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Organizational socialization: Optimizing experienced nurses' onboarding

By Cheryl A. Smith-Miller, PhD, MEd, RN-BC; Carla Jones, DNP, MSN,
RN, NE-BC; and Tamara Blakeney, MPS, BA



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RNs comprise the largest group of healthcare providers in hospital settings, and they may change positions many times over the course of their careers. Despite an estimated 27.1% turnover rate in 2021, the onboarding of experienced clinical nurses (ERNs) in hospital settings remains understudied.¹⁻³

Although it's difficult to quantify how frequently ERNs change positions, and the highest turnover rates (greater than 30%) have historically occurred among newly licensed RNs (NLRNs), the COVID-19 pandemic has contributed to unprecedented turnover among ERNs.^{3,4} This shift represents a loss of clinical knowledge and expertise that's negatively impacting organizations, patient care, and workplace teams.^{2,5} In response to the voluntary turnover among existing staff, hospitals have instituted a variety of retention strategies, but the impact of the onboarding process on retention remains largely overlooked.^{6,7}

The term *orientation* is often used to describe the initial education and training of new staff members upon hire. However, the term *onboarding*, as defined by Bauer and Erdogan, is used in this work to capture the intricate socialization processes that occur as individuals develop the "attitudes, knowledge, skills, and behaviors required to function effectively within an organization" (see *Figure 1*).^{7,8} In addition, the authors herein use the term *nursing professional development practitioner* (NPDP) to refer to master's-prepared nurses whose primary responsibility is nursing professional development and education in practice settings,

although the authors acknowledge that this position title can vary (for example, clinical nurse education specialist or professional development educator).⁹

Nurses are required to participate in some degree of orientation when entering a new organization or transferring to a new work unit. NPDPs understand the impact of onboarding on retention, job satisfaction, and performance and have a fundamental role in this process.^{2,4,9,10} Indeed, it was the preponderance of evidence regarding the significance of professional socialization and onboarding on NLRN retention that motivated many hospitals to initiate year-long professional residency programs.¹¹⁻¹⁴ In contrast, the onboarding process for non-NLRNs (such as ERNs) is abbreviated and seldom explored, so there's limited evidence available on how to effectively address the needs of this group.^{2,15} Therefore, the purpose of this study was to examine the onboarding experiences of a cohort of ERNs (with at least 1 year of experience), identify their onboarding needs, and make recommendations based on these findings using an organizational socialization framework.

Methods

Sample

Researchers at an academic, Level I trauma center in the southeastern US collected data using a cross-sectional survey. Prior to the start of any study activities, the University Office of Human Research Ethics deemed the study exempt from further human subject review.

Nurses who transferred into a new unit (internal transfer) or

were hired from outside (external hire) were eligible to participate. Inclusion criteria were at least 1 year of professional nursing experience (to identify RNs already socialized to the norms of professional nursing) and 3 to 7 months from the RNs' start date, or date of entry (to reduce the potential of positive response bias that can occur within the first few months of employment, also known as the honeymoon phase).¹⁶

Data collection

A literature search found that most survey instruments focused on NLRNs' experience, program assessment, or transitions into specialty practice settings.¹⁷⁻²⁰ Consequently, the research team used these findings to tailor items specific to ERNs to meet the study goals.¹⁹⁻²¹ Cognitive interviews were conducted among four expert nurses to review and assess the conceptual similarity, accuracy, and clarity of the items (see *Table 1*). A four-item Likert-type response scale (from 1 = strongly disagree to 4 = strongly agree) was used for survey items.²² Open-ended items (such as *what made your transition easier/more difficult*) were included to elicit specific examples from respondents and allow additional constructs to be introduced.

Researchers retrieved nursing employment lists from May to October 2021 and filtered them by position to identify RNs with one or more year(s) of experience (Clinical Nurse II level and above). The list was reviewed for accuracy, and anyone who had been inadvertently included (such as an NLRN) was removed. The survey link was embedded in an invitation to participate and emailed to the

final list of 489 ERNs. A reminder to participate was sent at the end of week 1 and the beginning of week 3. Participation was voluntary, responses were confidential, and recipients could opt out from

receiving reminders. The survey was open for 3 weeks and closed January 31, 2022.

A total of 136 survey responses were received and reviewed. Prior to analysis, researchers

deleted 24 responses that had more than three missing answers. The remaining 112 surveys were retained, representing a 23% response rate from the target population of 489.

