ORIGINAL ARTICLE

Rethinking Perianesthesia Orientation

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Purpose: *To discover the best orientation method for perianesthesia nurses.*
Design: *Pilot study comparing two approaches to orientation.*
Methods: *Nurses in one group were each assigned to a single preceptor, whom they followed regardless of which of the three distinct areas—the preoperative unit, postanesthesia recovery unit, or Phase II discharge unit—the preceptor was scheduled to work. In the second group, trainees remained in one area, with various preceptors, until proficiency was achieved. All trainees (n = 25) were surveyed.*
Finding: *New registered nurses in the perianesthesia department prefer to remain in a single area until competency is achieved.*
Conclusions: *Perianesthesia nursing has a distinct body of knowledge. Although conventional wisdom suggests that using a single preceptor for nursing orientation leads to better outcomes, our study indicates that allowing orientees to remain in one area until a level of competency is achieved may be more effective.*

Keywords: *orientation, preceptor, competency.*

CONVENTIONAL WISDOM FOR orientation practices suggests that maintaining consistency of preceptor is of great importance.[1] In the perianesthesia area, this practice is complicated by the need to cross-train among the different practice areas. Perianesthesia units generally comprise three distinct patient care areas—preoperative unit, postanesthesia recovery unit, and Phase II discharge unit—and orientation programs require a different approach and focus to patient care in each area. Furthermore, perianesthesia nurses transition through the different areas on a routine basis, thus maintaining proficiency in each distinct area of patient care. Because the experienced nurses are routinely working in different areas, maintaining a consistent approach to new nurse orientation is challenging.

In general, nurses hired into the perianesthesia department will be required to work in all three units. Because each unit is very different, the orientation process must allow for ample time in each area. However, preceptors may work in a different unit each day of the week, thus allowing for consistency of preceptor may detract from the ability of the orientee to develop a basic level of proficiency in any one area before moving to another. Further complicating the orientation process is the number of different shifts used to staff this area. The various areas are generally staffed from 5:30 AM to 11:30 PM daily, with more than 15 different shift options. As such, finding a balance between assigning a consistent preceptor, achieving competency in each area, and meeting the needs of the orientee

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can be a monumental task. Recognizing that orientation to a new unit and new nursing role is a vital component to staff satisfaction, retention, and patient safety,[2] the educational staff of one perianesthesia unit examined different modalities of orientation in an attempt to find the most appropriate method.

Literature Review

There is a paucity of research related to the unique orientation needs of the perianesthesia unit. As a result, we reviewed the literature related to general nursing orientation.

Traditional nursing orientation typically involves one or two preceptors and an orientee. The orientee follows the preceptor's schedule for a set amount of time, weeks to months, depending on the type of unit. Most nursing units use standard scheduling practices (day, evening, and night) and comprise a single patient care area. In general, in these areas, the preceptor/orientee dyad is very stable, with little need to switch between preceptors. Thus, the orientee and preceptor build a relationship, and the preceptor is aware of the experiences the orientee has had and those still needed. Furthermore, in this stable dyad, the preceptor is cognizant of the orientee's strengths and areas for improvement and can create a plan to address any deficiencies. Generally, there may be a weekly meeting with the educator or unit manager, but otherwise the preceptor maintains responsibility for the orientation process.

Poor preceptorships can be the catalyst for issues within a unit. For instance, the cost of orienting a new employee can be astronomical. Providing an unsatisfactory orientation can influence turnover among nurses. The quality of orientation is directly related to the new employee's work performance and job satisfaction.[2] Therefore, a quality orientation process can be quite valuable, and it is imperative to continue to investigate best practice options for orientation.

Chesnutt and Everhart[3] investigated the use of a communication tool to address problems created by having multiple preceptors. Without complete and appropriate communication, the orientee can feel as if he or she is restarting orientation each day. To ensure an efficient and successful orientation, the preceptor must be aware of the orientee's prior experiences, expectations, and limitations. Chesnutt and Everhart proposed that a uniform communication tool could alleviate some of these issues. However, when implemented in a critical care environment, they found that the tool was used inconsistently and therefore was not effective in facilitating the orientation process. Instead, they suggested that the orientation team should have routine scheduled meetings to discuss the progress of the orientee.[3]

Zawaduk et al[4] identified that the traditional consistent preceptor-student-educator triad tends to no longer be feasible. As preceptors work different shifts and have additional responsibilities, the unit educator may be the single constant in the orientation model. They suggested that continuity of unit and educator may be important factors in the success of the orientation process. They identified that repetition of skills and processes on a single unit allows for mastery of skills.[4] This may be of particular importance when considering orientation in a multiarea unit such as perianesthesia care.

Several studies have investigated the benefits and limitations of having multiple preceptors vs a single preceptor. Positive attributes to having multiple preceptors include wide exposure to different nursing styles, skills, knowledge, and background.[1,5] In a study of preceptor continuity, Smith and Chalker[6] found that multiple preceptors led to an increased sense of having numerous resources to access for problem solving and questions. They found that having the same preceptor increased the graduate's confidence in caring for a group of patients and created a sense of confidence related to decision making and skill development.[6] Haggerty et al[5] also found mixed results when comparing the effects of single vs multiple preceptors. Some new graduates noted it to be very challenging to have multiple preceptors, whereas others felt that being exposed to a variety preceptor styles of nursing practice was a positive experience. They noted that the most important factor may be finding appropriate matches between orientee learning style and personality with preceptor assignment.[5] Likewise, Lampe et al[7] theorized that orientee role stress and orientation success may be mitigated by matching communication style, technology expertise, and learning priorities between orientation and preceptor.