developing an online refresher course. *Journal of Continuing Education in Nursing*, *34*(2), 59-63.

Wilcock, A. (2000). A welcome return. *Nursing Standard*, *14*(30), 18-20.

APPENDIX A

BARRY UNIVERSITY'S INSTITUTIONAL REVIEW BOARD LETTERS OF

APPROVAL

BARRY
UNIVERSITY

OFFICE OF THE PROVOST
INSTITUTIONAL REVIEW BOARD

Research with Human Subjects
Protocol Review

Date:	August 29, 2012
Protocol Number:	120807
Title:	The Effect of a Refresher Program upon the Professional Role Confidence Level of Transitioning Returnee Nurses
Approval Date:	8/29/12
Name:	Ms. Virginia Hackett
Address:	School of Nursing
Sponsor:	Dr. Jessie Colin Barry University – School of Nursing N.A.

Dear Ms. Hackett:

On behalf of the Barry University Institutional Review Board (IRB), I have verified that the specific changes requested by the IRB have been made. Therefore, I have granted final approval for this study as exempt from further review.

As principal investigator of this protocol, it is your responsibility to make sure that this study is conducted as approved by the IRB. Any modifications to the protocol or consent form, initiated by you or by the sponsor, will require prior approval, which you may request by completing a protocol modification form.

It is a condition of this approval that you report promptly to the IRB any serious, unanticipated adverse events experienced by participants in the course of this research, whether or not they are directly related to the study protocol. These adverse events include, but may not be limited to, any experience that is fatal or immediately life-threatening, is permanently disabling, requires (or prolongs) inpatient hospitalization, or is a congenital anomaly cancer or overdose.

The approval granted expires on August 29, 2013. Should you wish to maintain this protocol in an active status beyond that date, you will need to provide the IRB with and IRB Application for Continuing Review (Progress Report) summarizing study results to date.

If you have questions about these procedures, or need any additional assistance from the IRB, please call the IRB point of contact, Mrs. Barbara Cook at ▓▓▓▓▓▓ or send an e-mail to ▓▓▓▓▓▓▓▓▓▓ Finally, please review your professional liability insurance to make sure your coverage includes the activities in this study.

Sincerely,

Linda Bacheller, Psy.D., J.D.
Chair, Institutional Review Board
Barry University

Cc: Dr. Jessie Colin

Note: Note: The investigator will be solely responsible and strictly accountable for any deviation from or failure to follow the research protocol as approved and will hold Barry University harmless from all claims against it arising from said deviation or failure.

BARRY UNIVERSITY

OFFICE OF THE PROVOST
INSTITUTIONAL REVIEW BOARD

Research with Human Subjects
Protocol Review

To: Ms. Virginia Hackett
            Barry University
            School of Nursing

From: Linda Bacheller Linda Bacheller, Psy.D., J.D.
            Chair, Institutional Review Board

Date: June 19, 2013

Protocol Number: 120807
Protocol Title: The Effect of a Refresher Program upon the Professional
                    Role Confidence Level of Transitioning Returnee Nurses

Dear Ms. Hackett:

Thank you for sending the request for modifications indicating that you would like to
make changes to your protocol regarding:

1. Change in end date from 8/29/13 to 5/29/14

The above changes have been accepted. You may proceed with your collection of data.
The approval granted expires on May 29, 2014.

Sincerely,

Linda Bacheller, Psy.D., J.D.
Chair, Institutional Review Board
Barry University

Cc: Jessie Colin

If you have any questions, please contact Barbara Cook at: █████████
****

Note: The investigator will be solely responsible and strictly accountable for any deviation from or failure
to follow the research protocol as approved and will hold Barry University harmless from all claims against
it arising from said deviation or failure.