Table 1: Survey results (N = 104-112^{a-e})

Item	Strongly agree (4) n (%)	Agree (3) n (%)	Disagree (2) n (%)	Strongly disagree (1) n (%)	SD	Mean
1. I am satisfied with my decision to work on this unit. ^a	47 (44)	49 (46)	5 (5)	5 (5)	.77	3.3
2. I feel confident communicating with the other healthcare providers (MDs, PAs, etc.). ^b	48 (44)	59 (54)	3 (3)	0 (0)	.55	3.4
3. I feel comfortable communicating with patients and their families.	64 (57)	48 (43)	0 (0)	0 (0)	.50	3.6
4. I am comfortable delegating tasks to clinical support technicians and/or nursing assistants.	48 (43)	60 (54)	4 (4)	0 (0)	.56	3.4
5. Preceptors provided helpful feedback throughout my orientation. ^a	45 (43)	52 (49)	6 (6)	3 (3)	.71	3.3
6. My precepting experience helped my transition into my role on this unit. ^c	46 (44)	44 (42)	10 (10)	4 (4)	.54	3.3
7. I am confident in my ability to problem solve in relation to patient care.	57 (51)	53 (47)	2 (2)	0 (0)	.54	3.5
8. My specialty practice orientation (e.g., Oncology Core, Psychiatric Core) helped in my transition. ^d	38 (37)	55 (54)	7 (7)	2 (2)	.54	3.5
9. My progress toward meeting orientation goals was sufficiently discussed. ^e	35 (32)	53 (49)	17 (16)	4 (4)	.79	3.1
10. I am comfortable asking for help.	66 (59)	43 (38)	3 (3)	0 (0)	.55	3.6
11. I am aware of how EBP (evidence-based practice) guides patient care on this unit. ^f	47 (42)	57 (51)	5 (5)	2 (2)	.65	3.4
12. I am comfortable participating in interdisciplinary team rounds.	49 (44)	58 (52)	3 (3)	2 (2)	.63	3.4
13. I am able to recognize changes in patients' conditions. ^b	66 (65)	44 (44)	0 (0)	0 (0)	.55	3.6
14. I am comfortable communicating with team members in other departments (e.g., transportation, radiology).	59 (53)	52 (46)	1 (1)	0 (0)	.52	3.5
15. I am comfortable taking action to solve problems.	66 (59)	44 (39)	2 (2)	0 (0)	.53	3.6
16. I am confident in identifying safety risks.	111 (99)	1 (1)	0 (0)	0 (0)	.10	4.0

Note: Percentages and means are rounded to nearest percent.

^a106 responses; ^b110 responses; ^c104 responses; ^d102 responses; ^e109 responses; ^f111 responses

Key: MD, doctor of medicine; PA, physician assistant

Analysis

Survey responses were imported into SPSS Statistics 28 and scrutinized for missing data. Standard descriptive and exploratory factor analysis (EFA) was performed to determine the number of domains represented. Comparisons were made using a binomial and Fisher's exact test to explore differences in ERNs' tendency to remain within the same specialty or acuity level.

Narrative responses were imported into NVivo 11 for data management, coding, and analysis. Any proper nouns were replaced with pseudonyms. Matrix analysis was used to discern patterns of similarities and differences (positive/negative), explore their relationship with components

Box 1: Detailed and advanced statistical analytics methodology

The Kaiser-Meyer-Olkin Measure (0.85) and Bartlett's Test of sphericity ($P < .00$) results indicated sample size was sufficient for EFA. The number of factors to rotate was based on scree test results, the number of eigenvalues greater than 1.0, and the hypothesis that the measure was multidimensional. Due to the sample size of fewer than 150 responses, the dimensionality of the 16 items was analyzed using principal axis factor analysis with a direct oblimin rotation (see *Table 2*).²⁵ The three-factor solution demonstrated a 71% cumulative proportion of the total common variance with factor correlations of .56 (Factor 1:3), .40 (Factor 1:3), and .44 (Factor 2:3) representing relationships among the factors but avoiding redundancy. All items loaded >0.40 except for Item 16, which indicates that a larger sample size or editing this item in future work may achieve greater specificity and/or better distinguish domain membership.

than 0.30 were observed with none exceeding 0.80, indicating no redundancy among two or more items (measuring the same thing).²⁴ See *Box 1* for additional information.

Descriptive statistical procedures were performed and are listed in *Table 1*. A response

Unit Socialization (Items 1, 5, 6, 9, 16), and Organizational Socialization (Items 11, 12) as shown in *Table 2*. The scores and overall means indicate ERNs have confidence in their clinical abilities and experienced positive unit and organizational onboarding experiences (see *Table 1*).



Empirical data revealed that more than 80% of respondents received adequate feedback regarding their progress toward orientation goals; narrative responses provided insights regarding the preferred form and context.

within the organizational socialization framework, and facilitate a more complete and contextual understanding of ERNs' onboarding experience.²³

Results

Results of the narrative data are presented in conjunction with quantitative findings to provide context and depth for a more complete understanding of ERNs' onboarding experience.

Scale psychometrics. Data were screened for appropriateness of factorability. Correlations between individual items greater

wasn't required for each survey item, which resulted in differences in the number of responses received on some items. Random missing responses were replaced by multiple imputation, which is less biased than replacing missing data with simpler methods, such as mean or median. The internal consistency of scale items resulted in a Cronbach $\alpha = 0.93$, which is considered excellent.

Survey responses. Survey items were categorized into three domains: Clinical Self-Efficacy (Items 2, 3, 4, 7, 8, 10, 13, 14, 15),

It's noteworthy that 10% of Item 1 respondents ($n = 10$) were dissatisfied with their decision to work on their current unit. Most respondents thought specialty practice orientation helped their transition (Item 8), but this item had the lowest number of responses ($n = 102$). The lowest mean score ($M = 3.1$) was observed for Item 9, with 20% ($n = 20$) reporting insufficient discussion about progress toward meeting orientation goals.

Empirical findings are presented in greater detail within an organizational socialization

framework (see *Figure 1*) in the sections that follow. The alignment of exemplars of narrative responses within organizational socialization components is illustrated in *Table 3*. These data are also included in the sections below to add context and additional information.

New employee characteristics

Participant demographics appear in *Table 4*. Comparisons between previous and current work settings were computed.

The results of a binomial test ($P < 2.2e-16$) indicated that, regardless of educational background, ERNs tend to enter work settings or specialty areas (acute to outpatient) that differ from their previous position. Diploma-trained ERNs may be more likely to remain in a similar setting, but no conclusion could be made due to their small sample size ($n = 4$).

There was a slightly higher correlation [$r(76) = 0.69, P \leq .00$] between previous and current

work settings among external hires compared with internal transfers [$r(36) = 0.47, P \leq .00$], but the Fisher's exact test comparing the tendency to switch showed no statistically significant difference. Years of experience and duration of precepting (period a new hire is paired with a staff member) differed slightly between external hires and internal transfers, but the difference was statistically insignificant. There were no negative comments about precepting duration,

Table 2: Experienced nurses' onboarding survey domains (N = 112)

Item	Survey domains		
	Clinical Self-Efficacy 1	Unit Socialization 2	Organizational Socialization 3
1. I am satisfied with my decision to work on this unit.		.55	
2. I feel confident communicating with the other healthcare providers (MDs, PAs, etc.).	.47		
3. I feel comfortable communicating with patients and their families.	.83		
4. I am comfortable delegating tasks to clinical support technicians (CSTs) and/or nursing assistants.	.62		
5. Preceptors provided helpful feedback throughout my orientation.		.95	
6. My precepting experience helped my transition into my role on this unit.		.83	
7. I am confident in my ability to problem solve in relation to patient care.	.79		
8. My specialty practice orientation (e.g., Oncology Core, Odyssey, Psychiatric Core) helped in my transition.	.31		
9. My progress toward meeting orientation goals was sufficiently discussed.		.63	
10. I am comfortable asking for help.	.67		
11. I am aware of how EBP (evidence-based practice) guides patient care on this unit.			.54
12. I am comfortable participating in interdisciplinary team rounds.			.87
13. I am able to recognize changes in patients' conditions.	.59		
14. I am comfortable communicating with team members in other departments (e.g., transportation, radiology).	.71		
15. I am comfortable taking action to solve problems.	.92		
16. I am confident identifying safety risks.		.36	

Note: Extraction method: Principal axis factoring direct oblimin rotation. SPSS results pooled over five imputed data sets. Key: MD, doctor of medicine; PA, physician assistant