APPENDIX B

COVER LETTER FOR RETURNEE NURSES DESCRIBING THE STUDY

Approved by Barry University IRB :

Date : AUG 29 2012

Signature : *[signature]* Lmo Brusella, PsyD, JD

Barry University
Cover Letter

Dear Research Participant:

Your participation in a research project is requested. This study is being conducted by Virginia Hackett, a doctoral student at Barry University, Division of Nursing. The purpose of this study is to test Meleis' (2010) transition theory model among a group of RNs participating in a refresher program with the intent to re-enter nursing practice after a period of non-practicing. This pre/posttest quantitative, correlational study would like to examine the effect of a preparatory refresher course upon the professional role confidence level of re-entry nurses while transitioning back to contemporary practice. Another aim of this study will be to examine other variables (loads/burdens in life and power/positive influence in life) that could inhibit or facilitate the transition of a returnee RN back to the workforce.

The number of participants anticipated for this study is a minimum of 108 registered nurses. If you decide to participate in this research, you will be asked to partake in two surveys (phase 1 and phase 2). In phase 1 you will be provided with four questionnaires with a total of 120 items, a pencil, a researcher's business card, an ink pen with a light as a token of appreciation, and an envelope to place the completed questionnaires into. This first survey should take 35-45 minutes to complete. You will be asked to choose an anonymous four digit number that is meaningful to you and can easily recall and inscribe it on the right hand corner of the survey and on the back of the researcher's business card (to place in your wallet for later reference if needed). After the course is completed you will be asked to complete one more survey (phase 2) consisting of 5 multiple choice questions that should take no more than 10 minutes to complete. You will again be asked to place your special anonymous four digit number on the right hand corner for correlation with the first survey. All completed questionnaires in Phase 1 and Phase 2 will be placed in a sealed box, which will be placed at the front of the classroom.

Your consent to be a research participant is strictly voluntary and should you decline to participate or should you choose to drop out at any time during the study, there will be no adverse effects on your progression in the refresher program.

There are no known risks to you for participating in the study. There are no direct benefits for your participation in this study. Your participation in this study may further assist our understanding of the many issues and obstacles facing the returning nurse as he/she transitions, the effects of a refresher program, and the impact on their confidence levels.

As a research participant, information you provide will be kept anonymous; that is no names or other identifiers will be collected on the questionnaires. Any published results of the research will refer to group averages only and no names or identifiers will be used. The surveys will be kept in a locked file cabinet in the researcher's office for five years and then data will be shredded by the researcher. By completing these surveys you have shown your agreement to participate in the study.

If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Virginia Hackett, at ████████████ my supervisor , Dr. Jessie M. Colin PhD, RN, FAAN at ████████████ or the Institutional Review Board point of contact, Barbara Cook, at █████████.

Thank you for your participation.

Sincerely, .

[signature] Virginia Hackett MS, RN

APPENDIX C

FLYER FOR RECRUITING PARTICIPANTS

RETURNEE NURSES ENROLLED IN THE RN REFRESHER PROGRAM

YOUR ACTIVE PARTICIPATION MATTERS!!!

This study is searching for the participation of a minimum of 108 Registered Nurses who are currently enrolled in an RN Refresher program. This study would like to determine The Effect of a Refresher Program on the Professional Role Confidence Level of Transitioning Returnee Nurses.

- The anticipated time for your participation should take no more than 35-45 minutes for phase 1 survey questionnaire at the beginning of the course and approximately 10 minutes for phase 2 survey at the end of the course.

- Your decision to participate in this study will not impact your involvement or completion of the current RN Refresher Program you are currently enrolled in. You may withdraw from this study at any time without consequence.

- A small gift in the form of an ink pen with a light will be distributed to all who participate in this study.

This study will be conducted by Virginia Hackett, MS, RN, doctoral student at Barry University, Miami Shores, Florida. For questions and concerns please contact the researcher at ▮▮▮▮▮▮ or by email at ▮▮▮▮▮▮▮▮; my advisor, Dr. Jessie Colin at ▮▮▮▮▮ or by email at ▮▮▮▮▮▮ or the contact person for Barry University's Institutional Review Board, Barbara Cook at ▮▮▮▮▮▮ ▮▮▮▮▮.