Table 3: Experienced nurses' onboarding: Exemplar text and alignment with selected constructs within the summary process model of organizational socialization^a

Exemplar text		Construct	Socialization domain
Negative	Positive		
Not enough time to learn unit work-flow and policies	Helpful guidance from preceptors	Information seeking	New employee behaviors
Lack of guidance, training, feedback, or regular communication	Frequent check-ins with management	Feedback seeking	
I was never included in staff emails.	Clinic D ^a has a "team" mindset, and everyone was clear that I was part of that team and could ask for help.	Relationship building	
Not knowing EMR, unit rules, guidelines, and charting procedures	Clearly defined expectations for each week of orientation	Formal orientations	Organizational efforts
Cliques	Staff are nice and easy to approach	Organizational insiders	
	My past psychiatric nursing experience	Role clarity	Adjustment
Feeling like I was a brand-new nurse again	Already knowing moderate sedation from a previous job	Self-efficacy	
There is no team mindset in the . . . unit.	Competent, caring, and patient preceptors	Acceptance by organizational insiders	
Not familiar with the outpatient world	Staff was very helpful and our CN4 and educators were very present and approachable.	Knowledge of organizational/unit culture	
The vast array of staff and teams; not knowing how this company worked			
Table 1, Item 1. 10% dissatisfied	Table 1, Item 1. 90% satisfied	Satisfaction	Outcomes

^aProper names and references to specific units are pseudonyms.
 Note: Exemplar text may represent domains in addition to those above.
 Key: EMR, electronic medical record; CN, clinical nurse

but respondents complained about having multiple preceptors and disorganized precepting experiences (for example, "It was like beginning all over every shift.").

New employee behaviors

Feedback seeking. Empirical data revealed that more than 80% of respondents (n = 88; Item 9) received adequate feedback regarding their progress toward orientation goals; narrative responses provided insights regarding the preferred form and context. Some respondents

viewed check-ins through email or hallway conversations with nurse managers (NMs) as inadequate, interpreting them as a lack of caring. A minority of respondents didn't receive regular feedback; those respondents felt undervalued and that their orientation was disorganized. Despite the key role of preceptors in onboarding, many respondents expressed a desire for increased NM involvement. One participant conveyed appreciation for the way her NM intervened to address bullying behavior, which she

viewed as demonstrating support and communicating clear behavioral expectations.

Information seeking. Inconsistent or conflicting information from preceptors and coworkers about policies and documentation standards "made it [the transition] more difficult and stressful," which contributed to many respondents proposing that NPDPs provide education on these topics. They also wanted unit-specific information, such as "frequently called numbers" and a "unit orientation book

with a few important policies," as a resource because this information would allow more independent practice.

Despite the low response rate to Item 8, narrative comments indicated that the value of specialized educational activities

depended on their timing and utility. When provided weeks or months after it was needed, it was viewed as a waste of time. Nurses also felt their preexisting knowledge and experience were discounted when they were required to complete training on topics with which they were already familiar.

Table 4: Demographics, internal transfer and external hire

	Internal transfer (32%; n = 36) n (%)	External hire (68%; n = 76) n (%)
Education		
Diploma	1 (3)	3 (4)
Associate degree	6 (17)	11 (15)
Bachelor of Science Nursing	25 (70)	55 (73)
Master of Science Nursing	4 (11)	7 (9)
Position		
Clinical Nurse II (≥1 year experience)	28 (78)	73 (96)
Clinical Nurse III	3 (8)	1 (1)
Clinical Nurse IV	3 (8)	1 (1)
Other	2 (3)	1 (1)
Clinical precepting duration		
Median	4 weeks	4 weeks
Mean	4 weeks	5 weeks
Years of experience		
Median	12 years	7 years
Mean	11 years	11 years
Current care/work setting		
Acute	6 (17)	18 (24)
Critical	5 (14)	15 (20)
Intermediate	2 (6)	5 (7)
Outpatient/ambulatory	15 (42)	10 (13)
Perioperative	4 (11)	14 (18)
Psychiatry	1 (3)	7 (9)
Other	1 (3)	7 (9)
Previous care/work setting		
Acute	11 (31)	22 (29)
Critical	3 (8)	16 (21)
Intermediate	4 (11)	2 (3)
Outpatient/ambulatory	13 (36)	10 (13)
Perioperative	1 (3)	11 (15)
Psychiatry	1 (3)	4 (5)
Other	3 (8)	11 (15)