APPENDIX D

LETTER OF PERMISSION FROM REFRESHER PROGRAM

ADMINISTRATORS

May 7, 2012

Dear Virginia,

Thank you for your request concerning your desire to sample the students enrolled in the continuing education Nursing Refresher Update Course at Broward College for your planned doctoral research. Your study, Critical Influences Impacting the Confidence Levels and Professional Role Identity of Transitioning Returnee Nurses, is timely in light of the projected nursing shortage forecasted in the near future and the concerns of the profession with variables affecting nursing attrition and transitioning to practice. The need for more nurses is a looming crisis as more baby boomer generation adults enter into their senior years and a large pool of nurses are projected to retire. Our nursing schools cannot keep pace with the projected needs of our nation. The healthcare outcomes for our patients will be at stake if we do not have a sufficient amount of nurses to care for them. Now, more than ever, we need to keep nurses in active nursing roles and encourage their return to practice after a personal or situational hiatus from the professional workplace.

You are granted approval from the Continuing Education/Workforce Development department to approach the upcoming classes of RN Refresher class of students enrolled at our college after you have received Institutional Review Board (IRB) approval from your university committee. Please be advised that after explaining your study to the students, their consent to participate in your surveys will be strictly voluntary on their part. Please coordinate with me and I will facilitate your access to meet with the students. Thank you for your interest in our students and I look forward to the future results of your research study.

Sincerely,

Katherine Jackson, EdD, RN

Dean, Continuing Education/Workforce Development, Health Science

June 11, 2012

Dear Virginia,

Thank you for your inquiry concerning your desire to sample the registered nurse (RN) students enrolled in the continuing education (CE) Nursing Refresher Course for your planned research. Your study, Critical Influences Impacting the Confidence Levels and Professional Role Identity of Transitioning Returnee Nurses, is timely in light of the projected nursing shortage forecasted in the near future and the concerns of the profession with variables affecting nursing attrition and transitioning into practice. The need for more nurses is at a crisis situation as more baby boomer generation adults enter into their senior years and a large pool of nurses are projected to retire. It is critical that we keep nurses in nursing and encourage their return to practice after a personal or situational hiatus from the workplace.

You are granted approval from the CE department of Molloy College to approach the Refresher Course RN students after you have received Institutional Review Board (IRB) exempt status approval from your university. Please be advised that after explaining your study to the students, their consent to participate in your anonymous surveys will be strictly voluntary on their part. Thank you for your interest in our students and I look forward to the future results of your research.

Sincerely,

Anna Jansson, MS, RN

Associate Director of Nursing Continuing Education

APPENDIX E

SURVEY/ QUESTIONNAIRES

Phase 1 Questionnaire (120 questions) that includes:

Professional Role Confidence Scale

Life Experience Survey

Margin in Life Scale

Demographic Survey

Phase 2 Questionnaire (5 questions) that includes:

Professional Role Confidence Scale

_____Location   Four-digit #_____

PHASE 1- RN REFRESHER QUESTIONNAIRE / SURVEY

By completing this survey, you are consenting to participate in this study. Study participants may be asked to be removed from the study at anytime; however, data already collected may be used. Your participation is voluntary and anonymous and will not affect your progression or outcomes in the RN Refresher Program.

Please choose a four digit number that is easy to recall and inscribe it in the right hand corner of this survey packet. You will be asked to recall that number for one additional follow-up questionnaire (phase 2) at the end of the program. This will maintain each participant's anonymous status and assist the researcher in collating answers post program with information recorded from the first survey questionnaire. Please record this same four digit number on the back of the researcher's business card (provided with survey). Please place this card in your wallet for later recall/reference.

Please answer each question appropriately (circling a response or providing one word answer) and refrain from writing any identifying information (names) on any of the pages. This survey should take about 35-45 minutes to complete and is composed of the following four questionnaires:

> 1) your current feeling about your professional role confidence as a nurse

> 2) your attitude about your life experiences this past year

> 3) your margin of life (energy reserve) that may help you to succeed (feelings about load and power items affecting your life situation)

> 4) demographic data

Thank you for taking the time to participate in this study and I hope you find the appreciative gift useful in your practice as a professional nurse (again!).

Directions for Questionnaire #1 (Professional Role Confidence): Circle the number that best describes how you think or feel regarding your current self assessment of your ability to assume the role of a professional registered nurse in the acute care setting (hospital). Make sure that the circle encloses just one number.

1. I am certain that my performance as a professional registered nurse (RN) to deliver safe, competent patient care is correct.
   1) Not at all certain
   2) Certain for only a few nursing tasks
   3) Fairly certain for a good number of nursing tasks
   4) Certain for almost all nursing tasks
   5) Absolutely certain for all nursing tasks

2. I feel that I perform nursing role tasks to deliver safe, competent patient care as a professional nurse without hesitation.
   1) Not at all certain
   2) Certain for only a few nursing tasks
   3) Fairly certain for a good number of nursing tasks
   4) Certain for almost all nursing tasks
   5) Absolutely certain for all nursing tasks

3. My performance as a registered professional nurse (RN) would convince an observer(s) that I'm competent to deliver safe care to patients.
   1) Not at all certain
   2) Certain for only a few nursing tasks
   3) Fairly certain for a good number of nursing tasks
   4) Certain for almost all nursing tasks
   5) Absolutely certain for all nursing tasks

4. I feel sure of myself as I perform nursing role tasks that ensure safe, competent patient care.
   1) Not at all certain
   2) Certain for only a few nursing tasks
   3) Fairly certain for a good number of nursing tasks
   4) Certain for almost all nursing tasks
   5) Absolutely certain for all nursing tasks

5. I feel satisfied with my performance as a registered professional nurse (RN) to deliver safe, competent patient care.
   1) Not at all certain
   2) Certain for only a few nursing tasks
   3) Fairly certain for a good number of nursing tasks
   4) Certain for almost all nursing tasks
   5) Absolutely certain for all nursing tasks

Directions for Questionnaire #2 (Life Experiences): Listed below are a number of events which sometimes bring about change in the lives of those who experienced them and which necessitate social readjustment. *Please check those events which you have experienced in the recent past and indicate the time period during which you have experienced each event (0 to 6 mos. or 7 to 12 mos.).* Be sure that all check marks are directly across from the items they correspond to.

Also, for each item checked below, *please indicate the extent to which you viewed the event as having either a positive or negative impact on your life* at the time the event occurred by circling the corresponding number. That is, *indicate the type and extent of impact that the event had.* A rating of 0 suggests no impact. A rating of +3 would indicate an extremely positive impact and a rating of -3 would indicate an extremely negative impact.

		Time Span		*Degree of Impact*
		0-6 mos. *7-12 mos.*		*Negative* *0* *Positive*
1.	Marriage	___ ___		-3 -2 -1 0 +1 +2 +3
2.	Detention in jail or similar institution	___ ___		-3 -2 -1 0 +1 +2 +3
3.	Death of a spouse	___ ___		-3 -2 -1 0 +1 +2 +3
4.	Major change in sleeping habits	___ ___		-3 -2 -1 0 +1 +2 +3
5.	Death of close family member			
	a. Mother	___ ___		-3 -2 -1 0 +1 +2 +3
	b. Father	___ ___		-3 -2 -1 0 +1 +2 +3
	c. Brother	___ ___		-3 -2 -1 0 +1 +2 +3
	d. Grandmother	___ ___		-3 -2 -1 0 +1 +2 +3
	e. Grandfather	___ ___		-3 -2 -1 0 +1 +2 +3
	f. Other _____	___ ___		-3 -2 -1 0 +1 +2 +3
6.	Major change in eating habits	___ ___		-3 -2 -1 0 +1 +2 +3
7.	Foreclosure on mortgage or loan	___ ___		-3 -2 -1 0 +1 +2 +3
8.	Death of close friend	___ ___		-3 -2 -1 0 +1 +2 +3
9.	Outstanding personal achievement	___ ___		-3 -2 -1 0 +1 +2 +3
10.	Minor law violations (ticket)	___ ___		-3 -2 -1 0 +1 +2 +3
11.	*Male:* Wife/girlfriend pregnancy	___ ___		-3 -2 -1 0 +1 +2 +3
12.	*Female:* Pregnancy	___ ___		-3 -2 -1 0 +1 +2 +3
13.	Changed work situation	___ ___		-3 -2 -1 0 +1 +2 +3