Organizational efforts

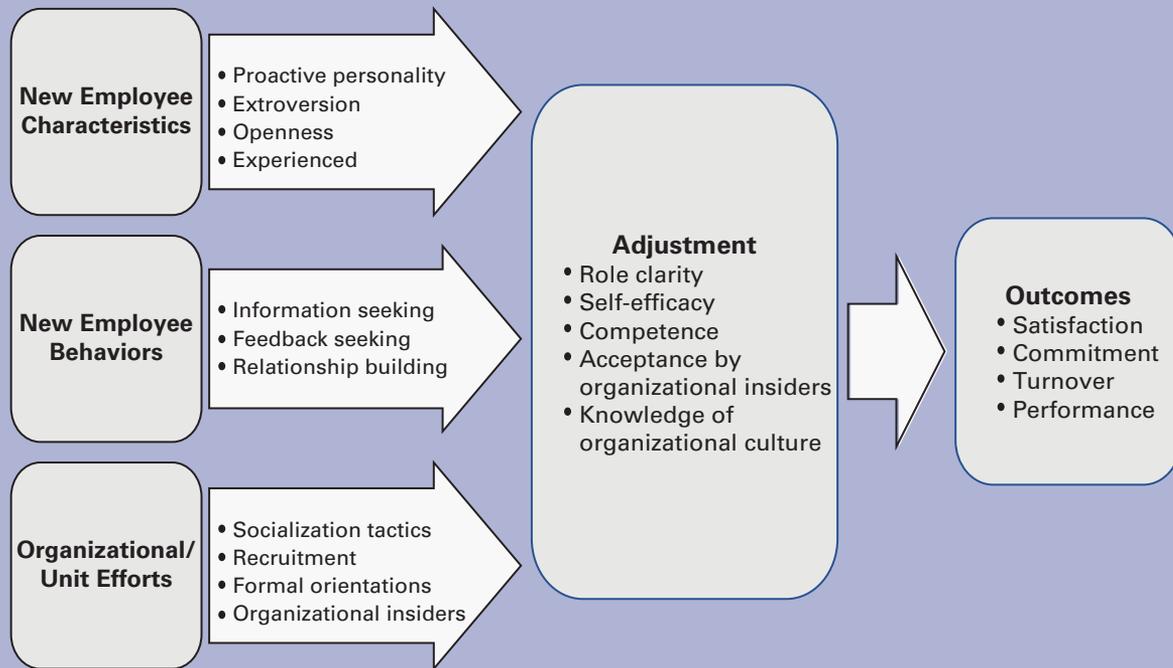
Two survey items (11 and 12) capture aspects of Organizational Socialization as illustrated in Table 2. Most respondents were aware of how evidence informed patient care on their unit (see Table 1, Item 11). The specificity of this item suggests that this particular topic was included in the onboarding process. Furthermore, most respondents were comfortable participating in interdisciplinary rounds (see Table 1, Item 12), which serve as a structured forum for a patient's care team (such as the nurse, physician, and respiratory therapist) to collaborate and plan care. These results could indicate that teammates modeled behaviors and socialization.

Formal orientations. Respondents want orientation plans that assess their skills competency in their new practice setting, with new patient populations, or both. The desire to meet performance goals and monitor their own progress was evident in requests for clearly delineated expectations, timelines, and regular face-to-face meetings with their NM.

Transition

Self-efficacy/role clarity. The quantitative responses (see Table 1) indicate that a majority

Figure 1: Bauer and Erdogan's summary process model of socialization



Modified from Bauer TN, Erdogan B. Organizational socialization: the effective onboarding of new employees. In: Zedeck S, ed. *APA Handbook of Industrial and Organizational Psychology, Volume 3: Maintaining, Expanding, and Contracting the Organization*. Washington, DC: American Psychological Association; 2011: 51-64.

of respondents were confident in their clinical abilities, but the competence and knowledge of coworkers were also important: "I had consistent preceptors who had been on the unit for a long time and were able to answer any questions." This observation illustrates the need and benefit of having experienced staff who are willing and qualified to precept new staff members.