(work responsibility, conditions, or hours)

	Time Span		Degree of Impact		
	0-6 mos.	*7-12 mos.*	*Negative*	*0*	*Positive*

14. New job   ___ ___   -3 -2 -1 0 +1 +2 +3

15. Serious illness or injury of close family member

    a. father   ___ ___   -3 -2 -1 0 +1 +2 +3

    b. mother   ___ ___   -3 -2 -1 0 +1 +2 +3

    c. sister   ___ ___   -3 -2 -1 0 +1 +2 +3

    d. brother   ___ ___   -3 -2 -1 0 +1 +2 +3

    e. grandfather   ___ ___   -3 -2 -1 0 +1 +2 +3

    f. grandmother   ___ ___   -3 -2 -1 0 +1 +2 +3

    g. spouse   ___ ___   -3 -2 -1 0 +1 +2 +3

    h. other _____   ___ ___   -3 -2 -1 0 +1 +2 +3

16. Sexual difficulties   ___ ___   -3 -2 -1 0 +1 +2 +3

17. Trouble with employer   ___ ___   -3 -2 -1 0 +1 +2 +3

    (demoted, suspension, or danger of losing)

18. Trouble with in-laws   ___ ___   -3 -2 -1 0 +1 +2 +3

19. Major change in financial status   ___ ___   -3 -2 -1 0 +1 +2 +3

20. Major change in closeness of family members ___ ___ -3 -2 -1 0 +1 +2 +3

21. Gaining a new family member   ___ ___   -3 -2 -1 0 +1 +2 +3

    (birth, adoption, family member moving in)

22. Change of residence   ___ ___   -3 -2 -1 0 +1 +2 +3

23. Marital separation from mate (conflict) ___ ___   -3 -2 -1 0 +1 +2 +3

24. Major change in church activities (attendance) ___ ___ -3 -2 -1 0 +1 +2 +3

25. Marital reconciliation with mate   ___ ___   -3 -2 -1 0 +1 +2 +3

26. Major change in number of arguments with spouse ___ ___ -3 -2 -1 0 +1 +2 +3

27. *Married Male:* Change in wife's work   ___ ___   -3 -2 -1 0 +1 +2 +3

    outside the home (beginning job, ceasing job, or changing to a new job).

28. *Married Females:* Change in husband's work ___ ___ -3 -2 -1 0 +1 +2 +3

    (losing job, retirement, beginning new job, etc.)

29. Major change in type and/or amount of recreation ___ ___ -3 -2 -1 0 +1 +2 +3

30. Borrowing more than $10,000 (for home or business) ___ ___ -3 -2 -1 0 +1 +2 +3

31. Borrowing less than $10,000 (TV, car, etc) ___ ___   -3 -2 -1 0 +1 +2 +3

32. Being fired from job   ___ ___   -3 -2 -1 0 +1 +2 +3

	Time Span		Degree of Impact		
	0-6 mos.	*7-12 mos.*	*Negative*	*0*	*Positive*
33. *Male:* Wife/girlfriend having an abortion	___	___	-3 -2 -1	0	+1 +2 +3
34. *Female:* Having abortion	___	___	-3 -2 -1	0	+1 +2 +3
35. Major personal illness or injury	___	___	-3 -2 -1	0	+1 +2 +3
36. Major change in social activities (parties, clubs)	___	___	-3 -2 -1	0	+1 +2 +3
37. Major change in living conditions of family	___	___	-3 -2 -1	0	+1 +2 +3
38. Divorce	___	___	-3 -2 -1	0	+1 +2 +3
39. Serious injury or illness of close friend	___	___	-3 -2 -1	0	+1 +2 +3
40. Retirement from work	___	___	-3 -2 -1	0	+1 +2 +3
41. Son or daughter leaving home (college, marriage)	___	___	-3 -2 -1	0	+1 +2 +3
42. Ending of formal schooling	___	___	-3 -2 -1	0	+1 +2 +3
43. Separation from spouse (due to work, travel)	___	___	-3 -2 -1	0	+1 +2 +3
44. Engagement	___	___	-3 -2 -1	0	+1 +2 +3
45. Breaking up with boyfriend/girlfriend	___	___	-3 -2 -1	0	+1 +2 +3
46. Leaving home for the first time	___	___	-3 -2 -1	0	+1 +2 +3
47. Reconciliation with boyfriend/girlfriend	___	___	-3 -2 -1	0	+1 +2 +3

Other recent experiences which have had an impact on your life. List and rate:

	Time Span		Degree of Impact		
48. _____	___	___	-3 -2 -1	0	+1 +2 +3
49. _____	___	___	-3 -2 -1	0	+1 +2 +3
_____	___	___	-3 -2 -1	0	+1 +2 +3

Directions for Questionnaire # 3 (Margin in Life): Adults face many demands in everyday life that can interfere with goals and aspirations. The purpose of the below scale is to find out how people view their present life situations and measures the adult's ability to handle these responsibilities. This instrument looks at: **Importance**- how important this item is to you in your daily living

        Load- the responsibilities or burden the adult encounters with that item

        Power- the strengths or powers the adult has as a resource with that item

Across from each of the following 58 items are four columns headed by the words:

        Importance of Item-----Load------Power-----Not Applicable

Please **rate each of the items** by circling the appropriate number for Importance (1 being the lowest and 10 being the highest) and then for Load and Power (1 being the lowest and 5 being the highest). Circle the zero for not applicable when appropriate (for example if you are asked about a spouse and never had one).

Generally Speaking	Importance of Item (circle one)	Load (circle one)	Power (circle one)	N/A
1. My mental health is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
2. My eyesight is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
3. Living with my spouse is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
4. Our children are	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
5. Frequent prayer is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
6. My hearing is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
7. My physical health is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
8. Reading religious material is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
9. My sense of smell is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
10. I would rate my present life as	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
11. Breathing is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
12. My sense of taste is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
13. Religious faith is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
14. My ability to concentrate is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
15. Belief in God is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
16. My blood circulation is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0

Generally Speaking	Importance of Item (circle one)	Load (circle one)	Power (circle one)	N/A
17. My appetite is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
18. The extent to which my family members cooperate with each other is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
19. Having goals in life is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
20. Being independent is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
21. My children's attitude towards me is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
22. My sexual abilities are	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
23. Making decisions is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
24. My hands and arms are	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
25. Being married is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
26. My type of employment is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
27. Being responsible is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
28. My digestion is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
29. My back is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
30. Belief in religion is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
31. My family's way of coping with problems is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
32. My feet and legs are	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
33. Self-reliance is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
34. Relating with my co-worker is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
35. The way my children and I get along is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
36. Having a few close friends is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
37. Controlling my temper is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0

Generally Speaking	**Importance of Item** (circle one)	**Load** (circle one)	**Power** (circle one)	**N/A**
38. A high standard of morality is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
39. My coordination is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
40. Consideration of others is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
41. The way my children act with each other is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
42. My body is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
43. The way my spouse handles responsibility is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
44. Mobility is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
45. My children's progress in school is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
46. The need for religion is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
47. The people I've met at church are	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
48. My attitude toward my family is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
49. Membership in a religion is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
50. My muscles are	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
51. Getting along with people is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
52. A spiritual way of life is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
53. Rest is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
54. Frequently finding it necessary to stand up for what I believe is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
55. Self-confidence is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
56. Participating in religious practice is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
57. Manual dexterity is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0
58. My concern for my family is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	0

Directions for Questionnaire #4 (Demographic Survey): Please circle the number that best describes your response or write in your response on the blank line. Please choose only one response for each item except when asked for "all that applies".