Overall, preceptors assisted in ERNs' transition; as one respondent described: "Having kind preceptors helped with transition." However, inadequate staffing and a lack of experienced staff negatively impacted onboarding; for example: "Having full staffing so that questions could be answered without nurses

feeling pressed for time." and "More supportive orientation with properly trained and experienced preceptors." These differences were also reflected in Item 6 (precepting experience) and Item 9 (progress toward goals) variances. Although both explored Unit Socialization, the large standard deviations suggest variability in precepting experiences (see *Table 2*).

Outcomes

Satisfaction. Satisfaction is considered an outcome in the organizational socialization model.⁷ Although only Item 1 (see *Table 1*) specifically assessed satisfaction, narrative data provided examples of both satisfaction and dissatisfaction as shown in the exemplar text in *Table 3*.

Limitations

In generalizing the results of this study, several limitations should be considered. Respondents may have been limited to those who had very positive or negative onboarding experiences, which may have biased the findings. The sample size was small for evaluating the psychometric properties of the survey instrument, and the experiences of ERNs at one academic medical center in the US may not apply to organizations in other countries or nurses in other settings. A larger data set and distribution to other entities is needed to adequately evaluate instrument psychometrics.

Discussion

This descriptive study used survey methods to examine ERNs'

onboarding experiences and frame the findings within organizational socialization domains.^{7,17} Demographic, quantitative, and narrative data were collected and analyzed from a cohort of 112 ERNs. The sections below are organized within relevant organizational socialization domains (see *Figure 1*).

New employee characteristics. Respondents expressed a high level of confidence in their clinical abilities (see *Table 1*) but identified additional learning needs. Although ERNs are confident in their practice, it's well established that confidence level isn't equivalent to knowledge.²⁶

demonstrated information-seeking as well as recognizing: 1) the legal and professional obligation to follow institutional protocols; and 2) NPDPs as trusted sources.

Specialty education is resource-intensive, requiring classroom space and participants', content experts', and NPDPs' time and effort. High patient acuity environments, such as ICUs, EDs, and similar settings, have always required additional training (such as airway management and cardiac rhythm interpretation) and although Item 8 (see *Table 1*) was excluded from statistical analysis, narrative data indicated that specialty education

onstrated that more frequent emergency response skills training resulted in increased competency, the definition of "low volume-high risk" can vary, as exemplified by Banks and colleagues' study on central venous access device care at a rural hospital.^{30,31} Therefore, prioritizing comprehensive and targeted training for ERNs on unit-specific competencies not only potentially enhances their ability to meet the unique demands and requirements of their respective units but offers an opportunity for valuable collaboration between NPDPs and clinical units.



Previous experience often guides the education and skills training that ERNs receive upon entry, but reported experience may not accurately reflect an individual's level of expertise, particularly for low-volume, high-risk procedures.

Assessing ERNs' knowledge and skills enables NPDPs to strategically address learning needs, credit ERNs for existing knowledge, eliminate redundancy, and reduce training costs.^{27,28}

New employee behaviors. Organizational socialization constructs were evident in respondents' desire to acquire the knowledge, skills, and behaviors to be successful, contributing team members.⁷ ERNs' desire for regular performance reviews showed feedback-seeking and may also reflect ERNs' understanding of NMs' role in evaluation and its significance during the probationary period. Suggestions for NPDPs to teach standards and policy information

was helpful in ERNs' transition. However, it was also noted that training/skills practice was most useful when provided in a timely manner, not after *learning by doing* on the clinical unit. These findings align with adult learning principles wherein individuals' readiness, desire, and need to learn can be leveraged to contribute to increased self-confidence and job satisfaction.²⁹

Previous experience often guides the education and skills training that ERNs receive upon entry, but reported experience may not accurately reflect an individual's level of expertise, particularly for low-volume, high-risk procedures. Although Ciurzynski and colleagues dem-

The number of "not applicable" text responses to Item 8, "specialty practice orientation" (see *Table 1*) indicates that respondents either possessed the necessary knowledge and didn't require further training, or the training wasn't provided. Although academic programs provide a foundation in medical-surgical nursing, specialized education is crucial when ERNs transition into an unfamiliar practice setting or when they're required to care for a patient population with whom they have limited or no prior experience.³²

A lack of prior experience in an academic medical center also may have informed the number of respondents who reported

being uncomfortable with (or unaccustomed to) communicating with other care team members (see *Table 1*; Items 2, 4, 12). Durbin and colleagues noted similar differences regarding communication and collaboration when comparing a hospital with an established physician residency program and a hospital with a new program.³³ These results are concerning given the significance of these skills and interactions in patient care.¹⁰ Consequently, preceptors should be well prepared to assess the comfort level of ERNs in interdisciplinary communications, effectively address role expectations in this regard, and actively coach ERNs on effective communication behaviors.