1. What is your gender?

     a. Female

     b. Male

2. What is your age? _____

3. What ethnicity do you identify with? _____

4. Your current marital status?

     a. Single

     b. Married

     c. Divorced

     d. Widowed

     e. Separated

     f. Other _____

5. What is your socioeconomic status?

     a. Less than $30,000

     b. $31,000 to $50,000

     c. $51,000 to $70,000

     d. Greater than $71,000

     e. Choose not to answer

6. Number of years of active nursing practice experience? _____

7. Highest academic degree?

    a. Diploma in nursing

    b. Associate degree

    c. Bachelor degree

    d. Master degree

    e. Other_____

8. Number of years away from active nursing practice? _____

9. Reason(s) for leaving active nursing practice? (circle all that applies)

    a. Pregnancy/Childrearing

    b. Inflexible work schedule

    c. Negative working environment

    d. Family obligations

    e. Health

    f. Other _____

10. Reason(s) for enrolling in the refresher program? (circle all that applies)

    a. Financial

    b. Loss of previous job

    c. Loss of spouse or significant other

    d. Missing professional nursing

    e. Empty nest

    f. Other _____

Thank you for your ACTIVE participation!

_____Location   Four-digit #_____

RN REFRESHER PHASE 2- FINAL QUESTIONNAIRE/ SURVEY

Directions for Phase 2 -Questionnaire (Professional Role Confidence): Circle the one number that best describes how you think or feel regarding your current self assessment of your ability to assume the role of a professional RN in the acute care setting (hospital). Please place your significant four digit number at the top right hand corner (no names or identifiers please).

1. I am certain that my performance as a professional registered nurse (RN) to deliver safe, competent patient care is correct?
    1) Not at all certain
    2) Certain for only a few nursing tasks
    3) Fairly certain for a good number of nursing tasks
    4) Certain for almost all nursing tasks
    5) Absolutely certain for all nursing tasks

2. I feel that I perform nursing role tasks to deliver safe, competent patient care as a professional nurse without hesitation
    1) Not at all certain
    2) Certain for only a few nursing tasks
    3) Fairly certain for a good number of nursing tasks
    4) Certain for almost all nursing tasks
    5) Absolutely certain for all nursing tasks

3. My performance as a registered professional nurse (RN) would convince an observer(s) that I'm competent to deliver safe care to patients.
    1) Not at all certain
    2) Certain for only a few nursing tasks
    3) Fairly certain for a good number of nursing tasks
    4) Certain for almost all nursing tasks
    5) Absolutely certain for all nursing tasks

4. I feel sure of myself as I perform nursing role tasks that ensure safe, competent patient care.
    1) Not at all certain
    2) Certain for only a few nursing tasks
    3) Fairly certain for a good number of nursing tasks
    4) Certain for almost all nursing tasks
    5) Absolutely certain for all nursing tasks

5. I feel satisfied with my performance as a registered professional nurse (RN) to deliver safe, competent patient care.
    1) Not at all certain
    2) Certain for only a few nursing tasks
    3) Fairly certain for a good number of nursing tasks
    4) Certain for almost all nursing tasks
    5) Absolutely certain for all nursing tasks

APPENDIX F

PERMISSION TO USE THE LIFE EXPERIENCE SURVEY, MARGIN IN LIFE

SCALE, AND CONFIDENCE SCALE

Accession Number : ADA027527

Title : The Life Experiences Survey: Preliminary Findings

Descriptive Note : Technical rept.

Corporate Author : WASHINGTON UNIV SEATTLE DEPT OF PSYCHOLOGY

Personal Author(s) : Sarason, Irwin G. ; Johnson, James H.

PDF Url : ADA027527

Report Date : 01 MAY 1976

Pagination or Media Count : 35

Abstract : This report describes the development of a measure of life changes, the Life Experiences Survey; and preliminary data related to this assessment instrument are presented. The RES is a 57 item scale that lists numerous events which individuals may experience and call for social readjustment. Subjects are asked to indicate events which they have experienced during the previous year and whether these events were perceived as positive or negative. Additionally, subjects are asked to rate on a 7-point scale the degree of impact these events have on their lives. From these responses it is possible to derive three life change scores: positive, negative, and total. This scale may be contrasted with earlier measures of life stress which failed to distinguish between positive and negative change and did not allow for individualized ratings of desirability of events and degrees of impact.

Descriptors : *STRESS(PSYCHOLOGY), *LIFE SCIENCES, MEASUREMENT, IMPACT, SURVEYS, HYPOTHESES, PERCEPTION(PSYCHOLOGY), ADJUSTMENT(PSYCHOLOGY), CHANGE DETECTION.

Subject Categories : PSYCHOLOGY

Distribution Statement : APPROVED FOR PUBLIC RELEASE

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Licensed content author	JOANNE STEVENSON
Licensed content date	Jan 1, 1982
Volume Number	31
Issue Number	4
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APPENDIX G

RESEARCH QUESTIONS AND HYPOTHESES INFO DATA SHEET

RESEARCH QUESTIONS AND HYPOTHESES INFO DATA SHEET

Research Question	Research Hypotheses	Instrument	Statistical Test
1-Is there a relationship between the nature of transition variable (perceived total life experience scores) and transitional conditions (margin in life composite score for health/body, inter-dependence/ connectedness, self-concept, parenting satisfaction, and religiosity/spirituality) among RNs enrolled in a Refresher Program?	H1. There will be a correlation between the nature of transition's predictor variable of perceived total life experiences and transitional condition's margin in life composite score for health/ body, inter-dependence/ connectedness, self-concept, parenting satisfaction, and religiosity/ spirituality, among RNs enrolled in a Refresher Program.	Life Experience Scale (LES) (Sarason, Johnson, & Siegel, 1978) Margin in Life (MIL) (Stevenson, 1982)	The research hypothesis was not supported. This hypothesis was tested by two-tailed Pearson product moment correlation. The correlation coefficient was not significant, $r= .24$, $p> .05$, indicating there was no correlation between the two variables.
2-Is there a relationship between transition condition variables (health, interconnectedness, self-concept, parenting, and religion) and the pattern of response (professional role confidence) among RNs enrolled in a Refresher Program?	H2. There will be a correlation between transition condition predictor variables of health/ body, inter-dependence/ connectedness, self-concept, parenting satisfaction, and religiosity/spirituality and the outcome criterion of pattern of response of professional role confidence, among RNs enrolled in a Refresher Program.	Margin in Life (MIL) (Stevenson, 1982) Confidence Scale (C-Scale) (Grundy, 1993)	The hypothesis was not supported. Regression analysis found that 31.0% ($R^2 = .310$, adj $R^2 = .12$) of the variance was explained by the model but the model was not significant, $F (5,18) = 1.62$,

			p = .21. Examination of the beta weights reveals that none of the predictor variables contributed to the model.
3-Is there a difference between the mean scores for pattern of response (professional role confidence, measured pre and post therapeutic intervention of a refresher program) among RNs enrolled in a refresher program?	H3. There will be a significant difference between the mean scores for pattern of response of professional role confidence, measured pre and post therapeutic intervention of a refresher program, among RNs enrolled in a refresher program.	Confidence Scale pre program Confidence Scale post program (Grundy, 1993)	The hypothesis was supported. A dependent *t* test found on average that participants experienced a significantly greater professional role confidence following the RN Refresher Program (M=18.90, SE= .47) than they did prior to the program (M= 14.21, SE= .50), *t(94)=* -11.09, *p*= .000, and the effect size was large, *r*= .75

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PUBLICATIONS

Lavandera, R., Whalen, D., Perkel, L., **Hackett, V**., Molnar, D., Steffey, C., Hershorin, I., Rafalko, S., Little, D., & Harris, J. (2011). Value-Added of HESI Exam as a Predictor of Timely First-Time RN Licensure. *International Journal of Nursing Education Scholarship*, *8*(1), Article 18. doi: 10.2202/1548-923X.2152