Nursing professional development and education is a recognized nursing specialty within the nursing profession, but there's often minimal investment in ongoing training and education for the clinical nurses who are responsible for precepting: a limitation that can hinder efforts to provide high-quality onboarding experiences at the unit level.⁹ Respondents' comments highlighting conflicting policies and standards information serve as examples of the challenges that clinical nurses encounter as they strive to fulfill the expectations and obligations of the preceptor role, which include teaching, coaching, and evaluating competency. Wallander Karlsen and colleagues detail the complexities of precepting in critical care settings, but the same stressors are present in any clinical environment where precepting occurs simultaneously with meeting the

demands of direct patient care.¹⁰ The current staffing shortage has exacerbated the situation, as nurses are asked to precept new staff more frequently, but there are fewer experienced staff members available to serve as preceptors.²⁷

Transition. Positive precepting experiences were reported in the narrative data, but the related survey responses had higher standard deviations compared with other items, indicating a wider variation in participant experiences (see *Table 1*). Although these experiences can be affected by many factors (such as the number of new staff hired at one time and current staffing), variations in precepting can be mitigated by developing formal processes and training. For example, instituting preceptor-dependent performance goals for onboarded nurses could be used to inform preceptor education and serve as reward criteria.

Implications for nurse leaders

Onboarding plays a fundamental role in unit functioning, and a wealth of evidence exists regarding the influence of nurse leader engagement on RN retention and satisfaction.³⁵ However, as the findings herein reflect, NMs are challenged to find sufficient time for staff interaction because of competing operational and administrative responsibilities.^{35,36} According to Gleason, 45% of NM respondents had inadequate time to interact with staff.³⁷ Furthermore, as evidenced by Jackson and Nowell, demands on NMs only worsened during the pandemic as the scope of their responsibilities increased.³⁸ Given the plethora of evidence about

the influence of leaders' engagement on retention and satisfaction, nurse executives should assess NMs' responsibilities and their impact on NMs' engagement with staff.

Mismatches between employees and their work unit can be due to myriad factors (such as personality, unit culture, and patient population) and was evident among ERNs who expressed dissatisfaction with their decision to work on their hiring unit (see *Table 1*, Item 1). This finding underscores the significance of assessing ERNs' satisfaction to evaluate fit within the unit and identify those who may be at risk for leaving. Additionally, it emphasizes the need to offer transfer opportunities when necessary to retain valuable nursing staff. Assessing satisfaction isn't only warranted due to its impact on work performance and unit culture, but it's essential for proactively addressing and mitigating dissatisfaction. Increased NPDP involvement in the unit onboarding process can be particularly beneficial for hiring units with high turnover rates, novice nurse leaders, or those lacking experienced staff.^{2,34}

The findings presented in this study highlight the congruence between ERNs' onboarding experiences and organizational socialization components.^{7,8} Successful onboarding requires dedicated time from NMs, clinical nurses, and NPDPs. However, other responsibilities can limit the amount of time available for staff engagement. Amid competing demands, administrative duties are often prioritized over staff needs even though greater engagement is linked to reduced

turnover rates and increased job satisfaction.

Clinical nurses who serve as preceptors require ongoing education, training, and incentives. Preceptorship programs should incorporate formal evaluations with performance outcomes as a basis for providing rewards. Expanding the role of NPDPs in standardizing and customizing unit onboarding and in ERNs' education and skills training could reduce redundancy, improve quality, enhance learning and performance, and promote patient safety. Optimizing ERNs' onboarding experiences requires organizational and nurse leader investment and support to achieve retention, job satisfaction, and performance goals. **NM**

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In Chapel Hill, N.C., Cheryl A. Smith-Miller is a nurse scientist at the Center for Nursing Excellence, UNC Medical Center and an IRB chair at the Office of Human Research Ethics, University of North Carolina at Chapel Hill; Carla Jones is a patient services manager at UNC Health; and Tamara Blakeney is senior business intelligence analyst at the Center for Nursing Excellence, UNC Medical Center.

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